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Managing population at the end of the 1980s: the construction of health promotion and disease prevention as an expression of a neoliberal rationality

A critical discourse analysis of White Paper no. 41, 1987-88 *Health Policy Toward the Year 2000. National Health Plan*

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"If the unknown principle that forms the character and the mind is the outcome of the climate, the regime, the custom, and the habit of certain actions, we can say that sovereigns, by wise laws, by useful establishments, through the inconvenience of taxes, and the freedom resulting from their suppression, in short by their example, govern the physical and moral existence of their subjects. Perhaps one day we will be able to call on these means to give whatever hue we wish to morality and the national spirit" – Moheau, *Recherches et Considérations sur la population de la France* (1778, sited in Foucault, 2007, pp. 22-23).

"[For the physiocrats of the eighteenth century,] analysis will move back a notch, as it were, or no doubt several notches, and take as its object, not so much the phenomenon of scarcity-dearness, but what I will call the history of grain from the moment it is put into the ground, with what this implies in terms of work, time passed, and fields sown – of cost, consequently. What happens to grain between seeding and the time when it will have finally produced all the profits that it can? The unit of analysis will no longer be the market therefore, with its effects of scarcity-dearness, but everything that happen to it naturally, as it were, according to a mechanism and laws in which the quality of the land, the care with which it is cultivated, the climatic conditions of dryness, heat, and humidity, and finally the abundance or scarcity, of course, and its marketing and so forth, will also play a part. The event on which one tries to get a hold will be the reality of grain, much more than the obsessive fear of scarcity. On this reality of grain, on its entire history, and with all the fluctuations and events that may, as it were, change its history or divert it from an ideal line, one will try to graft an apparatus so that fluctuations of abundance and cheapness, of scarcity and dearness, are not prevented in advance or prohibited by a juridical and disciplinary system that, by preventing from this and constraining to that, seek to avoid them. Albeille, the physiocrats, and the economic theorists of the eighteenth century, tried to arrive at an apparatus (*dispositive*) for arranging things so that, by connecting up with the very reality of these fluctuations, and by establishing a series of connections with other elements of reality, the phenomenon is gradually compensated for, checked, finally limited, and in the final degree, canceled out, without it being prevented or losing any of its reality. In other words, by working within the reality of fluctuations between abundance/scarcity, dearness/cheapness, and not by trying to prevent it in advance, an apparatus is installed, which is, I think, precisely an apparatus of security and no longer a judicial-disciplinary system" Michel Foucault, *Security, Territory, Population* 2nd Lecture, 18. January 1978 (2007, pp. 36-37).

"This malaise of the spirit reflects, like the discomfort of a badly fitted shoe, the maladjustment of men to the way they must obtain a living. There are those who are born handicapped; by the deterioration of the stock from which they spring they are without the capacity to make their way. Others grow up handicapped by disease in childhood, by malnutrition and neglect. Others are the casualties of a vicious or stupid family life, carrying with them forever the scars of inferiority and perversion. They do not adapt themselves easily. Then there are those who have been broken by the poverty and squalor of their youth, and who never do obtain an equal opportunity to develop their faculties. There is the whole unresolved task of educating great populations, of equipping men for a life in which they must specialize, yet being capable of changing their specialty. The economy of the division of labor requires, and the classical economics assumes, a population in which these eugenic and educational problems are effectively dealt with. But they are not yet dealt with. Nor do they settle themselves, as the dogma of laissez-faire supposes. And so they must take their place upon the agenda of liberal policy." Walter Lippmann, *The Good Society* (Lippmann, 2017 [1937], pp. 212-213).

"[When we consider this broad set of educational investments in relation to the acquirement of human capital,] we thus arrive at a whole environmental analysis, as the Americans say, of the child's life which it will be possible to calculate, and to a certain extent quantify, or at any rate measure, in terms of the possibilities of investment in human capital. What in the child's family life will produce human capital? What type of stimuli, form of life, and relationship with parents, adults, and others can be crystallized into human capital? […] In the same way, we can analyze medical care and, generally speaking, all activities concerning the health of individuals, which will thus appear as so many elements which enable us, first, to improve human capital, and second, to preserve and employ it for as long as possible. Thus, all the problems of health care and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital" Michel Foucault, *The Birth of Biopolitics* 9th lecture, 14. March 1979 (2008, pp. 229-230).

"[…] the concept of health must be something positive, that is to say more than the absence of disease. It should contain both bodily, psychological and social elements. It must place an emphasis on function, adaption and man's own responsibility. Health is not something that one gets, but something that one must work with and fight for (*kjempe for*) throughout life. Good health means that one has an excess (*overskudd*) in relation to everyday demands"[1] – Peter F. Hjort, *Helsebegrepet, helseidealet og helsepolitiske mål* (1982, p. 16).

"A population with good mental and physical health is one of the most important resources we have in society. The ability to learn, to creativity, development and flexibility and excess (*overskudd*) to contribute to society is to a greater extent social than genetic. It is social and environmental conditions that contribute to strengthening or weakening health and well-being [(Beddington et al., 2008)]. In a globalized competitive economy, social and environmental conditions that strengthen health, well-being and excess (*overskudd*) are an advantage, in addition to the fact that this is a good thing in itself. Health and knowledge are closely linked in that health provides good conditions for learning, and education provides health. Health and knowledge are included as central parts of what we define as human capital. Statistics Norway´s calculations show that human capital at the end of 2008 accounted for about 73 per cent of the national wealth. Investment in health and knowledge has both a direct effect on increased welfare, and an indirect effect on increased potential for future value creation"[2] – Helse- og Omsorgsdepartementet, *Folkehelsemeldingen: God helse – Felles ansvar* (2012-2013, pp. 162-163).

[1] "helsebegrepet må være noe positivt, altså mer enn fravær av sykdom. Det må romme både legemlige, psykiske og sosiale elementer. Det må legge vekt på funksjon, tilpasning og menneskenes eget ansvar. Helse er ikke noe en får, men noe en må arbeide med og kjempe for hele livet. God helse betyr at en har et overskudd i forhold til dagens krav."

[2] "En befolkning med god psykisk og fysisk helse er en av de viktigste ressursene vi har i samfunnet. Evne til å lære, til kreativitet, utvikling og fleksibilitet og overskudd til å bidra i samfunnet er i større grad sosialt enn genetisk betinget. Det er sosiale og miljømessige forhold som bidrar til å styrke eller svekke helse og trivsel. I en globalisert konkurranseøkonomi er gode samfunnsmessige og miljømessige forhold som styrker helse, trivsel og overskudd et fortrinn, i tillegg til at dette er et gode i seg selv. Helse og kunnskap henger tett sammen ved at helse gir gode forutsetninger for læring, og utdanning gir helse. Helse og kunnskap inngår som sentrale deler av det som vi definerer som humankapital. Statistisk sentralbyrås beregninger viser at humankapitalen ved utgangen av 2008 utgjorde om lag 73 prosent av nasjonalformuen. Investering i helse og kunnskap gir både en direkte effekt ved økt velferd, og indirekte effekt ved økt potensial for fremtidig verdiskaping."

Abstract – English version

The "neoliberal turn" that has played out since the last decades of the twentieth century has received much scholarly attention in terms of the ways in which neoliberalism – seen as a set of economic policies – has negatively impacted health. Less attention has been given to the ways in which the new social policies of prevention and health promotion, that were elaborated in the same period, can be understood as a part of the shift, as well as the empirical study of the particular ways in which the *neoliberal rationality of population management* is expressed in the concrete social policies themselves.

Part I of the thesis aims to demonstrate the importance of conceiving of public health not only in terms of how the economic policies responsible for "releasing market forces" has led to negative impacts on public health, but also as a central social policy in the construction of the conditions of possibility for the competitive market economy itself; as well as the relevance of such an approach to the study of social policies of prevention and health promotion in Norway during the 1980s, a country which is generally perceived to be "social democratic," rather than "neoliberal."

Part II presents the findings from a critical discourse analysis of "Health Policy Toward the Year 2000. National Health Plan," a White Paper published by the Department of Social Affairs under Labor at the end of the 1980s. The text is analyzed within a governmentality-framework and from the question: *how is public health discursively constructed in the text?* Part III discusses how a neoliberal rationality can be seen expressed in the discursive construction of "public health" found in this social policy.

Abstract – Norwegian version

Den «nyliberale vendingen» som har spilt seg ut siden de siste årtiene av det tyvende århundret har mottatt mye oppmerksomhet hva gjelder de måtene som nyliberalismen – forstått som et sett med økonomiske reformer – negativt har påvirket folkehelsen. Mindre oppmerksomhet er viet måtene hvor den nye forebyggende politikken, som ble artikulert i den samme perioden, kan forstås som del av skiftet, det samme gjelder for empiriske studier av hvordan denne *nyliberale rasjonaliteten for populasjonshåndtering* kommer til uttrykk i den konkrete sosialpolitikken som ble presentert av myndighetene.

Del I av oppgaven forsøker å vise viktigheten av ikke bare å forstå «folkehelsen» som et skadelidende offer for en økonomisk politikk som innebærer en «frigjørelse av markedskreftene», men også som en sentral form for politisk intervensjon som retter seg mot å skape betingelsene for en konkurranse-orientert markedsøkonomi; for det andre argumenterer den for at en slik forståelse av sosialpolitikk også er relevant tilnærming til studiet av Norsk forebyggende og helsefremmende arbeid mot slutten av 1980-tallet, en politikk som stadig karakteriseres som «sosialdemokratisk,» i motsetning til «nyliberal».

Del II presenterer funnene fra en kritisk diskursanalyse av det helsepolitiske dokumentet *Helsepolitikken mot år 2000. Nasjonal helseplan*, som ble publisert av Sosialdepartementet under Arbeiderpartiet i 1988. Teksten analyseres innenfor et governmentality-rammeverk og ut fra spørsmålet: *hvordan blir folkehelse diskursivt konstruert i teksten?* Del III diskuterer hvordan en nyliberal styringsrasjonalitet kan sees å komme til uttrykk i denne diskursive konstruksjonen av «folkehelse».

Preface

From its inception, this thesis has been led by two interlinked questions. The first question is theoretical: is it possible to conceive of a positive relationship between neoliberalism and public health. The second question is empirical: how does the politics of health in Norway come to look when viewed as a *part of* neoliberalism; what can we learn when we look at the re-orientation toward a politics of health that emphasizes prevention and health promotion in the 1980s in this light? The 1980s has been of relevance because it was for me, from the start, albeit in a very general and therefore insufficient way, marked out as the period when "the neoliberal turn" occurred in Norway, as it did in other industrial countries at the time.

Taking as my point of departure that there was few who had taken the opportunity to study how public health in that period was imbricated in the turn toward neoliberalism, I worked from the assumption that this might be connected to the way in which the notion of "neoliberalism" – and subsequently the conception of a "neoliberal turn" – was theoretically conceptualized. On the one hand, therefore, my aim has been to develop a conceptual framework that would allow me to conceive public health as an integral part of neoliberal politics. To put it in the simplest way possible, the answer I have arrived at, and that will be presented in this thesis, is that I conceive of public health as a part of what I call a "neoliberal population management," that is to say *as a form of social action that is deployed through a state apparatus in order to make the market possible*.

That is not to say that I simply assume that this is what is occurring in the Norwegian politics of health. What I have been interested in exploring, through the methodological approach of critical discourse analysis, is to see how this neoliberal governing reason, which is organized around the principles of *competition*, is expressed in the policy texts that were published in the late 1980s in order to articulate the Governments proposals for a new "politics of society" marked by prevention and health promotive action.

Assuming that the 1980s and 1990s was a time of rapid development in terms of how "prevention" and "health promotion" was conceived of, I initially had wanted to read multiple policy text from the period. And while I had initially included three texts at the start of the data analysis, due to various readjustments along the way, I have ended up only considering a single document: *Health Policy Toward the Year 2000. National Health Plan* (St.meld. nr. 41, 1987-88). This means that what was initially supposed to be a comparative analysis has ended up being a fairly detailed close reading of seven pages of text. And while I actually never got to

the part of that text called "Health promotive and preventive work – an overall social strategy",[3] I think that the analysis carried out and presented in this thesis will add valuable insights into a field of study that is surprisingly young, and which can fruitfully be explored in the future.

A word on language

In this thesis, I make use of sources that are written in three languages: *Norwegian, English, French*. The thesis itself is written in English. In the cases where it has been useful to provide quotes from any of the other languages, I am responsible for these translations, if otherwise is not specified. As a principle of transparency, I have provided the original quote in a footnote; if this principle is not followed throughout the text, I beg your pardon in advance.

Joakim Slinning Lange,
1st December 2021
Fredrikstad

[3] Chapter 13.

Acknowledgement

The formation of this thesis has been a very interesting journey that has taken me to places and states of mind which I have never experienced before. I would like to thank my two advisors, Ruth Kjærsti Raanaas at the Norwegian University of the Life Sciences (*NMBU*), and Debbie Rudman at the University of Western Ontario, Canada, for their excellent follow-up, support, interesting and engaging discussions, and for being available throughout the process.

Many thanks also go to my mother for the many engaging conversations along the way. With her own background as a public health nurse (*helsesykepleier*) in Sykkylven municipality, and being examined as a nurse in 1989, she has been able to give me some valuable insights into the real world of the health service; and have, I think, found it interesting to re-discover some of the world in which she were educated as a nurse in the late 1980s – when she "just wanted to be a nurse" and didn't worry that much about politics.

Lastly, I would like to express my gratitude for sharing this time with my partner Oda, for her encouragement and support through the many twists and turns of this thesis, for her patience, and our ritual morning walks. I have learned so much through our conversations.

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Introduction

The political imperative facing us today is that we must adapt to changing times; yet, this is not a pure struggle for survival where the strong come out on top and the weak are excluded; for while there is an emphasis on *individual responsibility*, the role of the state is not to stay away from the process: through policies of conservation it must ensure that the milieu and natural resources are not depleted, and that they can instead be made to serve as conditions for life and the source of riches for the human species, now and in the future; through policies of education it must teach man the new way of life best fitted to the demands of the global economy; and finally, through policies of public health it must intervene on the elements which determines the process of development of man's abilities to adapt: its ways of life, its social milieu (Stiegler, 2019).

In this thesis I explore the intersection between a neoliberal rationality which is organized around the principle of *competition*, and a public health policy which is organized around principle of *adaptation*. I was led to interrogate the connection following three observations:

(1) In 1979, Foucault speculates that the theory of human capital – such as it is described by the American neoliberals (Gary Becker, Theodore Schultz, Robert Mincer, etc.) – makes it possible to rethink the problems of public health (*public hygiene*) as elements that may or may not improve human capital (Foucault, 2008, p. 230).

(2) In a striking passage from the first *folkehelsemeldingen* from 2012 – *Good Health, Common Responsibility* – health is defined as "a resource and a precondition for economic growth," that serves as an "advantage" in a "globalized competitive economy," and is explicitly defined as a condition for the development of "human capital" (*humankapital*) (Meld.st. 34, 2012-2013, p. 162).

(3) In the 1970s and 1980s, a new conception of public health was being articulated in Norway: set against the "static" definition of health as *"not only the absence of disease, but also a complete state of physical, mental and social well-being"* (central in WHO's foundational charter), a "dynamic" definition, which emphasized the central role of *adaptation* in the meaning of "good health", was promoted: health should instead be understood as *"an excess (overskudd) in the face of everyday demands"* (Hjort, 1982, pp. 15-16).[4] The new public health would consist of a set of interventions that aimed to *keep people well* by preventing disease, and to *strengthen the individuals health* through health promotion.

[4] See also Berg (1973, 1975); Hjort (1995); Strøm (1980).

There is currently little discussion of how Norwegian public health can be seen as part of neoliberalism. Due to the conception that Norway is a "social democracy" the relevance of the term is disputed (Hervik & Thurston, 2016). When the term "neoliberalism" is evoked it often refers to the emergence of new public management in the public sector, free trade policy, privatization, competition (*outsourcing of service provision from the public to the private sector*), deregulation, etc.[5] And in so far as the emergence of a new public health has been linked to the "neoliberal turn" of the 1980s, it is either considered as a "compensation" for the loss of national sovereignty over the economic forces that "truly" affect the health of the population, or linked to the process of individualization wherein populations are governed solely through their "individual interest" as a motor for economic growth, an interest which needs to be protected, stimulated and hailed, to the detriment of the collective approaches that were central in the "social democratic" post-war era[6] (Elvbakken, 2009; Leonardsen, 2015).

I have not wanted to argue against these concerns. It seems to me that these concerns are legitimate and that the peoples involved in these struggles have a right to continue their struggles. But, in so far less analytical attention is currently being given to the ways in which *public health policies are involved in the technologies of power which are oriented toward the improvement and protection of the populations competitiveness*, that is to say, the ways in which it has been taken up as a form of social action whose principle aim is to *make the competitive economy possible* (Foucault, 2008), I have wanted to explore the possibilities and the fruitfulness of pursuing such a line of research.

In part I, I present the concept of neoliberal population management and discuss its historical and theoretical assumptions (chapter 1 and 2), as well as the relevance of deploying such a concept in the study of Norwegian public health policy at the end of the 1980s (chapter 3).

In part two and three I present and discuss an empirical analysis of the health policy-document *Health Policy Toward the Year 2000. National Health Plan* published in 1989 by Norwegian Labor (*Arbeiderpartiet*). In part II (chapter 5), the text is analyzed using a critical discourse approach (described in chapter 4), which have been organized around a *governmentality-framework* and the analytical question: *how is public health discursively constructed in the text*?[7] In part III (chapter 6), this discourse is discussed in relation to the research question: *how is a neoliberal rationality expressed in the discursive construction of public health?*

[5] The readers of *Klassekampen*, a daily Norwegian newspaper, will be familiar with these notions. For examples see Hofvind, Klyve, and Sveverud (2019); Innset (2020a); Lian (2003); Skaset (2003); Stalsberg (2019); Tranøy (2006).
[6] These tenets seems to underpin some of the critique that has been leveled against the new "public health and life mastery" primary school-curriculum that was launched in 2020, fall semester (Cf. Madsen, 2020).
[7] In the analysis, a particular emphasis is given to the objects "public health," "population," "subject," and "health".

Part I – theoretical framework: neoliberalism as a governing reason for the management of population

Introduction: defining the concept of neoliberal population management

To evoke the concept of "neoliberalism" in any analysis requires that one specifies the content that is to follow along with it. When one views public health as a part of neoliberalism, even more so.

In this thesis, I thematize the relationship with a concept that I call "neoliberal population management." This theoretical construct builds upon Michel Foucault's notion of "governmentality", that is to say: "the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instruments" (Foucault, 2007, p. 108) as well as the "the activity that consist in governing people's conduct within the framework of, and using the instruments of, a state" (Foucault, 2008, p. 318).

Through the notion of security mechanisms, public health is operationalized as an instrument in the management of population, of what Foucault calls "biopolitics": the modern political problem[8] of managing the "natural" processes of the population (i.e. birth rates, morbidity, mortality, rates of accidents etc.) by deploying a technology of power that is acting on the variables of the milieu determines their formation (Foucault, 2007, pp. 70-72).

Neoliberalism will be viewed as a "governmental reason," which refers to the "principle and method of the rationalization of the exercise of government" that is "directed toward objectives and regulated by continuous reflection" (Foucault, 2008, p. 318).

The neoliberal government of population is identified with the project of making the competitive market economy possible (Foucault, 2008). In relation to this, public health is deployed towards elements that are framed in terms of whether they improve the human capital of the population. The problem of human capital formation is in turn a central condition for the adaptability of the species, and therefore of the possibility of a competitive market economy (Cf. Stiegler, 2019).

[8] On the link between population management and the emergence of modern politics, see Foucault (2007): "The more I have spoken about population, the more I have stopped saying "sovereign." I was led to designate or aim at something that again I think is relatively new, not in the word, and not at a certain level of reality, but as a new technique. Or rather, the modern political problem, the privilege that government begins to exercise in relation to rules, to the extent that, to limit the king's power, it will be possible one day to say, "the king reigns, but he does not govern," this inversion of government and the reign or rule and the fact that government is basically *much more* than sovereignty, much more than reigning or ruling, much more than the *imperium* [emphasis in the original], is, I think, absolutely linked to the population. I think that the series, mechanisms of security – population – government and the *opening up of the field that we call politics*, should be analyzed" (p. 76; emphasis added).

Through Foucault's (2007, pp. 314-315) concept of *diplomatic-military apparatus*, I conceptualize the management of population within the broader context of Europe in the terms of "external relationships" between the population of a state and the relationship between the states of Europe; and an "internal relationship" that pertains to the relationship between the state apparatus and its citizens and population. Furthermore, I use Foucault's (1997a) notion of *ethics* and *techniques of the self* (self-work), in order to conceptualize the process of subjectivization (*assujettissement*) wherein the individual takes on the subject position of the *entrepreneur*, that is to say, the one who acts on the self in the form of *self-investments* aimed at the maintenance, development and use of *one's abilities and capacities* (Foucault, 2008, p. 230). The notion of ethics distinguishes four dimensions of the process of subjectivation (Davidson, 2009): (i) *telos* refer to the "goal that our self-work [should] be directed towards"[9] (p. 171); (ii) *self-work* refer to all the "measures we take in order to change or develop ourselves in order to become ethical subjects"[10] (p. 171), as well as the concrete sources of knowledge that subjects make use of in order to learn how to work on themselves; (iii) *ethical substance* refer to the "part of ourselves or our conduct that are considered as relevant for ethical veridiction"[11] (p. 170); finally, (iv) *forms of subjugation* refer to "the way in which people are invited or encouraged to acknowledge their moral obligations"[12] (p. 170).

Chapter overview

In the following three chapters I ask and discuss three questions that relate to the applicability and meaning of the analytical framework used in this thesis:

1) Does it make sense to view public health as an integral part of neoliberalism, and not only as a victim of market forces?
2) Does it make sense to consider public health as a mechanisms of security deployed in the management of population, which is aimed not only at the conduct of conduct, but also on life's fundamental events?
3) Does it make sense to use a concept of *neoliberal population management* as an analytical framework for understanding the discursive construction of public health policy in Norway at the end of the 1980s, a policy which is sometimes considered *social democratic*, sometimes

[9] «Mot hvilket mål burde vår selvdannende virksomhet rette seg?»
[10] «midlene vi tar i bruk for å forandre eller utvikle oss selv for å bli etiske subjekter.»
[11] «den delen av oss selv eller vår atferd som oppfattes som det relevante området for etiske dommer.»
[12] «måten folk blir invitert eller oppfordret til å anerkjenne sine moralske forpliktelser.»

individualizing, and sometimes even as a *compensation* for the reduced national sovereignty over the economic matters which truly affect the health of the population?

By considering these questions, I aim to mark out the conceptual and historical assumptions that underlines the discussion how a neoliberal rationality is expressed in the discursive construction of Norway's public health policy at the end of the 1980s.

In chapter 1 – *Neoliberalism, a dangerous concept* – I discuss this approach to neoliberalism and public health in relation to a recently published editorial in the journal *Critical Public Health*. In it, Bell and Green (2016) aims to take stock at the current use of the term "neoliberalism" in the critique of public health, in order "to ensure that it does what we *think* it does and *want* it do (sic.)," and in this way prepare the path for a more "critical, nuanced and reflective approach" to the study of the ways in which "public health is imbricated in the various manifestations of neoliberalism" (pp. 239, 241; emphasis in the original). While I am not disagreeing with the authors in their intention, I situate the approach deployed in this thesis by displacing two assumptions found in their argument.

(1) The assumption that neoliberalism and public health must be viewed in terms of how neoliberalism (seen as the results of a continuous political, social, economic and cultural process) affect public health in a negative way. This imposes implicit limitations for the kinds of "imbrications" that are subjected to critical investigation. My own thesis also studies how neoliberalism and public health overlaps, but I do this by situating public health (understood as a policy) within the neoliberal project.

(2) The historical and conceptual assumption that "neoliberalism" emerged in the 1970s, that it refer to the ideology of "unbridled capitalism" and excessive individualism (Dardot & Laval, 2009, p. 19), and that it can be found expressed in the political and economic reforms of privatization, austerity, tax-cuts, deregulation etc., that were pursued throughout the 1980s and the 1990s in much of the Western world (Harvey, 2007). This historical conception, which is central to the study of negative impacts on public health, is set up against the discussions for the "renewal of liberalism" that was set in the 1930s (Audier & Reinhoudt, 2017). Being both critical of the "laisser-faire" liberalism of the nineteenth century, and the limitations of the "totalitarian" approaches of the planned economic reforms (e.g. the American New Deal), "neoliberalism" was proposed as an ambitious set of social and juridical reforms that aimed to make the market economy possible by working on its conditions of possibility; reforming the actions of the state in accordance with the principle of the market economy (competition); and the dispersal of "entrepreneurial" ways of life through the reform of the social order (Stiegler, 2019). Within this project, public health policies now find their place within the "active,

multiple, vigilant and omnipresent" social action (Foucault, 2008, pp. 159-160) that were aimed at creating the "conditions of possibility for the market economy," and therefore central in the political program of the liberal state's "foundational role" vis-à-vis the market economy (Stiegler, 2019). Drawing upon Stiegler's (2019) reading of Walter Lippmann's (2017 [1937]) *The Good Society*, I relate neoliberal public health policy to the efforts of enabling the continual "readaptation" the human species to the ever changing "demands of the global economy" (Stiegler, 2019, pp. 158-159).

In chapter 2 – *Population half-present, on the neoliberal management of population* – I discuss my conception of neoliberal population management in relation to the idea, which is currently being promoted by certain "Foucault scholars" (here exemplified by the recent publications of Ferhat Taylan (2018) and Christian Laval (2018)), that neoliberal biopolitics, a concept which Foucault (2008) never got around to study in his lectures on *The Birth of Biopolitics*, should be envisaged as a form of "environmental technology" that acts on subjects "from a distance" by working on the psychological and behavioristic link found in the "behavioral milieu" (*milieu d'comportement*) (Laval, 2018, p. 66) between the individuals interest on the one hand, and its "rational" and thereby predictable responses to the "environmental variables" (*variables d'milieu*) of incitation, stimuli, etc. (Taylan, 2018, pp. 42-43); thereby sketching out the technical schema for a technology of power that would enable governments to conduct the conduct of every individual within the population, in a way that aligns their behavior with the entrepreneurial logic of self-investment aimed at the improvement of ones abilities (human capital), without altering the players themselves, but by "modifying the terms of the game" (Foucault, 2008, p. 260).

While it is certainly true that this regulation of the players freedom to act must be seen as an integral part of a neoliberal population management, this only form half of the picture. In addition to this dimension of population management, which hinges on the "naturalness" of the individuals interest as the "motor of action", and which is instrumental for the "[p]roduction of the collective interest" of the population (Foucault, 2007, pp. 72-73); the conception of a neoliberal biopolitics must also account for the other level of the populations "naturalness," which represent a *fundamentally different* side of things than what is seen in the "mechanistic" interaction (Canguilhem, 1992, p. 166) between the organism and its milieu; that is to say, the relationship between the human species (*l'espèces humaine*) and its milieu of existence (*milieu d'existence*) (Foucault, 1997b, p. 218). After all, it was the emergence of the problem of population identified with the natural processes represented by the *statistical phenomena* of birth rates, morbidity rates, suicides, rates of various disease etc., together with the new possibilities of intervening (from a distance) on the environmental variables of the populations natural and artificial milieu – "which seems far removed from the population, but

which, through calculation, analysis, and reflection, one knows can really have an effect on it" (Foucault, 2007, p. 72) – that Foucault linked to the emergence of "biopolitics."

The problem of human capital formation must therefore not only be viewed from the side of inciting entrepreneurial forms of conduct, but must also be seen in terms of a governmental action that intervenes at the "fundamental events" (*événements fondamentaux*) (Foucault, 2004a, p. 11; 2017 [1976], p. 48) in the history of the species. Neoliberal population management must be understood from the side of a government that are directed at the elements of reality that is made visible through an "environmental analysis" that describes the individual's life course in terms of the "possibilities of investment in human capital" (Foucault, 2008, pp. 229-230); this form of knowledge, it is true, enables the rational action of economic actors in the here-and-now with the aim of augmenting one's own abilities in the future, so as to be able to adapt oneself to the demands of the global economy; but it also opens up a field of intervention that is not perceptible from the limited and short-term perspective defined by the individual pursuit of private interest, and which enables a state to construct the historical and social conditions of possibility for the development of human capital (Stiegler, 2019, p. 233). It is by considering things from this angle that we can start to "rethink all the problems of health protection, and all the problems of public hygiene as elements that may or may not enable us to improve human capital"[13] (Foucault, 2004b, p. 236). It is this distinction that enable us, once again, but this time within a theoretical framework, to situate public health policy in relation to the neoliberal government of population.

Chapter 3 – *On the conceptual relevance of "neoliberal population management" in the analysis of Norwegian public health policy at the end of the 1980s* – discusses the conceptual and historical relevance of deploying the concept of neoliberal population management in order to analyze Norwegian public health policy published during the latter half of the 1980s. In order to apply the concept of *neoliberal population management* to the study of Norwegian public health policy in the 1980s, I argue, three notions of Norway's public health policy needs to be addressed: (1) that Norway's public health policy is an expression of a "social democratic welfare regime" as opposed to one that bears the distinguishing features of "neoliberalism" – exemplified by a study by Hervik and Thurston (2016); (2) that the public health policies that were actually proposed by the Norwegian government have increasingly become "individualized" (as opposed to a policy that deals with society) –

[13] "repenser tous les problèmes de la protection de santé, tous les problèmes de l'hygiène publique en éléments susceptibles ou non d'améliorer le capital humain." Here, the English translation is slightly different from the French original: "Thus, all the problems of health care (*protection de santé*, my edit) and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital" (Foucault, 2008, p. 230). It seems to me that the translation of "protection de santé" to "health care" is not apt.

exemplified by Vallgårda (2001) and Stenvoll, Elvbakken, and Malterud (2005); and finally, (3) that these policies should be understood as a form of *compensatory* policy that makes up for a *weakening governing position* vis-à-vis the economic sphere (due to the economic policies pursued from the 1970s that emphasized the integration of Norway's economy into the global economy) by intervening into the social sphere in order to deal with the "existential" problems which in fact stems from the changes in the economic sphere – a thesis found in a study by Leonardsen (2015).

Following each of these conceptions of Norway's public health policy is a critique of both empirical and theoretical assumptions, which I discuss in relation to the empirical and theoretical assumptions underpinning the concept of neoliberal population management. The over-all aim of this chapter is to distinguish the conceptual and historical conditions for applying this concept to the study of Norwegian public health policy at the end of the 1980s.

Chapter 1 *Neoliberalism, a dangerous concept*

Eirik Løkke:

> "We could have talked for a long time about [liberalism] Lars Fredrik, but briefly, could you touch upon the concept of "neoliberalism" that is often tossed around, as a description of everything that is bad in the world. What is the relationship between neoliberalism and liberalism?"

