

Beyond the art of governmentality: unmasking the distributional consequences of health policies

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The aim of this article is to critique health policy discourses that are taken for granted. This perspective will allow for the identification of ‘exclusionary’ health policies, which we define as policies that are thought to offer universal benefit, despite yielding adverse effects for significant groups of people in society. As such, policies that are said to be designed ‘for all’ frequently benefit only a subset of the population. Our intent is to highlight the distributional consequences of certain health policies that are largely institutionalized in contemporary society. We believe that these distributional effects are explicit representations of power in society and that institutions may provide individual ‘choice’ and ‘freedom’ that, in turn, yields separation as an outcome, a separating equilibrium. Specifically, if those who benefit from policies of partition are numerous and are to obtain significant advantage or incur limited costs, or if those who are adversely affected are scarce (or hidden), or the size of these adverse effects are small (or perceived to be minor), then partition becomes more likely as a ‘legitimate’, but exclusionary, instrument of public policy.

Key words: distributional consequences, economy, healthcare services, power, social exclusion.

This article is the product of several months of transdisciplinary (transparadigmatic) reflections and discussions between the authors concerning the distributional effects of health policies advanced by various levels of government, non-governmental organizations, or groups of individuals (including nursing scholars). It started as a challenge and in many ways remains one. Herein, the objective of our endeavor is to integrate two divergent paradigmatic positions, postpositivism and critical theory, in order to uncover taken-for-granted truths regarding so-called ‘universal’ health policies. In trying to merge these two approaches, which are rooted in conflicting epistemological underpinnings, our attempt has been to

infuse a poststructuralist flavor within a ‘logical and cartesian’ discipline (that of economics). We believe our effort is both exciting and necessary, despite its unconventional process.

In effect, we began this paper as if each of us were writing alone. The first draft was ‘*bicéphale*’. Through e-mails we shared many ideas while complaining to each other about the (ab)use of our, and the other’s, respective jargon. At that point, we were forced to leave our comfort zone (our paradigmatic shell) and explore the ‘other’s’ epistemological/theoretical territories. It was the only way through which we could reconcile our differences. In doing so, we ended up exchanging ideas about the *right* concept to use in order to recognize our respective paradigmatic postures.

As readers, you must be prepared for a bumpy ride. Perhaps poststructural scholars will be opposed to this paradigmatic mixture, as might economists. But we trust that this creative and innovative approach to a problem that is both social and

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conceptual will help us unmask governmental technologies (health policies) that are said to be beneficial to all.

Suppose we were to embark on a policy to advance patient-centered care, wherein health services and settings are designed to be responsive to the needs and preferences articulated by care recipients. On the surface, these policies, and the complementary organizational and personal strategies designed to operationalize them, have face validity in that they advance shared decision-making and offer the potential for a better match between scarce societal resources and the underlying preferences and needs of the population. But once the onus shifts to care recipients to articulate their needs and preferences, and accordingly, to select a course of action from an array of competing alternatives, the outcome may be one where the benefits of policy innovation may be unevenly distributed in society.

This inequity in pay-offs from policy innovations might be attributed to variations in the return to the effort expended in articulating preferences or may be due to variations in the capacity to expend such effort in the first place. These distributional effects emerge from the actions (or inaction) of care recipients when they and their resources (physical, mental, financial, time, and social capital) confront a modified policy environment. For instance, some groups in the community might not be able to participate in (shared) decision-making processes regarding particular health issues because of their lack of knowledge. Actual health policies strongly encourage individuals to be involved in shared decision-making with their healthcare providers under the guise of patients' empowerment and self-care. But to what extent are these decisions actually shared when one of the two persons involved in the decision-making process have the knowledge and the other has not? Promoting such policy through the use of tools such as patients' decision aids masks the power/knowledge imbalance between the ones who know (healthcare providers) and the ones who do not (majority of patients). Herein, the politics of the healthcare provider-patient interaction is simply overlooked while the 'appearance' of a shared-decision making process prevails in the collective consciousness. The fostering of such policies will serve those who are well informed and articulate about specific institutional processes while the others (the majority) will remain subjugated to their healthcare providers' expertise and perceived authority in the matter.

