NURSING, SOCIETY, AND HEALTH PROMOTION—HEALING PRACTICES:
A CONSTRUCTIONIST HISTORICAL DISCOURSE ANALYSIS

by

James Patrick Ronan

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SIGNED:  James Patrick Ronan
DEDICATION

This journey, above all, has been my journey in seeking knowledge and understanding—my life’s passion. However singular an endeavor one may venture, it is never without those individuals who mentor, support and make possible that space, that necessary freedom, for the long solitude sailing.…

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ABSTRACT

The purpose of this discourse analysis of health promotion and healing practices was to describe their functioning historically through practices of governance and risk in the context of neoliberal society. The results portray a constructed subjectivity (identity) among citizens and residents of contemporary society who enact expected health promotion and healing behaviors.

Two series of texts were analyzed from a Foucauldian perspective: the Healthy People series from the U.S. Department of Health and Human Services; and the series on Uninsurance published by the Institute of Medicine. The findings generated five themes that comprise the reality of current illness care system rationalities:

First, the U.S. illness care system, functioning through technology of insurance or wealth extraction, is dysfunctional as a comprehensive illness care delivery system.

Second, health promotion and healing have been subsumed under illness care—if they are addressed it is only as discrete indices that comprise compliance monitoring.

Third, micro determinants of health (such as behavioral patterns, genetic predispositions, social circumstances, shortfalls in medical care, and environmental exposures), while important, continue to be the single focus of illness care in the U.S. Conversely, macro determinants of health, contingent on macro-level economic and political structures, remain unrecognized as having any bearing on health outcomes. Macro determinants of health frame the configuration of the social infrastructure in which micro determinants of health unfold.
Fourth, neoliberal ideology in the U.S. continues to be the status quo for illness care.

Fifth, constructed health promotion and healing identity for individuals is one of health anomie, a new prudentialism where access to health promotion and healing has to be acquired from outside the venue of illness care.

How can we become different from what we have become? While acknowledging the limitations inherent in this current discourse of health promotion and healing, other alternatives must be explored for betterment of human health and wellbeing—such as a shift toward “care of the self” or “self care” that encompasses an embodiment of an arché health, a health that moves beyond contemporary illness discourses of mind-body, one that defies society’s inscription of our subjectivity.
CHAPTER I

STATEMENT OF THE PROBLEM

United States (U.S.) health and illness care systems driven by specific U.S. health care policies have failed to perform adequately in ensuring equal *access* and *quality* to its entire population (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004; Schroeder, 2003). Current health policy is focused primarily on microlevel determinants of health with strategies for implementation focused on disease prevention and health promotion behaviors and practices that are substantiated by modernist theoretical positions of governance and risk (Ewald, 1991; Lupton, 1999a; Pearce & Smith, 2003). The problem of interest for this study relates to the lack of evidence demonstrating that behavioral self-care changes in individuals have resulted from targeting disease prevention and health promotion activities over the last twenty years (Green & United States Public Health Service, 1996; National Center for Health Statistics, 2006). It is particularly troubling given the fact that nursing, by definition, focuses on health promotion and healing and promoting self-care in human beings.

Nursing locates aspects of their ontological and epistemological orientations for nursing practices on strategies of health promotion and healing. A predominant theme represented in the basic definition of nursing as *caring in the human health experience* (Newman, Sime, & Corcoran-Perry, 1991), proposes nursing practice methodologies of health promotion and healing that are unique to the discipline, thus minimizing traditional medical emphasis on disease and illnesses.
Additionally, the American Association of Colleges of Nursing (1996, 1998, 2006) has set essential competencies for nursing practice education at the baccalaureate, masters, and for the newly defined practice doctorate, the doctorate of nursing practice. At all levels of education—health promotion, risk reduction, and disease prevention are essential competencies for graduates (American Association of Colleges of Nursing, 1996, 1998, 2006). However, the focus in nursing has been on tertiary care with research studies measuring outcomes having focused on a predominance of curative, rehabilitative, and supportive care of individual responses to disease and illnesses. In this light, the realities of nursing practices can be understood as primarily reacting to the consequences of disease and illness at the individual level rather than on health promotion at the macrolevel of society.

It is understood that macrolevel socioeconomic factors derived from the government (political) sphere act as major determinants of health in a population or sovereignty. It is also clear that U.S. health policy as well as U.S. health and illness care systems concentrate on determinants of health focused at the micro level, suggesting that these strategies are primarily without context (Navarro, 2003b; Pearce & Smith, 2003). In addition, what is not apparent are health ramifications of evolving complex changes to contemporary societal structures derived from both the government (political) as well as the economic spheres.

Societal structures are complex societal functions historically termed liberalism and understood as the art of government that strikes a balance between too much government (such as a police state controlling all aspects of behavior) and no effective
government (such as states of anomie). This balance engages the autonomous yet overlapping spheres of sovereignty, population, economy and society each with their distinctive function in effective government.

Since the late nineteenth century a variant of classic liberalism has been social liberalism, the prominent art of government. This perspective focused on the collective wellbeing of the entire population. The duty and focus of government in this era was seen as the ethos of the welfare of society through collective social justice (Dean, 1999a).

In the late twentieth century, this art of government shifted to a focus on the economic sphere, or markets due, in part, to the Western World crisis of an inability to sustain the welfare state. Within this mode, the responsibility of government shifted from 

*man [sic] as a responsibility of society* to that of supporting the duty of *man [sic] in society*. This may be understood as a shift from social justice to one of market justice functioning. This evolved art of government, termed neoliberalism, represents current contemporary societal functioning (Barry, Osborne, & Rose, 1996; Dean, 1999a). It is my contention that the art of government practices of neoliberalism have been poorly understood in issues of U.S. health policy as well as in health and illness care systems.

Focus of the Study

Thus, the focus of this study is to examine the question, within the realities of liberalism or more predominantly neoliberalism, of how the practices of health promotion and healing operate and are made visible in current society and in the self-care practices of individuals. A second question for study addresses the possibilities for individuals in society to *practice* disease prevention and health promotion (or in nursing terms, health
promotion and healing) differently, within these formal societal structures of neoliberalism.

Background and Significance

Increasingly, over the past two decades, the health and illness care systems in the United States have failed to deliver societal health outcomes set forth in U.S. health policies specified in the Healthy People 2000 and 2010 Initiatives. (Green & United States Public Health Service, 1996; Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004). These Initiatives propose benchmarks for specific indices of health behaviors and practices deemed essential for optimal health as determined through empirical evidence as well as recommendations from health experts. Despite broad-based support and extensive dissemination of Healthy People community campaigns, outcome evaluations suggest that most goals continue to be unmet (Green & United States Public Health Service, 1996; Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004; National Center for Health Statistics, 2006).

Likewise, critiques of contemporary operations of societal structure, such as trajectories of capitalism, corporatization, and globalization, are implicated as failures in attaining these health policy goals (Allen, 1995; Navarro, 2002, 2003a, 2003c, 2004; Schroeder, 2003). These operations can be understood as “market prominent” strategies concerned with minimizing cost and maximizing profit. For example, these market driven practices affect health and wellbeing by reconfiguring structure. Popular social programs such as Social Security, Medicare, and Medicaid are undergoing schemes that limit access to services or services reduction through innovative plans simultaneously designed
to contain costs and reduce government liability. Such strategies, while marketed to the public as creating choice among many programs, actually limit traditional benefit coverage for retirement and health care by redefining eligibility, eliminating services completely, or by drastically reducing their scope. These types of contemporary operations of societal structure (societal restructuring) are termed neo-liberalism and understood as the duty of man [sic] in society not the duty of society.

The ethics of “duty of society” originated with the initiation of social liberalism set forth in government social programs such as the New Deal (1933-1937) in combination with Keynesian economics (economic strategies synergic with state planning) as a response to the social strife resulting from the Great Depression. With the advent of social liberalism, humanistic terms such as “social justice” and “social ethics” became the lexicon of moral behavior for all people: the duty of society was to be in service of the welfare of the entire population.

The effects of a slow demise of social liberalism can be seen today with contemporary societies being increasingly plagued with under-funding of social infrastructure which results from failures of traditional mechanisms of taxation that are no longer receiving adequate approval for sustainability. Everyone desires infrastructure, but no one wants to fund it as a collective enterprise. This shift in societal functioning has been evolving in an understated yet persistent fashion over the last twenty years. Neo-liberalism is understood as legitimizations of concepts such as “social justice” and “social ethics” only in terms of and through criteria of “market justice” and “market ethics”. That is, “social justice” and “social ethics” are plausible only if they are confined to the “rules”
of business or markets. The net effect is understood not only as society operating within the constraints of the economic but as society operating in service of the sphere of the “economic”. This stands in contrast to what was once described, in social liberal terms, as the “economic” in service of society.

An underlying assumption of current U.S. health policies is framed around disease prevention and health promotion activities advanced as specific recommendations targeted to a range of actors: professional disciplines, various stakeholders in the health and illness care industry, and individuals. Nursing, as a key discipline in the delivery of health and illness care, has a historical lineage of ontological and epistemological positions about health promotion and healing practices for their patients and clients. With the convergence of current U.S. health policy objectives of disease prevention and health promotion with that of orientations of health promotion and healing of contemporary nursing practices, it follows that outcomes of these efforts should be visible in societal practices as a result of translation, incorporation, and adherence (Bandura, 2004; Callaghan, 2003; Pender, Murdah, & Parsons, 2005). Since this evidence is not visible (National Center for Health Statistics, 2006; Ronan, 2003) it suggests that despite unique philosophical orientations to practice, nursing outcomes focused on health promotion and healing are no better than other health disciplines representative of the U.S. health and illness care systems (National Center for Health Statistics, 2006).

Questions for nursing suggest two lines of thinking: first, are the majority of nurses practicing a medicalized version care as Fawcett (1999) suggests, and second, if so, why is the rich heritage of nursing that is so carefully cultivated in formal education
not translating into practice? The evidence regarding health promotion healing suggests that nurses, despite health promotion and healing focus of their education and their positive professional belief systems about how they should practice within this context, follow a trajectory of a “biomedical focused” nursing practice (Fawcett, 1999; Ronan, 2003).

Current performances of the health and illness systems in the U.S. (including nursing) can be seen as “problematic” in terms of attaining outcomes stipulated in the Healthy People 2000 and 2010 Initiatives. Additionally, critiques of diminishing access to health and illness care are gaining momentum as a crucial national issue (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004). What is less clear, and what is the major focus of this study, is the impact of contemporary societal structure—neoliberalism—on current societal practices of health promotion and healing despite traditional health and illness care systems strategies and approaches.

Critiques of Nursing

Because the discipline of nursing is so intertwined within the current perspective of health and illness care in this country, I must look broadly at a historical trajectory of developments and practices that has led nursing critics to speculate that nursing as a discipline has been complicit with our unethical delivery system in the U.S (Allen, 1995; Drevdahl, 2002; Schroeder, 2003). It is deemed unethical from two convincing perspectives. First, access to health and illness systems is dependent on a threshold of means to purchase services which currently renders 48-50 million citizens without any coverage. Second, the net effect of current strategies of services—primary, secondary,
tertiary—does not yield outcomes consistent with goals delineated by health policy and practice disciplines alike despite knowledge and technologies to do otherwise.

Specifically, several nursing scholars have endorsed a nursing worldview that emphasizes health promotion or inner healing as essential features of nursing practice that sets the discipline apart from others (Fawcett, 1984; Koithan, 1994; Meleis, 1991; Mundinger, 1994; Newman, Sime, & Corcoran-Perry, 1991; Nightingale, 1859/1946; Pender, 1990; Reed, 1995, 1997; Watson, 1990, 1997). However, this worldview has had limited application within health care systems dominated by the biomedical model. In addition, it is my argument, based on growing evidence, that contemporary nursing theoretical approaches to health promotion and healing have had limited success in practice applications because of their sporadic practices in deference to the predominance of illness practices (Ronan, 2003; Rush, Kee, & Rice, 2005). This may suggest a need for re-thinking health promotion and healing practices methodologies.

Politics of Nursing

The politics of nursing surround the contentious debate of the relevance of theoretical metanarratives in practice realities. Additionally, the historical context of these debates is frequently set at the micro level, avoiding or ignoring macro level contexts such as the impact of modernism, functioning as liberalism and more recently neoliberalism.

While most nursing theoretical metanarratives are congruent with modernism—seen as a never ending belief in progress embracing capitalism, science and technology—an absolute central theme is the essentialized individual. These theoretical metanarratives
have presented the discipline with an array of conceptualizations that potentially address most of the wellbeing concerns of individuals. For example, “patterns of knowing” introduced by Carper (1978) provided conceptual tools for explicating ways of knowing for the discipline that were deemed unique to nursing. These conceptual tools were viewed as a break from the narrow approach inherent in the biomedical model that relied primarily on empirics for knowledge development and practice. Carper’s patterns of knowing—empirics, the science; aesthetics, the art; personal knowing, unique knowledge of the nurse, and ethics, the moral component—was hypothesized to have a fundamental impact on all aspects of nursing: theory, practice and research.

These patterns of knowing were expanded to include: unknowing, lacking awareness (Munhall, 1993); inexplicable, incapable of being explained or justified (Silva, Sorrell, & Sorrell, 1995); and sociopolitical, the environment of the persons and their interactions—society and its politics (White, 1995). A resounding theme through all these works is the mutual inclusiveness of all patterns of knowing as occurring simultaneously, not in isolation of each other (Silva, Sorrell, & Sorrell, 1995).

These ways of knowing can be understood to facilitate health promotion and healing endeavors that nurses and clients could mutually venture to address in everyday encounters (Loescher & Ronan, 1998). However, what is still not certain is how these “ways of knowing” make their way into actual nursing practices. Reed (2006), in criticizing the theory-practice gap that still exists, postulates that practice not only concerns knowledge application, but knowledge production through practice theorizing wherein application of various practices of nursing science leads to generating theories.
about healing processes learned and verified through caring acts of nursing practice (p. 37). The question remains, are these practice strategies evident in contemporary nursing practices?

While ways of knowing represent an important conceptual framing of aspects of ontological and epistemological orientations of the nursing discipline contributing most prominently to theorizing, their applicability is less evident in practice and even less prominent in research (Paley, 2006). Paley defines nurses who adhere to multiple dimensions or patterns of knowing as inclusionists, set apart from minimalist who identify predominately with empirics, privileging evidence-based practice over and above expertise, clinical judgment, and reflection (2006). The shift in current nursing disciplinary conceptualization is away from patterns of knowing to the “new” lexicon of evidence-based practice.

Rolfe (2005), in denouncing the current focus on evidence based practice, suggests that evidence based practice is the meta-narrative of nursing (p. 79). This is not only evident in the nursing literature, but is represented in standards for nursing education (American Association of Colleges of Nursing, 1996, 1998, 2006), as well as in standards for practice demanded by regulatory agencies and boards. The net effect is the reestablishment of the discipline of nursing within a similar narrow scope of legitimacy occupied by disciplines such as medicine. This means legitimacy resembles quantitatively-derived empirics as the gold standard. The diversity and rich heritage of nursing practice understood as an inclusionist domain is relegated to an insignificant past history, visible to only a minority of the discipline.
While evidence based practice does not exclude health promotion and healing practices, they are relegated a low priority in a practice environment of the U.S. health and illness care systems which predominately offer curative, rehabilitative, and supportive care in responses to disease and illness. Furthermore, if descriptions of the practice environment offered by Larsen, Adamsen, Bjerregaard, and Madsen (2002) are accurate, nursing practices are oriented primarily to the daily clinical environment in which they work, with inspiration, orientations, and learning derived primarily from colleagues, with theory informed practice little more than a footnote. Davina Allen (2004) goes further by suggesting that nursing practice is little more than a strategic “structural location within the contemporary healthcare systems and is at odds with the profession’s culture and ideals, focused as it is on the quality of relationships with individual patients” (p. 273). Allen continues that the nursing role can be seen as a “throughput” with nursing jurisdiction shaped in important ways by the requirements of health service organizations (p. 276).

Gastaldo and Holmes (1999) contend that the discipline of nursing has been founded on, and persist within, humanist philosophy and Cartesian principles, mirroring itself in the bio-medical model with its claims of neutral and truthful accounts of reality through science. Seeing reality only through the eyes of the discipline severely constrains knowledge and practice. “History of the present of nursing theory points to the construction of the nurse as a humanist subject—a patient centered practitioner; a neutral scientific observer, and an advocate scholar of nursing discipline” (Gastaldo & Holmes, 1999, p. 238). They suggest that what is lacking is broad understanding of nursing in a
societal context, a discipline without borders that is able to imagine nursing at the center of power relations in society, subscribing to regimes of truth and power that define professionals, nursing knowledge and our societies (Gastaldo & Holmes, 1999).

Societal context has been suggested to be the constraining element to most professional nursing practice (Browne, 2001; Drevdahl, 1999a, 1999b; White, 1995). This social context has most often been mistaken in the nursing literature to be the micro level context of everyday practice, the constraints each individual experiences as they struggle toward wellbeing in their daily lives. This is opposed to the macro level societal context that creates these limits: structures of modernism, and the functioning of liberalism and neoliberalism. Micro level social problems are the symptoms of macrolevel societal structures.

Dilemma for Nursing

The dilemma for nursing resides in the realities that there are competing priorities for what is deemed legitimate for optimum nursing practice. Since most practice venues for the majority of nursing resides in traditional illness-curative contexts, evidence based practice along the narrow scope of empirical evidence comprises the highest priority in guiding nursing care. While considerable effort is expended in formal nursing educational settings emphasizing the attributes and utility of nursing theory and knowledge for responding to complex human wellbeing challenges, little evidence outside the illness paradigm of practices, such as health promotion and healing (life trajectories), is evident in outcome studies.
This theory-practice gap results from the macro level contexts of modernism, liberalism and neoliberalism wherein complex limits are formulated to support capitalism, science, and technology in unending quest for progress and profits, minimizing alternative approaches to lifelong wellbeing for individuals and society.

*United States Health Policy*

We are currently fifteen years into a comprehensive twenty year health policy spanning the 1990s through 2010. This comprehensive health policy was outlined in Healthy People 2000 (Public Health Service, 1991) and subsequently Healthy People 2010 (United States. Dept. of Health and Human Services., 2000a). Goals for the Nation were outlined in Healthy People 2000 as: 1) increase the span of healthy life for Americans; 2) reduce health disparities among Americans; and 3) achieve access to preventive services for all Americans (Public Health Service, 1991). After mid-course and final review (preliminary) (Public Health Service, 1991; United States. Public Health Service, 1995), revised goals for Healthy People 2010 included: 1) increase quality and years of healthy life; and 2) eliminate health disparities (United States. Dept. of Health and Human Services., 2000a).

Findings from the first ten years of experience with Healthy People 2000 can be evaluated as marginal at best. There was positive movement in many of the measured indices, some with statistical significance. However, fifteen percent of the tracked indices moved in a negative direction relative to benchmark targets that indicate preferable health goals (National Center for Health Statistics [U.S.], 2001). The debate continues as to whether the improvements had any clinical significance for improving the overall health

The mechanisms of how the Healthy People 2000 and 2010 Initiatives are operationalized as processes of policy application require examination and clarification. It is assumed that targeted behaviors represent interventions primarily at the microlevel, the individual, and the community, while at the macrolevel, the population is only superficially implicated. These targeted behaviors are conceptualized collectively as disease prevention and health promotion practices of individuals, as health professionals, or as community level actors.

The inferences of the performance of these disease prevention health promotion practices, in a positive or negative direction, suggest the conceptualization of two specific and interrelated concepts: governance and risk. Governance implies disciplining conduct through a variety of techniques focused on certain desired goals or outcomes, in this case disease prevention and health promotion practices. These practices are seen not only as practices of individuals, but also of practice disciplines and community level actors as well.

This brings to light the second concept, that of risk. Risk is the underlying rationality substantiating the need for governance. It is a modernist technique resulting in management strategies derived through analyzing and balancing real or perceived dangerousness of an event or events in terms of the near or distant future. Within the context of the Healthy People 2000 and 2010 Initiatives, the agenda for risk management
is focused on the health of the population of the U.S. with disease prevention, health promotion practices resulting as the mechanisms (governance) for achieving the best possible approaches in realizing the most optimum outcomes.

Health policy, by its very nature, is a prescriptive activity, and cannot function in a vacuum. A health policy targets its recommendations, mandates, and prescribed activities at stakeholders who are best suited to incorporate and perform these desired activities. Hence, the successes or failures of such policy must be viewed through the outcomes or performances of these targeted organizations and institutions such as health and illness care systems.

Health and Illness Care Systems

The health and illness care systems in the United States, by all accounts, are the most expensive in the world, the least fair among industrialized countries, and provide questionable quality in an illness focused system (World Health Organization, 2000). There are two salient points that frame these facts: first is the lack of universal access to health and illness care; second, those with access to the health and illness care experience questionable quality as defined by numerous societal health indicators (University of Maine Bureau of Labor Education, 2001; World Health Organization, 2000). This is not to say that certain segments of the population do not receive excellent health and illness care. Rather, it is a reality that many segments of the population receive substandard or no health or illness care.

Stratification of access to health and illness care is based on capitalist principles of ability to pay; hence, the more privileged, the more likely you are to have adequate
coverage (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004; Navarro & Shi, 2001). There is no social collectiveness that defines health and illness care as a seamless basic entitlement. For example, the current health and illness care systems have the following four traits: no mechanism for a single payer plan, an absence of defined basic or minimum benefits for health and illness care, inequality regarding access to care, and no viable portability. What is in place is a mosaic of highly variable insurance programs, each with exclusionary terms regarding the scope of health care coverage, coupled with local and federal government programs that attempt to provide health care coverage for those without insurance, or for defined segments of the population such as children and those over age 65. This uneven access to health and illness care can be characterized as a hierarchy of privilege that mirrors class stratification, currently excluding 43 to 45 million citizens from any coverage at all (National Center for Health Statistics [U.S.], 2003).

During a two year period, from 1996 through 1997, one third of the U.S. population under 65 were uninsured for a month or more (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004). There is clear evidence that gaps in health and illness care coverage leads to protracted delays in restoring desired patterns of preventive behaviors and practices once health and illness care coverage is reestablished. The lag or delay in renewing positive prevention patterns indicates health ramifications beyond the period of actual absence of health and illness care coverage (Sudano & Baker, 2003).
Outcomes related to performance of our health and illness care systems are collated and evaluated at three distinct levels: the individual level, the community level (a county, a state or a region), and the population (the country as a whole). Metrics from the Healthy People 2010 Initiative tend to focus more prominently at the individual and community levels because practices of individuals and the health and illness care disciplines are focused and reside at this level. Disease prevention and health promotion activities and practices on the part of individuals are, for the most part, not directly measured but, rather, are inferred as an inverse to negative health outcomes indices collated at the individual and community levels.

Current performances of health and illness care systems in the U.S. fall short of expectations at all three levels (Green & United States Public Health Service, 1996; Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004; World Health Organization, 2000). A principal policy focus in correction of these outcomes continues to be centered on two deliberate themes: first, access to care for all of society (this includes health disparities among different segments of the population); and second, a complete focus on specific indices at the individual and community level of intervention that theoretically can increase quality and years of life (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004; United States. Dept. of Health and Human Services., 2000b).

Despite increasing costs to sustain the current health and illness care systems, outcomes continue to be substandard compared to expected results consistent with theoretical capabilities. In light of these realities, there is a substantial segment of the
population level health literature that continues to be excluded from policy and political
debate. These population level factors deemed determinants of societal health are
privileged in the sense that they are preeminent over individual or community level
factors in their ability to determine lifelong health and mortality. Because of their societal
scope, these determinants have far more impact on health and mortality than that of
individual or community level indices that now comprise the majority of current U.S.
strategic policy.

The plausibility of the preeminence of societal determinants of health creates
considerable tension with that of U.S. current policy and practice trajectories. Policy that
gives privilege to microlevel interventions while ignoring macrolevel social contexts is
precisely what is problematic. Following is an overview of the perspective of these
societal or population level factors.

**Society**

Socioeconomic factors are the major determinants of health and mortality and are
established in strong causal relationships (Pearce & Smith, 2003; World Health
Organization, 2000). Socioeconomic factors are described broadly to refer to social class
(or social status or position) in a social hierarchy that highlights factors of income,
education, or occupation. These are all strongly related to health outcomes. What is less
clear are the processes or factors identified as pathways to these relationships: income
inequality (contrast within population) and social capital (community capacity,
empowerment, and social support).
While there is no compelling agreement in support of income inequality and social capital as mutually exclusive processes of societal determinants of health, what is generally accepted is the following: health in the community, income inequity and social capital may all be consequences of macrolevel social and economic processes derived from the political sphere in which democratic processes and power relations—specifically, class power—influence health across the life course (Navarro, 2003b; Pearce & Smith, 2003). Since macrolevel economic and social policies set the bounds within which communities and individuals live, it follows that the health effect of these macrolevel policies should not be studied out of context, such as giving preeminence to community level actors (like social capital) or individual level factors (such as lifestyle) (Pearce & Smith, 2003).

Socioeconomic factors as major determinants of health are deemed *positive* when social political processes are prevalent which minimize the effects of class power and simultaneously enhance democratic determination. When contrasting the status of current U.S. health with that of other western democracies it has been inferred that socioeconomic factors as determinants of health are *negative* because class power and corporate power are politically well entrenched while democratic determination of health is absent (Navarro, 2003b, 2004; Navarro & Shi, 2001; Schroeder, 2003).

Additionally, contemporary neo-liberalism functioning within the complex synergy of government and economic spheres is understood to comprise social structures that emphasize maximizing “capitalism” as solutions to societies’ challenges—with the net effect of minimizing democratic solutions. A theoretical tension can be hypothesized:
disease prevention and health promotion (in policy terms) or health promotion and healing (in nursing theoretical and practice terms) operate within societal structures that constrain optimum health. This coincidence can be understood in terms of what we know as knowledge of limitations resulting from the government (political) sphere inextricably linked with how we live in contemporary society understood as neo-liberalism predisposed by the economic sphere.

Purpose of the Study

How society lives health in the U.S. is subjected to numerous constraints and limitations. These restrictions can be seen as the result of societal structuring and functioning. Nonetheless, individuals make choices about health within these parameters as they live out their lives. Currently, it is not clear how people in society practice health promotion and healing in seeking wellbeing. As reviewed, current metrics and theory do little to help illuminate the problem. In order to gain better insight, I am suggesting a historical discourse analysis of present-day health promotion and healing practices in society. This “history of the present” is focused not only on how health promotion and healing activities functions in contemporary society but more importantly how we arrived at where we are today.

The purpose of this study is to examine the functioning of multiple actors and conditions that comprise living health through health promotion and healing in our contemporary neo-liberal society. After this analysis (Chapter IV), a discussion will be possible regarding these findings, for a prelude to critically exploring how we may think
and act different than we have become. This will be a major focus in Chapter V, discussion of results.

Theoretical Perspective

Situated epistemologically from the standpoint of social constructionism, there are several contentious tensions regarding belief systems surrounding the health and illness systems in the United States. These belief systems, or theoretical rationalities, are incongruent with one another and can be seen as represented in the net effect of current outcomes and functioning. Modernist tenants of essentialism comprise the majority of western world belief systems. Essentialism is a philosophical perspective on human identity which locates the self as internal and existing independently and prior to social structure and or language. The decentered man [sic] by contrast is situated in contexts of complex interplay of language, social structures, and human agency—utilized to control, construct, or define reality described as a constructionist approach to the world (Crotty, 1998; Fox, 1999).

In essence, this study is an analysis of processes of governance, regarding issues of power, knowledge, and ethics that comprise a constructed society necessary for sorting out the current discourse of health promotion and healing behaviors of society. Guiding questions in this context would be: How is health knowledge constructed? Who decides? What is a health expert? Who controls health information? How are limits with respect to health choices and actions formulated? What are means of legitimate resistance? How does health promotion and healing become a part of self care?
The body of work of Michel Foucault offers us historical insights into how, “in our culture, humans beings have been made subjects” (Dreyfus, Rabinow, & Foucault, 1983). Foucault’s work, pertinent to understanding the functioning of modern society, represents a compelling explanation of the transitioning of the status of liberal governments through the demise of welfare state ideals to the formation of neoliberalism as a contemporary governmental structure. This societal transition in functioning is crucial in understanding health and illness care systems as well as health promotion and healing activities expected as a component of health in society since these areas respond in certain determined ways to these overarching structural changes.

Risk represents a modernist tool deployed to manage a range of problems resulting from modern society since industrialization (Fox, 1993, 1999; Lupton, 1999b). Since health and illness care in modernist terms is all about managing risks, it follows that this concept be explored in order to understand health promotion and healing practices of contemporary society. My intent is to examine governance and risk together as dual concepts since this is the best approximation of how the matrix of health and illness systems attempt to function today. Specific theories best suited for this effort are as follows: Michel Foucault’s bio-power and governmentality and risk forwarded by Robert Castel, Mitchell Dean, Francois Ewald, and Deborah Lupton. It is postulated that these theories will contribute substantially to the understanding of how health promotion and healing operates in our contemporary neoliberal society.
Bio-power

The objective of Foucault’s work can be characterized not as the analysis of “the phenomena of power, nor to elaborate the foundations of such analysis” but rather to “create a history of the different modes by which in our culture, human beings are made subjects” (Foucault, 1982, p. 208). However, in describing these different modes of subject production, a complex relation of power becomes evident. This element of power is not derived from sovereignty, a judicial-legal system, or repressive context (although they certainly exist) but is inherent in relations of power deemed positive or productive (Foucault, 1982, 1991a).

Power in this sense, a knowledge-power nexus, represents three inseparable but reciprocal types of relationships: objective capacities (intrinsic aptitudes or external instruments), power relations (play of relationships between individuals or groups) and relationships of communication (transmission of information by means of a language, a system of signs, or any other symbolic medium). Specifically Foucault suggests:

The application of objective capacities in their most elementary forms implies relationships of communication (whether in the form of previously acquired information or of shared work); it is tied also to power relations (where they consist of obligatory tasks, of gestures imposed by tradition or apprenticeship, of subdivision and the more or less obligatory distribution of labor). Relations of communications imply finalized activities (even if only the correct putting into operation of elements of meaning) and, by virtue of the modifying the field of
information between partners, produces effects of power [italic added]. (Foucault, 1982, p. 218)

Bio-power is a co-extensive development of the individual manifestations of subject and power advanced by way of understanding historical events. Its development is more or less simultaneous and indispensable with the advent of industrialization, capitalism, and modernity, situated from the seventeenth through the nineteenth centuries.

Power over life evolved along two basic forms, two poles “linked together by a whole intermediary cluster of relations” (Foucault, 1990, p. 139). The first of these poles developed while centering on the body as a machine: “its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its integration into systems of efficient and economic controls…by the procedures of power that characterized the disciplines: an anatomo-politics of the human body” (Foucault, 1990, p. 139).

The second of these poles, coalescing after the establishment of the first, was situated on the species body. This focus concentrated on the mechanisms of life serving as dossier, a cataloging of biological process: “propagation, birth and mortality, the level of health, life expectancy and longevity…” and the complex interactions of each of these indices and how these processes marched out over time (Foucault, 1990, p. 139). This supervision was marshaled through a new set of inventions seen as “regulatory controls: a bio-politics of the population” (Foucault, 1990, p. 139). These two mechanisms, the
disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed (Foucault, 1990).