Lars F. Svensen:

> "Well, "neoliberalism" is often used in such an *unclear* way that it is hard to give it a specific content; it is often evoked in relation to *New Public Management* and the like, and in that case "neoliberalism" is something that Social Democratic governments has been the most important promoters of. Very few actually call themselves neoliberalist, and I find that *most times*, when the term "neoliberalism" shows up in an analysis, it is the sign of an intellectual laziness; that one has not taken the trouble of describing something in a more precise way."[14]

1.1 Introduction: on the perils of evoking neoliberalism in public health critique

In 2016, Kristen Bell and Judith Green, the editors of the journal *Critical Public Health*, argued that it was time to take stock of the many uses of the term 'neoliberalism' in critical analyses of public health. In the editorial staff they had joked, "on more than one occasion," that the journal should be renamed "*Critical Public Health: the Negative Impacts of Neoliberalism*" to better reflect what seemed to be the real content of the articles published within it. While neoliberalism to them was, "in its strictest sense," defined as a "macro-economic doctrine" that could, in a more general sense, be seen in the ideology of unrestricted markets whose "prototypical" examples are the economic reforms of Margaret Thatcher and Ronald Reagan in the 1980s, and the structural readjustment programmes that were "promoted" to the Global South by the International Monetary Fund and the World Bank in the 1990s; the term itself had been taken up in a great variety of ways within the social sciences (Bell & Green, 2016, pp. 239-240). Siting a paper by Ward and England (2007), they highlighted "four distinct understandings of neoliberalism in the social sciences":

[14] Eirik Løkke: «Vi kunne snakket lenge om [liberalismen] Lars Fredrik, men et minutt helt til slutt, bare komme innom det begrepet «nyliberalisme» som ofte slenges ut, som ofte er en sånn derne beskrivelse av alt som er vondt og vanskelig i verden. Hva har nyliberalisme med liberalisme å gjøre egentlig?» Lars F. Svensen: «Nei altså, nyliberalisme brukes ofte på en så *uklar* måte at det er vanskelig å gi det et spesifiserbart innhold; det trekkes ofte inn *New Public Management* og den slags, og i så fall er nyliberalismen noe som sosialdemokratiske regjeringer har vært de viktigste forkjemperne for. Det er veldig få som kaller seg selv nyliberalister, og jeg synes vel at *oftest* når uttrykket «nyliberalisme» dukker opp i en analyse så er det uttrykk for en intellektuell latskap; at man ikke har tatt seg bryet med å forsøke å beskrive noe på en litt mer presis måte» (NRK, 2020, min 19:00-19:38 ; emphasis in the original).

> (1) neoliberalism as an ideological hegemonic project; (2) neoliberalism as policy and programme (e.g. policies enacted under the banner of privatization, deregulation, liberalization); (3) neoliberalism as state form – i.e. the 'rolling back' and 'rolling out' of state formations in the name of reform; and (4) neoliberalism as governmentality – the ways in which the relations among and between peoples and things are reimagined, reinterpreted and reassembled to effect governing at a distance (Bell & Green, 2016, p. 240).

This wide use of "neoliberalism" was not primarily seen as the sign of a flourishing scholarly community however. Due to the taken-for-grantedness of the terms "conceptual intelligibility," in many studies, they argued that it is rather linked to what they call an "over-extension"; a phenomenon which, in their eyes, risks leading to two analytical problems.

First, due to its "eclectic usage", the term can be used to study a great variety of phenomena – "the relationships between neoliberalism and everything from "cities to citizenship, sexuality to subjectivity, and development to discourse to name but a few (Springer, 2012, p. 135)" (Bell & Green, 2016, p. 240) –; and can be used to give "very different readings of the same phenomenon", which leads Bell and Green to question how useful the concept really is. Taking the concept of the "neoliberal diet" as an example, they show that when it is read within a political economy perspective – as have Otero, Pechlaner, Liberman, and Gürcan (2015, p. 48) – the "neoliberal diet" can be made to "characterize the high levels of consumption of energy-dense, low-nutrition 'pseudo-foods' among the working class" (Bell & Green, 2016, p. 240). Yet, when seen from a "Foucauldian governmentality perspective", the "neoliberal diet" can be read in "precisely the opposite [way]: as one that encourage the individual to take responsibility for his or her health by consuming more fruits and vegetables (e.g. Ayo, 2012)"[15] (Bell & Green, 2016, p. 240).

Secondly, neoliberalism itself tends to be reduced to a phenomenon whose "effects are so totalizing and monolithic that it starts to assume casual properties in its own right; [thus] "it becomes the "it" which does the explaining, rather than the political phenomenon that needs to be explained" (Phelan, 2007, p. 328)" (Bell & Green, 2016, p. 240). This, in turn, leads to a serious lack of historical and contextual precision. Taking issue once more with the governmentality approach to neoliberalism – which is one of the journal's most frequently deployed conceptual schemes, they remark – they argue that when neoliberalism is simply defined in terms identified by Kipnis (2008), of "governing from a distance; the emphasis on calculability; and the promotion of self-activating, disciplined, individuated subjects," it runs the risk of making unlikely Western something that

[15] Text continues: "When a concept can be used to describe such an extraordinary – and even downright contradictory – array of phenomena, questions can clearly be asked about how useful it actually is" (Bell & Green, 2016, p. 240).

> "can be found in a variety of contexts that are historically and culturally distant from Western neoliberal or liberal governing philosophies. [In the words of Kipnis (2008)] "These three categories correspond to broad human potentialities that have been imagined in a wide variety of ways in a broad range of settings and that have become more prevalent in *all* state-governed and industrial societies" (p. 284, emphasis added). Thus, characterizing such features exclusively in terms of neoliberalism runs the risk of exaggerating its scope by reifying it into a globally dominant force or stage of history (Kipnis, 2008). It also runs the risk of eliding other processes that deserve analytical attention in their own right. For such reasons, there have been growing calls to explore neoliberalism in terms of "concrete projects that account for specific people, institutions and places" (Kingfisher & Maskovsky, 2008, p. 118) – what Brenner and Theodore (2002) refer to as "actually existing neoliberalism"" (Bell & Green, 2016, pp. 240-241; emphasis in the original).

Despite of these risks of "over-extension," Bell and Green does not argue that we refrain from using the term entirely. Instead, they argue that in order to "advance our understanding of how, specifically, public health is imbricated in the various manifestations of neoliberalism" we need to take "a more critical, nuanced and reflective approach" (Bell & Green, 2016, p. 241). Specifically, three points are raised. It is necessary (1) that the specific use of the term is made clear, rather than taking its meaning for granted; (2) that the accounts given of the imbrication of public health and neoliberalism are nuanced and specific; (3) and that we speak of "neoliberalization" as an ongoing process, rather than as an already existing, already fully implemented "monolithic entity" (Bell & Green, 2016, pp. 241-242).

1.2 Critical remarks to Bell and Greens over-extension critique

While it is not hard to get behind the intentions of their editorial, I think it is necessary to interrogate two problematic aspects of their argumentation: (1) the nature of the relationship between "neoliberalism" and "public health" and (2) the historical phenomenon referred to as "neoliberalism."

1.2.1 Possible imbrications

The first point concerns the possible links – or 'imbrications' – that can be conceived of between public health and neoliberalism. "Imbrication," being synonymous with the word "overlap" holds multiple potential meanings. Yet, as the humorous renaming of their journal suggests – "*Critical Public Health: The Negative Impacts of Neoliberalism*" – what is most often of interest when treating public health and neoliberalism in the journal is to focus on how "neoliberalism" impacts "public health" in a negative way. This form of imbrication, furthermore, seem to follow from the conception of neoliberalism as a set of economic reforms – privatization, fiscal austerity programmes, etc. –, and the

notion that neoliberalism represents an ideological belief in "unbridled markets". Neoliberalism, in this sense, comes to be viewed of as a set of "forces" that are more or less specified, and which has the property that it can impact public health in a negative way.

In their suggestions for how to move forward with analysis of neoliberalism in relation to public health, more of this way of understanding the relationship between public health and neoliberalism can be identified. When aiming for "more nuance and specificity in accounts," Bell and Green write that it should be a question of "how, where and in what forms do the various processes of neoliberalism *impact* health" (Bell & Green, 2016, p. 241; emphasis added); when we look at the processes of neoliberalism, it is framed as a an ideal that analysis is able to "point not only to the potential negative effects for public health […], but also ways forward" for the people affected (Bell & Green, 2016, p. 241; emphasis added); and finally, they write that:

> "In general, rather than reifying neoliberalism as a monolithic entity, it may be more productive to speak of "neoliberalization" as an always partial and incomplete process (Ward & England, 2007). This raises potentially fruitful questions around when, where, and in what ways the economic, political and cultural *intersect* with health" (Bell & Green, 2016; emphasis added).

While it may indeed be fruitful to understand neoliberalism as a process, it is worth pointing out that the process in question here is one that is set within the conceptional universe of *determinants of health* (Dahlgren & Whitehead, 1991). "Health" comes here to signify an object which is acted upon or affected by various forces. And it follows that the *proper* goal for critical public health studies, when looking for the "imbrications" between neoliberalism and public health, should be that of making the negative effects on health visible, as well as opening up possibilities for a change in direction. The critique launched against "monolithic" accounts may also be read in this light: it does not produce the nuances necessary for making harmful effects visible at a detailed enough level for them to be acted upon, so as to be stopped, hindered, blocked, or that a more positive path forward can be pursued.[16]

While I would not like to suggest that those wishing to pursue such a path are mistaken, it seems to me that an equally fruitful analytical approach is elided when the relationship between neoliberalism and public health is conceived only in these terms. Alternatively, public health *policies* could themselves be viewed as integral to the neoliberal project. This connection could, furthermore be understood from the point of view of Foucault governmentality-framework. For this approach to be legible, however, two analytical blocks, found in the argumentation of Bell and Green, must be dealt

[16] For examples of researchers working within this vain, see Barnett and Bagshaw (2020); Baru and Mohan (2018); Bergeron and Castel (2018); Collins, McCartney, and Garnham (2016); Labonté, Mohindra, and Schrecker (2011); Labonté and Stuckler (2016); Navarro (2004, 2007, 2009); Schrecker (2016); Schrecker and Bambra (2015)

with. The first concern the historical phenomenon that is referred to as "neoliberalism" (treated in this chapter), while the second concerns the nature of "Foucault's governmentality-framework" (which will be treated in chapter 2)

1.2.2 When is neoliberalism?

While Bell and Green are certainly not wrong in pointing to the reality of political changes in the 1970s, 1980s, and 1990s (Cf. Harvey, 2007), this historical grid is hefted with a remarkable omission. By linking neoliberalism to the changes in this period, the complex history of the early movement is left out (Audier & Reinhoudt, 2017), that is to say, the numerous debates on the "renewal of liberalism" that were held in the wake of the Great Depression of the 1930s (pp. 4-5; Cf. Innset, 2020b; Stiegler, 2019). While they assume a negative relationship between "neoliberalism" and "public health," in the early history of the movement, the relationship was clearly framed in *positive terms*: as part of the program of reform that would reform the historical and social conditions of Society so as to create the conditions of possibility for the competitive market economy.

To a certain extent, the relationship between public health and neoliberalism changes when the historical phenomenon one considers is different. This is not to say that neoliberalism is suddenly rendered "theory-neutral" by evoking something that can be considered as a historical reality. However, the historical content one gives neoliberalism holds great implications for the analysis of the phenomenon itself. Considered from the point of view of the debates of the 1930s, neoliberalism can be identified with the attempts to formulate a "foundational role" (*rôle fondateur*) for the state for the construction of the market economy (Stiegler, 2019, p. 233), and set against the policies of *laissez-faire* promoted by the classical liberals (Audier & Reinhoudt, 2017; Foucault, 2008).

Conceived thusly, the distinction between neoliberal "ideology" and neoliberal "praxis" underlining Brenner and Theodore's (2002, p. 350) conception of an "actually existing neoliberalism" does not seem as relevant. For them, there is on the one hand, a neoliberal ideology, which have been promoted by people like Friedrich Hayek and Milton Friedman, that rests on "the belief that open, competitive, and unregulated markets, liberated from all forms of state interference, represent the optimal mechanisms for economic development". This "utopia of unlimited exploitation"[17] should not be taken at face value, however, Brenner and Theodore argue, but should instead be scrutinized as a fiction by emphasizing

[17] The concept of an "utopia of unlimited exploitation" is retrieved from Bourdieu (1998, sited in Brenner & Theodore, 2002, p. 350). See also Laval (2017)

> "the contextual *embeddedness* of neoliberal restructuring projects insofar as they have been produced within national, regional, and local contexts defined by the legacies of inherited institutional frameworks, policy regimes, regulatory practices, and political struggles" (Brenner & Theodore, 2002, p. 349; emphasis in the original).

While I would certainly not like to undermine the importance of making a distinction between neoliberalism as it is practiced and the "ideology" of unlimited markets; when considered from the point of view of the debates of the early movements – excluding the remarks made by Hayek and Friedman at that time[18] – it is clear that what was targeted by those who argued for a *new liberalism* was precisely this kind of extreme laissez faire liberalism.

Concretely, by taking aim at the "naive naturalism" of the classical liberalism, the new program of political reform involved a disregard for the split between the *agenda* and the *non-agenda*, which was another of the defining features of classical liberalism (Foucault, 2008). Those who argued for a new liberalism were not interested in distinguishing between the domains where the state could or could not intervene. In order to construct the market economy, the question was rather one of figuring out *how* to intervene. As Michel Foucault puts it, "the problem is the way of doing things, the problem, if you like, of governmental style" (2008, p. 133). Thus, neoliberalism as it "actually existed" in the 1930s does not refer to concrete policies that were in the process of being enacted; but refers instead to the conceptions of a set of policies aimed at the construction of a market economy. This political and social program, furthermore, did not involve the "unhindered release of market forces" and was instead critical to this "naïve" naturalism promoted by the classical liberalists: the market could not be "released" because it did not exist without constant, active and vigilant governing policies. Thus, the policies proposed as "neoliberal" in the 1930s was not so much a program for letting the market loos, as it was conceived as a *framework policy* aimed at making the market possible.

1.3 What is neoliberalism?

In order to see how this "neoliberalism" implies different relationship between neoliberalism and public health than the one assumed by Bell and Green, it is necessary to look closer at the nature of the neoliberal project that was proposed at the end of the 1930s, and the nature of the interventions that would make it possible.

[18] Historically speaking, both Hayek and Friedman can be considered as part of the early movement of the 1930s. A useful distinction to make, is that of the Austrian-American neoliberalism, which they adhered to, and the German ordo-liberalism, which is what I refer to here. On this distinction, see Foucault (2008)

1.3.1 The neoliberal project: reforming society as a condition of possibility for the principle of pure competition

First, the nature of the project. While the eighteenth-century liberalists had conceived of the market as a sphere of exchange, where the only form of intervention needed by the state was that of securing property rights and the security of peoples on the market; the neoliberalists of the 1930s, and more specifically the German ordo-liberalist, argued that the market economy should be considered as a sphere of *competition* (Foucault, 2008). According to Foucault, the nature of this competition was such that it could not exist on its own, it did not emerge spontaneously, but were dependent on specific *conditions* in order to exist. Highlighting the phenomenological roots of the German ordo-liberals, Foucault remarks that:

> "Just as for [Edmund] Husserl a formal structure is only given to intuition under certain conditions, in the same way competition as an essential economic logic will only appear and produce its effects under certain conditions which have to be carefully and artificially constructed. This means that pure competition is not a primitive given. It can only be the results of lengthy efforts and, in truth, pure competition is never attained. Pure competition must and can only be an objective, an objective thus presupposing and indefinitely active policy. Competition is therefore an historical objective of governmental art and not a natural given that must be respected" (Foucault, 2008, p. 120)

Because these conditions were not already in place, and because they could never be considered as being finally realized, for the market economy to function properly it relied on the "active, multiple, vigilant and omnipresent" interventions from a state (Foucault, 2008, pp. 159-160).

Instead of viewing capitalism as an inherently beneficial force that should be left to operate by itself, the ordo-liberals identified instead an inherent tendency toward *monopolies*. This was the fundamental problem that had to be avoided through the pursuit of the construction of the conditions that would allow a competitive market economy to function (Foucault, 2008).

By constructing the conditions of possibility of the market economy, the ordo-liberals wanted to enable the regulation of the social order through the regulating force represented by an economy which functions according to the principles of competition. That is to say, an economy that is considered as a game of inequalities (as opposed to a welfare economy which seeks the general equalization of society) (Foucault, 2008).

In addition to enabling the market economy to serve as the regulatory force of society, the problem that lies at the heart of ordoliberalism, which goes hand in hand with this project, according to Foucault, is the construction of a state from the bottom up, based on the principles of the market economy, as well as the pursuit of 'a "*Vitalpolitik*,"' or "a politics of life," whose concern is that "of

constructing a social fabric in which precisely the basic units would have the form of the enterprise" (Foucault, 2008, p. 148). It is "this multiplication of the "enterprise" form within the social body" which is "what is at stake in neo-liberal policy" (ibid.). In other words, "it is a matter of making the market, competition, and so the enterprise, into what could be called the formative power of society" (ibid.).

1.3.2 Neoliberal interventions: constructing the historical and social conditions of possibility for pure competition

In order to pursue this end, neoliberal policies utilize what they called a "framework policy" (*politique de cadre*) (Taylan, 2018, p. 41). The framework policy intervenes in the form of *juridical interventions*, and in the form of *social interventions*. The first aims to constructs the "rules of the game" (*règles de jeu*) of the economy. This enables the *freedom of action* for the actors within the market; as well as the state-led regulation of the market by adjusting the "institutional-juridical" order of the market, and thereby enabling the creation of different capitalisms. The government of a market economy, therefore, involves a decentralized approach, as Foucault underlines by quoting Valery D'Giscard, France's President during the 1970s: "The characteristic feature of the market economy is the existence of rules of the game, which enable decentralized decisions to be taken, and that these rules are the same for all" (Foucault, 2008, p. 202). In light of the historical injustices that were imbued in the current state of things – the *status quo* – the legal system was viewed as inherently biased to promote the interests of the elites of society; in order for the principles of competition to be realized in practice, the mechanisms of the law needed to be taken back into control and wielded in a desirable direction, thereby creating "equality of opportunity" (that the rules are the same for all) (Stiegler, 2019). By giving individuals an equal chance to compete (i.e. access to scarce resources) it was thought that this would produce a "natural" hierarchy that were not skewed by external conditions.

In light of the experiences of the Great Depression, the neoliberals argued that the reliance on adjustments to the institutional-juridical order of the economy was not enough (Stiegler, 2019). What was needed, more fundamentally was a set of social policies – what the German ordo-liberalists called a "*Gescellschaftspolitik*" – that aimed to "reform the social order" in order to constructing the social and historical conditions of possibility that would make the competitive market economy to function (Stiegler, 2019, p. 233).

The role of social policies in the neoliberal program should be distinguished from the one pursued by a welfare state, whose primary function can be seen to act as a *compensation* for the harmful effects of markets. As Foucault explains, ordoliberalism necessarily entails "a policy of society and a

social interventionism that is at the same time active, multiple, vigilant, and omnipresent," (p. 159-160) that "has to intervene on society as such, in its fabric and depth" in order for the "competitive mechanisms [to] play a regulatory role at every moment and every point in society and by intervening in this way its object will become possible, that is to say, a general regulation of society by the market"[19] (Foucault, 2008, p. 145). However, while there is a set of "active, intense and interventionist social [policies]" on the one hand, and the market economy on the other, it is important to

> "carefully underline that this social policy in ordoliberalism is not to function like a compensatory mechanism for absorbing or nullifying the possible destructive effects of economic freedom on society or the social fabric. In actual fact, if there is a permanent and multiform social interventionism, *it is not directed against the market economy* or against the tendency of the market economy. On the contrary, *this interventionism is pursued as the historical and social condition of possibility for a market economy, as the conditions enabling the formal mechanism of competition to function* so that the regulation the competitive market must ensure can take place correctly without the negative effects that the absence of competition would produce. The *Gescellschaftspolitik* must not nullify the anti-social effects of competition; it must nullify the possible anti-competitive mechanisms of society, or at any rate anti-competitive mechanisms that could arise within society" (Foucault, 2008, pp. 159-160; emphasis added)

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The nature of the project and the nature of the interventions involve a specific relationship between the state and the market:

> "There will not be the market game, which must be left free, and then the domain in which the state begins to intervene, since the market, or rather pure competition, which is the essence of the market, can only appear if it is produced, and if it is produced by an active governmentality. There will thus be a sort of complete superimposition of market mechanisms, indexed to competition, and governmental policy. Government must accompany the market economy from start to finish. The market economy does not take something from government. Rather, it indicates, it constitutes the general index in which one must place the rule for defining all governmental action. One must govern for the market, rather than because of the market." (Foucault, 2008, p. 121).

[19] "Since this is a liberal regime, it is understood that government must not intervene on effects of the market. Nor must neo-liberalism, or neo-liberal government, correct the destructive effects of the market on society, and it is this that differentiates it from, let's say, welfare or suchlike policies that we have seen [from the twenties to the thirties]. Government must not form a counterpoint or a screen, as it were, between society and economic processes. It has to *intervene on society as such, in its fabric and depth*. Basically, it has to intervene on society so that competitive mechanisms can play a regulatory role at every moment and every point in society and by intervening in this way its objective will become possible, that is to say, a general regulation of society by the market" (Foucault, 2008, p. 145; emphasis added).

The role of regulation, that of the social policies pursued by the neoliberals of the 1930s should be to work *for* the market, not against it. Not in the sense of "releasing" the forces of the market, but by creating its "historical and social conditions of possibility". Reform the social order so that it can make the *ideal* market economy, i.e. one identified with competition, possible.

The concept of "conditions" renders the whole of society legible in its relationship to the market. This does not mean, however, that everything is considered *as* a market, or that everything is considered in monetary terms. Instead, the conditions of the markets are understood to be representing values that cannot be valued within the market (Stiegler, 2019, pp. 231-234). In other words, if things, elements, factors and variables are now seen as relevant in the analysis that is involved in the creation of the conditions of the market, this is not because these conditions are seen in economic terms themselves. This is not to say that they are seen as "non-economic" either, or as existing in a field "much larger than the economy" itself, but because they are identified as conditions of possibility that exist *a priori* to the market, and which therefore are not perceivable for the private actors that operate within it (Stiegler, 2019, p. 233). As such, the values represented by the conditions of possibility of the market economy cannot be produced through competitiveness between the actors within the markets. As Stiegler explains:

> "If the perspective of market agents is considered here too narrow, it is not because their "utility" would cover, as believed [William] James and [John] Dewey, a field much broader than the economic. It is so because the agents, when they are in the interior of the market, cannot perceive what is the basis of or what constitute the market itself. This is the theme, which will prove to be fundamental in German ordo-liberalism, of an *a priori* set of conditions of possibility, in the Kantian sense of the word, required for the construction of the order (*ordo*) of the market, in its ideal normative or even "eidetic" functioning [(Foucault, 2008, p. 120)]. The values produced by education and by protecting the environment are therefore not an-economic. Rather, they are the transcendent conditions of possibility of the market economy itself and, for this very reason, not assessable by the market"[20] (Stiegler, 2019, p. 233; emphasis in the original).

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[20] "Si la perspective des agents du marché est jugée ici trop étroite, ce n'est donc pas parce que "l'utilité" recouvrirait, comme chez [William] James et [John] Dewey, un champ beaucoup plus large que l'économie. C'est parce que les agents, quand ils sont à l'intérieur du marché, ne peuvent pas percevoir ce qui fonde ou ce qui constitue le marché lui-même. C'est le thème, qui se révélera fondamental dans l'ordo-libéralisme allemand, d'un ensemble *a priori* de conditions de possibilité, au sens kantien du mot, requises pour que puisse se construire l'ordre (*ordo*) du marché, dans son fonctionnement normatif idéal ou même « eidétique ». Les valeurs produites par l'éducation et par la protection de l'environnement n'ont donc rien d'anéconomique. Elles sont bien plutôt les conditions transcendantales de possibilité de l'économie de marché elle-même et, pour cette raison même, non évaluables par le marché"

This notion of a project seeking the "general regulation of society by the market," and the premise that the state must be "omnipresent" in the way that it intervenes, might seem to evoke the kind of monolithic force that Green and Bell are critical of. Yet, what is at stake here is a conception of neoliberal politics as being *inherently limited* vis-à-vis the goals that it pursues, in so far as a neoliberal policy is never achieved, but is instead constantly pursued in so far as its project is never truly realized. Furthermore, while it would still be relevant to look for "negative impacts" on health that can be linked back to the policies pursued toward this aim, it is also relevant to consider *the ways in which the policies of public health are integrated in the attempts at reforming the social order that make up the conditions of possibility for the competitive market economy*. In other words, instead of only looking for the negative *effects* of the neoliberal project it might therefore be worthwhile to also consider the role that public health is given within it.

1.4 The role of public health in the construction of the conditions of possibility for the market economy

As Barbara Stiegler (2019) shows in her genealogy of maladjustment, public health was given a central role in the social policy of the new liberalism. Considering the writings of Walter Lippmann, who were one of the central figures in the debate,[21] Stiegler situates the role of public health as an instrument for the realization of the principle task Lippmann had given to liberalism: the "readjustment" of the human species to the demands of the global economy (Stiegler, 2019, p. 234). Like other liberals at the time, such as John Dewey, Lippmann identified a fundamental problem in what he called the "cultural lag,"[22] that is to say, the discrepancy between the culture, mental schemas, ways of life of the human species on the one hand, and the new milieu of existence created by the Industrial Revolution. While the human species had been adapted to live in small, local and self-sufficient communities, where they were to hold a single profession that they could specialize throughout their life; the Industrial Revolution had brought about a completely different world, one that, in the eyes of Lippmann, were market by the needs of the global market. As the members of a "Great Society" (i.e. the "world-wide-economy"), the

[21] Lippmann is the namesake of the "Walter Lippmann Colloquium" held in Paris in 1938, where the debated on the renewal of liberalism were held. On this, see Audier and Reinhoudt (2017), Foucault (2008, p. 132, sixth lecture 14 February 1979) and Stiegler (2019).

[22] The theme of a "cultural lag" has its roots in American sociology of the 1920s. The term was coined in 1922 by William Fielding Ogburn, when he published *Social Change with Respect to Culture and Original Nature* (Stiegler, 2019). On the differences between Lippmann and Dewey regarding the theme of "cultural lag" see Stiegler's pp. 247-256, sub-chapter titled "Le Retard Culturel de l'Espèce Humaine".

human species needed to constantly adapt their particular profession and specialization as the needs of the market (i.e. the global division of labor) changed and changed again (Stiegler, 2019, p. 244).

As Stiegler points out, while the identification of the problem of "cultural lag" was similar between Dewey and Lippmann, both taking part in the discussion on the renewal of liberalism in first half of the twentieth century, the solutions proposed were fundamentally opposed to one another. Dewey, believing in the "creative capabilities" of the human species, argued that the discrepancy between the new and the old would be adjusted as the human species came together in democratic forms of life, in order to figure out a new path for its own evolution (Stiegler, 2019, pp. 252-253). Lippmann, on the other hand, keeping the ends of the development fixed by the global economy, thereby using the "global economy as the *telos*" of evolution, situated the responsibility for adaptation on the side of the human species itself (Stiegler, 2019, p. 244). However, rather than believing in the ability of the species to adapt on its own – as did Dewey – or leaving the individual to fend for itself, as believed the classical liberalist, Lippmann argued that, if the species would be able to take on a "way of life" fitted for the ever changing demands of the global economy – that is to say, the demand of readapting "not merely to a new mode of existence but to one in which the newest situation has soon been transformed into a still newer one" (Lippmann, 2017 [1937], p. 166; cited in Stiegler, 2019, p. 254)[23] – it would require an ambitious set of public policies aimed at create the conditions of possibility for readaptation.

The problematization of the "adaptability" of the human species implies that the problem is framed in evolutionary terms. What was identified by Malthus in the nineteenth century, and taken up again by Lippmann at the start of the twentieth, was the problem identified in the discrepancy – or "dyschronie" as Stiegler calls it – between the two evolutionary paths followed by the global economy on the one hand, and the culture of the human species; its ways of thinking, acting and feeling (Stiegler, 2019, p. 254). The problem of "adaptation" thus became the main target of political intervention. The problem is that the "stasis" represented by man's old way of life, fitted to specialization into a single occupation that is to be kept throughout one's life, is no longer apt in the face of the "flux" of the new world that is marked by a global division of labor, and where the demands for specialization change constantly, with an increasing speed (Stiegler, 2019, p. 244).

By emphasizing the evolutionary dimension of the problem, Stiegler adds another level of depth to what Foucault identifies as the "stakes" inherent in neoliberal policy. While it is still true that what is at stake for Lippmann's proposals is a set of reforms that involve an active, intense and omnipresent social interventionism in order to create the conditions that enable the market economy

[23] All citations from Lippmann (2017 [1937]) attributed to Stiegler (2019) are based on Lippmann's English original.

to function; that he finds the principle of the market economy eligible for reforming the state itself; and that the diffusion of an entrepreneurial way of life is what is sought after in the reforms he proposes; by pointing to the evolutionary dimension of the stakes, Stiegler is able to show that while neoliberalism in this way a project that seeks to "normalize" society – a project involving the transformation of society according the prescribed ideals of competition –, when it concerns the transformation of the individual, the problem is not primarily one of "disciplining" the individual, or forcing him or her into becoming an entrepreneur. It is not a question of perfecting the individual and to constantly bring it closer to the ideal of the normal "entrepreneurial subject", and subsequently ridding him of all that which is "bad" in his nature, or abnormal. What is at stake, rather, is to work on the maladjustment that exist *between* the species and its milieu of existence. As Stiegler observes:

> "Taking up the Spencerian vocabulary of *fitness*, of the ability to survive in a selective context of competition, [Lippmann's proposals for reform][24] opens with the observation of a human species "unfit", or whose aptitudes are "poorly adapted": "The malaise of the spirit reflects, like the discomfort of a badly fitted shoe, the maladjustment of men to the way they must obtain a living" [(Lippmann, 2017 [1937])]. What Foucault identifies as the anthropological foundation of discipline,[25] this bad nature of the human body and its inclinations which justifies its training, is here renewed by the categories of Spencerian evolutionism. The bad is no longer, as in the ascetic disciplines which have been perfected for centuries in the monasteries, that of the flesh, but that of the "bad" adaptation or "bad" adjustment of the human species to the demands of its environment.[26] (Stiegler, 2019, p. 257).

Yet, while Lippmann works within the framework of "Spencerian evolutionism," he does not follow his prescribed policies. Unlike Spencer, who, believing that the "laws of evolution" would carry out this readaptation by sorting out the week from the strong, argued that the state should abstain from *all* policies of public health, as well as refraining from legal interventions in the relationship between doctors and patients; Lippmann argued that by not intervening into such matters Spencer inadvertently supported the imbalance that existed in the doctor-patient relationship, which in fact already implied a

[24] Originally: "the text" (*le texte*). The text referred to by Stiegler is Lippmann's chapter on «The Field of Reform» (see 2017 [1937], p. 212).
[25] This is described in *Discipline and Punish* (Foucault, 1991). See also Laval (2007).
[26] "Reprenant le vocabulaire spencérien de la *fitness,* de l'aptitude à la survie dans un contexte sélectif de compétition, le texte s'ouvre sur le constat d'une espèce humaine « inapte », ou dont les aptitudes seraient « mal adaptées » : « Ce malaise de l'esprit reflète, comme l'inconfort d'un soulier mal adapté *(badly fitted*), le mauvais ajustement (*maladjustment*) des hommes à la manière dont ils doivent gagner leur vie » [(Lippmann, 2017 [1937], p. 212)]. Ce que Foucault repère comme le fondement anthropologique des disciplines, cette mauvaise nature du corps humain et de ses penchants qui justifie son dressage, est ici renouvelé par les catégories de l'évolutionnisme spencérien. Le mal n'est plus, comme dans les disciplines ascétiques qui se sont perfectionnées pendant des siècles dans les monastères, celui de la chair, mais celui de la « mauvaise » adaptation ou du « mauvais » ajustement de l'espèce humaine aux exigences de son environnement" (Stiegler, 2019, p. 257).

set of juridical structures; Spencer also failed to consider how pre-existing social, political, economic and cultural environment of the new world were working against the spontaneous adaptation envisaged by him (Stiegler, 2019, pp. 236-237):

> "While Spencer believed that it was enough to "let go" (*laisser faire*) the mechanisms of evolution so that the fittest would be selected and the unfit be eliminated, Lippmann considered all competition to be skewed from the start by the flaw in the human material (*matériau humain*). It is this observation which legitimizes, in his eyes, both an ambitious public health policy and major public education policies, which the Spencerian laissez-faire believed, on the contrary, that one could abolish"[27] (Stiegler, 2019, p. 257).

