Governing Chronic Illness through Integrated Care

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Certificate of Original Authorship

This is to certify that this thesis comprises only my original work. The work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree. I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature:

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Date: 20/02/2017

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Abstract

As rates of chronic illness have increased in recent decades there have been significant changes in national and international health systems. Emerging approaches have shifted the focus from hospital-based, acute and curative interventions to the management of chronic illness through primary health care programs in local communities. Integrated care has emerged as an increasingly prominent approach within primary health care programs that target chronically ill populations.

This empirical doctoral study of an integrated care program explores how global discourses, which position the problem of chronic illness as an issue of cost to health care systems and a burden to the community, are translated from national policies to everyday lives in domestic households. Through close analysis of six chronically ill clients of a state-run primary health care program, named HealthOne Camara, this study brings to the fore the alignments, relays and connections of integrated care in ways that contrast with the dominant linear views typically generated through policy analysis and program evaluation studies.

Using a governmentality perspective based on the later work of Michel Foucault and other writers on governmentality, the study identifies patterns and consistencies across policy texts and everyday practices of integrated care in HealthOne Camara. Innovatively, Foucault's work on space and heterotopia is used in the study to identify the spaces of integrated care as heterotopias. In doing so, the focus shifts from *what* integrated care is to an analysis of *how* this care weaves through the lives of the HealthOne Camara clients.

By drawing on empirical and documentary data, this study offers a unique way of rethinking chronic illness and integrated care within primary health care programs. It highlights the tensions and complexities of integrated care for chronically ill clients in a local site. The analysis of these tensions opens up new ways of thinking about HealthOne's integrated care as an attempt to direct the self-governing abilities of people in certain ways. Examining the localised practices of care through the analytics of space and heterotopia brings to the fore the tension and resistance that emerges as practices of 'care' attempt to align complex lives with the often linear logic of policy. As rates of chronic illness increase, levels of health inequalities continue to rise and governments remain focused on reducing costs of care, the knowledge generated through this study argues for careful consideration of what the localised and unintended effects of programs of integrated care may be.

Abbreviations

AIHW:	Australian Institute of Health and Welfare
AMA:	Australian Medical Association
ARC:	Australian Research Council
CMC:	Christian Medical Council
COAG:	Council of Australian Governments
GPLN:	General Practice Liaison Nurse
IMF:	International Monetary Fund
MBF:	Medical Benefits Fund
NHHRC:	National Health and Hospitals Reform Commission
NSW:	New South Wales
OECD:	Organization for Economic Cooperation and Development
PCEHR:	Personally Controlled Electronic Health Record
WHO:	World Health Organization

Chapter One – Marking Out a Space

Introduction

In recent years, chronic illness has come to be seen as a significant threat to global health and national health care systems. Emerging primary health care management approaches have focused increasingly on the potential for programs of integrated care to reduce costs and burdens by optimising the ability of individuals to become responsible for managing their own health and care needs.

This empirical study explores how these global discourses of health, chronic illness and responsibility translate through national primary health care policy and into the domestic households of six chronically ill clients of a State-run program that provided integrated care. The study presents a detailed analysis of the program, HealthOne Camara, and integrates documentary analysis with rich, empirical descriptions of the integrated care that was observed in the homes of the program's clients.

Using a governmentality perspective based on the later work of Michel Foucault (2007) and other governmentality writers (Dean 2006, 2007, 2010; Li 2007; Miller & Rose 2008; Rose 1996b; Rose, O'Malley & Valverde 2006), the study identifies patterns and consistencies across policy texts and everyday practices of integrated care. Foucault's work on space and heterotopia (Foucault 2000a) is used to shift the analytical focus from *what* integrated care is to an analysis of *how* this care was woven through the lives of the HealthOne Camara clients.

The remainder of this introductory chapter fulfils three purposes. First, it situates this doctoral research within an Australian Research Council (ARC) funded project—*Remaking Practices*—and outlines how this study contributes to the internationally relevant objectives of that project. Second, this chapter explores primary health care as both a structural *component* of health systems and an *approach* to the management of health and care. The development of primary health care is traced through international policy, and links are made with global health care leaders such as the World Health Organisation (WHO). Integrated care as an approach to managing chronic illness is introduced through this discussion. Current literature from within the field of primary health care that connects integrated care and chronic illness is reviewed and gaps in this research are identified. Finally, following a brief introduction to governmentality (Foucault 2007) that explains how this study and its research questions address these gaps in knowledge, this chapter concludes with an overview of the structure of the following chapters and the analysis and discussion in each.

Primary health care and *Remaking Practices*

This doctoral study is a component of the Australian Research Council (ARC) Linkage project *Remaking Practices*[1] (2010–2014). The rationale and focus of the project emerged from the growing recognition, by both the NSW State Government and researchers, that reform within primary health care is an urgent national and international priority (Solomon et al. 2009).

The urgency of the need for primary health care reform is linked to recent shifts in global health needs (Szlezák et al. 2010) which WHO has described as a health transition. This transition in health and care needs relates to a shift from infectious diseases being the leading cause of death in developed and developing countries to a situation in which noncommunicable[2], chronic diseases are considered to be the preeminent global health problem (Boutayeb 2006; World Bank 2011; World Health Organization 2016). National health care systems have traditionally been centred around the provision of acute, hospital based treatment aimed at relieving symptoms of disease and returning individuals to health (Anderson 2011). However, changes in the incidence and prevalence of chronic diseases, as well as increased rates of multimorbidity (Primary Health Care Advisory Group 2016; Smith et al. 2012), have changed the types of health services that are needed. Rather than focusing on *cure*, interventions for chronic diseases are increasingly directed at long term management as individuals move out of hospital and into home and community based care (Harris 2010). Importantly, this approach to management crosses

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[1] This ARC Linkage Project (LP100200435) involved senior academic and research staff from the University of Technology Sydney, the University of Queensland, Griffith University and the University of Bedfordshire, UK. The project connected these academics and researchers with Partner Investigators from the NSW Ministry of Health. *Remaking Practices* received ethics approval from the Sydney Local Health District (Protocol No X10-0309) and the UTS Human Research Ethics Committee (Approval Number 2011-029).The Linkage Projects scheme provides funding to Eligible Organisations to support research and development (R&D) projects that are collaborative between higher education researchers and other parts of the national innovation system, that are undertaken to acquire new knowledge, and that involve risk or innovation. http://www.arc.gov.au/linkage-projects (Accessed 23/5/16)

[2] Bynum (2015) noted that use of the term noncommunicable diseases (NCDs) can be challenged on the basis that certain contemporary chronic diseases (e.g. some cancers) are communicable. The term *chronic* is used in this thesis.

multiple areas of an individual’s life as they learn to live with disease and its often disabling consequences (Anderson 2011; Smith et al. 2012). It is this focus on the long term implications and costs of particular diseases that is reflected in the use of the term *chronic illness*. For example, a diagnosis of Type Two diabetes confirms the existence of a chronic, incurable disease. However, it is the implications and consequences of these diagnoses that have increasingly become the concern of governments. Long term costs, complex management and the risk of reduced economic productivity are intertwined in this understanding of the *problem* of chronic illness. Additionally, the connection between many chronic diseases and lifestyle ‘choices’ made by individuals has opened up new ways for intervention programs to reduce the risk of disease development through the promotion of health and responsibility. This discussion is taken up in detail in Chapter Three.

The increased demand and diversification of the types of services needed in primary health care to address the causes and problems of chronic illness has provided impetus for reform across nations (Harris 2010; Jeon et al. 2010). This drive for change is evident in the pace and consistency of policy-led reform and restructure within health systems (Braithwaite, Westbrook & Iedema 2005; Jolley et al. 2008). However, as has been widely acknowledged, health systems are complex and reform is challenging (Garling & New South Wales Special Commission of Inquiry into Acute Care Services in NSW Public Hospital 2008; Kodner & Spreeuwenberg 2002; National Health and Hospitals Reform Commission 2009; Primary Health Care Advisory Group 2016). The scale and complexity of the challenges of reform and innovation are evident in what is reported as often disappointing and slow outcomes of investment and change initiatives (Bate, Mendel & Robert 2008; Bennett 2013; Braithwaite, Westbrook & Iedema 2005; Cumming 2011; Degeling, Close & Degeling 2006; Gauld et al. 2012; Glasgow 2012).

Remaking Practices (Solomon et al. 2009) sought to explore these challenges by investigating the variety and complexity of the practices, relationships and activities involved in innovation and change within primary health care. To do this, *Remaking Practices* undertook a detailed study of a major NSW Government health reform initiative, HealthOne, in two geographical areas in metropolitan NSW (Rule, Dunston & Solomon 2016). This project contributed to the field of primary health care research by:

1. Producing rich descriptions of the complex and multi-dimensional remaking of health practices as they are being developed in local practice settings;
2. Developing learning processes and practice improvement resources that are collaboratively designed, utilised and evaluated within the research sites;
3. Investigating the role and possibilities of existing and emerging technologies, in particular, information and communication technologies, in everyday practices and in achieving practice change;
4. Developing new and more adequate theorisations and conceptualisations of professional practice and learning (Solomon et al. 2009, p. 6).

This doctoral study (details of ethical approval for *Remaking Practices* and this doctoral study are detailed in the footnote below[3]) contributes primarily to the fourth aim of the *Remaking Practices* project. The contribution to theorisations and conceptualisations of the practices of integrated care is generated through the analysis of both documentary and empirical data and research materials gathered in HealthOne Camara - one of the sites included in the *Remaking Practices* project.

Primary health care: a field of *practice* and an *approach* to health and care

The organisation and provision of health care in countries including Australia, Canada, New Zealand, the United Kingdom (UK) and the United States is designed across three levels, often referred to as primary, secondary and tertiary care (Davies et al. 2009; Department of Health and Ageing 2009; Hurley et al. 2010; King & Green 2012). Secondary and tertiary health care refer to specialist services provided on an inpatient basis in hospitals and to some of those services that have been shifted out of hospitals through programs such as ‘hospital in the home’ in Australia (Caplan et al. 2012) and polyclinics in England (Imison, Naylor & Maybin 2008). Primary health care, in contrast, refers to health care services delivered within local communities in sites such as general practice surgeries, community health centres and people’s homes (Department of Health

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[3] This doctoral study was conducted between August 2012 and August 2016. The amendment to the *Remaking Practices* ethics approval (granted by both Western Sydney Local Health District and the University of Technology, Sydney, Human Research Ethics Committee - reference code UTS HREC Approval 2011-029 R) was received on 02/07/2013 (reference code 2013000025) and fieldwork was undertaken in the local health district referred to as HealthOne Camara between August 2013 and December 2013.

and Ageing 2009). Primary health care works to provide a wide range of services that address maternal and child health, mental health, disability, general practice and ancillary services such as physiotherapy, occupational therapy and dental services (Australian Institute of Health and Welfare 2014).

In addition to being a structural component of health systems, primary health care is also an inclusive approach to health and care that incorporates prevention, public health, health promotion and clinical intervention (Swerissen, Duckett & Wright 2016). The formalisation of this approach to promoting health and care occurred in WHO's 1978 'Declaration of Alma Ata' (World Health Organization 1978). This text explained primary health care in the following terms:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination…(it) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services (World Health Organization 1978, pp. 2-3).

This early description of primary health care as an approach to the health of populations was significant as it set out a spectrum of care—from care of the sick to the development of health. This marked a shift, away from curative care for those who are already sick, to the promotion of health, minimisation of risk and a focus on populations. Additionally, this idea of primary health care represented a change in thinking about the connections between individuals' lifestyle choices and health outcomes (Larsen 2012) and what came to be referred to as the social determinants of health (Lalonde 1974; Swerissen, Duckett & Wright 2016). These shifts in thinking about causes, consequences and programmatic 'solutions' to the problem of chronic illness can be traced through the reform of international health care policy.

International primary health care policy: connecting chronic illness and integrated care

In recent decades the profile of primary health care has risen, as it has been increasingly acknowledged internationally by policy makers, health care funders and researchers that health systems have to reform in order to respond to global health changes (Department of Health 2016; Harris 2010; Labonté et al. 2008; Ward 2009; World Health Organization 2008b). The World Health Organization has emphasised the magnitude of the threat chronic illnesses pose to international health systems in all countries—both developed and developing nations (World Health Organization 2005, 2008b). The significance of this growth in rates of chronic disease, and the associated social, political and economic challenges, are well recognised within policy and primary health care research literature (Jeon et al. 2010; McDonald et al. 2015; McNab, Mallit & Gillespie 2013; Ranson et al. 2016; Swerissen, Duckett & Wright 2016).

Reform across countries has drawn on the understanding that well developed primary health care systems are a key component of national and international responses to the challenge of increasing rates of chronic illness (Department of Health and Ageing 2009; Harris & Lloyd 2012; McDonald et al. 2015; Starfield & Shi 2002; Starfield, Shi & Macinko 2005; World Health Organization 2008a; Yallop et al. 2006). The significance of the primary health care sector is evident in the reconfiguration of health care spending in various countries. For example, the Australian Institute for Health and Welfare (AIHW) reported a significant shift in health care funding in Australia between 2001 and 2012:

> Between 2001-02 and 2003-04, for every dollar the Australian Government spent on hospitals, it spent on average 97 cents on primary health care. In 2011-12, the Australian Government spent around $1.16 on primary health care for every dollar it provided for hospitals (Australian Institute of Health and Welfare 2013).

Importantly, and as will be discussed, there are common patterns in policy-led reform across countries. Questions driving this reform focus on what work and costs are involved in care for those people with chronic illnesses, and how the care needed can be most effectively and efficiently delivered (Anderson 2011; Ward 2009).

Reform of primary health care systems is prominent across high-income countries including Australia, Canada, New Zealand and the UK (Gauld et al. 2012; Goodwin et al. 2014; Naccarella et al. 2008). These countries are useful comparators due to the structural similarities within their systems and their provision of varying degrees of universal health care coverage (Oliver-Baxter, Bywood & Brown 2013). These countries are also faced with similar health challenges in terms of ageing populations, decreases in the sizes of health workforces, population diversity and the need for delivery of services in regional and remote geographical areas (Flood 2001; Mossialos et al. 2016; Oliver-Baxter, Bywood & Brown 2013).

The pace of policy-led reform in these countries has been consistently rapid, particularly since 2000, and there are similarities in their approaches to reform (Oliver-Baxter, Bywood & Brown 2013). Key objectives have been increasing the efficiency and effectiveness of primary health care through localisation of services and reform of funding and governance arrangements. The push to devolve responsibility for designing and delivering services to local areas has been done through the development of networks of primary health care organisations (Harker 2011; Oliver-Baxter, Bywood & Brown 2013). The establishment of primary health care organisations in New Zealand (King 2001), Australia's Medicare Locals (Nicholson et al. 2012), regional health authorities in Canada (Hutchison et al. 2011; Strumpf et al. 2012), and primary care trusts (PCTs) and, more recently, Clinical Commissioning Groups (Department of Health 2012) in the UK are evidence of these moves within policy to shift focus to local populations and health needs.

The drive to localise the design and delivery of health services has occurred alongside changes in approaches to *how* the work of care for people with chronic illnesses is distributed. In Canada, the UK, New Zealand and Australia, the introduction of e-health initiatives and personally controlled health records have been key elements of moves to share the work of care with services users themselves (Hutchison et al. 2011; Oliver-Baxter, Bywood & Brown 2013). Additionally, local programs such as New Zealand's *Te Whiringa Ora* (Carswell 2015) and *Whanaau Ora* (Office of the Auditor General 2015) have taken up the idea of self-care as key in the prevention and management of chronic illnesses within local populations. It is within this context of policy-led changes to the structure, funding and distribution of work that integrated care has emerged as an approach to managing health and caring for people with chronic illnesses.

Rethinking care: the emergence of integrated care in policy

Integrated care has gained prominence within international health policy and primary health care research in recent decades and has been described by some commentators as a policy 'buzzword' (Kodner & Spreeuwenberg 2002). Integrated care has a range of meanings, and is often used interchangeably with other terms such as managed care, shared care and comprehensive care (Kodner & Spreeuwenberg 2002). According to the WHO, the *idea* of integrated care was the basis of many of the reforms to primary health care during the 1980s that marked the shift towards health promotion and population based care (World Health Organization 2008a). Integrated care is defined by WHO in the following terms:

> (integrated care is) a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency (Grone & Garcia-Barbero 2001, p. 7).

The broadness of this description of integrated care illustrates the diversity of care work done across the various stages of care for people with chronic illness. Reform across such diverse types of work and within such complex systems presents unique challenges (Kodner & Spreeuwenberg 2002). Conceptual models have been developed to clarify what integrated care is in structural terms and how progress towards this can be measured (Valentijn et al. 2015). For example, Valentijn et al. (2013) separated out the organisational and structural elements of integrated care at the macro, meso and micro levels as shown in Figure 1.1 (Valentijn et al., 2013, p. 8).

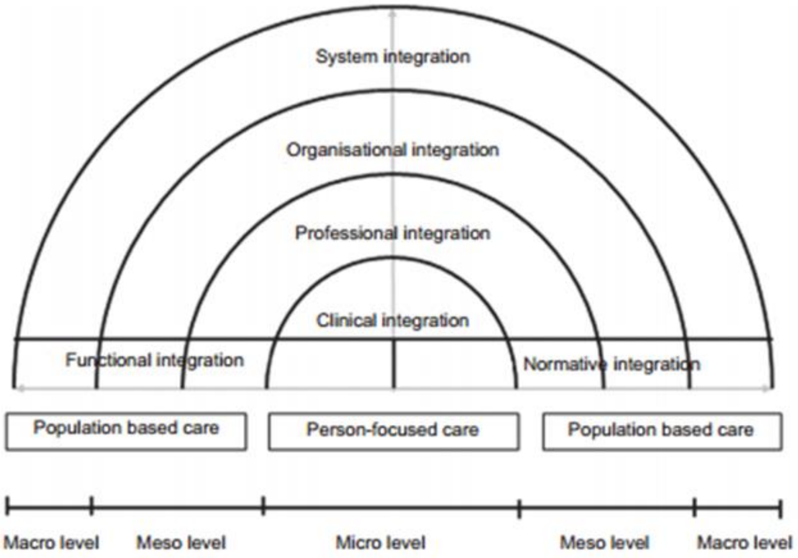

Figure 1.1: Conceptual framework for integrated care based on the integrative functions of primary care

This way of thinking about integrated care as a potential *outcome* of structural and organisational change is evident in the extensive body of international work that examines the policies of integrated care and procedural descriptions of how it can be achieved, through vertical and horizontal restructuring (Delnoij, Klazinga & Glasgow 2002; Kodner & Spreeuwenberg 2002; Struijs, Drewes & Stein 2015), at the macro and meso levels (Ehrlich & Kendall 2015). This interest in integrated care as structural and organisational change can be seen in the growth and diversity of studies of the methods by which the achievement of integrated care can be described and measured (Rosen, Gurr & Fanning 2010; Rosen et al. 2011). The focus on efficiency and effectiveness of integrated care within the literature highlights the economic imperatives associated with this drive for change (Bernabei et al. 1998; Lucas, Halcomb & McCarthy 2016; Mitchell et al. 2015). The push to achieve measurable outcomes that can be generalised to other settings also emphasises the way in which integrated care is approached as a *process* that can be broken down and analysed—"a process that is understood and that can be tinkered with to yield improvement" (Anderson 2011, p. 97).

The 'micro' level of integrated care suggested in Figure 1.1 (Valentijn 2013, p. 8) refers to the clinical experience or the encounter in which the individual and their carers are engaged in the processes and practices of integrated care itself (Strandberg-Larsen & Krasnik 2009). What happens at this micro level is influenced by the policies and practices circulating within the wider health system. It is at this *micro* level that changing ideas of what care entails for people with chronic illnesses can be seen in everyday practices. Changes in the terminology used in policy to refer to service users have occurred alongside shifts in thinking about how and what is involved in caring for people with chronic illness. As chronic illnesses are long term and incurable, their management and care is different from that required for acute illnesses. Terms such as service user involvement (Tierney et al. 2016), person-focused care (Valentijn et al. 2013), activation and empowerment (Chen et al. 2016) show a shift away from the traditional understanding of the patient as a passive recipient of care (Callaghan & Wistow 2006). This shift was described in an Australian policy text as a change in thinking about the aspirational *outcomes* of care for people who will never regain full health—"the client moves from being a passive recipient of care to being a proactive partner in the management of their condition(s)" (Department of Health 2005, p. 14). For example, in primary health care policy in recent decades, the recipient of care has been referred to as the consumer, service user or client rather than the patient or passive receiver of care (Burnham 2012; Callaghan & Wistow 2006; Iriart, Franco & Merhy 2011; Kodner 2003; McDonald et al. 2007; Ranson et al. 2016). A recent Australian policy text has referred to the care recipient as the "chronic condition consumer" (George Institute for Global Health & Consumers Health Forum Australia 2016, p. 2). These changes in the practices of care and naming of care recipients reflect what Timmermans (2013, p. 1) described as a "recent reconceptualization of health as the ability to adapt and self-manage".

Primary health care reform and integrated care: a review of the literature

This reconceptalisation of health and an emerging focus on adaptability has been drawn out through the extensive and international body of research into the reform of policy and primary health care practices. The development of this field has been supported through the investment of national governments in research infrastructure as part of driving improvements in efficiency and effectiveness (Bell 2016; Brown & McIntyre 2014; Findlay & Whitehead 2015; Minister of Health 2016). Just as the scope of work done within primary health care is broad, the literature associated with this field encompasses a wide range of research approaches, topics and methodologies. Of particular relevance to this study is the way in which the literature has examined chronic illness and integrated care.

Primary health care research draws on a diverse range of related fields of knowledge (Greenhalgh 2008) as well as clinical research (Yallop et al. 2006) to map patterns and trajectories of chronic illnesses. For example, epidemiology and demography have contributed knowledge about disease patterns, risk profiles and prognosis that have influenced the development of primary health care services (Greenhalgh 2008). Additionally, health economics and health geography (Andrews & Evans 2008) have provided data about costs and patterns of disease and relationships between health and social policy (Starfield 2011). This epidemiological and demographic information influences policy development as well as the priority given to research into particular chronic diseases. Current high priority chronic diseases targeted in research across countries include diabetes (Broom & Whittaker 2004; Erny-Albrecht, Bywood & Oliver-Baxter 2015; Higgs, Skinner & Hale 2016; Lauvergeon et al. 2016), asthma (Horne & Weinman 2002; Shah, Roydhouse & Sawyer 2008) and cardiovascular disease (Australian Institute of Health and Welfare 2010; McKillop, Crisp & Walsh 2012; Whittaker 2002; Wells et al. 2016). Insights from research into priority diseases and management strategies have identified ways of promoting effective and cost efficient care through long term management, preventative interventions and management in community and home settings (Australian Institute of Health and Welfare 2011).

Emerging processes and ways of managing these high priority diseases in community-based settings are also studied within the field of primary health care (Australian Institute of Health and Welfare 2011). Research into how this can be done through policy reform and the restructure of primary health care has been investigated using a range of methodological and theoretical approaches. For example, approaches taken have included systematic reviews (Powell-Davies et al. 2008), exploratory case studies (King & Green 2012) and critical analysis of the reform of primary health care policy (Cheung, Mirzaei & Leeder 2010; Greenhalgh et al. 2009; Hoare, Mills & Francis 2011; Hurley et al. 2010; Naccarella et al. 2011; Powell-Davies et al. 2008; Walt et al. 2008; Willcox, Lewis & Burgers 2011).

Links between policy reform and organisational change (Cresswell, Worth & Sheikh 2010; Hanseth, Aanestad & Berg 2004) and intended outcomes (Cheung, Mirzaei & Leeder 2010) have been examined. The impact of the divisions between operational structures and funding sources (Anderson 2011; Anell 2011) and the impact of reform on care delivery have also been explored (Foster et al. 2008; Rodwell & Gulyas 2013). This body of work has been dominated by research approaches that focus on evaluation and description of structural change and program implementation (Braithwaite, Westbrook & Iedema 2005; Valentijn et al. 2015). The dominance of these approaches to research into policy and program reform reflects the often close links between funders, policy-makers and research bodies (Kalucy 2012) and underlying concerns with performance, accountability, safety and development of the workforce (Brown & McIntyre 2014, p. 47). Importantly, the dominance of these research approaches suggests an urgency within the field to find reform strategies that 'work' and that can be generalised to other settings.