In this paper, we are concerned with the distributional effects associated with health policies advanced by various levels of government, non-governmental organizations, or groups of individuals. These distributional effects are brought about by the actions of individuals as they segment or stratify themselves (most of the time involuntarily) into distinct

groups. This stratification represents a separating equilibrium that we refer to as policies that further social inclusion or exclusion. Consequently, the purpose of this paper is to explore the circumstances under which such divisive policies and associated institutions are created, maintained and enforced. A review of the literature on social exclusion highlights the contributions from many theorists, such as Goffman (1975, 1998), Castel (1976), Kristeva (1982), de Certeau (1985), Douglas (1988, 1996) and Foucault (1995, 1996), among others. Some contemporary social scientists and health (or human) geographers have also addressed the issue of social exclusion (Poland 1998; Sibley 1999; Philo, Parr and Burns 2002a, 2002b).

To achieve our objective, we will draw upon the work of the late French philosopher Michel Foucault (1991) to deconstruct health policy discourses. Our 'deconstructive gesture' aims to critique taken-for-granted discourses associated with health policies. Such an approach will allow us to ask the following questions: Why are certain policies never questioned? What are the sociopolitical implications of such policies? What are the distributional consequences of these policies in the circuitry of social exclusion/inclusion? This poststructural posture will facilitate the identification of some exclusionary health policies, which we define as policies that are thought to offer universal benefit, despite yielding adverse effects for significant segments of society. As such, policies that are said to be designed 'for all' frequently benefit only a subset of the population. Here, our intent is to explore the substructures of institutional behaviors; to gauge their intended and unintended effects; to consider behavioural responses to these institutions; and finally, to examine the circumstances under which such institutions are created, maintained and enforced. But before getting to these objectives we will provide a brief overlook of the issue (and importance) of paradigmatic tensions.

COMPETING PARADIGMS

According to Guba and Lincoln (1998) a paradigm is 'a set of basic beliefs (or metaphysics) that deals with ultimate or first principles. It represents a worldview that defines, for its holder, the nature of the world' (200). Therefore, definition and effects of health policies, as well as methodological approaches to economics fall into many different and incommensurable paradigms. Kuhn (1983) stated that all disciplines shift paradigms according to historical context, thus introducing his idea of scientific revolution. Despite this, we believe, along with Guba and Lincoln (1998), that these paradigms, while heterogeneous ensembles, do not disappear when new ones emerge. The coexistence of paradigms allows for opposition and competition for the leading (most

influential) position within a discipline. The paradigm is the equivalent of a language or a culture: it determines the questions that can be asked and those that are excluded, the thinkable and the unthinkable (Bourdieu 2004).

A number of authors are concerned about the influence of postpositivism and accuse it of generating knowledge and discourse to serve the prevailing ideologies and reinforce established norms (health, scientific, social, etc.), and of reveling in a reductionism and determinism that undermines a thorough analysis of health policies and health-care. That is precisely why we decided to merge two competing paradigms in order to critically understand the effects of health policies.

GOVERNMENTAL TECHNOLOGIES AND EXCLUSIONARY PRACTICES

Have we ever considered the unintended effects of various public policies or organizational strategies and asked ourselves whether these effects might have been their 'real' intent, even though such policies were introduced under another guise? For example, consider the 'digital divide' and ask whether this might be a deliberate outcome of an overzealous reliance on new information and communications technologies. Or consider the suspension of 'disruptive' children from schools and ask whether this was the intended effect of 'zero-tolerance' policies. If these effects were the real intent of such policies or organizational strategies, what purpose do they serve?