In addition, Stiegler argues, Lippmann's emphasis on an ambitious social policy consisting of public health and education, represent an important turn (*un véritable tournant*) in his intellectual trajectory (2019, p. 231). Dismissing the possibilities of a "democratic" governing of society, as envisioned by Dewey, Lippmann had previously proposed a model for a decentralized government of society, whereby experts would decide the direction for the development of society (which corresponded to the demands of the global economy), and govern "from above" on the basis of the fundamental interaction between, on the one hand, the self-government of every individual that constituted society, and on the other hand, the possibility of changing their course of action through the alteration of the "rules of the game" or the "Highway Code" [28] that every actor prescribed to in so far as they could be considered as actors on a market; thereby enabling the voluntary management of the population in accordance with the demands of the global economy by way of legal interventions.

By the publication of *The Good Society*, however, articulating the problem in the evolutionary framework of the "cultural lag", and led by the experiences of the Great Depression (mass unemployment, poverty, malnutrition; that is to say, all the phenomenon of a grand scale that could not be solved or dealt with effectively by the private actors within the market), Lippmann believed that the sole reliance on "legal interventions" would not be enough to carry out the necessary adaption. The conditions of possibility for this "great adaptation of the human species" (Stiegler, 2019, p. 239) would have to be created and maintained by a public authority that were set beyond the limited perspective of the actors within the market.

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[27] "Tandis que Spencer croyait qu'il suffisait de « laisser faire » les mécanismes évolutifs pour que les plus aptes soient sélectionnés et les inaptes éliminés, Lippmann considère que toute la compétition est dès le départ biaisée par la défectuosité du matériau humain. C'est ce constat qui légitime à la fois, à ses yeux, une politique ambitieuse de santé publique et de grandes politiques publiques d'éducation, que le laisser-faire spencérien croyait au contraire pouvoir abolir"

[28] On the image of the "Highway Code," Stiegler (2019), chapter 6. "*Réformer l'espèce humaine par le droit*"; as well as Dardot and Laval (2009, 2017).

In order to create the conditions that would enable the readjustment of the species to the demands of the global economy, Lippmann proposed a series of policies that would be aimed at the conditions of the series of phenomena that affected the species ability adapt. At the heart of the policy, therefore, was a conception of the kinds of phenomenon that affected man's ability to adapt. Lippmann gives "handicaps"[29] a central role, as it limited man's ability to function self-sufficiently and make the necessary adjustments, as times changed. Then there was the precondition for adaptation, which Lippmann identified in the development of one's faculties throughout life.

An important distinction must be underlined in the way that Lippmann proposes to act on these phenomena by way of public health policies. Unlike policies of social aid, which sought to redistribute public funds so as to alleviate those who had been distraught, due to illness, poverty, etc., public health policies would act on the *causes* that led to the development of these conditions in the first place. With regard to poverty, Lippmann wrote that

> "The taxes levied on the rich must be spent not on doles to the poor but on the reform of the conditions which made the poor. The dole, by which I mean cash given by the government directly to the poor, is a relief of, but not a remedy for, their poverty, whereas money spent on public health, education, conservation, public works, insurance, and indemnification is both a relief and a remedy" (Lippmann, 2017 [1937], pp. 227-228; cited in Stigler, 2019 p. 237).

By working on the side of the conditions that created poverty, by arranging and working on them so that the phenomenon of poverty itself was reduced, the "foundations of the economy" would be created because this would in turn would improve the productive capacity, Lippmann explained,

> "both of the individual and of the national patrimony from which he must earn his living. By improving the marginal productivity of labor, it raises the minimum wage of all labor out of an increased national dividend. This is equivalent to saying that some portion of the national dividend must be invested, in order to conserve and improve the foundations of the economy, in the people and in the national estate from which they earn their living" (Lippmann, 2017 [1937], p. 228; cited in Stigler, 2019 pp. 237-238).

The kind of public health policy envisaged by Lippmann also implied the necessity of a knowledge of the *causes* that led to the formation of the elements that affected man's ability to adapt. With regard to "handicaps," Lippmann distinguishes between those who were born with handicaps, due to "the deterioration of the stock from which they spring"; and those who become handicapped in the early

[29] As Stiegler notes, the word "handicap," seeing as it is taken from the world of sports, is already imbued with connotation of "competition" and is linked, moreover, to one's ability to compete (Stiegler, 2019, pp. 320, fn. 371).

stages of life: due to "disease in childhood, by malnutrition and neglect," or, by being "the casualties of a vicious or stupid family life, carry with them forever the scars of inferiority and perversion." The development of one's "faculties" was, on the other hand, greatly affected by the conditions of one's youth: "Then there are those who have been broken by the poverty and squalor of their youth, and who never do obtain an equal opportunity to develop their faculties" (Lippmann, 2017 [1937], p. 212).

It can be seen that of the causes that Lippmann here lists, at no time does he "blame" the individual for his own lot in life. What is being problematized, is instead the ways in which heredity and the individual's life course (seen from the side of factors that lie *outside* the individual's control) affect his (or her) ability to "make his way in life" and thereby "adapt themselves" to the demands of the global economy. In sum, Lippmann writes:

> "The economy of the division of labor requires […] a population in which these eugenic and educational problems are effectively dealt with. […] The economy requires not only that the quality of the human stock, the equipment of men for life, shall be maintained at some minimum efficiency, but that the quality should be progressively improved. To live successfully in a world of the increasing interdependence of specialized work requires a continual increase of adaptability, intelligence, and of enlightened understanding of the reciprocal rights and duties, benefits and opportunities, of such a way of life" (Lippmann, 2017 [1937], pp. 212-213)

As Stiegler points out, despite the reference to the problems of "eugenics" needing to being treated in order for the demands of the global economy to be met, what is proposed should not be mistaken for classical eugenics, which assigns a dominant role to the "inherent" qualities of the individual; but must rather be linked the *new* eugenics movement, who, from the 1920s had argued against this "biological reductionism" and argued instead for the determining role of the *social environment* in the formation of the qualities of the species, such as they are inherited from one generation to the next, and the way that the individual develops from the time that he is born until his death (Stiegler, 2019, p. 259; see also Kevles, 1985).

Thus, what is being sought after in the social policy presented by Lippmann is the historical and social conditions that enable the members of the human species to make the "necessary" adjustments in their way of life so that they are able to meet the ever-changing demands facing them – as interdependent members of a "Great Society" – in the division of labor of the global economy. Public health, while not being devoid of direct contact with the individual (in that it can tech ways of life that will be beneficial for the health of the individual), must primarily focus on factors that are located at a level of reality that is not perceptible for the individual themselves, and which are thereby outside of their control. In other words, in order to enable the "great readjustment of the human species" to the

demands of the global economy, it will be necessary to intervene, as Foucault put it, at the "level of life itself and its fundamental events" (2004a, p. 11), by working on the social and historical conditions that determines the development of the species.

1.4.1 On the nature of critique in the face of a neoliberalism that deploys public health

It seems to me that the nature of critique is changed in the face of such a power. While it may be easy to be critical when the stakes are that of being on the side of defending health in the face of forces seeking to harm it; the landscape becomes much more complex, and much harder to orient in, when the adversary is also seeking to improve health, seeks to strengthen it, protect it. Consequently, if we do not stop to consider what health is *for*, then we cannot be sure if we are fighting on the side that we would like. In order to take a critical position to this program, I think it is unwise to brush it off as "illusory" and mere "rhetoric" (when set up against with the "reality" that is created in the "name" of good words (Cf. Ayo, 2012)). I think it is necessary to try to understand the complexities of what is presented.

1.4.2 On the relevance of a 1930s conception of neoliberalism for the study of neoliberalism in the 1980s

Because I have spent time on this older conception of neoliberalism from the 1930s, I would now like to finish up this section by discussing the relevance of it for the study of political changes in Europe during the 1980s.

In their study of neoliberal society, Dardot and Laval (2009, 2017), who are working within a governmentality framework, defines neoliberalism of the 1980s and 1990s in terms that are opposed to the conceptions of neoliberalism as an "ideology" and that of viewing it as a set of "economic policies"; they define it as pertaining, much more fundamentally, to a way of life that is plunged into "a universe of generalized competition" (*un univers de compétition généralise*):

> "What is at stake is no less and no more than the *form of our existence*, that is to say the ways that we are led (*presses*) to behave, to relate to others and to ourselves. Neoliberalism defines a certain norm of life in Western societies and, beyond this, in all the societies that follow them on the path toward "modernity". This norm enjoins everyone to live in a universe of generalized competition, it summons populations to enter into economic struggle against each other, it organizes social relationships according to the market model, it transforms the individual, who is called to see itself as an enterprise. For nearly one-third of a century, this norm of existence presides in

public policies, order the economic relations of the world, transforms society, remodel subjectivity"[30] (Dardot & Laval, 2009, p. 5; emphasis in the original).

This emphasizes that the *"stakes" of neoliberalism* is conceived of in similar terms as the ones I have described above. However, as I will detail in chapter 2, the conception that they have of the kinds of interventions that are deployed in the neoliberal management of population does not leave room for the possibility of deploying public health measures (conceived of as *mechanisms of security*) in the improvement of the human capital of the population (Cf. Foucault, 2007; Foucault, 2008, p. 230).

While I find Dardot and Laval's (2009) work on neoliberalism both inspiring and illuminating; their specific treatment of it – their emphasis on its *disciplinary forms* and the ways in which it acts on subjects of interest "from a distance" through the regularized play of incentives and disincentives, together with their focus on its *judicial interventionism* as a tool for constructing ideal markets, reframing states themselves at the level of their own actions, as well as envisioning a principal role of the construction of the "rules of the game" as the principal mechanism by which subjects are enjoined into entering into a way of living that is concomitant to that of *pure competition* (see pages 229-313; 457-458; Laval, 2018) – leaves little conceptual space for imagining how public health policies could function within this neoliberal governmentality. Following Barbara Stiegler's (2019) account of Walter Lippmann's proposals for a *new liberalism*, it is clear that the function and role of public health policy within neoliberal governmentality necessarily will have to be located somewhere else entirely; organized by a different type of problem than the one found in Dardot and Laval – indeed, even the one found in Foucault's treatment of neoliberalism –; a set of problems, linked not so much to the "discipline" of subjects and the diffusion of entrepreneurial subject position, as to the *evolutionary problem* of maladjustment between the *human species* and the new environment created by the Industrial Revolution of the nineteenth century, represented as the problem of constant adjustment to *ever changing demands of the global economy*; and situated at a different level of intervention, which accompanies the series of juridical interventions represented by the *common law* of the market that directs individuals in a market in a decentralized manner by setting up the 'rules of the game' (*règles de jeu*) on the one hand, and relying on the capacities *self-governing* on the part of subjects on the other (Cf. Dardot & Laval, 2009, pp. 14-15; Laval, 2018, chapter 3; Taylan, 2013, 2014, 2018). The

[30] "Ce qui est en jeu n'est ni plus ni moins que la *forme de notre existence*, c'est-à-dire la façon dont nous sommes pressés de nous comporter, de nous rapporter aux autres et à nous-mêmes. Le néolibéralisme définit en effet une certaine norme de vie dans les sociétés occidentales et, bien au-delà, dans toutes les sociétés qui les suivent sur le chemin de la « modernité ». Cette norme enjoint à chacun de vivre dans un univers de compétition généralisée, elle somme les populations d'entrer en lutte économique les unes contre les autres, elle ordonne les rapports sociaux au modèle du marché, elle transforme jusqu'à l'individu, appelé désormais à se concevoir comme une entreprise. Depuis près d'un tiers de siècle, cette norme d'existence préside aux politiques publiques, commande aux relations économiques mondiales, transforme la société, remodèle la subjectivité."

new liberalism proposed by Lippmann, as did the ordo-liberals which elaborated upon this program, took the form of a *social action* that was directed at the "foundations of the social market economy" (Stiegler, 2019). It is at this level that the policies of public health will have to be located in order to conceive it as a positive function within the 'governmental style' represented by neoliberalism, that is to say, as a form of social action that intervenes in order to create the conditions of possibility for the competitive market economy.

Chapter 2 *Population half-present – on the neoliberal management of population*

> Is it a question of disciplining subjects, making them produce wealth, or is it a question of constituting something like a milieu of life, existence, and work for a population? – Michel Foucault, *Security, Territory, Population Lectures at the Collège de France, 1977-1978* p. 30

2.1 Introduction

The public health policy described in the previous chapter does not seem to me to find its place within the framework of a "neoliberal governmentality" that is often deployed. Seen in the terms identified by Kipnis (2008; cited in Bell & Green, 2016, p. 240), the neoliberal governmentality identified as a "governing from a distance; the emphasis on calculability; and the promotion of self-activating, disciplined, individuated subjects," the public health policy proposed by Lippmann, which sought to intervene in the form of a social action that aimed at reforming the historical and social conditions that determined the development of the ability of the human species to adapt to the demands of the global economy, cannot be understood. One can argue that this has not been the aim of previous studies, whose focus has been directed at the ways in which the *conduct of individuals* has been governed in neoliberal societies. Yet, the same principle is also used in conceptualizations of neoliberal management of populations, or biopolitics.

In this chapter, I argue that the neoliberal government of population that is only conceived in terms of an action at a distance in order to conduct the conduct of subjects, so as to aligning the conduct of the individual members of the population with a neoliberal rationality marked by the entrepreneurial logic of investing in one's abilities, with the aim of improving one's competitiveness, is conceptually limited in so far as it confines the analytical scope of the investigation to only consider the technologies of power that takes the form of "environmental technologies" (Taylan, 2013) aimed at inciting certain forms of conduct on the part of the individual members of the population.

At stake here is whether the analysis is able to consider a neoliberal rationality deployed in the management of population in the full breadth of the notion of "government" that Foucault linked to the emergence of "biopolitics" at the latter half of the eighteenth century. The approach normally considered, I argue, is marked by an epistemological obstacle wherein the central dimension of *historical time* is omitted, thereby failing to consider the ways in which the management of population entails interventions that are not aimed at the body, but rather at the "level of life itself and its fundamental events" (Foucault, 2004a, p. 11), not primarily order to incite forms of behavior, but rather to act on the elements which determines the developmental process of the species. The category of

"environmental technology" and the associated meaning of the "action at a distance" is thereby multiplied in the sense that the environment. It will still refer to the environmental variables found in environmental psychology, that relates to the motivation to act; but must also be seen in the form of environmental variables found in the species' milieu of existence. Considering the specific "natures" of the population, such as Foucault (2007, pp. 69-75) defines it in *Security, Territory, Population*, this level of intervention must necessarily be "from a distance" because of the fact that the natural processes of the population occurs over a certain span of time and are not reducible to the actions of any single individual, but is nonetheless "penetrable" for the governor in so far at the variations of the population (rates of birth, mortality, morbidity etc. and the development of certain qualities) depend on the variables of the population's milieu of existence.

In order to discuss the point further, I will consider a recently proposed conception of neoliberal biopolitics presented by Laval (2018) and Taylan (2018). I will begin by presenting the conception of neoliberal biopolitics, such as it is presented by Christian Laval (2018) in his recent book on Foucault's analysis on neoliberalism; then I will turn to a confusion regarding the relationship between Foucault's notions of "milieu," concerning the supposed consistency between his treatment of Gary Becker's economic analysis of rational behavior in relation to environmental variables, and the way that it relates to the government of cites in the eighteenth century through public health campaigns, expressed in Ferhat Taylan's (2018) book on *Mesopolitics*, or the government of life through environmental technologies.

Ending the chapter, I will discuss how my conception of "neoliberal population management" manages to capture the phenomenon involved in the role that Lippmann ascribes to public health policies within his program of readapting the species to the demands of the global economy.

2.2 A conception of neoliberal biopolitics and a lingering question regarding the meaning of "milieu" in the neoliberal management of population

The relationship between neoliberalism and biopolitics is one that has long haunted Foucault scholars. While his famous analysis of neoliberalism is presented in the series of lectures held at the *College de Francè* in 1979, titled *The Birth of Biopolitics*, it would seem that Foucault never got around to articulate the specific connection between the "biopolitics" and "neoliberalism." Ending the first lecture by claiming that biopolitics would not be understood unless liberal governmentality was

understood[31] (Foucault, 2008, p. 22), he nonetheless had to tell he was sorry that he spent all that time talking about neoliberalism when he was in fact really meaning to talk about biopolitics[32] (Foucault, 2008, p. 185); and ended his course summary by stating that what was still needing to be done what to study how "the specific problems of life and of population have been posed within" liberal governmentality[33] (Foucault, 2008, pp. 323-324).

Considering that Foucault, when he broke away from focusing on biopolitics, chose instead to study neoliberalism in terms of "micro power" – i.e. "the way in which one conducts the conduct of men" (Foucault, 2008, p. 186) –, questions have remained regarding the kind of interventions that are involved in the neoliberal management of populations. Recently, Christian Laval (2018) and Ferhat Taylan (2018) has been arguing that the answer may be found in the lecture Foucault gave on the economic analysis of Gary Becker (Foucault, 2008, pp. 268-269), emphasizing that it was defined as the study of the systematic responses of *homo æconomicus* to the variables in the environment. According to Foucault, in Becker's analysis of crime, the figure of *homo æconomicus* allowed him to bypass the juridical and moral characteristics of the subject (*homo penalis*, *homo legalis, homo criminalis* etc.), and render it "governmentalizable" in so far, and *only* in so far as man can be understood as "accepting reality," that is to say "rational." If he does, Becker argues, then it will be possible to assume that he will respond in a systematic and non-random way to the variables of the environment. These variables are constructed in terms of factors that correspond to man's interest, and by changing the variables of the environment man will respond by acting in a parallel manner.

> "Becker says: Basically, economic analysis can perfectly well find its points of anchorage and effectiveness if an individual's conduct answers to the single clause that the conduct in question reacts to reality in a non-random way. That is to say, any conduct which responds systematically to modifications in the variables of the environment [*variables du milieu*][34], in other words, any conduct, as Becker says, which "accepts reality," must be susceptible to economic analysis […] and economics can therefore be defined as the science of the systematic nature of responses to environmental variables" (Foucault, 2008, p. 269).

[31] "it seems to me that it is only when we understand what is at stake in this regime of liberalism opposed to *raison d'État* – or rather, fundamentally modifying [it] without, perhaps, questioning its bases – only when we know what this governmental regime called liberalism was, will we be able to grasp what biopolitics is."
[32] "I would like to assure you that, in spite of everything, I really did intend to talk about biopolitics, and then, things being what they are, I have ended up talking at length, and maybe for too long, about neo-liberalism, and neo-liberalism in its German form."
[33] "What should now be studied, therefore, is the way in which the specific problems of life and population have been posed within a technology of government which, although far from always having been liberal, since the end of the eighteenth century has been constantly haunted by the question of liberalism."
[34] Applies to the rest of the paragraph. See Foucault (2004b, p. 273)

It is this basic relationship, argues Foucault, that enables the conduct of the conduct of man, not by intervening directly on the subject, but by changing the variables in the milieu. Or, in line with the logic of the market economy, by "[m]odifying the terms of the game, not the player's mentality" (Foucault, 2008, p. 260). According to Foucault, this can be understood as a "radicalization" of German ordoliberal governmentality:

> "We have here a radicalization of what the German ordoliberals had already defined with regard to governmental action: leave the economic game as free as possible and create a *Gescellschaftspolitik*. The American liberals say: if you want to maintain this *Gescellschaftspolitik* in the order of the law, you must consider everyone as a player and only intervene on an environment in which he is able to play" (Foucault, 2008, p. 261)

This American neoliberal governmentality is carried out through what Foucault calls an "environmental technology," which he sketches out by the following characteristics:

- the definition of a framework around the individual which is loose enough for him to be able to play;
- the possibility for the individual of regulation of the effects of the definition of his own framework;
- regulation of environmental effects
- non damage
- non absorption
- the autonomy of these environmental spaces (Foucault, 2008, p. 261).

With the reference to "the order of the law," Foucault is evoking the kind of *decentralized mode of governing* that I described in the previous chapter. The radicalization of the technology of power Foucault is attributing to American neoliberalism, comes in the form of not only applying it to the actors who are strictly speaking private actors within a defined market. By "considering everyone as a player," the American neoliberal governmentality has proposed an extension of the economic rationality that renders *every sphere of life* legible through the lens of economic analysis, which means that every human action can be understood and analyzed through the epistemological grid organized around the figure of *homo æconomicus*, the rational actor who responds in a systematic and non-random manner to the variables of the environment, and who's actions are thereby rendered governable by working on the "terms" of the game, which every "player" adheres to, and which therefore enables an "environmental technology" which organizes the field of player's actions according to the voluntary changes in the legal framework of the game.

By way of multiplication, Taylan and Laval has argued that the management of population is done by extrapolating the micro-management of individuals conduct through the use of economic variables of the milieu. According to Laval

> "it is the notion of *milieu* that gives coherence to the neoliberal rationality, and which allows us to grasp the way in which it takes up the challenge of an unlimited extension of the regulatory mechanisms of conduct. Neoliberalism makes it possible to tighten the definition of governmentality as a "government by the milieu" in so far as the milieu affects the play of interests [(Taylan, 2011, p. 188)]. Structuring the space of conduct of others, making them act in a determined way by structuring what Merleau-Ponty calls the "behavioral milieu" (*milieu de comportement*) of others, is the key to neoliberal power. But this milieu is evidently specified as "market""[35] (Laval, 2018, p. 66).

Which means that

> "Foucault's "detour" into to neoliberalism was done in order to talk about the "birth of biopolitics," that is to say of a form of government of populations that makes use of (*travers*) mechanisms of regulation of the individuals conduct by constructing the social milieu as a *market*. The latter is not a natural given, but a lever of government which permits a mass management (*gestion*) of the population, made possible by that fact that these individuals are supposed to act parallel – despite certain deviations from the norm – according to the government of oneself as a capital to be valorized" [36] (Laval, 2018, pp. 66-67; emphasis in the original).

It has been the source of controversy whether Foucault (2008, pp. 258-259), by identifying the neoliberal analysis of Becker with an "anthropological erasure" in so far as the analysis involved a governmentalization of the individual by reference to the link between the pursuit of his private interest and the elaboration of the decision process within a milieu comprised of different "ques," had thereby proclaimed that he had found a truly *non-disciplinary* mode of governing; that is to say, a form of government that did not rely in the process of *subjectivization*, i.e. the process of constitution of subject positions and relations to the self that would be functionally correspondent to the overall project of

[35] "c'est la notion de *milieu* qui donne sa cohérence à la rationalité néolibérale et permet de saisir la manière dont elle relève le défi d'une extension illimitée des mécanismes régulateurs des conduites. Le néolibéralisme permet de resserrer la définition de la gouvernementalité comme un « gouvernement par le milieu » en tant que le milieu affecte le jeu des intérêts. Structurer l'espace de conduite d'autrui, le faire agir d'une manière déterminée en structurant ce que Merleau-Ponty appelle le « milieu de comportement » d'autrui, c'est la clé du pouvoir néolibéral. Mais ce milieu est évidemment spécifié comme « marché »."

[36] "Ainsi, pour Foucault, ce « détour » par le néolibéralisme avait bien pour but de parler de la « naissance de la biopolitique », c'est-à-dire d'une forme de gouvernement des populations au travers de mécanismes de régulation de la conduite individuelle constituant à construire le milieu social comme un *marché*. Ce dernier n'est pas une donnée naturelle, mais un levier de gouvernement, permettant une gestion de masse de la population rendue possible par le fait que les individus sont supposés agir pareillement, malgré quelques écarts normaux à la moyenne, selon la gestion de soi comme capital valorisable."

governing (in the case of neoliberalism, whose aim is the functioning of the market economy, it is the subject position of the "entrepreneur" that holds this position: the individual who manages and works on his own "abilities" – protects them, develops them and makes use of them – oriented toward the process of adapting to the changing demands of the market). The question is whether Foucault maintained that Becker's "environmental variables" represents a way of governing the conduct of the individual in such a way that it behaves in an entrepreneurial manner, without having also the need to develop the *self-identification* with the entrepreneurial mode of life. This argument has been articulated by Michael C. Behrent (2016, p. 51). With reference to the "neuroeconomics" described by Bourgeois-Gironde (2008), Taylan (2011, pp. 209-211) argues that the this model for governing the conduct of conduct has been radicalized, not with reference to the "*homme economique*", but to the "*homme cerebral,*" the man who acts as a result of the stimuli that he has received to his neural pathways. Thereby furthering the displacement of the need for an active training and processes of subjectivation as a key in the functioning of global capitalism. Yet, as Laval (2018, pp. 55-58) argues, even if Foucault can be seen to describe Becker's analysis in these terms, considering the important role that techniques of the self would come to have for Foucault, and how important the processes of subjectivization (*assujettissement*) had been for him until 1979, it seems unlikely that the role of disciplinary institutions, like education (Laval, 2003), had been left out of the equation, thereby leaving room for his supposed "embrace" of neoliberalism. (On the controversy, see also Becker, Ewald, & Harcourt, 2012; de Lagasnerie, 2020; Dean, 2014, 2018; Newheiser, 2016; Sawyer & Steinmetz-Jenkins, 2019; Zamora & Behrent, 2016).

Still, considering these aspects, everything is not in its proper place. For, as Taylan writes, if Foucault saw the opening up of biopolitics in the campaigns of public hygiene deployed in the attempts to govern the cities of Europe from latter half of the eighteenth century, then what is the connection between the *physical environment* of the city and the *immaterial environmental variables* of Becker's economic analysis, considering the centrality of the notion of "milieu," with which Foucault used to describe them both?

> "How to conceive of the unity of practices and rationalities so diverse and distant in time? To what extent can we justify the continuity of the theme of milieu, between on the one hand the political rationality that governs the practices of urban improvement or hygienic campaigns (*hygiénisme*) from the eighteenth and nineteenth century, and on the other hand the neoliberal economic rationality of the 1970s which generalized the calculus of costs to the ensemble of human actions? Between the physical character of the urban milieu and the immaterial character of the milieu defined as the ensemble of variables of economic decisions, one have the right to be perplexed regarding the unity proposed by Foucault, as long as one does not have an analysis of continuity which would

> make it possible to move from the first to the second level. Mésopolitics is sketched out several times [in this book] without being elaborated as a field of investigation proper by Foucault, who leaves the scattered fragments of a complex history to his readers"[37] (Taylan, 2018, p. 43).

Taylan's inclination to dismiss Foucault's thought as "scattered" seems to me unprompted by Foucault's own words. In order to retrieve the analytical connection, already present in Foucault's published work, it is necessary to understand the difference between the sovereign model of power that were aimed at the "social body" of juridical subjects, and the new art of government which were responsible for the "technical-political" problem of managing and governing a population. Through this excurse, it will be shown that the "physical" environment of the city is itself rendered through the lens of environmental variable, albeit not one that is directed at the conducts of individuals, but rather aimed at the natural processes of a population.

2.3 The birth of biopolitics: From the sovereign and its juridical subjects to the government of the "nature" of the population

In order to understand the connection between the two forms of intervention defined by these seemingly incompatible notions of "milieu," it is important to recall the specific content Foucault gives to the notion of "population" when he links it to the emergence of new "economy of power," and the associated reasons for why the old model of Sovereign power directed at the collection of juridical subjects (set within the universe of the *social contract*)[38] was gradually taken over by the modern political problem of governing the natural processes of the population. Only then will it be possible to understand the way in which the "deployment of mechanisms of security" coincides with "the appearance of a project, a political technique that will be addressed to the milieu" (Foucault, 2007, p. 23; Cf. Taylan, 2018, p. 40).

According to Foucault, when the "population" emerges as a problem of government, it is no longer seen as a collection of subjects that are manageable by way of the sovereigns "juridical voluntarism," that is to say, the direction of man through the imposition of laws enacted by the

[37] "Comment concevoir l'unité de pratiques et de rationalités aussi diverses et éloignées dans le temps ? Dans quelle mesure peut-on justifier la continuité du thème de milieu, entre d'une part la rationalité politique qui gouverne les pratiques d'aménagement urbain ou d'hygiénisme des XVIII et XIX siècles, et d'autre part la rationalité économique néolibérale des années 1970 qui généralise le calcul des coûts à l'ensemble des actions humaines ? Entre le caractère physique du milieu urbain et le caractère immatériel d'un milieu défini comme l'ensemble des variables d'une décision économique, on a le droit d'être perplexe quant à l'unité proposé par Foucault, tant on ne dispose pas d'une analyse de la continuité qui permettrait de passer du premier au deuxième niveau. La mésopolitique est esquissée à plusieurs reprises sans pour autant être élaborée comme un domaine d'investigation propre par Foucault, qui laisse les fragments épars d'une histoire complexe à ses lectures."

[38] See Foucault (2004c), last lecture.

sovereign. In tandem with the demographic explosion and industrial revolution that began in the latter half of the eighteenth century, which corresponds to the emergence of the "technical problems of the town" (Foucault, 2007, p. 20) this model was rendered "inoperable" (Foucault, 1997b, p. 223) in the face of all the phenomenon that now started to slip away from the sovereign's grasp: "too many things were escaping the old mechanisms of the power of sovereignty, both at the top and at the bottom, both at the level of detail and at the mass" (Foucault, 2004c, p. 249). In order to "take charge of life," a series of disciplines directed at the body were developed within the institutions, and then, at a much slower pace, a series of mechanisms of security directed at the biological processes of the population were developed (Foucault, 2004c, p. 250), something that transformed both the nature and meaning of the law and the disciplines (Foucault, 2007, pp. 4-8).

The "population" now facing the sovereign was not a collection of juridical subjects, but was instead a mass-phenomenon identified with "natural processes" that depends on a series of variables[39] (Foucault, 2007, p. 70). As Foucault shows, the discovery of the "nature" of the population, made by the Physiocrats at the end of the eighteenth century, holds profound implications for the kind of power that one can be able to exercise in relation to the population. It means, principally, that a new relationship takes form between the "sovereign" and the object that it directs its attention to.

> "The population is a datum that depends on a series of variables, which means that it cannot be transparent to the sovereign's action and that the relation between the population and sovereign cannot simply be one of obedience or the refusal of obedience, of obedience or revolt. In fact, the variables on which population depends are such that to a very considerable extent it escapes the sovereign's voluntarist and direct action in the form of the law. If one says to the population "do this," there is not only no guarantee that it will do it, but there is quite simply no guarantee that it can do it" (Foucault, 2007, p. 71).

The population emerges as a natural process in light of the discovery made at the end of the seventeenth century by John Graunt,[40] which opened up the field of modern demography, that the phenomenon of life (death, suicides, birth, disease etc.) that one might expect to vary – in so far as they are dependent on "accidents, change, individual conduct, and conjunctural causes" (Foucault, 2007, p. 74) – are actually constant when counted and seen at a mass level: "it is enough to observe that these phenomena that should be irregular, it is enough to look at them and count them, to realize that in actual fact they are regular" (Foucault, 2007, p. 74). With reference to the mortality tables of England, Graunt was able to show that

[39] "It will be considered as a set of processes to be managed at the level on the basis of what is natural in these processes" (Foucault, 2007, p. 70).
[40] See Graunt (2018 [1662]); Petty and Graunt (1899).

> "there was a constant number of deaths every year in a town, but also that there was a constant proportion of different accidents, however varied, that produced this death. The same proportion of people die from consumption, the same proportion from fevers, from the kidney stone, gout, or jaundice. What clearly astonished Graunt is that in the London mortality tables the proportion of suicides is exactly the same from one year to the next. We also see other regular phenomena such as, for example, a higher birth rate for males, but boys suffering from more accidents of varied kinds than girls, so that proportion is re-established after a certain time. Child mortality is always greater than adult mortality for both boys and girls. Mortality is always higher in the town than in the Country, and so on" (Foucault, 2007, p. 74).

As Foucault explained two years prior, the new figure of the population that were the target of biopolitics, were represented by a series of "aleatory events that occur within a population that exists over a period of time" (Foucault, 2004c, p. 246). The phenomena proper to the "population," he writes

> "are collective phenomena which have their economic and political effects and that they become pertinent only at the mass level. They are phenomena that are aleatory and unpredictable when taken in themselves, or individually, but which, at the collective level, display constants that are easy, or at least possible to establish. And they are, finally, phenomena that occur over a period of time, which have to be studied over a certain period of time; they are serial phenomena" (Foucault, 2004c, p. 246).