The emphasis on the need for reform, a focus on cost effectiveness and the drive for evidence aligns with short term research, policy-driven approaches that focus on the outcomes and the processes of reforms (Shaw, Rosen & Rumbold 2011). Such policy-driven connections and pressures within the field of primary health care research have been noted (Kalucy 2012; Reed et al. 2011), and examined to a limited degree. For example, Yen et al (2010) identified Australian research funders as including governments, health services, insurance companies such as Medical Benefits Fund (MBF) (now BUPA) and interest groups such as the Heart Foundation and Diabetes Australia. The priorities of such groups are evident in the projects they agree to fund and the drive for efficiency and cost reduction. In Australia, BUPA described its research funding as being focused on "helping people to manage their conditions, improving patient outcomes and reducing health costs" (BUPA n.d.). However, these close connections between research, policy and funding are rarely examined within health and care research (Unger et al. 2011).

In addition to research into the structures and performance of health systems, work within the primary health care field has examined the changing relationships between practitioners and clients as services have moved towards long-term management of chronic illnesses rather than curative treatment (Callaghan & Wistow 2006; Dennis et al. 2009; El Enany, Currie & Lockett 2013; Hallinan & Hegarty 2016; Kodner 2003; McNab et al. 2016; Wood, Hocking & Temple-Smith 2016). This shift, and the rise of the notion of lifestyle prevention (Larsen 2012; Popay, Whitehead & Hunter 2010), can be seen in the growth of research into preventative interventions, health literacy and patient experiences of primary health care (Bonney, Magee & Pearson 2012; Cheong, Armour &

Bosnic-Anticevich 2012; Ham, Kipping & McLeod 2003; Mirzaei et al. 2013). There is also an emerging body of work within primary health care that aims to assesses the impact of long term, incurable diseases on relationships between patients or clients, practitioners, and the families and other support networks in the community (Giuffrida et al. 2009; Nolte & McKee 2008; Vassilev et al. 2011).

Primary health care research has also explored the new and different practitioner roles emerging within programs of integrated care that promote self-management and adaptation (Timmermans 2013). Ideas of integrated care and self-management have been prominent in policy in Canada, New Zealand, the UK and Australia for the last two decades (Kendall et al. 2011; Liddy et al. 2015; Oliver-Baxter, Bywood & Brown 2013). A pattern across these national policies and programs has been the development of named local 'experts', who work to link individuals into community-based programs (Goodwin et al. 2014) as part of achieving integrated care. For example, a feature of New Zealand's *Te Whiringa Ora* program was the introduction of a community support worker—the *kaitautoko*—who engaged with individual clients and linked them into local social and care services (Carswell 2015). Similarly, in the Canadian Chronic Disease Self-management Program, a facet of care involved individuals attending a series of workshops with designated 'leaders', who worked to support integration and self-management of care needs (Liddy et al. 2015). A range of terms is used in other programs, including care navigators (Kelly et al. 2015; Manderson et al. 2012), 'expert patients' who become trainers and tutors (Glasgow 2012), care coordinators and case managers (Goodwin et al. 2014).

Research into these new configurations of practices has identified that, although these jobs often involve clinical or nursing work, the primary objectives of support and liaison roles relates to the development of service user self-management (Audulv, Asplund & Norbergh 2012; Kendall et al. 2011; Kendall et al. 2012; Kendall & Rogers 2007) and their ability to integrate the multiple aspects of their own health and care (Goodwin et al. 2014). Some of this research has highlighted the potential limitations of self-management approaches that focus on providing education and information and, in the process, disregard the *implications* of structural inequalities (Morden, Jinks & Ong 2012; Morden, Jinks & Ong 2015). Additionally, writers have identified a limited focus within their research on the challenges of *realising* the objectives of integrated care within clinical practice (Mitchell et al. 2015) and the impact of integrated care on health outcomes and experiences (Goodwin et al. 2014). The limited examination of the new practitioner roles may also reflect the lower priority given to these community based programs (Carswell 2015; Manderson et al. 2012). Researchers (Dawda et al. 2015; Shaw, Rosen & Rumbold 2011; Struijs, Drewes & Stein 2015) have also argued that the lack of research into more complex everyday contexts and practices of integrated care reflects how hard it is to describe and measure these aspects. The challenges of this complexity may contribute to limitations in the volume of work done at this level, compared with research focused on the organisational and structural levels of integrated care discussed earlier (Davies et al. 2011; Delnoij, Klazinga & Glasgow 2002; Kodner & Spreeuwenberg 2002).

In summary, across the diversity of research into primary health care, integrated care and chronic illness have been examined predominantly through descriptive and instrumental research approaches. This type of research connects policy, organisational reform and program implementation in ways that reflect the often policy-driven research environment. A limited focus on the everyday practices of integrated care and the emerging roles of local 'experts' engaged in promoting self-management and adaptability highlights current gaps in research (Carswell 2015; Manderson et al. 2012). It is of note that despite years of investment in reform and research into primary health care programs in Canada, New Zealand, the UK and Australia, improvement is reported to be "slow and patchy" (Cumming 2011, p. 9), health inequalities across these countries have continued to worsen (Boyle 2011; Glasgow 2012) and systems remain ill-equipped to deal with the growing threat of chronic illness (Swerissen, Duckett & Wright 2016). It is for these reasons that, as noted by Solomon et al. (2009), research in the field needs to generate new theorisations and conceptualisations of primary health care practices that cut across current ways of thinking. It is this lack of well-theorised and critical research into the complexities and connections of integrated care and chronic illness that this study addresses.

Researching integrated care and chronic illness in primary health care: a new space

The observations made, along with acknowledged connections made within the existing literature between risk, populations and economic concerns, emphasise primary health care's linkages with social and political systems (Starfield 2011). Adams et al (2009) referred to research approaches that explore such links as incorporating "critical reflection" (p. 792) on the social and structural processes that influence ideas of health and care. Such critical reflection highlights entanglements (Schwiter, Berndt & Truong 2015) and "intricacies and tensions" (Adams et al. 2009, p. 796), rather than the processes and outcomes produced through the instrumental and descriptive research previously discussed. There is a shortage of such critical and reflexive studies in the literature on primary health care, chronic illness and integrated care. By moving away from evaluation and procedural description, such critical research can explore the "complex strategic relations" (Bacchi 2012a, p. 1) that connect people, chronic illness and changing notions of care. Such exploration can also extend and challenge the findings of policy-driven research which, although starting from a different point of inquiry, is vital to continued development of the field. Such extension is facilitated by the potential for critical approaches to research to bridge the often divided fields of epidemiology and public health, with their focus on disease trajectory and mapping, and those of the critical social sciences (Paparini & Rhodes 2016, p. 2). By putting these often separated fields in dialogue with each other (Paparini & Rhodes 2016), researchers can begin to unpack the understandings and processes that shape subjectivities, practices and ways of acting. Through such critical and reflexive processes, new and insightful knowledge can be generated (McCabe & Holmes 2009) and critical awareness raised (Shaw 2007).

As a way of addressing this shortage of critical and reflexive studies of primary health care, chronic illness and integrated care, this study takes up a governmentality perspective based on the later work of Michel Foucault (Foucault 2007). The utility of this perspective in health and care research has been demonstrated consistently in recent years (Keane 2009). Governmentality has been taken up in studies of health care organisations and policy priorities (Ferlie & McGivern 2014; Ferlie, McGivern & Fitzgerald 2012; Joyce 2001), policy analysis (Prince, Kearns & Craig 2006), care services (Keane 2009), evidence based medicine (Ferlie & McGivern 2014), nursing practices (Frederiksen, Lomborg & Beedholm 2015; Holmes 2005; Holmes, Perron & Savoie 2006; Perron, Fluet & Holmes 2005; Thompson 2008) and evidence based practice (Winch, Creedy & Chaboyer 2002). The knowledge generated through research projects has identified complexities and consistencies within contemporary approaches to health and care. For example, research into the design of organisations, networks and governance structures has identified ways in which government directed policy has gathered strength despite claims of localisation (Ferlie & McGivern 2014; Ferlie, McGivern & Fitzgerald 2012; Sheaff et al. 2004). The examination of programs that promote self-care amongst service users has drawn out the continued dominance of ideas of *compliance* despite changes in terminology (Thorne, Paterson & Russell 2003). Importantly, governmentality perspectives have been used to ask questions about the implications of such shifts within health systems for individuals as well as future reforms (Glasgow 2012).

Governmentality has been taken up enthusiastically in English-language studies of health promotion and the ideas of responsibility and self-management in relation to general health (Ayo 2012; Herrick 2011; Larsen 2012; LeBesco 2011; Lovell, Kearns & Prince 2014; Lupton 1995; McPhail 2013; Walkerdine 2009). Governmentality perspectives have been used to a more limited degree to explore how ideas of responsibility and self-management have been deployed within specific programs of primary health care. Research from the UK has focused on expert patient programs (Glasgow 2012; Wilson 2001), the introduction of new family health nurses (Thompson 2008) and changing patterns in the distribution of the work of patienthood (May 2011). This body of work has generated different ways of thinking and talking about the changing conceptualisations of health and care and how these are related to self-governing and the minimisation of risk (Joyce 2001). Such studies challenge the self-evident 'good' (Winch, Creedy & Chaboyer 2002) of programs and practices of care by exposing the rationalities and assumptions embedded within them. This process of critical and reflexive challenge generates knowledge and ideas that can be used to identify and discuss contemporary issues in creative and analytical ways. By taking up a perspective of governmentality and the associated language and analytic 'tools', this study responds to concerns raised in recent research (Dawda et al. 2015; Carswell 2015; Manderson et al. 2012; Shaw, Rosen & Rumbold 2011; Struijs, Drewes & Stein 2015), that the everyday practices and implications of integrated care and chronic illness are difficult to describe and analyse, by taking up Foucault's work on governmentality (Foucault 2007), space and heterotopia (Foucault 2000a).

Governmentality

Foucault's work on governmentality (Foucault 2007), and its development by subsequent writers (Dean 2006, 2007, 2010; Li 2007; Miller & Rose 2008; Rose 1996b; Rose, O'Malley & Valverde 2006), is explored in detail in Chapter Two. Of significance within this introductory chapter is understanding governmentality as a "research perspective in the literal sense: an angle of view, a manner of looking, a specific orientation" (Bröckling, Krasman & Lemke 2010, p. 15) rather than a social-scientific approach or a theory. Foucault's governmentality perspective is set out in the lectures he gave at the College de France in the spring terms of 1977–1978 and 1978–1979 (Dean 2010). These lectures were most comprehensively published in French to coincide with the twentieth anniversary of Foucault's death in 2004 (Elden 2007). The translation and publication of this version of the lectures in 2007 as *Security, territory, population* (Foucault 2007) generated a new body of scholarship on governmentality. Foucault differentiated his work on governmentality from the analysis of a unified State or political governance. Rather than analysing the State as an entity, Foucault was interested in how, over a long period of time, people and populations became the focus of a style of governing that involved complex assemblages of institutions, procedures, practices, knowledge and calculations. In this work the term government took on a very particular meaning:

> 'Government' did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or of groups might be directed – the government of children, of souls, of communities, of the sick …. To govern, in this sense, is to control the possible field of action of others (Foucault 1982, p. 790).

Foucault's governmentality perspective (Foucault 2007) offers a unique way of thinking about how the contemporary citizen has become a responsible, free and self-governing subject (Binkley 2010). Dean (2010, p. 20) noted that taking up this approach "provides a language and framework for thinking about the linkages between questions of government, authority and politics, and questions of identity, self and person". In this study, governmentality opens up a way of thinking about chronic illness, primary health care and integrated care that weaves across the domains of policy and practice and connects with discussions about contemporary "arts of governing"—ways of "employing tactics rather than laws…arranging things so that this or that end may be achieved through a certain number of means" (Foucault 2007, p. 99).

This way of thinking about governing generates knowledge that contributes to addressing the current gaps in primary health care research. These gaps, as have been previously discussed, relate to an absence of critical and reflexive research that challenges the self-evident ‘good’ of recent reconfigurations of care for people with chronic illness. As government concerns of costs and responsibility continue to drive health care reform, it is vital that well-theorised approaches are used to ask questions about the connections, effects and implications of emerging approaches to care. This focus, and the perspective informing it, is reflected in the research questions addressed through this study:

1) How has chronic illness been problematised within contemporary discourses of health and responsibility?
2) How and in what ways was HealthOne assembled as a response to this problematisation?
3) How have the governable spaces of HealthOne Camara’s integrated care assembled the subjectivities of the clients?

The responses to these questions, which are set out in the chapters that follow, reflect a particular *way* of engaging with Foucault’s work. Rose (1999) differentiated between those who claimed to be scholars of Foucault and his own more creative use of Foucault’s thoughts:

> There are those who seek to be Foucault scholars. That is their privilege. I advocate a relation to his work that is looser, more inventive and more empirical. It is less concerned with being faithful to a source of authority than with working with a certain ethos of enquiry, with fabricating some conceptual tools that can be set to work in relation to the particular questions that trouble contemporary thought and politics (Rose 1999, pp. 4–5).

In keeping with this ethos of investigation, rather than searching for truth or proving a hypothesis this study demonstrates an ethos of critical enquiry (Petersen 2003). This critical enquiry is directed towards the social, political and historical contexts in which chronic illness has come to be seen as a type of problem that requires programmatic solutions such as integrated care and HealthOne. Using this perspective presents an alternative way of thinking about how HealthOne Camara clients are part of a global problem of chronic illness.

Assembling this text: an overview of the chapters

Chapter Two, Assembling an Analytics of Governmentality, continues and extends the preliminary discussion of governmentality by setting out the analytical tools and methods of research used in this study. The chapter begins by exploring in detail Foucault's original work on governmentality. Key ideas of problematisation, discourse, power/knowledge, subjectivity and space are considered. Foucault's comments on space and heterotopia (Foucault 2000a) are introduced in this chapter and their analytic utility is discussed. This discussion provides an overview of a diverse range of literature from the fields of social policy (Elm-Larsen 2006; Marston & McDonald 2006; McDonald & Marston 2005; McKee 2009; Stenson 2005), health and care (Pii & Villadsen 2013; Villadsen & Wahlberg 2015), education and citizenship (Dahlstedt, Rundqvist & Vesterberg 2015; Fejes 2008; Olson et al. 2014; Sandberg et al. 2016), and geography (Andrews & Shaw 2008; Elden 2007; Huxley 2007; Johnson 2013; Legg 2005; Parr 2002; Rutherford 2007). The chapter concludes with an overview of the methods of research and analysis used in this study.

Chapters Three, Four, Five and Six mark a shift within this thesis as they directly address the research questions outlined on page 18. Each chapter focuses on a research question and concludes with a brief response to it. These responses are then pulled together in the final chapter, Chapter Seven. Assembling the chapters in this way presents a cumulative analysis that integrates documentary analysis with the empirical research materials gathered from HealthOne Camara and the in-depth observation of six Health One Camara clients during the period of fieldwork (August 2013–December 2013). As becomes evident within these chapters, these research participants are not presented as case studies in the way that often features in health care research, in which a case is described as an *entity* (Hoskins & Faan 2004). These people are progressively assembled as HealthOne *clients* and, in keeping with this approach, the biographical and medical details of individuals are not foregrounded. Details emerge about these people, their lives and medical needs in this research, but it is their subjectivity as HealthOne Camara clients that remains the focus across these chapters.

Chapter Three focuses primarily on the first research question: *How has chronic illness been problematised within contemporary discourses of health and responsibility?* Foucault's use of problematisation (explored in detail in Chapter Two) is used in this chapter to frame the discussion of how chronic illnesses have "come to be defined as problems in relation to particular schemes of thought, diagnoses of deficiency and promises of improvement" (Li 2007, p. 265). Ideas of freedom and choice are woven through the analysis of the understandings of health and the optimisation of life as moral and economic imperatives. The evolution of primary health care and the emergence of the approach of integrated care are discussed in this chapter. The chapter concludes with a brief overview of the way in this analysis and discussion responds to the first research question.

Chapters Four and Five extend this discussion by addressing the second research question: *How and in what ways was HealthOne assembled as a response to this problematisation?* Chapter Four marks a shift in focus within the research, as the analysis and discussion in this and following chapters draws primarily on the empirical research materials generated through fieldwork in HealthOne Camara, as well as a selection of interview data collected through the *Remaking Practice*s project. The analysis in Chapter Four focuses on tracing the emergence of HealthOne as an idea in policy in ways that reproduced the global problem of chronic illness. Assemblage (Li 2007) and translation (Rose 1999), which are discussed in detail in Chapter Two, are key concepts within this chapter.

Chapter Five extends the analysis and discussion presented in Chapter Four, by tracing the ways in which the assemblage of HealthOne was translated into *technologies* of integrated care in the local program (HealthOne Camara) and the homes of the clients referred to by the pseudonyms of Iris, Arthur, Keith, Frances, Clare and Maria. This translation, and the reproduction of ways of thinking about the moral and economic problems these people posed, as well as the solution offered through integrated care, emphasised the significance of ideas of responsibility and self-governing. This chapter concludes with an overview of how the analysis and discussion of Chapters Four and Five has provided a response to the second research question.

Chapter Six extends this discussion and analysis of integrated care by responding to the third and final research question: *How have the governable spaces of HealthOne Camara's integrated care assembled the subjectivities of the clients?* This chapter argues that the spaces of integrated care have been reconfigured as spaces of governing—spaces in which the client is reassembled as active and responsible within the terms of the program. This discussion takes up Foucault’s notion of heterotopia (Foucault 2000a) to present a more complex analysis of the patterns and consistencies that give these spaces of governing a productive function within the relations of integrated care.

Chapter Seven is the concluding chapter. This chapter returns to the three research questions in this study and collates the responses made to each one at the end of Chapters Three, Four, Five and Six. Chapter Seven draws these responses together and, in doing so, frames the unique and significant contribution this study makes to the field of primary health care. Through this discussion, opportunities to build on the knowledge generated through this research are considered and linked to ongoing developments in Australian and international primary health care.

Chapter Two – Assembling an Analytics of Governmentality

> I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area…I don't write for an audience, I write for users, not readers (Foucault cited in O'Farrell n.d.).

Introduction

The previous chapter introduced governmentality as a perspective or way of thinking about power, knowledge and subjectification. Taking up a governmentality perspective in this study offers an opportunity to ask unique questions about how chronic illness has been assembled as a particular type of problem that needs to be governed in certain ways. These kinds of questions are unique within the field of primary health care and provide a way of connecting primary health care, integrated care and chronic illness. As noted in Chapter One, the dominant methodologies used within the field of primary health care relate to the priorities and concerns of funders and powerful groups such as the Australian Medical Association and government bodies. Additionally, and in keeping with developments in related fields of health and medicine, evidence-based practice has gained prominence within the field of primary health care research. *Remaking Practices* (Solomon et al. 2009) argued that the complexity and pace of change within the sector, along with disappointing outcomes of reform programs, emphasises the importance of taking up different theorisations that can open up new ways of thinking in primary health care. This research responds to this need, bypassing evaluation and description and, instead, rethinking health, chronic illness and integrated care in relation to governing. This chapter sets out the analytic tool-box that is used in the study and, in doing so, explains how Foucault's perspective of governmentality can be applied to the study of the practices of care observed in the homes of HealthOne Camara clients.

The chapter begins with a discussion of what it means to take up such a perspective and draws on research within the field of governmentality studies that has generated a wide range of concepts and theoretical formulations (Li 2007). This chapter introduces ideas and notions that shape this way of thinking and that are used throughout this study. Political rationalities, technologies, translation and assemblage are examined in detail through Foucault's original work (Foucault 2007), as well as that of more recent writers on governmentality (Dean 2006, 2007, 2010; Lemke 2001, 2010; Miller & Rose 2008; Rose 1996b; Rose, O'Malley & Valverde 2006). The final section of this chapter turns briefly to the focus of this study, HealthOne and HealthOne Camara, to discuss the research methods involved in this work. The chapter then concludes by considering how these various notions and strands of work are pulled together to offer a unique way of thinking about the problem of chronic illness and the programmatic 'solutions' offered through programs of integrated care.

Building an analytical 'tool box'

Governmentality, as a very particular "manner of looking" (Bröckling, Krasman & Lemke 2010, p. 15), draws its creative and analytic potential from Foucault's original work as well as the way in which, in the years since Foucault's seminal lectures, it has "dispersed, hybridized with other approaches, and gone off in many different ways" (Rose, O'Malley & Valverde 2006, p. 100). Foucault's original lectures at the College de France (Foucault 2007) came to be known as *Governmentality*, following their publication in Italian and English in 1979 (Elden 2007). In this work, Foucault suggested that governmentality could be viewed as part of an analytical tool-box used to examine how approaches to governing had changed over time (Walters 2012).

In his 1978 lecture - *Security, Territory and Population* - Foucault explained that he wished to undertake a "history of governmentality" through the examination of a type of power (that is, government) that had come to dominate in the West and that worked through ideas of populations, knowledge and "apparatuses of security" (Foucault 2007, p. 108). This complex power worked through assemblages of "institutions, procedures, analyses and reflections, calculations, and tactics" (Foucault 2007, p. 108), which emerged to address historically contingent 'problems'.

Such an examination involves considering "how problems come to be defined as problems in relation to particular schemes of thought, diagnoses of deficiency and promises of improvement" (Li 2007, p. 264). Examining shifts in thinking about problems and how to address them reveals important changes in how authority is exercised over others, as well as how individuals come to "govern ourselves" (Dean 2010, p. 19). Understanding governmentality as a perspective or way of thinking is important, and writers within this field of study have noted the tendency for some researchers to use the perspective as though it is a fully-formed theory or methodology (Bröckling, Krasman & Lemke 2010). Such misunderstanding and applicationism (Walters 2012) reduces the creative and analytical potential of the perspective. Taking up a governmentality perspective to examine the integrated care of HealthOne Camara requires an understanding of what Foucault sought to do through such work and how subsequent writers have used and developed certain notions.

Governing ‘at a distance’: rationalities, technologies, translation and assemblage

In taking up a perspective of governmentality, this study draws on notions related to *how* programs of governing move out and away from a political centre and into the homes and lives of citizens. Rose, O’Malley and Valverde (2006) argued that the term advanced liberalism reflected a “way of doing things” (p. 84) that allowed governing to unfold at a distance. Rose (1999) described this way of operating as “*government at a distance*…distance in both constitutional and spatial senses”:

> Liberal rule is inextricably bound to the activities and calculations of a proliferation of independent authorities – philanthropists, doctors, hygienists, managers, planners, parents and social workers. It is dependent upon the political authorization of the authority of these authorities, upon the forging of alignments between political aims and the strategies of experts, and upon establishing relays between the calculations of authorities and the aspirations of free citizens (Rose 1999, p. 49).

Governing at a distance is complex and unfolds through multiple relays between people and sites. The technologies of this way of governing gain stability and coherence through unifying political rationalities. Savage (2013) differentiated these terms in the following way:

> Rationalities… are forms of *reasoned discourse* about how to govern (i.e. ways of thinking about or justifying forms of governance). Distinct from governmental reason, *political technologies* refer to the techniques, mechanisms, instruments and processes through which governance ‘gets done’. Technologies are, in this sense, *the mechanics* through which rationalities are put into practice (Savage 2013, p. 86).

Rationalities (or ways of thinking) are (re)produced through technologies and techniques that link ways of thinking to actions and behaviours. This can be discerned from the analysis of programs that seek to govern and direct the behaviour of individuals and populations.

The linkages between political rationalities, technologies and techniques allow attempts to govern to move from a source and to be localised within a multitude of sites. Rose (1999) described this as *translation*:

> Translation links the general to the particular, links one place to another, shifts a way of thinking, from a political centre – a cabinet office, a government department – to a multitude of workplaces, hospital wards classrooms, child guidance centres or homes. Thus national programmes of government can render themselves consonant with the proliferation of procedures for the conduct of conduct at a molecular level across a territory (Rose 1999, p. 51).

As illustrated in Chapter Four in relation to HealthOne, such programs unfold through the translation (Rose 1999) of policy documents and procedural texts, which distribute authority through local experts tasked with enacting programs. Rose and Miller (1992) referred to such complex arrangements as "technologies of government…through which authorities seek to employ and give effect to governmental ambitions" (p. 175). Technologies, however, are more complex than simply sets of tools or techniques. Technologies of government are formed through assemblages "of different techniques of government, technical objects, actors, financial and other resources and 'sociotechnical' forces" (Henman 2006, p. 208). The analysis of such rationalities, technologies and techniques focuses on how specific concerns emerge and are assembled as problems that need to be addressed.