The development of policy and organizational discourse and the consequent implementation of such policies and strategies are often predicated on the advancement of the interests of particular subgroups in a neoliberal society. Such societies are governed through individuals' desires and freedom (Dean 1999; Rose 1999). Freedom is not the opposite of government, but one of its key inventions and its main resource (Rose 1999). Since the birth of neoliberalism, the individual is said to be able to participate in his/her own welfare. Thus, individuals are part of broader governmental objectives.

According to McNay (1994), Foucault considered governmentality as a complex system of power relations that binds sovereignty-discipline-government in a tripartite manner. Governmentality involves domination (sovereign power) and disciplinary techniques (disciplinary power) as well as self-governing ethics (Deflem 1998). We agree with Deans' definition of government:

Government is any more or less calculated and rational activity, undertaken 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 definite but shifting ends and with a diverse set of relatively *unpredictable effects, consequences and outcomes* (Dean 1999; 11, emphasis added).

Hence, in the contemporary political environment, governing is an activity that aims to shape, mould or affect the conduct of an individual or a group (Gordon 1991). Means (or technologies) of governmentality are numerous and include activities such as policing, nursing, and the development and implementation of health and social policies for the purported well-being of citizens (Holmes and Gastaldo 2002).

Of course, citizenship entails duties and obligations: the obligation to obtain a job when employment is offered (or else suffer the loss of social benefits or face requirements to attend a training centre), the obligation to remain healthy and participate in disease screenings, and so on (Rose 1999). But as an effect, the emphasis on individual responsibility and empowerment may downplay the role of collective service provision; it implicitly assumes that individuals have the choice, the capacity and the obligation to exercise such choices and responsibilities. If such capacities were unevenly distributed in society, then some individuals (possibly the more educated) may garner greater benefits from a strategy that stresses individual responsibility than others. Here, a strategy of highlighting individual responsibility yields a potential reallocation of society's resources. Some members of society gain and others lose.

It appears here that, outside the communities of inclusion (the ones who can and want to be part of governmental programs for instance), there exists an array of microsectors, microcultures (subcultures) of 'non-citizens, failed citizen, anticitizens'. They consist of those who are unable or unwilling to enterprise their lives or manage their own risks, incapable (or resistant to) of exercising responsible self-government, attached either to no moral community or to a community of 'antimorality' (Rose 1999, 259). The marginalized and the excluded are fragmented and divided into categories. Their particular difficulties must be addressed not only by governmental programs but also by technicians who have the expertise to intervene directly upon the so-called 'endangered self'. The main objective of governmentality is to articulate governmental (institutional) policies and objectives with regards to the intervention (and mediation) of an expert, keeping in mind that such policies are said to be framed upon our desires and freedom (Rose 1999). For example, the language of disease and, furthermore, the language of contagion, toxicity and abjection associated with the construction of epidemics, such as AIDS, constitute 'sufficient' and 'rational' reasons for the deployment of legitimate prevention strategies on the part of governmental structures, namely the 'public health apparatus'. Relying on Foucault's theoretical work, the 'apparatus' (*dispositif*) is an ensemble of several 'technologies', associated with social and scientific discourses, cultural representations, architectural

designs, moral propositions, and legal and regulatory structures that may be used to (re)engineer 'appropriate' behavioral responses. Taken together, these technologies and the system of relations that may be so established are 'the apparatus' of control used in the codification and modification of behaviors (Foucault 1980).

But these strategies could also have the effect of stigmatizing some groups more than others. What are the impacts of such governmental strategies? Which agency is served? Recent research on unsafe sexual practices between men (Holmes and Warner 2005) has shown that prevention programs advanced by public health authorities and targeted to men having sex with men (as an inclusion trait), caused a perverse effect among a specific group of men known as barebackers. The barebackers are considered to practice a marginal sex (deliberate unsafe anal intercourse), namely, anal sex without the use of a condom. They are excluded from the preoccupation of HIV/AIDS prevention organizations (because their sexual practice is said to be marginal) and are rejected by many leading gay activists (Holmes and Warner 2005). These actions intensify their perception of exclusion from the gay/bisexual communities.