Yet, whereas the old model of power of juridical impositions, articulated in the form of commands ("do this"), is no longer legible in relation to the naturalness of the population, this does not mean, as Foucault puts it, "that [the natural phenomenon population] is an inaccessible and impenetrable nature, quite the contrary" (Foucault, 2007, p. 71). Quite the contrary because the new phenomena of the population's nature "is constantly accessible to agents and techniques of transformation, on condition that these agents and techniques are at once enlightened, reflected, analytical, calculated, and calculating." The field of knowledge that enables the government of population is the analysis of the variables that the population depends on. As Foucault writes:

> "Population varies with the climate. It varies with the material surroundings. It varies with the intensity of commerce and activity in the circulation of wealth. Obviously, it varies according to the laws to which it is subjected, like tax or marriage laws for example. It also varies with people's customs, like the way in which daughters are given a dowry, for example, or the way in which the right of primogeniture is ensured, with birthright, and also with the way in which children are raised, and whether or not they are entrusted to wet nurses. Population varies with the moral or religious values associated with different kinds of conduct; the ethical-religious value, for example, of the celibacy of priests and monks. Above all, of course, it varies with the condition of means of subsistence […]" (Foucault, 2007, pp. 70-71).

This means that in order to "manage" the population, one cannot rely on the obedience of subjects, but, by working on the reality of the naturalness of the population's dependence on a certain number of variables "it is possible to act effectively on the population through the interplay of all these remote factors":

> "Not only must voluntary changes in the law be considered if the laws are unfavorable to the population, but above all, if one wants to encourage population, or achieve the right relationship between the population and the state's resources and possibilities, then one must act on a range of factors and elements that seem far removed from the population itself and its immediate behavior, fecundity, and desire to reproduce" (Foucault, 2007, pp. 71-72).

It is in this sense that Foucault's (often over-extended[41]) notion that biopolitics involves the right of making of life and letting die should be read (Foucault, 1997b, 2004c). For what does it mean that biopolitics "makes life and lets' die," (*faire vivre et laisser mourir*) if not simply the practices, rationalities and analyses that are involved in the interventions aimed at the *level which determine the natural processes of the population*:

> "The mechanisms introduced by biopolitics include forecasts, statistical estimates, and overall measures. And their purpose is not to modify any given phenomena as such or to modify a given individual insofar as he is an individual, but, essentially, to intervene at the level at which these general phenomena are determined, to intervene at the level of their generality. The mortality rate has to be modified or lowered; life expectancy has to be increased; the birth rate has to be stimulated. And most important of all, regulatory mechanisms must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its aleatory field. In a word, security mechanisms have to be installed around the random elements inherent in a population of living beings so as to *optimize a state of life*" (Foucault, 2004c, p. 246; emphasis added).

The process of normalization, in the sense entailed in the application of mechanisms of security, should be kept separate from the "normation" entailed in the mechanisms of discipline.[42] The disciplines, who

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[41] See for example Agamben (2010); Bird and Lynch (2019); Hardt and Negri (2000); Porter (1999a, 1999b); Schiøtz (2017). In so far as she uses the notion in relation to Norwegian public health policy, it is interesting to note that Schiøtz (2017) takes the concept to refer to "how public health-regulations have contributed to shaping the "disciplinary culture" and the repressive nature which Foucault argues is characteristic of our society. It entails that one, through various mechanisms, monitor (*overvåke*), regulates and corrects the behavior of people"; "korleis public health-reguleringar har bidratt til å forme «disiplinærkulturen» og den repressive naturen som Foucault meiner karakteriserer vår tids samfunn. Det inneber at ein gjennom ulike mekanismar overvaker, regulerer og korrigerer åtferda til folk" (Schiøtz, 2017, p. 211)

[42] The observant reader will no doubt be able to point out that I am here going back and forth between the discussions Foucault have with regard to the role of the "norm" in relationship to mechanisms of discipline and mechanisms of security; staying on the side of the points he makes in *Security*, *Territory, Population*, while at the same time both making reference

start from the imposition of an ideal version of the "normal," aims to transform the individual or a given phenomenon so that it conforms with the norm, and distinguish between that which is able to conform (*the normal*) and that which is not able (*the abnormal*) (Foucault, 2007, p. 63). The process of normalization that involve mechanisms of security takes as its point of departure the normal distributions found in "forecasts, statistical estimates and overall measures" and establishes an acceptable range of differences – in mortality rates, birth rates etc., between groups, regions and so on – that is acceptable with reference to the political and economic effects that these differences involve (Foucault, 2004c, p. 246; 2007, p. 66). Therefore, in the process of normalization that involves the system of mechanisms of security "is exactly the opposite of the one we have seen with the disciplines," Foucault writes, because

> "we have here something that starts from the normal and makes use of certain distributions considered to be, if you like, more normal than the others, or at any rate more favorable than the others. These distributions will serve as the norm. The norm is an interplay of different normalities. The normal comes first and the norm is deduced from it, or the norm is fixed and plays its operational role on the basis of this study of normalities. So, I would say that what is involved here is no longer normation, but rather normalization in the strict sense" (Foucault, 2007, p. 63).

2.3.1 Mechanisms of security and the government of population emerges around the technical problem of the town

These mechanisms of security, furthermore, were developed in the latter half of the eighteenth century, in order to deal with the problem of the town. Whereas the "town" had in previous centuries served as a model for organization of the sovereigns territory – the ideal organization of the sovereigns territory in order to symbolize its strength being one where the kings throne were set in the center or capital, the peasant spread further out to the outskirts, and the vassals placed in the middle (Foucault, 2007) – the phenomenon of the town itself, represented certain problems that – as I noted above – increasingly came to be seen as being out of reach for the sovereigns imposition of laws: one could not deal with the problems of scarcity, of epidemics or the circulation of people and things within the city by imposing just laws (Foucault, 2007, p. 63). Instead of trying to eliminate these general phenomena, or modifying them directly, mechanisms of security needed to operate at the level of reality that determined them.

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to things he says in *Society Must Be Defended*, and avoiding the remarks he makes there that are in conflict with the discussions he holds two years later (Cf. Foucault, 2004c, pp. 252-253; 2007, pp. 56-63).

In relation to the problem of food-shortage, rather than imposing regulations on the price of grain, restrict exports or regulate the production of grain in order to limit the phenomenon of scarcity, the mechanisms of security developed by the Physiocrats took the aim at the *variables that determined the process of development of grain itself*. As Foucault explains, instead of focusing on the phenomenon of "scarcity-dearness" itself, analysis had to "move back a notch" and take as its object what he calls "the history of grain":

> "from the moment it is put in the ground, with what this implies in terms of work, time passed, and fields sown – of cost, consequently. What happens to grain between seeding and the time when it will have finally produced all the profits that it can? The unit of analysis will no longer be the market therefore, with its effects of scarcity-dearness, but *grain with everything that may happen to* it and will happen to it naturally, as it were, according to a mechanism and laws in which the quality of the land, the care with which it is cultivated, the climatic conditions of dryness, heat, and humidity, and finally the abundance or scarcity, of course, and its marketing and so forth, will also play a part. The event on which one tries to get a hold will be the reality of grain, much more than the obsessive fear of scarcity" (Foucault, 2007, p. 36; emphasis added).

In similar terms, rather than primarily working in order to discipline the individual, restricting or directing his or her actions, mechanisms of security will have to act on the variables of the milieu that determines the developmental process of the human species. This is not to say that the disciplines are now eliminated, but that their deployment are seen in relation to the overall reality of the development of the species (Foucault, 2004c). Yet, in order to see what this entails it will be to slow down and do a thorough reading of the specific way in which Foucault relates the nature of the "milieu" to the nature of the human species, in so far as it relates to the government of the population, by a sovereign, through the deployment of the mechanisms of security.

Unlike the "territory" that is capitalized by the sovereign, and unlike the "structured space" of disciplines where the aim is to set up a "hierarchical and functional distribution of elements," the "milieu" made object to mechanisms of security is seen in terms of "events or series of events or possible events […] that will have to be regulated within a multivalent and transformable framework" (Foucault, 2007, p. 20). In other words, the "milieu" is "the space in which a series of uncertain elements unfold."

The notion of "milieu" is itself important. Evoking the lesson from his master, George Canguilhem, Foucault recalls that the notion originates in the mechanistic conception central to Newtonian physics before emerging in the biology of Lamarck (Canguilhem, 1992). The milieu is the element which is "needed to account for action at a distance of one body on another," which means that it is both "the medium of an action and the element in which it circulates. It is therefore the problem

of circulation and causality that is at stake in this notion of milieu" (Foucault, 2007, p. 21). However, Foucault makes an important modulation to the sense given to the term by Canguilhem. Instead of relating this milieu to the "organism," Foucault maintains that the object that is targeted in the deployment of mechanisms of security through the milieu, is the "population":

> "The milieu is a set of natural givens – rivers, marshes, hills – and a set of artificial givens – an agglomeration of individuals, of houses, etcetera. The milieu is a certain number of combined, overall effects bearing on all who live in it. It is an element in which a circular link is produced between effects and causes, since an effect from one point of view will be a cause from another. […]. So it is this phenomenon of circulation of causes and effects that is targeted through the milieu. Finally, the milieu appears as a field of intervention in which, instead of affecting individuals as a set of legal subjects capable of voluntary actions – which would be the case of sovereignty – and instead of affecting them as a multiplicity of organisms, or bodies capable of performances, and of required performances – as in discipline – one tries to affect, precisely, a population. I mean a multiplicity of individuals who are and fundamentally and essentially only exist biologically bound to the materiality within which they live. What one tries to reach through this milieu, is precisely the conjunction of a series of events produced by these individuals, populations, and groups, and quasi natural events which occur around them (Foucault, 2007, p. 21).

In order to exemplify how the milieu is operated and taken up in mechanisms and technologies of security, Foucault goes on to talk about how the notion of milieu have appeared within the works of architects and town planners at the end of the eighteenth century. Yet, as Foucault admits, the notion of "milieu" itself does not seem to appear, but is visible in the form of a kind of technical schema: "the kind of […] pragmatic structure which marks it out in advance [that] is present in the way in which the town planners try to reflect and modify urban space. The apparatuses of security work, fabricate, organize and plan a milieu even before the notion was formed and isolated" (Foucault, 2007, p. 21).

Two years prior, in "*Society Must Be Defended,*" Foucault had analyzed the way in which town planning was carried out and reflected when he considered the different levels of intervention represented by discipline and biopolitics in the technical schemas of the work town (*la cite ouvrière*) of the nineteenth century (Foucault, 1997b). In addition to the systems of discipline which aimed to individualize, partition space into a grid-system, and fix things and people to particular points in order to ensure optimal surveillance of the whole, and the practices of surveillance among the inhabitants of the town, the work town also entailed a series of interventions that were aimed at the biological processes of the population:

> "Health-insurance systems, old-age pensions; rules on hygiene that guarantee the optimal longevity of the population; the pressures that the very organization of the town brings to bear on sexuality and therefore

> procreation; [the pressure that it exercises on the hygiene of families; the care given to children]; education, et cetera"[43] (Foucault, 2004c, p. 251).

In *Security, Territory, Population*, when the town is the subject once more, Foucault does not discuss an urban program infused with the techniques of public health and public hygiene. Yet, he nonetheless identifies the same fundamental link between mechanisms of security aimed at the milieu as a means to grab hold on the "natural" processes of the population. The example Foucault now gives, concerns a text by Jean-Baptiste Moheau, whom Foucault considers "the first great theorist of what we could call biopolitics, bio-power" (Foucault, 2007, p. 21).

In 1778, Moheau publishes *Recherches et Considérations sur la population de la France*, an important work in the history of demography, where he articulates the basic problem of an artificial and natural milieu that serves as the target of interventions of power in order to get to the "naturalness" of the population. Moheau says that

> "If the unknown principle that forms the character and the mind is the outcome of the climate, the regime, the custom, and the habit of certain actions, then we can say that sovereigns, by wise laws, by useful establishments, through the inconvenience of taxes, and the freedom resulting from their suppression, in short by their example, *govern the physical and moral existence of their subjects*. Perhaps one day we will be able to call on these means to give whatever hue we wish to morality and the national spirit" (Foucault, 2007, pp. 22-23; emphasis added).

As Foucault points out, while Moheau here evokes to figure of the "sovereign" it is not the figure "who exercises his power over a territory on the basis of a geographical localization of his political sovereignty" (Foucault, 2007, p. 23). The sovereign that can be found in Moheau's text deals instead with a "nature": "or rather with the perpetual conjunction, the perpetual intrication of a geographical, climatic, and physical milieu with the human species insofar as it has a body and a soul, a physical existence" (Foucault, 2007, p. 23). In relation to which, the sovereign will have to intervene

> "at that point of connection where nature, in the sense of physical elements, interferes with nature in the sense of the nature of the human species, at the point of articulation where the milieu becomes the determining factor of nature […] if he wants to change the human species, Moheau says, it will be by acting on the milieu" (Foucault, 2007, p. 23).

[43] My addition. The English translation is lacking in relation to the French original: "Des systèmes d'assurance-maladie ou d'assurance-vieillesse ; des règles d'hygiène qui assurent la longévité optimale de la population ; des pressions que l'organisation même de la ville fait jouer sur la sexualité, donc sur la procréation ; les pressions qu'on exerce sur l'hygiène des familles ; les soins apportés aux enfants ; la scolarité, etc. (Foucault, 1997b, p. 224)

Therefore, Foucault concludes, with the writings of Moheau, we encounter "one of the fundamental elements in this deployment of mechanisms of security, not yet the appearance of a notion of milieu, but the appearance of a project, a political technique that will be addressed to the milieu" (Foucault, 2007, p. 23). It is not a project whose aim is to govern the actions of subject, but rather the quality of the species by intervening into its milieu of existence.

2.3.2 Individuals of the population

What then about the ways in which mechanisms of security targets the individual and its conduct? All this that has been written above have not been a way of excluding the character of the subject from the equation. However, I have organized the presentation in this way because I have wanted to underline that it is the figure of the *population* – with its particular nature – and not the individual, which is the pertinent object for the mechanisms of security. Before turning to the implications of this population management in relation to neoliberal rationality, I will now describe to role of the individual in the government of population a bit closer.

First, from within the system of knowledge-power that marks mechanisms of security. I have said that with the emergence of mechanisms of security, the older model of the sovereign, with its emphasis on the deployment of law in relation to its juridical subjects, as well as the newer mechanisms of discipline, whose aim was to train and dressage the "working bodies" of the state's forces, was displaced in relation to the larger problem, or the problem which emerged on another level; that of the relationship between the population and its milieu of existence. In this it is important to underline that while these older systems of power are made "inoperable" in the face of the forces that "gnaws at life over time" (Foucault, 2004c) they are not excluded, but simply made to work in a different way. In relation to the analysis that are central to security mechanisms, which places an emphasis on the *development of the phenomenon* one wants to regulate, these mechanisms are seen as *elements* that must be made to work in relation to the "reality" of this development. The changes in the law must be considered in terms of their favorability to the population, and one must "act on a range of factors and elements that seem far removed from the population itself and its immediate behavior, fecundity, and desire to reproduce" in order to "encourage population, or achieve the right relationship between the population and the state's resources and possibilities" (Foucault, 2007, pp. 71-71). Yet, the management of population is not only concerned with "managing the collective mass of phenomena or managing them simply at the level of their overall results." It involves also the management of the

population "[in its] depth, in all its fine points and details"[44] (Foucault, 2007, p. 107). The management of population involves mechanisms of law and discipline – with reference to the connection that exist between them and the juridical subjects and working bodies – but they are organized in relation to the analysis of security, which involves the "taking up again and sometimes even multiplying juridical and disciplinary elements and redeploying them within its specific tactic" (Foucault, 2007, p. 9). In relation to how apparatuses of security deals with the problem of theft, Foucault describes the analysis in the following terms:

> "the apparatus of security inserts the phenomenon in question, namely theft, within a series of probable events. Second, the reactions of power to this phenomenon are inserted in a calculation of cost. Finally, third, instead of a binary division between the permitted and the prohibited, one establishes an average considered as optimal on the one hand, and, on the other, a bandwidth of the acceptable that must not be exceeded. In this way a completely different distribution of things and mechanisms takes shape" (Foucault, 2007, p. 6).

Therefore, it is clear that the apparatus of security deals with the individual, but it is not its primary target. It involves a re-arrangement of the mechanisms that dealt with the *body* and the *juridical subject*, and not their displacement.

The *role* of the individual in relation to the population is, however, fundamentally altered within the mechanisms of security. According to Foucault, within the government of population that deploys the mechanisms of security there exists a fundamental split between the population – which is the target of intervention – and the individual – who is not pertinent in and of itself, but may serve as an instrumental conduit that enables one to get to the population. This split does not exist in reality, it is not a difference between some peoples and others, it is situated within the system of knowledge-power, within the mechanisms and technologies of power:

> "We have two levels of phenomena […] Not a level of the collective and a level of the individual […] But we will have an absolutely fundamental caesura between a level that is pertinent for the government's economic political action, and this is the level of the population, and a different level, which will be that of the series, the multiplicity of individuals, who will not be pertinent, or rather who will only be pertinent to the extent that, properly managed, maintained, and encouraged, it will make possible what one wants to obtain at the level that is pertinent. The multiplicity of individuals is no longer pertinent, the population is. This caesura within what constituted the totality of the subjects or inhabitants of a kingdom is not a real caesura. There is not a real distinction between some and others. But within the system of knowledge-power, within the economic technology and management, there is this

[44] "Managing the population does not mean just managing the collective mass of phenomena or managing them simply at the level of their overall results. Managing the population means managing it in depth, in all its fine points and details."

> break between the pertinent level of the population and the level that is not pertinent, or that is simply instrumental. The final objective is the population. The population is pertinent as the objective, and individuals, the series of individuals are no longer pertinent as the objective, but simply as the instrument, relay, or condition for obtaining something at the level of the population" (Foucault, 2007, p. 42)

The second point I want to make refers to the other side of the "nature" of the population. I have paid attention to the connection between the "nature" of the human species and the ways that this is seen to be related to milieu of existence. By doing this, I have focused on only one of the sides that the populations "nature" is expressed. I have done this in order to compensate for the emphasis that is normally given to the other ways in which mechanisms of security is deployed in order to "regulate the freedom" of man as a means to produce the general interest of the population by relying on the mechanisms that rests on the role of "interest" in the animation of man's action. While there exists a transformation, from liberalism to neoliberalism, regarding the ways in which one can conduct the conduct of man, the role of interest as the "motor" of man's actions, are the same in both forms of governmentality.

Within the liberal utilitarian analysis of the populations "nature," the physiocrats posits that while it is true that the population consists of a multitude of individual's, who's actions cannot truly be predicted, there is one aspect that is similar for all (Foucault, 2007, pp. 72-73). This aspect, which is the key to understanding man's behavior, is that man acts according to his own *desire*. The motor of behavior is found on the side of desire, which is the pursuit of private interest. The utilitarian aspects come up in the assumption that the general interest of the population can be produced if one lets man follow his own interest. Two premises are important here: one, it is impossible to say no to man's interest – and one cannot therefore govern by way of imposing laws, as did the sovereign – because man will always find ways to follow his own interests. Therefore, the aim of government must be to find ways to say yes to desire by way of letting the *circulation of freedom* work to its maximum capacity. If this is ensured, the general interest of the population will be produced. Yet, this is not a proclamation that states that man is perfect and that the pursuit of his private interest is the same as the one produced for the population. The second premise of the utilitarian dimension of population management is that the individual may even be mistaken. But even if he is mistaken, what is not mistaken is that if he is allowed to follow his personal interest then this will, "within a certain limit and thanks to a number of relationships and connections," result in the production of the general interest of the population (Foucault, 2007, p. 73). Therefore, mechanisms of security will involve the circulation of man's freedom to pursue his own interest because it will eventually lead to the general interest of the population as a whole.

2.4 Discussion: on the role of "milieu" in the management of population

In sum, while Foucault's use of the notion of "milieu" may appear confusing, this is not due to a lack of consistency on the part of Foucault's own writing. In order to perceive the relationship between the role that "milieu" plays in relation to the conduct of conduct, on the one hand, and the development of the species, on the other, it is necessary to pay attention to the role Foucault assigns to mechanisms of security and the precise nature of its deployment in relation to the naturalness of the population. For, it is not only concerned with conducting the conduct of subjects, but rather aimed at the development of the species. In relation to the population's "naturalness" there exist two levels, an "utilitarian" level that concerns the production of the general interest of the population on the basis of the free play of individuals in the pursuit of their interest; and a "biopolitical" level that concerns the government of the human species in its relation to milieu of existence. Both involve a form of government through the milieu, but both the meaning and function of "action at a distance" is different: in so far as it relates to the utilitarian project of producing the general interest of the population, the "action at a distance" through the milieu relates to individuals conduct in the pursuit of their interest; in the liberal project it involves the maximalization of the individuals freedom to act, whereas in the neoliberal analysis it is a question of governing the conduct of individuals on the basis of the fact that they follow their interest within an environment that provides them with ques, incentives and disincentives in relation to which they make decisions, which means that the "behavioral environment" appear as a set of elements that inter into the "decision making process of individuals" (Taylan, 2011, p. 208). In so far as it is a question of developing the species it is a question of "acting at a distance" through a milieu that appears in the form of elements that affects the developmental process of the species. It involves a form of intervention within a field that is necessarily "at a distance" because it works within a "reality" that is analytically constructed in order to bring out the relationships between elements that appear distant from the developmental process (both in the temporal and spatial sense of the word) but which one knows, through calculation, analysis and reflection, has an effect on the development of the species.

The single focus on the "conduct of conduct" therefore seems to me to be somewhat reductive, and to a certain extent misleading, in so far as we give it prominence in the analysis and maintain that we are talking of "biopolitics" and the deployment of mechanisms of security. Similarly, the notion of "action at a distance" seems to me to be narrowly defined in so far as what is perceived to be governed is only man's action through the structuring of the behavioral milieu. It seems to me that in the analytical grid commonly deployed, too many elements of this complex phenomena are escaping from our view. What is at stake is whether the analysis of "neoliberal rationality" is able to consider more than this.

Therefore, I will now discuss (i) the implications of these distinctions for the concept of "neoliberal population management," and (ii) the aspects of Lippmann's public health policy that it can conceptualize.

2.4.1 Biopolitics, or the limits of decentralization

The conduct of conduct and the management of the natural processes of the population involves very different considerations. The conduct of conduct, in the way that it was conceived of by the Physiocrats, was concerned with how to say "yes" to man's interests; the neoliberal economic analysis presented by Gary Becker opened up for a conducting of man's conduct on the basis of the relationship between environmental variables and the behavior of economic actors that were rational in so far as they behaved in a systematic and non-random way in relation to the variables of the milieu. Both Taylan and Laval have argued that this decentralized mode of governing could be transposed to the level of the conduct of the entire population. However, as I have shown in this chapter, the management of population involves a much more complex set of considerations. While the conduct of conduct is one of the instrumental relays that allow the population to be managed, this is not enough, Foucault says, because, if you ask the population to do something, not only can you not be sure that it will do it, but it is not even guaranteed that it *can* do it. This was one of the principle limits to the sovereign relationship to its subjects that involved the juridical voluntarisms that were articulated in the form of an imposition. And it posed restrictions as to what kind of training individuals could be subjected to. Therefore, it is not enough to find ways to say yes to the individual's interest, and, subsequently, there is a limit to the range of possible responses that the individual can give to the variables of the milieu. The reflections and analysis that were involved in the management of population, proper to biopolitics, was, as Foucault explained, concerned with the links between elements that may seem far removed from the processes of the population, but which, through reflection and analysis, could be shown to have an effect on it.

These points are parallel to the distinctions proposed by the ordoliberals and Walter Lippmann. For them, it is not enough to merely construct the rules of the game in order to make the market possible. While actions within the market needs to be governed through the adjustment of the economy's juridical-institutional framework, if the conditions of possibility for the desired actions are not present, then the actors who are expected to behave in a manner that is concomitant to the entrepreneurial logic of competition *cannot do what they are being asked to do*, even if they would like to. In other words, freedom only takes one so far. Instead, in light of the experiences of the Great

Depression it was seen that it was necessary to at the same time construct the *conditions of possibility for action that correspond to the logic of competition*, i.e. both the equal access to scarce resources, as well as the necessary social and historical conditions for developing the ability to adapt to the demands of the market.

2.4.2 The problem of human capital formation reconsidered

The differences between the conduct of conduct and the development of the species also holds consequences for the role of milieu in relation to the problem of human capital formation. Conceived through the lens of conduct, environmental variables are set up in order to arrange stimuli's and motivational factors in such a way that they incite forms of behavior that run parallel to the entrepreneurial logic of self-investment into ones capacities (Laval, 2018, pp. 66-67). In relation to the development of the qualities of the species the environment appears as an "environmental analysis" (Foucault, 2008, p. 229) that describes *the history of the individual* in terms of all the factors that may or may not contribute to the formation of human capital throughout the individual's life. That is to say, the elements that have been rendered *pertinent* through an analysis of the connections between various factors in the species milieu of existence that affects the development of human capital:

> "What in the child's family life will produce human capital? What type of stimuli, form of life, and relationship with parents, adults, and others can by crystalized into human capital? […] In the same way, we can analyze medical care and, generally speaking, all activities concerning the health of individuals, which will thus appear as so may elements which enable us, first, to improve human capital, and second, preserve and employ it for as long as possible. Thus, all the problems of health care [*la protection de la santé*][45] and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital" (Foucault, 2008, p. 230).

This environmental analysis opens up, or, at any rate, constructs a field of knowledge that identifies the "possibilities of investment in human capital" (Foucault, 2008, p. 230). On the one hand, this knowledge opens up a field for individuals economic action. In order to invest in one's abilities, so as to render oneself better equipped for the kinds of adjustments that will be necessary to make throughout one's life, given that one lives and operate within a market economy, the identification of possibilities for "investments" in one self will be a fundamental precondition. In relation to this entrepreneurial conduct, governments can act in a decentralized in order to incite or disincentivize individuals interests

[45] "Il faut don repenser tous les problèmes, ou on peut en tout cas repenser tous les problèmes de la protection de santé, tous les problèmes de l'hygiène publique en éléments susceptibles ou non d'améliorer le capital humain" (Foucault, 2004b, p. 236)

to make the necessary investments into themselves; in addition to the educational practices involved in the diffusion of the knowledge of possible investments into human capital.

On the other hand, this knowledge can be seen to open up a field of action that is beyond the limited perspective of the interest-driven individual, and beyond his or her capacities for action. This concerns the construction of possibilities for action, and the factors that affect the individual's development. Governmental action thereby takes aim at the conditions of possibility for action. These conditions – or *elements* – is mapped onto a historical and a spatial horizon. Conditions of possibility refers therefore to the concrete possibilities for taking certain actions that are made possible by the construction or reform of the environment in which the individual acts. These conditions exist in the here and now, in the present social conditions in which the individual exist. The conditions of possibility also concern the history of development of the individual. In this sense, it concerns the process that has shaped and determined the individual's capacity to act in the present.

The problem of human capital formation is parallel to the concern Lippmann had for man's ability to adapt. Human capital refers to the capacities and abilities of the individual which enable them to act within a competitive market economy. The framework described above is consistent with Lippmann's critique of the limits of the decentralized mode of governing; and the "foundational role" that he assigned to the state with regard to the "fundaments of the market economy": concerning the problem of adaptation, the state must reform the social order that the individual is engulfed in – i.e. its *milieu of existence* – so as to create the possibilities for action, and work on the phenomenon – poverty, malnutrition, disease etc. – that affect the development of handicaps and creates the conditions of possibility for developing ones faculties. In this way, both the *ability* and the *possibility* to adapt to the demands of the global economy will be secured.

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Although it is true that what was at stake for the neoliberals of the 1930s was the diffusion of entrepreneurial mode of life, one that would be able to adapt to the changing needs of the market, the neoliberal rationality for population management should not be considered *only* on the side of governing the conduct of man so that it conforms with formal logic of competition. The role of the state was not confined to the order of legal interventionism and the form of decentralized action at a distance at the legal framework of autonomous entities. Considering the limits imposed on man's way of life that comes from the social environment, how it sets the conditions for his development, an ambitious set of policies, which included public health, were proposed. In this chapter I have described

this political program in the terms of Michel Foucault's concept of biopolitics and the mechanisms of security, thereby laying the conceptual foundation for the concept of "neoliberal population management."

Chapter 3 *On the conceptual relevance of "neoliberal population management" in the analysis of Norwegian public health policy at the end of the 1980s*

3.1 Introduction

In order to apply the concept of *neoliberal population management* to the study of Norwegian public health policy in the 1980s, three notions of Norway's public health policy needs to be addressed: (1) that Norway's public health policy is an expression of a "social democratic welfare regime" as opposed to one that bears the distinguishing features of "neoliberalism" – exemplified by a study by Hervik and Thurston (2016); (2) that the public health policies that were actually proposed by the Norwegian government have increasingly become "individualized" (as opposed to a policy that deals with society) – exemplified by Vallgårda (2001) and Stenvoll et al. (2005); and finally, (3) that these policies should be understood as a form of *compensatory* policy that makes up for a *weakening governing position* vis-à-vis the economic sphere (due to the economic policies pursued from the 1970s that emphasized the integration of Norway's economy into the global economy) by intervening into the social sphere in order to deal with the "existential" problems which in fact stems from the changes in the economic sphere – a thesis found in a study by Leonardsen (2015).

Following each of these conceptions of Norway's public health policy is a critique of both empirical and theoretical assumptions, which I discuss in relation to the empirical and theoretical assumptions underpinning the concept of neoliberal population management (see chapter 1 and 2). The over-all aim of this chapter is to distinguish the conceptual and historical conditions for applying this concept to the study of Norwegian public health policy at the end of the 1980s.

3.2 Neoliberal social policies in a social democratic welfare regime?

As a background to their study of lay perspectives of responsibility for health is conceived in a society which is not neoliberal, Hervik and Thurston (2016, p. 2) argues that the case of Norway provides a good context for such a study. In order to distinguish Norway's "social democracy" from "neoliberalism," they use a conceptual framework that is organized around the concept of "responsibility." Considering the different aspects of the two "welfare state regimes" (Esping-Andersen, 1990) represented by "neoliberalism" and "social democratic" states, Hervik and Thurston (2016) presents the difference in terms of the mix of state centered or individualistic responsibility for health.

Seen from this perspective, the neoliberal state comes to pursue a public health where the responsibility for health is placed mainly on the individual, both in terms of their responsibility for managing their own health (through life style), and in the responsibility for health outcomes. The social democratic state, on the other hand, is marked by an emphasis on *mutual responsibility for health*. While there is an emphasis on the responsibility for personal health management, the limitations of personal responsibility for rational free choice with regard to personal health is acknowledged with reference to social factors that affect personal health, but which are nonetheless *outside of the individual's control*, and which should therefore be the responsibility of the state.

3.2.1 Evidence for the claim that Norway' public health policy is social democratic

As evidence for the fact that Norwegian social policy is indeed a form of social democratic welfare regime, they make reference to two public health policy texts. One from 2003 (*Prescription For A Healthier Norway*), and another from 2013 (*Good Health – Common Responsibility*). The stated aim for Norway's public health policy, they remark, have for some time been to "reduce social inequalities in health such that no social group suffer," and that the country "has been described as one of the lading countries in promoting health through public policy action" (Hervik & Thurston, 2016, p. 4). In order to deal with this issue, Norway's public health strategy has chosen a mix of interventions which are clearly "social democratic," Hervik and Thurston argues, in so far as they emphasize the *individual responsibilities* for health, as well as the limitations of individual life style choses, due to the presence of social factors which the individual cannot control, and which must therefore be the *responsibility of the state*. As examples of such a thinking, they provide two examples, both of which I will show here:

2003-text:

> "Although it is important to emphasize the choices and actual responsibility of the individual – particularly when it comes to living habits – social inequalities in health will largely be a political and social matter. When the differences follow clear social patterns, it is not the individual's conscious choice of lifestyle that is the crux of the matter" (St.meld. nr. 16, 2002-2003, p. 20; cited in Hervik & Thurston, 2016, p. 4).[46]

2013-text:

> "… a balance between society's responsibility for public health and the personal responsibility an individual has for his or her own health. Individuals have considerable responsibility … and autonomy and influence over their own lives. At the same time, however, the individual's freedom in action in many areas is limited by circumstances beyond the individual's control. Even smoking, physical activity and diet are influenced by the economic and

[46] Translations are in both cases made by Hervik and Thurston.