Translation is not a linear or smooth process but, rather, a "matter of fragile relays, contested locales and fissiparous affiliations" (Rose 1999, p. 51) made possible through the strength of dominant political rationalities. It is through the 'fragile relays' of translation that discourses, agencies, people and material objects come together at points in time and work to (re)produce and stabilise political rationalities. As Li (2007) observed:

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

Such interventions have no essence or singular rationality but are somehow made intelligible as they temporarily cohere through the practices that constitute them. Li (2007) *deployed* the notion of assemblage (Foucault 1980a) to capture the idea of multiple elements temporarily coming together "only to disperse or realign…the shape shifts according to the terrain and the angle of vision" (p. 265).

These notions of translation and assemblage are key to the rethinking of primary health care and HealthOne presented in this thesis. As discussed in subsequent chapters, primary health care, as an approach to the management of the health of individuals and populations, has persisted as an idea within global, national and local policy and discourse for well over forty years. The forms it takes vary and change, yet retain a cohesion. It is this cohesion, and the persistence of the idea of primary health care, that demonstrates the work of assemblage and translation.

Shifts in power: sovereignty, discipline and biopower

Foucault's work on governmentality drew on his particular way of thinking about power/knowledge, discourse and subjectivity to conceptualise the state as a "relational ensemble" or assemblage (Jessop 2007, p. 34). These ideas were in marked contrast to the State-centric models associated with Marxism and other dominant political or state theories (Gillies 2013). Foucault described power in terms of *relations*, which are "mobile, reversible, and unstable" (Foucault 2000b, p. 292). Foucault suggested that power was exercised rather than possessed, circulated upwards and downwards and could be understood in relation to freedom (Foucault 2000b). Importantly, Foucault contrasted the "power formations associated with sovereignty, discipline and biopower" (Binkley 2010, p. xii) in terms of how power related to life and death and, ultimately, subjectification and self-regulation.

Sovereign power was "premised on the right to take life, it has power over life only so far as it can 'let live'" (Harwood 2009, p. 16). Foucault explained that sovereign power was "essentially a right of seizure: of things, time, bodies, and ultimately life itself; it culminated in the privilege to seize hold of life in order to suppress it" (Foucault 2008b, p. 136). Disciplinary power in, contrast, had a different relationship with life and death. Through techniques associated with the discipline of the body (for example, confinement) disciplinary power "centred on individual bodies seeking to render them docile"

(Harwood 2009, p. 17). Foucault described disciplinary power as working through and on the body:

> Techniques of power that were essentially on the body, on the individual body. They included all devices that were used to ensure the spatial distribution of individual bodies (their separation, their alignment, their serialization, and their surveillance) and the organization, around those individuals, of a whole field of visibility (Foucault 2003b, p. 242).

This power was enacted through systems of "surveillance, hierarchies, inspections, bookkeeping, and reports – all the technology that can be described as the disciplinary technology of labor" (Foucault 2003b, p. 242). The relations through which this power was enacted were not limited to an institution or apparatus but were instead a type of power comprising "a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology" (Foucault 1995, p. 215).

Foucault applied his study of disciplinary power to a variety of sites, including factories, schools and hospitals, which, he suggested, resembled prisons in their use of disciplinary power and techniques of surveillance (Foucault 1995). Foucault's work on Bentham's Panopticon in *Discipline and Punish* (Foucault 1995) is the often cited architectural representation of disciplinary power. This power works not just through an architectural structure but through the distribution and arrangements of "bodies, surfaces, lights, gazes" (p. 202) through which the effects of surveillance and self-surveillance become permanent:

> the surveillance is permanent in its effects, even if it is discontinuous in its action…the perfection of power should tend to render its actual exercise unnecessary (Foucault 1995, p. 201).

The third form of power Foucault discussed, and is the one most relevant to the current discussion, is biopower. Disciplinary power was enacted at the level of the individual body, but biopower was a "new nondisciplinary power…applied not to man-as-body but to the living man, to man-as-living-being; ultimately if you like, to man-as-species" (Foucault 2003b, p. 242). Foucault introduced the notion of biopower in the concluding chapter of *The History of Sexuality* (Volume One) (Foucault 2008b), through his discussion of the change in the relations of life and death during the eighteenth century. In that century, death was no longer an imminent threat and thus life, rather than death, gradually became a preeminent concern:

> [M]ethods of power and knowledge assumed responsibility for the life processes and undertook to control and modify them. 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, an individual and collective welfare, forces that could be modified, and space in which they could be distributed in an optimal manner (Foucault 2008b, p. 142).

These forms of power were not mutually exclusive, nor did one follow or supersede the other (Harwood 2009). Rather, biopower was able to "dovetail into [disciplinary power], integrate it, modify it to some extent, and above all, use it by sort of infiltrating it, embedding itself in existing disciplinary techniques" (Foucault 2003b, p. 242). Dumas and Turner (2013) described this as a shift from anatamo-politics, or discipline of the individual body, to the regulatory control of populations through bio-politics. This shift, however, did not represent a change in policy or methods of governance by the State, but rather suggested changes in the way in which the subject of power and government had become governed as a member of a population.

Understanding populations was a key contribution of Foucault's work (Elden 2016). Despite some inconsistencies in his use of the term, Foucault effectively used the notion of population to trace how problems relating to demographic growth and movement were defined and managed through new bodies of knowledge and approaches to intervention (Curtis 2002). In this context, a population was not something to be discovered; rather, it emerged from an interplay of social and economic factors and new problems. Foucault (2003c) argued that what came to be seen as problems not only marked the variations between "the submissive and the restive, rich and poor, health and sick, strong and weak" but also:

> the more or less utilizable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death and illness, and with more or less capacity for being usefully trained (Foucault 2003c, p. 342).

Population, in this sense, became an object that consisted of multiple elements and variables, one of which was the physical body of the individual. Importantly, the physical body came to be seen in terms of risk and potential. Scholars have traced how biopower, as a mode of governing, has unfolded across diverse domains of contemporary life including race, population and reproduction and genomic medicine (Rabinow & Rose 2006), population governance (Greenhalgh 2005), and through programs such as welfare to work (McDonald & Marston 2005) and family nursing (Thompson 2008).

Governing and the subject

In his lectures at the Collège de France in 1979, *The Birth of Biopolitics* (Foucault 2008a), Foucault explored the changing ways in which the subject was assembled by studying the emergence of liberalism (for a detailed discussion of Foucault's work on liberalism, refer to Dean 2010). Both classical liberalism and neoliberalism fostered the idea of the subject as *homo economicus*—"that is, the way in which they place a particular 'anthropology' of man as an economic subject at the basis of politics" (Read 2009, p. 4). What differentiated the classical liberal and neoliberal versions of *homo economicus* was the shift in emphasis from 'exchange' in the former to that of 'competition' in the latter (Read 2009). *Homo economicus* came to be understood in terms of economics and costs and benefits. Foucault (Foucault 2008a) observed this as a "complete change in the conception of this *homo oeconomicus"* (p. 226) as the worker became human capital and any income or salary earned a return on investment in this capital. Entrepreneurial approaches to improving the self and the likelihood of an increased return became seen as an investment. Foucault (2008a) noted that investment in this human capital came to include practices associated with formal education as well as those of parenting, management of family life and health care. Through this interest in ongoing investment and improvement, the *subject* shifted from being a partner in an economic exchange and instead came to be seen as an entrepreneur: "*Homo oeconomicus* is an entrepreneur, an entrepreneur of himself" (Foucault 2008a, p. 226).

Neoliberal strategies and techniques were applied to new spheres of life and promoted investment and improvement in ways that could be measured by the economics of the market system. Baker and Brown (2012, p. 17) described neoliberalism as involving a psychological reconfiguration "of attitudes, values, projects of the self and identities too". The modes of governmentality associated with the entrepreneurial, neoliberal *homo* *economicus* are “interest, investment and competition” (Read 2009, p. 6) rather than the rights and laws associated with sovereign and disciplinary power. Foucault considered the complexity and interconnected nature of governing the modern subject:

> [G]overning people is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself (Foucault 1994, p. 204).

Changing modes of subjectification draw on different ‘truths’, authorities and knowledges embedded within discourses. Foucault’s earlier work, including *The Archaeology of Knowledge* (Foucault 2010), introduced this way of thinking about discourse as more than words, structure or language itself. Importantly, Foucault described discourse as:

> practices that systematically form the objects of which they speak. Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this *more* that renders them irreducible to the language (*langue*) and to speech. It is this ‘more’ that we must reveal and describe (Foucault 2010, p. 49).

This way of thinking about discourse moved beyond the structural elements of language and grammar, to instead direct thought towards the conditions of possibility that constrain or enable ways of “writing, speaking, thinking” (Hook 2001, p. 524) within a historical period (Prior 2004). By considering discourse in this way Foucault explicitly distinguished “discourse from logic and linguistics and, through this, from the work of ideas and language: within a Foucauldian viewpoint discourse may include, but is not reducible to language” (Garrity 2010, p. 196). Vakirtzi and Bayliss (2013) emphasised the broadness of Foucault’s approach to discourse and its extension beyond systems of speaking and writing to the conditions “whose role has been to form *disciplinary* discourses, knowledges that result in(to) the creation of relationships of power” (p. 6). Thus power and knowledge became intertwined and are presented by Foucault in the format of power/knowledge:

> Knowledge does not enable power to be accessed, nor does power give access to knowledge. Discursive technologies of power constitute, disavow and resist

> particular knowledges. At the same time, power is an effect of knowledge and the discursive deployment of its 'truths' (Youdell 2006, p. 37).

Discourse and "constructed knowledge" (Jackson & Mazzei 2012, p. 60) are localised in times and places in ways that produces particular objects and subjects that 'need' to be governed. The productive power of discursive practices, which extend beyond language, is evident in the assembly of a subject within discourse. Foucault described the discursive production of the subject through power relations as follows:

> This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognise and which others have to recognise in him. It is a form of power which makes individuals subjects. There are two meanings of the word subject: subject to someone else by control and dependence, and tied to his own identity by a conscious self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to (Foucault 1982, p. 781).

Gillies (2013) gave the example of the 'pupil' as a subject and object that is understood within educational discourse rather than having a pre-existing 'essence' or being found within other discourses or places:

> No such entity exists in nature…The same term would never be used in the family, nor in medical discourse, nor religious discourse…the 'pupil' is a creation of educational discourse and can be seen to present a particular view of the young person which is distinctive and partial: inferior, lacking agency, subject to control, subordinate. (Gillies 2013, p. 11)

In this way, the subject is "constituted through" (Dean 2010, p. 43) the discourse and its associated practices. In previous decades, such a subject was located within institutional sites such as the school or, for the patient, the hospital. Importantly, and as is taken up in the later chapters in relation to chronic illness and integrated care, contemporary discourses and practices of governing exceed the "territorializing boundaries" of the institution and work through "flows of bodies power and capital" (Binkley 2010, pp. xii-xiii). Although institutions could be seen as points at which certain discourses crystallised and came together, Foucault argued that the analysis of institutions was more complex

(Thompson 2011). Rather than focusing on the physical boundaries of an institution, analysis extends out to the "domain of power relations, the various modes of orchestrating and molding the action of others, the deeper ontological element of which institutions are but one embodiment" (Thompson 2011, p. 4).

Governing the 'active citizen'

Foucault extended his work on the emergence of the entrepreneurial subject through his work on governmentality (Foucault 2007) as well as his later work on technologies of the self (Foucault 1988). This work focused on the way in which the movement between modes of power configured the individual subject as self-governing. Foucault examined in detail the *practices* by which individuals, either by themselves or with the intervention of others, "acted on their own bodies, souls, thoughts, conduct and way of being" (Martin, Gutman & Hutton 1988, p. 4) in order to reach a certain state. In this context, Foucault discussed technologies of the self as means by which individuals were understood as potentially self-governing:

> [T]echnologies of the self…permit individuals to effect 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 immortality (Foucault 1988, p. 18).

Just as Foucault emphasised that various modes of power were interconnected, so too were technologies of power and domination and technologies of the self. Foucault marked out the contact between these technologies as governmentality: "This contact between the technologies of domination of others and those of the self I call governmentality" (Foucault 1988, p. 19).

Foucault examined these shifts and changes in ways of governing within broader social and political contexts. The dominant "strategies of rule" changed markedly during the twentieth century as a new *formula* of rule emerged (Rose 1993, p. 285). These shifts were evident first in the emergence of the welfare state and then, in the latter half of the twentieth century, the emergence of ways of governing that were referred to advanced liberalism (Rose 1993). Through these shifts, the relations that connected individuals, populations and strategies of rule also changed. These changes were manifest in different ways in which the conduct and decisions of individuals and populations were directed; changes in “the forms of power that subject us, the systems of rule that administer us, the types of authority that master us” (Rose 1993, p. 283). Governing came to be about maximising the lives and productivity of individuals and populations (McPhail 2013). As discussed already in relation to biopower, technologies and techniques engaged individuals in practices of optimisation—subjects “who produce themselves as normative subject-citizen-bodies through a discourse of ‘free choice’” (McPhail 2013, p. 290). Autonomy and choice were offered to the individual citizen in return for living in ways that promoted flexibility and mobility (Jensen & Pfau-Effinger 2005, p. 7). These discourses and ways of thinking about governing and responsible citizens have an effect of dividing those who do self-govern from those who do not. Dean (2010) provided a succinct explanation of this division:

> One can identify an emergent division between *active citizens* (capable of managing their own risk) and *targeted populations* (disadvantaged groups, the ‘at risk’, the high risk) who will require intervention in the management of risks (Dean 2010, p. 195).

This way of thinking about the active citizen as involved, responsible and self-governing reinforces the constant movement and flux involved in subjectification. Importantly, this way of thinking positions the active citizen as an unfinished project, a work in progress and has “at its base…the notion of incompleteness: that there is something else we need to be, do, or have to become a coherent and self-actualized subject” (Rutherford 2007, pp. 298–9). Rather than working to produce the ‘docile body’ (Foucault 1995) associated with disciplinary power, biopower was associated with self-regulation as the subject became active in their own constitution, as knowledge and understandings of the self were developed (Leahy 2009). Foucault (2005) described such practices as pedagogical as the individual sought to ‘fold-in’ knowledge and understanding of themselves:

> Let’s us call ‘pedagogical,’ if you like, the transmission of a truth whose function it is to endow any subject whatsoever with aptitudes, capabilities, knowledges and so on, that he did not possess before and that he should possess at the end of the pedagogical relationship...the transmission of a truth whose function is not to endow any subject with abilities, etcetera, but whose function is to modify the

> mode of being of the subject to whom we address ourselves (Foucault 2005, p. 407).

The pedagogical practices associated with biopower are not necessarily linked to physical sites such as the school or hospital but are rather overlaid onto and through the notion of the active citizen itself. This argument is made in Chapter Three through analysis of the problematisation of health and chronic illness. Through the associated discourses health and citizenship are connected and understood in moral and economic terms. Ill health is quantified and problematised in and through ideas of costs and burden. These discourses reproduce the understanding that it is the responsibility of the individual citizen to work toward optimum health for their own benefit as well as that of the community. These ways of thinking are evident in programs of integrated care that seek to address the problem of chronic illness through enhanced self-management.

Governmentality and space

Foucault's work on power, knowledge and governing was connected to conceptualisations of space (Pykett 2012). Foucault did not develop a theory of space as such; rather, he used it as an analytical tool to consider how power, knowledge and governing intersected with ideas of space (Mitchell 2003; Pykett 2012). Through his earlier work on the clinic (Foucault 1994) and the prison (Foucault 1995), Foucault examined how practices of disciplinary power worked through the reorganisation and surveillance of bodies. Through this surveillance people were monitored across space and time:

> It works by partitioning, enclosing and codifying space, enabling the detailed management and training of conduct by organizing the movement of bodies in space and through time (Barnett 1999, p. 378).

Unlike the physical spaces of the prison or hospital, in which disciplinary power could be seen to crystallise in the structure of the institution, biopower and governmentality unfolded through multiple, decentralised spaces and configurations of self-governing (Barnett 1999). Thompson (2011) contrasted the *practices* of discipline, security and government in the following way:

> If discipline is defined by the construction of the cell and the series, if it is, as Foucault terms it…'centripetal', then security is marked by the creation of passage and transfer, by the formation of perpetually increasing expansion; in a word, security is 'centrifugal'. Spaces of security, spaces of governance, are thus sites not of confinement and constriction, but of incorporation and ever widening distribution (Thompson 2011, p. 10).

These ideas of incorporation and distribution connect to Rose's (1999) discussion of the translation of programs of government that make 'governing at a distance' possible. Similarly, Elden and Crampton (2007) also noted that Foucault's interest in space was evident in his focus on architectural plans, spaces of confinement and partition, as well as through his examination of how power and knowledge influenced in spatial distributions. In a 1978 interview (Foucault, Gordon & Patton 2012), Foucault linked governing and space in the following terms:

> I study things like a psychiatric asylum, the forms of constraint, exclusion, elimination, disqualification, of which reason is always precisely incarnate, in the body of the doctor, in medical knowledge, medical institutions, etc., exercised over madness, illness, unreason, etc. What I study is an architecture, a spatial organisation…what are the practices that one puts in play in order to govern men, that is, to obtain from them a certain way of conducting themselves? (Foucault, Gordon & Patton 2012, p. 105).

From a perspective of governmentality, space can be connected to questions of how attempts to govern conduct and direct aspirations unfolds through "diverse and disparate series and assemblages of practices, regulations, philosophies, texts, buildings and authorities" (Huxley 2007, p. 199). Foucault considered space as an additional "tool of analysis rather than merely an object of it" (Elden & Crampton 2007, p. 9). In keeping with this approach, a selection of Foucault's comments on space are used in this study to unpack the analysis of how HealthOne unfolds across sites and places and, as it does so, pulls in and connects multiple people and material objects. Foucault (1984) argued that such analysis is essential within the study of power/knowledge and the subject:

> It is somewhat arbitrary to try to dissociate the effective practice of freedom by people, the practice of social relations, and the spatial distribution in which they

> find themselves. If they are separated, they become impossible to understand (Foucault 1984, p. 246).

Similarly, in his interview in *Questions on Geography*, Foucault (1980b) explained the potential for space to highlight the complexity of the relations between power and knowledge:

> …through them I did come to what I had basically been looking for: the relations that are possible between power and knowledge. Once knowledge can be analysed in terms of region, domain, implantation, displacement, transposition, one is able to capture the process by which knowledge functions as a form of power and disseminates the effects of power (Foucault 1980b, p. 69).

Huxley (2007) noted that, although some studies of governmentality take note of considerations of space, conceptualising space as a *rationality* of government, particularly in terms of surveillance, can limit its analytical use. Taking up a spatial analysis is useful in the consideration of how subjectivities and subjects are formed in a range of spaces of governing—if "space is taken as integral to the exercise of power and the conduct of conducts; then spatial and environmental causality can be examined as central elements in the thought of government" (Huxley 2007, p. 199). The discussion of space and governing is extended further in Chapter Four, through the analysis of the translation (Rose 1999) of HealthOne as it moves out from the policy makers to the homes of clients, in HealthOne Camara.

Spaces of integrated care and heterotopia

Although notions of space and place have been taken up across the fields of health and care, space as an analytic tool remains under-conceptualised (Kitto et al. 2013). Studies have used space and place to focus on delivery systems and sites of care as well as patterns of illness (Kitto et al. 2013) and, notably within hospital based research, spatial orderings (Mesman 2009). This study, however, returns to Foucault's work connecting space and governing as a way of analysing the connections between power/knowledge and subjectivities. This analysis is taken up in Chapter Five, which focuses on rethinking of integrated care as spaces of reassembling and self-governing. This approach builds on recent work by writers from across the fields of health, care and human geography who have considered care and 'the clinic' as transitory, complex relations and configurations that are not limited to the institutional boundaries of spaces or places of care such as the clinic or hospital (Andrews 2003; Andrews & Shaw 2008; Johnsen, Cloke & May 2004; Patton 2010).

In turning to analyse how the subjectivities of HealthOne Camara clients are assembled in spaces of integrated care, Chapter Six takes up the notion of heterotopia (Foucault 2000a). Heterotopia was not a recurring element in Foucault's work and, as Johnson (Johnson 2006) noted, Foucault referred to the notion only three times throughout his career. Foucault first used the term heterotopia in 1966, in the preface of *Les Mots et al Choses*, which was translated into English as *The Order of Things* and published in 1970 (Foucault 1970). He referred again to the concept in a radio broadcast addressing the themes of utopia and literature and, finally, in his lecture to the *Cercle d'etudes architectuales* (Circle of Architectural Studies) in 1967 (Johnson 2006, p. 75). The lecture was scheduled in response to a request following the radio broadcast; thus, the content of both was similar, although the lecture was predominantly focused on the analysis of social spaces (Johnson 2006). It is the translation of this lecture (Foucault 2000a) that acts as the primary source for this discussion and use of heterotopia. Johnson (2012) noted that this translation of Foucault's 1967 lecture is more sympathetic than are other translations to the use of the French words *emplacement* and *espace*. Dehaene and De Cauter (2008, p. 25) suggest that Foucault's use of *emplacement* and *espace* emphasise the significance of the relations that connect sites, locations, discourses and practices. These ideas of *emplacement* and *espace* are relevant to the use of the notion of heterotopia in the analysis of the assemblage of HealthOne.

Foucault began his lecture to the *Cercle d'etudes architectuales* by tracing how conceptualisations of time and space developed during the medieval ages, then touched on modern space as predominantly relational:

> The space in which we live, which draws us out of ourselves, in which the erosion of our lives, our times and our history occurs, the space that claws and gnaws at us, is also, in itself, a heterogeneous space. In other words, we do not live in a kind of void inside of which we could place individuals and things. We do not live inside a void that could be colored with diverse shades of light, we live inside a set of relations that delineates sites which are irreducible to one

> another and absolutely not superimposable on one another (Foucault 2000a, pp. 177–8).

Foucault listed various sites that can be described through complex bundles or webs of relations, such as spaces of transit or movement like streets and trains, before turning to his particular interest in the lecture:

> But what interests me among all these emplacements are certain ones that have the curious property of being connected to all other emplacements, but in such a way that they suspend, neutralize, or reverse the set of relations that are designated, reflected, or represented by them. Those spaces which are linked with all the others, and yet at variance with all the other emplacements, are of two great types (Foucault 2000a, p. 178).

Foucault gave a range of examples of heterotopias and listed these under two types. The first is the heterotopia of crisis, which Foucault described as “privileged or sacred or forbidden places reserved for individuals who are in a state of crisis with respect to society and the human milieu in which they live. Adolescents, menstruating women, women in labor, old people, and so on” (Foucault 2000a, p. 179). The second type is heterotopias of deviation for individuals

> whose behavior is deviant with respect to the mean or required norm. These are the rest homes, and psychiatric hospitals; they are also, of course, the prisons, to which we should probably add old people’s homes…since after all old age is a crisis and also a deviation… (Foucault 2000a, p. 180).

Foucault explained the notion of a heterotopia by contrasting it with a utopia: utopias “are spaces that are fundamentally and essentially unreal” (Foucault 2000a, p. 178). Heterotopias, in contrast, are “different spaces, these other places, a kind of contestation, both mythical and real, of the space in which we live” (Foucault 2000a, p. 179). Johnson (2006) noted that, rather than being limited to heterotopias of deviation or crisis, heterotopias are also envisaged as “postmodern spaces of resistance and transgression” (p. 81). Such spaces come together in *relation* to but *apart* from other spaces of ideal or ‘normal’ citizenship. Sandberg et al (2016) argued that taking up heterotopia in this way “directs attention to certain spaces and their function” (p. 107). Elm-Larsen (2005) also noted the utility of the notion of heterotopia, by contrasting it with the *function* of Foucault's more widely used concept of panoptical spaces:

> …panopticon is related to rationalities of government that have been connected with surveillance, discipline and punishment rather than to rationalities of government that are based on decentralised, localised self-surveillance, self-control and self-punishment. The concept of heterotopia is especially well suited to describe marginal spaces, because this concept does not operate with the traditional centre-periphery orientation and because heterotopia is not related to unambiguous functions of discipline and surveillance. Heterotopia is both about expressing resistance and violation of norms and about order and control (Elm-Larsen 2005, p. 78).