The setting up of this “great bipolar technology” began the continuing era of “bio-power” (Foucault, 1990, p. 139). No longer could power be constituted only in the negative, that of sovereign’s right to kill, but this power of domination now was slowly being substituted with a bio-power, a power constituted as a positive, an “investment in life through and through” (Foucault, 1990, pp. 139-140).

The proliferation of bio-power throughout the eighteenth and nineteenth centuries cannot be viewed in isolation with the development of capitalism. Within capitalism, the trilogy of labor, capital, and property depended upon primarily the human element of labor and also presented unique problems for the state. The success of capitalism could not prevail without the “controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes” (Foucault, 1990, p. 141). This was not all that was necessary for sustainability of capitalism, “It also needed the growth of both of these factors, their reinforcement as well as their availability and docility; it had to have methods of power capable of optimizing forces, aptitudes, and life in general without at the same time making more difficult to govern” (Foucault, 1990, p. 141).

Within the state, consistent with the development of apparatuses (institutions of power) to sustain productive relations, there can be seen a transparency of “rudiments of anatomo- and bio-politics, created in the eighteenth century as techniques of power present at every level of the social body and utilized by very diverse institutions…”
operated in the sphere of economic processes, their development, and the forces working to sustain them” (Foucault, 1990, p. 141). To be clear, there were not just positive outcomes of these influences, there were also negative aspects as well. For example, a potent side-effect to these bio-politics influences was the structuring of segregation and social hierarchy, guaranteeing relations of domination and effects of hegemony (Foucault, 1990).

Societal transformation, to be sure, resulted from bio-power, a biological existence that was reflected in a political existence as bio-political. Viewed from a bio-history perspective, bio-power accounts for what “brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life” (Foucault, 1990, p. 143). Foucault (1990) asserts that “society’s ‘threshold of modernity’ has been reached when the life of the species is wagered on its own political strategies” (p. 143).

Another important consequence of the development of bio-power was the growing emphasis of its effect on “action of the norm” (Foucault, 1990, p. 144). This normalizing effect was delivered at the expense of the juridical system of laws, in that a transition from sovereignty armed with the right of death gave way to a power tasked to take charge of life needs through continuous regulatory and corrective mechanisms: “its effects [italics added] distributed around the norm” (Foucault, 1990, p. 143).

The result of such transition defines the role of the judicial as increasingly regulatory in nature resulting in a normalizing society. Foucault (1990) points out that “a
normalizing society is the historical outcome of a technology of power centered on life” (p. 143). As a result of bio-power, Foucault writes:

Western man was gradually learning what it meant to be a living species in a living world, to have a body, conditions of existence, probabilities of life, and individual and collective welfare, force that could be modified, and a space in which they could be distributed in an optimal manner. For the first time in history, no doubt, biological existence was reflected in political existence (Foucault, 1990, p. 142)

Foucault identifies many perspectives of bio-power, but of particular interest in this study are the effects of discipline and regulatory mechanisms evident in the practices of health and healing within various contexts of health and illness systems in the United States. Gastaldo (1997) defines bio-power, in a similar study on health education, as “the mechanisms employed to manage the population and discipline individuals” (p. 113).

The use of disciplining, regulatory mechanisms, and normalizing techniques are intrinsic to the very functioning of disciplines such as nursing, medicine, and social work, institutions such as hospitals, clinics, and public health, health policies such as Medicare, Medicaid, and the Healthy People 2010 Initiative. The question is, does bio-power described by Foucault as emerging and developing from the seventeenth through the nineteenth centuries apply to current problematics related to the twenty-first century? More specifically, is it germane to the health and illness care systems in the United States? Many contemporary Foucauldian theorists contend that bio-power is as pertinent as originally described with the following caveat: it has increasingly confounding
complexity (Barry, Osborne, & Rose, 1996; Dean, 1999a; Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2002; Petersen & Bunton, 1997; Petersen & Lupton, 1996).

Broadly speaking, disciplining, regulatory mechanisms, and normalizing techniques are theoretical elements of bio-power that can be collectively described as governance. I will subsequently expand this framing as well as describe and link the tenets of risk to create the theoretical perspective for this discourse analysis.

**Government, Governmentality, and Risk**

**Government**

The term ‘government,’ as Foucault presents, is not understood in the same syntax of everyday language—as political authority or the state viewed as ruler—but rather as the *conduct of conduct* (Gordon, 1991, p 2; Foucault 1982, pp. 220-221). This dual understanding of government in both a wide and narrow context—broadly, conduct as activity aiming to shape, guide or affect the conduct of some person or persons—and specifically, conduct as activity concerning the relationship between self and self, private interpersonal relationships involving some form of control or guidance, relations within social institutions and communities, and relations concerned with the exercise of political sovereignty (Gordon, 1991, pp. 2-3). Government encompasses not only how we exercise authority over others, or how we govern abstract entities such as states and populations, but also how we govern ourselves. Merging these understandings of *conduct* infers government as any attempt to shape, with some degree of deliberation, aspects of our behavior according to particular sets of norms and for a variety of ends—or rather
conduct in plurality (Dean, 1999, p.10). Dean further stipulates that the conduct of conduct can be expanded:

Government is any more or less calculated and rational activity, under-taken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs, for a definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes. (1999, p. 11)

Government in this sense involved not as a means to order people about or to move things around—but expressly involved in the attempt to deliberate on and to direct and shape human conduct rationally (Dean, 1999, p.11).

Beginning with Kant (Foucault, 1982), and especially since Weber (1985), we have known that there is no single rationality or reason that acts as a universal standard to judge all forms of thought: that what we understand as reason today is only a particular artifact of Western society. Since Foucault, we know that there is a multiplicity of rationalities, of different ways of thinking in a fairly systematic manner, of making calculations, of defining purposes, and employing knowledge (Dean, 1999, p.11).

This rational attempt to shape conduct infers another dimension of government—moralties—in the sense of an attempt to make oneself accountable for one’s actions, or as a practice in which human beings take their own conduct to be subject to self-regulation (Dean, 1999). Notions of morality, standards of conduct that are accepted in society as right or proper, and ethics, the study of morality’s effect on conduct, are deemed to be ideals of self-government. Not only can the practice of the self act as
instruments in the pursuit of political, social, and economical goals, but it may also be a means to resist other forms of government. If morality and ethics are linked to government in this way, questions of freedom follow. Government is an activity that shapes the field of actions and thus attempts to shape freedom. Government as conduct of conduct incorporates the idea that the one governed is an actor and therefore a locus of freedom, one that precedes and establishes a presupposition of these freedoms and capacities inherent in and incumbent on those that govern (Dean, 1999).

**Governmentality**

Governmentality is the term Foucault uses to describe the origins of governmental rationality in western societies. It depicts the historical development of subjectivity in terms of government as the ‘conduct of conduct’ in a narrow sense—from a form of activity aiming to shape, guide or affect the conduct of some person or persons—to more broadly, government as an activity concerning the relation between self and self, private interpersonal relations involving some form of control or guidance, relations within social institutions and communities. In the broadest sense, it is the relations concerned with the exercise of political sovereignty (Foucault, 1991a; Gordon, 1991, pp. 2-3). Specifically, Dean stipulates that “governmentality seeks to distinguish the particular mentalities, arts and regimes of government and administration that have emerged since ‘early modern’ Europe” (Dean, 1999a, p. 2).

In presenting the genealogy of governmentality it is necessary to briefly revisit Antiquity-Early Modern histories to understand how Modern governmental rationalities developed into the realization of what Foucault calls the ‘daemonic’ coupling of ‘city-
game and ‘shepherd-game’: the invention of a form of secular political pastorate which couples ‘individualization’ and ‘totalization’ (Gordon, 1991, p. 8).

Community governed prior to states. The city-game has its origins in early Greek history whereby the object of rule was the city, conceived as a community of free citizens, within the larger political unity of the Empire. The objective was to nourish the city by doing ‘good for it’ through acts of giving, deeds, or attention, and by these actions, to establish oneself as a noble and memorable being. The beneficiaries of rule were the citizenry, with the relationship of the ruler to the ruled being a firm solidarity that a free citizen feels towards his fellow citizens, rather than a feeling of pity or charity (Dean, 1999a, p. 78).

Likewise, it is essential to understand the privileged aspect of the city-game citizenry which can be understood through specific criteria of qualification such as living in a defined territory with specific membership in a citizen family or being identified as belonging to a recognized civic group. Devoid of this citizenship were those who lived beyond the boundaries of the city, those who were the faceless refuse of the ancient economy, immigrants from the countryside and smaller towns, and refugees from war. These people were not the benefactors of citizenship but rather of systematic exclusion. The ‘city-citizen game’ implied the careful cultivation of a set of attributes and a form of moral personality on the part of the ruling class—attributes that involved a particular relation to oneself, manifested in a particular demeanor which was both physical and ethical. This demeanor entailed specific relationships to others: to other members of the ruling class, to the city and its citizens, and to those who were outside its limits. Most
importantly, nourishment of the city was the central objective or mechanism (Dean, 1999a, p. 79).

The shepherd-game originates in late Antiquity of the fourth century, when early Christian thought became modified along the following three themes (Dean, 1999a, p. 75). First, the shepherd becomes accountable for the actions of all through complex and moral ties binding the shepherd and the members of his flock. Second, obedience comes to be understood as a key virtue for all. The members of the Church are bound to the shepherd’s will in a relation of complete dependence, by obeying the shepherd not because it is the law but because it is his will. Third, the shepherd requires in-depth individual of knowledge of each member of the flock, through a knowledge of the needs and deeds, and the contents of the soul (Dean, 1999a, p. 75).

The claims of moral leadership of the Church in the fourth century was bound to the radical asceticism of the anchorite monks rooted in the authority of the desert and the marginalized populations of the ancient economy, and in the claim of almsgiving, of the new Christian notable, the bishop, whose focus was ‘lover of the poor’ (Dean, 1999a, p. 79). This relation to the poor and the sick was a component of the Christian love commandment: first love God, and then, as a reflection of that love of God, love thy neighbor as thyself. Christian love found one of its expressions in the command to practice ‘good works’ in atonement for sin. This movement beyond exemplary good works included acts ranging from self-abasement and self mortification to the establishment of philanthropic institutions (Dean, 1999a, p. 79).
Pastoral power. Foucault’s genealogically derived notion of care of the welfare of citizens is situated in the ‘demonic coupling’ (forced union of dissimilar entities) of the ‘city game’ and the ‘shepherd game’—the invention of a form of secular political pastorate which couples ‘individualization’ and totalization’ (Gordon, 1991, p. 8). What does this notion comprise and how is it manifested?

As Dean stipulates, “it is hardly contentious to argue that one key source of a concern for the welfare of individuals and of populations, of each and all, is to be found in the development of the pastoral techniques of government in Christianity” (1999a, p. 74). On the other hand, remnants of the ‘city game’ are still evident in the Western world’s conception of sovereignty and the resulting mechanisms of law and juridical systems.

Foucault’s opposition between the city-citizen game and the shepherd-flock game portrays a contention that is more complex than a polarization of different philosophies, sets of beliefs, or ideology. What can be understood is that the city-citizen game and the shepherd-flock game are embroiled in practices for the government of the conduct of self and others. These oppositions are not based on principles but, rather, on different forms of ethical self-government (cultured deportment contrasted with Christian asceticism), different forms of moral personality (the noble, the bishop, the monk), and different sets of ethical obligations embodied in giving (lover of the city verses lover of the poor) (Dean, 1999a, p. 81).

Pastoral power is inextricably linked with a notion of the living individual and his or her needs, with the relation between the collective and the individual, with notions of
obedience and duty, with knowledge and, most importantly, with the idea of salvation. In addition, the exercise of pastoral rule rests on a specific conception of the potential inclusion of all humankind within the community, the solidarity of rich and poor, and the duty of almsgiving (Dean, 1999a, p. 82).

By contrast, the ancient city in not simply a community of free and equal citizens but a form of systemic exclusions (of the marginalized, of women, of slaves) from the rights and prerogatives of citizenship. The duties of rulers are to fellow citizens as members of the city rather than to all souls as God’s creatures. The appropriate attitude of the rulers is of patrician pride and the relation to the ruled that of hardened solidarity of free citizens (Dean, 1999a, p. 82).

Dean suggest that these two viewpoints can be expressed at the end of the twentieth century as a genealogy of the welfare state resulting from this demonic coupling of the two different ways of conceiving the government of the political community embodied in the shepherd-flock game and the city-citizen game (1999a, p. 82).

This tension is expressed as demonic coupling of:

- the individual as citizen who exercises freedom and rights within the legal and political structure of the political community on the basis of equality with other citizens, and,
- the individual as a living being whose welfare is to be cared for as an individual and as a part of a population, as one who must be integrated within complex forms of social solidarity (Dean, 1999a, p. 82)
If most modern conceptions of politics refer back to the ancient model of the *polis*, then most modern conceptions of government and administration refer back to the model of the pastorate (Dean, 1999a, p. 83).

*Reason of the state and police.* Following the establishment of the pastorate power as a mechanism of government of late antiquity, the emergence of doctrines of reason of state began in sixteenth-century Europe with the identification of governmentality as an *autonomous* rationality (Gordon, 1991, pp. 8-9). This was made possible because the principles of government were no longer part of and subordinate to the divine, cosmo-theological order of the world, but rather, principles of the state are imminent, precisely to the state itself (Gordon, 1991, p. 9).

Foucault offers a genealogy representing the development of *rationality of government* spanning the sixteenth through the eighteenth century that are specific to the western world. Marching forward from the Middle Ages and classic antiquity, there are innumerable texts which are seen as “advice to the prince,” concerning his proper conduct, the exercise of power, the means of securing the acceptance and respect of his subjects, the love of God and obedience to him, as well as the application of divine law to the cities of men (1991a, p. 87).

As previously introduced, government seen as “government of oneself”, the “government of souls and lives, the entire theme of Catholic and Protestant pastoral doctrine”, “government of the family, children, and pedagogy”; what remains is a discussion of the role of government of the state by the prince (Foucault, 1991a, p. 87). Historically and schematically, how to govern oneself, how to be governed, how to
govern others, by whom the people will accept being governed, how to become the best possible governor—are the result of two processes. First, the one which shatters the structures of feudalism and leads to the establishment of the great territorial, administrative, and colonial states; and second, the totally different movement, which, with the Reformation and Counter-Reformation, raises the issues of how one must be spiritually ruled and led on this earth in order to achieve eternal salvation (Foucault, 1991a, pp. 87, 88). It is at this juncture, state centralization on one end and of dispersion and religious dissidence on the other, that the problem of government becomes intensified—how to be ruled, how strictly, by whom, to what end, by what methods—a problematic of government (Foucault, 1991a, p. 88).

Foucault offers up a single text that best depicts this tension: Machiavelli’s ‘The Prince.’ This text initially was embraced during the sixteenth century, but by the beginning of the nineteenth century was understood in anti-Machiavellian terms. What comprised this conception of the prince, and how did this rationalization change over these two decades?

*The Prince* was characterized by one principle: “for Machiavelli, it was alleged, the prince stood in relation of singularity and externality, and thus of transcendence, to his principality”, while at the same time, developing the art of manipulating relations of force that would allow the prince to ensure the protection of his principality, understood as the link that binds him to this territory and his subjects (Foucault, 1991a, p. 90). In short, it was a treatise about the ability of the prince to keep his principality. The anti-Machiavellian literature was posed to replace this mode of ‘holding out’ with an
emerging art of government. The art of government therefore was a developing form of rationality that was intrinsic to itself, separate from problematic of the prince and of his relationship to the principality of which he was lord and master (Foucault, 1991a, p. 89).

Understanding of the practical terms “to govern” and “governor” (who governed, how, and by whom) was defined in the anti-Machiavelli literature as signifying a role such as “monarch, emperor, king, prince, lord, magistrate, prelate, judge and the like” as well as a process of “governing” a household, souls, children, a province, a convent, a religious order, a family (Foucault, 1991a, p. 90). What was emerging was an understanding of the process of ‘governing” as multifarious and involving many kinds of people as juxtaposed to the prince (or governor) as occupying a position of externality and transcendence to the principality as occupying one particular mode, whereas all these other kinds of government are internal to the state and society (Foucault, 1991a, p. 90).

The doctrine of the prince and the juridical theory of sovereignty are constantly attempting to delineate the power of the prince and any other form of power due, in part, because of its task in explaining and justifying this essential discontinuity between them. The art of government as a functional task is to establish a continuity in both an upwards and a downwards direction as depicted by the art of self government, connected with morality; the art of properly governing a family, which belongs to economy; and finally the science of ruling the state, which concerns politics (Foucault, 1991a, p. 91).

The upward continuity implies that a person wishing to govern must first learn how to govern himself, his goods and patrimony, after which he will be successful in governing the state, seen as a pedagogical formation of the prince. Conversely, a
downward continuity exists when a state is well run; the head of the family will know how to look after his family, his goods and his patrimony, which means, in turn, that individuals will behave as they should (Foucault, 1991a, p. 92).

Reason of the state was seen primarily in terms of its internal operation based on the government of the family. Whereas the upward continuity was understood in terms of pedagogical formation of the prince, the downward continuity was beginning to be identified as police science. The advent of police science, based on internal set of techniques and rationality were evolving as both the condition of order in the community and ordinances that sought the institution and maintenance of that order (Dean, 1999a, p. 99). The range of activities which police science encompassed was the expectation of an orderly, modest, courteous and respectful fashion of daily living tempered by guidance and instruction, and ensured by oversight and enforcement.

A central feature of *reason of state* was summarized by Foucault in the following terms:

First, it is government by reference to reason alone. It is a rational ‘art’ of government—a specific, secular set of techniques conforming to rational rules. Reason of state makes reference neither to God nor strategies of the prince. Government has its own peculiar rationality.

Second, it has an art of government that requires that we take account of what is to be governed, namely the state. The state in this context is a kind of natural object despite the juridical concern with how it is constituted.
Third, the aim of reason of the state is to reinforce the state itself, its own strength, greatness, and well being, protecting itself from competition of other states and its own internal weakness. Reason of the state is concerned with the ‘holding out’ of the state itself rather than with the relation of sovereign to kingdom.

Fourth, this art of government presupposes a certain type of knowledge. This is the concrete, precise and measured knowledge of the strength of the state. (Dean, 1999a, p. 86)

*Art of government.* Situated at the beginning of the eighteen century, the framework of the sovereignty had become large, abstract, and rigid. Conversely, the art of government was weak and unsubstantial due, in part, to its reliance on the family model. As Foucault (1991a) points out, this family model as a means of an economy of enrichment “was unlikely to be able to respond adequately to the importance of territorial possessions and royal finance” (Foucault, 1991a, p. 98).

During this same time, the art of government was discovering problems related to a new concept: that of problems of the population as aggregate. The mechanism for this conceptualization was through the advent of statistics that henceforth became a fundamental instrument of government. It was in these events, unfolding slowly and deliberately, that the science of government (art of government), the re-centering of the theme of the economy on a different plane from that of the family, and the emergence of the population as singular domain, was realized to be related (Foucault, 1991a).
The net effect was the emergence of a science of government now separate from, but collateral to, the juridical framework of sovereignty (Foucault, 1991a). Within this framework, three specific net effects can be realized: first, the family as a mode of functioning as a model for the art of government was supplanted and functioned as an instrument of the population, second, the population comes to appear to all else as the ultimate end of government, and third, the population now represents more the end of government than the power of the sovereign and additionally, the acceptance of legitimacy by sovereignty of this development (Foucault, 1991a, p. 100).

Foucault (1991a) summarizes governmentality, the lineage of govermentalization of the state, as follows:

Accordingly, we need to see things not in terms of the replacement of a society of sovereignty by a disciplinary society and the subsequent replacement of a disciplinary society by a society of government; in reality one has a triangle, sovereignty—discipline—government, which has as its primary target the population and its essential mechanism the apparatuses of security. (p. 102)

Foucault (1991a) contends that we live in an era of governmentality, first discovered in the eighteenth century. Bio-power and governmentality frame the theoretical basis for governance in this discourse. What follows is development of the theoretical tenets of risk that arises within governmentality and because of governmentality.
Risk

Foucault did not specifically address the topic of risk in his work but a number of scholars have used governmentality, as an approach to social regulation and control, to analyze risks as a sociocultural phenomenon (Lupton, 1999a). Ewald’s (1991) definition of risk helps to set the context: “Nothing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyses the danger, considers the event” (p. 199). Risk becomes, as Dean (1999b) stipulates, “… a way—or rather, a set of different ways—of ordering reality, of rendering it into a calculable form” (Dean, 1999b, p. 131).

Risk can be implicated politically, whereby technologies of normalization are used in concert with expert knowledge to elicit specific purposes and outcomes. Viewed in this way, risks are made plausible within political agendas, where calculated risk are set to “master time, to discipline the future” (Ewald, 1991, p. 207).

Risk, developed through normalization, initially deflects attention away from individuals and their behaviors toward populations or aggregates. After this information is gleaned, it is then applied as advice to individuals as to how they should conduct their lives. Discourses on risk are directed at the regulation of the body: “how it moves in space, how it interacts with other bodies and things… contributing to the constitution of selfhood, or subjectivity” (Lupton, 1999a, p. 88).

Castel (1991), in his work on contemporary preventive strategies of social administration, suggests that these innovative “… strategies dissolve the notion of subject or a concrete individual, and put in its place a combination of factors, the factors of risk”
Additionally, the essential component of intervention no longer takes place as a direct relationship between “care-er and the cared, the helper and the helped, the professional and the client” (Castel, 1991, p. 281). “It comes instead to reside in the establishment of flows of population based on the collation of a range of abstract factors deemed liable to produce risk in general” (Castel, 1991, p. 281).

Castel (1991) makes a distinction between dangerousness and risk suggesting that the advent of privileging risk is attributable to our advanced industrial society. Dangerousness suggests an imminent quality of the subject, a potentiality that dwells within and may or may not be manifested. Therefore, the only evidence of dangerousness would be based on observation of a patient’s present symptoms and speculations about what these might mean for future behavior. People judged to be insane could be seen as carrying this potentiality for dangerousness within them, despite their otherwise benign exteriors. They could subsequently be treated with such preventive strategies as confinement from the rest of the society (Castel, 1991).

However, risk, by contrast, accumulates and acknowledges through systematic statistical correlation and probabilities based on populations rather than the close observation of individuals. Risk can be seen as more selective and precise, but at the same time applies to a larger group of people than the notion of dangerousness. “A risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behavior” (Castel, 1991, p. 287).
While appearing benign when analyzed as a singular example, one might ask: What are the cumulative consequences of subsequent risks layered on ones’ subjectivity? Would risk continue to have a disciplining effect? Is there a threshold beyond which risk would have negative consequences? These are questions, I believe, that merit additional scrutiny.

To be designated “at risk” as part of a “risk population” or “risky population” based on a “risk profile” has to have consequences on subjectivity. Castel (1991) notes: … that the shift from dangerousness to risk entails a potentially infinite multiplication of the possibilities for intervention. For what situation is there of which one can be certain that it harbors no risk, no uncontrollable or unpredictable change factor” (Castel, 1991, p. 289)?

While Castel’s (1991) dangerousness and risk analogies can be seen as a homogeneous approach to contemporary western societies, Dean (1999b) suggests that there are three types of risk rationalities that have developed in our current western, neoliberal society. These include insurance risk, epidemiological risk, and case management or clinical risk. These three types of risks are characterized as unique because of the specific calculations and rationalities that define them as well as the specific nature they employ.

In terms of insurance risk, Ewald (1991) suggests insurance is not initially a practice of compensation or reparation. It is the practice of a certain type of rationality that is formalized by the calculus of probabilities. There are three distinct conditions to be met in the process of insurance:
1. Risk is calculable: for an event to be a risk, it must be possible to evaluate its probability. Insurance has a dual basis; first, the statistical table which establishes the regularities of events; and second, the calculus of probabilities applied to that statistic, which yields an evaluation of the chance of that class of event actually occurring.

2. Risk is collective: whereas an accident, as damage, misfortune and suffering is always individual, striking at one and not another, a risk of accident affects a population. Strictly speaking there is no such thing as an individual risk; otherwise insurance would be no more than a wager. Risk only becomes something calculable when it is spread over a population.

3. Risk is capital: what is insured is not the injury that is actually lived, suffered and resented by the person it happens to, but a capital against whose loss the insurer offers a guarantee. (Ewald, 1991, pp. 199-204)

Dean (1999b) defines epidemiological risk as follows:

Epidemiological risk is concerned with the rates of morbidly and mortality among populations. It is similar to insurance risk in that the calculus of risk is undertaken on the basis of a range of abstract factors and their correlation within populations and, indeed, can be linked to insurance risk in public and private practices of health insurance. However it has its own distinctive rationality and set of techniques and interventions. It is not the losses of capital but the health outcomes of populations that are subject to risk calculation. (1999b, p. 142)
Case management risk is distinct from insurance risk and epidemiological risks in that it is expressly qualitative in nature. Dean (1999b) suggests:

Case management risk is linked to a clinical practice in which certain symptoms lead to the imputation of dangerousness. Here risk concerns the qualitative assessment of individuals and groups, especially families, as falling within ‘at risk’ categories. Those judged ‘at risk’ of being a danger to the wider community are subject to a range of therapeutic and disciplinary practices in an effort to eliminate them completely from communal spaces or to lower the dangers posed by their risk. (Dean, 1999b)

These three risk technologies represent an extensive matrix surrounding the contemporary functioning of health and illness systems in late western societies, especially in the United States. Understand how these risk strategies are used as instruments will certainly facilitate comprehension into how individual subjectivities are lived within the context of health promotion and healing.

While not an exhaustive presentation of risk theory, I have outlined and defined tenets of risk that are most germane to the context of health and illness operating in contemporary society.

Research Question

The central research question for this historical discourse analysis is as follows:

How do practices of governance and risk operate in the context of a neoliberal society to construct subjectivity (identity) specific to the discourse of health promotion and healing?
Summary

In conclusion, chapter one describes the current dilemma of a poorly function health and illness system in the United States. Within this context, I have proposed governance and risk as a theoretical framing useful for conducting a historical discourse of how health promotion and healing practices of individuals are formulated and maintained so that alternative ways of thinking and acting may be explored. Additionally, rethinking the professional role of nursing in facilitating these practices will be examined extensively after the initial historical discourse analysis.
CHAPTER II

BRIEF HISTORIES

Discourse analysis involves three major components: context, discourse, and text. Two brief histories will be presented as background for this study. These two histories refer to the context, neoliberalism, and the focus of the discourse under study, health promotion and healing. Texts selections and approaches to analysis are presented in Chapter III.

Neoliberalism History

As a prologue to presenting neoliberalism, a description of liberalism which precedes this complex social functioning is essential. Liberalism first was understood in the late eighteenth century when discipline, sovereignty, and government emerged as separate but interrelated functions understood as three movements: government, population, and political economy (the science and technique of intervention of government in the field of the economic) (Dean, 1999a; Gordon, 1991). Governmentality is the descriptive term representing these developments, and is seen as the understanding of how we govern ourselves and others in the contemporary world. The structure and functioning of governmentality must be viewed as an antecedent to liberalism understood as a critique as well as an art of government (Barry, Osborne, & Rose, 1996; Dean, 1999a).

Liberalism

Liberalism is approached historically neither as a coherent set of ideas nor as a definite institutional structure. A more accurate framing would include, not a philosophy
based on the “rule of law” and the protection of individual rights and freedom against the unnecessary encroachments of the state, but rather as a critique, a characteristic way of posing problems against the previous forms of government it wishes to distinguish itself from (Harvey, 2005). This means, historically, that targets of liberalism have changed over time. Dean (1999a) suggests that “at the end of the eighteenth century, it was notions of ‘reason of the state’ and police; at the end of the nineteenth century, it was earlier forms of liberalism; after the Second World War in Europe, it was forms of national and state socialist totalitarianism; at the end of the twentieth century, it includes not only the ideal of a welfare state but also the very concept of the nation-state” (p. 49).

Liberalism can be seen as the critique of state reason understood as advocating for limits of sovereignty and the pedagogy of sovereigns and statesman. These limits can be understood as the concerns of what is possible to know and shape at will, and the state actions concerning the nature of political subjects who are individuals with rights, desires, needs, and interests that cannot be dictated by governments (Dean, 1999a, p. 50).

An understanding of the reality to be governed is situated among several processes that are both necessary to the ends of government and not directly visible to the agents of sovereignty. These processes can be understood as both autonomous and overlapping spheres of the economy, population (bio-political) and civil society. A key component of liberalism as an art of government is to find a set of political norms that can balance the competing imperatives derived from knowledge of the processes that constitute these spheres (Dean, 1999a).
For liberalism as an art, the balance as to what circumstances and in what combination to allow play of the forces of the market, the afflictions of families, the sympathies of community, and the laws of population, and when to intervene to protect and invoke the rights and liberties of individuals that are vital to securing such processes. Liberalism is an art of government not only because it is recognized that there are limits to the role of the state but because of what is determined as falling outside the political sphere is itself necessary to the ends of government. Liberalism in these terms can be understood as the net effect or balance of the art of government situated in temporal dialogical tensions of critique (Dean, 1999a; Gordon, 1991).

**Social Liberalism or Welfare State**

Social liberalism, a variant of classical liberalism, developed in the late nineteenth and early twentieth centuries in response to the extreme economic depression of most of the western world (Barry, Osborne, & Rose, 1996). These developments coalesced from the failures of laissez-faire government and unfettered capitalism. Inherent in classic liberalism during this era was a two class society, the exploiter and the exploited. Elements of reform, or more accurately stated, shifts in art of government centered on acceptance of restrictions in economic affairs, such as anti-trust laws to combat economic oligopolies, and regulatory government such as minimum wage laws, intending to secure economic opportunities for all. A primary shift was the expectation that governments would provide a basic level of welfare or workfare, health and education, supported by progressive taxation. The intent was to enable the best use of talents of the population, perceived as serving the collective public good.
Like classic liberals, social liberals were intent on individual freedom and liberty situated as a central objective for government. What was unique was the belief that the lack of economic opportunity, education, health care, and most importantly equality were considered a threat to these liberties. Humanism conceptions informed these perspectives such as human rights and social justice and were held in check through an economy (in economic terms known during this era as a Keynesian balance) that ensured these values, and a state that provided public services that upheld social rights as well as civil liberties (Gordon, 1991). In descriptive terms, government was viewed as welfare-oriented interventionist state on behalf of a basic equality for all citizens.

Simultaneously with mechanisms of social insurance, that was an inclusive technology of government, was a surveillance of public norms. These norms were set in motion—legitimized by experts, rendered calculable in terms of norms and deviations, judged in terms of their social cost and consequences and subjected to regimes of education or reformation (Rose, 1996). The net effect was implanting techniques of responsible citizenship under the surveillance of experts and in relation to a variety of sanctions and rewards.

The political subject was reconstructed as a citizen with rights to social protection and social education in return for duties of social obligation and social responsibility, while retaining a liberal identity inclusive of democracy, freedom, and privacy (Dean, 1999a).
Neoliberalism

The last thirty years of the twentieth century experienced slow but deliberate changes to the balance of operations of governments and the interacting autonomous spheres of the economy, population and civil society. In the Western World, growing economic stagnation, ramped inflation of currencies, and war were the all-consuming realities of that era (Harvey, 2005). The growing argument was that the increasing levels of taxation and public expenditure to sustain social liberal programs of the welfare state were damaging the health of capitalism because of the excessive burden on private profit (Rose, 1996). A contradiction resulted with those situated on the Left delineating the problem as a “crisis of government, as opposed to those on the Right who viewed this situation as the growth of an “unproductive” welfare sector that created no wealth at the expense of the “productive” private sector in which all of the national wealth was actually produced (Rose, 1996, p. 51).