> social background factors which the individual has not consciously chosen" (Meld.st. 34, 2012-2013, p. 19; cited in Hervik & Thurston, 2016, p. 4).

The focus on social inequalities is marked by the universe of determinants of health (see discussion in chapter one), the articulation of "responsibility for health" refers to who has the responsibility for dealing with specific determinants of health. Life style is seen as an individual responsibility, but it is also understood to be affected by factors that are outside of the individual's conscious control and must be the responsibility of the state.

3.2.2 Critiquing Hervik and Thurston's conceptual framework

The framework used by Hervik and Thurston to distinguish between the social democratic and neoliberal regime builds on different assumptions than the ones I do. In my conception, a "neoliberal social policy" is not one that leaves the individual to fend for itself. This was precisely what was critiqued in the 1930s. A "neoliberal social policy" was instead defined as one that emphasized the necessity for individuals to take on a new way of life (marked by entrepreneurship), but that they could not be counted on to manage everything themselves; and insofar as what was needed was the ability to adapt to the changing needs of the market economy, the state needed to intervene into the social and historical conditions that could make this adaptability possible.

From the point of view of my conception of "neoliberal social policy," it therefore does not seem to be the notion of "responsibility" that should serve as the principle of distinction between it and a "social democratic social policy." The neoliberal reforms proposed by Walter Lippmann did not rely on the distinction between the spheres of intervention and non-intervention (the *agenda* and *non-agenda*) of government but involved the articulation of the ways in which to govern in order to make the competitive market economy possible. This program involved a re-articulation of public health policies to orient toward the conditions of possibility for the individual to be able to adapt to the needs of the market. By only focusing on the placement of "responsibility" for health, therefore, Hervik and Thurston does not consider the function that public health policies can be given in relation to the global competitive economy.

In order to underline this point, I will now be looking closer at one of the policy texts that Hervik and Thurston made use of in order to argue that Norway's health policy was indeed social democratic.

Under the headline "Health as resources and condition for economic development,"[47] in the White Paper *Public Health, Good Health – Common Responsibility*, we find the following piece of text:

> "A population with good mental and physical health is one of the most important resources we have in society. The ability to learn, to creativity, development and flexibility and excess (*overskudd*) to contribute to society is to a greater extent social than genetic. It is social and environmental conditions that contribute to strengthening or weakening health and well-being [(Beddington et al., 2008)]. In a globalized competitive economy, social and environmental conditions that strengthen health, well-being and excess (*overskudd*) are an advantage, in addition to the fact that this is a good thing in itself. Health and knowledge are closely linked in that health provides good conditions for learning, and education provides health. Health and knowledge are included as central parts of what we define as human capital. Statistics Norway´s calculations show that human capital at the end of 2008 accounted for about 73 per cent of the national wealth. Investment in health and knowledge has both a direct effect on increased welfare, and an indirect effect on increased potential for future value creation"[48] (Meld.st. 34, 2012-2013, pp. 162-163).

In the context of a globalized competitive economy, this discourse argues for making investments in health and education due to, among other things, the indirect effects that this will bring in terms of an "increased potential for future value creation". Health and knowledge are presented as conditions for learning, and thus a basis for human capital. Health is here divided into "physical" and "mental" health and refers to certain abilities that are seen as central in the global competitive economy: "the ability to learn, to creativity, development and flexibility and excess [*overskudd*] to contribute to society." These abilities for learning are seen to be depending on social and environmental factors more than they are on genetic ones, that is to say, one is not predominantly seen to be born in a certain way but can instead acquire human capital throughout life given the right set of environmental and societal conditions. Seen in this way, the promotion of health is presented as a way in which to strengthening the abilities necessary for the educational activity, and thus presented as a crucial precondition for the economic competitiveness of individuals, the population and society.

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[47] "Helse som ressurs og forutsetning for økonomisk utvikling."

[48] "En befolkning med god psykisk og fysisk helse er en av de viktigste ressursene vi har i samfunnet. Evne til å lære, til kreativitet, utvikling og fleksibilitet og overskudd til å bidra i samfunnet er i større grad sosialt enn genetisk betinget. Det er sosiale og miljømessige forhold som bidrar til å styrke eller svekke helse og trivsel. I en globalisert konkurranseøkonomi er gode samfunnsmessige og miljømessige forhold som styrker helse, trivsel og overskudd et fortrinn, i tillegg til at dette er et gode i seg selv. Helse og kunnskap henger tett sammen ved at helse gir gode forutsetninger for læring, og utdanning gir helse. Helse og kunnskap inngår som sentrale deler av det som vi definerer som humankapital. Statistisk sentralbyrås beregninger viser at humankapitalen ved utgangen av 2008 utgjorde om lag 73 prosent av nasjonalformuen. Investering i helse og kunnskap gir både en direkte effekt ved økt velferd, og indirekte effekt ved økt potensial for fremtidig verdiskaping."

Within this quote there is a reference to a text by Beddington et al. (2008), titled "The Mental Wealth of Nations," which can serve as an example of the kind of "history of the individual" that further emphasizes the usefulness of the notion of "neoliberal population management" for interrogating Norway's public health policy. It provides an analysis of the development of "mental capital of the course of life" (Beddington et al., 2008, p. 1058) in terms of "negative influences" and "positive influences" that occurs in "the" various stages of life: "school", "work" and "retirement," coupled with a series of stages in individual development, each with their own particular relationship to the development of mental capital: starting with a particular "genetic endowment," mental capital develops through the "Prenatal" stage, which involves "fetal programming" (by parents) whose negative influences include parents use of tobacco, poor diet, and consummation of drugs or alcohol; "Early childhood (0-4)," which involves "early development" that can be positively influenced by "good parenting skills" and "early home experiences," "Child (5-12)" stage which is marked by a disposition to learn which can be negatively affected by "early stress exposure" and "child trauma" and positively influenced by "supportive teaching and education" and so on. The life course analysis ends with a process marked by "waste of mental capital" with the "older adult" who has a "cognitive reserve" that is negatively affected by factors such as "anxiety, depression and chronic illness" and positively influenced by "physical activity, mental activity, social stimulation and medication or dietary intervention" (Beddington et al., 2008, p. 1059)

The distinguishing mark of the neoliberal rationality in this life course analysis by Beddington et al., is not only found at the level of *influences* (whether these factors points to individuals responsibility of behavior, or whether actions must be taken with regard to forces outside of their control), but in the fact that the *object of analysis* is the development of "mental capital," an object which is understood as central for the economic and social prosperity of nations, framed in terms of "competitiveness":

> "To prosper and flourish in a rapidly changing world, we must make the most of all our resources, both mental and material. Globalization and its associated demands for competitiveness are increasing the pressures in our working lives. […] Mental capital encompasses both cognitive and emotional resources. It includes people's cognitive ability; their flexibility and efficiency at learning; and their 'emotional intelligence,' of social skills and resilience in the face of stress. The term therefore captures a key dimension of the elements that establish how well an individual is able to contribute to society and to experience a high quality of life" (Beddington et al., 2008, p. 1057).

Thus, while Hervik and Thurston may work within the assumptions that Norway is a social democratic welfare state, they operate within a conceptual framework that omits aspects which, despite the

placement of "individual" or "state" responsibility for health, should warrant our analytical attention. The construction of health, the knowledges produced around it, in so far as it relates to the management of populations, could be viewed in terms other than *responsibility*, and instead be viewed in terms of population management, which could open up other analytical possibilities.

3.3 Norwegian public health as a compensatory and individualizing social policy?

3.3.1 Individualization-thesis

The transformation toward prevention has been characterized as a turn toward individualization by a number of scholars. The turn toward individualization is by some identified with the change from social medicine to epidemiology during the 1970s, thereby opening up a "factor-based approach" which lend itself to an individualized risk perspective (Schiøtz, 2003). It has been linked to the emerging dominance of the pharmaceutical industry in the 1990s, and the increasing emphasis given to "health-fads" in the media, which tends to emphasize individual lifestyle-focused solutions to problems, which thereby tends reduce what is a complex, multifaceted and socially, economically, politically, and culturally determined process to simple behaviors that the individual can control (Ayo, 2012; Skaset, 2003). And finally, it has been associated with the turn from a "social democratic" regime in the post-war period towards a "conservative" from the 1970s, which thereby goes from placing the emphasis on state-responsibility for health, toward an emphasis on individual responsibility (Skaset, 2003). Herein lies a displacement from, one the one hand, what science knows, that is to say, that the social determinants of health are more important than the individual determinants of health, and on the other, the actual emphasis given to the various health-determinants in concrete policy texts (Sandtrø, 2018).

Of the few studies that have looked at the individualization-thesis in relation to Norwegian public health policy, focus has tended to be on documents published from the beginning of the 1990s. In 2001, Vallgårda studied the Background Document *Everybody is Wanted*[49] (NOU: 18, 1998). And identified an emphasis on *empowerment* as a means to improvement of health, which may be taken as a sign of individualization. The Norwegian emphasis was particular compared with the other countries included in her study: England emphasized both a change in behavior and an emphasis on structural changes, Sweden focused on structural factors that determined health in combination with emphasizing individual behavior; while Denmark focused on healthy behavior within specific target areas (tobacco, alcohol, diet and exercise). The function of empowerment in the Norwegian document was to

[49] Vallgårda's translation.

strengthen individual's responsibilities for themselves and capacities for action, with the belief that "people will act as the committee finds appropriate in relation to health if they get more control over their lives" (Vallgårda, 2001, p. 390). Stenvoll et al. (2005), following up a recent historical study of Denmark and Sweden's public health policy from 1930 to 2000 by Vallgårda (2004), that showed that both countries had veered toward an individualized focus, wanted to explore the tendency in Norway. Comparing the White Paper *Challenges in Health Promotive and Preventive Work* (St.meld. nr. 37, 1992-93) with the White Paper *Prescription for a Healthier Norway* (St.meld. nr. 16, 2002-2003), they argue that there is a tendency toward individualization in so far as the 1993-document emphasized structural factors and institutional efforts, and the document from 2003 placed a larger emphasis on individual's responsibility for their own health.[50]

Like Hervik and Thurston, when "individualization" is identified by the scholars above, it is done by referring to the placement of "responsibility" for health. Considering that Hervik and Thurston reads the same document as Stenvoll et al. in *different manner*, there is reason to doubt the evidence supporting the individualization thesis. In light of the excerpt provided by Hervik and Thurston underlines the *shared responsibility for health* – and is to them an example of the social democratic nature of Norwegian health policy – Stenvoll et al. seemed to have given a *too narrow* reading of the text, which may have given the impression that there is "increased individualization" in public health policy (Stenvoll et al., 2005, p. 603). The same critique can be applied to Vallgårda's reading, which, from a document of over 500 pages, focus mainly on the concept of "empowerment," which is framed as "a very central means" that is to be used for the reduction of life style related diseases, as well as reducing "social inequalities in living conditions, quality of life and living standards causing bad health" (Vallgårda, 2001, p. 390). This despite of the fact that empowerment is only one of many tools proposed by the document, such as environmental measures (NOU: 18, 1998, pp. 65-67). This may also be a consequence of her methodological choice when comparing policies from four countries, that she wanted highlight what is *different* between each, less than noting the similarities (Vallgårda, 2001, p. 390).

In one regard, both Vallgårda and Stenvoll et al. can be considered as more nuanced than Hervik and Thurston in their presentation, in that they also consider the meaning given to "health" in the policy texts. However, it seems to me that both studies offer a narrow conception of "the meaning of health" in the texts. Vallgårda aims to "identify the different ways of thinking and talking about health and about how to govern, i.e. it also contains an analysis of the rhetoric used in the papers" (2001, p. 387) which also seems to be the field of interest of Stenvoll et al.. Their analysis of "health" is framed as a

[50] For a study of more recent documents, see Sandtrø (2018); Vallgårda (2011)

response to the question "how is prevention justified (*begrunnet*)?"[51] (Stenvoll et al., 2005, p. 603; Vallgårda, 2001, p. 386). In their study, Stenvoll et al. show that there is a connection between "health" and "the good life," and show that there are "economic considerations" involved in relation to the prevention of disease (Stenvoll et al., 2005, pp. 603-604), which they critique both as being unspecified in the text (what is the meaning of the "good life," of "good health", and how will prevention lead to economic benefits? And will not increased longevity mean an increase in costs of living?). They also call attention to the "models" that are used to depict health, but reduces the consideration to how well these models convey the division of labor (responsibility) between society and the individual (Stenvoll et al., 2005, pp. 603-604). In Vallgårda's study, the justifications for the improvement of health are divided into "state reasons," which concerns "for the sake of a common good such as the improvement of the nation's well-being or prosperity, the reduction of public expenditure etc.," and reasons having to do with "care for the single citizen, aiming at giving him or her a good life" – the meaning of which is something that is defined by the individual (Vallgårda, 2001, p. 386). In the first case, health is a means to achieve something else, while in the latter it is an end in itself. On the basis of this distinction, she identifies a conflict in Norwegian policy, regarding the state reason and "the aim of creating good lives for the individuals," in so far as

> "it is stated that politicians promote health because they have a 'responsibility for the welfare of the people and the economy of society' [(NOU: 18, 1998, no page number given)]. On the other hand they maintain that possible economic benefits for society are irrelevant, because it is considered a goal in its own right to maintain good lives as long as possible [(NOU: 18, 1998, no page number given)]." (Vallgårda, 2001, p. 387).

What is missing from the analysis is a discursive approach to the conceptions of *health*, *the subject*, and possible links between this and the over-all governing of society. While both Vallgårda and Stenvoll et al. remarks that health is seen as a *means* to achieve economic effects; they do not explore how public health is oriented and organized around this governmental aim: how it is articulated within "the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics" (Foucault, 2007, p. 108) that are described in the documents they have read. For example, how is health constructed in the text as an object that is subject to analysis and intervention; what elements are constructed as fields of interventions that will lead to the realization of this aim; how is the subject constructed, invited to look at itself as someone with "health," what aim (*telos*) should be pursued by

[51]; Stenvoll et al. defines the question as "hvordan forebyggingsarbeidet begrunnes"; Vallgårda frames the question within a "governmentality-framework" in the following way: "how the exercise of power aimed at improving the health of the population is justified by those trying to govern."

way of working on the self, and what techniques of the self should be deployed in order to realize this aim.

This point is linked to a larger issue: these studies does not explore the connections between public health policy and, what can in perhaps too general terms be called, "the parallel changes in capitalism," which Dardot and Laval have linked to the emergence of a "universe of generalized competition" (2009, p. 5). For example, when the emphasis on the "individual" versus "the state," this is located within a sort of timeless and universal horizon, as the "classical problems tied to the tension between society and the individual's interests […]"[52] (Stenvoll et al., 2005, p. 604). At the most, when the tendency of "individualization" is identified, therefore, what seems to be described is what Dardot and Laval (2009, p. 19) calls an "ideology of excessive individualism." What is subsequently left unconsidered is *how is public health policy constructed during the neoliberal turn towards generalized competition of the 1980s; how is the content of and the links between health, subject, population and public health constructed during this period?*

3.3.2 Compensation-thesis: social policy in a competitive society

An attempt to link the deployment of social policies that emphasizes prevention during the "neoliberal turn" of the 1980s and beyond can be found in Dag Leonardsen's (2015) *History of Prevention – A Story of a Moving Target*.[53] In it, he argues that the new social policies of prevention that were pursued during the 1980s and onward were deployed in order to compensate for the harmful effects of neoliberal (economic) policies pursued from the 1970s and on. This reading rests on a conception of the state which, through "state-administrative management" aims to govern two systems which are principally opposite one another: "the economic system," which pertains to the "productive sphere," and "the socio-cultural sphere," which pertains to the "reproductive sphere." These systems are each identified with opposing values, defined as "ideal types": the economic system is marked by the values of "efficiency, competitiveness, output, qualification/certification, goal rationality, individualism, egotism, flexibility, fluidity, independence"[54] as opposed to the values of the socio-cultural system: "Time, collaboration/solidarity, acknowledgement/respect, open access, value rationality, collectivism, altruism, predictability/control/security, rootedness, dependence"[55] (Leonardsen, 2015, p. 23).

[52] "Dette er klassiske problemstillinger knyttet til spenningen mellom samfunnets og individets interesser […]"
[53] Forebyggingens historie. Fortellingen om et bevegelig mål.
[54] "Effektivitet, konkurranse, ytelse, kvalifisering/sertifisering, formålsrasjonalitet, individualisme, egoisme, fleksibilitet, fluiditet, uavhengighet."
[55] "Tid, samarbeid/solidaritet, anerkjennelse/respekt, åpen adgang, verdirasjonalitet, kollektivisme, altruisme, forutsigbarhet/kontroll/trygghet, forankring, avhengighet."

Based on this framework, Leonardsen situates the new social policies of prevention pursued in the 1980s in a narrative of Norway's post-war development, wherein social and economic policy were in harmony (mutually beneficial) in the period *1945-1970*, since the efforts of strengthening the social system through social policy aimed at rebuilding the nation after the war, was seen as necessary for economic growth, and that economic growth would enable investments into social policy. Then, in the period *1970-2000*, as the Norwegian government turned toward a new kind of economic policy aimed at *opening up the Norwegian economy* to the West (principally Europe and America), social policies aimed at prevention were now pursued in order to *compensate* for the harmful effects on population, which, Leonardsen argues, could be traced back to the new economic arrangements (Leonardsen, 2015, pp. 18-19; 81-112): new social problems could be traced back to the problems of adaption associated with the transition to a "post-industrial society" the "never-ending demands of the market society"

Leonardsen's analysis is based on empirical material that consists of White Papers, Background Documents and the Political programs of Labor (*Arbeiderpartiet*), and is presented according to four questions: (1) what is the goal that government has set for itself; (2) what problems are identified as needing to be solved in order for this goal to be realized; (3) what solutions or forms of interventions are proposed in order to solve these problems; (4) have the solutions resulted in the intended consequences?

From this framework he identifies a paradox. For, while the government – represented by Labor – had explicitly stated that it aimed to create a "warmer society," a "qualitatively better society," this goal was constantly undermined by the economic policies that they pursue. From the policies pursued in the name of economic integration into the European market leads to a "tougher competitive situation" and a "harder and colder society," which thereby weakens social solidarity overall (Leonardsen, 2015, p. 85). The transition toward a "post-industrial society" were also linked to problems of "adjustment," leading to a series existential and moral problem characterized by the weakening of the solidarity of Society (Leonardsen, 2015, pp. 104-105). Theparadox stems from the contradictory approach taken by government in order to deal with these issues. For while the problems that "pops up" in the social system stems from the actions taken in the economic sphere, the government pursues a ""hands-off"-ideology toward the market [which would] be compensated by a "hands-on"-ideology toward the socio-cultural system"[56] (Leonardsen, 2015, p. 93):

[56] "En «hands-off»-ideologi overfor markedet skulle kompenseres med en «hands-on»-ideologi overfor det sosio-kulturelle system"

> "they wanted full membership of the European free trade system. But as "compensation", it was instead agreed that "in all fields [there] should be more emphasis on preventive strategies to prevent injuries and problems from occurring" (Principle Program [Labor], 1996)"[57] (Leonardsen, 2015, p. 86).

Central in the critique that Leonardsen makes with the compensation thesis is that when the policies of prevention didn't give the intended effects (social problems are not reduced, but instead tends to increase in many instances) this was *not followed up by a change in economic course* (despite the fact that important conditions for the problems are created there); instead, the government continues to pursue its hands-off approach to the market and a hands-on approach toward the socio-cultural system. Instead of changing the economic imperatives of competition, interventions were confined to the socio-cultural system (Leonardsen, 2015, p. 112).

3.4 Critiquing the compensation-thesis: what about the social policies aimed at enabling the competitive economy to function?

I will now consider two points that are central in Leonardsen's compensation-thesis: (1) the "goal" of government; (2) the conceptualization of "prevention" as a form of intervention.

3.4.1 Government's aim: A warmer competitive society?

The text marks out a contradiction: the goal of warmer society on the one hand, and an economic policy which creates a tougher competitive situation which leads to a "harder and colder society." The contradiction exists in so far as the Norwegian government is trying to realize a goal through means which defeats the very same goal. While I have no reason to doubt the existence of such a contradiction, I would like to point out that the goal of a "warmer society" is not the only goal that is pursued by the Norwegian government in the period that Leonardsen considers. Specifically, by focusing on the goal of a "warmer society," which is undermined by the *effects* of the "competitive society," Leonardsen omits an important part of Norwegian social policy which, I would argue, is geared toward creating the conditions of possibility for the adaptation to the marked economy.

This line of policy is articulated within the educational policy sector and is known by the name "learning through out life." According to the Department of Church and Educational**,** the reasons for adopting the new policy line at the middle of the 1960s came from the reason that the way of life which

[57] "man ønsket fullt medlemskap i det europeiske frihandelssystemet. Men som «kompensasjon» gikk man i stedet inn for at det «på alle felter skal [det] satses mer på forebyggende strategier for å hindre at skader og problemer oppstår» (Prinsipprogrammet, 1996)."

consisted in specializing, once and for all, to a single profession, would not be fit in light of the ever changing demands of industry, which were linked to the change in demand on the global market (St.meld. nr. 45, 1980-81, p. 11). In the Economic Program of 1988, which Leonardsen makes reference to on several occasions,[58] this focus can be seen expressed in the notion that an *updated* competence is a central part of international competitiveness in the knowledge economy (St.meld. nr. 4, 1987-88). This means, in other words, that learning, and the abilities involved with learning is a fundamental aspect of the competitive economy.[59]

This way of thinking is similar to the terms set by Lippmann. It implies that the goal (*telos*) of development is fixed by the demands of the global economy; that individuals needs to adapt to an entrepreneurial way of life that involves constantly *adapting* to the changing demands of the market (Stiegler, 2019). It indicates that the relationship between social policy and "competitiveness" can take another form than the one envisioned by Leonardsen: rather than simply *dealing with* the consequences of an economic development which is fixed, it can be conceived of as a policy of society that is geared toward the construction of the conditions of possibilities within the social milieu that enables the population to make the necessary adaptations to demands of the competitive market economy (Foucault, 2008). Considering the conception of "health as a resource and a precondition for economic development" that I discussed above, this seems to be what is currently shaping Norwegian public health policy (Meld.st. 34, 2012-2013, p. 162).

3.4.2 What is prevention? A curative intervention?

What then of the role of prevention? In a paradoxical way, Leonardsen seems to present prevention as a form of treatment. This is linked to his focus on prevention as an intervention which deals with the socio-cultural system that deals with problems created by the economic system. In other words, prevention comes to represent a form of cure in so far as it is seen as dealing with problems that are already created.

This is paradoxical in so far as prevention, when it was promoted from the 1970s on, was a sustained critique against the curative focus of the bio-medically oriented medical institutions which had, for half a decade, been at the center of health policy. The arguments launched in Norway must be seen in light of the international movement arguing for a *New Public Health* (Cf. Cueto, Brown, &

[58] See for example Leonardsen (2015, p. 88).
[59] This is a central premise in Norwegian population management. See also NOU: 12 (2019); NOU: 23 (1986); St.meld. nr. 43 (1988-89)

Fee, 2020). Two points were central, the launch of a new concept of health, and a conception of prevention organized around it.

(1) the notion of health, such as it had been defined by WHO, that is to say as "not only freedom of disease, but complete physical, mental and social well-being" were critiqued on two accounts: first, it was seen as static: one either was or was not healthy (most were not, the critics argued); second, related to this, because the notion of health as "complete wellbeing" was more than most people could ever aspire to be, most people would consequently be defined as sick or being non-health, which meant that they would become subjected to the medical institutions. This process and dynamic was labelled as "medical imperialism" or "medicalization", and was related to the soaring economic costs of the medical institutions themselves (Hjort, 1982, p. 15; Illich, 1975). Instead of the "static" definition of health, "dynamic" definitions of health were proposed.

During the 1980s it was Peter F. Hjort's definition that become dominant in Norway (Elvbakken, Fjær, & Jensen, 1994). At the start of the 1980s he defined "good health" as "excess (*overskudd*) in the face of everyday demands" (Hjort, 1982, p. 16; 1995). This understanding of health is related to the evolutionary problem of *adaptation* in relation to man's milieu of existence. As Hjort explains,[60] the new definition builds on Ole Bergs (1973, 1975) emphasis on "the ability to work and function under changing conditions and demands" and the definition of health as ""functional fitness" (English in the original)," something which points to "the dynamic aspect of man's life and to the need to function within society"; Axel Strøm's (1980) identification of "adaptability" as the foundation for good health: "Good health is great (*stor*) adaptability in the face of external and inner demands (*påkjenninger*)";[61] and finally, Ivan Illich definition of health as "a constant process of adaptability" which is defined as being mainly the individual responsibility (consequently, medicine was harmful since it "reduced man's own responsibility and their ability to master illness (*sykdom*), pain and death")[62] (Hjort, 1982, pp. 15-16). Hence, the concept of health should therefore

[60] The following quotes are taken from Hjort's article, pp. 15-16.
[61] "Ole Berg legger hovedvekten på evnen til å arbeide og fungere under skiftende forhold og krav, og han definerer helse som «functional fitness» […] Denne definisjonen tar vare på noe vesentlig ved å peke på det dynamiske I menneskenes liv og på behovet for å fungere I samfunnet, I motsetning til WHO's bade statiske og ekstatiske "fullstendige velvære". Axel Strøm resonerer på samme måte når han understreker at det er evnen til tilpasning – adaptasjon – som er det grunnleggende ved helsen. God helse er stor adaptasjons evne overfor ytre og indre påkjenninger" (Hjort, 1982, p. 15).
[62] "Ivan Illich […] har lignende tanker om helse som en stadig tilpasningsprosess, og han understreker også menneskenes eget ansvar. Helse er en oppgave, en jobb, og ikke bare en fysiologisk balanse […] Derfor ser han på medisinen som skadelig, fordi den minsker menneskenes eget ansvar og deres evne til selv å mestre sykdom, smerte og død" (Hjort, 1982, p. 16).

> "be something positive, that is to say more than the absence of disease. It should contain both bodily, psychological and social elements. It must place an emphasis on function, adaption and man's own responsibility. Health is not something that one gets, but something that one must work with and fight for (*kjempe for*) throughout life. Good health means that one has an excess (*overskudd*) in relation to everyday demands"[63] (Hjort, 1982, p. 16).

As to the nature of these "everyday demands" Hjort specified that this was not necessarily tied to a level set externally; he preferred a definition "which is not tied to maximal challenge, and not even average challenge, but to the individual's own situation and the mastery of it"[64] (Hjort, 1982, p. 16).

(2) The understanding of prevention was tied to the new conception of health. Again, two more distinctions were central: on the one hand, health could not be achieved through individual work alone because man was fundamentally immersed in and dependent on the conditions of milieu of existence; second, in relation to this it was obvious that the sole focus on the health service was not enough to strengthen the health of the population.

Returning to the article by Hjort (1982), Hjort distinguishes "health policy" by two dimension: on the one hand, the health service – which should "really be called the diseases service" in so far as it only concerned with those who have become ill, and on the other hand, preventative politics (*forebyggende politikk*), which should be considered as the "real" health policy in so far as it is concerned with strengthening health and preventing that people become ill (Hjort, 1982, pp. 19-20). Historically, Hjort explains, prevention have dealt with infectious diseases such as tuberculosis through "specific measures, (*spesifikke tiltak*)" which is targeted infectious agents through isolation, hygienic measures and vaccination, and "unspecific measures (*uspesifikke tiltak*)," which targeted "the general resistance to disease". While it was first believed that it was the specific measures, implemented by doctors, that caused the retreat of infectious diseases, research by McKeown (1976) have showed that the unspecific measures was much more important (Hjort, 1982, pp. 20-21).

With the changes in "disease panorama" (increased prevalence of chronic diseases, and a reduction of infectious diseases) as well as an ageing population (leading to more chronic diseases, social problems, such as loneliness), from the end of the 1960s, the importance of unspecific measures became even more apparent, and the single reliance on medical specific interventions more problematic. According to Hjort, chronic diseases are fundamentally different from an infectious disease that strikes suddenly and wipes out life, in that they develop over a longer period of time –

[63] "være noe positivt, altså mer enn fravær av sykdom. Det må romme både legemlige, psykiske og sosiale elementer. Det må legge vekt på funksjon, tilpasning og menneskenes eget ansvar. Helse er ikke noe en får, men noe en må arbeide med og kjempe for hele livet. God helse betyr at en har et overskudd i forhold til dagens krav."
[64] "som ikke er knyttet til maksimal utfordring, ikke en gang til an gjennomsnittlig utfordring, men til individets egen situasjon og til mestringen av den."

from the cradle to the grave – and cannot be related to a single factor but must instead be understood as *multi-factorial* (Cf. Foucault, 2004c). Thus, Hjort writes, prevention is a "hard task, first and foremost because it does not consist in genius one-time measures, but a laborious (*møysommelig*) work with people and society"[65] (Hjort, 1982, p. 22).

Hjort (1982, pp. 22-25) distinguishes "prevention politics" into four dimensions, each more important than the next: (1) the continuation and continuous improvement of specific measures targeted at infectious diseases; (2) a system of health surveillance (*helsekontroll*) that follows the population "from the cradle to the grave," which aims to identify symptoms of disease or other problems at an early stage, which thereby enables the implementation of effective measures before the condition is allowed to develop; (3) individual behavior (*life style*) that is aimed at preventing disease (*disease prevention*) and strengthening health (*health promotion*). Public authorities can work on individuals life style through "education and influence"[66] which depended on peoples understanding of what a healthy life style was, that they accepted it and chose to live by the tenets of the healthy life style; (4) finally, Hjort identifies the "social milieu" (*samfunnsmiljøet*), which was the "milieu" in which health was formed, and consisted of "employment, work environment, housing, education, traffic, economics and social politics."[67] While many focused on chemical factors in the milieu, Hjort argued that "the social and economic factors are far more important. Everything that creates security, connection and well-being gives good health"[68] (Hjort, 1982, p. 24).

In a line of thought that is very close to what Foucault (2007) called biopolitics and mechanisms of security, Hjort draws out some fundamental consequences for politics in light of his notion of the social milieu: prevention is carried out mainly outside of the health sector; prevention is mainly politics; and that every policy is related to health;[69] consequently, it means that "every law should be considered from its effects on health," and that "both the population (*befolkningen*) and politicians must understand these broad (*store*) connections"[70] (Hjort, 1982, p. 24). In other words, the politics of prevention that Hjort is describing can be understood through the concept of governmentality that I use in the thesis: it does not only revolve around individual behavior but is concerned more over with elements of the milieu which affects the formation of health. It involves the transformation – at the level of knowledge-power – of the law, and all other aspects of society, as elements that may or may

[65] "en vanskelig oppgave, først og fremst fordi det ikke dreier seg om geniale enkelt-tiltak, men om et møysommelig arbeid med menneskene og samfunnet."
[66] "opplysning og påvirkning"
[67] "sysselsetting, arbeidsmiljø, boliger, utdanning, trafikk, økonomi og sosialpolitikk."
[68] "de sosiale og økonomiske faktorer er langt viktigere. Alt som skaper trygghet, tilhørighet og trivsel gir god helse."
[69] "Forebyggende arbeid foregår i det alt vesentlige utenfor helsetjenesten. Forebyggende arbeid er stort sett politikk. All politikk er helsepolitikk (eller uhelsepolitikk)."
[70] "Dette betyr at hver eneste lov skulle granskes ut fra helsemessige konsekvenser. Både befolkningen og politikerne må forstå disse store sammenhengene."

not affect the health of the population; hence, a necessary condition for the politics of prevention is that these *elements* are considered in terms of the *possible effects* that they have on the development of health (Cf. Foucault, 2007, pp. 70-75, 21-23).