The HIV/AIDS prevention strategy creates a schism between 'responsible gay/bisexual men' and 'irresponsible (potentially toxic)' ones. It appears here as if outside the 'men having sex with men' community there exists a subculture of so called irresponsible gay/bisexual men, who are unable or unwilling to manage their own sexual life, incapable of exercising responsible self-government. Why would we invest energy in trying to understand such 'extreme' sexual practices charged with abjection and disgust, when the majority of gay/bisexual men are engaging themselves in safe anal sex? We are now witnessing the birth of political rationalities (based on economics, society's tolerance, etc.), which, through programs and policies, serve to 'naturalize the division between the autonomous and the dependent, the willing and the unwilling, the contented and the discontented, the haves and the have-nots' (Rose 1999, 254). At this point we affirm that several institutional objectives may create perverse effects. But what if these perverse effects were only the desired effects masked under the guise of progress, health, personal and professional growth and so forth?

ECONOMICS AS A MEANS OF GOVERNMENTALITY

If institutions exist to cultivate (or construct) perceptions of 'self' and 'other', how and why are such institutions established and how and why are they maintained? And if such institutions result in a separating equilibrium, where some

individuals or organizations are adversely affected and separated from the 'norm', why would these institutions persist? In order to initiate dialogue on these and other issues, a simple conceptual representation of society is outlined. This framework highlights the factors that support the development and maintenance of institutions that enforce social exclusion/inclusion. Such institutions may be explicit representations of power in society or may be subtle in providing for individual 'choice' and 'freedom', which, in turn, yields separation as an outcome, a separating equilibrium.

The purpose of the simple conceptual model presented in this section is to deconstruct some taken-for-granted policy objectives (and narratives). The recent movement towards patient-centred care, evidence-based practice (Winch, Creedy and Chaboyer 2002; Angus, Hodnett and O'Brien-Pallas 2003; Walker 2003) and individual responsibility for health are examples of such taken-for-granted discursive practices that need to be deconstructed. This is because, instead of being fully inclusive, they exclude some people, types of research, forms of knowledge, and so on.

Consider a society constructed with two competing interests, whereby the actions taken by one group, here the alpha group, advance their interests, but are both costly to undertake and may yield adverse effects for others in society, here the beta group. Individuals are distinguished in their capacity to engage in inclusionary/exclusionary activities; i.e. they face varying financial, time and psychosocial costs in the pursuit of these activities. Alpha group members are identified as those individuals endowed with a greater capacity to engage in inclusionary/exclusionary activities than members of the beta group are. Moreover, individuals may also vary in their capacity to benefit from such actions; i.e. the pay-offs may vary. Thus, inclusionary/exclusionary activities may yield important distributional effects for society.

Let the two groups in society be represented by the subscripts α and β , with the number of members of each group represented by A and B , respectively. Let well-being for each member of the alpha group be defined as:

$$1) \quad U_{\alpha} = U^* + \alpha e_{\alpha}$$

where e_{α} reflects the effort expended by members of the alpha group to advance their interests, α reflects the incremental pay-off in terms of enhanced well-being through such group activities, and U^* reflects well-being in the absence of exclusionary actions. (These actions might be viewed as deliberate acts — hence, costly to undertake) — to favor one group over another, thereby enhancing their relative standing, which yields enhancements to the well-being of the favored group.)

In addition, actions pursued by members of the alpha group may also have adverse effects for individuals who

are excluded, here represented by the beta group. Let the well-being for each member of the beta group be defined as:

$$2) \quad U_{\beta} = U^* - \beta e_{\alpha}$$

where β reflects the incremental decline in well-being associated with the actions pursued by members of the alpha group. If $\alpha = \beta$, the benefits received by individual alpha group members are just offset by the adverse effects for beta group members. If $\alpha > \beta$, the benefits of exclusion more than compensate for the adverse effects.