Dialogue and critique from the civil society sphere reframed the conceptualization of social solidarity inherent in social liberalism as mere techniques (expert knowledge and programs) of the state apparatuses to control individual freedom and liberties. What resulted from these tensions was the fragmentation of the place of experts and expert knowledge that were situated as the devices of social government. What emerged was a new formula for the relation between government, expertise and a new subjectivity (identity) centered on individual choice. Expert pedagogies were replaced by rapid-fire simple solutions outlined in mass media, marketing strategies deployed in commodity advertising, and consumption regimes (Rose, 1996).
Neoliberalism does not inherently abandon the “will to govern or be governed” but rather maintains a view that failure of government to achieve its objectives can be overcome by inventing new strategies of government that will succeed (Rose, 1996, p. 53). Rose (1996) outlines three transitions inherent in neoliberalism: first, a new relation between expertise and politics; second, a new pluralism of “social” technologies; and third, a new specification of the subject of government.

*New Relation Between Expertise and Politics*

Social liberalism or welfare can be considered a “substantive” rationality of rule: expert conceptions of health, income levels, and types of economic activity were transitioned into the mechanisms and objectives of government (Rose, 1996, p. 54). As a result, the powers that the technologies of welfare invested in experts and expert knowledge became unchallengeable because of the reign of truth claims over political positions. What evolved in neoliberalism was that the power once accorded to the positive knowledge of human conduct—transferred, over time, to the calculative regimes of accounting and financial management (Rose, 1996, p. 54).

The domains of experts and their knowledge were demystified through several new techniques for exercising scrutiny over authority primarily through the tools of budget disciplines, accountancy and audits (Harvey, 2005). The new lexicon—marketization seeks various forms of distance between the political and experts with their knowledge. This transition is seen as de-evolution of regulatory powers from “above”, constituted through planning and compliance to “below”, decisions made by consumers (Rose, 1996, p. 54).
The net effect of the deployment of these new tools of budgets, accounting and audits has been the displacement of the plurality and conflict of multiple truth claims of experts. In its place, security is instituted through “evidence based” protocols with practices and knowledge conceptualized as a “re-managing” of risk. Risk is rendered manageable by creating new grids of visibility for the conduct of organizations and those that inhabit them (Dean, 1999b; Rose, 1996, p. 55). Complexity and diversity of problems are no longer valued or respected, but rather decisions about risk are reduced to simplified choices inherent in criteria of efficiency, appropriateness, and effectiveness of markets (Dean, 1999a, 1999b; Rose, 1996, p. 56).

_A New Pluralization of “Social” Technologies_

A reconfiguring of the sphere of the social emerges from a welfare government situated since the late nineteenth century constituted as the social citizen within a common society to the responsible individual situated within a self-governing community. In detaching from centralized social government a displacement of norms inherent in expert knowledge as well as concepts of service and dedication have been supplanted with competition, quality, and customer demand (Rose, 1999, p. 56).

Through the reshaping of the social sphere, different networks of accountability and responsibility are reconfigured in fundamental ways. Former governmental programs are “privatized” such as “public” utilities—gas, water, electricity, prisons, police, as well as private bidding for social services such as Medicare and Medicaid. Methods of surveillance include contracts, targets, indicators, performance measures, monitoring and evaluation are used to govern their conduct while according them certain autonomy of
decision-making power and responsibility for their actions (Rose, 1996, pp. 56-57). The dispersing of social technologies from government to market rationalities is seen to be conducted through the economic sphere. Likewise, technologies of the reconfigured distant government are designed to facilitate, maintain, and promote these same economic realities (Harvey, 2005).

**A New Specification of the Subject of Government**

The enhancement of the powers of the client as customer—consumer of health services, education, or training—specifies the subject of rule in a new way: as active individuals seeking to “enterprise themselves”, to maximize their quality of life through acts of choice, creating meaning and value in life to the extent that wellbeing can be rationalized as the outcome of choices made or potential choices to be made (Rose, 1996, p. 57). Rose (1996) stipulates that:

Political reason must now justify and organize itself by arguing over the arrangements that are adequate to the existence of persons as, in their essence, creatures of freedom, liberty and autonomy. Within this new regime of actively responsible self, individuals are to fulfill their national obligations not through their relations of dependency and obligation to one another, but through seeking to fulfill themselves within a variety of micro-moral domains or “communities”—families, workplaces, schools, leisure associations, neighborhoods. Hence the problem is to find means by which individuals may be made responsible through their individual choices for themselves and those to whom they owe allegiance, through the shaping of a lifestyle according to grammars of living that are widely
disseminated, yet do not depend upon political calculations and strategies for their rationalities or for their techniques. (p. 57)

The actively responsible individual is made possible because of new apparatuses that integrate subjects into a moral connection of identifications and allegiances in the very processes in which they appear to act out their personal choices. Examples of these new pedagogies are: the new “fair and balanced” media, documentaries, soap operas, blogs, opinion polls and other internet links to perceptions of authority and subjects. These new knowleges regulate lifestyles through advertising, marketing and the world of goods, and most importantly, experts of subjectivity (self-help—you can be rich like me). These technological schema and mechanisms do not have there origins in “the state” but nonetheless enable government at a distance to translate goals of political, ideological, social, or economic authorities fashioned as choices in the preservation of freedom and liberty (Rose, 1996, p. 58).

What was historically apparent was the collapse of social insurance as the principal of social solidarity of social liberalism and, in its place, a privatization of risk management. This new form of prudentialism, an insurance against the future possibilities of unemployment, ill health, and old age, became a private obligation and affair (Castel, 1991; Dean, 1999b; Rose, 1996, p. 58). The active citizen incorporates the obligation of adopting a calculative prudent personal relation to fate through calculable dangers and avertable risks. Individuals are to become “experts of themselves”, to adopt an educated and knowledgeable relation of self-care with respect to their bodies, their minds, their forms of conduct (Rose, 1996, p. 58)
Neoliberal political regimes enacted an array of measures to reduce benefits for those out of work, to discipline delinquents and law breakers, and impose personal responsibility upon them, to reverse the infrastructure of institutions within which welfare government has attempted to manage social problems. Neoliberal programs responded to the less privileged as if they were the author of their own misfortune—the disadvantaged individual has come to be seen as potentially and ideally an active agent in the fabrication of their own existence (Rose, 1996, p. 59).

Neoliberal thinking conceptualizes:

those “excluded” from the benefits of a life of choice and self-fulfillment are no longer merely the passive support of a set of social determinants: they are people whose self-responsibility and self-fulfillment aspirations have been deformed by the dependency culture, whose efforts at self-advancement have been hindered for so long that they suffer from “learned helplessness”, whose self-esteem has been destroyed. (Rose, 1996, p. 59)

It follows that the less fortunate are to be assisted not through charity and welfare checks, but through their engagement in a whole array of programs for their ethical reconstruction as active citizens—training them to equip themselves with the skills of self-promotion in order to restore their sense of self-worth and self-esteem, thus empowering them to assume their rightful place as the self-actualizing and demanding subjects of a neoliberal democracy (Rose, 1996, p. 60).
Governance and the Context of Neoliberalism

Because Foucauldian genealogies of governance describe the art of government in a liberal context, the question may be logically posed: are they applicable in a contemporary neoliberal world? Following are arguments present by Lemke (2001), based on Foucault’s university lectures, that establishes the congruence of mechanisms of governance with neoliberalism rationalities. The next section is a brief review of governance followed by a discussion of its expanded applicability.

Governance vs. Critique

The *art of government* denotes *how* governance is manifested through techniques and technologies in which *risk* is but one, although essential, technology deployed in health promotion and healing rationalities. Insights about governance are indispensable because they facilitate understandings of how “we have arrived where we are today” with regard to the performance of health promotion and healing behaviors in society. We have transitioned from social liberalism in which societal functioning was understood in egalitarian terms (equal access to health care, resources, and knowledge) with social justice and social ethics as cornerstones of practices, to that of contemporary society realities “the era of the individual” in which most decisions are congruent in terms of the markets, with rationalities understood through market justice and market ethics.

Analysis from the perspective of governance through *the art of government* is understood to be empirical, problem-centered, and present-oriented. This standpoint is distinguished from that of *critique* found in critical theory wherein theoretical legitimatization regarding structures of society are evaluated from the perspective of
striving to correct current realities with theoretical ideals or ideal types. Further, the primary agenda of critique focuses on criticizing outcomes and usually bypasses or minimizes how society’s mechanisms actually function, thus masking underlying relationships and motives that may not be easily apparent. These “unexposed” operations of structures of society most often expose fallacies inherent in theoretical ideals.

This analysis was conducted from a governance frame of reference (governance with risk as a technology of governance) to include the challenge of keeping separate a critique from a critical theory perspective. Specifically, I was primarily analyzing governance practices, processes, and functioning through understanding the art of government, not results, outcomes, or effects. However, in most cases, processes of functioning or the art of government require some discussion about results and outcomes. This task is difficult given that the documents being analyzed were framed in a modernist reality-ideal scenario in which ideal outcomes were the assumption and focus. For example, from the documents of Healthy People 2000, 2010 the data suggest that we are at some particular level of health regarding indices X and Y, and given the perspective of science, we can do much better by scrutinizing behavior alpha and bravo. These recommendations of solutions for improvement include some aspect of behavioral change (most always a micro-determinant of health) without substantially understanding how a particular health behavior functions, is constructed, or inhibited within the broader context of society.
Governance

The term “government” that Foucault re-introduced is not the contemporary definition understood as solely a political meaning, but rather a historical definition of government that foreshadows the close link between forms of power and processes of subjectification (Foucault, 1982). Historically, government was a term discussed not only in political terms, but also in philosophical, religious, medical and pedagogic texts. In addition to the management by the state or the administration, “government” also signified problems of self-control, guidance for the family and for children, management of the household, directing the soul as well as the “governing of others” by the professional disciplines (Dean, 1999a; Foucault, 1982; Lemke, 2001). Government is best expressed in the “conduct of conduct” understood as a range from “governing the self” to “governing others” (Foucault, 1991a).

Power can be seen as foremost about guidance and governing the forms of self-government, structuring and shaping the field of possible actions of subjects (Foucault, 1982). The concept of power as guidance does not exclude consensual forms of power, or power that resorts to violence, it signifies that coercion or consensus are reformulated as means of government among others, they are “elements” or “instruments” rather than the “foundation” or “source” of power relationships (Foucault, 1982, 1991a; Lemke, 2001).

Governmentality Revisited

Governance is a broad term that embodies the collective practices of governmentality through a multiplicity of deployments of “the art of government”. The term governmentality was derived by Foucault to enjoin the semantic linking of
governing ("gouverner") and modes of thought ("mentalité") to indicate that it is not possible to study the technologies of power which are inherent in the art of government without analyzing the political rationality underpinning them (Lemke, 2001).

Governmentality can be understood as a historical continuum of types of society presentations characterized as three subsequent heterogeneous realities of power relations spanning Ancient Greece to modern neo-liberalism. Their subsequent emergence did not supplant the previous form, rather their relevance continues, exacting increasing complexity. These multiple societies are understood as the society of sovereignty or the state, the society of discipline, and the society of government. The history of governmentality reflects on how the modern sovereign state and the modern autonomous individual co-determine each other’s emergence (Foucault, 1982; Lemke, 2001).

Governmentality represents an understanding wherein the “autonomous” individual’s capacity for self control is linked to forms of political rule and economic exploitation. This mode of power does not represent subjectivity primarily viewed as “docile bodies” but rather the notion of government is utilized to investigate the relations between technologies of the self and technologies of domination (Foucault, 1982).

Foucault (2003a) describes these technologies of the self as those “which permit individuals to affect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immorality” (p. 146).
Techniques of domination and techniques of the self do not operate in isolation. On the one hand, the understanding is how technologies of domination of individuals over one another have an alternative processes on which the individual acts on themselves. On the other hand, individuals must account for techniques of the self that are integrated into structures of coercion and domination (Foucault, 1982). “Government” is the fluid conversion point where these technologies of domination and technologies of the self converge (Foucault, 1991a).

Another facet of governmentality is government. In deriving the concept of government in terms of the historical origins of its operation, Foucault introduces a differentiation between power and domination situated between the “relationships of power as strategic games between liberties—strategic games that result in the fact that some people try to determine the conduct of others—and the state of domination, which are what we ordinarily call power (Foucault, 1988b, p. 19). Foucault (1988b) identifies three levels or types of power relations: strategic games between liberties, techniques of government, and levels of domination.

Power as strategic games is an ever-present feature of human interaction, expressly as it signifies structuring the possible field of action of others. This may manifest as ideological manipulation or rational argumentation, moral advice, or economic exploitation, but it does not necessarily mean that power is exercised against the interests of the inverse of a power relationship. Expressly, it does not imply that to determine the conduct of others is fundamentally “bad.” Moreover, power relations do not always result in a removal of liberty or options available to individuals, rather, power
can be understood as a move of “empowerment” or “responsibilisation” of subjects, forcing them to “free” decision-making in fields of action (Lemke, 2001).

Power as techniques of government is indicative of systematized or regulated “technologies” that go beyond the spontaneous exercise of power over others, by constructing a specific form of reasoning or rationality which defines the purposeful actions or the adequate means to achieve it. It may be understood that disciplinary power and sovereign power are not reinterpreted as opposite forms of power but as different technologies of government (Lemke, 2001).

Power as domination is a power relationship that is stable, hierarchical, fixed and difficult to overturn. Foucault reserves the term “domination” for “what we ordinarily call power” (Foucault, 1988b, p. 19). Domination refers to those asymmetrical relationships of power in which the subordinated persons have little room for maneuver because their margin of liberty is extremely limited” (Foucault, 1988b, p. 12). States of domination are not the mutually exclusive source for holding power or exploiting asymmetries, but rather they are the effects of technologies of government. Technologies of government account for the systematization, stabilization and regulation of power relationships that may lead to a state of domination (Dean, 1999a).

Neoliberalism and Governmentality

Governmentality was described by Foucault (1991a) spanning the eras of classic liberalism, liberalism, and social-liberalism. A legitimate question may be posed: Is governmentality still applicable in our current neoliberalism era—the era of problematization of the welfare state with its features of bureaucracy, rigidity and
dependence formation? Critique, especially from critical theory, offers the following three arguments about neoliberalism: as ideology, as an economic political reality, and as practical anti-humanism (Barry, Osborne, & Rose, 1996; Harvey, 2005; Lemke, 2001).

_Ideology_

First, neoliberalism is sometimes treated as a manipulative “wrong knowledge” of society and economy, which has to be replaced by “right knowledge” or as a means of emancipation, which implies a scientific or “impartial” knowledge. Often, criticisms focus on “inherent contradictions” or the “faulty theory” of neoliberalism that could not stand the light of the “true” laws of society and “real” mechanisms of politics (Lemke, 2001). This “right—wrong” dichotomy is seen as neoliberalism as ideology.

Lemke (2001) suggests that the first important aspect of the concept of governmentality is that it does not contrast politics and knowledge but articulates a “political knowledge”. It concentrates on the mechanisms of the legitimization of domination or the masking of violence; beyond that, it focuses on the knowledge that is part of the practices, the systematization and “rationalization” of the pragmatics of guidance (government). In this perspective, rationality does not refer to a transcendental reason, but to historical practices; it does not imply normative judgment since it refers to social relations (Barry, Osborne, & Rose, 1996; Lemke, 2001).

_Economic Political Reality_

Second, some critics see in neoliberalism the extension of economy into the domain of politics, the triumph of capitalism over the state, the globalization that escapes the political regulations of the nation-state. This conclusion is followed by the following
solution: The (defensive) strategy aims to “civilize” a “barbaric” capitalism that has nowadays gone beyond control. The emphasis is now placed on deploying a re-regulated and re-embedded economy by the political sphere (Lemke, 2001). These tensions identify neoliberalism as an economic political reality.

The concept of governmentality also proves to be useful in correcting the diagnosis of neoliberalism as an expansion of economy into politics, that takes for granted the separation of state and market. The argument goes that there is some “pure” or “anarchic” economy that can be “regulated” or “civilized” by a political reaction of society. But as history has proven, there is no market independent of the state, and economy is always political economy. The problem with this critique is that it shares the neoliberal program of separation between politics and economy (Lemke, 2001).

The perspective of governmentality makes possible the development of a dynamic form of analysis that does not limit itself to starting the “retreat of politics’ or the “domination of the market” but deciphers the so-called “end of politics” as a political program (Lemke, 2001). Foucault (1991a) shows that the art of government is not limited to the field of politics as separate from economy; instead the constitution of a conceptual and practically distinguished space, governed by autonomous laws and a proper rationality, is itself an element of “economic” government. Furthermore, Foucault’s discussion of neoliberal govermentality shows that the “retreat of the state” is in fact a prolongation of government; neoliberalism is not so much the end but rather, a transformation of politics, that restructures the power relationships in society (Barry, Osborne, & Rose, 1996; Foucault, 1991a; Lemke, 2001).
Practical Anti-Humanism

The third line of criticism is leveled against endangering collective bonds, the imperatives of flexibility, mobility, and risk-taking that threatens family values and personal affiliations. This concern is neoliberalism as “practical anti-humanism” (Lemke, 2001). While many forms of contemporary critique still rely on the dualism of freedom and constraint, consensus and violence—from the perspective of governmentality, the polarity of subjectivity and power ceases to be plausible. Government refers to a continuum which extends from the political government to forms of self regulation—“technologies of the self” (Foucault, 2003a; Lemke, 2001).

These theoretical stances allow for a more complex analysis of neoliberal forms of government that feature not only direct intervention by means of empowering and specializing state apparatuses, but also characteristically develop indirect techniques for leading and controlling individuals. Lemke (2001) continues:

The strategy of rendering individual subjects “responsible” (including collectives, such as families, associations, etc.) entails shifting the responsibility for social risks such as illness, unemployment, poverty, etc., and for life in society into the domain for which the individual is responsible and transforming it into a problem of “self care”. One key feature of the neoliberal rationality is the congruence it endeavors to achieve between a responsible and moral individual and an economic-rational individual. It aspires to constructs responsible subjects whose moral quality is based on the fact that they rationally assess the costs and benefit of a certain act as opposed to other alternative acts. As the choice of options for
actions is, or so the neoliberal notion would have it, the expression of free will on the basis of a self-determined decision, the consequences of the actions are borne by the subject alone, who is also solely responsible for them. This strategy can be deployed in all sorts of areas and leads to areas of social responsibility becoming a matter of personal provisions. (p. 201)

**Summary**

The strategies inherent in social liberalism, or the “welfare state,” attempted to govern *through society*. Yet, as is evident in neoliberalism, the technologies deployed seek the possibilities of how it is possible to govern without governing society in any fashion. To be governed in this way, government from a distance, by many actors, elicits an understanding that regulated and accountable choices of autonomous agents operate through rules and limits of the market that comprise the economic sphere.

Governmentality is a legitimate framework for analysis of neoliberal mentalities. In fact, “the theoretical strength of the concept of governmentality is that it construes neoliberalism not as ideological rhetoric, a political-economic reality or practical anti-humanism, but as a political project that endeavors to create a social reality that it suggests already exists” (Lemke, 2001, p. 203).

Neoliberalism, the context in this study, offers unique challenges in sorting out potential interpretations of texts. Yet these insights are essential in accounting for current identity of health promotion and healing, prevalent in our contemporary society.
Health Promotion and Healing

A history of health promotion and healing can be understood through the writing of Judith Smith (1983), in her work titled The Idea of Health. Her inquiry was based on the “need for clarification of the idea of health” (p. vii). While explicitly stating that health is multifaceted and that the adoption of one model of health by nursing would be inappropriate and premature given the diverse nature of the discipline and the evolution that appears to be occurring within practice domain, Smith (1983) proposed four models of health which were viewed as “alternatives” (1983, p. 89). Furthermore, the idea of health could be envisioned as increasingly expansive, reflecting an idea of health as eudaimonia based on the classic definition of health from ancient Greek society (Smith, 1983). These four models of health are as follows: the clinical model, the role performance model, the adaptive model, and the eudaimonistic model (Smith, 1983). The unique characteristics of each of these models are explained.

The Clinical Model of Health

The clinical model of health is based on a model of physiological and psychological stability and homeostasis. Health is considered measurable via a continuum which has as anchors absence of signs and symptoms of disease or disability (health) at one extreme and presence of signs and symptoms (illness) at the opposite pole. The presence of disease or illness is an indication that the human organism has suffered from an irregularity or “derangement” originating from: failures in homeostasis, heredity, or intrusion of foreign substances (Smith, 1983, p. 40). “Aberrations” from the “norm”
are diagnosed, described, and verified by the health care professional and form the basis of professional medical practice (Smith, 1983, p. 35).

Health promotion and healing within the clinical model would be described as a series of prevention-centered activities, the goal of which would be avoidance of disruption or preclusion of aberrations within the normal state of homeostasis. Language such as primary, secondary, and tertiary would thus characterize the beliefs about the spectrum and scope of clinical health promotion, with healing described as curative in nature through which future aberrancies are prevented (Koithan, 1994, p. 35).

*The Role Performance Model of Health*

Health does not necessarily refer to adequate physiological and mental function of human beings based on a predetermined set of normative values. Health may also be interpreted within the social context of the defining person (Smith, 1983). The role performance model of health seeks to define health in terms of the ability of the person to fulfill a set of societal roles and functions. Roles are an implicit set of normative behaviors, set by society, which an individual is expected to fulfill for the good of self, family, friends, and society (Smith, 1983). These roles are “other determined” and predicated upon the person’s family life, occupation, and context of living (Smith, 1983).

Health is defined as the capacity, intent, and desire to perform roles as assigned by others with these behaviors judged by three characteristics: efficiency, endurance, and effectiveness over time (Smith, 1983, p. 51).

Health promotion and healing within the role performance model are centered on the elimination of role conflict and the return to assigned roles through the retrieval of
individual functioning capability. Healing strategies that assist the individual include clarification of role behaviors, definition of role expectations, delineation of societal assumptions and the negotiation of role changes and modifications. Health promotion interventions prepare individuals for the assumptions of appropriate roles based on prescribed characteristics mediated through socialization, education, and societal and cultural traditions as well as interpersonal relationships (Koithan, 1994, pp. 41-42).

Health promotion and healing are defined by the interaction of norms, traditions, and values of the dominant culture in society interfaced with the personal decisions and sociohistorical context of individuals by inferring preservation of self and societal stability (Koithan, 1994, pp. 41-42).

*The Adaptive Model of Health*

Adaptation is viewed as a continual process of change and growth which results in the positive outcome of equilibrium between person and environment. Adaptation occurs in two modes: first, as biological adaptation, wherein the human being, through complex biochemical and behavioral changes, develops positive responses to the organismic and non-organismic environments, and second, social adaptation, which results in environmental growth and change in response to people in society. Change occurs within these two systems via alternative, yet complementary, mechanisms: “passive acquiescence” or “maximal acceptance” as described in Social Darwinism (Smith, 1983, p. 60). Changes may be actively pursued so that both environment and human life are more conducive to happiness and health, however, neither system is stable.
with health understood as “the capacity of the individual to meet the ever-present threats” (Smith, 1983, p. 61).

The adaptive model incorporates the social as well as the physical environment expanding the narrow definitions of health promotion and healing outlined in the two previous models of health, with the net effect of becoming more adaptive across a spectrum of human behavior. Healing within the adaptation model of health infers a relationship between these two diverse phenomena. Healing of disease within an extension of the medical model that includes a comprehensive context of the person that is assessed and “adequately attended to” (Smith, 1983, p. 66). Strategies are seen as incumbent on addressing the physiological changes within the individual, including the physical and social environments.

Health promotion, as related to the phenomenon of disease, is seen as prevention. Preventive activities include a consideration of internal and external environmental systems and the creative alteration of ways that a person deals with “stressful situations and life events” (Smith, 1983, p. 66).

Adjustment and change are viewed as a natural “constant way of life”, a continual process directed toward change in an upward and forward movement in which the individual “tends to better his life physically, intellectually, and morally,” striving, but never fully achieving optimal health because of “continuous threats” (Smith, 1983, pp. 61-71). Because an “ideal” human life is inferred in this model, the sense of the “right” environment pervades the model (Koithan, 1994, p. 54).
The Eudaimonistic Model of Health

Smith (1983) offers the fourth model of health as a comprehensive idea of health. Eudaimonia concentrates on the “entire nature of the individual: physical, social, aesthetic, and moral instead of just certain aspects of human behavior and physiology” (p. 87). Smith (1983) also suggests that the three other models could be incorporated into this complex and comprehensive conception of health and that one could view the models developmentally, each representing an ideal of humanity. Health promotion and healing may include the transcendence of self, the ability to abstract, identify and describe values.

As the most comprehensive model of health, the eudaimonistic model defines health as harmony of the individual’s mind, body, and spirit through the process of self-actualization. Harmony of self allows the individual to strive for and achieve fulfillment of life’s greatest potentials—advancing ideal humanity, advancing civilization, and moral virtue to be pursued as readily as societal and individual justice (Koithan, 1994, p. 63).

Health promotion and healing behaviors challenge traditional and historical approaches to health. Roles broaden and diversify as facilitation of growth and development of the self-actualized person becomes the focus of care and therapeutic transactions shift from the “physical” to “congenial” environment, which supports the human in search of health (Koithan, 1994, p. 64).

Summary

I have discussed an overview of models of health as described by Smith (1983) in an attempt to frame how health promotion and healing practices are positioned not only
in the nursing discipline but other health professions as well. This brief history will be operationalized in the research question for this study:

How do practices of governance and risk operate in the construction of subjectivity (identity) specific to the discourse of health prevention and healing, operating within contemporary social life seen as realities of neoliberalism? After this analytical examination, I will discuss and critique these findings related specifically to nursing practices of health promotion and healing.
CHAPTER III

METHODOLOGY

This study was a historical discourse analysis of the practices of health promotion and healing understood through contemporary neoliberal society. An assumption of realities inherent in liberalism and neoliberalism is that there are limits, constraints, and legitimizing control imposed on societal functioning. It can be postulated because of these barriers, that possibilities exist regarding health promotion and healing which fall outside the mainstream rationalizations that may generate a renewed thinking. The methods derived for this historical discourse analysis were designed to understand how we have become what we are today so that we may expose ways to think and act differently regarding health promotion and healing. This may help us in recasting our identity or subjectivity regarding health promotion and healing.

Discourse analysis is the analytical examination of discursive and non-discursive practices that are expressed as discourses. Discourse can be described as an interrelated set of texts and practices of their production, dissemination, and reception, that brings an object into being (Phillips & Hardy, 2002, pp. 2-3). Discourse analysis is used to interrogate how language constructs phenomena, not how it reflects and reveals it. Specifically, “... it views discourse as constitutive of the social world—not as a route to it—and assumes that the world cannot be known separately from discourse...without discourse there is no social reality, and without understanding discourse, we cannot understand our reality, our experiences, or ourselves” (Phillips & Hardy, 2002, pp. 2-6).
Consistent with this constructionist approach to reality, Fairclough (1995) forwarded a “three dimensional” conceptualization of discourse analysis that not only acknowledges the linkage of texts to discourse but also recognizes their location within a historical and social context. Specifically, this “three dimensional” framework for studying discourse suggests that the aim is to map three separate forms of analysis onto one another. First, the analysis of language texts, second, the analysis of discourse practice such as processes of text production, distribution and consumption, and third, analysis of non-discursive events such as socioculture practices (Fairclough, 1995, p. 2).

Historical Discourse Analysis

Fairclough’s (1995) three dimensional framework for discourse analysis, inclusive of text, discourse, and context simultaneously—with the addition of a temporal overlay—comprised the methodology of a historical discourse analysis set forth in this current study. There are four elements that outline this approach. First, a dialogue of a semiotic theory of language forwarded by David Allen and Pamela Hardin (2001) is positioned as a logical antecedent to texts. Second, as a methodological approach to texts I followed the framework offered by David Armstrong (2002) who situates texts differently by de-privileging the hierarchy of texts and de-emphasizing their primacy given to agency in traditional historical accounts. Third, the discourse for this study, health promotion and healing, was developed based on “care of the self” in terms of living in contemporary society as offered by Foucault (1988a) and elaborated by Allen and Hardin (2001). Fourth, the context of this discourse, that of neoliberalism described by Dean (1999a) and Barry, Osborne, and Rose (1996) was the framed reality.
Language

The first element considered in conducting a historical discourse analysis is the preeminence of language. Postmodern and poststructural thinking since the linguistic turn—the major development in Western philosophy during the late twentieth century that situated language as 'constituting' reality—have radically reconfigured how we view the world. This is opposed to most traditions of western philosophy wherein reality preexists, with words functioned only as labels acting correspondingly between them. In its place, a semiotic theory of language takes hold wherein language is situated in two distinct ways: the marking of difference and through repetition (Allen & Hardin, 2001). This relates to health promotion and healing in ways that different concepts contrast each other through distinct language usage (difference), and how each concept establishes consistent meaning in the vocabulary of language through its recurring practices (repetition). This is essential to understanding tensions between health care experts and consumers as similar vocabularies may represent different meaning.

These assumptions of language outlined by Allen & Hardin (2001) are essential antecedents to the subsequent discussion on text, discourse, and context. This understanding is an important distinction due, in part, to the simultaneous reality that language may still be conceptualized traditionally (reality preexists, words) in realms that evoke the “language of sciences” which comprise health policy, health and illness systems, and professional disciplines. These are challenges that were considered and addressed in this analysis.
Methodological Approach to Texts—Hierarchy and Agency

The second element in conducting a historical discourse analysis, the text, represents the essential matrix comprising the data from and within a historical perspective. De-emphasizing a hierarchy of texts as well as conceptualizing history without agency represents important strategies in creating an identity of health promotion and healing in contemporary neoliberal society. What follows is an elaboration of this approach.

History provides an account of the past—at least since the eighteenth century. Before that time, history was just as much a story about myth and storytelling than a representation of what actually happened. Modern history, with its disinterested account for an objective narrative of the past was believed to fill the void. This unquestioned method continued until the advent of the linguistic turn when the foundations of the historian’s craft were called into question. Although “objective” histories were still sought, some authors began to exercise a self-reflective awareness of the assumptions behind their work that resulted in the view that history was more “invented than discovered” (Armstrong, 2002). With this understanding, the historian was far closer to being a novelist in constructing a good story than a scientist producing aspects of an objective world.

The “invented” notion of history is a history that is inexcusably narrated in a contemporary setting. As Armstrong accounts, following Foucault, it describes a “history of the present rather than of the past, telling not what went on before but how we arrived in the “now”” (Armstrong, 2002, p. 188).
In this study I was accounting for identity of the health promotion and healing practices of people in society. As with any historical analysis, many accounts could occur from the same set of texts. However, if meaning is based on the final goal, that of accounting for identity, then two significant conventions of historiography must be addressed: the distinction between primary and secondary sources and the place of the author in relation to the text (Armstrong, 2002, p. 188).