In the context of this study, heterotopia opens up a way of thinking about the dispersed yet interconnected spaces of HealthOne Camara's integrated care. These spaces function as spaces of crisis and deviation, as well as liminality and reform – as heterotopias. They do not work through confinement, yet are marked out by procedures of access and inclusion that simultaneously work to include and exclude:

> Heterotopias always presuppose a system of opening and closing that isolates them and makes them penetrable at the same time. In general, one does not gain entry to a heterotopian emplacement as if to a windmill (Foucault 2000a, p. 183).

Subsequent chapters extend this discussion by considering how HealthOne Camara's spaces of integrated care (like other contemporary spaces of care and self-governing) worked to produce the *client* as an active partner in health and care. Through such approaches, sites and spaces of health and care have multiplied and dispersed beyond the hospital and clinic and increasingly into local communities and homes. In relation to chronic illness, the function of these spaces of care differs from the curative interventions of care that were discussed in Chapter One. These spaces transcend the limits of sites and places and instead converge across the body and life of the HealthOne Camara client. This discussion is extended in Chapter Six, through the analysis of the HealthOne Camara's spaces of integrated care.

Questions of method

This chapter has set out the analytical perspective taken up in this study of chronic illness and integrated care. However, questions remain about how such a study proceeds and the methods of research used. Unlike other research methodologies, an analytics of governmentality does not have defined methods of research, and such prescription would contradict the ethos of the perspective (Rose, O'Malley & Valverde 2006). Formulating the methods by which such a study proceeds involves returning to Foucault's original work and discussion of what he sought to achieve through such analysis. Foucault reiterated that his focus of analysis was practices and their own "specific regularities, logic, strategy, self-evidence and 'reason'" (Foucault 1991, p. 75). His comments on critique, problematisation and genealogy offer guidance on how to proceed creatively and coherently through the study of the conditions that make certain ways of thinking appear logical.

Foucault (2003a) explained that his approach to critique and problematisation involved an ongoing process of questioning and challenging things and spaces which appeared problematic:

> It is true that my attitude isn't a result of the form of critique that claims to be a methodical examination in order to reject all possible solutions except for the one valid one. It is more on the order of 'problematization'- which is to say the development of a domain of acts, practices, and thoughts that seem to me to pose problems for politics (Foucault 2003a, p. 20).

Foucault contrasted this work on problematisation with that of a polemicist or ideologist, arguing that the polemicist seeks to dominate or defeat an "adversary" and to "bring about the triumph of the just cause he has been manifestly upholding from the beginning" (Foucault 2003a, p. 19). In contrast, Foucault directed his own work on problematisation toward the analysis of the "historical process of producing objects for thought…the terms of reference within which an issue is cast" (Bacchi 2012b, p. 1). The methods through which such studies are undertaken seek to expose the thoughts, rationalities, practices and techniques that work to assemble problems in ways that then open out opportunities for programmatic 'solutions'.

Studies of governmentality have tended to draw heavily on the analysis of documentary sources such as government and organisational texts (Clarke 2008). The accompanying analysis draws out the patterns and consistencies embedded within and reproduced through such texts. Importantly, the purpose of this analysis is not to determine whether the elements of discourses are true or false, but rather to find the patterns and connections that make up ways of thinking. In recent years, writers (Brady 2011; Gallagher 2012; Hill 2009; Pii & Villadsen 2013; Li 2007; McDonald & Marston 2005; McKee 2009; Stenson 2005) have extended the predominantly textual focus of governmentality studies by integrating empirical research materials. Brady (2011) argued that such integration offers a more "finely grained picture" (p. 28) of how governing unfolds. Integrating empirical analysis also draws out the tension, contestation and transformation that unfolds as programs and practices are taken up by diverse subjects (Pii & Villadsen 2013). Additionally, as argued by Clarke (2008) and Stenson (2005), advanced liberal ways of governing have focused increasingly on the importance of local sites and spaces through ideas of community, population and the citizen. Ideas of the local are thus brought to the fore. Rethinking local spaces of governing as assemblages of discourses, rationalities, people and material objects moves away from more linear views of programmatic attempts to govern (Clarke 2008).

Locating the research in HealthOne Camara

The following chapters integrate the analysis of documentary data with research materials gathered from fieldwork undertaken in HealthOne Camara between August 2013 and December 2013. Chapters Three and Four consist primarily of analysis and discussion based on a range of "linked and contingent" (Gallagher 2012, p. 465) texts associated with the program of HealthOne and its social and political context. As noted in Chapter One, this analysis is supplemented by extracts from interviews with senior health service managers undertaken through the *Remaking Practices* project during 2011 and 2012. During this period 40 individual interviews were conducted, recorded and transcribed. The extracts from these interviews used in this doctoral study are referenced accordingly.

It is of note that HealthOne was a new and developing program when the *Remaking Practices* research project commenced. Thus, the interviewees referred to in later chapters were those in post at the time and tasked with developing the plans and everyday activities which shaped HealthOne. The involvement of *Remaking Practices* researchers (senior academics at the University of Technology, Sydney) in the early stages of HealthOne's development meant that, although the pool of possible research participants was limited, positive relationships with health service managers were formed and individuals were keen to participate in interviews. It is also of note that due to the new and developing nature of HealthOne there was not an extensive body of program texts on which to draw for analysis. The texts that were available and that are included in the analysis are policy and operational texts set out the history, structures and arrangements of HealthOne and have been revised and updated during the period of this doctoral study. For consistency within this study, the versions of the HealthOne texts that were in use during the period of fieldwork and analysis (2013–2014) are used and referenced throughout. The analysis and discussion contained in the following chapters illustrates how HealthOne texts drew on and were linked to numerous other texts and policy documents. A snowballing approach (Gallagher 2012) was taken to build a comprehensive repository of materials that give insight into dominant discourses and practices which shaped HealthOne.

In addition to this repository of documentary materials, a period of fieldwork was undertaken to observe, describe and analyse *how* ideas of integrated care and chronic illness translated into the everyday practices of HealthOne Camara and connected local experts and clients. To this end, the key method of research undertaken during fieldwork was participant observation (Hoskins & Faan 2004; May 1995). This involved linking up with and shadowing the local expert in Camara—the General Practice Liaison Nurse (GPLN)—as they engaged in the everyday work and practices of integrated care. Due to the positive relationships with the *Remaking Practices* researchers, this local practitioner was very willing to be engaged in this research process. As has been discussed in relation to the method of participant research (May 1995), relationships were established with the research participants through conversation, the process of observation itself and through the sharing of personal spaces and private discussions about health and care. This method of research led to the collection of a multitude of documents used in the everyday work of the GPLN as well as the production of field notes, a reflexive journal and recordings (when agreed by the participants) of meetings and interviews which were later transcribed. The ongoing "reflexive rationalization" (May 1995, p. 138) involved in such research formed an important element of the analysis itself and this is discussed through the analysis contained in the chapters that follow.

The clients of HelathOne Camara were selected as potential research participants on the basis of their long term involvement with the GPLN. Although the GPLN visited a higher number of clients across the week the program itself sought to engage with clients on a short term basis only (less than six months) and those with ongoing involvement were limited in number. The six long term clients of HealthOne Camara all consented to become research participants. All research participants were informed of the study and were given the approved information and consent forms to read and complete in advance of being observed (see Appendix Two for the information and consent form).

During the period of fieldwork (August 2013–December 2013) these clients were observed during 15 home visits made to them by the GPLN. Additional data and materials were gathered through approximately 70 hours of observations of the GPLN engaged in direct and non-direct client related activity. Activity included visiting clients at home and in hospital, meeting with clients and families, attending case conferences with other practitioners and engaging in the incidental and ad hoc activities which shaped and made up the GPLN's work day. Ad hoc activities included informal discussions in the corridors of the health centre, phone calls, emails and discussions with people as the GPLN travelled between and within work sites. It is important to note that the fieldwork undertaken was influenced by the nature of the work being done by the GPLN. As will be drawn out in later chapters, the GPLN needed to react to unpredictable client needs and thus the timetable for the day often changed at short notice. This unpredictability also influenced the type of research activities undertaken. For example, at times client confidentiality and respect for the very personal nature of their health and social needs made it inappropriate for audio recordings to be made. At times, data collection was suspended for periods of time whilst certain needs were addressed. In contrast, scheduled interviews and meetings were recorded and transcribed. Drawings and photographs were also taken and used to enhance and add depth to field notes and the reflective journal kept during this field work period. Documents and the transcriptions from audio recordings were analysed for dominant themes and linked in Microsoft Excel.

Conclusion

This chapter, A*ssembling an Analytics of Governmentality*, has set out in detail how Foucault's work on governmentality (Foucault 2007), space and heterotopia (Foucault 2000a) are used as analytic tools in this study. The utility of this approach to the field of primary health care is drawn from its capacity to ask unique questions about how chronic illness is problematised in ways that position programs like HealthOne and integrated care as programmatic solutions. By doing this, this study situates HealthOne within much broader historical and political contexts. Understanding HealthOne as reflecting significant shifts in thinking about health and chronic illness opens up an opportunity to challenge the taken-for-granted effectiveness of integrated care. This 'analytical tool box' and the methods of research detailed above align with Foucault's work on problematisation, which seeks to explore and interrogate dominant ways of thinking:

> It's a matter of shaking this false self-evidence, of demonstrating its precariousness, of making visible not its arbitrariness, but its complex interconnection with a multiplicity of historical processes, many of them of recent date (Foucault 1991, p. 75).

Providing such an analysis is of value to the field of primary health care, as it offers a different way of thinking about the 'problem' of chronic illness and the 'solutions' offered by models of integrated care.

Chapter Three – The Problematisation of Health and Chronic Illness

> One man's right to indulge in behaviour conducive to an expensive illness becomes another man's shackle in extra taxes and/or rising private health insurance premiums (Beard & Commonwealth Department of Health 1979, p. 53).
>
> The citizen's right to medical care should carry an obligation to do all he can to keep his health intact. There is a case for forfeiting certain 'rights' when the reciprocal obligations are deliberately abandoned (Beard & Commonwealth Department of Health 1979, pp. 59–60)
>
> The burden of these conditions can be high both for people who have them and for their families and carers. People with chronic disease are less likely to participate in the labour force, less likely to be employed full-time and more likely to be unemployed than those without chronic disease (Wentwest Medicare Local Sydney n.d., p. 1)
>
> Many of us make choices about the way we live our lives that potentially damage our bodies or our minds – healthy choices are not always easy choices (National Health and Hospitals Reform Commission 2009, p. 45)

Introduction

Chapter One introduced the contemporary global health transition reported by various bodies, including WHO (World Health Organization 2016). This shift from communicable diseases to chronic diseases being the most significant cause of global death and disability, as was noted in Chapter One, is a key element of arguments made for reform to primary health care services (Department of Health and Ageing 2009; Harris & Lloyd 2012; McDonald et al. 2015; Starfield & Shi 2002; Starfield, Shi & Macinko 2005; World Health Organization 2008a, 2008b; Yallop et al. 2006).

Primary health care, as an approach to health and care as well as a type of health care provision, is often linked to the statements made by WHO at the Alma Ata conference in 1978 (Cueto 2004; World Health Organization 1978). This conference and its statements, which outlined a vision for primary health care, remain relevant in international health policy (Lawn et al. 2008) and WHO's commitment to this approach was renewed in 2008 (World Health Organization 2008b). As will be discussed, these statements and the connections made between health promotion, preventative interventions and care for the sick draw on ways of thinking about chronic illness, lifestyle and health that emerged in the middle decades of the twentieth century, particularly in the USA, UK and Canada.

These connections are evident in the extracts from policy texts, published forty years apart, that open this chapter.

To explore current understandings of chronic illness and the connections made between primary health care and integrated care, this chapter traces the emergence of this way of thinking through the analysis of policy texts. The chapter focuses on the first research question set out in Chapter One:

> *How has chronic illness been problematised within contemporary discourses of health and responsibility?*

As discussed in Chapter Two, Foucault saw problematisation as the ways of thinking and acting that assemble an object of thought as a problem that needs to be addressed through political means (Foucault 2003a). Foucault described his analysis of a problematisation as focusing on the "the process of 'problematization' – which means: how and why certain things (behaviours, phenomena, processes) become a *problem*" (Foucault 2001, p. 171). This is in contrast to research that seeks to prove a truth or a fact or to trace the natural history of a concept (Weisz 2014).

This chapter provides an important link to the analysis of HealthOne Camara and the ways of thinking about and practicing integrated care that were observed in the homes of Keith, Frances, Iris, Maria, Clare and Arthur. The practices of integrated care analysed and discussed at length in Chapters Four, Five and Six are illustrative of ways of thinking about health, disease and illness that have emerged over the last sixty years. These ways of thinking about health, illness and care are (re)produced within international discourses of primary health care and the local policies of HealthOne Camara. As will be shown in this chapter, tracing these patterns and consistencies in thinking gives important context to the program of HealthOne, as well as insight into the ways of thinking that are embedded within integrated care.

This chapter begins by returning to consider the rapid global growth in rates of chronic disease, exploring how this problem emerged and evolved through discourses of health and illness over the course of the second half of the twentieth century. The analysis in this chapter initially focuses on research and policy texts from the UK and the USA. Weisz (2014) noted that the interest in chronic disease displayed by these nations during this period was linked to unique national priorities. Influential research and literature from these countries, as well as Canada (Lalonde 1974), connected chronic disease with what came to be referred to as the social determinants of health and the development of lifestyle prevention (Larsen 2012). These ways of thinking about chronic disease and programmatic solutions can be traced through the analysis of Australian health policy from the late 1970s up to the recent publication of Australia's first national primary health care strategy and an associated health promotion program, Get Healthy (NSW Government n.d.-a).

The chapter then moves to consider how contemporary Australian primary health care policy positions chronic illness as a type of problem that requires particular programmatic 'solutions'. This analysis reveals consistencies across programs that target general health as well as chronic illness. These consistencies in thinking reproduce ideas of lifestyle prevention (Larsen 2012) and the individualisation (Glasgow & Schrecker 2015) of the *problem* of chronic illness and its *solutions*. This resonates with Wahlberg and Rose's (2015, p. 60) observation that concerns have shifted from the "problem of morbid death… to that of morbid *living"* (italics in original). The chapter concludes by pulling together this analysis and responding to the research question set out earlier.

The transition from chronic *disease* to chronic *illness*

As noted in Chapter One, a range of terms have been used in public, policy and research texts to illustrate the gravity of the reported "epidemiological explosion" (May 2005, p. 18) in rates of chronic diseases. The magnitude of this threat and problem has been quantified in terms that relate to economics and human life. For example, the WHO has warned that "the global burden of chronic disease is increasing rapidly and predicts by the year 2020 that chronic disease will account for almost three quarters of all deaths" (Department of Health and Ageing 2009, p. 9). In 2014, the US Health Department reported that, in 2010, 86% of health care expenditure was directed towards the management of chronic diseases (Gerteis et al. 2014). Similar rates of chronic diseases were found in low and middle income countries and were reported to account for approximately 80% of deaths in these nations (Slama et al. 2013, p. 83). In 2015, the Australian Government's Department of Health stated that "chronic diseases are the leading cause of illness, death and disability in Australia, accounting for 90% of deaths in 2011" (Department of Health 2015). In 2016, Swerissen, Ducket and Wright (2016, p. 4) reported that 75% of Australians over the "age of 65 now have one or more chronic diseases and 90% of Australians die from chronic disease". This way of thinking about and measuring the incidence and prevalence of disease reflects the shifts described by Foucault as *populations* became targets of governing (Foucault 2007).

A variety of explanations is given for this shift: advances in medicine and health care, enhanced understandings of causes of diseases, changes in lifestyle which have increased the risks of developing certain diseases as well as increased life expectancy (Gerteis et al. 2014). However, tracing the emergence of the problem of chronic illness through the analysis of policy and research texts gives insight into the broader political, economic and social changes that have influenced these shifts in thinking (Armstrong 2005, 2014; Galvin 2002; Glasgow & Schrecker 2015; May 2005). The need for such analysis is highlighted by the acknowledgement that many of the chronic diseases that have become of such recent concern have been studied in fields such as epidemiology and gerontology for decades (Armstrong 2005). However, during the middle of the twentieth century there was a shift in thinking about these diseases that was evidenced in the way diseases were grouped and what it was about these diseases that were seen as problematic. These shifts were evident in research and policy in the USA and UK, both of which had unique reasons for focusing on chronic diseases (Bynum 2015). In the USA, for example, demographic differences such as shorter life-spans and the early emergence of the private and insurance sectors drove the development of profiling and measurement of diseases (Weisz 2014). The UK, in contrast, intensified its focus on chronic disease after World War II as a social justice issue in the context of the reform of institutions, the establishment of the National Health Service (Rivett 2015) and practical concerns about shortages of hospital beds (Weisz 2014).

During the first half of the twentieth century economists, demographers and epidemiologists had begun to measure and compare levels of health within national populations (Wahlberg & Rose 2015). Armstrong (2005, p. 26) noted that the term chronic illness was introduced and used consistently as a classificatory term in the US-based *Index Medicus* around 1950. The use of this term to classify groups of diseases within populations marked a shift in the reporting and measuring of characteristics and impacts of disease. Rapid advances around this time (Armstrong 2005) in the sciences of epidemiology and statistics as well as the development of tools such as the sociomedical survey (Galvin 2002) made it possible to measure, predict and describe health and disease in new and increasingly detailed ways. In its first issue in January 1955, the North American *Journal of Chronic Diseases* referred to an “awakening” in the “medical and public interest in the increasing importance of chronic illness” (Moore & Seegal 1955, p. 1). The authors went on to attribute this *awakening* to an increased understanding of “the ramifications of the problems” of chronic diseases and recent advances in medical and scientific knowledge that had informed developments in preventative interventions (Moore & Seegal 1955, pp. 1–2). The work of the English physician, Thomas McKeown, was also prominent in this field, as he and colleagues began first to study historical health and population changes in England (McKeown & Brown 1955) and, later, the social determinants of health (McKeown 1976) .

Irrespective of the aetiology of the specific disease, however, from the early 1950s in the USA, illnesses began to be grouped together, and these groupings were “studied and reported upon, more illnesses were identified as ‘belonging’ to the group and soon there appeared to be an ‘explosion’ in their prevalence” (Armstrong 2005, p. 26). The *ramifications* of these groups of diseases that were particularly concerning related to their nature as long lasting, incurable and thus requiring medical care for indefinite periods of time. The diseases listed as of concern at that time included “heart disease, high blood pressure, cancer, arthritis and rheumatism, tuberculosis, diabetes (mellitus), blindness, cerebral palsy, poliomyelitis, and multiple sclerosis” (Moore & Seegal 1955, p. 1). More recent lists (Dowrick et al. 2005; National Public Health Partnership 2001; Swerissen, Duckett & Wright 2016) contain most of these diseases and have expanded to include depression, kidney and oral diseases and previously-terminal conditions such as HIV/AIDS which, as a result of medical and scientific advances, are now manageable and have thus shifted to be long-term, chronic diseases (Timmermans 2014, p. 1). Chronic illness has thus become an ever expanding category with problems requiring diverse solutions, which has driven the development of an accompanying “biomedical-industrial complex” (May et al. 2014).

Of particular relevance to this study is how over time the categorisation of chronic diseases reflected particular types of concerns. The diseases that were included in this category shared features that related to their long term and expensive nature (Dowrick et al. 2005; Swerissen, Duckett & Wright 2016), amenability to preventative and rehabilitative interventions, and an association between disease and economic and personal disability. This changing concern marked a shift in thinking about the boundary between disease and illness (Armstrong 2014). In previous decades, disease was delimited by the physical body of the patient, in terms of a diseased organ or the site or space occupied by a lesion (Walsh 2010). During the closing decades of the twentieth century, however, disease was increasingly discussed in terms of "its disabling qualities and these appeared beyond the body, in social interaction and in population spaces" (Armstrong 2014, p. 18). Ideas of functional impairment, loss of capacities and the mapping of population health emerged within medical and scientific fields (Armstrong 2014). New ways of measuring the impact of these functional losses emerged, such as metrics of "severity, disability and impairment" (Wahlberg & Rose 2015, p. 60). The focus moved from disease patterns to disease burdens within populations (Wahlberg & Rose 2015). This shift has contributed to what Wahlberg and Rose (2015, p. 60) described as a "governmentalization of living, in the course of which the social and personal consequences of living with disease come to be an object of political concern".

Understandings of chronic illness and the active citizen

These understandings of chronic illness shifted alongside changes in thinking about the relationships between individuals, communities and governing bodies. As discussed in Chapter Two, advanced liberal ways of governing that emerged during the twentieth century drew on understandings of the individual as an "entrepreneurial subject" (Foucault 2008a, p. 226) who could be responsible and self-governing. These "autonomous agents" (Rose 1993, p. 298) associated with advanced liberal ways of governing were granted freedom in return for demonstrating responsibility and self-governing capacities. Halse (2009, p. 47) noted that the stabilisation of these discourses during the twentieth century also suggested a shift in thinking about the rights and responsibilities of the citizen, who was "transformed from a subject with legal and constitutional rights and duties into a social being whose existence was articulated in the language of social responsibilities and collective solidarity". The emergence of this way of thinking about the citizen, as having the potential to be responsible for their own health, is evident in the Magnuson Report, a significant report within the history of the US health system (Poen 1996). This report, which was influential in the development of the private health insurance system in the USA, connected chronic illness, self-responsibility and a changing relationship with the traditional expert physician for the first time:

> Ten years ago the physician was considered the single important factor. Today we recognize that, even more than in acute illness, the patient has a tremendously important role to play…the patient himself has to decide that he wants to make an adjustment to his illness and work his way through to rehabilitation. …. (Magnuson Report 1952, cited in Moore & Seegal 1955, p. 2).

This report also stressed the connections between chronic illness and the financial burden experienced by families and communities:

> To the individual family, chronic illness often presents an overwhelming financial problem, in fact wiping out family resources and causing dependency on public funds (Magnuson Report 1952, cited in Moore & Seegal 1955, p. 2)

These shifts in thinking about chronic illness and personal responsibility were also evident in Australian health policy in the latter part of the twentieth century. Australian health care had been structured and funded around systems of community-based general practitioners (Nicholson et al. 2012; Swerissen, Duckett & Wright 2016) and hospital services that delivered acute, curative care. Policy texts of the Australian Medical Association (AMA) stated in 1972 that health care and health promotion was of "limited development in a country with an unusually favourable physical environment and a generally high standard of living" (Australian Medical Association 1972, p. 18). However, by the late 1970s, connections that emphasised responsibility were being made between individuals and their health. For example, in 1979, Australia's Commonwealth Department of Health published the report *Promoting Health: Prospects for Better Health throughout Australia*, which included a section entitled *Health – a right or an obligation?* This section highlighted the connections between freedom, rights and health care that had been evident in the international texts discussed above (McKeown & Brown 1955; Moore & Seegal 1955):

> [there is a] contradiction involved in sanctifying individual freedom while at the same time demanding rights from a beneficent government. One man's right to indulge in behaviour conducive to an expensive illness becomes another man's shackle in extra taxes and/or rising private health insurance premiums (Beard & Commonwealth Department of Health 1979, p. 53).

This text also linked economic productivity with an individual's obligation and responsibility to be healthy:

> It is also of interest to note that a healthier life is generally a less expensive one. It is cheaper, as well as better, to walk or ride a bicycle to work. This is true both for the individual and for the nation's fuel reserves … personal behaviour has been a neglected frontier and has been steadily increasing importance as a source of preventable disease and premature death. The citizen's right to medical care should carry an obligation to do all he can to keep his health intact. There is a case for forfeiting certain 'rights' when the reciprocal obligations are deliberately abandoned (Beard & Commonwealth Department of Health 1979, pp. 59–60).

The links made between rights and obligations occurred alongside rapid and significant technological advances and commercial developments that impacted on ways of thinking about life itself (May et al. 2014). Through this period, ageing and some of the illnesses associated with it were increasingly pathologised (Armstrong 2014). For example, heart disease became the reported cause of death in increasing numbers of older people during the late decades of the twentieth century as it replaced other descriptors such as *senility* or *decrepitude* (Armstrong 2014). This relabelling did not alter the reality of the disease process that was linked to the death, but did have an effect of pathologising a process of ageing:

> The senescence of ageing was wrestled from nature and located in a degenerative space and the further transformation of that space into a pathological one (Armstrong 2014, p. 21)

Knowledge about life processes that had developed through advances in biological sciences allowed for calculation and control at different levels of life and the body (Villadsen & Wahlberg 2015). Aspects of life that had previously sat outside the jurisdiction of medical diagnosis or treatment were connected, as life and the body were increasingly medicalised, commodified and marketised (Fredericks & Legge 2011, p. 17). The following example illustrates such a shift:

> Previously, acid reflux was known simply as heartburn and treated with a glass of milk or an over-the-counter antacid. In the 1990s in the U.S., Glaxo began

> promoting one of its drugs to treat heartburn under a new name, GERD (gastroesophageal reflux disease), and described it as having serious health consequences if not treated (Iriart, Franco & Merhy 2011, p. 6).