From this point of view, prevention is not solely directed at dealing with the problems of adaptation (the problems created by the transitions of society) but is itself involved in the process of enabling adaptation, by working on the factors that determines the populations "excess in relation to everyday demands," whether they are the individual's life style or factors in the social milieu.

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This new concept of health, and the politics of prevention associated to it, seems to me to open up a possibility of combining the neoliberal project of making the competitive market economy possible, and the policies of public health by enabling the process of adaptation. Granted, Hjort is not making any explicit links between the "necessary adaptations to the demands of the market economy" and the policies of public health, like Lippmann does; Hjort is only speaking of the adaptability to "everyday demands". But the new conception opens up an interesting possibility: for this is an everyday which is changing, at least implicitly, with the demands of the global economy. In other words, it is this new definition of health, which is centered on the individuals adaptability, and the parallel emergence of a new "political imperative" that emphasizes precisely *adaptability* in the name of international competitiveness on the global market (Stiegler, 2019), which seems to me a very important development, but one which seems to have been overlooked by scholars in the Norwegian public health field until now.

Part II – Analysis: how is public health discursively constructed in the text?

Introduction

In part II, I present the methodological approach (*critical discourse analysis*) that has been used in order to select and analyze the document *Health Policy Toward the Year 2000. National Health Plan* (Chapter 4); then I present the findings of this analysis (chapter 5).

Chapter 4 *Methodology and study design*

In this chapter I present the methodological approach that has been pursued in the selection and analysis of *Health Policy Toward the Year 2000. National Health Plan*.

4.1 Critical discourse analysis

In order to study how a neoliberal rationality is expressed in the National Health Plan I utilized a critical discourse analytical approach (Rudman & Dennhardt, 2015). The critical discourse analysis builds on a social constructivist perspective and aims to raise awareness of how particular ways of talking and writing are situated in a concrete sociohistorical context. By deconstructing dominant modes of thought such an analysis aims to unsettle and disrupt taken-for-granted assumptions about the world, on the part of both readers and researchers (p. 139).

Critical discourse analysis is not a fixed set of rules or a strict methodology. Rather, it refers to a qualitative "approach to conceptualize and study discourses as social practice" (Rudman & Dennhardt, 2015, p. 138). A discourse refers to a particular way of writing and/or talking about a phenomenon, object or subjects. Discourses can be understood as the ways in which particular rationalities comes to be expressed: "systems of meaning conveyed through talk and text, which produce particular versions of concepts, objects, and subject positions" (p. 139).

In ontological terms, critical discourse analysis builds upon the assumption that what we know as "social reality" comes to be constructed over time through various "interactions of social, political, economic, cultural, gender and other factors"; which produce a vail of "naturalness," a sense that reality is not a construct but simply what *is* (Rudman & Dennhardt, 2015, p. 139). It is this feeling of naturalness that critical discourse analysis attempts to disturb.

The study of talk and various forms of text is the foremost analytical object in a critical discourse analysis. Epistemologically, language is given a central role in the production of a particular version of social reality and comes to be understood as a way in which power is enacted. It is assumed that the way in which an object or a group of people is discursively constructed "shapes the way

systems, structures, processes, and practices are constructed and enacted in relation to" a phenomenon (Rudman & Dennhardt, 2015, p. 139). Language is therefore not seen as an "extra-linguistic" aspect that to an already existing object, but is itself the medium through which our sense of reality of this object is created, how we come to understand it, as well as our particular ways of acting towards and relating to it (Rudman & Dennhardt, 2015, pp. 139-140).

4.2 Analytical process

In critical discourse analysis, both the reading of documents and the construction of the research field (i.e., the process of selecting the specific documents that are analysed) is an emergent process that is guided by theory, research question and analytical focus (Rudman & Dennhardt, 2015). During the process of selecting and reading documents I made changes to both the study design and analytical focus. In terms of study-design I went from attempting to make a cross-comparison between three text, to do an in-depth reading of a small section of a single text.

4.3 Creating the research field

In this section I will go over the main features of the process of selecting the National Health Plan as the document that is subjected to critical discourse analysis. First, I describe the process of identifying and selecting relevant documents for the analysis. Then, I describe the process of subsequent narrowing of the analytical scope that reduced the number of texts from three to one.

4.3.1 Identifying and selecting relevant documents for the analysis

At the start of the thesis I was interested in looking at how a neoliberal rationality was expressed in the discourse on public health, such as it was constructed in several public documents in the period 1980 to 2000. During the search for text I decided to focus on the period 1986 to 1996 because this corresponded with the governing period of Labor, and with the publication of the WHO's (1986) Ottawa Charter, which presented Health Promotion as a strategy that should be taken up by European countries. Because I was interested in how the Norwegian Government constructed their new public health strategy – that now included both a health promotive and preventive strategy – I wanted to identify policy documents that constructed health promotion and prevention in relation to particular problematizations, and which subsequently presented health promotion and prevention as particular kinds of solution frames that would enable the government to deal with these problematizations. Therefore, I decided to focus on two types of public documents: *Report to the Storting,*[71] which is here

[71] Stortingsmelding, st.meld.

referred to as White Paper, is a public document in which the siting Government proposes its policies to the Storting. These White Papers, more specifically, are presented by the particular Ministry that is responsible for any given policy area. The second type of text is the *Norwegian Official Report,*[72] which is here referred to as Background Document, is a text that is published by a panel or committee on a specific topic or policy area. The Background Document, which is ordered by the Government, may serve as background to a subsequent White Paper.

At the beginning of research, I had little knowledge of the period (1980-2000), nor what documents would be relevant. In order to identify relevant documents from the period, two strategies were used. (i) In order to get an overview of the text that had been published in this period, I made use of various online archives – such as publikasjon.dep.no; regjeringen.no; and nb.no/statsmaktene – that enabled me to locate and obtain potential documents through the use of both open search (e.g. looking at every document within a category, such as year or policy field) and by using specific search terms. Examples of search terms include: *folkehelse*, *folkehelsepolitikk*, *helsefremming*, *helsefremmende arbeid*, *forebygging*, *forebyggende arbeid*, *helse*, *helsepolitikk.*[73]

(ii) In order to become familiar with the period and the context of the text identified in the first strategy, I read secondary literature which provided contextual information on the period and the documents that I was interested in. Examples of such secondary literature include: Cueto et al. (2020); Ellingsæter, Hatland, Haave, and Stjernø (2020); Haave (2020); Leonardsen (2015); Schiøtz (2003, 2017); Skaset (2003).

While being conscious of my own preconceptions, I have aimed to read documents with a 'fresh mind'. In the context of this thesis, and the process of selecting texts, this meant that I tried to avoid reading potentially relevant document before submitting them to analysis. The strategies described above allowed me, first, to get an overview of existing documents, and second, to make an informed decision based on contextual awareness.

In order to go beyond a surface reading of text, I planned to do multiple readings of each text, using multiple reading approaches, such as open reading, analytical reading, linguistic reading and semiotic reading (Rudman & Dennhardt, 2015). Assuming that this would require some time be spent on each document I decided to limit the selection of document to three. Because I had planned for two months of analysis this would allow for 2,5-3 weeks per text.

[72] Norsk Offentlig Utredning, NOU
[73] English: public health, public health policy, health promotion, health promotive work, prevention, preventive work, health, health policy.

Three documents were selected:

St.meld. nr. 41 (1987-88) *Helsepolitikken mot år 2000. Nasjonal helseplan*
NOU: 10 (1991) *Flere gode leveår for alle. Forebyggingsstrategier*
St.meld. nr. 37 (1992-93) *Utfordringer i helsefremmende og forebyggende arbeid*

These documents were published in a period where, according to Skaset (2003) health promotion and prevention was given "more political attention" (p. 539). *Health Policy Toward the Year 2000. National Health Plan*[74] was the Norwegian attempt at following up WHO EURO´s Ottawa Charter on Health Promotion (Haave, 2020). It was presented by the Ministry for Social Affairs in 1988 (Brundtland´s second cabinet, Labor). After its publication, the Minister for Social Affairs, Tove Gerhardsen, ordered the development of a Background Document that would allow for an elaboration on what Prevention and Health Promotion look like. This Background Document, *More Good Life Years for Everyone*, published in 1991, served as a foundation for the White Paper that was called *Challenges for Health Promotion and Prevention*, published by the newly created Ministry for Health and Social Affairs in 1993.

4.3.2 Narrowing the scope of the research field

After these documents were selected, a further process of narrowing the scope of the analysis began. The process of refining the research field and narrowing the focus to sections of one text was iterative and involved on-going meetings with my supervisors.

Early in the process, mid-December, the need for reducing the number of chapters that would be included in the analysis was identified. While three documents were initially thought to be manageable, it was raised as an issue that too many chapters were probably not going to be relevant for the analysis; such as chapters detailing changes in the health service. Given that I had planned for two months of fairly detailed analysis, it was assumed that I would not be able to cover every chapter of those deemed relevant. Thus, there was a need for making a prioritized list of relevant chapters and sub-sections within each document.

In order to identify relevant chapters, I read the table of contents of each document. It was seen as important that I did not read chapters in advance so as not to favour the chapters where I 'knew' that I would find 'good' quotes. By not knowing what I would find, I was also forcing myself to pay closer attention to the details and particularities of each section that I ended up analysing.

[74] Helsepolitikken mot år 2000. Nasjonal helseplan.

Table of contents were read line by line and comments were drawn up regarding the possible meaning of and content of each chapter. These comments and reflections served both as a first analytical step, wherein I noted particularities about how prevention and health promotion were framed; and as the basis for arguing for why and how any particular chapter could be relevant for the analysis.

From this process, 17 chapters were identified as relevant. Seeing as this would probably still be too much to cover, a prioritized list of relevant chapters was made. When prioritizing within the list of relevant chapters I followed the principle that, if I could only choose one chapter from each document, which one should it be; if I could read two chapters… and so on.

In order to get on with the analysis I started to read the introduction of each document, seeing as I knew that these sections would have to be included in the analysis. I assumed that the introductions would provide a good launching-off point, from where to identify what chapters that should be read next. While reading these sections I was also considering which (small number) of chapters that would be included. A list of 9 chapters where made (3 chapters for each document).

After presenting the some of the findings from these introductions it was suggested that I should go more in-depth into the first document, the National Health Plan. In the presentation of these findings it was decided that I should not look at the other two documents. The more in-depth analysis had proven fruitful and time consuming. Rather than starting the same process anew with the other two documents, it was thought that it would be more worthwhile to continue reading subsequent chapters within the same text.

Within the National Health Plan, two documents were identified as relevant: Chapter 4 (‘Main Goals for Health Policy’) could possibly enable me to analyse how health promotion and prevention were constructed as solution frames for the problematizations that were presented in the introduction. This construction as a solution frame had only been hinted at in the introduction, but never described in any details. Chapter 13 (‘Health-Promotive and Preventive Work – An Overarching Strategy for Society’) would enable me to do a more detailed analysis of the rationales behind health promotion and prevention, the construction of problem fields, and details regarding the organization and carrying out this strategy. After analysing chapter 4 it was decided that it was not necessary to also read chapter 13. While chapter 13 could still provide richness to the analysis, it was also thought that chapter 4 would provide me with enough material for analysis. Second, while it was possible to include chapter 13 into the analysis this would most likely have strained my own working capacities; which I wanted to allocate towards the remaining sections of the thesis.

4.3.3 Research field

Thus, the scope of the analysis was narrowed down to White Paper no. 41 (1987-88) *Health Policy Toward the Year 2000. National Health Plan*, and only included the introduction (3 pages) and chapter 4 (5 pages) as material that would be used for analysing how health promotion and prevention was constructed.

4.4 Method for analyzing and reading text

In this section I provide an overview of the method that was used when document was read. Documents were read in a structured and systematic manner that was refined during the reading process itself. I implemented steps that enabled me to generate and develop analytical ideas and reflections. Documents were read as a physical copy, and notes were written down manually, and then transcribed into a text-editing software.

Four rounds of reading were done. Two open readings, one in-depth reading and an analytical reading that was guided by an analysis sheet.

The first time reading a section I would have a small notebook by my side and I would immediately write down thoughts and impression. As a principle I tried not to filter or sensor any thoughts that came to me; this was both helpful for generating ideas, but also helped me to remain focused on reading, and not worried about the chance of good ideas slipping by.

The second time reading the document I was also annotating the text by indicating paragraphs by letters (a, b, c etc.) and sentences in paragraphs by numbers (a.1, a.2, a.3 etc. would refer to sentence 1 2 and 3 in the first paragraph of a sentence). This allowed reflections and analytical notes to be linked to specific sections of the text, which was very helpful when reviewing these notes afterwards.

After these two readings I transcribed the notes from both reading sessions.

Then a more in-depth process followed, in which I would go through a section within a chapter that I had deemed relevant (in the text, chapters were divided into numerated sub-sections, e.g. 1.1, 1.2, 1.3 etc.). Relevance was judged based on the initial two rounds of reading, and then a systematic combing of the text where I looked for the inclusion of the words ‘public health’ (‘prevention’ and ‘health promotion’), ‘health’, ‘population’ in the text, and noting what kinds of subject positions were present.

This in-depth stage involved reading the text paragraph by paragraph, and each sentence within a paragraph. As a preparation, the whole chapter had been transcribed into Microsoft Word, a word

processing software. Two reading approaches were used. First, an open reading where I tried to come closer to what the text tried to say and how it was saying it. Then, an analytical reading where I systematically went over each paragraph and sentence (where relevant) with the last version[75] of the analytical sheet. The intension was to try to answer the questions on the analytical guide by using what was said in the text.

For each round of reading – open and analytical – reflexive notes were manually made and transcribed into Word.

4.5 Analytical sheet

In the investigation of Norwegian public health strategies, focus has been given to the following objects: public health, the subject, the population, health, and external and internal relationships. Reading document are done with an aim to understand how these objects are constructed in the text. In an attempt to facilitate a theoretically founded reading of texts, I constructed an analytical sheet that was used in one of the circles of reading that will make up the process of generating data for the discourse analysis (Rudman & Dennhardt, 2015). The analytical sheet consists of a series of questions regarding the central objects of analysis (see Appendix 1 and 2). Questions were framed with theory in mind.

The analytical sheet can be used by the reader who would like to understand more about how the theoretical framework of the thesis informed the reading of the texts, and thus how data about the texts were generated. With that said, the reader should be aware that the analytical sheet has been subject to change. As documents were examined, it became apparent that other objects were relevant as well, and that the objects already included needed some revision. As one specific and important example, the notion of 'public health' needed to be specified as 'prevention and health promotion', seeing as these concepts represented a content that were closer to what I had in mind when wanting to study the construction of public health in these texts. The analytical sheet was first developed in light of the analytical framework that I had constructed during the process of making a project description. It was revised following the first attempt of analysis (see Appendix 1 and 2).

[75] Two iterations of the analytical sheet used for analytical reading. See Appendix 1 and 2.

Chapter 5 *How is public health discursively constructed in the text?*

5.1 Introduction

The findings from the analysis is organized around the *discursive construction of public health* identified in the text and is presented according to key problematizations found and solution frames identified in relation to this concept.

The chapter is divided into two parts. Part 1 presents the problematizations linked to public health: *the loss of life years*, and the problems related to the *improvement of the health of the population*. The improvement of health is problematized in terms of the *apparatus* involved in the government of population: (1) the problem of inequalities in health; (2) the problem of contributing to the improvement of the health of the population; underneath the aim to improve health I also place (3) problematization of increased need for health services; and (4) the problematization of the provision of health services.

Part 2 presents the solution frames linked to public health policy: *the responsibilities* of individuals to take on healthy living habits, and society's responsibility for creating the conditions of possibilities for health: (i) making healthy life styles possible for individuals, and (ii) by preventing factors that are harmful for the health of the population. Ending part 2, I analyze the role of *decentralization* as a key framing for the responsibility of "society" for disease prevention and health promotion.

Part 1: Problematizations

5.2 Improving health and reducing lost life years

In the National Health Plan, health promotion and prevention are designated/constructed as the proper strategies for dealing with two phenomena: the health and morbidity of the population and "life years". The "health of the population" should be "improved" while morbidity and the loss of life years should be "reduced". This connection can be seen in the following excerpt which is taken from Health Policy Goal no. 1:

Health promotion and preventive work must be strengthened in the years to come as a more central strategy for improving the health of the population and reduce the lost life years that are caused by diseases, such as cancer and cardiovascular

disease, accidents – especially child accidents, infant mortality and certain infectious diseases[76] (St.meld. nr. 41, 1987-88, pp. 56-57; emphasis in the original).

In this excerpt the problems are implied in the presentation of solutions. The text makes a connection between what it calls "health promotion and preventive work" and the accomplishing a "strategy for improving the health of the population and reduce the lost life years…". As to my suggestion that morbidity was also an important object for prevention, the text also specifies a field of phenomenon that becomes relevant due to their impact on "life years": "diseases, such as cancer and cardiovascular disease, accidents – especially child accidents, infant mortality and certain infectious diseases" are presented as *causing* a *loss* of life years. These events or phenomenon are thus problematized because they lead to "life years" to being "lost".

5.2.1 Lost life years

The meaning of the concept of "life years" is not explicitly stated in this quote; seeing as the term is not taken up anywhere else in the text that I have read, my analysis will have to be based on what is stated here. From there, three points can be inferred.

(i) At a nominal level, the word "life year" – translated from the Norwegian word "leveår"[77] – contains two words: "life" and "year". I take this to mean that what is in question is a unit of measurement where "life" is object one is interested in, and where a year serves as the unit of measurement. This means in turn that what is being problematized is that one or more years of "life" (or "living"[78]) are being lost. Seeing as the concept of "health" at the level of the population, it seems reasonable to assume that "life years" is also applied as a concept at this level. The category of 'life year' therefore seems to be used as a descriptor for a property of the whole population. It also seems to function as an effect measurement: something that is lost due to various causes; and, reversely, that these causes can be problematized with reference to the effect of lost life years.

(ii) The concept of "life years" is defined in negative terms. It is something that is "lost" due to a series events: "diseases," "accidents" – with a special emphasis given to accidents related to children ("infant mortality") and "certain infectious diseases." These events or phenomenon can be seen to occur throughout and at various stages of the life Infant mortality and accidents related to

[76] «*Helsefremmende og forebyggende arbeid* må styrkes i årene framover som en mer sentral strategi for å bedre helsetilstanden i befolkningen og redusere tapte leveår som følge av sykdommer som kreft og hjertekarlidelser, ulykker – særlig barneulykker, spedbarndødlighet og visse smittsomme sykdommer.»

[77] Directly translated, 'leveår' would not refer to 'life year' but 'living years'; the translation of 'leve' is not 'life' but 'living'. When I translate 'leveår' to 'life years' this is with reference to the term Quality-Adjusted Life Year (QALY), which in the official Norwegian usage is translated to Kvalitetsjusterte *leveår* (Cf. Sælensminde & Torkilseng, 2010)

[78] See previous footnote.

children occur during an early stage; cancer and cardiovascular diseases can possibly be understood to be events that occur later in the life course; and, finally, infectious disease, together with accidents, can be understood as occurring at any particular stage of life. Second, these events occur *before* the loss of life years. This holds implications for where prevention and health promotion will be situated as a solution frame for reducing the loss of life years: prevention and health promotion will work on the *causes* that eventually leads to life years being lost. The underlying rationality seems to be that "life years" is dependent on other factors and cannot be directly intervened on. The state of life years of the population is determined by other factors that one has to control in order to control the state of life years. One will have to work on the determining causes in order to reduce this loss from occurring. Additionally, that the goal is to "reduce" lost life years seems to suggest that the field one is working on is not constituted by factors that one has a total control over – one cannot "stop" the loss of life years, and one will have to work on factors that are removed from the phenomenon of life years, but which still has some sort of effect on it that leads to its loss.

(iii) That life years can be lost suggest that life years is constructed as a phenomenon that exists as a potentiality. By this I mean that the category of 'life year' refer to a potential of some kind; whatever "a life" (or "living") might possibly produce within the span of a year, is what is lost. It seems to me that there would be two primary dimensions involved here: on the one hand there is the potential that is represented by "life years" itself – the potential that is lost due to various undesirable events – and on the other there is the effects caused by accidents, diseases and infant mortality. As to the former, no concrete potential of a life year is defined. But, as to the latter, a very concrete effect is constructed for disease and accidents, or what is referred to as "morbidity" in the text: the need for health services. Before turning to how the need for health services are constructed in the text I will go over how the goal of improving health problematized in the text.

5.2.2 Improving health

Properly speaking, improving health is not a problem, and is rather an aim that is launched by the National Health Plan. Associated to the pursuit of improving the health, however, there are two important problematizations that should be considered. On the one hand there are all the problems that necessitates the continued improvement of the health of the Norwegian population: the problem of *inequalities in health between various social groups and geographical regions*. On the other, there are the problems and questions that are brought up in relation to the contribution to the attempt of improving the health of the population.

5.2.2.1 *Inequalities in the state of health of the population*

The clearest expression of the problem of inequalities in health can be found on p. 57 under the description of Policy Goal no. 4:

> *Greater equality of results in health*. There are still such large differences in living conditions and health between different parts of the country and between social groups in the population that it must be a key goal to achieve greater equality of results and not just a more equal treatment offer.
>
> Compared with other European countries, Norway has a relatively good public health. Nevertheless, it is necessary to be vigilant against factors that weaken the state of health and work for continued improvements.
>
> The Government will pay increased attention to the inequalities that exist in the state of health of the population. There is reason to believe that these differences are strongly related to differences in living conditions. One of the Government´s main goals is therefore to reduce inequalities in living conditions and counteract conditions that can have a negative effect on people´s state of health. [79] (St.meld. nr. 41, 1987-88, p. 56; emphasis in the original).

The problem presented in the text can be summarized thusly: Despite of Norway having a "relatively good public health" compared to other European countries, there exists differences in health status *within* the country, seen in the differences between *geographical regions* (i.e. "parts of the country") and *social groups*. These differences are caused by and corresponds to inequalities in "living conditions" and "conditions that can have a negative effect on people´s state of health."

Health promotion and prevention are not mentioned explicitly in this textual example. A reference to these solution frames can still be found in the concept of "living conditions" and "conditions that can have a negative effect on people´s state of health." In the latter group of "conditions" it seems reasonable to place the same set of undesirable events that in the previous excerpt was linked to prevention and health promotion. The verb "counteract" can also be understood as similar to that of "preventing." The underlying logic that can be detected is also similar to that of health promotion and prevention, as described above: in order to deal with the problem of inequalities in the health of the population, action will not be taken on the health of the population itself. Efforts will instead be directed at the *causes* – or in this case "conditions" (*forhold*) – that are seen to underlie the existence of the problem being addressed.

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[79] «Større *resultatlikhet i helsetilstand*. Det er fortsatt så store forskjeller i levekår og helse mellom ulike deler av landet og mellom sosiale grupper i befolkningen at det må være et sentralt mål å oppnå større resultatlikhet og ikke bare et mer likeverdig behandlingstilbud (kursiv i original). // Sammenlignet med andre europeiske land har Norge en relativt god folkehelse. Det er likevel nødvendig å være på vakt mot faktorer som svekker helsetilstanden og arbeide for fortsatte forbedringer. // Regjeringen vil rette økt oppmerksomhet mot de ulikheter som finnes i befolkningens helsetilstand. Det er grunn til å tro at disse ulikhetene i sterk grad har sammenheng med forskjeller i levekår. Et av Regjeringens hovedmål er derfor å redusere ulikheter i levekår og motvirke forhold som kan virke negativt inn på folks helsetilstand.»

The problematization of inequalities in the state of health of the population is located at an aggregate level. The objects involved are social groups of the *population* (not individuals) and parts of the *country*. This suggest that the point of departure when identifying "differences" has been the overall level of health of the Norwegian population. From this point, a statistical analysis was done to map out of the distribution of different states of health according to geography, and according to social grouping. From this analysis, the text presents the conclusion that differences in health is *too* big.

The notion that differences in living conditions and health between parts of the country and social groups is too big, seems to suggest that there is an external reference point that enables one to make such a claim. It is not explicitly stated what differences in health is positioned in relation to. In the excerpt above there is made reference to the result of health, and there is presented a goal that there should be a "greater equality of results in health." The notion of "equality" here seems to suggest that two or more elements should have a similar value – the state of health in different parts of the country. The existence of "difference" or "inequality" between these elements are framed as problematic, a fact that is taken up in the text and presented as a problem that should be dealt with. Yet, the way in which the difference comes to be defined as "too big" is not specified. Possibly, the problematic aspect of differences in health stem from the effects that are produced when the level of health in any part of the country or in a social group is below a certain threshold. In other words, implicit in this problematization of differences in health is the effects that are produced from the causes of the differences: i.e. differences in living conditions and conditions that cause harmful effects on people´s health, such as diseases and accidents. Again, in the National Health Plan, these events are linked to the need for health services. I will return to this problematic after treating the problems related to contributing to the improvement of the health of the population.

5.2.2.2 *Problems related to the contribution of the improvement of the health of the population*

At the very beginning of the National Health Plan, we find a concise statement of the main intent of the health plan.

> For the first time since the processing of White Paper no. 9 (1974-75) on hospital development in a regionalized health system, a discussion and review of health policy in its full breadth is now presented. The paper addresses the problems and challenges we face in the work of improving the health of the population, how the health service can contribute to solving the problems and what is first and foremost dependent on efforts in other sectors of society. It must be acknowledged that there is a limit to what the health service can contribute in terms of improving the public health. In this White Paper, the Government presents how the health service can nevertheless

be the main pillar in the preventive work locally, cf. also Ot.prp.[80] no. 40 (1986-87) on environmental health protection[81] (St.meld. nr. 41, 1987-88, p. 7).

Here the problematization springs from the crossing of the goal of improving the health of the population and the proposed solution to that problem. The way in which a sector contributes to the improvement of the public health is framed in terms of *local preventive work*. The solution frame represented by prevention can be seen as a framing tool that constructs the public sector (i.e. "sectors of society") in terms of their ability to contribute to the overall goal of health policy. In order to contribute, a particular sector must be partaking in the activities and mode of though (i.e. governing rationality) represented by prevention and health promotion. In particular, the health sector is framed as having a limited ability to contribute to the improvement of public health. On this basis the text constructs a need for the health service to undergo a transformation. The change necessary for the health service to contribute to improvement of the health of the population is to become "the main pillar of preventive work locally."

A tension is thus introduced. On the one hand, there is an implied notion that the most important preventive and health promotive efforts lies *outside* of the realm of the health sector. And on the other, the attempt to turn the health service *into* a central part of health promotive and preventive efforts.

The notion that health promotive and preventive work lies *outside* of the health sector can be seen as implied in the assessment that the contribution that the health service is able to make is *limited*; as well as the juxtaposition of it and the other sectors of society, which implies that it is *there*, and not in the health service, where most of the efforts can be made. The latter establishes a fragmented field wherein the health service serves only one of many roles in contributing to the improvement of the public health, and has a limited role to play at that. These notions are explicitly stated in other places in the text. Regarding the placement of health promotive and preventive work *outside* of the health service, see for example:

[80] Until 2009, Ot.prp, or *Odeltingsproposisjon* was the term that term used to signified proposals from the Government to the Odelsting, regarding matters of related to law. An *Odeltingsproposisjon* refers to a proposal for a new law, and a proposal to revoke or make changes in a law. See https://jusleksikon.no/wiki/Odelstingsproposisjon [**make proper reference**.]

[81] «For første gang siden behandlingen av St.meld. nr. 9 (1974-75) om sykehusutbygging i et regionalisert helsevesen legges nå fram en drøfting og gjennomgang av helsepolitikken i sin fulle bredde. Meldingen tar opp de problemer og utfordringer vi står overfor i arbeidet med å bedre befolkningens helse, hvordan helsetjenesten kan bidra til å løse problemene og hva som først og fremst er avhengig av innsats på andre samfunnssektorer. Det må erkjennes at det er begrenset hva helsetjenesten kan bidra med når det gjelder bedringen av folkehelsen. I meldingen presenterer Regjeringen hvordan helsetjenesten likevel kan være hovedpillaren i det forebyggende arbeidet lokalt, jfr. Også Ot.prp. nr. 40 (1986-87) om miljørettet helsevern.»

> Some of the most important health-promoting and disease-preventing measures *lies outside* the health service´s actual sector boundaries, and good health for all can therefore only be achieved by united effort from all sectors[82] (St.meld. nr. 41, 1987-88, p. 56; emphasis added).

As for the fragmented field of possible contributors to the realization of the goals of health policy, the National Health Plan frames these conditions for the realization of its goals: "the challenges of health policy must be met with a broad commitment *across several focus areas*,"[83] and that "the health sector will only be *one of several*, albeit important focus areas"[84] (St.meld. nr. 41, 1987-88, p. 56; emphasis added).

Thus, the tension consists in the following: (i) to contribute to improving health means to participate in local preventive work; (ii) the most important health promotive and preventive measures lies outside of the health services sectorial boarders; (iii) yet, the health service shall become a "main pillar" in local preventive work. Or, in other words, the health service is decentered by the very nature of how the problem of improving public health is proposed solved; yet will regain a central position by contributing to the same strategy.

5.2.2.3 *Problematizing the increased need for health services*

The need for health services is problematized in two different ways and can be seen in the text as being located at two distinct, but ultimately interrelated levels. *Within the health service*, the increased need for care and treatment will require that the health service produce a supply that meet the demand for services. The production of health services will require two things: economic resources and qualified personnel to perform the tasks involved in service provision. Both of which are limited relative to the need for service. *At the national economic level*, concentrated on the object of the "Norwegian economy," the need for health services is framed as a "public expenditure." With reference to the "balance of the Norwegian economy" the National Health Plan proposes to "subdue" the growth of public expenditures through increased productivity and effectivization.

Regarding both of these problematizations, prevention and health promotion can be understood as a solution frame that is located and aimed at the *causes* that underlies the need for health services; health promotion and prevention thus represents an *alternative* strategy to that of effectivization and increased productivity, a strategy which is located *before* the problem of an increase in the need for health services arise in the first place.

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[82] «Noen av de mest sentrale helsefremmende og sykdomsforebyggende tiltakene ligger utenfor helsetjenestens egentlige sektorgrenser, og god helse for alle kan derfor bare oppnås ved en forent innsats fra alle sektorer.»
[83] «Helsepolitikkens utfordringer må [...] møtes med en bred satsing over flere innsatsområder.»
[84] «helsesektoren bare blir ett av flere, om enn viktige satsingsområder.»

The institutional and national level can be found in the following excerpt from chapter 4:

Previous chapters have told us about the following challenges:

1. Still significant inequality in morbidity and health in different groups of the population.
2. Still large geographical differences in the health service offer.
3. A large part of the morbidity can be reduced by better prevention.
4. Large variations in the health service´s treatment practice.
5. Increased pressure for more resources for the health service as a result of;
   - More elderly and changes in the pattern of illness
   - New technology creates new treatment options
   - Clinical freedom and demands for the best possible treatment from a professional point of view
   - Patients´ expectations that new treatment options will be used in order to provide the best possible treatment.
6. Smaller cohorts of young people towards the turn of the century weaken the basis for the increased supply of personnel needed to cover the growing need for health and care services.

Major resource requirements and inequalities in the population´s living conditions, which are usually sought to be resolved with increased public resource input, will thus be met at the same time as the economic framework conditions become tighter and require:

- Better balance in the Norwegian economy with subdued growth in domestic use of goods and services.
- Better resource utilization in the Norwegian economy.
- Subdued growth in total public expenditure and stronger demands for streamlining and restructuring of the business[85] (St.meld. nr. 41, 1987-88, p. 56).

The need for health services can be seen as caused by inequalities in health and morbidity, an ageing population (increasing number of elderly), changing patterns of illness, and various changes in the supply and demand of treatment (technological development producing new treatment, and a corresponding need for the "best possible" treatment).