**Hierarchy of Texts**

Traditional history shows distinctions between primary and secondary sources. Primary sources are understood to be materials such as diaries, registers, letters, or chronicles which are analyzed, interpreted, and synthesized into historical texts that become secondary sources. Secondary sources can however be understood to be layered on top of numerous secondary sources. Primacy is always given to materials closest to primary sources with higher levels of suspicion cast on secondary sources. The distinction between primary and secondary sources embeds an important concept to which many historians would subscribe, specifically the separation of interpretation of the evidence, from the evidence itself, a separation that implies that observers can be held apart from the historical events external to them (Armstrong, 2002).

Rationalities of the linguistic turn in which witnessing of the “death of the author”—the act of removing the author from her/his privileged position with respect to the interpretation of texts to, instead, situating full responsibility and interpretive authority on the shoulders of the reader presented a complex dilemma to understand history. What resulted was the author-presence distilling primary knowledge into a
secondary rendition; the text invited the reader to construct the author in her or his imagination (Armstrong, 2002). Additionally, neither primary nor secondary text had priority in this interpretive process since all texts were interpretations; “one text could not be more ‘interpretive’ than another” (Armstrong, 2002, p. 189).

Text, author-historian, and time were all constructed at the moment of their reading: a reading of a text in 1970 would offer a different view of the past from a reading of the same text in 2005. A primary source may have been used to account for a past event, but these events were selected, interpreted, edited and collated to produce a coherent narrative. It could be viewed as primary only to the extent that the historian had not fashioned it (Armstrong, 2002).

Armstrong (2002) suggests that the problem can be posed in terms of whether to stabilize the present or the past. The source is a text but a text needs readers to bring them to life and establish their core message. The act of reading in the present produces three possible histories: “one is history as a story about the past; another is a story as constructed by a historian in that historian’s present; and third is an immediate history constructed at the moment of reading” (Armstrong, 2002, p. 190).

For the past, a fourfold classification of historical material can be conceptualized: “first, there is the ‘pre-text’ moment of the event, or rather events as many things happen contemporaneously in time. The pre-text moment is surely ‘raw’, filled with myriads of trivia, of actions, of states, of movements. Then there is the primary text, the conventional primary source, an account that selects out some of those infinite series of events at the pre-text moment and makes sense of them as
is a register. The secondary text (and there might be layers of them) is the secondary source, a synthesis by the historian, or others, of primary texts, a distillation informed by some purpose or agenda, a contemporary gloss on times past. Finally, there is the present point of reading. (Armstrong, 2002, p. 190)

A history, therefore, can be read in two ways: as a description of a past it professes to record or as a refraction of the time it was written or published. For the purposes of the current study, history was viewed in the “present”, the time of its writing and publication. All texts in this rendering were treated as primary, as constructing the world at the time of their publication. Secondary sources, histories, commentaries, past reflections were all aligned with their date of publication. This is seen as “flattening the hierarchy of texts” (Armstrong, 2002, p. 191).

With this perspective, there was no attempt to ascribe a notion of truth to any of the texts, but rather the approach was to accept all texts as speaking the truth, that texts do not lie. “They should not be rejected by juxtaposition against some arbitrary external referent or because of their ideological or political position… each text belongs to a regime of truth and the task is not to judge that truth but to make clear its relationship to the present” (Armstrong, 2002, p. 193). Part of the problem is the Enlightenment language through which history constructs itself—the past is ‘discovered’ or ‘revealed’ or ‘found’ implying that it previously existed but was obscured from view. What is more accurate is that histories are “invented” (Armstrong, 2002, p. 193).

Armstrong (2002) suggests we reorient the way we think about history in western society by re-conceptualizing how we catalog our libraries. For example, libraries are
organized by structuring content by subject or author. This is similar to how we think in western society as well. What if libraries were reorganized to reflect a temporal orientation wherein all materials, fiction art, history, science were cataloged by publication date? What would that do for context, history? This is how “history in the present” will appear in the current discourse analysis: truthful texts with context, and a flattened hierarchy.

*History without an Agent*

Foucault (2003b) reminds us that the primacy given to the author in Mediaeval times corresponded to the truth of the text that was to be discovered in the truth of the author. In modern times, however, this has shifted to the text: the truth of the author is not to be found intrinsically but in the text, as we scan the author’s words to find out who she or he really was (Armstrong, 2002; Foucault, 2003b). What was the author really like? It depends on what they say in their text as Armstrong (2002) illustrates in an example from nursing:

Nursing textbooks prior to about 1970 offered a way of managing the dying derived from Nightingale’s own *Notes on Nursing* (Nightingale 1859). This involved not telling the patient they were dying, offering physical comfort and remaining cheerful at all times. After 1970, nursing textbooks changed their advice. Patients should be told and counseled while the nurse herself should reflect on her own death. And the rationale for this position? Nightingale’s own words in *Notes on Nursing*. So who was Nightingale? Before 1970 and after she
was two different people, each a reflection of the particular reading of her text. (p. 196)

History places the author or subject at the center of the world in two ways. First, the privileging of various texts places the authorial imagination at center-stage: the author is ever-present as recorder, interpreter or distorher of events. Second, history is about humans, it celebrates a man-made world. For historians, the person is the primary input into the story, it is the person who thinks and acts. If a text wishes to explain ‘the person’, however, then the traditional polarity must be reversed (Armstrong, 2002).

If the task is to write a history that removes Man [sic] from the input side of the equation and asks instead ‘what makes Man [sic]?’ then a different sort of historical method needs to be used. What this means in practice is that the traditional historical interpretation of texts (Who wrote this text? What was their motive? What was their view? What was their ideological position? etc.) can be rejected and replaced by an analysis that reads text as a mechanism of constructing Man [sic] [italics added] (What sort of Man [sic] could this text see?). Man [sic] must become the dependent variable rather than the independent. The constancy of Man [sic] must disappear. (Armstrong, 2002, p. 197)

The problem of the universal model of Man [sic] can be expressed in terms of agency wherein a thinking, acting individual has thoughts and carries out deeds on behalf of themselves. The strategy then becomes one of accounting for agency rather than assuming it, the relationship between thinker and thought, between doer and deed needs
to be reversed: in its place is the thought that constructs the thinker and the deed or act that constructs the doer (Armstrong, 2002, p. 197).

This historical discourse analysis centered the practices of health promotion and healing through analysis of selected texts read with intent of dissolving the privileging of texts as well as de-emphasizing agency and authorship. The objective, seeking identity (what we think, what we believe, what we do) in terms of how health promotion and healing is practiced in contemporary neoliberal society will help in the understanding of how we may begin to think and act differently than we have become.

Discourse

The third element of a historical discourse analysis is the discourse itself, the subject matter in question. Health promotion and healing were center stage for this discourse analysis. The journey was through the theoretical perspectives of governance and risk that were situated in selected texts. How is this societal identity formation conceptualized? What does it look like? Foucault and colleagues argue that modern societies increasingly organize themselves around discourses of the “self” conceptualized as “care of the self” (Allen & Hardin, 2001; Barry, Osborne, & Rose, 1996; Foucault, 1988a).

Self is a discursive object constituted in such a way that we can ‘work’ on it; we can ‘reflect’ on our ‘self’ and in doing so, we are ‘recruited’ into two levels of discourse: first is the discourse of self monitoring, self reflection, and self analysis; second is the content of that monitoring or reflection—we take up discourses about what we ‘should’
be like and compare ourselves to them and adjust ourselves to meet them (Allen & Hardin, 2001, p. 168).

The processes of ‘care of the self’ are the types of behaviors consistent with health promotion and healing practices that are central, my unit of analysis. It will be these behaviors that were identified and described in the selected texts for analysis.

Context

The fourth and final element of a historical discourse analysis is context. Liberalism and neoliberalism set the stage of societal functioning pertinent to the discourse—health promotion and healing. Although previously presented, what follows is a brief review of the role of these societal functional realities.

Classic Liberalism

Classic liberalism is a term that describes the critique of excessive government that began with the historical evolution of governmentality—the advent of a separation from sovereignty and establishment of separate yet overlapping spheres of autonomous processes of government, the population (biopower), the economy, and society (Dean, 1999a). It is an approach to government that recommends mechanisms of regular review and rationalization. It can be approached as a form of political philosophy or as a practical art of government. As the former, it usually refers to a philosophy of limited government that respects the rights and liberties of citizens and employs the rule of law. As the latter, it uses the capacities of free subjects as one of the means to achieve its purposes and goals. As an art of government, classic liberalism seeks to shape the capacities of individuals and collectivities through disciplinary and bio-political means.
Classic liberalism can be understood more broadly as a way of articulating a democratized form of sovereignty, and its notion of the rights of responsible and autonomous juridical and political subjects, with a bio-politics.

A variant of classic liberalism, social liberalism, developed during the late nineteenth century, emphasized mutual collaboration through liberal institutions in protecting liberty and opportunity for all citizens. Like classic liberals, social liberals believe in individual freedom as a central objective but also included tenets of economic opportunity, education, health-care, social security, in a collective context for all of society. These objectives were bolstered by strategies of progressivism (equalizing activities such as sliding scale taxation) that facilitated opportunity addressing these needs of the entire society. Collectively, implemented social liberalism was understood as the social welfare or workfare state.

For example, the context of social liberalism can be seen to influence health policy as is presently activated through the Healthy People 2010 Initiative (United States. Dept. of Health and Human Services., 2000a). It is within this context of social liberalism, that a standpoint for the requirements of government is seen as the duty of society through social justice. However, evolving social structures such as the demise of social liberalism in deference to neoliberalism suggests a different set of societal priorities are representing current realities.

Neoliberalism

Several different governmental rationalities might be described as variants of neoliberalism (Barry, Osborne, & Rose, 1996; Dean, 1999a). They are modes of
problematization (critical critique designed for active reform) of the welfare-state and its features such as bureaucracy, rigidity and dependency formation. These critiques recommend the reform of individual and institutional conduct so that it becomes more competitive and efficient within a capitalist frame of reference. These critiques also seek to affect this reform by the extension of market rationality to all spheres (market justice), by the focus on choice of individuals and collectives, and by the establishment of a culture of enterprise and responsible autonomy. This approach is understood as the governmentalization of government and seen as a duty of man in society not the duty of society. Neo-liberalism rationalities serve to represent our current history of western world economic, societal and governmental conduct and is an essential contextual focus for understanding societal identity regarding health promotion and healing.

Neo-liberalism served as the cornerstone of context for this study. It was postulated that elements of this context are specifically what have gone unrecognized in the current debates on health and illness in the United States. Specifically missing are issues related to “market justice” that have reshaped our society and especially our health care over the past twenty years (Barry, Osborne, & Rose, 1996; Lupton, 2003). Likewise the effects of this element of social reshaping are of primary concern in this historical discourse analysis.

Method

Because this study sought to understand the nature of health promotion and healing practices as identity of individuals at a societal level, it involved a historical discourse analysis of selected texts from 1990 to 2006. This time frame marks the
genesis, implementation, and evaluation of the Healthy People 2000 and 2010 Initiatives which are represented by texts that frame U.S health policy over the course of the past sixteen years and into a future yet to be determined. These texts are the first attempt at a concerted health policy focused on disease prevention and health promotion for the U.S. population.

This approach is chosen because it mirrors research strategies of seasoned researchers who have studied identity formation within similar theoretical frameworks, that of governance and risk with a societal context. (Armstrong, 2002; Cruikshank, 1999; Gastaldo, 1997; Lupton, 1994, 1995, 2003).

Process and Procedures

Historical discourse analysis was operationalized through an articulation of a “three dimensional” conceptualization of analysis that maps language texts, discourse practices, and social and historical context onto one another (Fairclough, 1995). This complex reflexive approach was conducted through a thoughtful consideration of the following processes: the selections of the texts (data), the approach to the data (texts), the analytic strategy, the writing of history (reporting results) and diagnostics (critique).

Selections of the Texts

Texts for analysis were selected using two distinct approaches to understanding health promotion and healing in contemporary society. First, texts outlining the design and functioning of health policy were analyzed for understanding how the conceptual linking of governance and risk frame health promotion and healing. Second, specific texts written to critique the current framing and functioning of health promotion and healing
were analyzed for the differences between current realities and the *ideal* as delineated in these critiques.

Sampling framework was divided into two distinct phases and analyzed sequentially. These two phases were: texts of structure and texts of critique. First, texts of structure outlining the scaffolding of what constitutes current U.S. policy regarding approaches to health and illness as strategic objectives were identified. Questions asked of these texts were framed around “how” questions related to structure and functioning of governance and risk in delineating health promotion and healing. The texts were *Healthy People 2000* (United States. Public Health Service, 1991) and *Healthy People 2010* (United States. Dept. of Health and Human Services., 2000b), including governmental evaluations of these initiatives, *People 2000 Mid-Course Review* (Green & United States Public Health Service, 1996), *Healthy Healthy People 2000 Final Review* (National Center for Health Statistics [U.S.], 2001), and *Healthy People 2010 Mid-Course Review* (National Center for Health Statistics, 2006). These documents were selected for this phase because they represented consensus and comprehensiveness of U.S. health policy over the course of the past twenty years.

Second, texts of critique are texts forwarded by authors who find deficits in the current structure and functioning of U.S. policy. These critiques were framed by social justice and fairness in access and delivery health and illness care and asked why the *ideal* is not evident. In analyzing these texts, the following questions were posed: Why does the structure and functioning act as it does? What are the tensions inherent in current structure and functioning? What are the ramifications? How can structure and
functioning be different? Text selected for analysis were written between 2001-2004 and constituted a *critical critique* of current U.S. Health policy and health care. A six text series commissioned by the Institute of Medicine to evaluate U.S. healthcare represented the most independent assessment available. These texts were as follows: *Coverage Matters* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2001), *Care Without Coverage: Too Little Too Late* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002a), *Health Insurance Is a Family Matter* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002b), *A Shared Destiny: Community Effects of Uninsurance* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003b) and *Insuring America’s Health: Principles and Recommendations* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004).

*Approach to the Texts*

Texts were analyzed following methodology described by Armstrong (2002). Two significant conventions of historiography—distinctions between primary and secondary sources and the place of the author in relation to the text were reconsidered. First, no text were privileged by a hierarchy established through notions of primary or secondary sources. Rather, a “flattened hierarchy” was used with all texts deemed “true” as read. Second, agency, or man-in-the-world conceptualizations, were refashioned into a decentered author and with the constancy of Man disappeared (man [*sic*] decentered). Removing author and man [*sic*] from the center shifted the analysis to the “propositional
content of the text”. From this standpoint of historical studies, identity of health promotions and healing practices is fashioned.

Analytic Strategy

To be sure, identity was not lurking in the text, waiting to be described. Identity of health promotion and healing was acknowledged through the careful analysis of governances, the understanding of how it is deployed (the net effect) through governmentality (sovereignty, discipline and government) and the interface with instruments of risk set apart and within the myriads of contexts. Foucault (1982) offers an analytic strategy by privileging the position of “how” questions, not because eliminating “what” and “why” questions are necessary, but because presenting these questions in a different way offers clarity: to know if it is legitimate to imagine power which unites in itself a what, a why and how (p. 217) [see additional works (Foucault, 1991b, 2003c, 2003d)]. Likewise, Dean (1999a) suggests that priority should be given to “how” questions. “It asks ‘how do we govern?’ and ‘how are we governed?’ … it doesn’t mean that we simply describe how authority operates in a particular situation… rather, it directs us to attend to the practices of government that form the basis on which problemizations are made and what happens when we govern and are governed” (p. 28).

In examining the Healthy People 2010 Initiative (Healthy People 2010 [Group] & United States Dept. of Health and Human Services, 2000), questions for considerations were: How does this policy suggest, guide, or expect behaviors related to outcomes? How is knowledge deployed? How is the rationality of knowledge made explicit, feasible? How are the roles of professional disciplines incorporated in carrying out policy? In
adjacent texts the questions was asked: How is health promotion and healing evident? How does it operate? How are conflicting agendas addressed? Is the identity of health promotion and healing evident? Does it support practices of health promotion and healing? What explicit health promotion practices are indicated in the document? These questions are examples of beginning strategies in the analytical process. The important point is that the answers to these questions drove similar questioning as the texts were examined.

**Dimensions of “Thinking” Governance in Regimes of Practice**

In this study, the discourse of health promotion and healing was framed in terms of a “regime of practice” (Dean, 1999a, p. 21). Regimes of practices are the organized ways or formulated strategies that represent institutional practices. These institutional practices in the case of health promotion and healing were framed as a “regime of practice of health promotion and healing”. Dean (1999a, pp. 23-32) suggests four dimensions that facilitate understanding *how* we govern and are governed: visibility; knowledge; practices, techniques, and technologies; and identity formation. These dimensions are co-present in each regime of practice, each presupposing the others without being reducible to any one.

For the regime of practice of health promotion and healing, these four dimensions are manifested as follows:

**Visibility.** First, characteristic forms of *visibility* (Dean, 1999a, p. 23)—the non-discursive—the characteristic forms of visibility identified as the material and spatial ways of *seeing and perceiving* that are necessary to the operation of a regime of practice,
in this case health promotion and healing. These forms of visibility manifest such as in nursing and medicine, the presupposition or gaze of a field of visibility of the body and its depth, or public health through location of the individual body within a visible field of social and political spaces. These visibilities make it possible “to ‘picture’ who and what is to be governed, how relations of authority and obedience are constituted in space, how different locales and agents are to be connected with one another, what problems are to be solved and what objectives are to be sought” (Dean, 1999a, p. 30)

Knowledge. Second, knowledge (Dean, 1999a, p. 23), the discursive, a distinct ways of thinking and questioning, that relies on defined vocabularies and procedures for the production of truth such as those inherent in the social, human, and behavioral sciences such as the disciplines of nursing and medicine.

Situated as an approach to government as a rational and thoughtful activity, Dean (1999a) poses the following questions:

What forms of thought, knowledge, expertise, strategies, means of calculations, or rationality are employed in practices of governing? How does thought seek to transform these practices? How do these practices of governing give rise to specific forms of truth? and How does thought seek to render particular issues, domains and problems governable? (p. 31)

These questions formulate a realism that simply describes or analyzes what exists, or how practices work in a particular way. Government of all orientations, from the individual oriented around ‘the conduct of conduct’ spanning up to and including sovereign states have an intrinsically programmatic nature. What is sought is an
understanding of the rationality of its thoughtful construction (episteme) and consequential practices, mapping the purposeful attempts to organize and reorganize institutional spaces, their routines, rituals, and procedures, and the conduct of actors in specific ways (Dean, 1999a).

*Practices, techniques, and technologies.* Third, *practices, techniques, and technologies* (Dean, 1999a, p. 23), is the mediator as well as the net effect between visibility and knowledge, a specific ways of acting, intervening and directing, made up of particular types of practical rationality (‘expertise’ and ‘know-how’), and relying upon definite mechanisms, techniques, and technologies. Foremost, but not exclusively, this analysis foregrounds the technologies of risk deployed in the regime of practice of health promotion and healing. Insurance risks, epidemiological risks, case-management risks, and clinical risks are elaborated. Also, technologies of agency, technologies of citizenship, and technologies of performance were extensively analyzed within the selected texts.

*Identity.* Fourth, *identity formation* (Dean, 1999a, p. 23), understood as the characteristic ways of forming subjects, selves, persons, actors, or agents. What is the identity formation resulting from the contemporary regime of practice of health promotion and healing?

The attention to the formation of identities is understood as the forms of individual and collective identity through which governing operates and which specific practices and programs of government try to fashion. Dean (1999a) suggests the following series of clarifying questions:
We might ask what form of person, self and identity are presupposed by different practices of government and what sorts of transformation do these practices seek? What statuses, capacities, attributes and orientations are assumed of those who exercise authority and those who are to be governed? What duties and rights do they have? How are these capacities and attributes to be fostered? How are these duties enforced and rights ensured? How are certain aspects of conduct problematized? How are they to be reformed? How are certain individuals and populations made to identify with certain groups, to become virtuous and active citizens? (p. 32)

The forms of identity promoted and presupposed by various practices and programs of government are the ideal or desired subject—a subject that is the endpoint of these practices, constituted through them. This is not to be confused with real subject, subjectivity or subject position. Regimes of government do not determine forms of subjectivity. They elicit, promote, facilitate, foster and attribute various capacities, qualities and statuses to particular agents (Dean, 1999a, p. 32). For example, they are successful to the extent these agents come to experience themselves through such capacities (rational decision-making), qualities (having a sexuality), and statuses (being an active citizen) (Dean, 1999a, p. 32).

Diagnostics

Foucault’s strategy for diagnostics in discourse analysis was part of the process in this work. Diagnostics is the notion of keeping the analysis, or more specifically, the analytical portion, separate from an application dimension or diagnostics. After the
analytical phase is complete, diagnostics, the process of discussion and critique, occurs. Diagnostics are conducted within selected contexts such as nursing, health and illness care, or society and involve a critical discussion of the applicability of the results. Foucault’s concern for rigor, his desire not to mix things up and to maintain his reader’s confidence prompted him to keep analytics (analysis) and diagnostics separate in his work (Deleuze, 1992; Tully, 1999). The diagnostics will follow the analytics section in Chapter IV.

The results of drawing on findings from the analytics in the diagnostics discourse—a reformulated identity situated in an emerging reconstruction of health promotion and healing—cannot avoid the question: “How can we be different than we have become?”

*The Writing of History*

Writing and re-writing while reading was a primary method used. Field notes, recordings of reflections, and transcriptions of the researchers thinking were done concurrently with the reading of the texts. This is a reflective-reflexive method. *Trustworthiness*

In this historical discourse analysis, there was no attempt to derive truth from any preexisting text or in the text that evolved from this analysis. Each text had its own regime of truth. The task of the researcher was not to judge truth but to make it explicitly clear how in matters in contemporary circumstances. Validity flowed from how well the reader judges that this objective has been satisfied.
Patti Lather (1993) in her work *Fertile Obsession: Validity after Poststructuralism*, laments that validity, in a foundational sense, is dead. However, the ultimate validity still holds: validity rests in the consumer of the work. As Foucault suggests, for the specific intellectual, as a citizen, to circulate his or her work in public and local discussions that leads to participation in democratic action—is the ultimate validity (Tully, 1999).

From a Foucauldian historical approach, history is without an agent or author, and the task is to ask of the texts “what makes man [sic]?” The author is supposed to be invisible, decentered, even obscured. However, with respect to concerns about trustworthiness in scholarly work, it is helpful to identify three key perspectives—from clinical practice, education, and research—of the author, which can be read as decentering biases. My work is informed by many years of experience and expertise in health promotion and healing as an educator, and as a nurse and nurse practitioner in the U.S. military as well as the private sector. I hold a constructionist philosophical orientation from which I seek out discourses of social justice and social ethics that are congruent with my values for comprehensive or holistic approaches to wellbeing. Foucauldian orientations on governance or governmentality are the lens through which I currently view the world.
CHAPTER IV
RESULTS

This chapter presents the results of a historical discourse analysis of health promotion and healing within the context of neoliberalism. The theoretical perspective of the discourse of this study, health promotion and healing, was seen through the lens of Foucauldian genealogies of governance and risk. Health promotion and healing were collectively understood as a specific regime of practice. This regime of practice “involved practices for the production of truth and knowledge that comprise multiple forms of practical, technical and calculative rationality; and are subject to programs for their reform” [italics added] (Dean, 1999a, pp. 18-19). Programs for reform in this analysis were seen as the U.S. health policy of the Healthy People series, the selected texts for analysis in this study in which the discourse of health promotion was found. In discourse analysis, the text is the data. However, the analytic approach was not to examine the meaning of the texts or data but to explain how texts construct health promotion practices and specifically how the historical context has enabled and/or constrained the discourse of health promotion and healing practices.

As a historical discourse analysis, this chapter is presented in a specific order beginning with an overview of analytics that describes the strategic logic of a regime of practice as contrasted with programs such as policy. Next, a brief history of the regime of practice of health promotion and healing is offered with the intent of identifying antecedents to current health promotion and healing practices seen through its co-present dimensions of visibility, knowledge, as well as practices, techniques, and technologies,
and finally, identity. A brief journey through three centuries attests to the historical struggles that human kind has faced in their quest for wellbeing.

The remainder of the chapter centers on the analysis which is comprised of two key components: the analytics and the diagnostics. The analytics are empirical and occur prior to diagnostics. The empirical findings are then introduced into a diagnostic socio-political-ideological dialogue about potential actions.

Two groups of texts were selected for analysis. For the analytics phase, the Healthy People series representing U.S. health policy over the last 16 years was evaluated for their program effectiveness. Analyzed separately but linked temporally to each subsequent publishing of the five Healthy People series are regimes of practice of health promotion and healing. For each sequential publication of the Healthy People series there is a simultaneous “era” evaluation for the regime of practice of health promotion and healing. These evaluations and analysis are coupled throughout the analytic portion of this chapter. For example, the first text analyzed, Healthy People 2000, is coupled to the era of the regime of practice of health promotion and healing from 1990-1994.

The second set of texts—Uninsurance in America—comprise a comprehensive appraisal of illness care insurance in the U.S. from 2001-2004. The Institute of Medicine conducted this six series analysis. These texts were the medium for the diagnostics phase of the analysis. Concluding this chapter is a theoretical analysis of micro and macro determinants of health that are contrasted with these findings within a neoliberal context.
Analytics & Analysis

The regime of practice of health promotion and healing has been called into question or “problematic” through specific programs of policy (Healthy People series) that are designed to formulate specific outcome criteria intended to modify the regime of practice of health promotion and healing. These programs do not subsume the intelligibility of the regime of practice of health promotion and healing. What must be acknowledged is that the regime of practice of health promotion healing constructs, constitutes, and operates under an “intrinsic logic” or strategy (Dean, 1999a, p. 22).

The strategic logic of the regime of practice of health promotion and healing can only be constructed through understanding its operation as an intentional but non-subjective assemblage of all its elements (Dean, 1999a, p. 22). An essential task in this analysis was to keep separate the strategy of the regime of practice of health promotion and healing from the programs that are designed to invest them with a particular purpose. In this analysis programs denotes the policy of the Healthy People series. A vital outcome for this analysis was to describe the difference between the explicit, calculated and programmatic rationality that is indicative of programs of policy and the non-subjective intentionality that can be constructed through analysis of strategy of a regime of practice (Dean, 1999a, p. 22). To be clear, the intentions vested through policy must be distinguished from the intentionality inherent in day-to-day operations of a regime of practice of health promotion and healing. This distinction is crucial in determining the results of functioning or operation of each.
With this approach in mind, the regime of practice of health promotion and healing is able to be understood within its own logic and reality. The benefit of keeping clear this distinction between the programs of policy and the strategies of a regime of practice is to avoid a premature reduction or co-mingling of intensions and actions of each, the strategies of the regime of health promotion and healing from the program of policy. These steps forestall a premature reduction of them to an order of existence that is more fundamental or real such as institutions, structures, or ideology that seek to invest them with certain purposes toward specific goals. For example, ideology is inherent in theoretical perspectives such as critical theory. This is not an indictment against critical theory that is focused on the ideal: doing what is right, focus on desired outcomes, ethical outcomes and goals. Rather, it is an opportunity to brush aside obstacles and to understand how the regime of practice of health promotion and healing actually functions from levels of an empirical, problem-centered, and present-orientation. As such, it is not an idealistic orientation of how it should function, or a strategy of hiding or ignoring realities of functioning. Policy, with their programs for action, are political and ideological by default due to their relationship with the state.

The analysis tactic was to ask how questions. Asking the how questions are central to how we govern and are governed (Ashenden & Owen, 1999; Dean, 1999a; Foucault, 1982, 2003c, 2003d).

“How?” not in the sense of “How does it manifest itself?” but “How is it exercised?” and “What happens when individuals exert (as we say) power over others?” [emphasis in original] (Foucault, 1982, p. 217).
History of Regime of Practice of Health Promotion and Healing

The histories of human well being and suffering are many, but what are most intriguing are the muddy histories of the divergence and convergence of concepts of health, and concepts of illness. Health and illness beliefs in premodern societies were inextricably caught up with notions of religious purity and danger (Turner, 2003). Since notions about scientific hygiene were not yet known, medical concepts were directed at the health of the soul rather than that of the body.

What predominated was taboo, a notion that divided the world into dichotomies of acceptable/not acceptable in terms of a conceptual mechanism for giving structure and meaning to the world. People got sick because they transgressed a social norm or a taboo that separated the sacred from the profane (Turner, 2003). For example, sicknesses associated with foods were known through edible/not edible understanding. If sickness was caused adjacent to foods, it was seen as profane, a violation of taboo, rendering blame on the sick individual. In such systems of meaning, sickness was associated with evil forces or discourses of sacred phenomena (Turner, 2003).

As the process of modernization evolved, health and illness took on roles consistent with secular paradigms and were increasingly informed by various scientific discourses. In Western medicine, disease entities became increasingly differentiated and disease states more specified as the human body was itself differentiated into component parts. Microbiology offered an account of viruses that invade the body and overtly had no connection with the moral or religious status of the individual. As scientific concepts of disease replaced traditional notions of the quasi-religious state of illness, the status of the
medical professional increased dramatically (Turner, 2003). Coincidental to the “professional role” was a marked decline in the role of traditional healers.

There was an important division resulting from Cartesian rationalism in the fifteenth and sixteenth centuries characterized by the split between physical and mental health (the body/mind dichotomy). This mind/body dualism, although largely discounted in the twentieth century, continues to operate in a pragmatic sense in contemporary insurance dominant illness care systems where coverage for mental health is most often excluded or severely restricted in deference to illness “body” care.

It is important to note that in the nineteenth century the concept of prevention was deeply imbedded in illness rationalities, not yet differentiated as a separate entity. What was understood as prevention was the science of hygiene but this science was claimed exclusively by “medical” science. Community health measures, such as clean water and adequate housing were the precursors to concepts of prevention although these too were held tightly as the domain of “medical science”.

In 1910, the Flexner Report on *Medical Education in the United States and Canada* ushered in the most dominant framing of illness care that would crown the golden age (1910 to 1950) of twentieth century scientific medicine (Turner, 2003). The Flexner Report recognized and authorized the social dominance of a research-oriented scientific medicine in which the biological sciences, along with laboratory training, provided the foundation of medical understanding and rationalization. One of the hallmarks of this report was the net effect of creating an exclusive market for illness care
for the discipline of allopathic medicine, excluding or minimizing complementary and homeopathic practices.

Medicine became increasingly specialized in terms of its knowledge base, with increasing specialization (division of labor) surrounding separate organs of the body, manifested through anatomy, physiology, and pharmacology. Medical faculties were organized separate from the rest of the university in spatial and in academic terms. This physical separation reinforced the social solidarity of the medical faculty and effectively isolated the medical curriculum from influence of other scientific disciplines (Turner, 2003).

During the second half of the twentieth century, the essential importance of the hospital as a venue of practice led to an explosive growth in infrastructure orchestrated by the “disciplines of practice.” These disciplines, led by the medical associations that in effect controlled entry into medical practice—the subordinate disciplines of nursing, dentistry, and pharmacy as well as numerous paraprofessional groups—collectively represented a dramatic increase in an illness workforce (Turner, 2003).

This “medicalized” social transition ushered in the era of the medical-industrial complex that set the stage for an unheralded proliferation of costs related to illness care as well as a new wave of social criticism directed at the negative consequences of the “medicalization” of society. As Foucault (1982) reminds us “…the medical profession is criticized not primarily because it is a profit-making concern but because it exercises an uncontrolled power over people’s bodies, their health and their life and death” (p. 211).
A variety of medical analysis have argued that since the 1970s there has been a profound transformation of illness-care systems associated with the decline in the centrality of professional medicine and its professional autonomy (Turner, 2003). The decline of medical dominance has also been associated with the erosion of social security schemes, centralized welfare states, and the commercialization of medical provision. As the insurance companies began to influence debates and policies about health funding, the professional autonomy of doctors became constrained.