This medicalisation and marketisation was also evident in the changes in the visual images associated with health and health promotion during the 1970s and 1980s. By the 1980s:

> the boundary that had come to separate the health poster from the commercial advertisement, and which over time was consolidated through its image, ceased to exist. The medicalization of life was now as fully commercialized in the visual assemblage of the health poster as in the promotion of proprietary medico-lifestyle products (Cooter & Stein 2010, p. 187).

By the end of the twentieth century, these shifts had repositioned health and illness in subtle ways. The experience of being sick was, in effect, "sidelined in the quest for health" (Burnham 2012, p. 776).

This changing relationship between illness and health was influenced by moves away from the biomedical model of disease and disease treatment. This was evident in the influential work of the Canadian Minister for Health and Welfare, Marc Lalonde (Lalonde 1974), and English physician Thomas McKeown (McKeown 1976), who both gained international notoriety around this time. Although social factors had been recognised as contributing to ill health in earlier decades, the Lalonde Report marked the acknowledgement of the social determinants of health—biology, health services, environment and lifestyle—in official government policy for the first time (Hancock 1985). Similarly, in England in 1976, the report *Prevention and Health, Everybody's Business* (Department of Health and Social Security 1976) clearly linked government health policy with health promotion and preventative interventions. Such intentions reflected a commitment to realigning ideas of health and illness with responsibility—an attempt "to reappraise, in the light of our current knowledge of disease, the various ways in which we can all take more responsibility for insuring our own health" (Prince 1976, p. 460). As will be shown through the analysis of Australian health policy, this way of thinking has persisted over the subsequent decades. The ongoing influence of this work is evident in how primary health care was assembled, both internationally, by WHO, and locally, through Australian health policy.

Primary health care: integrating life and health

Primary health care as a field of practice and an approach to health and care was introduced in Chapter One. Primary health care services have varying national histories (for selected national histories, see Crooks & Andrews 2012); however, developments from the 1970s onwards in the UK, Canada, New Zealand and Australia shared important features. From the 1970s, WHO became an international leader in the development of the approach of primary health care (Cueto 2004). In the years immediately after its establishment in 1948, the work of WHO focused on targeting specific illnesses, such as malaria, and on improving the provision of hospital-based services (Chorev 2012). However, during the 1970s, the focus of WHO primary health care programs developed in different directions. There was an increasing awareness of community-based models of care, such as the 'barefoot doctors' in China (Cueto 2004). This awareness drew on the experiences of the neighbour of WHO in Geneva, the Christian Medical Commission or CMC (Cueto 2004). The two organisations had formalised collaborative relationships by 1974, and Kenneth Newell, a senior WHO staff member, collected and published stories of local practice from CMC missionaries in the report *Health by the People* (Newell 1975). This report, along with work by Lalonde (Lalonde 1974), McKeown (McKeown 1976) and the US cardiologist John Knowles (Knowles 1977), influenced international approaches to health care generally. As will be discussed, it was during these years that the idea of lifestyle prevention emerged within international health care policy. Such an approach sought to counter the increase in chronic illnesses by identifying 'at risk' populations and "getting individuals to make healthy choices about smoking, alcohol, diet and physical exercise" (Larsen 2012, p. 227).

This shift, from ill health being seen as a primarily physiological state to the foregrounding of risks and individual responsibility for health, is also evident in the texts of the WHO's 1978 Alma Ata conference (World Health Organization 1978). The conference, entitled *Primary Health Care and Health for All by 2000* (World Health Organization 1978), was of note because it formalised the shift in the focus of WHO's priorities away from the management of acute health issues (such as the eradication of malaria) and the provision of hospital care, to community-based primary health care services (Bryant & Richmond 2009). The conference promoted an integrated approach to health and socioeconomic development through community participation and health education at all levels of society (Brown, Cueto & Fee 2006). As noted in Chapter One, the 'Declaration of Alma Ata' (World Health Organization 1978) cast primary health care in the following terms:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination…(it) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services (World Health Organization 1978, pp. 2-3).

This period of change also saw the increased involvement of bodies such as the World Bank and International Monetary Fund (IMF) in the fields of health and care (Brown, Cueto & Fee 2006). The World Health Organization did not have adequate resources to fund many of its own primary health care programs, and by the 1980s the World Bank and other government and non-government agencies had become influential stakeholders in the development of primary health care programs (Cueto 2004). The World Bank, initially founded in 1946 to aid in the reconstruction of Europe, began to invest in population control and health education. By the 1980s, it had embedded its own neoliberal market approaches in the programs it funded (Girdwood 2007). The World Bank's 1993 report *Investing in Health* expressed such rationalities in its description of health and care services:

> healthcare services in terms of the economic benefit that improved health could deliver, and sees health improvement mainly in terms of improvement of human capital for development, rather than as a consequence and fruit of development (Hall & Taylor 2003, p. 19).

The World Bank only supported health care programs that emphasised private sector delivery of health services, and the marketisation of health care was evident in these programs—"user pays, cost recovery, private health insurance, and public-private partnerships" (Hall & Taylor 2003, p. 19). Similarly, the involvement of the IMF in lending money to poorer countries to institute reforms in the health sector moved some programs away from the primary health care approach envisioned in the Alma Ata declaration towards the IMF's objectives of macroeconomic stability (see Anyinam 1989 for a country-specific example).

The dominance of advanced liberal ways of governing and neoliberal rationalities of efficiency and cost minimisation remain evident within the texts of these global bodies. For example, in the IMF working paper *Waste Not, Want Not* (Grigoli & Kapsoli 2013), public health expenditure was discussed in terms of "health outputs and outcomes". Thompson (2008) noted these changes in the priorities of WHO, in which the improvement of population health was linked with attempts "to reduce the economic burden of disease" (p.78). These changes were associated with the priority given to ideas of *health outcomes* and initiatives that worked to integrate health promotion, preventative interventions and clinical care:

> …to achieve the best outcomes, the WHO argues for an integrated philosophy within which health promotion, disease prevention, diagnosis, treatment, rehabilitation and care represent a continuous linked process to improve health gain (Thompson 2008, p. 78).

The remarkable growth of the self-help sector (Guthman 2009) in recent years illustrates the continuation and intensification of these trends. Individual responsibility for the optimisation of health has supported the development of networks of information, advice and expertise which both (re)produce discourses of health and responsibility and also provide information, support and knowledge. The Internet has also become a powerful tool in the spread of strategies and techniques that promote such self-help and self-management (Clarke et al. 2003). The growth in the digitisation of health promotion has opened up new ways of governing the body and health (Lupton 2015). Mobile phone applications and self-tracking devices that connect via smartphones to websites offer new ways of "monitoring, measuring and visualizing the human body and sharing personal information and experiences with others" (Lupton 2015, pp. 176–7). Video games that store and monitor physical details actually work to promote self-monitoring and self-surveillance under the guise of 'leisure' (Millington 2009, p. 629). Television shows (Rail & Lafrance 2009) and reality TV (Litwack 2015) also reiterate these ideas of affiliation and optimisation of health and life. Lupton (1995) noted the complexity of health promotion and its alliance with a biopolitical mode of governing that targets both the individual and population:

> That is, they are directed at the level of the population, they constitute individuals and groups as 'problems' and domains of governance needing the assistance of health promotion 'experts', they are systematic, calculated and directed at defined ends, they emerge from the state but are also articulated by associated independent institutions and agencies, they are constantly subject to evaluation and revision, they are not crudely repressive of rights but are directed at productive purposes (the health and happiness) of the population (Lupton 1995, pp. 48–9).

Such connections bring the body into the political domain. As LeBesco (2011, p. 154) argued, the body becomes marked with evidence of success or failure as a healthy body "has come to signify the morally worthy citizen – one who exercises discipline over his or her own body, extends the reach of the state and shares the burden of governance". Health promotion and the connections made between risk, responsibility and self-governing have been examined extensively elsewhere (Ayo 2012; Larsen & Manderson 2009; Larsen 2010, 2012; Lupton 1995, 2015; Pii & Villadsen 2013). Of particular relevance to this study, and the current chapter, is the tendency within health promotion programs to increasingly focus on individual lifestyle factors rather than the social determinants of health and inequalities. Such a shift in focus has been described as "lifestyle drift" (Popay, Whitehead & Hunter 2010, p. 148).

This focus on the individual and their lifestyle is evident in the Get Healthy health promotion campaign which was run in New South Wales alongside HealthOne Camara. Although the target groups for these programs are different, as is discussed in subsequent chapters there is a noteworthy resonance between them. A brief consideration of the Get Healthy program illustrates how the outcome of health optimisation is connected to *choices* made by individuals who have received a very specific type of education and support from relevant experts. Enhancing the individual's ability to make good choices with regard to their health is positioned as being of benefit to the community in ways that (re)produce the dominant economical and moral arguments associated with the problem of chronic illness. Importantly, Get Healthy presents health as something that can be optimised through individual choices that are ultimately for the benefit of individuals, their families and communities. This way of shaping and connecting notions of health, choice and responsibility has significant implications for the framing and problematisation of chronic illness in Camara as the discourses, techniques and mechanisms of education and intervention are also evident.

get healthy®
Information & Coaching Service
1300 806 258
Monday - Friday 8am - 8pm
www.gethealthynsw.com.au

Figure 3.1: Image from Get Healthy Information and Coaching Service (www.gethealthynsw.com.au)

Promoting life and health in Camara: Get Healthy

The purpose of the Get Healthy program was described as being to "offer free and confidential telephone-based expert advice and plenty of motivation to help you find a healthier, happier, you" (NSW Government n.d.-a). The implication from these words is that there is something missing—something lacking that can be remedied. The image in Figure 3.1 is a powerful representation of advanced liberal understandings of the active citizen and the ongoing pursuit of health and self-improvement. The man appears overweight, yet is working to reform his health himself by exercising. The exercise he has chosen is walking outdoors, which is free and easily attainable. The words next to the picture set out information and coaching as the strategies through which reform can be achieved. A certain relationship with the program and its experts is suggested, and telephone support and access hours are offered.

The advertisement for the Get Healthy program sets out ways of thinking about health and self-management that run through policies and programs of health and care: "assumptions about the nature of 'responsible' patients, the availability of the right knowledge and the capacities of people to apply this knowledge to achieve right outcomes” (Howard & Ceci 2013). In relation to health and illness, this process involves accessing and accepting information presented by approved experts—a type of *tutelage* that emphasises “strengthening the capacity of the individual to play the role of actor in his or her own life” (Rose 1996b, p. 348). This way of thinking is evident in the following extracts from the Get Healthy program.

> **Ian**
>
> **“I have gone from being an overweight guy who didn’t exercise, to now where I consider myself very fit, very healthy. This has turned my life around!”**
>
> After watching a Get Healthy Service advertisement on TV it clicked with Ian that he was leading an unhealthy lifestyle and that he needed to do something about it.
>
> Indulging in take-away foods, constant snacking and not enough exercise was leaving him unhappy “I had no energy and consumed too much alcohol. I knew it was bad, I just had never taken that first step.”
>
> After signing up to the Get Healthy Service Ian completely changed his way of life and since joining the program has lost 23 kilograms.
>
> “Every time I talked to my coach I would come away with something really helpful. They never criticised, always encouraged.”
>
> Even though Ian knew all along that he needed to exercise and eat healthier foods, having that backup to reinforce the positive actions was the key.
>
> Ian’s wife is loving the transformation to a happy and active husband “I can’t believe it, it’s like a different person the way he jumps out of bed.”
>
> Ian now enjoys cycling and bush walking and claims after 32 years of marriage it’s great to be able to live an active lifestyle with his wife.
>
> Source: http://www.gethealthynsw.com.au/success-stories (Accessed 02/03/2015)

This extract connects self-knowledge with the ability to self-govern. Once Ian knew and understood what he was doing incorrectly, he was able to reform his behaviour and improve his health and well-being. Importantly in this extract, Ian’s health and its improvement is positioned as being of benefit to those around him. His friends and his wife are happier as well now that Ian is healthier and more active. Similarly, Laurel’s ‘success story’ emphasises how she was able to govern her own health as a result of being engaged in the program.

Laurel
Laurel knew she was putting on weight and decided after seeing The Get Healthy TV commercial she had nothing to lose by making a change to her life. Having recently moved to Sydney, Laurel admits finding a new job, establishing new friends and moving all contributed to her emotional eating.
However, with the help of her Get Healthy health coach Laurel now has the right knowledge and outlook to live a balanced lifestyle, and always has a constant reminder in the back of her head to make the right decisions. Laurel has continued to follow the program and now understands the principles of good nutrition.
Laurel has been an inspiration to her family and is very proud to say her daughter has since joined the program following her success. Laurel's husband is incredibly proud of her and they now both enjoy her new healthier lifestyle. They both lead a more active lifestyle and are more inclined to do something active together like kayaking, cycling and they play social tennis together with another couple.
Source: http://www.gethealthynsw.com.au/success-stories **(**Accessed 02/03/15)

Like Ian, Laurel was able to take responsibility for improving her health once she understood how to do so. She took up the offer of education and monitoring, which allowed her to develop her self-knowledge and become the expert on her own health. Laurel was also rewarded by gaining the approval of her daughter and others around her. These examples of how the promotion of health works through techniques of education and self-knowledge illustrate the ways in which discourses of health and responsibility are connected with ideas of active citizenship and impact upon family and community relations (Burrows 2009).

An important effect of the (re)production of these discourses of responsible, active citizenship has been to reinforce that certain behaviours and ways of living healthily as "worthy, desirable and necessary virtues" (Halse 2009, p. 47). As Guthman (2009, p. 1115) noted, the consistent reiteration of discourses that link health, citizenship and self-governing have rendered them common sense, and the logic with which they are associated has become invisible and implicit. Important in the context of this analysis of the problematisation of chronic illness is the way in which these discourses of health and active citizenship assemble individuals as having the potential to optimise their own health and life. Glasgow and Schrecker (2015, p. 282) described an increased focus on the individualisation of both the location of the problem and the focus of the solution. These discourses of health and responsibility produce subjectivities that draw on the idea that individuals can be mobilised through education and advice to modify their own health behaviours (Perron, Fluet & Holmes 2005, p. 542). Although the body of a person with a chronic illness may not be capable of returning to full health, as an active citizen the individual can still work to optimise the functioning and management of their body and, thereby, minimise its costs. As is shown in the analysis that follows, in recent years Australian health care policy has shifted its focus to the development of primary health care programs that work to optimise life and health.

Australian primary health care: promoting life and problematising chronic illness

The global shifts in discourses and "international dilemmas" associated with chronic illness (Yen et al. 2011) are evident within the period of intense reform of Australian health policy led by the Commonwealth Labour Government elected in 2007 (Baum 2011; NSW Government 2012; Primary Health Care Research and Information Service n.d.). Historically, the focus of the Australian Commonwealth and State health systems has been on the provision of short term, episodic care through hospitals and general practice; this was facilitated through the provision of rebates for both hospital visits and general practice consultations with considerable diversification of funding streams in recent decades (Department of Health and Ageing 2009). However, as is discussed in detail in this thesis, recent policy has marked a shift in focus to primary health care and programs that work to mobilise individuals as "rational economic actors" (Glasgow & Schrecker 2015, p. 282), who can be helped to take responsibility for the optimisation of their own health.

This period of reform was led by the formation of the National Health and Hospital Reform Commission (NHHRC) in 2008 (Primary Health Care Research and Information Service n.d.). The NHHRC issued its final report in 2009 and contextualised the need for reform in the following terms:

> Over the last century, chronic disease has become more prominent than infectious disease as a cause of death; this trend is likely to continue. It has been estimated that almost four in five Australians have at least one long-term or chronic health condition ranging from asthma and arthritis to depression and diabetes. Already, more than 50 per cent of GP consultations are for people with a chronic condition such as heart disease, cancer, neurological illness, mental disorders and diabetes. Expenditure on chronic disease in Australia accounts for nearly 70 per cent of total health expenditure on disease, some as a consequence

> of unhealthy behaviours (National Health and Hospitals Reform Commission 2009, p. 62).

The rising costs associated with these diseases and illness are shared by all Australian taxpayers, who contribute to this health care system even if they are healthy and taking responsibility for their body and 'life'. This generalising of 'concern' gains a sharpness when it is connected with the attribution of responsibility to the individual who is able to make better choices about their health:

> Many of us make choices about the way we live our lives that potentially damage our bodies or our minds – healthy choices are not always easy choices. For some, the 'lottery of life' delivers special challenges to health and wellbeing and living with a disability, chronic disease or disadvantage can be a hard reality (National Health and Hospitals Reform Commission 2009, p. 45).

This text also reiterated the responsibility of individual citizens to make choices that reduce the risk of chronic diseases:

> We know that many chronic diseases are preventable. Smoking, excessive alcohol, lack of physical activity and low fruit and vegetable consumption are all risk factors which contribute to the burden of chronic disease (National Health and Hospitals Reform Commission 2009, p. 62).

The connections between an individual's health and illness and the *population* or *community* who shares the burden of the costs of their illness are evident within this text. Although an individual may make choices that affect their physical body, the financial costs of these decisions are shared with others. This risk and burden is quantified and directly linked to behaviour and choices of individuals:

> In fact, 32 per cent of Australia's health burden has been attributed to these risky behaviours and choices. Good progress has been made in reducing the incidence of some chronic diseases, particularly coronary heart disease and stroke. Of concern, however, 54 per cent of adult Australians and one in four children are overweight or obese and at risk of developing chronic disease, such as diabetes, heart disease and cancer. If current trends continue, nearly three-quarters of the

> Australian population will be overweight or obese by 2020 (National Health and Hospitals Reform Commission 2009, p. 62).

A key report issued by the Commonwealth Department of Health and Ageing articulated the challenge facing Australia's health care sector in the following terms:

> While the primary health care sector delivers services that meet the needs of most people requiring treatment for isolated episodes of ill-health, it is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are 'hard to reach' (Department of Health and Ageing 2009, p. 19).

This report asked the question "why is reform in primary health care needed?" and, in the answer that followed, (re)produced the international concerns identified by bodies such as WHO, IMF and the World Bank:

> There are a number of reasons why reforms to primary health care service provision and restructuring the health system to place greater focus on primary health care are needed:
>
> - The first is the burden of disease, workforce pressures and effects on patient wellbeing from increasing rates of chronic disease;
> - The second is to minimise the need for people to be admitted to hospitals and for people to spend less time in hospital by providing clinically appropriate care in the community; and
> - A third reason is evidence that not all people are receiving equitable levels of primary health care service due to where they live, their ability to pay or their health condition (Department of Health and Ageing 2009, p. 8).

The need and justification for new and different primary health care programs were framed in relation to the economy, national identity and security:

> The health of our people is critical to our national economy, our national security and, arguably, our national identity. Health is one of the most important issues

> for Australians, and it is an issue upon which people often turn to governments for leadership.
>
> Health is a major part of our national economy. It generates a significant proportion of economic activity and employs over 7.3 per cent of our working population. Health also underpins our economy. A healthy workforce is a productive workforce; every employer has an interest in keeping their employees safe and well (National Health and Hospitals Reform Commission 2009, pp. 45-6).

These texts set out the importance of the population's health and well-being. They also positioned the function of the State and its agencies as being to provide leadership and support so that individuals can make the right choices:

> Good health is therefore about more than health care. Governments must take action to nudge people towards health-promoting behaviour through better information, evidence based prevention and health promotion programs (such as QUIT, the National Tobacco Strategy, and SunSmart) and to create the environments which 'make healthy choices easy choices' for every individual (National Health and Hospitals Reform Commission 2009, p. 62).

Running through these texts are ideas of individual responsibility, freedom and choice, but also shared burdens and costs. *Good* choices in relation to optimising health and lifestyle have an impact on the individual and their communities. Making choices that are risky and have potentially negative consequences become concerns that are shared by others, not just the person directly involved. These texts position the rational individual as willing and able to make 'good' choices that optimise their health and life and thereby reduce the risk and burden imposed on the community. Positioning such individual choices as being rational and easy, yet also of concern to the community, situates the individual within a complex set of relations. The individual is understood as free and able to make choices, yet at the same time their choices have effects on others. These potential effects on others positions the individual as accountable to a wider community as the burden of their disease is shared across a community.

These discourses and discussions of trends and future predictions reiterate the anxiety and urgency contained within the texts of organisations such as WHO and IMF discussed earlier in this chapter. The distribution of the economic burden of chronic illness across a community or population has an effect of sharing responsibility for deciding how to address the problem. The problem, as stated within these texts, is related to individual inadequacies and failures to be an active, responsible citizen. Framing the problem in this way then leads to programmatic 'solutions' that need to address personal inadequacies and failings. By targeting populations and groups identified as being 'at risk', the burden for all will be reduced. Dean (2010, p. 195) referred to an "emergent division" between those active citizens who are considered "capable of managing their own risk" and those who need "intervention in the management of risks." This resonates with what Rose (1996b, p. 340) described as "a re-coding of dividing practices…the distinctions between the *affiliated* and the marginalised". Neoliberal rationalities of responsible self-governing imply that certain practices are required to attain and maintain status as affiliated; "to remain affiliated one must 'enterprise' one's life through active choice" (Rose 1996b, p. 340). This idea of enterprising one's life connects with the social determinants of health and an understanding of 'risk factors', some of which are evident in the lives of individuals—"how they live their lives – their behaviours and lifestyles; and their biological and genetic predispositions" (National Health and Hospitals Reform Commission 2009, p. 18). Within the context of problematisation of health and illness, citizens who are seen as successful in the optimisation of their health and life are affiliated and rewarded as a result of their responsible choices. This way of rewarding individuals through affiliation and approval was evident in the Get Healthy 'success stories'; Ian and Laurel were both praised publicly and their achievements were acknowledged by their families and friends as being of value.

Part of the reward associated with being able to enterprise and optimise life involves a shift to a position of influence and judgement over those who remain *unaffiliated* and at risk. This idea of a shared interest in legitimating programmatic solutions is evident in the NHHRC's report (2009), which suggested that community as potentially involved in making decisions about the rationing of health care resources:

> As a community, we would find it confronting to be asked to make a decision about rationing high cost health care, such as renal dialysis to the elderly, if it released resources to extend the lives of sick children. The so-called 'rule of rescue' means that we feel a moral imperative to invest in the care of identifiable

> individuals, no matter what the economic metrics may show. But the reality is all health care costs money, and money is scarce, facing us all with ‘tragic choices’ (National Health and Hospitals Reform Commission 2009, p. 46).

Key reform recommendations included incorporating health literacy into the National Curriculum for schools as well as “fostering community participation – for example, through citizen juries on issues such as the allocation of scarce resources among competing priorities” (National Health and Hospitals Reform Commission 2009, p. 7). The use of citizen juries in the development of inclusive health policy in the UK and Australia has been reviewed by others, for example Street et al. (2014). Of relevance to the current discussion is the way in which such techniques work to engage *communities* in collective decision-making about health and care priorities. Through such techniques, and in ways that reflect advanced liberal ways of governing, responsibility for ‘health’ is dispersed to individuals and local communities.

These texts considered in this section link the ability to make ‘good’ health choices with access to information and education. This implies that, once an individual is presented with the required knowledge, they are able to make the ‘right’ choice and *will do so*—the moral, responsible citizen is obliged to act out and fulfil the ideal of ‘being empowered’ (Cruikshank 1994). Here, empowerment is an inherently political notion, and can have the effect of further categorising and subdividing groups of people into those who have chosen to be empowered and those who have not (Brown & Baker 2012). Importantly, and as will be discussed in relation to HealthOne Camara, this focus on individual responsibility and its collective implications has become a dominant theme in contemporary international health policy (Glasgow & Schrecker 2015). This balance between individual responsibility and collective accountability can be discerned from the NHHRC’s report (National Health and Hospitals Reform Commission 2009), which linked individual and collective action:

> We support strategies that help people take greater personal responsibility for improving their health through policies that ‘make healthy choices easy choices’. This includes individual and collective action to improve health by people, families, communities, health professionals, health insurers, employers and governments.