Inclusionary/exclusionary activity is not costless to pursue or to enforce to alpha group members. Suppose further that these costs are an increasing function of the effort expended by each alpha group member and represented as:

$$3) \quad C = \delta e_{\alpha}^{\theta} + F$$

where $\delta > 0$ and $\theta > 1$. In this formulation, F represents the fixed costs associated with inclusionary/exclusionary activities, while δ and θ , respectively, represent the level and rate of growth of such costs. Variations in the capacity to engage in inclusionary/exclusionary activities are captured in this formulation through variations in δ and θ . Individuals endowed with smaller values to δ and θ have a larger capacity (face lower costs) to engage in such activities, irrespective of the associated benefits.

The optimization problem confronted by each alpha group member is to determine the level of effort (e_{α}) to allocate towards inclusionary/exclusionary activities in order to ensure that the difference between well-being (U_{α}) and costs (C) incurred through these actions is maximized. This optimization problem entails a comparison of the incremental benefits from inclusionary/exclusionary actions (α) and the associated incremental costs from the actions themselves ($\theta \delta e_{\alpha}^{\theta-1}$). These incremental effects of inclusionary/exclusionary activities are shown in Fig. 1.

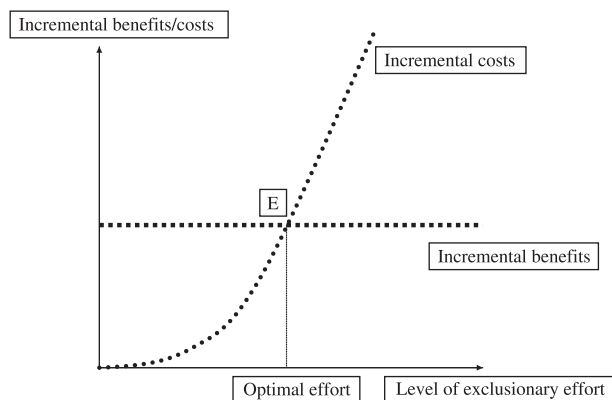


Figure 1 Optimization of inclusionary/exclusionary effort.

The incremental benefits are invariant to the level of effort expended and are shown as a horizontal line in Fig. 1. The incremental costs begin at the origin and are increasing in the level of effort expended. Optimization occurs where the incremental benefits just offset the incremental costs, as represented by the point E that occurs at the intersection between the two schedules in Fig. 1, thereby yielding the optimized value to inclusionary/exclusionary efforts as:

$$4) \quad e_{\alpha} = [\alpha / \theta \delta]^{1/(\theta-1)}$$

In equilibrium, the level of effort expended is an increasing function of the pay-off (α) to these activities, and a decreasing function of both the level (δ) and rate of growth (θ) of the cost of inclusionary/exclusionary activities. These results might be shown in Fig. 1 though an upward shift in each of the incremental benefit and cost schedules.

While the optimal level of effort expended by alpha group members is defined by equation 4, this optimization problem ignored the adverse effects for members of the beta group. If society were interested in establishing institutions that regulate inclusionary/exclusionary effort by members of the alpha group, what level of effort would achieve a social optimum and how would this solution compare to that based on the private interests of members of the alpha group?

The optimization problem confronted by societies interested in advancing aggregate social welfare may be characterized as the selection of inclusionary/exclusionary effort (e_{α}) that maximizes the difference between aggregate well-being and the aggregate costs incurred in such activities. Consequently, the social optimum occurs where the level of effort (e_{α}) maximizes:

$$5) \quad A(U^* + \alpha e_{\alpha}) + B(U^* - \beta e_{\alpha}) - A(\delta e_{\alpha}^{\theta} + F)$$

where A and B represent the sizes of the alpha and beta groups, respectively.