Governments have also turned to a mixture of prevention medicine, third-sector finance, and public health policies to support self-regulation. These fiscal crises in health care are closely related to the graying of the population. These political and economic changes have emulated in reality what Foucault calls governmentality (Turner, 2003).

What is a crucial historical note is that the early 1970s was the first formal notation of prevention as a concept separate from medicine in professional and public discourse. It may be postulated that this resulted from many external forces, such as government, other disciplines such as nursing, and most importantly as a constraint to upward spiraling of illness care expenditures. It could be construed as “inside-outside medicine”. It is complicated because sub-specialties of medicine such as public health are primarily prevention oriented while most other specialties concentrated primarily on illness dominated practices. This timeframe also marks the premier edition to *The American Journal of Preventive Medicine* which featured a multidisciplinary approach to prevention. Ironically, the title does not reflect this commitment.
The professional discipline of nursing was on a similar trajectory with that of the discipline of medicine regarding illness and prevention primarily due to the medical profession’s dominance; however, the emphasis of illness over prevention as highlighted and practiced in the medicine discipline is seen juxtaposed in nursing where a prominence of prevention over illness was in play ever since the time of Nightingale (Dennis & Prescott, 1985; Koithan, 1994; Nightingale, 1859/1946; Rafael, 1999).

The practice of prevention in nursing, though, is not as simplistic as the prevention/illnesses dichotomy would suggest. Rafael (1999) describes prevention as a complex “(r)evolving conceptualization of health promotion” predicated on the political dominant strategies of medicine to apprehend, co-opt, and minimize the role of nursing in prevention practices. The complexity of definitions and theoretical posturing of both nursing and medicine leaves a largely confused and distraught public regarding identification of concepts, health knowledge legitimacy, and prevention practices.

Since Nightingale, prevention has been understood in nursing to mean not only an emphasis on “social and economic issues that affect health” but also a deliberate promoting of “self-care” (Rafael, 1999). Nightingale wrote that “money would be better spent in maintaining health in infancy and childhood than in building hospitals to cure disease” (Nightingale, 1859/1946). In a 1919 editorial in Public Health Nursing the question was posed “Why not come boldly forth, one and all and claim the right to exercise the promotion of health as a profession?” (Rafael, 1999, p. 25).

In the last quarter of the nineteenth century, the discipline of medicine began to apply the scientific principles surrounding germ theory that were the antecedents to the
development of the science of a medical model. These advancements resulted in a biomedicalized view of public health that relied exclusively on the narrow practices of the treatment and prevention of disease. This constrained view of preventive practice is the dominant paradigm that continues through contemporary practices.

To highlight the confusing (although rational) discourse between the nursing and medical disciplines regarding prevention is to situate the many terms and conceptualizations that were in play. This struggle between these professional disciplines (and others) can be seen as the challenge to the dominance of a biomedical model by an anti-medical-health promotion movement (Rafael, 1999). The complexity of the health promotion debate can be identified in the numerous terms that comprise the definitions of prevention or health promotion although one cannot underestimate the overwhelming hegemony of the medical discipline in sustaining the biomedical approach. These descriptors represent the entire spectrum—micro to macro determinants of health: health, healing, prevention, wellness, public health, community health, health promotion, high-level wellness, primary health care, holistic care... (Koithan, 1994; Rafael, 1999).

Pender, Murdaugh, and Parsons (2005) identify over twenty different theoretical models for expressing individual and community health promotion applicable to nursing practice. Bracht (1999) delineates over fifty theories, models, and projects that represents health promotion at the community level. A central definition for health promotion was provided during the first International Health Conference on Health Promotion (World Health Organization, 1986) titled the Ottawa Charter in which the definition of health
promotion was defined as follows: *health promotion is the process of enabling people to take control over, and to improve their health* (Bracht, 1999).

Subsequent conferences in Adelaide in 1988, Sundsvall, Sweden in 1991, and Jakarta in 1997, built on the original definition by including five primary strategies with subsequently five revised strategies added after Jakarta (Bracht, 1999):

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

The Jakarta Declaration:

- Promote *social responsibility for health*
- Increase *investments for health development*
- Expand *partnerships for health promotion*
- Increase community capacity and empower the individual
- Secure an *infrastructure for health promotion*

These two groups of strategic definitions from the World Health Organization ten years apart imply an evolution of health promotion conceptualizations. This may be interpreted as signifying a fluid context for understanding health promotion practices in an increasingly neoliberal world.

Emerging from this very brief schematic of a history of health promotion and healing is the acknowledgment that there is no single approach that can claim to
describe, capture, or represent these practices. Furthermore, health promotion and healing eclipses all disciplines, especially those of medicine and nursing. From this viewpoint it can be understood that even as the regime of practice of health promotion healing is superior to and precedes the disciplines of nursing and medicine, specific knowledge, expertise, and actors from these disciplines are needed to inform and conduct its operation and functioning.

For the purpose of this analytics and analysis, the regime of practice of health promotion and healing is broadly defined as:

- spanning the individual to the state, micro to macro determinants of health to include all activities construed to contribute to health—the optimal state of functioning or wellbeing understood through healing—the process of maintaining and restoring health, to become and remain whole and sound.

This definition is inclusive of medical or illness care; however, medical or illness care is understood as a “carve-out” from health in the era of modernity—specific for the creation of capitalization of markets. Additionally, it must be stressed, that improvements in the quality or use of medical care have had a relatively small impact on the health of populations (McGinnis, Williams-Russo, & Knickman, 2002). For example, McGinnis, Williams-Russo, and Knickman (2002) define determinants of health along four domains with their relative contribution to mobility and mortality specified as follows: genetic predisposition, about 30 percent; social circumstances, 15 percent; environmental exposures, 5 percent; behavioral patterns, 40 percent; and shortfalls in medical care, 10 percent (p. 83).
These facts do not preclude the medical profession’s attempts to apprehend and capitalize on the conception of “health” or “health promotion and healing” through gauntlets of illness schemes. Why else does the “approximately 95 percent of the trillion dollars we spend as a nation on health go to direct medical care services, while just 5 percent is allocated to population wide approaches to health improvement” (McGinnis, Williams-Russo, & Knickman, 2002, p. 78)?

Prologue

What follows are the historical analysis of the intrinsic logic (rationality) and the inherent strategy of the regime of health promotion and healing reacting to an explicit program of the Healthy People 2000-2010 series that represents a particular purpose for U.S. health policy.

Contrasting Strategies of the Regime of Practice of Health Promotion and Healing with Programs of Healthy People Policy

The context of Healthy People policy spans a period of approximately thirty years beginning in 1979 with the issuance of the report Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention (Public Health Service & Department of Health Education and Welfare, 1979), followed the next year by Promoting Health—Preventing Disease: Objectives for the Nation (Public Health Service, 1980). These documents set the stage for introducing a set of broad national goals for improving the health of Americans by 1990. In this initial initiative, specific health goals were addressed in three areas: health promotion, health protection and preventive health services.
These initial policy efforts had minimal impact outside of government circles and were regarded as an academic exercise for cataloging public health trends. In 1987 work began on the goals and objectives for the next decade, 1990-2000, with a new imperative as an underlying context: upward spiraling illness care costs specific to the government as well as to the citizens of the nation as a whole (Public Health Service, 1991).

Five specific texts were analyzed for their programmatic intent on the regime of practice of health promotion and healing. The strategy of the regime of practice of health promotion and healing was identified in the analysis so the net effect of this practice regime can be understood in terms of a response to programs of the Healthy People series. Additionally, and most importantly, the degree to which the regime of practice of health promotion and healing attempts to modify (as part of its inherent strategy) subsequent programs of the Healthy People series will be explicated and described as a non-subjective intentionality.

In order of publication dates these texts are: Healthy People 2000 (Public Health Service, 1991); Healthy People 2000 Mid-Course Review (Green & United States Public Health Service, 1996); Healthy People 2010 (United States. Dept. of Health and Human Services., 2000b); Healthy People 2000 Final Review (National Center for Health Statistics [U.S.], 2001). Healthy People 2010 Mid-Course Review (National Center for Health Statistics, 2006). The Healthy People series have two distinct functions that are not common among health policy programs: they have a prescriptive dimension as well as an evaluative dimension. Hence, measurement is the hallmark of how successful the prescriptive segment disciplined adherence.
Healthy People 2000

The policy rhetoric. In opening remarks, from the Office of the Assistant Secretary—priorities for our nation’s health were stipulated in terms of “we can no longer afford not to invest in prevention. From the perspective of avoiding human suffering as well as saving wasteful costs for treating disease and injuries that could have been prevented…” (Public Health Service, 1991, p. enclosure). This statement highlights a shift in U.S. policy wherein concern for public health was no longer an “objective” science concerned with the health of citizens but a political reality that cost is intertwined in achieving health goals.

This shift in emphasis to include economic concerns resulted in stipulating a hierarchy of responsibility—that is, stipulating three goals, the first being personal responsibility and the second, extending the benefits of good health to the most vulnerable among us. This means building in the most vulnerable populations a “culture of character” meaning a culture or way of thinking and being that actively promotes responsible behavior and the adoption of lifestyles that are maximally conducive to good health. The third goal, health promotion and disease prevention, comprises the best opportunity to reduce the ever-increasing portion of our resources we spend to treat preventable illness and functional impairment (Public Health Service, 1991, p. v).

The priority of economics in the nation’s health continues to be stated… “We would be terribly remiss if we did not seize the opportunity presented by health promotion and disease prevention to dramatically cut health-care costs, to prevent the
premature onset of disease and disability, and to help all Americans achieve healthier, more productive lives” (Public Health Service, 1991, p. vi).

These changing priorities can be seen as a shift from social liberal ideals to neoliberal realities—cost concerns first and second, healthier citizens so they may be productive longer (contributing to the well being of the state by not requiring services). What vanished is the notion of wellbeing for individuals for the sake of wellbeing, an optimizing of human kind.

A neoliberal thematic may be seen as inherent:

We began the current century with a sense of fatalism about the Nation’s health problems. As we reach its conclusion, we do so with confidence in our ability to control many of the events that form our health prospects. A century of biomedical research has made available sophisticated techniques for diagnosing and intervening against disease. Scientific studies of even the last generation have revealed much about the factors that predispose to various health threats and therefore about actions that each of us can take to control our risks for disease or disability. [italics added] (Public Health Service, 1991, p. 1)

Is this “fatalism” as a sense of accepting our “health fate” recapitulating to the new salvation of expert knowledge and science? How is this science different from knowledge gleaned from experiences in “self care” or “care of the self” such as common sense about health passed from experiences of daily living, like exercise, physical work, good nutrition, and avoiding excesses? Is this a glimmer of what Foucault (1982) calls
the medical profession’s “…uncontrolled power over people’s bodies, their health and their life and death” (p. 211)?

Knowledge, as opposed to behavior, is a crucial distinction. People may have knowledge but what are the reasons it is not transmitted into behavior? Are these expert knowledge(s) examples of medicalization of inherent human wisdoms based on experiences over time of societies or cultures? Or is it issues of class? For example, the “new science in health” knowledge(s) has brought a keen sense of potential as well as realizations of how far most Americans, especially those with low incomes, are from that potential (Public Health Service, 1991, p. 1).

Societal issues also lend themself to an era of fatalism, …“momentous new issues emerging on the horizon—the aging of our society, the prohibitive costs of many technologies developed for diagnosing and treating disease, and the ecological consequences of industrialization and population growth” [italics added] (Public Health Service, 1991, p. 1). These seem like problems for the state: costs, and increased liabilities if optimal health cannot be realized. These concerns certainly run parallel to the assertions that increasing health problems are symptoms resulting from industrialization and capitalism as Beck (1992) and Ewald (1991) suggest.

*The policy legitimatization.* “Healthy People 2000 offers a vision for the new century, characterized by significant reductions in preventable death and disability, enhanced quality of life, and greatly reduced disparities in the health status of populations within our society” (Public Health Service, 1991, p. 1). This vision was created by a consortium of “experts” understood as a consensus of experts—professionals and
citizens, private organizations and public agencies from every part of the country. “Three hundred membership organizations and all state health departments” (Public Health Service, 1991, pp. 1-2)

A political approach to The Healthy People 2000 process was to project legitimacy through linking the dichotomy of “science” and “experts” with a consensus of a cross-section of citizens. This was also melded into a consensus of everyone involved, establishing “truth” to the legitimacy process. For example:

“The Healthy People 2000 Consortium, facilitated by the Institute of Medicine of the National Academy of Sciences, helped the United States Public health Service to convene 8 regional hearings and received testimony from over 750 individuals and organizations. This testimony became the primary resource material for working groups of professionals to use in crafting the health objectives. After extensive public review and comment, involving more than 10,000 people, the objectives were refined and revised to produce this report.” (Public Health Service, 1991, p. 2)

Part of the structuring of legitimatization included the citing of “progress” from the previous initiatives, Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention (Public Health Service & Department of Health Education and Welfare, 1979) and Promoting Health—Preventing Disease: Objectives for the Nation (Public Health Service, 1980). Inherent biases were that these initiatives were framed exclusively around micro-determinants of health and were devoid of any implementation structure. Additionally, the role of macro-determinants was completely
ignored such as the economy (the transitioning to neoliberalism rationalities), political climate (the stagnation and reversal of the “great society programs”), and access to health care (rapidly transitioning into an era of “managed care”). Most importantly, and probably most pertinent, was the ability of the state to accurately capture what was transpiring in reality due to the limited sophistication of metrics to capture indices of micro-determinants of health.

Additional legitimization can be seen in the following economics of prevention: GNP in 1960 for health care was 5% with estimates to increase to 12% by 1990. Lost economic productivity (attributed to illness and early death) compounded the impact of health care costs, with total costs of illness near 18% of GNP in 1980. Technology for diagnosis and treatment of disease conditions outstripped society’s ability to pay for it. Most were avoidable (Public Health Service, 1991, p. 5). So, if technology is so costly, who is privileged to receive it? Are there consequences for those who do not take prevention seriously? Who decides? Who pays? It appears that a commodity orientation to prevention is intrinsic to our society.

**Challenge and goals.** Prevention understood in economic terms transitions in the following section whereby goals take on a social theme similar to a social liberalism perspective. For example:

Good health comes from reducing unnecessary suffering, illness, and disability. It comes as well from an improved quality of life. *Health is thus best measured by citizens’ sense of well-being.* The health of a Nation is measured by the extent to which the gains are accomplished for all the people…The challenge of Healthy
People 2000 is to use the combined strength of scientific knowledge, professional skill, individual commitment, community support, and political will to *enable people to achieve their potential to live full lives*. It means preventing premature death and preventing disability, preserving a physical environment that supports human life, cultivating family and community support, *enhancing each individual’s inherent abilities to respond and to act*, and assuring that all Americans achieve and maintain a maximum level of functioning. [italics added]

(Public Health Service, 1991, p. 6)

There are three major goals for *Healthy People 2000* that are subdivided into four distinct categories representing twenty-two priority areas. These goals, categories and priority areas are the matrix from which interventions are to be designed, implemented, and subsequently measured over the course of the prospective decade. What follows is a schematic of these goals, categories, and priority areas:

Three major goals for *Healthy People 2000*:

1) Increase the span of healthy life for Americans
2) Reduce health disparities among Americans
3) Achieve access to preventive services for all Americans

These three goals are divided into four distinct categories representing twenty-two priority areas. These priority areas are considered separately for age groups comprising children, adolescent and young adults, adults and older adults:

First, *health promotion strategies* were defined as those relating to individual lifestyle:
1) Physical Activity and Fitness
2) Nutrition
3) Tobacco
4) Alcohol and Other Drugs
5) Family Planning
6) Mental Health and Mental Disorders
7) Violent and Abusive Behavior
8) Education and Community-Based Programs

Second, *Health Protection Strategies* were those relating to environmental or regulatory measures that confer protection on large population groups:
9) Unintentional Injuries
10) Occupational Safety and Health
11) Environmental Health
12) Food and Drug Safety
13) Oral Health

Third, *Preventive Services* included counseling, screening, immunization, or chemoprophylactic interventions for individuals in clinical settings. Multiple clinical experts provide these services.
14) Maternal and Infant Health
15) Heart Disease and Stroke
16) Cancer
17) Diabetes and Chronic Disabling Conditions
Fourth, *Surveillance and Data Systems* were designed to monitor progress toward the stated goals.

22) Surveillance and Data Systems

(Public Health Service, 1991, p. 7)

A dimension of *Healthy People 2000* centered on the health of special populations and was divided into two separate categories. First, these are people with low income, and secondly, people in minority groups identified as follows:

- Black Americans
- Hispanic Americans
- Asian and Pacific Islander Americans
- American Indians and Alaska Natives
- People with Disabilities

(Public Health Service, 1991, pp. 29-42)

A matter of intense debate was that “our health care programs are characterized by unacceptable disparities linked to membership in certain racial and ethnic groups…a compelling disparity of most minority populations in the U.S. is socioeconomic” (Public Health Service, 1991, pp. 31-32). What was more compelling was the proportion of racial groups that were economically disadvantaged compared to the white American
population. Differences within and between racial, ethnic, or disadvantaged groups were greater than when compared to the general population, especially on correlates of education and income. Disadvantages in education created income disparities which translated into poor access to health care, poor life choices such as in nutrition, increased depression and despair. This raised concern for all citizens, but directed particular attention when these trends were disproportionately low in any particular group.

These issues are intricate, multifactorial, and layered with complexity. The challenge for analysis was not to simply identify the uncomplicated category of racial or ethnic groups as underlying rationale for results, but to sustain an open sensitivity that shows the complexity of possible interrelationships intrinsic to cause and effect assessments.

Policy to tactical plan of reductionism. A tactical reductionism takes place, not specifically delineated in the Healthy People 2000 initiative, but implied by reading and interpreting the totality of the objectives. This shift was completed by consumers of the text, primarily health experts, and this reductionism was played out in professional literature, expert opinions and dialogue. Specifically, the text (Health People 2000) was deemed as too complex for a segment of the intended audience, the individual. What was reiterated was that aspects of the policy which targets the individual—health promotion, the behaviors related to individual lifestyle—were not easily accessed with respect to intervention and required interpretation through experts, or more specifically clinical experts. This (mis)reading resulted in the unintended consequence of exclusively requiring experts to assess, interpret, and recommend healthy behaviors rather than
empowering individuals to act in conjunction with clinical experts and community stakeholders to optimize individual prevention practices. Importantly, this unintended consequence was later acknowledged for its merits (as beneficial to expert) and was codified with the introduction in 1994 of the Put Prevention Into Practice initiative (Public Health Service, 1994) which was introduced to assist expert clinicians in implementing the goals of Healthy People 2000.

This reductionism sequenced the three major goals—as follows: increase the span of healthy life for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans. These goals are operationalized under three of the four sub-categories: health promotion, health protection, and preventive services.

Responsibility for deployment was collapsed into two groups: health promotion, defined as strategies related to individual lifestyle and preventive services, the counseling, screening, immunization, or chemoprophylactic interventions for individuals in clinical settings. These two groups were tactically merged and given primary responsibility for implementation of prevention care situated almost exclusively with clinical experts in primary care settings. This key tactical move strategically shifted responsibility for the regime of practice of health promotion and healing and for the implementation Healthy People 2000. It was now in the hands of clinical experts with expert knowledge.

The health protection strategies, those activities related to environmental or regulatory measures that conferred protection on large population groups, were assigned
to stakeholder community groups. The road map for implementation of this objective was contained in *Healthy Communities 2000: Model Standards, Guidelines for Attainment of Year 2000 Objectives for the Nation* (United States. Office of Disease Prevention and Health Promotion., 1998).

The fourth sub-category, *surveillance and data systems*, were the responsibility of stakeholders in U.S. agencies tasked with the development of psychometric procedures for collating and interpreting data for the entire Healthy People initiative. The surveillance and data systems arm was the *policy evaluation phase* for the Healthy People 2000 initiative.

*Policy objectives.* The individual objectives were written in behavioral format and were quantitatively measurable and clinically tangible. Most all measurement outcomes were considered microlevel determinants of health. The following are examples of outcomes if a particular objective is met as well as the degree of change:

17.2 Reduce disability from chronic conditions to no more than 8% of people (a 15% decrease).

10.1 Reduce work-related injury deaths to no more than 4 per 100,000 workers (a 33% decrease).

2.3 Reduce overweight to a prevalence of no more that 20% of people (a 23% decrease).

1.3 Increase moderate daily physical activity to at least 30% of people (a 36% increase).

1.5 Reduce sedentary lifestyles to no more than 15% of people (a 38% decrease).
With the inherent increased emphasis on clinical experts in the provision of clinical preventive services, an important objective became an imperative: To expand access and use of clinical preventive services, by the year 2000. It requires medical and health professionals to prevent, not just treat, the diseases and conditions that resulted in premature death and chronic disability. For example:

21.4 Eliminate financial barriers to clinical preventive services

Other objectives target increasing the proportion of people with specific source of ongoing primary care; increasing primary care provider’s delivery of recommended preventive services; increasing the number of people who receive recommended clinical preventive services, increasing delivery of preventive services to patients of publicly funded providers of primary care; and increasing representation of minorities among primary care providers. (Public Health Service, 1991, p. 77)

Policy vision. The pledge of a healthy vision for all Americans is located in a shared responsibility located in personal accountability, the family, the community, health professionals, media and government (Public Health Service, 1991, pp. 85-88). A medicalization, an emphasis on disease or a lack of a health focus can be read through the following vision:

The promise embodied in Healthy People 2000 involves people in all their variety: age, gender, family relationships, racial and ethnic identity, income level, educational, and occupation. In involves birth and death, two sentinel health
events. Birth frames the potential for a healthy lifetime; death often summarizes how that potential was used. In involves the values of family, neighborhood, community, and Nation, enabling or undermining the health course that a life takes. It involves an array of risks—some posing apparent, immediate danger and others invisible and delayed in their effects. Finally, it involves medical science and medical care, with their ability to thwart infections, reverse the course of some chronic diseases, and enhance ability to function where limitations exist. [italics added] (Public Health Service, 1991, p. 43)

Policy as program. Policy in governance terms is seen as the concerted effort to invest regimes of practices with some particular purpose (Dean, 1999a). In the complex interplay of governementality (the state, professional disciplines, stake holders, and individuals) in the development of the Healthy People 2000 policy a specific program emerges understood as the net effect of all developmental processes as well as the interpretations that result from the final document. As a primer for what is to follow, the Healthy People 2000 policy was condensed to a program that has the following characteristics: Healthy People 2000 represents the knowledge and rationality necessary for implementation of programs identified as health promotion, health protection, and preventive services explicated through two actors—expert clinicians and expert community stakeholders. As such, this program attempted, through a variety of mechanisms, to influence the regime of practice of health promotion and healing.
The Regime of Practice of Health Promotion and Healing 1990-1994

The regime of practice of health promotion and healing refuses to be reduced to practice approaches of any one discipline, but incorporates these disciplines instead as one of many actors in a larger schema of behaviors and practices spanning the individual to the state. As such, we talk about ever changing or revolving actors (such as disciplines or individuals) that inform strategy through the dimensions of how this regime of practice is played out. These dimensions are conceived as the “how” in the functioning of a regime of practice, and are applicable to the regime of practice of health promotion and healing analysis in this discourse.

Dimensions of the regime of practice of health promotion and healing.

Understanding the simultaneous co-present dimensions of a regime of practice of health promotion and healing—visibility; knowledge; practices, techniques, and technologies; and identity formation—assists in understanding how specific strategies are formulated and initiated.

First, visibility, the seeing and perceiving activity related to the target of health promotion and healing, the body and mind. Everything is about the gaze: the gaze of the surface, the prodding of its internal structure, the quantifying, the qualitative, the purposeful or spontaneous actions, the space, the void, the soul, the thought, the thinking is scrutinized by the medical gaze of the clinical experts. It is the non-discursive how and the effects of the medical gaze of clinical experts.

Second, there is knowledge, the discursive, the distinctive way of knowing, thinking, questioning, and developing rationalities for a deliberate purpose. In this
particular instance it is deploying of rationalities in a specific privileged way, speaking the “truth” about health promotion and healing.

Third are the practices, techniques, and technologies that rely on knowledge, practically formed rationality, and appropriate deployment are essential in formulating successful strategies. Most importantly, risk technologies involving mechanisms derived from principles of epidemiological risk are proven to be indispensable. The calculus (technique) of risk is undertaken on the basis of a range of abstract factors and their correlation within populations. Screening is a central technique for monitoring populations in order to engage in a systematic pre-detection that eliminates or minimizes future pathologies through interventions on modifiable risk factors. Epidemiological risk is understood to have a preventative ethos. Monitoring, screening, tracking, counseling, dialoging, educating, consulting, and recommending are all complementary practices and techniques that enhance strategy.

Fourth, there is identity formation understood as the characteristic ways of forming subjects, selves, persons, actors or agents understood as consequential in the complex interrelationship of regime of practice of health promotion and healing. An identity pre-dating the deployment of strategy during the 1990-1994 era reflected an individual identity that is “prescriptively knowledgeable and disciplined for adherence resulting from participating in obligatory collaborations.”

*Strategic moves.* In this analysis, I identify three distinct strategic moves made in the regime practice of health promotion and healing that are historically situated and contribute to the understanding of how functioning occurs in contemporary 2006. These
strategic moves do not occur in isolation but rather are the net effect of knowledge, rationality, and experiences from program deployments such as: Healthy People 2000; actors, such as professional disciplines; and social consequences such as politics and the effects of neoliberalism.

First strategic move. As a preamble, the reformulated program intent of the Healthy People 2000 initiative, which stipulated that individual access to prevention requires accessing clinical experts (and would potentially create new markets), was recognized. The first strategic move for the regime of practice of health promotion and healing commenced from 1990-1994. During this time, an excitement generated by the prospect of major reform to the illness care system propagate by the Clinton Health Care Plan was expressly apparent. Numerous innovative proposals, plans, and models flourished in the literature, all targeting the coming revolution of health care. This strategic move was understood as: “segregated prevention and illness care with equal significance and priority”.

One plan that emulated from this prospect focused on establishing the practice of prevention on equal footing with illness within the primary care setting. This was a novel approach in that prevention practices were to be construed and conducted as “wellness visits” and would utilize the science of learning theory, that specified readiness to learn was best timed when one was well and open to dialogue about healthy life choices (Public Health Service, 1993).

The uniqueness of this proposed plan was that is was based on extensive prospective modeling, accounting for age, gender, wellness, and illness requirements, in a
comprehensive approach suggested by the best science. The most dramatic aspect to this model was the determination of the time required to provide comprehensive wellness and illness care to each individual. The analysis suggested that this hypothetically “managed population” could sustain a client panel size no larger that 1200 to 1500 patients. Specific cost analyses were completed to dispel notions of an “unworkable idealist approach” (Public Health Service, 1993).

While this duel approach was both consistent with nursing theoretical perspectives of holism and comprehensiveness in care (Fawcett, 1993; Mitchell & Cody, 1992; Newman, Sime, & Corcoran-Perry, 1991) and delineated in the scope of practice for nurse practitioners (National Organization of Nurse Practitioner Faculties, 1990), it was summarily dismissed by the medical profession as economically impractical and administratively impossible to accomplish (Institute of Medicine [U.S.], 1996).

*Second Strategic move.* What resulted in short order was the call for the integration of prevention services *within* the illness delivery paradigm, transitioning the delivery of preventive services from equal magnitude to that of secondary, opportunistic, and sporadic. This represents the second *strategic move:* “*integrated prevention within the precedence of illness care*”.

This era persisted from approximately from 1994 to 2004. It was solidified as a rubric of practice by the *Put Prevention Into Practice* initiative (Public Health Service, 1994) set in motion by the Office of Disease Prevention and Health Promotion due in part to the lack of enthusiasm up to that point for the *Healthy People 2000* initiative. Unlike the introduction of the *Healthy People 2000* initiative, the *Put Prevention Into Practice*
initiative enjoyed the most formidable publications relations campaign from the U.S. Department of Health and Human Services in recent times. While the “put prevention into practice” phraseology has a broad connotation, it was construed narrowly to mean prevention in primary care settings by clinical experts.

*Initial Healthy People 2000 measurement.* The Healthy People 2000 initiative established baseline data needed as benchmarks for future outcomes assessments of the provision of clinical preventive services. However, instruments for measurement were lacking. In 1991, the Office of Disease Prevention and Health Promotion developed the Primary care Providers Survey based on 17 major objectives outlined in *Healthy People 2000.*

The initial survey was administered to 3,881 primary care physicians and nurse practitioners across the spectrum of primary care specialties. Results from the survey showed that apart from nurse practitioners, clinical preventive service practices were a foreign concept. Although the results from this survey remained unpublished for 10 years, researchers had access to the results and to the instruments (Ewing, Selassie, Lopez, & McCutcheon, 1999).

In 1992, this study was duplicated by the National Alliance of Nurse Practitioners with 2000 nurse practitioners participating. While results were encouraging, with improvements in most areas, none could be deemed clinically significant. Clinical significance would be met for example, if a composite of all age-appropriate clinical preventive services for a particular individual met a threshold of occurring at least eighty percent of the time. Results suggested that some elements for each individuals were met
leading to the assumption by the nurse practitioners that they practiced prevention (Lemley, O'Grady, Rackhorst, Reussell, & Small, 1994).

The picture that was becoming clear is the irony of two prospects. First, access to prevention, or clinical preventive services, was made contingent on accessing clinic experts. Second, increasingly, these clinical experts were not shown to be effectively transmitting expert knowledge about clinical preventive services to their clients and patients.

This leads us to question the partnership stressed as essential in Healthy People 2000. Why is it functioning so poorly? Despite intense initiatives, such as the Put Prevention Into Practice (Public Health Service, 1994), as well as deliberate formal education of practicing disciplines to integrate the science of prevention into their skill sets (National Organization of Nurse Practitioner Faculties, 1990), outcomes are not prevalent or widespread. These thematic concerns continue in the Healthy People 2000 Midcourse Review (Green & United States Public Health Service, 1996).

Healthy People 2000 Midcourse Review

In summarizing the results of the Healthy People 2000 initiative from its introduction in 1991 to 1995, the following points were reiterated: The U.S. Public Health Service (PHS) set out objectives addressing improvements in health status, risk reduction, public and professional awareness of prevention, health services and protective measures, and surveillance and evaluation, expressed in terms of measurable targets to be accomplished by the year 2000. Additionally, increased emphasis was focused on prevention of disability and mortality; greater attention to improvements in the health
status of definable population groups at highest risk of premature death, disease, and disability; and inclusion of more screening interventions to detect asymptomatic diseases and conditions early enough to prevent early death or chronic illness. (Green & United States Public Health Service, 1996, p. 2).

This commitment continues a well established theme that can be framed as “what needs to be done”. What follows is the “where it should be done”:

Full achievement of the goals and objectives of Healthy People 2000 is dependent on a health system reaching all Americans and integrating personal health care and population-based public health. The vision of healthy people in healthy communities’ moves beyond what happens in the physicians’ offices, clinics, and hospitals—beyond the traditional medical care system—to the neighborhoods, schools, workplaces, and families in which people live their daily lives. These are the environments in which a large portion of prevention occurs. [italics added] (Green & United States Public Health Service, 1996, p. 2).