[85] «Foregående kapitler har fortalt oss om følgende utfordringer: 1. fortsatt betydelig ulikhet i sykelighet og helsetilstand i forskjellige grupper av befolkningen. 2. Fortsatt store geografiske forskjeller i helsetjenestetilbudet. 3. En stor del av sykeligheten kan reduseres ved bedre forebygging. 4. Store variasjoner i helsetjenestens behandlingspraksis. 5. Økt press om mer ressurser til helsetjenesten som følge av; - flere eldre og endringer i sykdomsmønsteret; - ny teknologi skaper nye behandlingsmuligheter; - klinisk frihet og krav om best mulig behandling ut fra et faglig synspunkt pasientenes forventninger om at nye behandlingstilbud skal tas i bruk for å å best mulig behandling. 6. Mindre ungdomskull framover mot århundreskiftet svekker grunnlaget for den økte personelltilgang som trengs for å dekke stigende behov for helse- og omsorgstjenester.

Store ressurskrav og ulikheter i befolkningens levekår som vanligvis er søkt løst med økt offentlig ressursinnsats skal således møtes samtidig med at de økonomiske rammebetingelsene blir strammere og krever: - Bedre balanse i norsk økonomi med dempet vekst i innenlandsk bruk av varer og tjenester. – Bedre ressursutnyttelse i norsk økonomi. – Dempet vekst i de samlede offentlige utgifter og sterkere krav til effektivisering og omlegging av virksomheten.»

(i) ***Institutional framework***

The need for health services is problematized with reference to the "increased pressure for more resources for the health service" and lacking base from which to draw "personnel needed to cover the growing need for health and care services." Both of these problematizations can be located at the *internal or institutional level* of the health service: they relate to the actual management of the health service as an institution that is responsible for *producing* services that correspond to the actual need for services represented by the population.

Lacking resources and lack of personnel both comes to be represented as challenges for delivering the services demanded by the population. With regard to personnel, this aspect is explicitly stated in the text, but with regard to resources, this link is only implied. In other parts of the text, the connection is made more explicit:

> Norway will, in the next years, be faced with great challenges in health policy. This is especially in terms of the increasing number of elderly people in the population, and the increased need for care and treatment this represents. At the same time, it will be challenging to recruit qualified personnel, and the economic conditions will be tight *relative* to the tasks[86] (St.meld. nr. 41, 1987-88, p. 7; emphasis added).

The need for services is framed as a dynamic factor that can fluctuate, while resources are presented as a more or less fixed point. Thus, when the need for services increases the result will be an imbalance between the need for services and available resources. The increase in the number of the elderly in the population comes to be problematized with reference to how this population group will bring with them an increase in the need for services.

(ii) ***National economic framework***

The national economic level of the problematization of the need for health service can be found in the bottom half of the first excerpt. Here, the problem of increasing demand for resources at the institutional level is framed as a "public expenditure," which in turn is related to "the Norwegian economy."

The text marks out a contrast between *previous* solutions which relies on "increased public resource input," and the proposed solution, which works within a "tight" (*stramt*) economic framework. With reference to the "Norwegian economy" the text also situates the problems of resource

[86] 'Norge står i de nærmeste årene overfor store utfordringer i helsepolitikken. Dette gjelder særlig i forhold til det økende antall eldre i befolkningen og det økte pleie- og behandlingsbehov dette representerer. Samtidig vil det bli vanskelig å rekruttere kvalifisert personell, og de økonomiske rammebetingelsene vil bli stramme i forhold til oppgavene.'

requirements and inequalities in the population´s living conditions within a *national economic* framework.

The goal to be achieved is a "better balance in the Norwegian economy." The Norwegian economy is the object, and the goal is that it should be in a better balance. The balance of the Norwegian economy, furthermore, is dependent on 'domestic use of goods and services' and "public expenditures." In order for the Norwegian economy to have a better balance, both of these factors must not be allowed to grow. It is not a question of cutting spending, but on how to "subdue growth." In order to achieve this effect, resources must be used better with a "stronger demand for effectivization and restructuring."

This solution frame is also taken up in relation to the aforementioned problematization of the increasing number of elderly in the population. Within the health service, the increase of the need for services will result in the need for making priorities:

> Conflicts related to prioritization will therefore become tougher. Resources must be exploited better, and it will become necessary to reject certain demands to increase resources for parts of the health service[87] (White Paper, no. 41 1987-88 p. 7).

Prioritization is presented as an action that is framed by two imperatives: (i) resources must be exploited more efficiently, and (ii) demands for additional resources – "for parts of the health service" – must be rejected. Prioritization can be understood as both a *problem* and a *solution*. Seeing how it is linked with conflict, it is implied that the situation is not desired. On the other hand, it is a solution to the problem of having limited resources in the face of demand for services. Thus, within the health service, the need for treatment and care leads to an undesirable situation that is framed both as a solution and as a problem.

While it is not explicitly stated in the same way, health promotion and prevention can be understood as an alternative solution frame to the internal organization and restructuring that is proposed within the health service. Both of these solution frames deal with the problem of need for services, but they are located at different ends of the problem: prioritization, better resource utilization, and restructuring comes up as a solution for facing the actual fact of service need; health promotion and prevention is directed at the sources of that need, and is deployed in order to reduce the need for health services from appearing in the first place.

[87] «Prioriteringskonfliktene vil dermed bli vanskeligere. Ressursene må utnyttes bedre, og det blir nødvendig å avvise enkelte krav om økte ressurser til deler av helsetjenesten.»

5.2.2.4 *Problematizing the provision of health services*

The problems related to care and treatment does not end when services are provided: service provision is problematized with reference to the negative effects that services and the health service can have on individual's health. An example of this framing can be found in Policy Goal no. 7, which argues for "increased democratization, user influence and legal security for patients":

> The health service manages large resources and knowledge of significant importance for people´s living conditions and welfare. A better basis must be created for political prioritization of resource management. The health service is so important for people´s safety and living conditions that it is an independent value that there is an opportunity for increased democratic control through elected bodies that must take political responsibility for their priorities and decisions toward the population. The health service is traditionally a sector that in its organizational form and practice reduces patients´ sense of control over their own lives and health. Opportunities to reach out to the system with wishes and complaints and control of the consequences of treatment are in practice limited. The individual who seeks the health service with their problems must be given a greater degree of insight and the opportunity to influence the measures that are implemented and better control over their own lives.
>
> The legal and practical possibilities for access to the enterprise, legal security in the treatment and the access to compensation for treatment injuries must be increased[88] (St.meld. nr. 41, 1987-88, p. 58).

Here, the health service is framed as an actor who has large amounts of "resources" and "knowledges" that have an impact on "people's living conditions and welfare." Second, the way that the health services have "traditionally" been organized and practiced in a way that "reduces patients' sense of control over their own lives and health," and gives patients "limited" opportunity to communicate and control key aspects of the patient-health service relationship: represent ones wishes and complaints, and controlling the consequences of treatment.

The link to health promotion and prevention is never stated outright but can be inferred from certain formulations in the text. Care and treatment are presented as a factor that can be damaging to individual's health. The connection can be seen in the second sentence of Policy Goal 7: "The health service manages large resources and knowledge of *significant importance* for people´s living conditions and welfare" (emphasis added). As I have shown, with reference to other parts of the text,

[88] «Helsetjenesten forvalter store resurser og kunnskaper av vesentlig betydning for folks levekår og velferd. Det må skapes bedre grunnlag for politisk prioritering av ressursforvaltningen. Helsetjenesten har så stor betydning for folks trygghet og levekår at det er en selvstendig verdi at det blir mulighet for økt demokratisk kontroll gjennom folkevalgte organer som må ta et politisk ansvar for sine prioriteringer og avgjørelser overfor befolkningen. Helsetjenesten er tradisjonelt en sektor som i sin organisasjonsform og praksis reduserer pasientenes følelse av kontroll med eget liv og helse. Ulikheter til å nå fram overfor systemet med ønsker og klager og kontroll med konsekvenser av behandling er i praksis begrenset. Den enkelte som søker helsetjenesten med sine problemer må få større grad av innsyn og mulighet for innflytelse på de tiltak som iverksettes og bedre kontroll med eget liv.

De legale og praktiske mulighetene for innsyn i virksomheten, rettssikkerhet i behandlingen og adgangen til erstatning ved behandlingsskader må økes.»

living conditions is linked to the health of the population. The problem of differences in treatment and the difference in health can therefore be seen as interrelated – the problem of differences in service provision, which was addressed in the quote on page, can be understood as a cause for the differences in health status between parts of the country and social groups due to the connection made between the health service and individuals living conditions. In other words, the provision of services is problematized with reference to how it affects health in a negative way, and the causal links used to make this connection locates the health service *before* potential damages to health occur. The solutions that are presented in policy goal no. 7 ("increased democratization, user influence and legal security for patients") can therefore be seen as being in line with the solution frame represented by health promotion and prevention – as activities that are aimed at the causes of the problem, rather than dealing with the *effects* of problems.

As I will now go onto show, providing "opportunities" for individual activity beneficial for health, is central to the solution frame represented by health promotion and prevention.

Part 2 – Solution frames

5.3 Health promotion and disease prevention as "responsibilities"

The framing of health promotion and prevention as "responsibilities" play an integral part in the elaboration of these solution frames. Two subjects are designated as responsible for taking part in the efforts related to the improvement of health and the reduction of lost life years: "society" and "individuals":

> *Health promotive and preventive work* must be strengthened in the years to come, as a more central strategy for improving the health of the population and reduce the lost life yeas that are caused by diseases, such as cancer and cardiovascular disease, accidents, especially child accidents, child mortality and certain infectious disease.
>
> In order to succeed, we must reduce risk factors and create a positive attitude towards health as a value. This is both a responsibility for society and an individual responsibility[89] (St.meld. nr. 41, 1987-88, pp. 56-57; emphasis in the original).

The responsibilities given to each is distinct but are connected in an important way. Individuals, on the one hand, should live in a manner corresponding to and resulting in 'health':

[89] «*Helsefremmende og forebyggende arbeid* må styrkes i årene framover som en mer sentral strategi for å bedre helsetilstanden i befolkningen og redusere tapte leveår som følge av sykdommer som kreft og hjertekarlidelser, ulykker – særlig barneulykker, spedbarndødlighet og visse smittsomme sykdommer. // For å lykkes må vi redusere risikofaktorer og skape en positiv holdning til helse som verdi. Dette er både et samfunnsansvar og et individuelt ansvar.»

> The individual citizen must also place a greater emphasis on healthy living habits[90] (St.meld. nr. 41, 1987-88, p. 57).

Society, on the other hand, is designated a supporting and enabling function vis-à-vis this life project, which is defined in terms of a focus on the "conditions" for action:

> Society must create the conditions so that it is possible for the individual to lead the most healthy lifestyle possible[91] (St.meld. nr. 41, 1987-88, p. 57).

> Society must also have a responsibility to reduce pollutants that are harmful to health in our local environment and workplaces[92] (St.meld. nr. 41, 1987-88, p. 57).

Thus, a basic structure can be identified between the responsibility of society and that of individuals: individuals are responsible for working on themselves in ways that are 'healthy', which thus produces a state of health; society´s responsibility is to create the 'conditions' that enable this form of conduct. But society is also responsible for factors which are not linked to conduct, but which is more directly linked to (harmful) health.

I will now analyze the discursive construction of the "responsibilities" of "individuals" and "society."

5.3.1 Individual responsibility

5.3.1.1 *Healthy living habits*

The meaning of "healthy living habits" is never defined in explicit terms. At a nominal level, the terms seem to refer to the regular conduct – or habits – that is dominant in a person's life. The way in which an individual lives their life, understood in terms of the kinds of habits that they take on. If "living habits" is a general category, then "healthy" (*sunne*) specifies a certain kind of living habit. It is the content of the specific category of *healthy* living habits that is not clear from the text.

By looking at another part of the text, where the same relationship identified above/between conduct and health is present, it is possible to suggest something of what "healthy living habits" might refer to.

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[90] «Den enkelte innbygger må også i større grad legge vekt på sunne levevaner.»
[91] «Samfunnet må legge forholdene tilrette slik at det for den enkelte er mulig å føre et mest mulig sunt levesett.»
[92] «Samfunnet må også ha et ansvar for å redusere helseskadelige forurensninger i vårt nærmiljø og arbeidsplasser.»

> It is important that we get to develop, maintain and use our physical, mental and emotional abilities. It is a prerequisite for a subjective experience of good health[93] (St.meld. nr. 41, 1987-88, p. 56).

In this excerpt, the focus is placed on individual activity which leads to health. The sentence is framed by the wording "It is important that we *get to*," which suggest that there is a need for establishing the conditions that allow individuals to work on themselves in this particular manner. This reading is supported by the sentence immediately following the paragraph presented above: "The main emphasis must be placed on health promotive and disease preventive work"[94] (St.meld. nr. 41, 1987-88, p. 56), which suggest that there is a connection between health promotive and disease preventive work and the establishing of opportunities tantamount to "getting to" work on ourselves so that health is realized.[95]

Health is presented as an ideal that the individual should strive towards. It is implied as an ideal because of the importance laid on performing actions that will lead to the realization of a "subjective experience of good health." establishes health as the object that subjects should orient their self-work around. Health is defined as "a subjective experience." This suggest that health is not defined in terms of an external and unified standard that is applied to every case/individual; instead, health is framed as a (subjective) relationship between the self and itself. "Good health" is something that is determined by the individual, based on an examination of his or her own subjective experience. This subjective experience, in turn, is linked to a project of self-work. This self-work is distinguished by two aspects. A set of activities, defined by the words "develop," "maintain," and "use." And a particular part of the self which is defined as "abilities." The word "abilities" is further divided into three dimensions: physical, psychic and emotional abilities.

By working on their own abilities, individuals will experience "good health." In other words, if individuals want to experience good health for themselves, they must work on their own abilities. Given that there is an explicit mention of the need for "*creating* positive attitudes toward health as a value" (see quote at the beginning of this section; emphasis added) there seems to be implied that some of the strategy entails getting individuals to want to be healthy.

Well, given that individuals want to be healthy, what does the related project of self-work imply? The word "develop" suggest a process that occurs over an unspecified and potentially unlimited period of time which involve the improvement of abilities. Starting at a given level or state of one´s

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[93] «Det er viktig at vi får utvikle, vedlikeholde og bruke våre fysiske, psykiske og følelsesmessige evner. Det er en forutsetning for subjektiv opplevelse av god helse.»
[94] «Hovedvekten må legges på helsefremmende og sykdomsforebyggende arbeid.»
[95] Complete paragraph: "It is important that we get to develop, maintain and use our physical, mental and emotional abilities. It is a prerequisite for a subjective experience of good health. The main emphasis must be placed on health promotive and disease preventive work."

abilities, development involve the process of getting more out of the abilities one has or altering them qualitatively. That abilities should be 'maintained' suggest a process of degradation that individuals must try to avoid or work against. Both of these processes relate to a notion of change in individual's ability. With the aim of maintaining abilities, change refers to a negative development that is *occurring* to their abilities, which individuals must actively work against. With the aim of developing abilities, change is instead something that is created by the individual. Finally, the framing of abilities as something that can be "used" constructs these abilities as a capacity to act. In turn, it is this capacity to act that must be "developed" and "maintained." In other words, the acts of "development" and "maintenance" can be understood as a form of self-work that is aimed at one´s capacity to act.

5.3.2 Society's responsibility

5.3.2.1 *Creating the conditions of possibility for health*

In both the aim of "development" and society's responsibility to create the conditions that enable the "*most* healthy life style possible" there can be detected an inflection toward *maximization* (e.g. without specifying a limit, development can continue indefinitely). Therefore, it is important to note that the text constructs a limit on the level of health that the individual is able to achieve.

> Everyone cannot be equally healthy. For that, individual prerequisites are too different, but the individual must be given opportunities for the best possible health based on their prerequisites. We can partly facilitate these conditions through the overall policy we pursue. The health service will only be one element here, but we must still in the formulation of health policy be aware of the health differences and design the measures so that they especially reach vulnerable and weak groups.[96] (St.meld. nr. 41, 1987-88, p. 57).

The excerpt is a continuation of the text from policy goal no. 4. In that way, the word "everyone" here refers to the totality of the Norwegian population. The idea that prerequisites are "too different" also corresponds to the problem of inequality in health – linked through the notion that differences in living conditions are linked to differences in health.

The idea that is being presented seems to be that, while individuals should work on themselves to realize "the best possible health," the level of health they are able to realize will ultimately be dependent on their "prerequisites" or "conditions" (*forutsetninger*). These conditions, in turn, are made subject to governmental action – i.e. "the overall policy we pursue." Again, the underlying rationality

[96] «Alle kan ikke bli like friske. Dertil er de individuelle forutsetningene for ulike, men den enkelte må få muligheter for en best mulig helse ut fra sine forutsetninger. Disse forutsetninger kan vi delvis tilrettelegge gjennom den samlede politikk vi fører. Helsetjenesten blir bare ett element her, men vi må likevel i utformingen av helsepolitikken ha helseforskjellene bevisst og utforme tiltakene slik at de særlig når utsatte og svake grupper.»

therefore seems to be that subjects will work on themselves, and that governmental action is defined in terms of enabling this project of self-work which is directed toward the realization of health. Or, that the individuals self-work will be dependent on factors that are subject to governmental intervention; interventions which has the aim of "giving opportunities for the best possible health." Implicit in this reasoning seems to be that the *only* thing that stands in the way of individuals realization of the best possible health is these conditions, meaning that if they are given opportunities, individuals will take advantage of them. Alternatively, there is a responsibility placed on the individual to make use of the opportunities afforded to them through the adjustment in conditions made by the government.

While it is not explicitly stated in the quote above, based on the reference to "vulnerable and weak groups," the meaning of "prerequisites" and "conditions" seems to have two meanings. On the one hand, "vulnerable" may refer to the *external conditions* that individuals and groups are exposed to. (The Norwegian word "utsatt", which here has been translated into "vulnerable" can also be translated into "exposed"). This meaning also seems to be covered by the word "living conditions" (*levekår*), as well as the reference to "factors that weaken the state of health" and "conditions that can have a negative effect on people´s state of health" (White Paper, no. 41 1987-88 p. 56). On the other hand, the word "weak" suggest that the group in question is marked by an *internal deficiency*.

I will now present four textual example that exemplify the solution frame which is organized around the construction of possibilities for healthy living habits: (1) the planning and designing of the milieu of individuals; (2) health education; (3) training provided to subjects who are on the verge of disability; (4) juridical possibility for participation.

5.3.2.2 *"planning and designing" a milieu*

At a general level, the creation of conditions that make it possible for "individuals to lead the most healthy lifestyle possible" is described in the following manner:

> Society must create the conditions so that it is possible for the individual to lead the most healthy lifestyle possible. In order to achieve this, living environments, workplaces and leisure life must be planned and designed in a way that addresses the need for safety and a good social network, but which also provides opportunities for development [*utfoldelse*][97] (St.meld. nr. 41, 1987-88, p. 57).

[97] 'Samfunnet må legge forholdene tilrette slik at det for den enkelte er mulig å føre et mest mulig sunt levesett. For å oppnå dette må bomiljøer, arbeidsplasser og fritidsliv planlegges og utformes på en måte som ivaretar behovet for trygghet og godt sosialt nettverk, men som også gir muligheter for utfoldelse.'

Here, certain spheres or milieus are designated: "living environments" (*bomiljøer*), "workplaces" and "leisure life" (*fritidsliv*) and defined as relevant for two kinds of actions: planning and designing. The category of "conditions" seems to refer to three spheres in which individuals are situated. Two of them are fairly concrete: "living environment" (*bomiljø*) and "workplaces" while the third is more abstract; "leisure life" (*fritidsliv*) does not contain an explicit reference to a material environment and seeing as what people do on their free time is less specific regarding the kinds of activity involved. Regardless of these differences, however, these spheres are made subject to governmental intervention, and this intervention is framed as 'planning' and 'designing'. Lastly, it is specified that these interventions should aim to transform the milieu so that they "*addresses* the need for safety and good social network, but which also provides opportunities for development" (emphasis added).

With the reference to the provision of "opportunities for development" the connection between governmental intervention in the form of health promotion and prevention, and the creation of "opportunities" for a healthy lifestyle is explicit. This reference also underlines the connection between "healthy lifestyle" and the self-work constituting development, maintenance and use of one's physical, psychic and emotional abilities. While the connection is not explicitly stated, the aim of accommodating individuals "need for safety and good social networks" may also be read in the same light. The reference to "needs" (*behov*) suggests that safety and good social networks are somehow fundamental for a healthy lifestyle. The relationship is not specified.

5.3.2.3 *Health education*

Another sense of creating conditions and establishing opportunities for a healthy lifestyle comes in the form of "health education" (*helseopplysning*):

> The individual citizen must also place greater emphasis on healthy living habits. Health education must be provided in a way that make sense to everyone and that provides opportunities to change living habits[98] (St.meld. nr. 41, 1987-88, p. 57).

Health education seems to attach itself onto the realm of ideas/In this excerpt, health education can be seen to provide the opportunities to "change living habits". The change, presumably, is from unhealthy to healthy living habits. The reference to "education" (*opplysning*) suggests that individual citizens *learn* how to take on healthy living habits, or live in a healthy manner, and that opportunities are created through the provision of knowledge. While the "teacher" is not specified it seems reasonable

[98] «Den enkelte innbygger må også i større grad legge vekt på sunne levevaner. Helseopplysning må gis på en måte som kan få mening for alle og som gir muligheter til å endre levevaner.»

to assume that the government is supposed to fill out this role. The emphasis that health education should be "provided in a way that *makes sense to everyone*" (emphasis added), also makes reference to the level of ideas, ensures that everyone will have the opportunity to change their living habits from unhealthy to healthy.

The use of health education, therefore, seems to hint at a belief that if individuals have the proper knowledge, then they will make proper decisions. The reference to creating opportunities seems to imply that there is an underlying desire towards health – on the part of subjects – and that the lack of opportunity is a barrier that must be removed/worked on.

5.3.2.4 *"to provide relief, treatment and training for the many who barely manage at home"*

A third sense of the creation of opportunities can be found in Policy Goal no. 2. Here, the solution frame is located within the health service.

> *Care and nursing services must be increased* and the quality of services improved. Varied and coordinated services must be developed that can meet different needs and be adapted to the recipients´ different life situations. Disabled people and the elderly must be given the opportunity to live as independent a life as possible based on their own health-related social conditions. The individual must be given better opportunities for an independent life and not experiencing the care and nursing service as disempowering. The institutional offerings must be softened and greater emphasis placed on the housing function. Patients must be given the greatest possible freedom of choice with regard to circadian rhythms, daily activities and social contacts. The main tasks of nursing homes should be;
>
> - to provide safe and lasting care and treatment for those who have become too disabled to manage in their own home
> - to provide relief, treatment and training for the many who barely manage at home.
>
> The latter can be done by providing flexible and differentiated day care services, and by providing relief stays at fixed times and in the event of an urgent need for care[99] (St.meld. nr. 41, 1987-88, p. 57; emphasis in the original).

The subjects being addressed – the elderly and the disabled (*funksjonshemmet*) – are framed in terms of their *abilities* to remain at home. The *maintenance* of this ability is related to the ideal of living "independent life." In one sense because an independent life is equated with the ability remain at home,

[99] «*Omsorgs- og pleietilbudet må økes* og kvaliteten på tjenestene bedres. Det må bygges ut varierte og samordnede tjenester som kan dekke ulike behov og tilpasses mottakernes forskjellige livssituasjoner. Funksjonshemmede og eldre må få muligheter for å leve en mest mulig selvstendig tilværelse ut fra egne helsemessige sosiale forutsetninger. Den enkelte må gis bedre muligheter for en selvstendig tilværelse og ikke oppleve omsorgs- og pleietjenesten som umyndiggjørende. Institusjonstilbudene må mykes opp og legge større vekt på bofunksjonen. Pasientene må få størst mulig valgfrihet med hensyn til døgnrytme, daglige aktiviteter og sosiale kontakter. Sykehjemmenes hovedoppgaver bør være; - å gi trygg og varig omsorg og pleie for dem som er blitt for funksjonshemmede til å klare seg i eget hjem; - å gi avlastning, behandling og trening for de mange som så vidt klarer seg hjemme.

Det siste kan skje ved å gi fleksible og differensierte dagtilbud, og ved å gi avlastningsopphold til faste tider og ved akutt oppstått pleiebehov.»

and in another because the dependency on an "institutional" solution, in the form of being admitted into a "nursing home" is associated to a lack of freedom – e.g. "disempowerment." In both cases the underlying message seems to be that one should not rely on nursing homes.

The emphasis on remaining in one's home seems, furthermore, to correspond to the problematization of the increasing number of elderly in the population, due to the increase in need for services. If the elderly would manage to remain in their home, then the need for services would be reduced. At the same time, it does not seem to be a question of *withdrawing* services: in fact, there are multiple formulations in the excerpt above that suggest that services *should* be provided to those who need it. "Care and nursing services must be increased…" (emphasis removed); nursing homes should "provide safe and lasting care and treatment for those who have become too disabled to manage in their own home." What is at stake here, instead, is that subjects who are *about to* become dependent on nursing homes – because they "barely manage at home" – work on themselves. Secondly, for this group it is also not a question of withdrawing services. Instead, services should be provided in a way that "can meet different needs and be adapted to the recipients' different life situations" and be provide "the opportunity to live as independent a life as possible based on their own health-related social conditions."

Thus, the underlying rationality fits with the solution frame that was identified for health promotion and prevention. What is new in this case is that health promotion and prevention is provided *through* health services. While it is never made explicit, this case therefore seems to provide an example of how the health service can become a "main pillar" in local preventive work. This shift can also be detected in the references made to the need for service provision to be changed or undergo a transformation: "the quality of services must be improved"; "the institutional offering must be softened and greater emphasis placed on the housing function"; "providing flexible and differentiated day care services, and by providing relief stays at fixed times and in the event of an urgent need for care." These examples can be understood as supporting the abilities of the elderly and disabled to remain in their homes. In this there might also be an example of a "weak" group, that has an *internal insufficiency* that requires the attention from the health service. Aimed at making sure that the health outcome is not worsened for elderly, who will have to rely on the health service and staying in nursing homes, unless given "relief, treatment and training."

5.3.2.5 *Opportunities for user participation*

A fourth example of the creation of opportunities as a means to promote health and prevent negative effects on health can be found in the emphasis on the opportunities that patients or "users" of health

services has for participation and influence. The construction of 'user participation' as a form of conduct beneficial for health can be found in the following example:

> User participation is a fundamental prerequisite for a subjective experience of good health. A well-informed and actively participating society is therefore an important element in all work leading up to HFA 2000 [Health for all by the year 2000][100] (St.meld. nr. 41, 1987-88, p. 56).

In this excerpt, there is an emphasis that people who are "users" – i.e. they make use of a service of some sort, in this case health services – should "participate" (*medvirke*), and that this serves as a precondition for "a subjective experience of good health." A positive outcome (regarding health) is stimulated if this is allowed. Subsequently, supporting health involves the creation of "a well-informed and actively participating society."

In the following example, the emphasis is on the negative effects of a *lack* of participation for patients who make use of health services:

> *Increased democratization, user influence and legal security* for patients. The health service manages large resources and knowledge of significant importance for people´s living conditions and welfare. A better basis must be created for political prioritization of resource management. The health service is so important for people´s safety and living conditions that it is an independent value that there is an opportunity for increased democratic control through elected bodies that must take political responsibility for their priorities and decisions toward the population. The health service is traditionally a sector that in its organizational form and practice reduces patients´ sense of control over their own lives and health. Opportunities to reach out to the system with wishes and complaints and control of the consequences of treatment are in practice limited. The individual who seeks the health service with their problems must be given a greater degree of insight and the opportunity to influence the measures that are implemented and better control over their own lives.
>
> The legal and practical possibilities for access to the enterprise, legal security in the treatment and the access to compensation for treatment injuries must be increased[101] (St.meld. nr. 41, 1987-88, p. 58; emphasis in the original).

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[100] «Brukermedvirkning er en fundamental forutsetning for en subjektiv opplevelse av god helse. Et godt informert, og aktivt deltakende samfunn er derfor et viktig element i alt arbeid fram mot HFA 2000.»

[101] «*Økt demokratisering, brukerinnflytelse og rettsikkerhet* for pasientene. Helsetjenesten forvalter store resurser og kunnskaper av vesentlig betydning for folks levekår og velferd. Det må skapes bedre grunnlag for politisk prioritering av ressursforvaltningen. Helsetjenesten har så stor betydning for folks trygghet og levekår at det er en selvstendig verdi at det blir mulighet for økt demokratisk kontroll gjennom folkevalgte organer som må ta et politisk ansvar for sine prioriteringer og avgjørelser overfor befolkningen. Helsetjenesten er tradisjonelt en sektor som i sin organisasjonsform og praksis reduserer pasientenes følelse av kontroll med eget liv og helse. Ulikheter til å nå fram overfor systemet med ønsker og klager og kontroll med konsekvenser av behandling er i praksis begrenset. Den enkelte som søker helsetjenesten med sine problemer må få større grad av innsyn og mulighet for innflytelse på de tiltak som iverksettes og bedre kontroll med eget liv.

De legale og praktiske mulighetene for innsyn i virksomheten, rettssikkerhet i behandlingen og adgangen til erstatning ved behandlingsskader må økes.»

As with the pervious example, health promotion and prevention are not explicitly mentioned as solution frames. The measures presented in the text can be understood in this light, however; as both health promotive, in that user participation is constructed as beneficial to health, and as a preventive measure, as it is also constructed as a counteractive towards the negative effects on health originating from the health service.

The health service "reduces patients' sense of control over their own lives and health" and there are limited "opportunities" to "reach out to the system with wishes and complaints and control of the consequences of treatment."

Here, the opportunities that should be afforded can be understood as working on the *conditions* for the relationship between patients and the health service. These conditions are framed in a particular way: in "legal" and "practical" terms.

There is also a framing that suggests that the health service needs "control." Thus, two objectives seem to be achieved in the solutions presented in this excerpt: on the one hand, individuals health will be both promoted and protected by having their "legal security" strengthened and given better "practical" possibilities for influencing matters that are related to their experience as patients (the process of seeking out and receiving treatment seems to be the defining feature of this relationship). On the other, there is an emphasis on controlling the health service that seems to go beyond these concerns. Linked with the control of health service is a focus on the management of its economic resources and knowledge. The solution frame presented in this section therefore serves a double function of both limiting the negative effects on patient's health while being treated (this refers to increased user influence and legal security for patients), and as a (better) way to manage the health services resources (this refers to democratic control).

5.3.2.6 *Children as objects of negative impacts on health*

Within the text, children and infants are designated as particular subject positions. This comes most clearly up in the first Policy Goal, when it is said that the goal to reduce lost life years will focus on these causes: "diseases, such as cancer and cardiovascular disease, accidents – *especially child accidents*, *infant mortality* and certain infectious diseases"[102] (St.meld. nr. 41, 1987-88, p. 57; emphasis added). Within the context of the sentence, it can be seen that accidents related to children and infant mortality are in some way *extra* important for the strategy of reducing lost life years.

[102] «sykdommer, som kreft og hjertekarlidelser, ulykker – særlig barneulykker, spedbarndødelighet og vise smittsomme sykdommer.»

Pertaining to the solution frame presented for dealing with this problematization, children and infants are again brought up as a special category:

> The individual citizen must also place greater emphasis on healthy living habits. Health education must be provided in a way that make sense to everyone and that provides opportunities to change living habits. Increased attention must be paid to children´s living conditions and, from the health service´s point of view, increased attention must be paid to the prevention of traffic accidents among children, other child accidents and mortality around birth[103] (White Paper, no. 41 1987-88 p. 56-57). (St.meld. nr. 41, 1987-88, pp. 56-57).

While "individual citizens" are framed as an active agent who shall make use of proper knowledge provided by the government on how to live a proper (healthy) life, children are framed as an almost non-acting subject that are dependent on outside help. I say *almost* because it can be argued that accidents among children do involve some active participation on the part of the child. Yet, the text does not make reference to the kinds of actions that the child can take themselves in order to prevent accidents from occurring.