> We urge all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers, food manufacturers and retailers, employers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and make decisions about their use of health services (National Health and Hospitals Reform Commission 2009, p. 18).

These extracts set out detailed and extensive networks of people and organisations involved in the optimisation of health and life. Organisations such as food manufacturers and retailers have a responsibility to make appropriate information available to the consumer. However, it is the individual's responsibility to take up this information and integrate it into their decision making. The statement that people need to make better decisions about their use of health services reinforces the idea that individuals are responsible for *mediating* their use of shared resources such as hospitals and medical services. This way of thinking advocates what Trnka and Trundle (2014) described as a "reflexive prudence":

> individuals and collectives must increasingly conduct moral evaluations of their actions in relation to their potential effects, calculating and designing their life course in ways that attempt to mitigate harm and risk, and maximise benefit to themselves and others (Trnka & Trundle 2014, p. 139).

Here, Trnka and Trundle also nominate the individual as the ideal coordinator and manager of their health care information. This is evident in the recommendation of tools to allow the individual to self-manage information about their own health care needs:

> To support people's decision making and management of their own health we recommend that, by 2012, every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person (National Health and Hospitals Reform Commission 2009, p. 18).

The personally controlled electronic health record (PCEHR) was introduced across Australia in 2012 (renamed as 'my health record' [MyHR] from 2014) (Department of Health 2013). Unlike other e-health record systems, which are controlled by clinicians and used to collate and share clinical data (Gray et al. 2011), the PCEHR was part of a drive to engage "the consumer as stewards of their own health and their own medical record" (Department of Health 2013, p. 19). These recommendations and reforms situate a significant responsibility for the everyday enactment of health reform at the level of the individual. Organisations and government bodies provide information, advice and infrastructure but the individual must become the active, enterprising citizen—the *steward* of their own health and care.

In 2010, the Australian Commonwealth Government launched the first National Primary Health Care Strategy (Department of Health and Ageing 2010). This marked the Commonwealth Government's extension into health care service delivery beyond general practice and into primary health care for the first time, and incorporated many recommendations from the reports already discussed.

Key to the reform of Australian primary health care were the following five 'building blocks', which aimed to promote regional integration (through the establishment of Medicare Locals[4]); the development of e-health technologies (including the PCEHR); workforce development; and improved funding and systems management (Department of Health and Ageing 2010, p. 12).

This strategy signalled significant change within Australian primary health care and elements of the reform program mirrored international shifts. The introduction of Medicare Locals as primary health care organisations, a focus on e-health and the reform of financing to incorporate performance related funding emphasised a drive to disperse responsibility through networks and localised services. Advanced liberal ways of governing are evident in such shifts and translations (Rose 1999) of the problematising discourses.

Conclusion: responding to the research question

This chapter has responded to the first research question set out in Chapter One: *How has chronic illness been problematised within contemporary discourses of health and responsibility?*

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[4] Medicare Locals were established by the Commonwealth Government in 2009 and replaced the General Practitioners Division of Practice that was established in 1992 (Nicholson, Jackson, Marley and Wells 2012). Medicare Locals were envisaged as functioning as local primary health care organisations and were key in the Australia-wide roll out of the National Primary Health Care Strategy (Department of Health and Ageing 2013). Medicare Locals were replaced with Primary Health Networks from 1 July 2015 (Australian Government n.d.).

In assembling the response, this chapter has focused on what Li (2007, p. 264) described as the consideration of "how problems come to be defined as problems in relation to particular schemes of thought, diagnoses of deficiency and promises of improvement". This chapter began by extending Chapter Two's discussion of contemporary understandings of the citizen as active and self-governing and engaged in a drive to maximise life through freedom and choice: "individuals who are, by their own efforts, motivated, willing and able to take the initiative" (Dahlstedt, Rundqvist & Vesterberg 2015, p. 97). Rather than being granted freedom through sovereignty, the entrepreneurial citizen has opportunities to earn freedom through the "energetic pursuit of personal fulfilment" (Rose & Miller 1992, p. 201).

Within these discourses, health is assembled as a moral and economic imperative; a state to be optimised through good choices and responsible lifestyle decisions.

This changing understanding of health and life as attributes to be optimised emerged from broader shifts in thinking about disease patters and trajectories during the middle decades of the twentieth century. Research and policy linked health with social determinants of disease (Lalonde 1974), lifestyle and risk (Larsen 2012). Understandings of disease and long-term illness developed, and the impact of disease was quantified in costs and burdens. Within this context of social, scientific, economic and political drivers, chronic illness came to be seen as a "socially salient problem" (Armstrong 2005, p. 26) that needed to be addressed.

This chapter has discussed how the problematisation of health and chronic illness has positioned the individual within a complex set of relations that reinforce the ideas of individual responsibility and collective burden. As the 'truth' of the argument that individual behaviours have collective implications stabilises, there is a reconfiguration of the relationship between individuals and their communities. Although the texts analysed in this chapter acknowledge the impact of factors other than individual choice, the bulk of responsibility for the management of chronic illness is placed with the individual. Just as health was assembled as an achievement that validates the individual and benefits those around them, so chronic illness has become a 'problem' for the person affected, a burden for the community and a threat to national identity and security (National Health and Hospitals Reform Commission 2009).

Rethinking chronic illness in this way has highlighted the ways in which the relations that connect individuals, populations and the government bodies have been reconfigured. As the problem of chronic illness has been assembled largely as one of individual choice and responsibility, the government and its institutions have taken on functions as facilitators of improvements that benefit the individuals as well as the community: “Governments must take action to nudge people towards health-promoting behaviour…and to create the environments which ‘make healthy choices easy choices’ for every individual” (National Health and Hospitals Reform Commission 2009, p. 62). As has been discussed through the analysis presented in this chapter, this way of thinking about promoting the choice-making abilities of individuals reinforces the idea that education, information and advice can improve self-knowledge and, thus, self-governing capacities. As education, information and the promotion of health have been positioned as the ‘solution’ to the problem of chronic illness, responsibility for the provision of such information has been dispersed to retailers, food manufacturers, insurers and employers. This pattern of problematising individual behaviour and choice making has been identified in studies of health promotion (Larsen 2012), and discussed in this thesis in relation to the Get Healthy program. As this emphasis on individualised problems and solutions unfolds through programs such as Get Healthy, the focus of reform shifts from the complex social determinants of health to the individual as a site for “quick fixes and low-lying fruit” (Popay et al. 2008, p. 148). These patterns in thinking are increasingly evident in the design of policy and programs that seek to address the problem of chronic illness. The analysis presented in this chapter has argued that, in recent Australian health care policy, chronic illness has been increasingly presented as an outcome of poor choices. Although efforts to address the social determinants of health are evident within various political and social discourses, preventative interventions that promote good choice-making have become an increasingly important part of addressing the problems of chronic illness. Also evident within Australian policy is the tendency towards promoting the ability of individuals to self-manage existing and future health needs. It is within this context that HealthOne was assembled as a programmatic response to a localised problem of chronic illness.

Chapter Four – Assembling HealthOne

> You say to me: nothing happens as laid down in these 'programs'; they are not more than dreams, utopias, a sort of imaginary production that you aren't entitled to substitute for reality…To this I would reply: had I wanted to describe 'real life' in the prisons, I indeed wouldn't have gone to Bentham. But the fact that this real life isn't the same thing as the theoreticians' schemes doesn't entail that these schemes are therefore utopian, imaginary, and so on. …These programs induce a whole series of effects in the real (which isn't of course the same as saying that they take the place of the real): they crystallize into institutions, they inform individual behavior, they act as grids for the perception and evaluation of things (Foucault 1991, p. 81).

Introduction

Chapter One identified governmentality as the analytic perspective guiding this study. Bröckling, Krasmann and Lemke (2010, p. 15), observed that governmentality "signifies a research perspective in the literal sense: an angle of view, a manner of looking, a specific orientation". In the preceding chapters this perspective has been used to analyse how chronic illness has been problematised within and through the discourses of health and responsibility. These discourses have positioned primary health care and programs of integrated care as solutions to the problems of chronic illness. Lemke (2011, p. 42) noted a risk within studies of governmentality of presenting programs as "closed, coherent entities, as achievements and accomplishments rather than projects and endeavours". The analysis and discussion presented in Chapters Four, Five and Six directly addresses this concern, by extending the problematisation of chronic illness through the documentary and empirical analysis of the program of HealthOne and its local enactment in HealthOne Camara.

The analysis and discussion in this chapter focuses on the second research question set out in Chapter One:

> *How and in what ways was HealthOne assembled as a response to this problematisation?*

Examining HealthOne in this way moves beyond descriptive or evaluative analysis and instead analyses it as a complex assemblage of discourses, techniques, technologies, expertise, subjectivities and material objects that come together. As discussed in detail in Chapter Two, using assemblage (Rose 1999) and translation (Li 2007) as tools of analysis enables a view of HealthOne as a group of "elements…drawn together at a particular conjuncture only to disperse or realign, and the shape shifts according to the terrain and the angle of vision" (Li 2007, p. 265). There is no overriding essence attributed to the HealthOne program itself. The analytic value of such an approach is derived from its capacity to examine how this assemblage coheres, even temporarily, in daily practices of integrated care. Using translation and assemblage in this way also makes it possible to ask more complex questions about the underlying rationalities that facilitate this coherence.

To fulfil this purpose, this chapter begins by tracing the global discourses of health and responsibility in the local texts of HealthOne that were discussed in Chapter Three. The chapter then analyses a range of empirical materials, including interviews with senior health service managers and GPLNs. This analysis traces the translation of discourses of health and responsibility into the policies of HealthOne and, then, into the daily practices of the GPLN. The analysis shows how neoliberal political and economic rationalities were mobilised in ways that established a local need and urgency for reform within the primary health care sector. This need for reform was aligned with solutions that focused on the ability of clients to manage their own chronic illnesses in ways that would reduce demand on the public health system, especially inpatient hospital services. Analysis and discussion then turns to review the ways in which key texts produce the subjectivities of the GPLN and the HealthOne Camara client. The discourses and rationalities that are (re)produced through the subjectivities have the effect of continuing the translation of HealthOne. The chapter then concludes with a response to the research question that is the focus of this chapter.

Assembling HealthOne

Chapter Three traced the problematising of chronic illness through global and national discourses of health and active citizenship. This understanding of chronic illness emphasises concerns about costs and burdens of illness as well as the responsibility individuals have for managing the risks and costs of their own health and care. This way of thinking is evident in international and Australian health policy texts, which have in recent decades emphasised the importance of health promotion and preventative interventions for all citizens, including those with chronic illnesses. As noted in Chapter Three, these shifts in thinking about health and care suggest changes in the relations between individuals, communities and governments. Recent Australian policy set out the functions of government, in relation to health, as being to “nudge people towards health-promoting behaviour through better information, evidence based prevention and health promotion programs” (National Health and Hospitals Reform Commission 2009, p. 62). The responsibility for taking up these opportunities, however, rests with the individual. As is shown in the following analysis, HealthOne was assembled through these shifts in thinking about how to care for people with chronic illness. This analysis also highlights how HealthOne was assembled as a local program that maintained a connection to a government policy centre.

Chapter One introduced HealthOne as a primary health care program established by the NSW State Government in 2006–2007 as part of a major reform initiative (NSW Government n.d.-b). The programs objectives were set out as being to:

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

These objectives (re)produced the problems associated with chronic illness that were discussed in the previous chapter—risk, prevention, disability, costs of hospital care and sustainability of services. They also set out the “programmatic logic” (Rose & Miller 1992, p. 190) of HealthOne and a linear, rational view of policy enactment. In contrast with this view, however, HealthOne unfolded through a succession of alignments, relays and affiliations.

Advanced liberal ways of governing from an often distant political centre are dependent upon political authorisation, forging of alignments and “establishing relays” (Rose 1999, p. 49). This translation is evident in the assemblage of HealthOne. For example, HealthOne was described in a key text as a set of aims and objectives enacted by various care providers:

> HealthOne NSW aims to create a stronger and more efficient primary health care system by bringing Commonwealth-funded general practice and state-funded

> primary and community health care services together. Other health and social care providers may also be involved in the HealthOne NSW model, for example pharmacists, public dental services, private allied health professionals, other government agencies and non-government organisation (NSW Government n.d.-b).

Another text, *Guidelines for Developing HealthOne NSW Services*, described HealthOne services as coming together through the practices of professionals:

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

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

> There is no single model of integrated care that is suited to all settings; Local Health Districts should be guided by their community needs about the configuration that is best suited to each locality. To date three broad service configurations have been described for HealthOne NSW services:
>
> 1. Co-located services
> 2. Hub and spoke
> 3. Virtually integrated services
>
> These are not mutually exclusive and some locations may use two configurations, for example hub and spoke and virtual, or co-located and hub and spoke (NSW Government 2012, p. 3).

The structure of these services' configurations remains unclear, but of significance in this current chapter is the way the text describes the care offered in terms of collaboration, outreach and coordination. This text offers guidance for developing HealthOne programs and provides two 'case studies', to illustrate how co-located services and the hub and spoke model can work:

Case study: HealthOne Mt Druitt and HealthOne Willmot – a hub and spoke model
HealthOne Mt Druitt is a hub located in a purpose-built extension to the Mt Druitt Community Health Centre. The integration of services is, in part, virtual and achieved by the collaboration of GPs, Community Health and other service providers. The HealthOne Mt Druitt hub operates several joint clinics and outreach clinics at the spoke site of HealthOne Willmot.

Case study: HealthOne Blayney – integrated care for small populations through co-location
At HealthOne Blayney the general practice is co-located with community health in a single building with a shared reception. More than 20 visiting services operate from HealthOne Blayney. The local hospital is also located in the same building but with a separate entrance. All clients who attend the service consent through a single process and they are all provided with integrated, holistic care….The Clinical Integration Coordinator is the first point of contact for staff in the wider team and is responsible for ensuring services are coordinated. Every two months the HealthOne Blayney team come together to discuss clients who require additional coordination of their care (NSW Government 2012, p. 22).

The virtual model is not illustrated through a case study but is described in the following way:

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

These extracts use words such as integrated, co-location, holistic care and coordinated to describe how HealthOne will work to achieve the agreed objectives. They set out what the program is to achieve and give guidance as to how it can be done and, in doing so, hand over the responsibility for action to local practitioners. These ways of governing populations of chronically ill people from a distance are evident in the techniques of integrated care—colocation, collaboration, coordination – and the associated daily practices enacted by the clients and practitioners.

These statements of intent and the linking of the program's integrated care with various models of care set out a linear, rational process of governing through programmatic solutions to problems. Such programs attempt to link problems and solutions together in a linear way. Policy attempts to extract "from the messiness of the social world, with all the processes that run through it, a set of relations that can be formulated as a diagram in which problem (a) plus intervention (b) will produce (c), a beneficial result" (Li 2007, p. 265). In the case of HealthOne, the "programmatic logic" (Rose & Miller 1992, p. 190) is set out and guidance is given for local implementation. However, the program relies on the practices of local people. It is this that emphasises the translation (Rose 1999) involved in advanced liberal ways of governing. Governing in this sense is not a rational, linear process, but rather a series of conjunctions and moments in which assemblages come together. As is discussed and illustrated through the following empirical analysis, the strength of the discourses of health and responsibility, and the concerns of cost and burden, are assembled in the translation of HealthOne across policy and into the homes of the clients observed in HealthOne Camara.

HealthOne: translation and assemblage through policy and practice

In assembling HealthOne as a programmatic solution to the problem of chronic illness, the program's texts reproduce the concerns and truths identified in international and Australian texts that were discussed in Chapter Three. The discussion that follows analyses the complex translation of HealthOne NSW as it moved from being named in policy texts and into the discourses and practices of integrated care, observed in a selection of interviews, first with policy makers and practitioners, then in the homes of clients in Camara.

> *My records commence in 2006 just prior to me starting this job. This notion of proof of concept comes through quite clearly but there was a strong sense of the cart before the horse. What happened is that COAG[5] had a meeting, certain decisions were made about giving priority to integrated primary care. There was a small amount of Commonwealth funding being allocated out to jurisdictions. We wanted to organise around this concept and leverage it.* (Interview with senior policy maker, 26.10.11)

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[5] The Council of Australian Governments (COAG) is the key intergovernmental forum in Australia and is chaired by the Prime Minister. Other members of COAG include State and Territory Premiers and Chief Ministers and the President of the Australian Local Government Association (ALGA). The purpose of COAG is to promote coordination of national policy priorities. COAG usually meets twice a year although additional meetings may be called. The outcomes of COAG meetings are contained in communiqués released after a meeting. When formal agreements are made these are often embodied in intergovernmental agreements, including National Agreements and National Partnership Agreements (Council of Australian Governments n.d.).

This brief comment on the history of HealthOne from the perspective of a senior manager contrasts with the rational image of programmatic planning set out in policy texts. The idea of integrated care and a perceived 'need' for service improvement were evident at the local level and the 'leveraging' of funding allowed these ideas to be translated into the forms of expertise, practices and technologies that came to *be* HealthOne. HealthOne was assembled through discourses, practices, people and material objects that came together and cohered at certain points in time.

The discourses of primary health care and integrated care were central to and worked to stabilise ways of thinking about HealthOne. However, these understandings were themselves contested and hard to define:

> *I think it's fair to say that everyone means something different when they talk about primary health care and integrated primary health care. There's no right or wrong. It's how you conceive it to be and how it works for you. But it is differently interpreted, differently applied.* (Interview with senior policy maker, 26.10.11)

That primary health care was being "differently interpreted, differently applied" aligns with the way governing at a distance unfolds through the (re)production of ways of thinking that maintain a coherence with key discourses. HealthOne NSW is described as suiting local needs as determined by local 'experts':

> *… that reductionist approach to describing an integrated primary healthcare model or service, we don't fit it because we learnt and I think deliberately have allowed – it must be clinician led at the local level. It must suit local circumstances, local needs, local conditions. Therefore, there isn't the one model.* (Interview with senior policy maker, 26.10.11)

Although the HealthOne programs were localised and had the potential to vary, practices were linked through technologies that aligned with a particular way of governing at a distance while maintaining some connection to a centre (Rose 1999). An interviewee's comments illustrated the way in which such rationalities of governing embed technologies of accountability through localised programs:

> *We've become – this is just my opinion – is we've gone from this really holistic primary health care where we really espoused primary health care probably 15 to 20 years ago, to having to become much more task focused because of the work load and the KPIs and all of those other things that impact on what has to be achieved.* (Interview with HealthOne local manager, 01.03.12)

This illustrates the translation (Rose 1999) of advanced liberal governing. The (re)configuring and localising of the programmatic response then links a multitude of workplaces and people as the program is taken up in potentially varying ways. This linking and relaying is neither smooth nor permanent. Captured within the notions of assemblage and translation are a sense of ongoing flux and movement. This is evident within the diversity of the descriptions of HealthOne NSW and the accounts of its history and emergence. Yet, somehow, from within this flux the elements of the assemblage of HealthOne NSW cohered and crystallised within the daily practices of local practitioners and clients.

(Re)producing truths and knowledge of chronic illness

The problematisation of health and chronic illness were discussed in Chapter Three. Of particular relevance within the current chapter is how these discourses were (re)produced through the *translation* of HealthOne. The economic concerns associated with illness and the provision of care were a recurrent theme within interviews and were used to explain why HealthOne NSW emerged at a specific point in time:

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

These discourses of costs and budgetary concerns were identified in the analysis of international texts in Chapter Three. The consistent reproduction of these concerns works to stabilise their 'truth'. This perceived crisis was further localised to specific concerns with the high costs of hospital care and the linking of these to the ongoing care needs of people with chronic illnesses. Significantly, the responsibility for reducing hospital costs was spread across the health sector and into primary health care:

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

The perceived crisis in the acute hospital sector was used to explain the urgent need for a program like HealthOne to achieve change both immediately and into the future:

> *HealthOne has to minimise people going to hospital unnecessarily. That's got to be big, big neon sign number one. To me, longer term, more importantly it's HealthOne has the capacity to actually tackle health – major health – issues in a population that ultimately contributes to (the) avoidance of people getting chronic conditions down the track.* (Interview with senior policy maker, 14.10.11)

This problematisation of chronic illness and its associated costs is repeated and relayed across sites and locations. In this way the discourse is stabilised and takes on the authority of a 'truth'. The programmatic response to the 'crisis' draws on the notions of population and identifiable and predictable 'risks':

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

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

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

This localisation is illustrated in the rationale given for establishing HealthOne Camara in 2011, which set out the problem in terms of access, communication and need for the education of 'at risk' groups:

> Camara LGA was considered an important site for the implementation of HealthOne NSW, as service partners identified Camara Local Government Area (LGA) to have:
>
> - One of the highest Culturally and Linguistically Diverse (CALD) populations in the state, particularly refugees
> - Limited access to interpreter services in the area
> - Limited service access by CALD populations, particularly refugees
> - Overstretched health services with long waiting lists or closed books, particularly GPs
> - Poor communication and service coordination between existing service providers
> - Poor health status due to being a significantly disadvantaged community (2013, pers. comm., in meeting documents 8 October).

This (re)contextualisation of the problem of health and illness in local terms reinforces the linkages between risk factors such as cultural and linguistic diversity, disadvantage and the resettlement of population groups with the *potential* to need costly health care. These risk factors reproduce the understandings of the social determinants of health discussed in Chapter Three. Importantly, in these extracts from texts and interviews, risk and disadvantage are clearly linked to poor health outcomes and the potential for greater costs of care.

Assembling and authorising a programmatic 'solution': integrated care

The discourses of HealthOne set out in policy texts and (re)produced in the words of senior managers are further translated out into local areas. Key issues at this point of local enactment related to what HealthOne's care aimed to achieve. A key HealthOne NSW text named the program's care as being client-centred, and described it in the following way:

> Research has identified three key elements of client-centred care that HealthOne NSW services should consider when planning for services
>
> - communication with clients, including explanation of health issues and exploration of feelings, beliefs and expectations;
> - partnerships with clients so that they have the autonomy within the client-clinician relationship to be involved in decision making;
> - a focus beyond specific conditions, on health promotion and healthy lifestyles (NSW Government 2012, pp. 12–3).

The text sets out a unique relationship between the practices of the program and the clients that incorporate “exploration of feelings, beliefs and expectations”, partnership, health promotion and healthy lifestyles along with the option of clinical care. Importantly, this extract links this approach to *research* that has identified and validated these key elements. Evident within this extract is the (re)production of discourses of health promotion and healthy lifestyles for people with chronic illnesses. This illustrates the shift in thinking about health discussed in Chapter Three. Health has taken on a much more complex meaning than the absence of disease, and now encompasses “the ability to adapt and self-manage” (Timmermans 2013, p. 1). Even those with incurable chronic illnesses can optimise their own health. The will to govern through the “desires, practices and beliefs” (Li 2007, p. 287) of individuals rather than coercion is evident in the text. This resonates with the pedagogical relationships discussed by Foucault that work to transmit “a truth whose function is not to endow any subject with abilities, etcetera, but whose function is to modify the mode of being of the subject to whom we address ourselves” (Foucault 2005, p. 407). This way of working in partnership with clients sets out key relationships and networks that facilitate the translation of HealthOne into everyday practices of care.

Connecting subjects of HealthOne: the expert and the client

The everyday translation of HealthOne unfolds through the practices of its subjects—the HealthOne Camara clients and the local experts, the GPLNs. These “situated subjects” (Li 2007, p. 265) do the work of pulling together the assemblage. In this way, the practices of care that connect the GPLN and client of HealthOne work to pull the assemblage together. These everyday practices of care do not relate *only* to traditional clinical or medical treatment for a diseased organ or system. Instead, the everyday practices that constitute HealthOne's integrated care seek to optimise and extend 'life' and health. This configuration of care connects the GPLN and the client in a unique relationship. These subjectivities do not exist in other segments of the local health service, or society more generally, but come into view as HealthOne comes together through the practices of integrated care.

The GPLN is named as a key expert within the texts of HealthOne, and the description of this job function shows the program's version of integrated care. This text describes the GPLN as working to support coordination and continuity of care for clients, as well as helping clients to manage their own ongoing health needs:

> The General Practice Liaison Nurse (GPLN) is the linchpin for this model, facilitating effective exchange of information and co-ordination of care in partnership with the patient, their General Practitioner (GP) and other relevant service providers (2013, pers. comm., in meeting documents 8 October).