A sense of urgency or frustration can be detected in the previous statement suggesting that the current reconfigured program deployment, accessing clinical experts through primary care settings was not working as well as initially planned. The statement suggests a shifting of responsibility, yet retaining a “system” still relying on experts for providing and interpreting health knowledge: people are directed on what to do, but where is the why and the how? Where are the rationalities for the knowledge that substantiates what people are to do? Clinical preventive services were still intended to be a prescriptive adventure orchestrated by experts.
Measurement and results. One of the hallmarks of the Healthy People 2000 initiative was the commitment for measurability. For example:

Healthy People 2000 objectives were adopted and deployed using a management-by-objective planning process familiar in the world of business (Green & United States Public Health Service, 1996, p. 272).

However:

This midcourse review reports progress toward the national health promotion and disease prevention objectives. Much has been accomplished; more than two-thirds of the objectives for which data are now available are moving toward the targets. However, in order for the Nation to achieve its prevention agenda and to make profound difference in the health of all Americans by the year 2000, renewed efforts will be required. The purpose of this report is to assess the challenges that remain and to demonstrate that the opportunities for achieving a healthier America are at hand. [italics added] (Green & United States Public Health Service, 1996, p. 3)

This statement sounds like hedging. There is no discussion of statistical or clinical significance, rather, a moving toward the targets. It is difficult to see a scientific interpretation of positive progress. Is this a wake-up call to move quickly to the next plan at hand?

Specific objective findings were not reported and only general findings were delineated. For example, progress was reported on 47 sentinel objectives representing the four categories of health promotion, health protection, preventive services, and
surveillance and data systems. Data displays included the following “direction of goal”
aggregation: right direction 32 of 47 (68%); wrong direction 9 of 47 (19%); no change 2
of 47 (4%) and no data 4 of 47 (8.5%). This general summary seems suspicious since the
data collected could be analyzed more completely. For example, I examined the
objectives that were deemed moving in the right direction (68%), and found that by
calculating the percent of goal attainment in meeting the Health People 2000 category
areas of health promotion, health protection, preventive services and surveillance and
data systems helped to understand the magnitude of “movement in the right direction”.
To illustrate, a composite of all objects were distributed along quartiles for each of the
category areas:

Results for the category of health promotion, displayed in number of objectives
moving toward the established goal by percent of attainment: 0-25 percent quartile—2
objectives; 26-50 percent quartile—4 objectives; 51-75 percent quartile—2; 76-100
percent quartile—1; with one objective exceeding 100 percent. It can be easily
summarized that 60 percent of these goals attained less that one-half of their targets.

The data for the category health protection: 0-25 percent quartile—2 objectives;
26-50 percent quartile—4 objectives; 51-75 percent quartile—1; 76-100 percent
quartile—2. In the case of health protection, 67 percent of goals fell below 50 percent
attainment.

The outcome for category of preventive services: 0-25 percent quartile—4
objectives; 26-50 percent quartile—2 objectives; 51-75 percent quartile—3; 76-100
percent quartile—4. For preventive services, 46 percent of goals were below the 50 percent threshold.

For surveillance and data systems category, 40 out of 50 states met these requirements in little over five years. Infrastructure for gathering data about prevention had dramatically improved.

The goals of Healthy People 2000 were not established as ideal outcomes but rather as attainable within the specified decade 1990-2000. What was expected was at least 75 percent attainment on all goals as delineated by the experts (Public Health Service, 1991). What can be gleaned from this snapshot of the data is that the degree of success or failure was certainly dependent on how one read the results.

What is obviously absent are results about many of the individual objectives, especially those that pertained to clinical preventive services (17 objectives) that measure the level of success in delivering these services to consumers—especially individuals. The million dollar question becomes, “how effective are the experts in primary care settings in delivering the knowledge of prevention?

The growing chasm. The mid-course review demonstrated for the careful reader a growing chasm between the projected obtainable goals and the actual attainment level. Moreover, there was a sense of urgency, a plea for help to consumers themselves, as in the following:

This report calls for renewed commitment to improve the Nation’s health. Healthy People 2000 cannot be accomplished by the Federal Government alone.

Leadership must come from institutions and individuals throughout the Nation.
Each person makes decisions about how fast to drive, whether to wear a safety belt, what to eat, and how much alcohol to drink. In families, parents have opportunity to promote health and encourage healthy habits for their children. Community organizations—schools, religious institutions, and voluntary organizations—can become more actively engaged in promoting health. Employers can make worksites healthy. This midcourse review offers not only a report to the Nation on progress to date, or a blueprint for what is possible by the year 2000, but it outlines opportunities to renew the Nation’s commitment to making a difference in the health of its citizens as the 21st century approaches. [italics added] (Green & United States Public Health Service, 1996, p. 5)

*The Regime of Practice of Health Promotion and Healing 1995-2000*

The social context between 1995 and 2000 had dramatic impact on the regime of practice of health promotion and healing. This changing context began with congressional elections in 1994 when a conservative movement swept the nation and elected conservatives to both houses of Congress.

*Changing politics, changing policy.* Almost immediately, the hopes and dreams of a comprehensive revamping of the nation’s inefficient, ineffective, primarily proprietary illness care system faded. With this new wave of conservatives armed with a “contract for America” came a swift and overwhelming defeat of the Clinton Health Care Plan. Bolstered by the pharmacology and corporate managed care systems, the medical industrial complex was back to business as usual with illness care as the means and wealth extraction as the mechanism.
The next social ramification occurred in 1996 when Welfare reform resulted in the “uncoupling” of Medicaid from benefits of aid assistance stipulated in the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*. In its place was instituted state block grants titled Temporary Assistance for Needy Families (TANF).

Assistance for illness care such as Medicaid required a separate qualification criteria that differed from state to state. An unintended consequence was a decrease in Medicaid utilization which related to the dramatic drop in utilizations rates of TANF due to strict lifetime eligibility of sixty months as well as performance based education-to-work requirements. The result was an inordinate displacement of eligible Medicaid recipients, especially children, primarily due to poor communication, change in family status, or extensive state bureaucracy.

This increased the shift of Medicaid eligible but un-enrolled individuals from the safety net of a health plan to uninsured status resulted in either deferring care or seeking care from expensive alternatives such as hospital emergency rooms. This uninsured status is coupled with the understanding that individuals who have breaks in coverage or intermittent insurance forgo, delay, or dramatically reduce practices of most preventive services (Schoen & DesRoches, 2000).

However, these findings are based on a looming reality that is increasingly called into question in the literature: are clinical experts in primary care settings utilizing clinical preventive services as well as transmitting health knowledge to individuals at levels and intervals that rival standard of care for “illness treatments”? 
Clinical experts or not? In order to test this question, Ronan, Phillips, and Koithan (Ronan, 2003) sought to examine nurse practitioners in a controlled environment, the U.S. military, under the following assumptions. First, nurse practitioner formal education was graduate level and founded on principles of prevention, health promotion and healing. Second, military nurse practitioners practiced in an environment in which the corporate structure was supportive of the Healthy People 2000 initiative—the U.S. military health care system. Third, military nurse practitioner reimbursement was predicated on salary, not fee-for-service or other incentive plans. Finally, the fourth assumption was that a socialized structure for universal coverage for all military members and their families reduced access to care issues for this population.

In this scenario, a cohort was created by involving participation of all nurse practitioners in the Air Force, Army, and Navy (Ronan, 2003). The findings are outlined below:

On three domains of primary care prevention, assessment, counseling/treatment, and preventive services, military nurse practitioners reported marginal improvement in level of provided services contrasted with a reference group of national nurse practitioners surveyed five years earlier. When queried, most military nurse practitioners valued providing higher levels of services although these values fell short of the recommended levels indicated in Healthy People 2000. Reasons most identified as barriers were, clinician uncertainty, insufficient time with patients, and fragmentation of health care delivery. Behind levels of success with prevention activities was a salient desire for legitimacy seeking
through extraordinary “niche filling” activities. These activities were necessary for successful “role identity” within a context of an inadequate infrastructure for disease prevention health promotion activities. From patients/clients perspectives, prevention was an invisible concept. Health care in the military is experienced as the development of interpersonal and systems relationships with others, grounded in personal commitment, efficiency of services and health/illness problem resolution, regardless of the professional role and title of the health care provider. From a systems point of view, there is evidence to suggest that an overarching strategic plan for integrated healthcare is lacking. (Ronan, 2003, p. 5) (see Appendix A)

These findings suggest that even in optimal practice environments, clinical preventive services lack a comprehensive focus. Additional researchers were finding similar results during this same period of time. Kottke, Solberg, Brekke, Cabrera, and Marquez (1997) conducted a mail survey of 7,997 randomly selected patients from 44 primary care clinics. Their results raise similar questions as previous studies:

On the average, about two-thirds of the patients in each clinic reported being up-to-date on preventive services before each clinic visit; an exception was pneumococcus immunization (mean rate 33%). Except for blood pressure and smoking cessation advice, less than 30% of patients who were not up-to-date on a preventive service were offered it if the clinic visit was for a reason other than a checkup or physical exam. For patients who said that they saw their physician for a checkup or physical examination, the rate was more than 50% for Papanicolaou
smear only. In contrast, nearly all responding practitioners agreed that each of the eight preventive services was very important or important. (Kottke, Solberg, Brekke, Cabrera, & Marquez, 1997, p. 515)

Conclusions were that preventive services consensus goals were not being met, even for patients who reported that their clinic visit was for a checkup or physical exam. “This finding suggests that it may be necessary to develop clinical systems that support and enable the delivery of preventive services” [italics added] (Kottke, Solberg, Brekke, Cabrera, & Marquez, 1997, p. 515).

In another comprehensive study that was conducted by the American College of Preventive Medicine titled “The 1998 National Prevention in Primary Care Study” (American College of Preventive Medicine, 1998) in which 15,208 surveys were mailed to nurse practitioners, physician assistance, doctors of osteopathy, and doctors of medicine in primary care specialties. This survey was designed on the dimensions and objectives from Healthy People 2000 initiatives that were used in previous studies (Ewing, Selassie, Lopez, & McCutcheon, 1999; Ronan, 2003).

On all dimensions, physicians practicing in primary care specialties failed to meet objectives for the three domains of primary care prevention, assessment, counseling/treatment, and preventive services. Nurse practitioners and physician assistants fared much better, but all groups failed to display a comprehensive approach for individual patients and clients (American College of Preventive Medicine, 1998). Similar to previous research results regarding poor performances of physician practices of clinical preventive services in which publication was delayed ten years (Ewing,
Selassie, Lopez, & McCutcheon, 1999), “The 1998 National Prevention in Primary Care Study” was never published in the scientific medical literature.

Oversight. Governance of illness care organizations began in earnest in 1991 when the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization began accrediting managed care organizations in response to the need for standardization, objective information, and quality concerning illness care institutions. In 1995, NCQA developed a health plan “report card” with the Health Plan Employer Data and Information Sets (HEDIS), a tool used to measure performance on important dimensions of care and services on over 60 different measures.

The impact this new surveillance had on regimes of practice of health promotion and healing was dramatic, due in part because these measures were focused broadly across health care systems and not on a composite of preventive care that any one individual might be expected to receive. Institutions began “chasing” HEDIS indicators in order to increase their “report card” scores that would make them more competitive in the market place. This placed the clinical expert in a position of responding to the demands of their institution to shore-up discrete indices that may be deficient, such as immunizations at the expense of addressing the spectrum of individual prevention needs that were consistent with the evidence as a standard of care.

More evidence based data. The “new surveillance” was followed by another strategy of the clinical experts to sequester monopoly over the regime of health promotion and healing knowledge: operationalizing of evidence based knowledge for practice which first appeared in the medical literature in 1991. This notion gained

Simultaneously, this “preeminence” to evidence based knowledge for practice was an attempt to foil the knowledge explosion occurring with the newest innovation of information, the “internet,” through which individuals sought to exploit the wealth of health information in order to help themselves in their wellness quests. As a response, instead of embracing this medium, the internet was marketed by the *clinical experts* as “unreliable and unsafe, even dangerous” because *expert knowledge* must come from *clinical experts* located in primary care settings.

Extensive effort was afforded the persistence of the *strategic move* that began in 1994 that insisted on the practices of health promotion and healing as “*integrated prevention within the precedence of illness care.*” The reality of “prevention as step-child to illness care” continued as an attempt by the discipline of medicine to continue its apprehension of the regime of practice of health promotion and healing. This stranglehold was apparent despite the substantial literature which indicated *expert clinicians* were practicing clinical preventive services at a level below the standards of care expected in illness management.
Dramatic changes were made in the nation’s health goals projected over the subsequent decade 2000-2010. These revisions, justifications, and plans were presented in the publication of *Healthy People 2010* (Healthy People 2010 [Group] & United States Dept. of Health and Human Services, 2000).

*Missing links.* *Healthy People 2010* objectives were designed to achieve two overarching goals: first, increase quality and years of healthy life; and second, eliminate health disparities. These goals are contiguous to the goals outlined in *Healthy People 2000* with one glaring omission—the lack of achieving access to preventive services for all Americans.

This omission was not an accident. Since the discipline of medicine had no data to support that they were practicing clinical preventive services consistent with the evidence or as a standard of care, they made a face-saving effort to absolve themselves of responsibility based solely on the assertion that their poor performances was due exclusively to the poorly reimbursement for clinical preventive services (Wilson, 1998). Consequently, they were abandoning their efforts until it became financially conducive to practice clinical preventive services. Of course, we could not expect them to work for free!

The influencing of policy on the part of medicine is noteworthy in that it substantiates how policy (*Healthy People 2010*) now stipulates, through its concerted programs, a status quo consistent with the discipline’s business plan, and not with the science of clinical preventive services narrowly or the regime of practice of health
promotion and healing broadly. This influence of the program of policy is an example of reflexive governance in play including a reformulated ethic.

The structure to Healthy People 2010 includes three levels: first, two overarching goals—increase quality and years of healthy life and eliminate health disparities; second, 28 “focus areas” (see figure example 1) similar to the 22 “priority areas” in Healthy People 2000; and third, 10 leading health indicators that represent the major health concerns for the nation. These “priority areas” or health indicators were adopted due, in part, because “a major challenge throughout the history of Healthy People has been to balance a comprehensive set of health objectives with a smaller set of health priorities” (Healthy People 2010 [Group] & United States Dept. of Health and Human Services, 2000, p. 25).

The leading health indicators were as follows:

Physical activity; overweight and obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence; environmental quality; immunizations, and access to health care (Healthy People 2010 [Group] & United States Dept. of Health and Human Services, 2000, p. 24).
**Figure 1. Healthy People 2010 Focus Areas**

<table>
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<th>Focus Area</th>
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<tr>
<td>1. Access to Quality Health Services</td>
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<td>2. Arthritis, Osteoporosis, and Chronic Back Conditions</td>
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<td>3. Cancer</td>
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<td>5. Diabetes</td>
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<td>6. Disability and Secondary Conditions</td>
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<td>7. Educational and Community-Based Programs</td>
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<td>8. Environmental Health</td>
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<td>9. Family Planning</td>
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<td>10. Food Safety</td>
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<td>11. Health Communication</td>
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<td>12. Heart Disease and Stroke</td>
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<tr>
<td>13. HIV</td>
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<tr>
<td>14. Immunization and Infectious Diseases</td>
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<tr>
<td>15. Injury and Violence Prevention</td>
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<tr>
<td>16. Maternal, Infant, and Child Health</td>
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<td>17. Medical Product Safety</td>
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<td>18. Mental Health and Mental Disorders</td>
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<td>19. Nutrition and Overweight</td>
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<td>20. Occupational Safety and Health</td>
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<tr>
<td>21. Oral Health</td>
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<tr>
<td>22. Physical Activity and Fitness</td>
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<td>23. Public Health Infrastructure</td>
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<tr>
<td>24. Respiratory Diseases</td>
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<tr>
<td>25. Sexually Transmitted Diseases</td>
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<tr>
<td>26. Substance Abuse</td>
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<tr>
<td>27. Tobacco Use</td>
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<td>28. Vision and Hearing</td>
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Micro—macro determinants of health. Determinants of health are identified in model format for the framing of the Healthy People 2010 initiative (see figure example 2 & Appendix B). What is troubling is that there is no distinction as to the types of determinants—micro or macro—or more concerning, that micro determinants are the total sum of determinants. On closer examination and after deciphering the definitions provided, one can be fairly certain that the intent of this model is to target only micro determinants of health.

Macro determinants of health include the sum total of effects of the complex interactions of governance as it relates to macrolevel social and economic processes derived from the separate, yet interrelated, political and economic spheres. These processes are played out in quasi—democratic processes in combination with power relations or, more specifically, class power that influence health across the life course (Foucault, 1991a; 2004; Navarro, 2003b; Pearce & Smith, 2003). Since macrolevel economic and social policies set the bounds within which communities and individuals live, it follows that micro determinants of health—behavioral patterns, genetic predispositions, social circumstance, shortfalls in medical care, or environment exposures—should not be studied out of context (Pearce & Smith, 2003). The degrees of expression of microlevel determinants of health are contingent on the degree of constraints or expansions of macrolevel determinants of health.

The determinants identified in this model are: biology, behavior, social environment, physical environment, and policies and intervention (see Appendix B).
Figure 2. Healthy People 2010 Determinants of Health

Additionally, “access to quality health care” was deemed to be concert with these micro
determinants of health. What is comprehensive health care? *It certainly does not include
the measures of comprehensive clinical preventive services it infers.* Yet the preeminent
requirements for desired outcomes delineated by the Healthy People 2010 assumes its
incorporation into all aspects of quality health care. Illness care better describes what
actually occurs.

*Psychometrics.* A subtle but blatant change was made in the psychometric
methodology in the transition from *Healthy People 2000* to *Healthy People 2010*, all
without explanation or rationalization.

Objectives were no longer written at an “*interval level*” as they were previously.

*Ordinal level objectives replaced interval level.* Several examples follow:

*Healthy People 2000*: 2.3—Reduce overweight prevalence of no more that 20%
of people (a 23% decrease).

*Healthy People 2010*: 19-2—Reduce the proportion of adults who are obese.

Target setting method: Better than best. Baseline 23%, target 15%.

This transition means that in order to meet the goal or measure success, improvement
only needs to exceed the current baseline, “better than best” and not necessarily attain the
target in order to declare success. Additionally, it attempts to hide a national trend of an
increasingly overweight population (BMI of 25-30) by shifting measurement to only the
obese, defined as a BMI of over 30.

*Healthy People 2000*: 1.12—Increase to at least 50 percent the proportion of
primary care providers who routinely assess and counsel their patients regarding
frequency, duration, type, and intensity of each patient’s physical activity practices.

*Healthy People 2010*: 3-10h—Primary providers who counsel about physical activity. Target setting method: Better than best. Baseline 22%; Target 85%. Success would be declared if the threshold of baseline were exceeded, not with a degree of target attainment.

More dramatic are the objectives that disappeared between 2000 and 2010. Most notably the following *Healthy People 2000* goal:

21.6 Increase to at least 50 percent the proportion of primary care providers who provide their patients with the screening, counseling, and immunization service recommended by the U.S. Preventive Services Task Force.

The emphasis on clinical preventive services disappears as well from 2000 to 2010. None of the 17 objectives that comprised the basis for clinical preventive services are measurable in *Healthy People 2010*. In its place appears the following:

1-1 Increase the proportion of persons with health insurance. Target 100%. Target setting method total coverage.

1-2 (Developmental) [this means if no progress or measurable data by mid course review, this objective will be deleted] Increase the proportion of insured persons with coverage for clinical preventive services (no baseline, no target)

The effects of these changes are an apparent removal of responsibility or accountability for the clinical experts to provide clinical preventive services. Yet an assumption is made that if you have health insurance, clinical preventive services will
happen at a level that meets the established high standards in the evidence. Individuals
are now responsible for their own preventive care, which all agree is desirable, but how is
it accomplished? Where is the correct knowledge? What do I not know? How much does
it cost? Conversely, the clinical experts who have specialized knowledge, now, instead of
using those knowledges to facilitate optimum clinical preventive services outcomes, sit in
judgment through non-adherence and blaming discourses.

The previous partnership between health care provider and the individual is
dissolving and disappearing and in its place is an intricate network of “personal
responsibility.” Gone is the notion of shared responsibility which included personal
responsibility, the family, community, health professionals, media, and government.

The Regime of Practice of Health Promotion and Healing— post—Healthy People 2010
Publication

Governance effects are prevalent in the strategic reformulation of health policy
represented in Healthy People 2010. The usual outcomes of policy vested through
programs are to affect regimes of practices with predetermined objectives. In this study
one would expect to observe that health policy, specifically Healthy People 2000 would
vest through specific program deployment particular purposes related to healthy
outcomes for the nation. This is the usual outcome one would expect in understanding
governance from a structural/functional starting point. However, what actually occurred
with the deployment of Healthy People 2000 is still governance, just a more complex and
sophisticated version.
In this complex mode of governance, elements of the regime of practice of health promotion and healing specifically, the discipline of medicine, were able to reflexively co-opt the policy of Healthy People 2000 through re-writing the functioning of its underlying objectives. This was accomplished in order to realign them with a more optimum business plan conducive to the discipline of medicine—health as illness practice. The discipline of medicine should not be condemned for these games and strategies they deploy because they are just proxies for a whole host of interested parties such as the pharmaceutical industry, proprietary hospital associations, and the medical industrial complex—that are solely vested in capitalizing on human illness as an industry.

With the operationalization of Healthy People 2010 what was left standing was not health policy with independent motive and autonomy, but instead, policy functioning with re-written knowledge—health as illness—organized as a monolith of authority for clinical experts to scrutinize the various levels of an individual’s health promotion and healing non-adherence.

Healthy People 2000-Final Review

The “new agenda” of Healthy People 2010 was presented before the final data were published from Healthy People 2000. The timing of this report most likely contributed to the lack of attention that these results from Healthy People 2000 received in the press as well as the scientific literature.

Rosy data is contrived data. “Healthy People 2000 was an ambitious effort and invaluable in setting 319 specific objectives for the Nation. In fact, progress was achieved
on over 60 percent of the objectives” (National Center for Health Statistics [U.S.], 2001, p. iv). Is this progress? Is this success? Actually, only 83 of 367 were met for a 22% attainment rate.

“We can all take pride in the fact that the past decade saw substantial improvements in the quality of life for many Americans” (National Center for Health Statistics [U.S.], 2001, p. iv). These rosy evaluations are, for the most part contrived. The most important concern is how the data were analyzed. In most cases, data was measured at the interval level. It was more precise measurement with the net effect of holding each interest area more accountable for potential improvement. For example:

2.3—Reduce overweight prevalence of no more than 20% of people (a 23% decrease).

However, data were only reported using ordinal level principles: met, moved toward target, mixed progress, no change, moved away from target, cannot assess.

By reanalyzing the composite of 376 goals, through collapsing the categories of met and moving toward target, we find: 83 met, 154 moving toward, for a total of 237 out of a total of 376, equals 63%, an acceptable attainment rate. However when looking at met goals, 22% is the reality. An accurate assessment of the results was evident in the following statement: “some of the changes observed were relatively small and may be within what could be expected on the basis of sampling or random variation” (National Center for Health Statistics [U.S.], 2001, p. 3). The technique of reducing the data resulted in less precision but a more positive light for the results—is the dominant theme throughout this report.
And the clinical experts? Clinical preventive services, comprised of the 17 objectives that represented a cross-section of desired practices and levels of desired services, received little attention. The results: none were met. What must be understood is that these goals were structured in such a way that they represented a “low-end” standard of care for preventive care services for providers (the experts with the knowledge accessed through the health and illness care systems). Reported data were primarily from nurse practitioners with physicians reporting on average only 10 percent of the time on all indices (National Center for Health Statistics [U.S.], 2001).

If a corollary were to be made between meeting the standard of care for preventive practices compared to illness care, a paradox emerges. Practicing below a standard of care in illness care is paramount to malpractice. Preventive care, as most expert clinicians would attest, has no standard of care—it is only “value added.” It is well established that prevention has a much larger impact on health over the life-course than illness management—so why no standard of care?

The answer most often received is a neoliberal perspective, prevention “is individual responsibility.” Does it follow that clinical experts with expert knowledge are not responsible for conveying this knowledge to their clients in any substantive way, yet hold those same clients responsible for preventive care? It can be conjectured that in the integrated conception of health and illness care, hypothetically clinical experts are charging for prevention services that they are not providing. Where do people receive the necessary expert knowledge for prevention, health promotion and healing? Increasingly, it appears from nowhere.
Not all contingencies of the discipline of medicine—specifically public health—were happy with the direction of the health of the nation. In 2001 the Guide to Community Preventive Services: Systematic Reviews and Evidence-Based Recommendations (Truman, Smith-Adkin, Hinman, Gebbie, Brownson, Novick, Lawrence, Pappaioanou, Fielding, Evans, Guerra, Vogel-Taylor, Mahan, Fullilove, & Zaza, 2000) were published to offset the exclusive individual clinical expert approach to health prevention and promotion expressed in the Guide to Clinical Preventive Services (U.S. Preventive Services Task Force, 1996).

New community guidelines. The most important aspect of the new community guidelines was a shift of behavior from its previous focus of risk factors on which we could intervene directly to a position of “intermediate outcome” (Green & Kreuter, 2000). For example, Green (2000) states:

Rather than putting behavior in the role of “determinant,” the Task Force has placed it alongside other intermediate outcomes in the “causal pathway between a determinant and the final health outcome.” This is consistent with the social determinants theories and ecologic approaches that have emerged in health promotion internationally with Healthy People initiative in the United States; the Ottawa Charter; and various Canadian, European, and World health Organization initiatives in health promotion and population health. (p. 7)

Non-health effects such as quality-of-life, social, and environmental effects are given new attention (Green & Kreuter, 2000). This approach “is a refreshing departure
from the single-minded focus other professionals and sectors have come to expect of health professions and sciences” (Green & Kreuter, 2000, p. 7).

While the results of this new community focus may be years away, it is at least a fresh beginning. What must be stressed is that the new community guidelines are not intended to supplant the focus of clinical experts in primary care practices, rather the new focus is proposed to be used alongside of existing strategies. After all, community level determinants of health are still understood to be micro-determinants of health (Pearce & Smith, 2003).

Education of clinical experts. With the dismal results of the Healthy People 2000 initiative, and the introduction of community focused guidelines, a reemphasis of efforts was seen from the proponents of the clinical experts vested in comprehensive professional education for experts. This educational effort aimed at the professional disciplines was instituted by the Healthy People Curriculum Task Force (Allan, Barwick, Cashman, Cawley, Day, Douglass, Evans, Garr, Maeshiro, McCarthy, Meyer, Riegelman, Seifer, Stanley, Swenson, Teitelbaum, Timothe, Werner, & Wood, 2004) with the intent to create clinical prevention and population health curricula that would be transdisciplinary. Content included four components—evidence base of practice, clinical preventive services-health promotion, health systems and health policy, and community aspects of practice. A central mission was to standardize these components of “expert knowledge” across all practicing clinical disciplines.

More negative findings. While the “new” initiatives may impact the regime of health prevention and healing at some future date, current realities suggest a well
established trend that education is not effective. A study entitled *Health Promotion in Physician Organizations: Results from a National Study* (McMenamin, Schmittdiel, Halpin, Gillies, Rundall, & Shortell, 2004) found that over 60 percent of physician organizations offered at least one health promotion program targeting one or more of eight areas: prenatal education (42%), smoking cessation (39%), nutrition (39%), weight loss (34%), health risk assessment (25%), stress management (25%), substance abuse (20%), and sexually transmitted disease prevention (16%). It is alarming that these are viewed as targeted health promotion areas and not a comprehensive composite of needed services for each individual in these practices. Even as targeted prevention services their performance in delivery of clinical preventive services was dismal. The authors conclude that “physical organizations have a long way to go in offering these important programs to patients” and that by “offering recognition and incentives for quality improvement, and by funding the expansion of information technology, the healthcare community can encourage and enable physician organizations to increase the availability of health promotion programs nationally” (McMenamin, Schmittdiel, Halpin, Gillies, Rundall, & Shortell, 2004).

Why do we need to keep coaxing the “medical experts” to practice clinical preventive services? Are they not experts? Or is it a matter of a financial model? Yarnall, Pollak, Ostbye, Krause, and Michener (2003) propose a more telling reason for the 

continued lack of preventive care services provision.

In their research, they compile a detailed listing of all preventive recommendations from the *Guide to Clinical Preventive Services* (U.S. Preventive
Services Task Force, 1996). Their intent was to determine how much time it would take to implement the guidelines in a typical hypothetical family practice setting of 2500 patients or clients. They determined that if only the prevention interventions rated most important (category A & B) were implemented, it would take 7.4 hours of each day to deliver these services. This would leave 0.6 hours each day to provide illness care to the entire population of the panel.

These are stunning results on first reading. But if we recall, panel size recommendations in 1993 (Public Health Service, 1993) were optimally to be no larger that 1200-1500 patients or clients for each primary care provider. If you divide this hypothetical panel in half, reducing the size from 2500 to 1250, the time requirement for preventive services per day would drop to 3.7 hours. This equates to 4.3 hours per day for illness care for panel of 1250 patients or clients. These numbers are consistent with the hypothetical panel size set in 1993 (Public Health Service, 1993) where a balance between wellness and illness care was projected to have parity.

One of the of the key recommendations that Yarnall, Pollak, Ostbye, Krause, and Michener (2003) offer is that it may be incumbent on physicians to develop team practices in concert with other health professionals such as nurses. Ironically, these same recommendations were made seven years earlier by the Institute of Medicine in Primary Care: America’s Health in a New Era (Institute of Medicine [U.S.], 1996). Practice by interdisciplinary teams was promoted as essential for the best possible outcomes and was most likely to occur with multiple experts with diverse professional training.
A growing trend in the medical literature is discussions concerning restricting or forgoing clinical preventive services altogether due to the growing complexity of illness care (Blau, 2004; Hofer, Zemencuk, & Hayward, 2004; Trude, 2003). The American Academy of Pediatrics is considering “rethinking well-child care,” in light of the growing complexities and demands of illness care (Schor, 2004). Well-child care comprises 20-40 percent of time for most pediatricians, and increasingly this practice is plagued with compliance issues related to prevention indices (Schor, 2004). The simple answer seems to be to eliminate or rework clinical preventive services.

**Trends and tensions.** There is also a growing clarion call in the literature to transition to a consumer driven health care (illness care), one in which individual responsibility coupled with a savvy consumerism for prevention and medical services becomes the norm. This focus is for an exclusive market model where third-party insurance takes the lead from prudent consumers (Herrick, 2005).

The tension surrounding clinical preventive services delivery in primary care setting is reaching a point of confrontation fueled by requirements to maintain a business plan with lucrative reimbursement levels. Additionally, demands from health care organizations to acquire and sustain competent HEDIS measures, along with increasing complexity of illness care are also contributory. Last, individual’s concerns for their health promotion and healing needs, mapped out as patient, client, and customer, are increasingly burdens for their clinical experts.

**Third strategic move.** These emergent tensions regarding clinical preventive services mark the third strategic move: “illness care matters: assigning blame for
preventive lifestyle non-adherence”. This era spans 2004-2006 and beyond, with no end-point in sight.