In this formulation, the full effects of the inclusionary/exclusionary activities are incorporated into the selection of equilibrium effort. In equilibrium, the incremental benefit from these activities is composed of two terms, the first represents the gain in well-being achieved by members of the alpha group, while the second represents the loss in well-being suffered by members of the beta group: $A\alpha - B\beta$. Similarly, the incremental cost is composed of the aggregate cost of such efforts for both groups and is represented as: $A\theta \delta e_{\alpha}^{\theta-1}$. Thus, the social optimum occurs where:

$$6) \quad e_{\alpha} = [(A\alpha - B\beta) / A\theta \delta]^{1/(\theta-1)}$$

In equilibrium, the socially optimal level of inclusionary/exclusionary effort is smaller than that achieved in the private optimization problem if $B\beta/A > 0$. The larger $B\beta/A$ is, the smaller the level of inclusionary/exclusionary effort required in order to achieve a social optimum.

In the social optimum, which is represented by equation 6, there will always be some level of inclusionary/exclusionary activities if $A\alpha > B\beta$. This condition implies that if the aggregate incremental benefit of inclusionary/exclusionary activities more than compensates for the aggregate adverse effects, then institutions of exclusion will proliferate and be maintained in order to advance such inclusionary/exclusionary activities.

FINAL REMARKS

The proposed conceptual framework suggests that private gains from inclusionary/exclusionary activities exceed those associated with a broader societal perspective. Moreover, once the societal perspective is adopted there are circumstances where a policy to regulate inclusionary/exclusionary activities enhances social welfare. The magnitude of the inclusionary/exclusionary activities is predicted to be: larger when α and A are larger; and smaller when β , B , δ , and θ are larger. Specifically, in circumstances where the group (A) that benefits from exclusionary policies is large, where their pay-offs are great (α), where the group (B) that is adversely affected is scarce and their adverse effects (β) are minor, and where the level (δ) and the rate of growth (θ) in the costs of pursuing inclusionary/exclusionary policies are small, then the magnitude of such activities, even those that are supported by society, will be larger.

Activities that (explicitly or implicitly) exclude or partition society (to see indigenous and refugees as rubbish, barebackers as not worth the efforts) into various strata may achieve private, and sometimes social, goals. The factors that account for variations in the level of such activities are highlighted in this paper and may shed some light on why we see what we see. Moreover, while the private gains to social exclusion are well documented, this paper highlights the potential for such policies to be vehicles that advance social welfare, albeit with detrimental effects for segments of society. As with any policy initiative, there are distributional effects. Advocates for regulated policies of social exclusion, here described in the social optimum, aim to preserve the gains to aggregate well-being, while limiting the overzealous partition of society, which not only adversely affects those who are excluded, but also uses scarce resources in the generation and enforcement of policies of social exclusion.

Let's return to the areas of interest that we briefly touched on at the outset, namely, patient-centered care, policies that

advance more choice, and greater emphasis on individual responsibility for health. On the surface these policies are designed to empower care recipients, to aid the customization of health and social care, and to involve care recipients and their family/friends in the decision-making process. But such policies may also be perceived as policies that exclude and partition care recipients on the basis of their capacity to participate in the opportunities that are being presented. As such, a strategy of patient choice or an emphasis on individual responsibility for health status has distributional effects, and in some instances, may adversely impact those without the capacity to capitalize on such opportunities. Society may be better off, in a utilitarian sense, but some may be adversely affected. In these circumstances, those who benefit from these policies of partition are large, obtain significant pay-offs and incur limited costs, whereas those who are adversely affected are scarce (or hidden), and the size of the adverse effects are small (or perceived to be minor) for them. Partition then becomes a 'legitimate' instrument of public policy. Such, unspoken policies 'legitimate' social exclusion, but present it under the guise of other policy objectives.

In this paper, we have married two paradigmatic perspectives in order to illuminate our mutual understanding of health policy discourses. By identifying the interest groups that are privileged by health policy innovations, important mechanisms that support the creation, maintenance and enforcement of institutions of social exclusion are highlighted. While we illustrate circumstances under which exclusionary policies may be advanced by society, we stress the need to be cognizant of those (marginalized groups) who may be disadvantaged by such policies. By raising awareness of such adverse effects, complementary policies and associated regulations should be strenuously pursued in order to minimize the harm that 'universal policies' might yield.

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