In a sense, there seems to be an underlying rationality that prevention refer to a field that is *outside* of subjects control. Accidents are attributed to children's living environment; "mortality around birth" seems similarly to be a category that in a clear way refer to something that is outside of the control of the subject – in this case the infant. Implied in this logic may be that there are some instances where government cannot rely on the actions of subjects

While a paragraph had already been devoted to detailing the responsibilities of Society, wherein the creating of conditions that establishes possibilities for healthy life habits, and the protection against pollution within the living environment and work place was designated as focus areas; the text once again raise these issues in relation to children and infants. Thus, the notion that these subject positions are special, and of special interest to the strategies of health promotion and prevention, are once again emphasized.

A reason for this might be that life years are particularly dependent on what happens to individuals during their earlier years; certain conditions – such as cancer – may materialize later in life due to events that occur when the subject was a child or an infant; other events, such as mortality around birth, produces a permanent loss of life years. Thus, the following series can be seen: undesirable events – afflicting children and infants – reduces life years of the population.

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[103] «Den enkelte innbygger må også i større grad legge vekt på sunne levevaner. Helseopplysning må gis på en måte som kan få mening for alle og som gir muligheter til å endre levevaner. Det må rettes økt oppmerksomhet mot barns levekår og fra helsetjenestens side særlig rettes en økt oppmerksomhet mot forebygging av trafikkulykker blant barn, andre barneulykker og dødlighet omkring fødselen.»

5.3.3 Contextualizing society's responsibility: health promotion and disease prevention in a decentralized system of government

Finally, in this section I analyze the role of *decentralization* in shaping the discursive construction of "society's responsibility" for health promotive and preventive work.

5.3.3.1 *"strengthening" health promotion and prevention at a local level*

In the first sentence of Policy Goal no. 1, health promotion and preventive work was framed as a "strategy" that "must be strengthened in the years to come." Whereas the realization of this strategy was designated as a responsibility for "society" as a whole, the notion of 'society' can be seen to be linked to two types of actors: a National Government and a group of "local political/autonomous entities" referred to as "municipalities," "municipalities," "the health service." In relation to the strategy pertaining to health promotion and preventive work, the Government is constructed as an actor who holds an overall view of the situation, and as the one who sets out strategic aims; municipalities, county municipalities and the health service, on the other hand, are seen as responsible for carrying out and realizing these aims. This hierarchical relationship can be seen in the following excerpt:

> An overall perspective and program for the development and effectivization of the health service, can only be maintained by national governments. We are dependent on municipalities, counties and other professions in the health service in order to achieve a successful realization of the government's goals[104] (St.meld. nr. 41, 1987-88, p. 9).

Here, the central aim is to develop and increase effectivity of the health service. "National governments" is constructed as the *only* type of actor who can "maintain" "an overall perspective and program" for this aim. On the other hand, the "successful realization of the government's goals" is "dependent on municipalities, counties and other professions in the health service."

This hierarchical relationship can be understood as fundamental to the governmentality, in which health promotion and preventive work is situated. This can already be seen in the above quote, since one of the aims that the national health plan was supposed to help realize was the development of the health service as a "main pillar" of local preventive work. The framing of health promotion and prevention within this solution frame can be seen more explicitly spelt out in the following excerpt:

[104] «Et samlet perspektiv og program for utvikling og effektivisering av helsetjenesten kan bare ivaretas av nasjonale myndigheter. Vi er avhengige av kommuner, fylkeskommuner og de ulike profesjonene i helsetjenesten for å få til en vellykket realisering av Regjeringens mål.»

> The government is planning a comprehensive strategy for prevention. Through the law on the municipal health service and the changes that were presented in Ot.prp. no. 40 (1986-87) on Environmental health protection and later adopted by the Storting, a better legal basis has been created for preventive work in the municipalities. The government will work to strengthen resource input in this field[105] (St.meld. nr. 41, 1987-88, p. 57; emphasis added).

Here, the role of government can be seen as that of a "planner" that presents "a comprehensive strategy for prevention." The role of municipalities is to realize this strategy. More specifically, the municipalities realization of the overall strategy launched by Government can be seen to operate within a field that is determined by juridical and economic frameworks which are set up at a national level: "a better legal basis" for "preventive work in the municipalities" was created by the Storting when it "adopted" the legal changes proposed for Environmental health protection; similarly, the Government, another national entity, is the one who provides the "resources" for preventive work.

5.3.3.2 *Creating framework conditions for local political entities*

The idea of guiding the conduct of these local actors through the establishment of a particular "framework" is explicitly stated in this longer excerpt from the introduction of the National Health Plan. What is important to note is the framing of the national health plan as a "framework plan" for developing the health service, and the discussion of the "government management instruments aimed at local government," which include the construction of a 'new income system' or 'fixed framework financing schemes' for municipalities and counties.

> The Government proposes that the report to the Storting on health policy (referred to as the national health plan) shall constitute a framework plan with main guidelines for future organization, distribution of resources and decisions on the forms of governance in the health service.
>
> In the field of tension between national ideals of equality and considerations of local influence and self-government, the Storting will, through the consideration of the report, be able to determine the framework conditions for the design of health services.
>
> In the welfare society as we know it, the state guarantees equal treatment and equal opportunities for all citizens. As mentioned above, the state itself directly takes care of part of this task through the income distribution policy at the individual level. However, the idea of equality also includes a requirement that everyone should receive an equal offer of public welfare services. Possibility of e.g. medical care shall not vary according to where in the country one resides.

[105] «Regjeringen legger opp til en omfattende strategi for forebygging. Gjennom lov om kommunehelsetjenesten og de endringer som ble lagt fram i Ot.prp. nr. 40 (1986-87) om Miljørettet helsevern og senere vedtatt av Stortinget er det skapt et bedre lovgrunnlag for forebyggende arbeid i kommunene. Regjeringen vil arbeide for å styrke ressursinnsatsen på dette feltet.»

The idea of the state´s responsibility for an equal service offering has gradually given birth to a number of government management instruments aimed at local government. These are discussed below.

A main idea behind the new income system, the free municipality experiment, etc. has been shifting the focus in direction of local autonomy. This can easily come into conflict with national equality requirements. Demands for equality in specific service provision have in part been replaced by a strengthened requirement that all municipalities and county municipalities must be treated equally with regard to the part of society´s resources that they have at their disposal. The state has expressed a willingness to accept greater local variation in problem solving and prioritization of various public tasks between municipalities. Part of the background for this development is that the level of income and activity in all municipalities is so high that it has been assumed that national minimum requirements will at least be met.

In addition to the fixed framework financing schemes, the state has very limited financial opportunities to influence the county municipalities and municipalities prioritization and disposition of resources. Following the implementation of the new revenue system for county municipalities and municipalities, local political units are responsible for prioritizing health services in relation to other tasks such as roads, schools, etc. They must also prioritize within the health service – e.g. open care versus institutional care. The introduction of the new revenue system can be perceived as a state declaration of confidence in local political priorities and economic dispositions. Through statistics and planning systems, the local authorities will have the opportunity to base decisions on analyzes of needs and economic conditions. The aim is to improve and systematize the information basis for the decision-making process locally. Local priorities open up for variation and different adaptations. There may be differences in the service offer. State authorities have a responsibility to ensure that this does not affect vulnerable groups. It is therefore still a need for some state control of the health sector within our decentralized management system. However, the degree of control must be differentiated[106] (St.meld. nr. 41, 1987-88, p. 8; emphasis added).

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[106] «Regjeringen legger opp til at stortingsmeldingen om helsepolitikken (omtalt som nasjonal helseplan) skal utgjøre en rammeplan med hovedretningslinjer for framtidig organisering, ressursfordeling og beslutninger om styringsformene i helsetjenesten.

I spenningsfeltet mellom nasjonale likhetsidealer og hensyn til lokal innflytelse og selvstyre, vil Stortinget gjennom behandlingen av meldingen kunne fastlegge rammebetingelsene for utformingen av helsetjenester.

I velferdssamfunnet slik vi kjenner det, står staten som garantist for lik behandling og like muligheter for alle borgere. Som nevnt foran ivaretar staten selv direkte en del av denne oppgaven gjennom inntektsfordelingspolitikken på individnivå. Likhetstanken omfatter. Imidlertid også et krav om at alle skal få et likeverdig tilbud av offentlig velferdstjenester. Mulighet for f.eks. legehjelp skal ikke variere etter hvor i landet en er bosatt.

Tanken om statens ansvar for et likeverdig tjenestetilbud har etterhvert avfødt en rekke statlige styringsinstrumenter rettet mot lokalforvaltningen. Disse er drøftet nedenfor.

En hovedide bak nytt inntektssystem, frikommuneforsøket m.v. har vært å flytte tyngdepunktet i retning av lokal selvråderett. Det kan lett komme i strid med nasjonale likhetskrav. Krav til likhet i konkret tjenesteyting har tildels blitt byttet ut med et forsterket krav om at alle kommuner og fylkeskommuner må stilles likt når det gjelder den del av samfunnets ressurser som de disponerer. Det har fra statens side vært uttrykt vilje til å godta større lokal variasjon i oppgaveløsning og prioritering av ulike offentlige oppgaver kommunene imellom. Noe av bakgrunnen for denne utviklingen er at inntekts- og aktivitetsnivået i alle kommunene er så høyt at en har antatt at nasjonale minimumskrav i alle fall blir oppfylt.

Utenom de faste rammefinansieringsordningene har staten svært begrensede økonomiske muligheter for å påvirke fylkeskommunenes og kommunenes prioritering og disponering av ressurser. Etter gjennomføringen av det nye inntektssystemet for fylkeskommuner og kommuner har lokalpolitiske enheter ansvar for prioritering av helsetjenester i forhold til andre oppgaver som veier, skoler m.v. De må også prioritere innen helsetjenesten – f.eks. åpen omsorg kontra institusjonsbasert omsorg. Innføringen av det nye inntektssystemet kan oppfattes som en statlig tillitserklæring til lokalpolitiske prioriteringer og økonomiske disposisjoner. Gjennom statistikk og planleggingssystemer. Skal de lokale myndigheter få muligheter til å basere beslutninger på analyser av behov og økonomiske forhold. Målet er å forbedre og systematisere informasjonsgrunnlaget for beslutningsprosessene lokalt. Lokale prioriteringer åpner opp for variasjon og

Around the question of how to develop the health service in a desired direction, the national health plan is presented as a "framework plan," which specifies the "main guidelines for future organization of resources and decisions on the forms of governance in the health service," as well as the "framework conditions for the design of health service," and is constructed by the Storting and the National Government. The national health plan can also be seen to be presented as a necessary tool for managing the "field of tension" that arises from the different levels of government: the national government, which represent an "ideals of equality," on the one hand, and local government, which represents "local influence and self-governance" on the other.

These local political entities can in turn be seen to be constructed as both a solution that is actively sought realized, as well as a problem that needs to be managed. Local autonomy can be seen as a desired outcome – and thus a necessary aspect of how to govern well – in the fifth paragraph: "A main idea behind the new income system, the free municipality experiment, etc. has been *shifting the focus in direction of local autonomy*." While no arguments are presented for why this development is seen as necessary or desirable, it is implied that "local autonomy" is actively created through concerted efforts such as a "new income system" and "the free municipality experiment." While local governance is presented as holding the potential of coming "into conflict with national equality requirements," the risk associated with "local variation" is deemed acceptable because "the level of income and activity in all municipalities is so high that it has been assumed that national minimum requirements will at least be met." Implicit in this assessment seems to be a notion that local government will use the autonomy given to it in an acceptable manner, framed in terms of "activity" and "income"; alternatively, a responsibility for achieving certain results are given at the same time as local autonomy is created.

Local autonomy can be seen to be connected with an economic framework. The turn towards "local autonomy" was created by the introduction of a "new income system," and involves a shift away from "demands for equality in specific service provision" towards "a strengthened requirement that all municipalities and county municipalities must be treated equally with regard to the part of society's resources that they have at their disposal." In this way, "local autonomy" is set up as starting from a given amount of resources, allocated from a national economic framework (i.e. "the part of society's resources that they have at their disposal"), that is equal to all local political entities, from which they must find ways to meet certain levels of "activity" and "income," which exceed the national minimum requirement, through the activities of "problem solving" and prioritizing between "various public

ulike tilpasninger. Det kan oppstå ulikheter i tjenestetilbudet. Statlige myndigheter har et ansvar for å påse at dette ikke rammer svake grupper. Derfor er det bl.a. fortsatt behov for en viss statlig styring av helsesektoren innen vårt desentraliserte forvaltningssystem. *Graden* av styring må imidlertid differensieres.»

tasks." This solution frame would also seem to correspond with and provide a solution to the problem of growth in public expenditure: the framing that everyone gets an equal amount of resources, also holds the implication that the amount of resources allocated to local political entities will be given a limit that enables the central government to limit the growth in public expenditure at a national level.

The use of local autonomy is also constructed in economic terms, as can be seen in the first sentence of the last paragraph: "prioritization and disposition of resources," which involves the responsibility for "prioritizing health services in relation to other tasks such as roads, schools, etc. They must also prioritize within the health service – e.g. open care versus institutional care."

The notion of local autonomy can also be seen to be constructed in a specific relationship to the national level. Already have been mentioned the construction of two distinct levels – the national and the local – and that of the potential conflict between them. The state is also defining local autonomy as something that is distinct from it, as something that is cannot – in most cases – intervene on (see first sentence of the last paragraph). This places the responsibility for resources allocation firmly at the local level, as something distinct from the national. The only case that call for state intervention is when local autonomy is used in a way that causes negative impacts on "vulnerable groups."

Thirdly, while the state has "very limited financial opportunities" to influence local prioritization and disposition of resources, it nonetheless designates itself the role of creating the opportunities for making *better* decisions "through statistics and planning systems," which will give "local authorities […] the opportunity to base decision on analyzes of needs and economic conditions"; and thus "improve and systematize *the information basis* for the decision-making process locally."

Summary

This constellation: a hierarchical structure between the national and the local level, the use of economic frameworks, which corresponds to economic imperatives, and juridical frameworks which represents the public goods promised for the whole population by the state, and the reliance on local autonomy for its realization – all of which is captured in the word "decentralization" – should be born in mind when reading that health promotion should be "strengthened," that the municipality has a "responsibility" for health promotive and preventive work, or that the health service will become a main pillar in preventive work locally. It means that health promotion and prevention are framed as "activities" that must be performed by local entities by acting within an economic framework set up at the national level in order to realize its juridically determined obligations towards the population.

Part III – Discussion: How is a neoliberal rationality expressed in the discursive construction of public health?

Part III conclude the thesis by discussing how a neoliberal rationality can be seen expressed in the discursive construction of public health described in chapter 5.

Chapter 6 *Discussion*

In this chapter I discuss the thesis' methodological framework; I discuss how a neoliberal rationality can be seen expressed in the discursive construction of public health; and I identify future lines of research.

6.1 Methodological considerations

The quality of a critical discourse analysis is not decided with reference to the production of *the* truth about a phenomenon which can be tested and whose results can be reproduced, and thereby *verified* (as objective truth) (Malterud, 2017; Rudman & Dennhardt, 2015). The quality of this analysis pertains to the opening up of different ways of seeing by presenting a different perspective to the reader, with the intended effect of destabilizing the readers taken-for-granted assumptions about the world's naturalness. At the same time, it seems clear that the quality of the analysis must also refer to the way in which analysis is conducted and presented to the reader; the analysis presented must be given in such a way as to make it possible for readers to remain *critical* vis-à-vis what is presented. This is done by being transparent about the process that informs the selection of texts and the analysis of them (Rudman & Dennhardt, 2015). In so far as what is presented in the critical discourse analysis is only *one reading*, it is necessary that the one presenting the reading makes (i) underlining assumptions clear to the reader, and (ii) that the material that is the basis of the reading is clearly presented: that context for the piece of text is made clear, and that the textual examples pertains to what is being discussed.

In this thesis, the selection of text has been an emerging process. What started out as a body of text comprising over 500 pages, was eventually narrowed down to 7 pages from a single document. This necessarily means that the analysis only covers a specific section of the text; in so far as the methodological principle of text-selection involved that I refrained from reading other parts of the text, I have a limited perspective on what has thereby been left out. This necessarily means that *more research can and should be done* by looking at the parts of the document that was left out, and the documents that ended up being excluded from the study (e.g. NOU: 10, 1991; St.meld. nr. 37, 1992-93).

I find that the methodological principle of confining myself to particular part of the text to be a valuable challenge. It forced me to look harder and deeper (multiple times) into a smaller section of the text, making it stand out and become more complex; it gave me more time to consider and reflect on parts of the text (particularly *decentralization*), which I think would not have been given much attention had it not been for the fact that I had to spend more time on the first parts of the document. In other words, if the methodological framework had remained a *comparative analysis*, it is possible that I would have had to reduce the amount of complexities considered in the analysis.

Considerable time was spent reading text that ended up being excluded from the final analysis. Still, valuable insights were gained in this early phase of the analytical process. (i) It informed the shaping of the analysis sheet – because I saw that certain themes were appearing across the documents; and (ii) it informs the identification of future research topics (see last section in this chapter, "future research").

6.2 The expression of a neoliberal rationality through the discursive construction of public health

The expression of a neoliberal governing reason will be discussed through the following sets of question: What is the object analysis, in relation to which elements are identified, and interventions organized? How are the deployment of interventions organized? On the one hand, the object of analysis is an object of health which is linked to individual's *mental, physical* and *emotional* "abilities"; in relation to which a series of elements are defined, which comprises individual behavior, institutional arrangements and factors in the social milieu. On the other hand, the deployment of interventions are organized around the principle of *decentralization*. I would now like to discuss these two aspects further: first, the construction of public health as organized around the population's abilities; and second, the notion of decentralization as a organizational principle of the deployment of interventions.

6.2.1 A public health that is organized around the abilities of the population

The presence of a neoliberal rationality can be seen in the notion of "abilities," in so far as it can be linked to the notion of "human capital." While the notion of "human capital" does not appear in the text, the notion of "abilities" is constructed in a similar manner. It can be seen that a specific relationship to the self that relates to one's abilities which is constructed in the text, mirrors the *entrepreneurial logic* of self-investments in the form of *improvement*, *maintenance* and *deployment* of one's "capital". The notion of "capital" must be understood in the broad sense that it is given in the

analysis of the American neoliberals: not strictly speaking *formal competences* linked to educational attainment, but a certain *quality* and *ability to produce* a future value (Foucault, 2008, pp. 229-230); much more than a specific object, the notion of "capital" serves as a *grid of intelligibility* that makes certain connections stand out. In the text, the individual's ability can be seen to be linked to a certain capacity to act. Except for the case of the ability to remain in their home for as long as possible, this capacity is not tied down to any one single end but seems instead to be constructed as a general capacity to act. Given the limits of the field of research analyzed in this thesis, the question of *how the abilities of the population should be utilized* (what different *telos* is constructed for its action) can be explored further.

In what ways are public health discursively constructed as organized around the population's abilities? In the text, public health is divided into two types of interventions: Health promotion aims to improve health; disease prevention aims to maintain health and reduce the loss of life years. Furthermore, health promotive and preventive work is explicitly linked to the *enabling* (make possible) of the specific care of the self that aims to improve, maintain and use abilities. The link between "ability" and "health" is never explicitly defined in the text but given the similarities in the choice of words (improve and maintain), as well as the role that health and ability can be seen to have as *parts of the self*, the connection seems reasonable to make. This means that public health is explicitly related to the population's abilities.

Furthermore, the problems of improving and protecting health is defined in terms that express the neoliberal rationality of decentralization. In the text, public health interventions are seen as something which must include and make use of the efforts of a variety of sectors of society, and cannot rely on the efforts of a single institution. Each sector has a responsibility for acting on a certain element that has been identified in the *milieu* of living in which health is formed and develops over time. The document is particularly focused on the *role of the health service*, with the understanding that the purpose and function of the other sectors would be described closer in later policy-texts.

6.2.1.1 *The ability to remain in one's home as an element in the management of the global economy*

In order to discuss these points further, I will now consider the construction of the ability to manage to stay at home for as long as possible.

From the emphasis given to the health service, it is clear that the object of health/abilities is at the center of consideration: both in terms of how the health service can be seen as *harmful* to the individual's health (cf. problematization of the provision of health services) and in the ways that it can be made to *maintain abilities*. The latter can be seen in the construction of the elderly's abilities to remain in their homes for as long as possible. For this particular subject position – the elderly and all

those who barely manage to remain in their homes – what is being highlighted is that they are on the verge of being *disabled* (*funksjonshemmet*). This process is framed as unavoidable, in so far as the only proposed goal of intervention was to *maintain* this ability.

These considerations, furthermore, also imply a certain care of the self. In the text, the reasons for this care of the self is framed in terms of *freedom* and *economics*.

For the individual, it was associated with a *loss* of freedom to be unable to remain in one's home, and instead having to be taken care of within a care home facility. "Freedom" was in turn linked to maintaining abilities in a more indirect way: by *not being able to remain in one's home*, one would also lose control over factors that determine their health, such as deciding their own nocturnal rhythm and their social life within the institution.

From an institutional and national perspective, this particular care of the self is given a clear economical dimension: the problem of the increasing number of elderly in the population was associated with a demand on services, which in turn put pressure on the demand for economic resources.

This could be seen as a strain on the decentralized system of governing in two senses. (i) In so far as it was based on the allocation of a given amount of resources from the national budget to municipalities and county municipalities, who had to allocate funds to institutions in the health service (for which they had been made responsible); (ii) and in so far as the system was set in place in order to keep down costs, which were tied to spending from the national budget; the national budget was in turn given an international dimension, in so far as the problem of "balancing" the budget can be read as pertaining to a balance vis-à-vis the economies of Norway's trading partners (Leonardsen, 2015; Rye, 2019). Herein may lie an important link to "competitiveness", in the sense that the amount of spending on health services are linked to the cost of goods exported, to the cost of living, and therefore to an increased minimum wage (Foucault, 2008). This is a topic that is outside of the research field considered in this thesis; further research could look at how the policies of prevention is discussed in White Papers which more directly discuss the *economic reasons for deploying prevention and health promotion* (e.g. St.meld. nr. 4, 1987-88).

The goal of remaining at home can also be linked to Hjort's (1982) discussion of health. Considered as a "dynamic" adaption to changing environments, it concerns the adaptation of elderlies to a time in their lives wherein they are not able to do as much as before, but where the distinction between the "healthy" and the "ill" is not as clear cut as in the "static" definition that sees health as "complete well-being". Hjort imply that the elderly should "realize" that they can adjust the strain put on themselves, so that they are *still able to have an excess in relation to the demands of their everyday*

life. The consequence is that they will not depend on health services, and thereby not put a strain on the national economy, and thereby not weaken national competitiveness in the global economy.

Considered from the point of view of biopolitics, the problematization of the elderly's abilities to remain in their home appears as a phenomenon which is entered into an overall analysis of the economic and social consequences of the demand for health services, which is linked to the increase in the number of old people in the population. Then, mechanisms of security (public health) is deployed in order to bring the "phenomenon" into an acceptable boundary (defined in economic terms with reference to institutional budget, national budget and finally, the balance of the global/European economy) by working on the elements that have been related to the "history" of the population ability to remain at home – i.e., to *not* be dependent on "costly" care from the health service. In the text, these "elements" can be seen in the deployment of disciplinary mechanisms in the form of training of elderly aimed at *maintaining* their ability; they can be seen in the consideration of how the legal framework of the patient-health service relationship affects the individual's health; and, in so far as the formation of diseases affect one's ability to remain in their home, they can be related to the formation of chronic diseases, which are dependent on multiple factors (that are both situated in the social milieu, and depending on the individuals life style) across the life of the individual (Foucault, 2004c; Hjort, 1982).

Within this governing reason, the function of the elderly's ability to remain in their home seems to be that of not causing economic strain; an aim which is linked more to the economic competitiveness of the nation, than to the economic competitiveness of the elderly themselves.

6.2.2 Decentralization, or the limits to biopolitics

In relation to the biopolitical function represented by public health, the neoliberal governing style represented by decentralization produces a contradiction. In a way, this is a contraction within the neoliberal rationality itself. In relation to the "foundational role" (Stiegler, 2019) that the neoliberals envisaged for the state during the 1930s, that is to say a state that could act on the foundations of the market economy, foundations which could not be produced by relying on the *narrow perspectives* of the *interest-driven* actors on the market because they existed as the *a priori* conditions of possibilities for the actions taken within the market (education, conservation of national resources, infrastructure, public health etc.), the decentralization of the internal structure of government involves the introduction of the interest-driven and short-term narrow perspective of economic actors at the level of governmental action (Cf. Dardot & Laval, 2017, pp. 301-302).

Through the reforms of decentralization, the "foundational state" is broken up and structurally impaired in so far as the central government will retain its long-term perspectives of strategic thinking, and its analysis which identifies all the pertinent levels of governmental action; while at the same time giving the task of enacting and intervening into these elements to a set of actors whose *constructed nature* is organized by the economic principle of allocating scarce means to alternate ends (Cf. Foucault, 2008). From the point of view of the *local political entities* represented by municipalities, county municipalities, and the like, the "return on investment" from investing in health promotion and the prevention of disease is not visible in the short-term, and may not even appear within their artificially constructed jurisdiction (Fosse, 1994; Skaset, 2003).

In a sense, the internal organization of government offer a pure example of the model of *decentralized government* of neoliberal subjects evoked by Laval (2018) and Taylan (2018): municipalities are narrowly defined in terms of their *economic conduct*, which are understood to be the source of the general interest of the population – through the production of public services (within a certain quality standard, and which are not imposing harm to vulnerable groups) and by investing in preventative and health promotive work (thereby creating equal conditions for individuals and groups, and reduction in harm for vulnerable and exposed groups). In so far as emphasis is continually placed on the actors at the local level, the government at the central level can be seen to make up for the contradiction inherent in decentralization in a paradoxical way by intensifying the decentralized government of the local actors by intervening in the *artificial milieu* in which they are immerged, and not by altering these actors themselves.

6.3 Further research: the history of public health as an element in the improvement of human capital

I have written this thesis in order to explore the possibilities and fruitfulness of situating the new policies of prevention and health promotion that emerged during the 1970s and 1980s, in relation to the history of human capital in Norway's policies; through the concept of neoliberal population management, I have thematized a form of power that makes use of public health in order to take charge of the elements which affect the development of the capacities of the human species, and not merely to conduct the conduct of citizens. In light of the thesis that have now been written, I think that further research can fruitfully pursue the following paths:

- Explore how *public health* have been constructed in economic policy texts (Norway's economic four-year plans and the white papers on economic policy (e.g. St.meld. nr. 4, 1987-88)) in order to understand more of how public health have been through of as part of the

mechanisms of power deployed in order to manage the economic effects of population; how population is constructed as an economic subject-object in these texts; how public health is constructed as a technique for bringing these effects within an acceptable band-width;

- Explore how the policies of prevention have been constructed in relation to the educational policy of "learning throughout life"; an important link may be how the logic of "adaptation" underlines the connection between health and educational attainment, and thereby the production value (Meld.st. 34, 2012-2013).
- Explore how the object of "health" and development of the individual is treated in the concrete life course analysis that have been developed.[107] The life course analysis may serve as an interesting object of analysis, in the sense that it can be viewed as a surface of articulation where the identification of object of analysis and the elements identified as determining its development which can be studied as a an integral part of the management of population (e.g. Beddington et al., 2008).

In other words, it is a question of studying the ways in which "the specific problems of life and population have been posed within" the technologies of government that are "haunted by the question of [neo-]liberalism" (Foucault, 2008, pp. 323-324).

[107] It seems to me that the life course perspective was explicitly introduced at the start of the 1990s (Cf. NOU: 10, 1991), but may have come earlier than this (Cf. Elder, Johnson, & Crosnoe, 2003).

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Appendix 1 – Analysis sheet, version 1

Table 1. Questions Used in the Analytical Sheet. Version 1.

Version 1	
Public health	
What is public health presented as?	How is public health presented?
What are the problematizations presented as necessary for government to act on?	How are problematizations presented as necessary for government to act on?
What actions are presented as necessary and legitimate for addressing these 'problems'?	How are actions presented as necessary and legitimate for addressing these 'problems'?
Subject	
What subject positions are presented? What values are given to different subject positions? What form or state of being should individuals strive for? What part of the self is relevant for achieving this state or form?	How are subject positions presented? Who are defining subject positions? How are subject positions problematized? Who are problematizing subject positions? How should individuals strive to achieve a state or form of being? How are individuals interpellated to take on various subject positions? How are individuals discouraged to take on various subject positions?
Population	
What is the population presented to be? What are the properties of the population? Is there a relationship between subject positions and the population? What forms of knowledge is used to construct the population? What are the problems of the population presented to be? What fields of intervention are presented in relation to various problems? What actions are presented as legitimate and necessary in order to address certain problems?	How is the population divided into various properties? How is the population problematized? How are fields of intervention constructed for various problems? How are various actions presented as legitimate and necessary for addressing specific problems? How are subject positions related to the population?
Health	
What is health presented to be? Where is health taken up? What are the problems of health presented to be? What significance is given to health? Where is health located? Is health taken up in relation to subject positions? Is health taken up in relation to the population?	How is health presented in the text? How is health problematized? How is health presented in relation to subject positions? How is health taken up in relation to the population?
External relationships	
What external relationships are taken up in the text?	How are external relationships presented in the text?
What external relationships are related to public health?	How are public health related to external relationships?
What external relationships are related to subject positions?	How are subject positions related to external relationships?
What external relationships are related to the population?	How are the population related to external relationships?
What external relationships are related to health?	How is health related to external relationships?
Internal relationships	
What internal relationships are taken up in the text?	How are internal relationships presented in the text?
What internal relationships are related to public health?	How are public health related to internal relationships?
What internal relationships are related to subject positions?	How are subject positions related to internal relationships?
What internal relationships are related to the population?	How are the population related to internal relationships?
What internal relationships are related to health?	How are health related to internal relationships?

Appendix 2 – Analysis sheet, version 2

Table 2. Questions Used in the Analytical Sheet. Version 2.

Version 2	
Public health	
What is 'public health' presented as (implicit and explicit) What problematizations are presented as necessary to act on? What actions are presented as necessary and legitimate for addressing these 'problems'? In what **epistemological** (power/knowledge) **field** are problems and actions constructed? What **fields of intervention** are constructed in order to act (**power**) What **knowledges** are constructed in order to act?	How is public health presented? How are problematizations presented as **necessary** to act on? How are actions presented as **necessary** and **legitimate** to act on Who are interpellated (invited) to act? In what way are **entities** invited to act?
Subject positions	
What subject positions are presented? What subject positions are **problematized?** What values are given to different subject positions? What form or state of being are presented as **ideal** What part of **the self** is presented as relevant for achieving the ideal state or form of being? How should people action order to achieve the ideal state or form of being? How are individuals **interpellated** to take on various subject positions? How are individuals **discouraged** to take on various subject positions?	How are subject positions taken up and constructed? (defined) Who are defining subject positions? How are subject positions problematized? How are values designated to different subject positions? How are ideal states or forms of being presented and constructed in the text? How is this part of the self constructed?
Population	
What is the population presented to be? (directly/indirectly) In what sort of **political reflections** are the 'population' taken up? What are the properties of the population? Is there a relationship between subject positions and the population? What forms of knowledge is used to construct the population? What are the 'problems' of the population presented to be? What fields of intervention are presented in relation to various problems? What actions are presented as legitimate and necessary in order to address certain problems?	How is the population problematized? How is the population divided into various properties? What is the principle(s) of classification? What are the relationship between different properties? How are **subject positions** related to the population? How are fields of intervention constructed for various problems? How are actions presented as necessary and legitimate for addressing specific problems
Health	
What is **health** presented to be? In what sort of **political reflections** are the 'population' taken up? Where is health taken up? In relation to **what other objects** are health taken up? - Is health taken up in relation to subject positions? - Is health taken up in relation to the population? What **significance** is given to health? What are the 'problems' of health presented to be?	How is health taken up in the text? How is health taken up in relation to subject positions? How is health taken up in relation to the population? How is health problematized?
External and internal relationships	
What internal relationships are taken up in the text? What external relationships are taken up in the text? How are internal and external relationships related to each other?	What are the objects of the relationship? What is the function of the relationship? What is involved in the relationship? Who is involved in the relationship? What is the relationship between those who are involved?

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