The result of these tensions has been to increasingly shift the burden back on the individual, through fostering “more responsibility for their own health promotion and healing.” This move can be seen as “technologies of citizenship” (Dean, 1999b), the techniques called upon to create a self-reliant individual, one with discipline and self-esteem who is empowered to care for the self. “Technologies of agency” (Dean, 1999b), the contracting out for services, are increasingly advanced. In the case of health promotion and healing, the individual is encouraged to compete in the marketplace to meet health promotion needs, acting as an agent for her/himself. Simultaneously, “technologies of performance” (Dean, 1999b) are implemented, the numerous techniques that comprise performance indicators, benchmarks, and expected outcomes. Technologies of performance are the mechanisms for monitoring success of both technologies of citizenship and technologies of agency. All these strategies are intertwined in the expectation of a new individual prudentialism. The non-adherent individual is now solely responsible for her or his actions and bears these consequences, singularly.

The new prudentialism is visible in a recent interview with stakeholders in the states of Kentucky and West Virginia where Medicaid patients were made the target for constraining costs. The Governor of Kentucky, Ernie Fletcher, stipulates that “we want members to be “personally responsible and actively engaged in their health care” shifting to a “private healthcare market for more consumer awareness, education, and decision
making” (Montagne, 2006, p. 1) In Kentucky, Medicare rewards members for healthy behaviors that hold down cost. West Virginia has taken the same position, but with an additional caveat as outlined by Nancy Atkins Medicaid Director: “patients who don’t live up to their member agreements won’t have access to what the state is calling its enhanced benefit package. That means, for example, they won’t be eligible for mental health care or diabetes care or more than four prescriptions per month” (Montagne, 2006, p. 2). The new prudentialism has dawned.

Healthy People 2010 Midcourse Review

The most dramatic action taken in the Midcourse review was the deletion of several objectives. The primary objective deleted that pertains to clinical experts is the following:

1-2 Deletion: Health insurance coverage for clinical preventive services.

Why was this removed? Answer: no data were available or projected. Does that mean that insurance schemes are only focused on illness care? Or is prevention now totally subsumed under illness care? The intention is quite instructive.

A theme of very little progress is the hallmark of the Healthy People 2010 Midcourse Review (National Center for Health Statistics, 2006). Data trends suggest that “only minimal progress has been made for the population-based objectives at this early point in the decade” (National Center for Health Statistics, 2006).

Given the dismal progress thus far for most objectives in the Healthy People series, is it possible to ask if the Healthy People 2010 initiative is nothing more than a program of health promotion and healing knowledge through which clinical experts with
expert knowledge leverage authoritative technologies of risk and blame onto individuals? This program has failed in its attempt to instill purposeful intent into the strategies of the regime of practice of health promotion and healing and has reflexively rewritten and redeployed to be congruent with the agenda of the illness care system. Bluntly, the program of health policy was out-maneuvered and subsumed by elements of the regime of practice of health promotion and healing.

Identity

We have arrived in this analytic process at a particular point where an individual’s health promotion and healing identity is affirmed. This is the result of complex governances played out through the regime of practice of health promotion and healing over the course of approximately sixteen years. In 1990, health promotion and healing identity was situated in an individual who was “prescriptively knowledgeable and disciplined for adherence as a result of participating in obligatory collaboration”.

Over the course of this analytics I have described three strategic moves of the regime of practice of health promotion and healing that have contributed to how we have arrived at where we are today. First, the strategic move, “segregated prevention and illness care with equal significance and priority” reigned briefly from 1990-1994. The second strategic move, “integrated prevention within the precedence of illness care” and existed for approximately ten year, 1994-2004. In the third strategic move, “illness care matters: assigning blame for preventive lifestyle non-adherence” was identified in 2004 and persists today.
What exists in 2006 is an identity fashioned for individuals by the regime of practice of health promotion and healing that resembles a “health anomie.” This is to be understood not as a final subjectivity but rather as a beginning point for individual resistance through technologies of “care of the self” (Foucault, 2003a) or “self care” (Braden, 1990, 2000). Fox (1999) described the deliberate act of resistance or movement as health-becoming or “arché health,” the provisional embodiment of health as subjectivity.

*Analytics Revisited*

What was accomplished in this analytics section was not to explicate a perfect or ideal regime of practice of health promotion and healing, but to schematically suggest how it actually functions, the net effect of immeasurable interrelated rationalities that are strategically fashioned into the multifaceted governances in which we live. In the next section, I examine the diagnostics, the process of asking how we can *act differently than we have become*—resisting the realities just exposed in the analytics of the regime of practice of health promotion and healing. Likewise, contextual questions pertinent to the application of the results from the analytics will also be explored.

*Diagnostics*

Foucault’s strategy for diagnostics in discourse analysis guided the final part of this work. The *analytics* and *diagnostics* are kept separate from each other for mythological clarity; that is, the empirics are explicated more accurately and precisely if theory and ideology are temporarily suspended. In diagnostics, the empiric findings are examined in a broader socio-political-ideological context. The analytical portion reveals
the structures and functioning of regimes of practice and the diagnostics consists of the
critical discussion of applicability of analytical findings. The diagnostics is the process of
discussion and critique of the results within a context of applicability, the U.S illness care
system including illness insurance. Foucault’s concern for rigor, his desire not to mix
things up and to maintain his reader’s confidence, prompted him to keep analytics
(analysis) and diagnostics separate in his work (Deleuze, 1992; Tully, 1999).

Two distinct topics will be discussed in the diagnostics phase that highlights the
applicability of the findings of current regime of practice of health promotion and healing
governance. First, health insurance, the scheme the U.S. uses to provide (or not provide)
ilness care to their population and second, the reality of macro determinants of health
within the context of neoliberalism.

Insurance

A six-text series commissioned by the Institute of Medicine evaluating
contemporary U.S. illness care insurance and the health consequences for citizens and
residents represents the most independent assessment of the illness care and insurance
industry to date. These texts span a four year period 2001-2004 and present the follows
topics:

1. Coverage Matters (Institute of Medicine [U.S.], Committee on the
   Consequences of Uninsurance, 2001);

2. Care Without Coverage: Too Little Too Late (Institute of Medicine [U.S.],
   Committee on the Consequences of Uninsurance, 2002a);
3. *Health Insurance Is a Family Matter* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002b);

4. *A Shared Destiny: Community Effects of Uninsurance* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003b);

5. *Hidden Costs, Value Lost: Uninsurance in America* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003a);


Prior to analyzing these texts, technologies of insurance will be presented so that mechanisms of insurance operating in the U.S. illness care system are clearly delineated. **Technologies of Insurance**

Ewald’s (1991) discussion of insurance and risk provides a good understanding of its operation. Risk is essential to all insurance schemes. Risk contains three crucial points, all of which must be satisfied in order for insurance to function as it was intended: as an efficient (economic) collective enterprise to disperse hazards and dangers of populations.

Risk is calculable. This is the first essential point, whereby insurance is radically different from a bet or a lottery. For an event to be a risk, it must be possible to evaluate its probability. Second, risk is collective. Whereas an accident, as damage, misfortune and suffering is always individual, striking at one and not the other, a risk of accident affects a population. Strictly speaking there is no such thing as an individual risk; otherwise insurance would be no more than a wager. Third, risk is capital. What is insured is not the injury that is actually lived, suffered, and resented by the person it happens to, but a
capital against whose loss the insurer offers a guarantee. The lived injury is irreparable: afterwards it can never be the same as before (Ewald, 1991, pp. 201-205).

Insurance is the practice of certain type of rationality. It has no special field of operations. Rather than being defined in terms of its objects, it is ubiquitous. It provides a general principle for the objectification of things, people and their relationships. Ewald (1991) suggests that insurance involves several specific dimensions of technique.

First, insurance involves an economic technique. It is a means of providing a service, an indemnified technology, and a contract for potential profit. Second, insurance involves a moral technology, a challenge to conduct one’s life in the manner of an enterprise. To provide for the future does not just mean living from day to day and protecting oneself against ill fortune but, instead, transforming one’s relationships with nature so that, even in misfortune, one retains responsibility for one’s affairs by possessing the means to repair its effects. Third, insurance involves a technique of reparation and indemnification of damages (pp. 206-207).

The combination of these different dimensions makes insurance a political technology. It is a technology of social forces mobilized and utilized in a very specific way. Insurance creates a new grouping of human interests. People are no longer juxtaposed alongside one another in society. Instead, a reciprocal penetration of souls and interests establishes a close “solidarization” of interests (Ewald, 1991, p. 207).

The technologies and techniques deployed in illness care insurance are a complex structure of epidemiological risk coupled with highly scrutinized coverage requirements
such as preexisting medical conditions including mental health, demographics including age, sex, and occupation, and behaviors including smoking, alcohol use, and obesity.

In general, the usual approach to insurance involves three mechanisms of profit extraction. First, a hypothetical baseline for the entire insurance pool of clients is set to include costs of administration plus a pre-determined profit margin. This base-line also represents a projection of health care costs that are contractual over a specified period of time. Second, risk adjustments are made individually for each client in the insurance pool based on their calculated risk of deviation from the hypothetical base line, resulting in their insurance premium being modified. *The Health Insurance Portability and Accountability Act* (HIPAA) minimally corrected this problem—the practice continues of using the exclusionary language of the act as a work-around. Few people meet the stringent requirements for preexisting conditions to be excluded hence must forgo the pre-existing exclusions provision outlined in the Act.

Thus far, the only criticism of insurance is why are certain insured individuals assigned increased differential in premiums when insurance is about sharing the risk for calamities surrounding an event—in this case, illness? But this cost differential scheme is not the most treacherous technique commonly applied. The third mechanism or technology of wealth extraction used by the insurance industry is the scrutinizing of services provided or about to be provided in order to justify cheaper, and, in most cases, less effective treatment modalities. These techniques usually result in one of four outcomes—reduced or denied services, negotiated partial payment, declined payment, or increasingly, cost-shifting back to the insured. But most importantly it is a technology for
profit in the illness insurance scheme. A caveat that must not be understated is the
insurance industry’s position on reimbursement for clinical preventive service. The
literature specifies that prevention is integrated within illness care implying the
contention that reimbursement for illness care includes prevention. The insurance
industry subsequently asks of clinical experts—why are you not practicing what the
literature stipulates?
Over time the discipline of medicine has been able to secure a fairly steady revenue
stream from the insurance scheme of reimbursement, while at the same time allowing the
insurance industry to extract excessive profits. Insurance pools that result are contrived in
the sense that they represent a population without high illness variability compared to the
general population. Most needy patients are excluded through screening processes and
end by receiving no care or care from state or federal programs (Woolhandler &
Himmelstein, 1997, 2002). While this is to be expected somewhat in a competitive
market-based insurance market, the degree of these actions makes insurance companies
predators on the illness misfortunes of the U.S. population.

Coverage Matters

An important context of the Institute of Medicine series on insurance is its narrow
scope. It is specifically limited to the population without any form of insurance, no-
insurance, excluding those with any form of federal or state illness insurance and the
population with illness insurance that do not have comprehensive coverage (Institute of
Medicine [U.S.], Committee on the Consequences of Uninsurance, 2001, p. 28).
Individuals with illness coverage through federal and state-sponsored programs such as Medicare and Medicaid represented 27.3 percent of the population in 2006 (Kaisernetwork.org, 2006). Furthermore, estimation of the under-insured population ranges from 20-25 percent of all U.S. residents (Kaiser Commission, 2002). In 2006, 46.6 million residents did not have any form of illness care (Kaisernetwork.org, 2006). This represents 20 percent of the population under the age of 65.

In Coverage Matters (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2001), three persistent myths about the illness care crisis are dispelled.

First, people without illness insurance get the medical care they need. In fact, the uninsured are much more likely than persons with insurance coverage to go without needed care.

Second, people who lack illness insurance are in families where no one works. The reality is that more than 80 percent of uninsured children and adults under the age of 65 live in working families.

Third, growth in the numbers of immigrants has been a major source of the increase in the number of uninsured persons. Importantly, while the growth in the numbers of recent immigrants who have arrived within four years have higher-than-average uninsurance rates, they comprise a relatively small proportion of the general population (six percent nationally), while representing fewer that 20 percent of uninsured residents. (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2001, pp. 2-5)
The balance of this report concentrates on describing the mechanisms of how illness insurance works: how coverage is gained and lost, opportunities to purchase coverage, limited coverage options, and coverage trends over time. A portrait of the uninsured includes: the social and economic factors affecting coverage, coverage variations over the life cycle, demographic disparities in coverage, geographic differences affecting coverage, and factors influencing uninsured rates.

This well intended effort is fatally flawed on one crucial assumption: illness care insurance is the solution to the nation’s illness care needs. Their premise of insurance for all is formulated into the following question: what must be done to secure insurance for everyone? A more pertinent question to pose would be: why is insurance the only solution forwarded by the experts?

Care Without Coverage: Too Little Too Late

In this text, the Institute of Medicine’s conclusions centered on the following three points:

First, the health of uninsured adults is worse than it would otherwise be if they were insured; Second, providing health insurance to uninsured adults would result in improved health; and third, increased rate of health insurance coverage would especially improve health of those in the poorest health and most disadvantaged in terms of access to care and thus would likely reduce health disparities among racial and ethnic groups. [italics added] (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002a, p. 5)
While these conclusions are logical, what is troubling is the data from which they are derived.

Findings: Health insurance coverage is associated with better health outcomes for adults. It is also associated with having a regular source of care and with greater and more appropriate use of health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and the effective treatment of acute conditions such as traumatic injury and heart attacks. The ultimate result is improved health outcomes.

Findings: Health insurance is most likely to improve health outcomes if it is continuous and links people to appropriate health care. When health insurance includes preventive and screening services, prescription drugs, and mental health care, it is more strongly associated with the receipt of appropriate care than when insurance does not have these features.

Findings: Increasing health insurance coverage would likely reduce racial and ethnic disparities in the use of appropriate health care services and may also reduce disparities in morbidity and mortality among ethnic groups. [italics added] (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002a, pp. 7-8)

These findings sound like they are straight from ideology propagated by the American Medical Association. Appropriate health care is a code phrase for clinical experts and in this case, physicians. If that is the case, how is it that the health of the nation fares so poorly as indicated in the findings of Healthy People 2000? With regard
to clinical preventive services, we can state unequivocally that these services occur in all practices at such low frequency, that there cannot be a cause and effect relationship drawn as was implied. It is an illusion. Illness care insurance may increase your chances of receiving clinical preventive services, but minimally, as the literature points out.

Are these findings not intuitive, why would you expect otherwise? Anyone who previously has no care, and receives care, are they not better off? Is this support for the continuation of the medical agenda, a business plan that highlights the exclusivity of physicians in the hierarchy of illness care? Where is the discussion about cost? Or, what is the profile of those without insurance?

The problem of uninsurance is predominantly an issue of class. Those most likely to have difficulty obtaining illness care insurance are trapped in a compromising social-economic crisis. Addressing illness care in isolation is certainly an overstatement of its potential to contribute to overall population wellbeing. It is important to recall that lack of illness care accounts for only 10 percent of morbidly and mortality on a population basis, with attention to macro determinants of health having a far greater impact on health than illness care (McGinnis, Williams-Russo, & Knickman, 2002; Navarro, Borrell, Benach, Muntaner, Quiroga, Rodriguez-Sanz, Verges, Guma, & Pasarin, 2003). While illness care should be universal for all residents, its problematic portrayal in this Institute of Medicine report that suggests universal insurance is the solution the nation’s illness care crisis is vastly overstated and inconsistent with the science.
Health Insurance is a Family Matter

This Institute of Medicine account, Health Insurance is a Family Matter (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2002b), offers the most revealing analysis of consequences of class than compared to the two previous reports. Three major topic areas are discussed: insurance coverage of families, insurance transitions over the family life cycle, and financial characteristics and behavior of uninsured families.

Insurance coverage of families. Four demographic characteristics implicate the impact of class on the potential for family illness insurance coverage. First, if parents have health insurance, children are likely to be covered as well. Second, in 20 percent of the more than 38 million families that include children, one or more family members is uninsured. This has ramifications beyond the individual(s) without insurance, since it affects all members in that family from a financial perspective if illness is encountered. Third, many uninsured children are eligible for, but not enrolled in, public programs. More than half of the eight million children who remain uninsured are eligible for Medicaid or State Children’s Health Insurance Program (SCHIP) coverage.

During welfare reform in 1996, Congress passed legislation barring legal immigrants entering the U.S. after August 1996 from Medicaid for five years after immigration. It is this population of children along with undocumented residents that comprise the ineligible cohort of children living in the U.S..

Why are four million eligible children not enrolled in some scheme of coverage? Maybe the structure of the programs suggests we don’t want them to participate. For
example, there are two major plans related to health care, Medicaid and SCHIP, and three plans related to poverty, TANF (Temporary Assistance for Needy Families), State Food Stamps, and State Child Care programs. Each of these federal through state or state programs has different qualification criteria, each has its own application process and they are unlinked from one another. Additionally, these programs are different from state to state. Can we make it any more complex?

The fourth demographic characteristic that has overtures of class is that family insurance coverage is strongly and positively related to income. Only 59 percent of families with children and with income less that 50 percent of the federal poverty level (FPL) have members covered, compared with 90 percent of families whose income is above 200 percent of federal poverty level. The FPL for a family of four in 2006 is $20,000. In restating these facts in terms of dollars we understand that: only 59 percent of families with children and with income less than $10,000 dollars have members covered with 90 percent of families with income of $40,000. How can anyone who makes $10,000 a year, in real terms, $2,500 per family member per annum, afford illness insurance? How can families secure illness insurance when the issue is poverty?

*Insurance transitions over the family life cycle.* Due to the structure of public health insurance programs and the cutoff of age for dependents’ eligibility in private insurance plans, it is more likely that dependent children will become uninsured as they transition from home to the workforce where they are more apt to secure some type of illness insurance coverage. The likelihood of illness insurance coverage during this transitional period is tempered by several primarily economic factors: the ability of the
launching family to assist, the capability of the child to secure opportunities and negotiate
the preparation necessary to access the work force, and the probability that the child’s
chosen occupation offers employment with employer-based illness insurance coverage.

The link between health insurance and employment for most families creates
potential for loss of coverage. In order to obtain or maintain coverage, family work
choices may be constrained. Work choices for families enrolled in public insurance
programs may also be inhibited because of the income restrictions for eligibility. What is
the prospect for wellbeing if the need for illness insurance coverage drives employment,
vocation, or career choices?

Family structure has an important impact on securing illness insurance coverage.
For example, marriage increases the chances of having employment-based health
insurance for the whole family. Disunions such as separations, divorced, or being
widowed may increase the risk that the family members lose their employment-based
coverage. Aside from the facts, does this say something about what our society values?

Financial characteristics and behavior of uninsured families. Four points are
highlighted that again draw attention to the issues of class in a family’s quest to obtain
illness insurance coverage. First, families with at least one uninsured member are
predominantly lower-income families. Second, most uninsured families do not have
sufficient funds in their budget to purchase health insurance without substantial premium
subsidy. Third, on average, families in which some or all of its members are uninsured
spend less on health care in absolute dollars using fewer services than families with all
members covered by private insurance. Families with uninsured members are also more
likely to have high health expenditures as a proportion of family income than are insured families. Fourth, among families with no health insurance for the entire year and who have incomes below the poverty level, more than one in four have out-of-pocket expenses that exceed five percent of income—four percent of all uninsured families have expenses that exceed 20 percent of annual income.

Is this data news to people living in poverty? Framing the problem in this way implies that issues of illness care (implying health) can be solved if only we can obtain illness care insurance for everyone. Are the poor being silently implicated as the scapegoat for ills of the illness care system? Why are the uninsured charged higher rates for the same services than those fortunate enough to be insured?

Bankruptcies have increasingly been the “only way out” for many U.S. residences. In a study completed in 1999, 40 percent of all U.S. bankruptcies were related to medical bills (Gottlieb, 2000). Mathur (2006) reported that nearly 27 percent of bankruptcy filings were the direct consequence of primary medical debt with 36 percent of cases representing substantial medical debt that co-existed with primarily credit card obligations. The impact of medical costs and illness care overwhelming falls inequitably on financially disadvantaged residents. The insensitivity of U.S. lawmakers to these issues is evident in the recent passage of Bankruptcy Abuse Prevention and Consumer Protection Act that makes bankruptcy a far more complex option for overwhelming medical and illness care debt. The lawmakers intent is implied in the title of the act—personal responsibility. How is this not a class issue?
A Shared Destiny: Community Effects of Uninsurance

The focus of illness insurance shifted to the community in the next installment in the series titled *A Shared Destiny: Community Effects of Uninsurance* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003b). The Committee summarized its finding in the following statement:

The adverse effects of uninsurance that accrue to uninsured individuals and families in a community, as well as the financial strain placed on the community’s health care system, have important spillover on community health care institutions and providers. (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003b, p. 1)

This entire text is devoted to attributing the demise of the U.S. illness care system to the uninsured—the result of uncompensated care has severely compromised the wealth generating machine of insurance companies, hospitals, pharmaceutical companies, and especially the *experts*—the medical care providers.

This text represents a missed opportunity to discuss the community in terms of how a community should be discussed—as an essential element of societal infrastructure that facilitates health promotion and healing of its residents. Instead, the community is depicted as a characterization of an environment that has failed in disciplining compliance with the capitalistic strategies of the illness care machine. Blame is set squarely on a segment of society least likely to help themselves—the poor. These arguments represent an example of how the literature is used to pronounce an ideology centered on capitalization as the model of the illness care industry. Salvation for the
nation rests with securing a revenue stream to pay for everyone’s insurance for illness care.

*Hidden Costs, Value Lost: Uninsurance in America*

Placing a dollar value on the consequences of uninsurance is the intent of the next text in the series titled *Hidden Costs, Value Lost: Uninsurance in America* (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003a). In this volume, findings suggest:

The Committee’s best estimate of the aggregate, annualized cost of the diminished health and shorter life spans of Americans who lack health insurance is between $64 and $130 billion for each year of health insurance forgone. These are the benefits that could be realized if extension of coverage reduced the morbidity and mortality of uninsured Americans to the levels for individuals who are comparable on measured characteristics and who have private health insurance. (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003a, p. 4)

Furthermore, the cost of providing for the segment of the population that is uninsured is stated as follows:

Estimates of the cost of the additional health care that would be provided to the uninsured once they became insured range from $34 to $69 billion per year, assuming no structural changes in the systems of health care financing or delivery, average scope of benefits, or provider payment. (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2003a, p. 103)
In contrasting these two sets of findings, one can see that if these statements are in fact accurate, an investment in illness insurance for the uninsured is financially cost effective and highly lucrative from the standpoint of a national investment. Are these facts legitimate? They might be close to the mark if, for example, the assumptions underlying these assertions were realities. A key assumption is that the illness care system actually delivers results that it socially contracts to perform: comprehensive integrated illness and prevention services. While there is plenty of evidence suggesting that illness management outcomes fall far from the mark (Himmelstein, Woolhandler, Hellander, & Wolfe, 1999), findings from the previous analytics section suggest that clinical prevention services rarely, if ever, meet standards of care for the currently insured population.

With this in mind, a more accurate assertion would be: if practices of the illness care system met standards of care for illness management and health promotion the health of the nation surely would benefit from universal illness insurance coverage for all its residents. If this assertion were realized, the above findings from the Institute of Medicine would have more merit.

What is most troubling is the unrecognized limitation of the scope of the illness care system to deliver overall population health (Navarro & Shi, 2001; Pearce & Smith, 2003). The overriding arrogance is the assumption that the illness care system capability includes the identification, apprehension, and control of all micro and macro determinants of health.
Insuring America’s Health: Principles and Recommendations

The culmination of the Institute of Medicine’s series on the uninsured was outlined in Insuring America’s Health: Principles and Recommendations (Institute of Medicine [U.S.], Committee on the Consequences of Uninsurance, 2004). In this text, four prototypes were described that represent differing approaches to the status quo. Three of these recommendations continue on variations of the capitalization of illness through illness insurance models. Only one, single payer, offers a comprehensive solution both in terms of cost effectiveness and guaranteeing a defined benefit to all residents of a nation (McCormick, Himmelstein, Woolhandler, & Bor, 2004; Navarro, 2003a; The Physicians' Working Group for Single-Payer National Health Insurance, 2003).

Woolhandler and Himmelstein (2002) specify that 59.8 percent of total illness care costs in the U.S. is already funded through tax-financed federal-state plans. These include tax subsidies that accrue mostly for the affluent and health benefits for middle-class government workers and the military. National health insurance would require smaller tax increases than most people imagine and would make government’s role in financing more visible and explicit. This, of course, would mean the elimination of the insurance industry as a technology of wealth extraction where 25-30 percent of illness care dollars go to administrative costs compared to 2-4 percent overhead for Medicare and Medicaid federal and state programs (Bitton & Kahn, 2003). This is to contrast with Canada’s single payer system that has a one percent cost for administration (Bitton & Kahn, 2003).
The transition to a single-payer illness care plan is not constrained by the lack of compelling evidence; it is the political power (power as domination) of the illness industry machine, such as insurance companies, hospitals, pharmaceutical business, and the political arm of discipline of medicine that block changes to status quo.

No matter how well intentioned the Institute of Medicine’s motives were in creating these series of texts on the uninsured, I have refocused the critique by centering the effects of their arguments within the context of current U.S. health policy. The illness care system in place relies primarily on private schemes of illness insurances for the majority of the population, with government programs designed only to fill in the gaps for the most needy. Based on past longitudinal performances, by all accounts, this policy has failed citizens and residents alike and requires complete restructuring (McCormick, Himmelstein, Woolhandler, & Bor, 2004; Woolhandler & Himmelstein, 2002).

**Macro Determinants of Health Within the Context of Neoliberalism**

Macro level determinants of health are the *consequences* derived from the collection of economic and social policies that sets the bounds within which we live (Navarro & Shi, 2001; Pearce & Smith, 2003). These macro determinants of health as *consequences*, are viewed as being imbedded in the complexity of power relations that comprise the interconnecting spheres of the “autonomous processes” of rationalities of government, political economy, as well as the social sphere (Foucault, 1991a) (see figure example 3).
Figure 3. Relationship of Macro to Micro Determinants of Health

Macro Determinants of Health

Rationalities of Government

Social

Political Economy

Micro Determinants of Health

Individual and Community

Behavioral Patterns 40%
Genetic Predispositions 30%
Social Circumstance 15%
Shortfalls in Medical Care 10%
Environmental Exposures 5%
Political Economy, Rationality of Government, and the Social

Political economy, comprises one of the effects of interrelationships, played out strategically through complex governance as forms of class power represented by the business class (capital), working class, opportunistic classes, and social movement classes. The relationships among these classes are inversely related, representing unrelenting struggles and antagonisms. Socioeconomic or economic inequalities represent the effects of class struggles, strata within a society or group, and are without characteristics of real social relationships between them, such as in class relations themselves.

Rationalities of government result in specific structures of sovereignty that represent the spectrum from welfare regimes (collective socialism) to conservative or ex-fascist dictatorships (scarcely developed welfare states). The following are examples moving from the most social to least social: the social democratic states—the Scandinavian countries; corporatist or family welfare states (class and status-based insurance schemes and heavy reliance on the family to provide support) such as Christian democratic states—Germany, France, and Italy; liberal welfare states (market-dependant)—the U.S., England, and Australia; and scarcely developed welfare states such as Spain, Portugal, or Greece (Navarro, Schmitt, & Astudillo, 2004).

The sphere of the social represents the “living space” of citizens and residents. The entire population of sovereignty is in various states of compliance, response, or resistance to the political economy and rationalities of government. The activities of the social are implemented as individual or cooperative public discourse, and various
democratic actions. Discourses, democratic actions, dissidence, and acts of resistance are targeted at governance processes in attempts to modify policies that adversely affect the wellbeing of the social. The continuum of power relations enacted in the public sphere ranges from “conduct of conduct” to domination.

Past historical tension (how to govern) between rationalities of government (sovereignty types), political economy, and the social—represent a critique of excessive state power, termed liberalism. In contemporary times, critiques moved progressively from social liberalism (more state involvement) to liberalism (a balance) to neoliberalism (less state involvement). Since the 1970’s the increasing influence of global capital coupled with growing critiques of the welfare state have ushered in an era of global neoliberalism (Chomsky, 1999; Harvey, 2005; Saad-Filho & Johnston, 2005).

A major contention held in contemporary sociological and public health literature is that the degree of neoliberalism is linked to the degree of health inequalities within and between nations (Coburn, 2003; Navarro, Schmitt, & Astudillo, 2004; Navarro & Shi, 2001). The most cited mechanisms of health inequalities within and between nations are sovereignty structure (type of state), class power, and income differentials. A cursory review of the literature suggests that most attention is focused on income differentials as a primary mechanism of health inequalities. The income disparity hypothesis is represented by three positions: absolute-income, relative-income, and income inequality.

The absolute-income hypothesis states that income alone, in isolation from any other social factors, determines an individual’s health. Next, the relative income hypothesis states that the individual’s relative—rather than absolute—income affects his
or her health. Relative is referenced in terms of a social context. Relative income related to a social or class strata in which one is enmeshed, the negative or positive effects are seen through psychological-social mechanisms of social cohesion. The income inequality hypothesis states that individual health is directly influenced by income disparity; health is affected by the scale of social and economic difference within the population (Wilkinson & Bezuhrchka, 2002; Wilkinson, 1996).

**The Class/Welfare Regime Model**

Coburn (Coburn, 2003) suggested that income inequality may be correlated with health but that income inequality probably reflects, or is a proxy for, a variety of social conditions, operating through individual and collective, material and psycho-social pathways, rather than income inequality being a single main cause of poor health (p. 43). These factors relate to social infrastructure—education level and availability of community and social resources.

Income inequality is itself a consequence of fundamental class structure changes which have produced not only income inequality but numerous other forms of health-relevant social inequalities (Coburn, 2003, p. 43). In the U.S., the tax reformulation strategies favoring the capital class during the Bush regime was a form of class restructuring, an inverse progressivism. Similarly, the loss of power of labor movements resulted in shifting class power to the corporate class.

As for sovereignty, Navarro and Shi (2001) suggested that positive welfare measures depend on basic social, political, and economic institutions linked to the degree to which societies take care of their citizens or leave their fate up to the markets of
neoliberalism. Income inequality is a consequence, not the determinant of social hierarchies and social class (Navarro, 2003b). Political traditions that are more committed to redistributive policies, both economic and social as well as committed to policies of full-employment are most successful in improving the health of their populations (Navarro & Shi, 2001, p. 20).

Coburn (2003) offered a class-based model (see figure example 4) that describes inequality resulting from macro-determinants of health within a broad conceptual framework. This model minimizes the prominence of effects attributed to income inequality and social cohesion and places them among multiple material factors—their interpretations and meaning—within an ever changing social infrastructure. Together they are central mechanisms of health inequalities (p. 53). Coburn (2003) contends in his descriptive model (see figure example 4) that with increased globalization, neoliberalization and power of capital (A), there is a reduction in the degree of welfare regimes of nation-states with a simultaneous increase reliance on markets to solve social problems (B). Outcomes resulting in this structure reconfiguration include the following: decreased social cohesion, income inequality, poverty, and differential access to numerous social recourses—including work type, education, health care, housing, transportation, nutrition, etc. (C). The net effect is decrease health and wellbeing as well as decreased economic wealth for the middle and lower social strata (D). This model best represents processes of macro determinants function.