The translation of this intention is evident in the position description for the job of HealthOne Camara GPLN, which was advertised in 2012. 'Conduit' was used to describe how the GPLN linked and moved across sites and people:

> The GP Liaison Nurse (hence referred to as the GPLN) provides a conduit to facilitate information sharing, planned care and care coordination for clients with chronic conditions who have complex care needs, across the community – hospital – community continuum through liaison and networking with key stakeholders...a model of care based upon the philosophy of comprehensive multidisciplinary assessment and coordinated care to ensure that clients with chronic conditions or complex care needs are treated and maintained at optimal levels of function and independence in the community. Services are provided in a range of community settings, including clients' homes and in clinics in various locations (Western Sydney Local Health District 2012).

Within the texts of the program, the subjectivity of the GPLN encompasses practices of a clinical expert, as well as their function as a conduit and implementer of HealthOne's care. The GPLN's authority derived from their clinical expertise as well as their ongoing connection with the institution of the hospital and their capacity to liaise and network with a range of stakeholders such as general practitioners (GPs). The breadth of this work allowed the further translation of HealthOne out and into community settings and a variety of agencies. A senior manager described the local GPLNs as key to the program and a vital connection to general practitioners:

> *On the ground the [GPLN]are absolutely essential to be the first face for GPs so we can then build all the systems around it. They're the entry point, they're the cross over, and that's been a really important initiative.* (Interview with senior policy maker, 14.10.11)

These extracts from the text and interview set out the practices of care that extend beyond the body of the client and include information sharing and networking. These practices work to keep clients in the community and out of hospital. A GPLN replied in the following way to an interview question about what their job entailed:

> *How I see the role? Well I won't repeat the blurb that's in my job description but I think it's about formalising the ad hoc approaches that had occurred previously into more meaningful outcomes for the patients. With flow on effects for workload management, less work, communication, information exchange. I think – I don't think – I'm positive that it genuinely puts the patient at the centre.* (Interview with HealthOne Camara GPLN, 08.10.13)

This comment suggests that the job involves much more than what is represented in the formal job description. Patient-centred care, workload management, communication and information exchange are key elements of the GPLN's work. Another GPLN reiterated the primary importance of the elements of networking and engagement captured within ideas of integration and coordination and in contrast to 'front line' clinical work:

> *We're not actually at the front line obviously providing care management but a lot of the stuff that we do is that promotion of networking and engagement.* (Interview with HealthOne Camara GPLN, 08.10.13)

The idea that the work of the GPLN is focused on networking, engagement and information sharing can be seen in the images included in the brochure *HealthOne Camara: Information for PATIENTS* (see Appendix Two). The text of this brochure is discussed in detail in the following chapter.

Figure 4.1: Photographs from *HealthOne Camara: Information for PATIENTS*

In the images in Figure 4.1 taken from the brochure, experts are shown working in technical environments, gathering and managing information and devising care in the absence of the client. There is a link to medical authority that is made through the inclusion of a traditional image of a doctor wearing a white coat and stethoscope. The GPLN is situated within these discourses and images; an authority figure planning and devising care by working with other experts. Words such as partnership, networking, communication, autonomy and “a focus beyond specific conditions” (NSW Government 2012, pp. 12–3) appear in the texts and images of the program, and can be discerned from the comments of interviewees, yet remain hard to define. The provision of clinical care could be described in terms of measuring body systems, changing dressings and adjusting medication, but the practices of care enacted by the GPLN are hard to define. This resonates with the work of McDonald and Marston (2005, p. 381), in which they noted that the case managers in Workfare programs in Australia can be seen as “engineers” and “agents” of advanced liberal ways of governing as they work to produce the desired and active citizen. When reconsidered in this way, it is possible to see that the GPLN is caught up in a type of care that is assembled through discourses of health and responsibility and the associated problematisation of chronic illness. The GPLN enacts practices of care that are both specific to the program of HealthOne NSW and characteristic of an advanced liberal way of governing ‘at a distance’ and through practices that promote health and responsibility.

Just as the GPLN is assembled as a subject of HealthOne, so too is the client of the program. HealthOne emerged from the convergence of notions of health and illness and advanced liberal approaches to governing that seek to optimise life and health. The clients of HealthOne NSW are assembled through the (re)production of these discourses as they are translated into local sites. In this sense, the HealthOne client is not an embodiment of a specific physical disease or disorder but rather an *opportunity* and a *potential* for reform, together with the realisation of active citizenship, health and life. The chapters that follow focus in detail on the subjectivity of the HealthOne Camara client and how this comes together within the local program through its technologies of integrated care. Assembling the HealthOne client in this way illustrates how discourses of health, illness and responsibility span global, national and local contexts. Such localisation has an effect of connecting disparate people as part of the local and international problem of chronic illness.

Conclusion: responding to the research question

This chapter has focused on responding to the second research question:

> *How and in what ways was HealthOne NSW assembled as a response to this problematisation?*

This response builds on the analysis of the problematisation of chronic illness set out in Chapter Three. Chapter Three traced how the economic concerns associated with chronic illness have emphasised the ways in which programs focus on building an individual's ability to be responsible for their own health and care. The current chapter has traced the translation of these discourses of health and responsibility out into the texts that assemble HealthOne as a programmatic response to the local problem of chronic illness. This analysis has shown a consistency within these discourses in focusing on the economic threat of chronic illness and the importance of individuals being at the centre of their own care. Significantly, this chapter has shown the consistencies and patterns across policy texts and the words of interviewees involved in HealthOne. Compared with more medical and technical descriptions of clinical care, HealthOne's care suggests an ambiguity, as its focus settles "beyond specific conditions" (NSW Government 2012, pp. 12–3). Despite this ambiguity, HealthOne cohered as an assemblage and way of thinking because of the consistency and strength of the discourses of health and responsibility that it reproduced. As discussed in Chapter Three, ideas of individual responsibility and the potential to optimise life are embedded within programs of health promotion, as well as in everyday life. These ways of thinking also translate through HealthOne.

This chapter opened with an extract from Foucault's interview, *Questions of Method* (Foucault 1991). In this interview, Foucault highlighted the difference and the importance of studying programs, not for their utopian representation, but in the acknowledgement that such representations influence what happens in the real: "they crystallize into institutions, they inform individual behaviour, they act as grids for the perception and evaluation of things" (Foucault 1991, p. 81). This chapter has presented a preliminary response to the second research question, by focusing on how HealthOne was assembled as a programmatic response to the local problem of chronic illness in a range of texts and interviews. This analysis has highlighted consistencies and linearity within the texts and practices of HealthOne. This linearity, however, contrasts with the complexity that emerges as the program translates further out and into people's homes. Chapter Five continues this discussion by analysing the translation of HealthOne Camara out and into the homes of the clients observed. This empirical analysis draws out some of the *effects in the real* of this programmatic response to the problem of chronic illness.

Chapter Five – HealthOne Camara and Technologies of Integrated Care

> I am not someone to just throw a brochure[6]. I don't think its professional anyway just to throw down a brochure…in front of a patient and ask them to sign consent forms when they haven't been informed, haven't had a choice anyway. So really, at the end of the day that's what you have to be aiming for – that they have a choice, that they've been informed. Really, it's all good that patients will get enrolled in HealthOne anyway but, at the end of the day, if they don't want to be they don't either. (Interview with HealthOne Camara GPLN, 08/10/13)

> Become whole, become what you want, become yourself: the individual is to become, as it were, an entrepreneur of itself, seeking to maximize its own powers, its own happiness, its own quality of life, through enhancing its autonomy and then instrumentalizing its autonomous choices in the service of its lifestyle. (Rose 1996a, p. 158)

Introduction

Chapter Four presents the argument that HealthOne could be usefully viewed as a complex assemblage of people, places and material objects that came together through technologies and techniques of integrated care. Interviewees and the program's texts used words such as motivation, autonomy and partnership to describe how this integrated care aimed to improve outcomes, life and costs for people with chronic illnesses. This care was contrasted with descriptions of clinical care, which may, for example, describe a process such as healing a wound, setting a broken bone or treating a diseased body system. The integrated care described by the HealthOne texts and interviewees worked through an understanding of life and health that (re)produced advanced liberal ways of governing through ideas of freedom, choice and responsibility. This integrated care drew on and reproduced dominant ways of thinking about engaging clients in a type of care that could optimise their own relative health and life. This optimisation would, in turn, reduce the costs of care provided by the government and other agencies and thus be of benefit to the broader community as well.

The first quote at the start of this chapter is taken from fieldwork notes and is provided here to illustrate the ongoing translation of HealthOne into the homes of the clients observed in HealthOne Camara. Through this translation, the discourses of responsibility

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[6] *HealthOne Camara: Information for PATIENTS* brochure (see Appendix Two).

and choice that assemble HealthOne Camara's integrated care move further out from the policy-makers and into the practices of care. The analysis of the empirical and documentary materials that follow extends this discussion and adds to the previous chapter's focus on the second research question:

> *How and in what ways was HealthOne assembled as a response to this problematisation?*

This chapter extends the previous analysis by turning to focus on the enactment of HealthOne's integrated care in Camara. The chapter begins at a point of entry to the local program by reviewing its processes of referral, assessment and enrolment, which are set out in the *HealthOne Camara: Information for PATIENTS* brochure (refer to Appendix Two). This text was written by local GPLNs and distributed to all newly referred clients. Rose and Miller (2008) noted the significance of the processes of inscription and calculation that serve to assemble what is to be governed in an intelligible form. Considering the ways in which patients are identified, assessed, referred and enrolled to HealthOne highlights the practices of inscription and calculation that assemble and which are reproduced through the program.

The chapter then moves to consider how the daily practices of care between the GPLN and the clients observed in Camara unfolded through technologies of integrated care. As is illustrated through the analysis of empirical data and research materials, HealthOne Camara's integrated care (re)produced the notion of the active citizen as potentially responsible and self-governing. Networks of experts gathered information, made judgements and engaged with these clients to help them to reach certain goals and objectives for their own health and life. This way of working assembled the chronically ill HealthOne client as aspirational, motivated and able to optimise their own life and health. In doing so, it also connected the client with the knowledgeable and authoritative 'expert'. This way of working resonates with the analysis of health promotion programs discussed in Chapter Three. However, unlike the clients of the Get Healthy program, the clients of HealthOne Camara have complex medical, social and personal needs. The analysis of these instances and enactments of integrated care suggests that attempts to engage the HealthOne Camara client in programs of activation and responsibility have often-unintended effects.

The instances and enactments of care considered in this chapter were not stand-alone events, nor can their analysis be generalised to other situations. However, these instances were moments at which the circulating discourses crystallised as the assemblage of HealthOne came together temporarily before dissipating and fading away. By attending to moments of integrated care in this way, it is possible to trace a resonance across times and places that illustrates not only the strength of the discourses and connections of the assemblage but also the dominance of particular technologies and techniques. The clients who feature in this chapter—Arthur, Clare, Keith, Frances, Maria and Iris—had diverse backgrounds and medical and physical needs, yet, through HealthOne's technologies and practices of care, these people were produced as *clients* who had the potential to become active citizens.

Integrated care: from *patient* to *client* of HealthOne Camara

Chapter Four analysed the discussions of senior policy makers involved in the design of HealthOne. By using ideas of translation (Rose 1999) and assemblage (Li 2007), this analysis identified the patterns and consistencies within these discussions and connected them to a selection of associated texts. Through this translation and movement of ideas back and forth between texts and policy makers, it was possible to start to examine *how* HealthOne moved out from the policy makers who named it, and into the homes of the clients in Camara. This movement was not a finite or bounded process, nor did it proceed in a single direction. The translation of HealthOne and its integrated care continued as more and more people, places and material objects came together in the assemblage. For the HealthOne Camara clients, an entry point into the assemblage of HealthOne was marked by the arrival of the GPLN at their homes and the knock on the door that announced their arrival. The process of referral and enrolment had been initiated away from the bodies of these people by other 'experts', who had identified their potential for reform and improved management of their health. The initial visit from the GPLN signalled the opening up to the client of the opportunity to enter into HealthOne Camara's integrated care.

The distribution of *HealthOne Camara: Information for PATIENTS* and the comment the GPLN made to Iris—"Have you had a chance to read the brochure I left you?"—are illustrative of techniques of integrated care. The GPLN reported that all clients were given a copy of this brochure during her first visit to them after referral. For some clients, this was the first knowledge they had of the program and the first time they were given information about it. On the GPLN's follow up visit to Iris, the brochure was on the bookshelves in her front room near the chair she spent most of her day sitting on. Another HealthOne Camara client, Arthur, said his brochure was in a blue folder and pointed to where it was lodged down the side of the television cabinet. The distribution of the brochure was a key technique of the translation of HealthOne into local sites and into the homes and lives of these clients.

This brochure, according to the GPLN who was involved in writing and reviewing it, was the only written information about the local program aimed at potential HealthOne clients. During an interview, the HealthOne Camara GPLN explained how she used the brochure with Iris:

> *I would go through with her and highlight some of the main things she would need to be aware of in terms of what HealthOne means for her and that is what I would explain to her about HealthOne. But I just think for someone in her case who's not running away she's a long term client, someone like her you…would give them an opportunity to read the brochure and then troubleshoot.* (Interview with HealthOne Camara GPLN, 08.10.13)

The significance and authority of the text was emphasised in this comment; the GPLN said the "main things" Iris needed to know about HealthOne were in the brochure. Additionally, the brochure was written in a question and answer format and thus told the client both what they needed to ask and provided the answer. This information (re)produced the author's (GPLN's) understandings of HealthOne, as well as drawing out the information they thought was important. In this way, HealthOne and its understandings of integrated care moved further out into the multiple sites in which the program was enacted.

The title of the brochure itself is significant, as it outlines the subjectivities that are key to this program. *HealthOne Camara: Information for PATIENTS* sets out relations between the various people involved in the program. 'Patient' is used in the title and is capitalised. Using the word *patient* in this way links HealthOne to discourses of medicine and the hierarchical relationships that structure the relations between medical authorities and patients. Within the body of the text, however, the word *patient* is not used again.

Through processes of referral, assessment and enrolment, a new and different subjectivity is offered to the patient. The process of referral is described in the following terms and, importantly, at the end of this process, the patient is reassembled as a HealthOne *client*:

> Referrals to HealthOne Camara are generally made by GPs, Community Health workers and hospital staff.
> Once a referral is received, an assessment will be completed by a Community Health worker.
> HealthOne will be explained to you and your consent obtained to be enrolled as a HealthOne client.
> Your GP will be contacted and their consent obtained for their participation. At this point you become a HealthOne client (see App. Two).

This process of referral, assessment and access to HealthOne Camara marks a transition from the subjectivity of *patient* to that of *client*. The subjectivity of client is active in comparison to that of the patient, who is a passive recipient of care. In contrast, the subjectivity of client draws on ideas of activation, engagement and the realisation of *potential.* Networks of experts were connected to discuss and identify patients who had the need and potential to take up the subjectivity of the *client*. The use of the word ‘client’ links into discourses of choice and responsibility and opens up an opportunity for experts to engage with the client in a different way (Mol 2008). Within the bounds of the institution, the doctor or nurse is associated with medical authority and expertise. However, in a program that seeks to activate the responsible and self-governing client, the expert takes on a subjectivity that works through techniques that seek to engage, guide and educate, rather than through the surveillance associated with the bounded institution. As discourses of choice and responsibility have become dominant, a diverse range of experts and professionals have come to work with citizens on self-development and improvement. This work is done by altering the understanding and relationships individuals have with themselves; that is, by “inculcating desires for self-development that expertise itself can guide and through claiming to be able to allay the anxieties generated when the actuality of life fails to live up to its image” (Rose 1999, p. 88). These shifts are evident in an increasing emphasis on ‘choice’ and autonomy within health care policy and practice (Mol 2008).

This shift in thinking builds an understanding of the citizen as intrinsically willing and able to engage in projects of development and improvement. Significant within this are the *implications* for those who are seen to reject offers and opportunities for improvement. Rose (1999, p. 88) argued that the implications of rejecting such choices are embodied by the groupings of those who remain outside the "regime of civility", and gave examples including the homeless, alcoholics, drug users and lone parents; "an amalgam of cultural pathology and personal weakness". The HealthOne Camara client does not, however, sit outside this regime of self-improvement. Being referred and then consenting to enrolment in the program clearly situates the client within relations and practices that help them to make the right choices and accord them the status of client.

HealthOne worked to identify groups and individuals who were are at risk of being problematic in terms of choosing to be self-governing. Within the program brochure, specific populations are identified as *potentially* problematic. As indicated in the brochure, the program's target groups are identified in terms of the complexity and 'risk' of their existing or future health care needs:

Who is HealthOne for?
HealthOne is for:
People with complex health needs or chronic illnesses who are living at home
People who are frail and elderly and living at home
Refugees who:

- Are pregnant and need support
- Have young families (under the age of 3 years have priority)
- Young people with difficulties accessing health care
- Require coordinated health care

Disadvantaged communities within the Camara area with specific health needs and/or limited access to health services (see App. Two).

These 'at risk' categories assemble clients by defining them in terms of age, frailty, chronic illness, refugee status and disadvantage. Although these categories are broad, the very naming of these target groups has an effect of focusing in on particular problems within the local geographical area and (re)producing the 'truth' of their problematic nature. Assembling 'problem populations' in this way also links the individual into a group or population. For example, Iris, as an 83 year old woman living independently, is from a population described as *frail, elderly and living at home*. This group is problematised through the *risk* associated with their *independence*—risk of falls, risk of needing hospitalisation. When framed in this way, the details of Iris' life fade away as she is reassembled as a subject and client of a program that aims to minimise her risk and optimise the efficiency of her 'life'. Iris was only one of any number of frail, elderly people living at home in the geographical area of Camara. Something, however, differentiated Iris within this population and brought her to the attention of HealthOne and its experts. As Rose (1999) argued through the discussion of choice and agency, the legitimate subject and citizen is assembled in terms that assume a desire and ability to seek out optimisation of the self. Iris was offered an opportunity to shift further towards this position of legitimacy and away from those who did not display this potential.

Maria, Frances, Keith and Arthur were selected from the similar category of *people with complex health needs or chronic illnesses who are living at home*. The inclusion of the phrase *living at home* is significant, as it differentiates between these subjects as living in the community and 'patients' in a hospital or institution. The physical location of these people presents new challenges. Each of them has significant physical and medical needs that will require ongoing care and support. Such care, even when delivered in the community, is expensive, and there remains a high risk that these people will need hospital admissions at times. In previous decades, patients with such complex needs would have been patients in hospitals or institutions. However, scientific and medical advances, and redefinitions of what care is in itself, have allowed these people to be shifted out of institutions and supported to live at home. This approach to support suggests changes in conceptualisations of what care entails. As discussed in Chapter One, such movement out and away from the hospital has added new complexity to the work of care that allows people with such complex medical needs to live in the community. Approaches including self-care (Thorne, Paterson & Russell 2003) and self-management (Kendall et al. 2011; Kendall et al. 2012; Kendall & Rogers 2007; Vassilev et al. 2011) have been emphasised in recent health care policy, as a way of engaging people in different types of care and care work.

As part of this shifting of care out of the hospital and into the community and clients' homes, multiple providers and carers are pulled into these people's lives. According to the GPLN, Keith, for example, had up to 20 carers visiting him in his home during a single week. Keith was able to live 'independently' but there were still significant costs incurred by the government in terms of providing the care required. Additionally, as a result of his long term quadriplegia, Keith had developed pressure sores at various places on his upper legs, and required additional care and possible hospital admissions to manage these. The objective of HealthOne and the GPLN was to work with Keith to maximise his self-care in order to minimise the long term costs of his care and the risks of hospital admissions. Promoting self-care as part of the management of long term conditions involves varying degrees of delegation of the work of illness to individual clients as part of an attempt to manage demand for services (Vassilev et al. 2011, p. 60). Additionally, for clients like Keith who are involved with multiple services and agencies, there is a risk that care will become fragmented as duties and responsibilities are dispersed. Such fragmentation has cost implications for the government, as people in these situations are more likely to require hospital admissions (Plant et al. 2015).

This concern with costs, complexity and risk of needing care for certain populations in Camara is addressed in the policy texts that set out the GPLN's role as key in promoting integrated care. This "programmatic logic" (Rose & Miller 1992, p. 190) is evident in the description of the GPLN's job, which was discussed in Chapter Four. The GPLN was described as the *linchpin* of the HealthOne's model of care and as a facilitator of the improvement of clients' understanding and control over their health (McNab, Mallitt & Gillespie 2013, p. 1). As a result of this improved understanding and control, enhanced self-management could be achieved and, importantly, measured through metrics including a reduction of rates of hospital admissions (McNab, Mallitt & Gillespie 2013).

The processes of referral, assessment and enrolment to HealthOne Camara drew clients into the assemblage of integrated care, which sought to optimise, improve, control and shift the responsibility for managing care to the aspirational and motivated client. This approach to care resonates with a "notion of incompleteness" (Rutherford 2007, p. 299) within understandings of the self-governing citizen. Prior to referral to HealthOne Camara, the *patient* was identified by the professionals involved in their care to be at risk and thus a member of a "targeted population" (Dean 2010, p. 195) that required intervention and support to manage the risks associated with their health and care. This intervention and support originated in the actions of the professionals already involved in the care of these people. Dean (2010, p. 195), noted that certain professionals act as "calculators, managers and tutors of risk, taking on educative, estimative and preventative functions". In Camara, district and community nurses monitored such targeted populations and referred individuals to HealthOne, This way of identifying potential clients from within a population of patients was evident in the way in which the GPLN explained the program to a new client, Clare, on her first visit to see Clare at home:

The GPLN entered the client's house and introduced herself. She then explained that Clare had been referred to HealthOne Camara through a discussion at a recent monthly meeting of the community health nurses. The GPLN then said:
"I'm here to join the dots…What's happening at the moment?" (Field notes 10/10/13)

Through the practices of referral and enrolment, HealthOne Camara was assembled as a set of relations and practices that connected clients and experts such as the GPLN. These experts monitored and gathered people to be referred to HealthOne Camara. The way in which Clare was introduced to HealthOne echoes the description contained in the brochure: Clare is informed that a group of experts have discussed her health and care needs and deemed her appropriate to become a HealthOne Camara client. The GPLN's description of her own practices as being to "join the dots" illustrates the discourses of coordination of services and information giving as key techniques in Clare's integrated care. Referral to HealthOne Camara was a result of practices and connections within the networks of experts that detected inadequacies, failures and *potential* within *patients* who could then become 'clients'. These practices marked out 'care' as beginning before the GPLN entered the person's home or went to see them in the hospital or clinic. The process of referral directed the program towards the individual; this subject was 'marked out' by experts as problematic and as needing additional support. Referral was not instigated by the patient or client but rather was made within meetings of professionals, such as the monthly meeting of community nurses, or in response to a request from a nurse or general practitioner. Access to HealthOne Camara was dependent upon assessment by an expert that, like the referral itself, was done before the patient was even made aware of the program. By the time the patient was referred and enrolled as a HealthOne Camara client, a significant amount of work on their subjectivity had already taken place. The technologies and techniques used to assemble the patient as a *client* drew the individual from a population and positioned them as ready and willing to engage in the program's integrated care.

HealthOne Camara: technologies of integrated care

Within the text of the HealthOne Camara brochure (see App. Two), the patient is reassembled as the HealthOne Camara client. These techniques of subjectification are bundled into an approach and type of care that is framed by ongoing interactions between experts and clients that involve education and advice. The discourses that are (re)produced within the brochure emphasise ideas of active citizenship and responsibility that are key to the subjectification of the client and the HealthOne's integrated care. The text of the brochure asks and answers the question *What will HealthOne do?* in the following way:

> HealthOne links together all the providers involved in your health care to
>
> - Identify your health care needs
> - Identify other services that you may need to help you
> - Manage your health and your daily living needs
> - Share information about your care between providers (with your consent)
> - Coordinate health services that you need
> - Provide you with access to specialist clinics and services through HealthOne
> - Support you to monitor your own health and access services you might need to manage your changing health needs
> - Provide you with a single contact person to speak to about your health
> - Provide you with written information on your care for you to keep and show other providers who may not be part of HealthOne (see App. Two).

Within this extract from the brochure, the practices that make up HealthOne's integrated care are described. HealthOne is positioned as an entity in itself and becomes an agent that takes action: *What will HealthOne do?* Initially, this text states that HealthOne and its experts will work to identify and organise the client's *health and daily living needs*. The client is absent from the description of this process; referral was managed by experts on behalf of the potential client. Once this assemblage of services and experts is established, however, the practices of referral and assessment mark out a change in subjectivity as the patient becomes a client who is integrated into the management of their own care.