It is well acknowledged that macro determinants of health have a much greater impact on mobility, mortality, and life expectancy than a composite of micro
determinants of health (Navarro, 1998; Navarro, Borrell, Benach, Muntaner, Quiroga, Rodriguez-Sanz, Verges, Guma, & Pasarin, 2003; World Health Organization, 2000). However, all determinants of health should be addressed in such a way that facilitates optimum well-being for all (McGinnis, Williams-Russo, & Knickman, 2002).

Summary

A major thematic linking the diagnostics findings with analytics results divulges an ironic conjecture: all that is needed for citizens and residents to have optimum health is to have health insurance—especially for the benefit of clinical preventive services offered by clinical experts. Unfortunately, my findings suggest that clinical preventive services are not occurring for anyone, with or without insurance. This simplistic reduction is an example of the rationalities that are persistently offered in favor of sustaining our current U.S. illness care (neglect) system.

A summary follows in the next chapter of the analytics and the diagnostics results of this historical discourse analysis to set the stage for recommendations for the discipline of Nursing within the context of these findings.
Figure 4. Class/Welfare Regime Model

The Class/Welfare Regime Model

- Economic Wealth
- Well-being
- Health
- (Trust, Social Cohesion)
- Markets
- Welfare Regimes
- Neo-liberalism
- Globalization
- Economic Power of Capital
- Differential access to resources including income inequality
- Health care, housing, work, education
- Transportation
- Nutrition, etc.
CHAPTER V
DISCUSSION AND RECOMMENDATIONS

Discussion

The central research question for the historical discourse analysis was as follows:

How do practices of governance and risk operate in the context of a neoliberal society to construct subjectivity (identity) specific to the discourse of health promotion and healing?

In this discussion, I will map out the answer as well as the process of how I arrived at the final conclusion posed in the research question. I begin with a review of this inquiry and a proposed perspective from which the construction of identity of health promotion and healing was developed.

U.S. Illness Care System

I began my inquiry by sketching the state of viability of the U.S. illness care industry that, by all measures of performance, is dysfunctional. However, from the point of view of the illness care industry’s ability to extract wealth from U.S. citizens and residents, market outcomes are marvelous. The U.S. illness care system consumes two times per capita compared to the next most expensive illness care system in the 29 country Organization for Economic Cooperation and Development (OECD). In fact, U.S. costs are three times that of the U.K., a neoliberal stalwart. In 1999, the U.S. percent of GNP (Gross National Product) spent on the illness care industry was 13.6 percent. By 2015 it is projected to grow to 4 trillion dollars, or 20 percent of GNP (National Coalition on Health Care, 2004). The U.S. was ranked the least fair in distributing illness care to its
citizens and residents, lowest, among all the 29 OECD countries, and is the only
developed country in the world that does not provide illness care coverage for its entire population (World Health Organization, 2000).

From the standpoint of outcomes, the U.S. had the following ranking among OECD countries in 2003 (OECD, 2005): life expectancy, total—22nd out of 30 nations; life expectancy, men—22nd out of 30 nations; life expectancy, women—23rd of 30 nations. Infant mortality ranking was 26th out of 30 nations. Ranking on obesity defined by percent of population aged 15 and above with a BMI greater than 30—represents 30.6 percent of the U.S. population—with ranking of worst, or 30th of 30 nations.

Domestically, the U.S Census Bureau estimated that on Tuesday, October 17, 2006 the U.S. officially passed the 300 million people landmark for the nation. Of the number, 47.7 million U.S. citizens were projected to be without any illness care insurance based on 2005 calculations (Kaisernetwork.org, 2006). Furthermore, twenty percent of the U.S. population is underinsured, defined as sub-standard coverage relative to comprehensive illness care plans resulting in substantial out-of-pocket costs to make up the difference. This equates to 50.5 million people. When totaling the uninsured and the non-insured we currently have 98.7 million people with no or sub-standard illness care coverage in the U.S., representing nearly 33 percent of the total population.

These realities of the U.S. illness care system demonstrate that market ethics is all that counts in neoliberal societies.
Apprehension and Reformulation of Health Promotion and Healing

My major premise is that there is a concerted effort on behalf of the illness care industry to monopolize the entire spectrum of human wellbeing so markets can be carved out for profit, or wealth extraction. When looking at the lexicon “health care” in the U.S. we are actually describing only what happens in illness care, the institutions that are perpetual illness machines in quest of better illness care.

The results of the discourse analysis of Healthy People 2000 indicate that health promotion and healing is a mythical entity, a belief system that is disguised and repackaged as illness care for the purpose of deceiving citizens and residents into believing they are receiving a service that they expect and paid for. Yet, as the evidence suggests, they are not.

My proposed reformulation of health promotion and healing attempts to situate health as it is understood in most global definitions such as the World Health Organization, as a collection of multiple practices leading to the well-being of human kind. Specifically, the definition of health promotion and healing outlined in this analysis encompasses most, if not all, descriptions of movement toward positive well-being. These terms include but are not limited to: health, healing, prevention, wellness, public health, community health, health promotion, high-level wellness, primary health care, holistic care... What I hope to project is that the definition of health promotion and healing includes all activities that lead toward human wellbeing.

It is with this understanding that I introduced health promotion healing in terms of it’s functioning, as a regime of practice, that includes the entire collective efforts of
realizing human wellbeing. I attempted to *re-appropriate* health conceptually as wellbeing wherein matters of illness and illness care are only minuscule components. As such, the definition used to guide this analysis was:

the regime of health promotion and healing spans the individual to the state, micro to macro determinants of health and includes all activities construed to contribute to health—the optimal state of functioning or well being understood through healing—the process of maintaining and restoring health, to become and remain whole and sound.

*Analytics*

The discourse of the regime of practice of health promotion and healing details how certain practices follow trajectories of strategy in functioning. As such, many programs attempt to influence strategies of the regime of practice of health promotion and healing by investing them with a particular purpose or an agenda. The *Healthy People* series is such a program, an example of how U.S. health policy attempted to influence the strategies of this regime of practice. In this analysis, the functioning and strategies of the regime of practice of health promotion and healing are understood as governance—the deployment of intricate power relations—that detail the breadth and degree of inclusion or incorporation of *programs* of health policy.

Dean (1999a, pp. 23-24) suggested there are four dimensions which are co-present and co-create governance in the strategies of regimes of practice. The first, characteristic is forms of *visibility*, the non-discursive—the visibility of the body and its subjection to “the clinical gaze.” Second is *knowledge*, the discursive, a distinct way of
thinking and questioning, relying on defined vocabularies and verbal and written
procedures for the production of truth. Third are practices, techniques, and technologies,
the mediator between and the net effect of visibility and knowledge. These three are a
specific way of acting, intervening and directing, made up of particular types of practical
rationality such as mechanisms, techniques, and technologies. Fourth is identity
formation, which are the characteristic ways of forming subjects, selves, persons, actors,
or agents.

By tracing and collating the non-subjective empirical evidence in these four
dimensions it was possible to describe the strategies of the regime practice of health
promotion healing over a period of approximately 30 years. A critical preamble to the
prevention era was the apprehension or reduction of well-being into the context of illness.
Following Foucault, “it might be argued that health has been transformed into an object
of medical treatment” (Foucault, 2004, p. 13).

The composite of texts analyzed from the Healthy People series comprised the
medium of analysis for determining the strategies of the regime of practice of health
promotion and healing from 1979 to 2006. From these analytical results, three strategic
moves of the regime of practice of health promotion and healing were deciphered that
contribute to how we have arrived at where we are today.

In the first strategic move, “segregated prevention and illness care with equal
significance and priority” reigned briefly from 1990-1994. As the result of anticipated
health care reform, there was great zeal to develop an “ideal” illness care delivery system.
This translated into prevention and illness care co-existing on even footing. However, an
important caveat was that access to prevention was possible only through accessing *clinical experts* in primary care settings, a continuation of the reduction of health to illness care venues. Experimental models for practice proliferated in the literature. Nurse practitioners were especially emboldened because this integrated model of practice was consistent with their profession’s ontological and epistemological roots—holistic, comprehensive care, steeped in notions of essentialism. This era was short lived as the illness care reform movement perished with a transition to a conservative political climate.

In the second *strategic move*, “integrated prevention within the precedence of illness care” existed for approximately ten years, 1994-2004. Prevention as a separate entity with it own “defined benefits package” emulating from a “standard of care for prevention” disappeared, subsumed under the rubric of illness care as “value added care” delivered at the convenience of the *clinical expert*. Additionally, HEDIS (Health Plan Employer Data and Information Sets) measures were developed that targeted discrete prevention practices and focused the *clinical experts* away from providing clinical preventive services comprehensively. During this timeframe, the literature was replete with study after study stipulating that *clinical experts*’ performance in providing clinical preventive services was substantially sub-standard. The final results of the *Healthy People 2000* initiative confirmed the numerous studies in the literature: comprehensive clinical prevention practices were an illusion.

The third *strategic move*, “illness care matters: assigning blame for preventive lifestyle non-adherence” was identified in 2004 and persists today. Amid ongoing
performance studies reflecting clinical preventive services continually were sub-standard, a new lexicon of clinical preventive services was beginning to emerge in the medical literature. This new movement “spun off” responsibility for clinical preventive services due to the growing complexity of illness care, and placed it where it was thought to logically belong—on the noncompliant individual. The clarion call was to transition the individual into a consumer driven market for prevention services outside the venue of illness care.

This arrival of the new “prudentialism” for individuals in their quest for health concluded the analytics analysis. What remained was to describe the newly emerged “identity” that has evolved over 16 years of transition of the regime of practice of health promotion and healing. What was expected of individuals regarding their health promotion and healing identity in the late 1980’s was an individual inscribed as “prescriptively knowledgeable and disciplined for adherence resulting from participating in obligatory collaborations.”

Contemporary identity of health promotion and healing fashioned for individuals by the regime of practice of health promotion and healing portrays a health anomie.

This resembles an individual set adrift without mooring in the sea of health promotion and healing, searching for the life vest of truth. The clinical expert is off on new pursuits shoring up their particular discipline’s plan for survival in competitive uncertain markets. For nursing, this means heightened focus on “hospital non-system” functioning—reducing risks and errors, efficient staffing, improving the workplace, dealing with labor shortages and, most importantly, protecting “our” division of labor.
Diagnostics

The purpose of diagnostics is to articulate the empirical results from the analytical analysis section within a larger socio-political-ideological context. I focus on the U.S. illness care system technology of insurance. Additionally, discussing the findings of the analytical section from the perspective of macro determinants of health exposed the limited scope of the effectiveness of the illness care system in yielding overall health for the nation. In this analysis, a series of six texts from the Institute of Medicine on insuring health was critiqued. The objective of the Institute of Medicine was to highlight awareness about the consequences of uninsurance for 47.7 million (2006 projections) citizens and residents of the nation. The Institute of Medicine explored the spectrum of this consequence for those unfortunate individuals with no illness care insurance, and identified the cascading ramifications for the family, community, the illness care system, and finally, the nation. While the intent of this comprehensive review of the illness care insurance industry delivery system is commendable, it falls short on several counts.

The first major assertion made by an expert panel assembled by the Institute of Medicine was that the uninsured need illness insurance so that they can receive clinical preventive services. While this is to be expected as an endorsement of current U.S. health policy, it certainly does not reflect what happens in actual practice. Clinical preventive services are poorly provided, never meeting a standard of care expected for illness care management. These results were for populations already with illness insurance. The assertions of the expert panel were only theoretical and were not based on actual practices.
The second major assertion that was more thematic than specific: illness care problems would dissipate if a revenue stream could be secured so that all citizens and residents were able to obtain illness insurance. The “class of the poor” was featured in a compelling way. Their condition, economic deprivation, was demographically portrayed as the symptom most likely to result in uninsurance. The burden of illness on the poor was highlighted and described accurately, but only in light of identifying the cause of uninsurance. No compelling critique on why poverty exists to such a level in the U.S. was ever offered. The “class of the poor” became the poster child for “what is wrong with our illness care system.” It is the poor who seek uninsured care in emergency rooms, and hospitals driving up cost due to “uncompensated” services, “cost-shifting” onto hospitals, providers, and the insured population, resulting in higher and higher illness care costs for everyone.

The data used to frame the uninsurance problem did not take into account the complex interaction of macro and micro determinants of health. Their analysis was a simplistic reduction of complex multi-causal social factors and concluded that uninsurance is a major cause of our nation’s poor health. Many of the studies did not account for the problem of under insurance, the 20 percent segment of the population who has sub-standard illness care insurance.

However “well intended” this series on the uninsured by the Institute of Medicine was, it fell short of the mark. A more comprehensive examination of how the illness care system functions in the U.S. would have demonstrated that it is the insurance industry that accounts for the technology of wealth extraction from citizens and residents that has
led, in part, to the portrayal of U.S. illness care system as the “most expensive in the world” with one of the poorest performance outcomes. The net effect of this series was the promulgation that universal illness insurance is the answer to our illness care dilemma in the U.S. This “band-aid” solution is typical of U.S. health policy for the past seventy-five years.

Many types or structures of illness care systems exist in the world ranging from single payer systems to complex market driven insurance plans similar to those in the U.S.. Compelling data suggest the single payer plans are more cost-effective and egalitarian, yet it is political and economic will that determines the type of illness care system a nation ends up supporting. How much do illness care systems contribute to the overall health? While important, there is substantial data to suggest that the most important determinants of health are not micro determinants—the focus of the illness care system, but rather macro determinants of health that focus on the complex relationships of rationalities of government, political economy, and the social.

Rationalities of government yield the structure of sovereignty a nation ends up with along with the consequential social infrastructure. Political economy gives way to structures of class power played out through capital that extends beyond the bounds of sovereignty. The social space is where degrees of resistance counteract outcomes resulting from the tensions between political economy and rationalities of government.

The results of these tensions and resistance to sovereignty—critique of excessive state power—over history has progressed through phases termed classic liberalism, to social liberalism, to a new era that has been in play since the 1970’s—neoliberalism.
general terms, within sovereignty, neoliberalism represents less government and unconstrained markets conceptualized not as a fixed entity, but as dynamic tension between rationalities of government, political economy and the social. The term neoliberalism represents the degree the scale is tipped toward class power and capital power.

Within the U.S. illness care system not only are macro determinants of health not recognized, micro determinants are the single focus of intervention. Additionally, a cycle of blame is leveled at individuals if these interventions are not successful. The rationality of the U.S. illness care system is that the upwardly spiraling cost are due to the non-adherence of individuals in responding to the interventions of these micro determinants and not the wealth extraction mechanism of the technology of insurance (see figure example 5).
Figure 5. Scapegoat Cycle: the Individual or Wealth Extraction?

Scapegoat Cycle: the Individual or Wealth Extraction?

(-) Measured Indices

(-) Clinical Experts

(-) Individual

(-) Blame!!

(-) Increased Illness

(-) Cost to the Nation

(-) Poor Results

(-) Manipulated

Macro Determinants

Micro Determinants
Conclusions

I have analyzed health promotion and healing through specifically chosen texts on health policy in the U.S. spanning approximately thirty years in order to ascertain what type of identity is created for individuals seeking health or wellbeing in their lives. I have characterized the practice of health promotion and healing not as an endpoint, but rather as coherent sets of ways of going about doing things—functions of routines, rituals, institutional practices, or disciplinary practices framed by codes of conduct. These governances represent a conceptual sequestering of practices that through their functioning lead to a common outcome. This global collection of practices was termed: regime of practice of health promotion and healing. The context of neoliberalism was crucial in understanding the trajectory and governance of the various actors in this history; the U.S. as sovereignty, the illness care system inclusive of the insurance industry, various professional disciplines, and stakeholders comprising the regime of practice of health promotion and healing.

The results of this historical discourse analysis have brought us to a “temporal reality” that can be characterized by the following points.

1. The U.S. illness care system, functioning through technology of insurance or wealth extraction, is dysfunctional as a comprehensive illness care delivery system.

2. Health promotion and healing has been subsumed under illness care—if they are addressed it is only as discrete indices that comprise compliance monitoring.
3. Micro determinants of health (such as behavioral patterns, genetic predispositions, social circumstances, shortfall in medical care, environmental exposures), while important, continue to be the single focus of illness care in the U.S.. Conversely, macro determinants of health, contingent on macro-level economic and political structures, remain unrecognized as having any bearing on health outcomes. Macro determinants of health frame the configuration of the social infrastructure in which micro determinants unfold.

4. Neoliberal ideology in the U.S. continues to be the status quo for illness care.

5. Constructed health promotion and healing identity for individuals is one of health anomie, a new prudentialism where access to health promotion and healing has to be acquired from outside the venue of illness care.

The research question posed at the commencement of this discourse analysis is restated:

How do practices of governance and risk operate in the context of a neoliberal society to construct subjectivity (identity) specific to the discourse of health promotion and healing?

My statement of the identity of health promotion and healing is based on a systematic analysis of the functioning of the regime of practice of health promotion and healing over the course of the past 16 years. The context of neoliberalism suggests a clear picture of the future dynamics of the strategies facing the regime of practice of health promotion and healing. Challenges for the trajectories of an individual’s identity of health promotion and healing remain very fluid. The question to ask is: “How can we become different from what we have become?” In asking this question, we as nurses acknowledge
the limitations of the current discourse while expressing hope in a goal that the discourse
can be changed for betterment of human health and wellbeing.

Recommendations

The essential question is where is the voice of the discipline of nursing in the
discourse of health promotion and healing? The reality in this question is precisely the
point. If it were not for the recent efforts of three nurse leaders—Hurdis M. Griffith,
Kristine M. Gebbie, and Janet Allan—in the arena of health policy, the discipline’s voice
would be completely silent.

Following David Allen (1995), the complicity of nursing in accepting the status
quo of the illness care system has positioned nursing in the shadow of medicine that is
cast so broadly that even our own literature is an obscurity to all other disciplines.
Nursing is invisible to everyone but us. We are perceived as subsumed under the
“watchful eye” of the discipline of medicine who discounts our knowledge as illegitimate
because it competes with theirs. Nurses lack voice in the illness care debate.

What is it about the discipline of nursing that has brought us to where we are?
Precisely, it is working within the confines of illness that has sequestered us to single-
mindedness, an enslavement of thinking that defines our practice only in terms of the
illness machine. The work venue of the majority of nurses is in hospitals, yet the potential
of what we have to offer is in the community. If health is our focus as we laud in our
theories, then we must reorient how we practice. Nightingale certainly had it right, how is
it that we have strayed so far off course? Where are the nurses in the community? You
won’t find them in physician’s offices; they have been replaced by a cheaper worker.
You won’t find them in private practice, they haven’t developed any markets. But maybe the answer is as one anonymous public health nurse said, relenting—“the only nurses in the community are selling real-estate.” The following recommendations in the areas of theory, research, and practice are offered in the interest of charting a new course for survival of the discipline in our transitioning neoliberal world.

Theory and Research

The challenges facing nursing have been around us for generations; it is our loss of a “vigilant discipline”—the absence of social critique, which has brought us to where we are. As Foucault reminds us: “…since Kant, the role of philosophy is to prevent reason from going beyond the limits of what is given in experience. But from the same moment—that is, since the development of the modern state and the political management of society—the role of philosophy is also to keep watch over the excessive powers of political rationality” (Foucault, 1982, p. 210). Have we met that challenge in nursing? Have we questioned the rationality of an illness care system that ignores providing services to a forgotten segment of the population? Are we continuing to accept “tainted science” from the pharmaceutical industry whose only interests are to establish a requirement for life-long medicines for individuals? Have we not abandoned the practice of health for that of illness? What will it take for the profession to be successful in our neoliberal world?

First, it would be helpful to reorient the discipline to what our practice currently is: illness care. We must call it what it is, for if we are interested in health promotion and healing a totally different trajectory must be established. Many of our scientific efforts
are now focused on “basic science” that we somehow call nursing research. Where are
the efforts of “application research” or “action research” about health promotion healing
that look broadly at and engage society in knowledge development instead of a narrow
and paternalistic, individualistic—essentialist approach (Holmes & Gastaldo, 2004)? In
response to illnesses, we have tended to the mind far too long—meaning, coping, self
esteem—that we have forgotten the evolutional requirements of the body? Where is the
embodiment of an arché health, a health that moves beyond contemporary discourses of
mind-body, one that defies society’s inscription of our subjectivity (Fox, 1999)? We need
to answer the question “is our philosophy congruent with our new educational
requirements for the CNL (Clinical Nurse Leader) and the DNP (Doctorate of Nursing
Practice)? Are we able to critique these new boundaries of the discipline’s
rationalizations?

Macro determinants, if not the main focus of research efforts, must at least
become the context for all future nursing research. The critical importance of this
understanding is precisely what is missing in our discipline—a macro-social context
(Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2002). A focus on a new approach to
studying the micro determinants of health is also warranted through technologies of “care
of the self” or “self care” as can be see in the following discussion.

Research agendas must be focused on technologies surrounding the nurse as well
as the individual. For the nurse practicing in any setting, these technologies of
performance are a double-edged sword. Not only will these activities monitor outcomes
of practices in highly sophisticated ways (HEDIS measures are a crude beginning), how
nurses practice will face increasing scrutiny as demands for demonstrating the ability to apply evidence or science in practice will replace traditional disciplinary oversight. For the individual, technologies of agency, technologies of citizenship, as well as technologies of performance will be compulsory (Armstrong, 1995; Coyte & Holmes, 2006; Dean, 1999a).

Technologies of agency surround the ability of individuals to represent themselves in the “contracted out” small markets that develop from the inability of the illness care industry to provide needed services sufficiently. This means making prudent choices among a plethora of possibilities. Technologies of citizenship are necessary for the successful implementation of “care of the self.” These are multiple techniques resulting in improved self-esteem, empowerment, consultation, and negotiation over health and wellbeing needs (Cruikshank, 1993; Cruikshank, 1999; Dean, 1999a). For the individual, technology of performance is the self monitoring of one’s ability to incorporate technologies of agency and citizenship effectively in the quest for health and wellbeing.

*Nursing Practice in a World of Neoliberalism*

Our survival as a discipline is contingent on how well we respond to the realities of our neoliberal society. For professional nursing this means reconfiguring and realigning theoretical and conceptual practice approaches within the new educational models established by our discipline: the Clinical Nurse Leader (CNL) and the Doctorate of Nursing Practice (DNP). Core competencies are well established for these roles but I
wish to dispel an overriding assumption that will become a barrier to success with our patients, clients, and customers if left unheeded.

For some time, our mantra for interventions has been based on education. We have assumed that when education is delivered by the expert nurse, behavior change will somehow happen. This model of intervention assumes an individual who is competent in basic life skills, has a desire and capacity to learn, has aspirations to question certain life-health behaviors, and the capability to interface with society in the quest for the tools needed to translate new found knowledges and skills into reconfigured health trajectories. This model is a myth. Unfortunately we have relied on this tactical approach far too long. It ignores learning theory, underestimates or trivializes an understanding of basic human behavior while embracing the rhetoric of health literacy.

I would like to characterize a new identity of the individual: the twenty-first century individual is the product of modernism—technologies, divisions of labor, and divisions of expertise, that create highly competent practices in narrow areas of specialization. Gone are the broad-based education practices that rendered individuals proficient to make critical judgments about an array of subjects, issues, and problems. Despite our global information explosion, the twenty-first century individual is \textit{pragmatically challenged}. Information is unusable because of a lack of practical capacity. In its place are global ideologies, and values that are unable to apprehend the specific. If this were not the case, why is it that we spend so much time counseling college educated individuals on their real deficits in hygiene, nutrition, mobility, child rearing, communication, life behaviors, and decision making? A return to Paulo Freire is required.
The new individual identity is *health anomie*, representing an individual set adrift in a sea of unusable datum. The imperative for nursing is to launch individuals on their own trajectories of “care of the self” or “self care.” In a neoliberal world this is an imperative, not a luxury. Failure to do so will be at one’s own peril. There are no more social safety-nets. Focusing on “care of the self” or “self care” is not a rescue attempt, or a response to the need to enact with our historical enabling skills. It is rather an emancipation—everyone’s.

Our newly defined roles for the CNL and DNP will need to be innovative in order to survive. Our new venue needs to be the community as market-place, away from the center of illness, the hospital. In this scenario, professional nurses are tasked to create markets—markets that are created by *creating demand* for services. In the past, all that was necessary to provide services was our expert knowledge, but today that is not enough. These services must now be reconfigured and redeployed. Instead of demanding that the illness care systems offer a “defined benefits package” of preventive services consistent with the science, interventions transition to solutions in the market place. Marketing these “collection of essential services” directly to consumers, represents a paradigm shift away from traditional illness care delivery systems as the singular resource for health promotion and healing services.

A mechanism of market creation is to contract for *co-managing* of primary care panels with physicians in primary care settings. Marketing nurses acknowledged expertise in systems management, clinical teaching, and the management of health promotion and healing with individuals and their families represents a marketing
technique. These marketing strategies include innovative education venues—the internet, email, group chat sessions, cohort teaching, and maybe even a Nightingale technology—home visits.

Innovation is open, exciting, and essential. But first, we must find emancipation from the illness care industry before we take the new journey.

Postscript

The humanism that once served as a cornerstone in nursing is fading. As we look at our global world, and the results of neoliberalism we see human rights, social justice, and social ethics give way to market justice and market ethics—a morality based in the markets. However, we need not remain as bystanders, wringing our hands until the next election cycle. We must resist. Because, if we haven’t noticed—humanism is on a death march—slowly trudging through the Balkins, Afghanistan, Iraq, Lebanon, Darfur….

How much rationalization can we tolerate? Is it social justice we seek or are we satisfied with the market justice that frames our contemporary identity? Are we still human?
APPENDIX A

PREVENTIVE SERVICES: ROLE OF THE NURSE PRACTITIONER—ABSTRACT

*Purpose:* To describe current practices of military nurse practitioners with regard to clinical preventive services; develop a grounded theory that explicates factors that facilitate and inhibit the delivery of clinical preventive services; describe the military consumer’s experience of care given by nurse practitioners; and determine the essential features of a clinical preventive health care system within the military, the feasibility of initiative implementation, and the readiness of the system for implementation.

*Design:* Naturalistic inquiry, through applying multiple instances of triangulation within and across methodologies in order to reveal a unique dimension embedded within the whole.

*Sample:* The entire population of military nurse practitioners (Air Force, Army, and Navy) in the Department of Defense was invited to participate (N=403) with 246 consenting participants (61%). Additionally, 32 patients/clients of a subset of 20 military nurse practitioners also consented to participate.

*Instrumentation:* Preventive Care Survey II (Ronan, 1996), procedures consistent with qualitative methodologies for content analysis, grounded theory, and phenomenology.

*Methods:* A descriptive quantitative/qualitative survey designed was used in Phase I, Grounded Theory in Phase II, Phenomenological approaches in Phase III, and triangulation methodologies in Phase IV.
Analysis: Quantitative and qualitative data analysis for Phase I were used to describe the clinical preventive services offered by military nurse practitioners as well as aspects of practice that detracted from and facilitated the ability to provide these services. In Phase II, data was used to develop a grounded theory that explicated the impact of social-structural and social-psychological processes in the delivery of clinical preventive services from the perspectives of military nurse practitioners. Interviews from patients/clients in Phase III were analyzed to capture a description of the essence of the care experience from the perspective of the military consumer through phenomenological approaches. In Phase IV data triangulation analysis, a comparative thematic matrix of the three previous data sets, was used to form a theoretical schema including: the milieu of military health care and the presence of clinical preventive services, the role of the nurse practitioner within this system, and the process of military nurse practitioner-client transactions within the health care experience.

Findings: On three domains of primary care prevention, assessment, counseling/treatment, and preventive services, military nurse practitioners reported marginal improvement in level of provided services contrasted with a reference group of national nurse practitioners five years earlier. When queried, most military nurse practitioners valued providing higher levels of services although these values fell short of the recommended levels indicated in Healthy People 2000. Reasons most identified as barriers were, clinician uncertainty, insufficient time with patients, and fragmentation of health care delivery. Behind levels of success with prevention activities was a salient desire for legitimacy seeking through extraordinary “niche filling” activities. These
activities were necessary for successful “role identity” within a context of an inadequate infrastructure for disease prevention health promotion activities. From patients/clients perspectives, prevention was an invisible concept. Health care in the military is experienced as the development of interpersonal and systems relationships with others, grounded in personal commitment, efficiency of services and health/illness problem resolution, regardless of the professional role and title of the health care provider. From a systems point of view, there is evidence to suggest that an overarching strategic plan for integrated healthcare is lacking.

Ronan, J.P. (2003). Preventive services: Role of the nurse practitioner: University of Arizona, College of Nursing, Tucson, AZ; TriServices Nursing Research Program, Bethesda, MD.
APPENDIX B

HEALTHY PEOPLE 2010 DETERMINANTS OF HEALTH DESCRIPTORS

**Biology** refers to the individual’s genetic makeup (those factors with which he or she is born), family history (which may suggest risk for disease), and the physical and mental health problems acquired during life. Aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse, injury or violence, or an infectious or toxic agent may result in illness or disability and can produce a “new” biology for the individual.

**Behaviors** are individual responses or reactions to internal stimuli and external conditions. Behaviors can have a reciprocal relationship to biology; in other words, each can react to the other. For example, smoking (behavior) can alter the cells in the lung and result in shortness of breath, emphysema, or cancer (biology) that then may lead an individual to stop smoking (behavior). Similarly, a family history that includes heart disease (biology) may motivate an individual to develop good eating habits, avoid tobacco, and maintain an active lifestyle (behaviors), which may prevent his or her own development of heart disease (biology).

Personal choices and the social and physical environments surrounding individuals can shape behaviors. The social and physical environments include all factors that affect the life of individuals, positively or negatively, many of which may not be under their immediate or direct control.

**Social environment** includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs; language; and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.

**Physical environment** can be thought of as that which can be seen, touched, heard, smelled, and tasted. However, the physical environment also contains less tangible elements, such as radiation and ozone. The physical environment can harm individual and community health, especially when individuals and communities are exposed to toxic substances; irritants; infectious agents; and physical hazards in homes, schools, and worksites. The physical environment also can promote good health, for example, by providing clean and safe places for people to work, exercise, and play.

**Policies and interventions** can have a powerful and positive effect on the health of individuals and the community. Examples include health promotion campaigns to prevent smoking; policies mandating child restraints and safety belt use in automobiles; disease prevention services, such as immunization of children, adolescents, and adults; and clinical...
services, such as enhanced mental health care. Policies and interventions that promote individual and community health may be implemented by a variety of agencies, such as transportation, education, energy, housing, labor, justice, and other venues, or through places of worship, community-based organizations, civic groups, and businesses.

The health of individuals and communities also depends greatly on **access to quality health care**. Expanding access to quality health care is important to eliminate health disparities and to increase the quality and years of healthy life for all people living in the United States. Health care in the broadest sense not only includes services received through health care providers but also health information and services received through other venues in the community.

The determinants of health—individual biology and behavior, physical and social environments, policies and interventions, and access to quality health care—have a profound effect on the health of individuals, communities, and the Nation. An evaluation of these determinants is an important part of developing any strategy to improve health.

Our understanding of these determinants and how they relate to one another, coupled with our understanding of how individual and community health affects the health of the Nation, is perhaps the most important key to achieving our Healthy People 2010 goals of increasing the quality and years of life and of eliminating the Nation’s health disparities.

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