This shift is marked by a handing over of responsibility to the client. The experts are positioned as having knowledge and abilities that can be used to develop the skills of the client: "the expert gives kindly advice to the subject in the journey that strives for completeness" (Rutherford 2007, p. 299). The GPLN and other experts monitor and support the client as they take up the opportunity to demonstrate their own responsibility and ability to self-govern their health and care needs. The outcome of HealthOne Camara's integrated care is stated in the brochure—the client will be able to "monitor your own health needs and access services you might need to manage your changing health needs”. This outcome of integrated care reflects the discussion in the previous chapter and the acknowledgement that such contemporary approaches to care promote the idea of health in terms of adaptability and self-management, rather than the absence of disease (Timmermans 2013). This way of thinking about integrated care positions the expert and client in relations in which the exchange of information and advice is vital. The expertise of the GPLN in HealthOne Camara can help the client identify flaws and weakness and take action to correct these. The brochure predicts that, over time, through the guidance and support of the GPLN, the HealthOne Camara client will be able to take up ongoing management of their care needs and to seek out additional support. The text in the brochure also states that it is up to the individual to seek out such support and future advice. These practices of integrated care work towards adaptability and self-management.

For these clients of HealthOne Camara, management of their chronic illnesses is a “journey” (Rutherford 2007, p. 299), and the GPLN provides initial assistance to build knowledge and skills. Over time, however, rather than the care being given by an expert of the program, the client *becomes* the expert, and is thus both the source and the provider of their own ‘care’. When viewed in this way, the pedagogical function of HealthOne Camara’s integrated care becomes evident. Kendall et al (2011, p. 87) argued that contemporary Australian health policy that emphasises self-management as a programmatic outcome of education has had an effect of framing the users of services as “‘people in need of instruction’ rather than as people who are managing their own lives”.

HealthOne Camara’s processes of referral, assessment and enrolment grouped Iris, Keith, Frances, Arthur, Maria and Clare together as people in need of integrated care in order to develop their own self-management skills. Their position as HealthOne Camara clients was a temporary subjectivity. Once knowledge and skills in self-management were demonstrated the client could move out of HealthOne Camara and to a new category of chronically ill but self-governing clients. The care needs of these clients were complex, and involved multiple people, agencies, places and practices that needed to be integrated together. HealthOne Camara’s technologies of integrated care aimed to link these together to promote efficiency and effectiveness of the health care sector. To do so, the knowledge and skills of the client had to be improved so they could take up the responsibility of being their own expert. This “programmatic logic” (Rose & Miller 1992, p. 190) of

HealthOne Camara's integrated care is drawn out through the analysis of the vignettes that follow. This analysis shows how integrated care unfolded through practices which sought to educate, give advice and encourage the client to rethink their own understandings of their individual health and care in ways that reproduce the pedagogical relations and subjectivity set out in the *HealthOne Camara: Information for PATIENTS* brochure (see App. Two).

Clare

On her initial visit to Clare, the GPLN explained that she had been referred to HealthOne Camara through the community nurses. The GPLN then asked Clare when she had last been hospitalised; this, Clare reported, was about three weeks earlier, as a result of complications with her asthma. The GPLN then asked a series of questions related to the management of Clare's asthma and chronic obstructive pulmonary disease (COPD).

"*When was your last visit from the community nurse? Do you have an asthma prevention plan?"*
"See the GP – he might want to check your medications." (Field notes 10/10/13)

The GPLN gave advice about using saline in Clare's nebuliser to help manage her asthma at home. She then summarised her intervention as being related to avoiding a potential *crisis* which, within the terms of the program, could be measured by a hospital admission:

> *"You don't want to get to a crisis point – that's what I am trying to avoid for you."* (Field notes 10/10/13)

Local experts identified Clare as 'in need' of additional education and advice so that she could take on the responsible management of her own care. Through the process of referral and enrolment, Clare took on the opportunity of becoming a HealthOne client.

This exchange shows how HealthOne Camara's integrated care unfolds through ongoing exchange on information and advice, facilitated by the expertise of the GPLN. The GPLN asked a series of focused questions informed by information gathered from others through the practices of referral and assessment. The GPLN then suggested a course of action that involved Clare doing specific things: seeing the GP, using saline in her nebuliser, getting a new asthma plan. The summary of the purpose of the GPLN's intervention, as being to avoid a crisis point, suggests that Clare is at risk of a crisis if she does not take up the advice and information she has been given. That crisis may be an admission to hospital or a sudden worsening of her asthma. Clare is given the opportunity to take actions that will avert the risk of such crisis. She has been presented with information and options that give her a choice to manage her care in a way that the experts saw as appropriate and likely to mitigate the risk of a ‘crisis’ and the potential anxiety associated with that. The GPLN has enacted techniques associated with “transforming” (Rose 1999, p. 88) the way in which Clare thought of herself in relation to her asthma and associated medical needs. It is significant, however, that the responsibility for following through on this advice rests with Clare. The role of the GPLN is clear in terms of giving advice and using expert knowledge to inform Clare of what she can do. The implications for not following this advice are unclear; it is up to Clare to decide what to do next.

Frances

Similar concerns related to risks and potential care needs are embedded within the care practices that make up integrated care for Frances. Frances, a long term HealthOne Camara client, presented with complex care needs. Her care involved multiple agencies and experts; in addition to her quadriplegia and diabetes, Frances had ongoing problems with infected pressure sores on her lower back. The following extract from field notes taken during a case conferred in Frances’ home shows how a perceived ‘crisis’ had been reached in relation to Frances’ *cooperation* with her carers.

> The GPLN had therefore organised a case conference so that representatives from the various health and social care agencies could meet with Frances to determine a way forward. As Frances was confined to her bed the meeting was held in her bedroom at her home. Eight social and health care professionals attended and gathered around her bed. A senior nurse walked in and saw a number of soft drink bottles on the tray near Frances’ bed next to a packet of cigarettes and an ashtray. The nurse said to Frances
> *“You’re not drinking those are you?”*
> Frances replied that the bottles did not have soft drink in them – they were used to freeze water so she had a supply of cold water to drink during the day. The nurse said that she was glad Frances wasn’t drinking soft drink in front of her.
> Once the various representatives from the health and social care agencies had arrived and gathered around Frances bed, the GPLN began the meeting by stating to the group:
> GPLN: *“The purpose of the meeting is to discuss coordinated care and what Frances would like from the various services. What would you like to get from this Frances?”*
> Frances: *“I would like my pressure sores to heal.”*

The meeting progressed through the discussion of an appointment Frances attended the previous week at the hospital when nursing staff re-dressed the pressure sores on her back. Frances complained that the dressings had not been done properly and that by the time she arrived home in the patient transport her clothes were wet and smelly – “the smell of decay”. A senior nurse told Frances that next time she should ask for the “other nurse” or phone someone from the community team while she is there.
The GPLN stated that Frances must “cooperate” with the people who come to care for her. Frances responded:
“I yell because I get so frustrated with them. They don’t wash, they don’t clean, they complain about me, they go outside to talk.”
Frances continued to say that that she had not had her hair washed for four months – the carers had refused to do it and Frances cannot move her own body in a way that would allow her to do it herself. One of the practitioners said she will look into that and agrees that Frances should have her hair washed and she will direct the carers to do so. (Field notes 02/09/13)

The exchanges that took place during this case conference show how Frances was an active participant in the discussion: “What would you like to get from this Frances?” In contrast with a *patient*, who listens attentively to the instructions or information given by the medical expert, Frances was drawn into an exchange in which she was an active participant and partner. Experts had gathered around her and expressed their willingness to talk to her; if she were to choose not to take up this opportunity then it would be her ‘loss’ and to her own disadvantage. There is, however, a tension evident within the way this meeting was set up. The meeting was planned in advance by the experts through discussion between the GPLN and the others about particular ‘problems’ within Frances’ care. Rather than being the patient who simply *receives* care, as the HealthOne Camara client, Frances has responsibility for monitoring and intervening in the work of the nursing staff who gather around her. She is told it is her responsibility to speak up and contact other staff if she feels the dressings are not done properly. This responsibility is independent of her physical abilities; as a quadriplegic she cannot twist around to see how the dressings have been done. As Frances said she knew by the smell and wetness in the ambulance that they had not been done properly. Yet Frances can, in the opinion of the professional who spoke up, somehow judge the work of others and challenge them, based on her own knowledge and expertise.

In this extract, the complexity of Frances’ care and responsibility is evident. Part of her responsibility involves monitoring the work of nursing staff and demonstrating a “reflexive prudence” (Trnka & Trundle 2014) as she makes ‘choices’ about her health and the optimisation of her life. This optimisation involves taking on an element of professional work, by monitoring the competency of clinicians and problem-solving what to do when things go wrong. Kendall et al (2011) noted that a risk of such reorganisation of the work and responsibility of care is an obscuring of the structural inequalities between clients and experts. Despite the intention to give choice and 'power' to the client "this type of freedom is not really freedom, choices are limited by hidden 'rules'" (Kendall et al 2011, p. 94).

Choice and negotiation are intertwined within Frances' care. For example, Frances said that she has tried to get the carers to wash her hair and, as they have refused and she is physically unable to do it herself, the carers will be directed to do so by an authority figure. This expert has chosen a point and an occasion to intervene on behalf of Frances. Such intervention may be part of a negotiation – if Frances cooperates in other ways with the carers than they may begin to regularly wash her hair. This is an *opportunity* for Frances to demonstrate choices and behaviour that others view as responsible and legitimating.

The assemblage of HealthOne Camara that came together in Frances' integrated care drew together various professionals, agencies and local experts who shared and discussed information, reports and problems arising in relation to Frances. Through this network, experts were also able to discuss ways of managing Frances that would improve her own understanding and knowledge of herself and her care. Elements of this aspect of 'care' resonated with Foucault's work on confession as a modern technology of power and government:

> it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console and reconcile…And this discourse of truth finally takes effect, not in the one who receives it, but in the one from whom it is wrested (Foucault 2008b, pp. 61–2).

The discourses observed among and between the experts of HealthOne Camara can be understood as such practices of confession; an important element of the subjectification of HealthOne's integrated 'care'. One example of the presence of this element of confession can be seen within a series of conversations about Frances and her reported non-attendance at a hospital appointment.

> The GPLN pulled over to take a phone call while we were driving to Frances' house. She is talking to the caller about Frances being "difficult" and not attending a hospital appointment. The GPLN tells the caller that she is on her way to see Frances now and will call her from there. When we arrive we go into the house and sit down in the bedroom with Frances. The GPLN says – *"so what has been happening? I have heard a few things"*. (Field notes 25/10/13)

This exchange about Frances began well before the GPLN arrived at her house. Frances' non-attendance at a hospital appointment was reported and discussed through the network of experts involved in her care. When the GPLN arrived at Frances' house, she had a view of what had happened that was based on information gathered away from, and independently of, Frances. The visit began with Frances being given an opportunity to present her own 'story' of the events. She responded to the GPLN's question in the following way:

> Frances explained that the ambulance transport came to collect her to take her to the clinic appointment at the hospital but they didn't have a hoist. Frances said she asked *"how are you going to lift me?"* They said they would just lift her (she gestured with her hands) but she said *"No – O H and S* (occupational health and safety). *I need a hoist – I'm not letting you lift me".* (Field notes 25/10/13)

Frances presented her version of events and attributed her non-attendance the first time as being due to the transport workers not having the correct equipment to lift her safely. Through this refusal to be lifted in an unsafe manner, Frances demonstrated her awareness of what it meant to be responsible in relation to being lifted safely. She knew there were guidelines for lifting her that the transport workers ought to follow and, as they arrived without the correct equipment, she refused to be moved.

By presenting this challenge to the transport workers, Frances was taking on the individual responsibility for monitoring the work of others, which she had been encouraged to do at the earlier case conference. In that exchange, Frances was also advised to monitor the work of the nurses at the hospital when they changed the dressings on her infected pressure sores. In the extract presented above, Frances monitored the work of the ambulance transport staff and objected when they did not comply with regulations. However, in this instance, rather than being 'rewarded' for demonstrating responsibility, Frances' behaviour was reported as 'non-compliant' and 'non-attendance' at hospital. The network of experts that ran through the background of Frances' care had discussed and reported this 'non-compliance' and agreed that intervention from the GPLN was required. Frances had breached a 'rule' or an expectation and been penalised by being reported as non-compliant and not attending the appointment. Frances then explained why she missed the hospital appointment the next day.

> The workers called another ambulance but it never turned up. Another transport was booked for 7.30am the next day so Frances' carers had time to come and get her dressed. The transport turned up at 6am – the two workers wanted to get her moved before their shift finished and so came early. They had arrived before Frances had been washed or dressed for the day. They took her to the Emergency Department (ED) – *"I didn't think I was going to ED – I thought I was going to the wound clinic…They reckon she (a nurse) did come down and said there's nothing wrong with my wound…I wanted to get home for the 5 o'clock (carers visit). They said there was nothing wrong…"*. (Field notes 25/10/13)

Frances argued that she had attended hospital the second time but been taken to the emergency department rather than the wound clinic she usually attended. Within the next stage of the exchange, the GPLN reinforced her own position as an expert and knowledge holder by (re)presenting the 'truth' of what happened on Frances' second visit to hospital.

> The GPLN explained that the wound clinic was closed that day as the staff were attending the bushfires in the local region and that is why Frances was taken to the emergency department. (Field notes 25/10/13)

Through this process Frances is presented with certain 'facts' that question her own knowledge of 'events' and reinforce the status of the experts as holders and interpreters of this knowledge. This marks a shift within the relations of HealthOne Camara that were based on the premise of the 'client' as an autonomous 'partner' and learner within the programs'. Frances is not, within this exchange, a partner or client but has shifted back towards the position of the patient who is subject to the disciplinary power/knowledge of the expert. This shift was reinforced as the GPLN informed Frances that she did not have a correct understanding of the test results:

> The GPLN then explained to Frances that an infection has shown up in her blood tests and she will need to attend an appointment at the hospital's wound clinic. (Field notes 25/10/13)

This new information prompts another re-alignment of Frances' knowledge of her own health—an infection has shown up in a blood sample and she will have to attend further hospital appointments. There was another shift within the relations of power and knowledge that shaped the practices of integrated care: the GPLN was the authoritative knowledge holder and had important information from the hospital that she could share with Frances.

Keith

Like Frances, Keith had complex health and care needs that involved multiple carers and experts. As a HealthOne Camara client, Keith was understood as having the potential to become more responsible and active in the management of his own care. Practices and techniques of integrated care aimed to provide Keith with information and advice in relation to the care of his physical body and future implications for the costs of his care.

The information provided to Keith could be used in his own decision making. This is evident within an exchange between Keith and the GPLN, who visited his at home to discuss a report from a recent visit to a cardiac specialist. The GPLN advises Keith that she wants to check his understanding of the report and its recommendations.

> We arrive at Keith's house and walk up the path. Keith is sitting in his wheelchair chatting to a couple of friends. The GPLN greets Keith and explains the purpose of his visit. *"Do you understand what happened last Friday?"* she asked. Keith says yes – one of Keith's friends' comments on the visit to the specialist and the GPLN asks them to stop so Keith can talk. She says she wants to check Keith's understanding. (Field notes 23/09/13)

In this interaction the GPLN is positioned as the 'expert'- the holder of information - as well as the 'examiner' of Keith's ability to understand and be seen to apply the knowledge he has gained from his visit to a specialist. In this exchange, the GPLN asks Keith's friend to be quiet; she is attending to the knowledge and understanding Keith has an individual. Keith's knowledge and understanding is based on the integration of information from a variety of sources. Keith is asked to demonstrate his ability to use this information and advice to make decisions about his future care.

Foucault argued that the different modes of power he discussed did not simply replace one another, but, rather, *dovetailed* into each and formed a triangle: "sovereignty, discipline, and governmental management, which has population as its main target and apparatuses of security as its essential mechanism” (Foucault 2007, pp. 107–8). Movement between these modes of power was evident in the integrated care that unfolded around Keith and Frances. These clients were presented with ‘choices’ in relation to their health and care. However, these ‘choices’ were directed by the knowledge and advice of the experts. At times, there was a hint of potential for this integrated care to shift towards disciplinary techniques if it was consistently resisted by the clients. This potential is evident in the following extract from the observation of a case conference. This case conference was held at the local health centre and Keith was not present. A group of professionals and carers had agreed to meet to discuss his continued refusal to comply with a directive to use a foam wedge and spend more time in bed.

> The GPLN has arranged a case conference to be held at the local health centre to discuss plans and concerns with regard to Keith’s current care arrangements. Keith is a long term patient and is known to a range of health and social care agencies and has up to 20 carers visiting him throughout a week. There are concerns about his pressure sores – the advice is that he needs to have more bed rest so the sores have time to heal. Keith is not complying with the directives for more bed rest or using a foam wedge to keep him on his side when he is lying down. His case manager says that the “carrot and stick” approach usually works. There is time spent discussing how to encourage Keith to comply with the directive for more bed rest. The case manager says that ultimatums usually work with Keith – *“tell him that if the sores don’t heal he will have to go to hospital”*. (Field notes 08/10/3)

In this exchange, increasingly disciplinary techniques are being discussed to encourage Keith to comply with the directives for increased bed rest and using a foam wedge that will help his pressure sores to heal. The processes of information giving, coaching and encouraging self-governance have been deemed unsuccessful; thus, more explicit forms of disciplinary power are suggested—a ‘carrot and stick’ approach with the threat of hospitalisation.

Arthur

HealthOne Camara’s technologies of integrated care can also be seen in the occasions in which clients were considered to have achieved ‘success’ and demonstrated what was seen as responsible self-management. The following example of Arthur’s ‘success’ illustrates this.

We go to visit Arthur who lives on the second floor of a low rise housing block. The GPLN explains that the purpose of the visit is "care co-ordination" to ensure that Arthur has the support that he and his family need. There is a social care agency organising personal care and respite and that case manager, Louis, had contacted the GPLN. Louis has previously arranged for occupational therapy and physiotherapy assessments but as Arthur had refused to use a wheelchair so nothing progressed. Arthur has now agreed to use a wheelchair so Louis will arrange OT and physiotherapy reviews. (Field notes 26/08/13)

Within the terms of HealthOne Camara, Arthur's decision to use a wheelchair is considered a 'success' and he is 'rewarded' by being able to access additional services and potentially be rehoused. Kendall et al (2011, p. 94) observed a "double bind" in the 'choices' offered in some of the care programs that promote self-management. In line with neoliberal notions of choice and freedom to choose, the options for some are narrowed. For example, when an individual exercises a choice that contradicts expert opinion, they are "likely to be viewed as deviant or problematic even when their right to make this decision is acknowledged" (Kendall et al. 2011, p. 90). Arthur was given the choice to use a wheelchair but his refusal resulted in some services being withdrawn. The way in which these services were reinstated once he agreed to use a wheelchair reinforces this observation.

The techniques and practices through which HealthOne's coordinated and integrated care was enacted positioned the clients as central to achieving success within the terms of the program. This success was not, however, simply measured by their body's capacity to heal or return to relative health. Success in HealthOne Camara's integrated care was related to the *potential* of these clients to be active citizens who were willing and able to minimise their costs by caring for their bodies in the ways that were recommended to them. These clients could, and were expected to, take up the advice and support offered to them and become the experts and providers of their own care. The GPLN used techniques that reinforced these expectations. For example, as discussed previously, after explaining to Clare that her job was to "join the dots", the GPLN then asked questions that both gathered information and generated tasks for Clare to follow up: "Do you have an asthma prevention plan? ... See the GP – he might want to check your medications" (Field notes 10/10/13).

Similarly, the GPLN engaged with Iris by both collecting information and issuing advice on what she, the client, should do:

"How many medications do you take? Have you seen a urologist recently?" Iris was advised to see a pharmacist and to ask for a medicine card that explains what medications she is taking and to visit an optometrist to have her eye-sight reviewed. (Field notes 08/10/13)

Similarly, on a subsequent home visit to Arthur, the GPLN asked if he had resubmitted the application to be rehoused, since he could now be described as a wheel-chair user. Arthur replied that there were some sections of the form that the GPLN needed to complete. In response, the GPLN said she would look at the forms but wouldn't fill them in – "that is someone else's job". The GPLN did not stipulate whose job it was—the responsibility for finding out was returned to Arthur.

Keith

The movement between 'self-managed' and 'integrated care' is evident in a conversation between Keith and the GPLN in which her position as an advisor, facilitator and conduit between the program and practices of HealthOne is reinforced.

"It's not my job to be telling you what to do…You need to be seen by a podiatrist."
"I need a Medicare card for that. How do I get another one?"
"I will drop a letter over with your Medicare number and you can get yourself up to Camara." (Field notes 23/09/13)

These exchanges reinforced the importance of HealthOne Camara clients taking responsibility for integrating the various aspects of their own care. Whilst the GPLN played an important part in helping them to manage the numerous elements of their own care, there were limits to her responsibilities. These limits were imposed in order to help clients demonstrate how they were moving towards greater independence and self-governing, in keeping with discourses of health and economic responsibility.

Maria

In addition to taking up responsibility for tasks associated with their care, there was an expectation that the HealthOne Camara client would have an awareness of the financial costs of their care and the resources they consumed. This is evident in an exchange between the GPLN and the social care coordinator involved with Maria. In this conversation, the social care coordinator is telling the GPLN that Maria is attempting to exceed and change her allocation of resources.

Social care coordinator: *"She wants seven bottles of hand wash. She's not entitled to seven bottles. She stockpiles them in the garage and won't let anyone use them. Her entitlement is to three bottles per month. I found her an extra one so she got four but she still wants seven bottles. Everything has to be her way. I don't know why she even wants seven bottles. Can you get any?"*
GPLN: *"I could try but I am not here to deliver stock. I will tell her that we don't provide hand wash."*
The social care coordinator then tells the GPLN that Maria wants to trial a new type of surgical tape.
GPLN: *"I will have to look into that, I am not sure what the costs are like."* (Field notes 18/10/13)

Global and national concerns with the costs of care associated with chronic illness are reproduced here at the level of the individual. In this exchange about Maria's request for more resources, these economic concerns have translated into a discussion about her request for additional hand wash and changing the type of surgical tape she uses. Within this extract, the expectation is that the client is aware of the limits of their allocation of resources. The exchange between the social care coordinator and the GPLN suggests a shift within the power relations of Maria's integrated care. Maria needs to be reminded that, as an active, responsible client and partner, she needs to be aware of and respect the limits imposed on resources such as hand wash, as well as the functions of others involved in her care.

Conclusion: responding to the research question

This chapter has drawn on the analysis of empirical observations to extend the response presented in Chapter Four to the question *how and in what ways was HealthOne assembled as a response to this problematisation?*

HealthOne was assembled through discourses of chronic illness that emphasise problems of risk and burden for individuals and broader communities. Aspects of this risk and burden can be addressed through the programmatic 'solutions' presented within HealthOne Camara's notion of integrated care. This programmatic logic of HealthOne reproduces understandings of the client and citizen as active, self-governing and motivated to optimise life and potential. Assembling the HealthOne Camara client in these terms frames these people as being in need of instruction and guidance (Kendall et al. 2011, p. 87). HealthOne Camara's integrated care works through technologies and techniques that reposition the patient as a client and partner who is able to manage and respond to their own changing health and care needs. Integrating the management of health and care in this way shifts some of the work associated with illness from the professionals to the individual client. To do this, HealthOne Camara's integrated care drew on discourses of responsibility and self-management of health and care. Clients were offered education, information and advice from a range of professionals and local experts, and worked through techniques of referral, assessment and enrolment that engaged the *patient* in an ongoing process of becoming a *client*. The subjectivity of the HealthOne Camara client drew on ideas of autonomy, partnership and communication. These ideas were translated into the practices of integrated care enacted between the GPLN and the HealthOne Camara client. The subjectivities are assembled through the discourses of efficiency, cost saving and individual responsibility that are evident throughout contemporary health care policy.

Self-governing is complex, and the GPLN is assembled as a temporary guide or mentor who can help the HealthOne Camara client take up this new subjectivity. The client is expected to take on and integrate information and knowledge provided by experts. HealthOne Camara worked through technologies of integrated care that offered education and advice to develop the client's self-knowledge and self-governing. However, the choices the HealthOne Camara client was offered were narrowed and shaped by the experts and authorities around them, and in accordance with the dominant discourses that problematised chronic illness in particular ways. The techniques of HealthOne Camara were also disciplinary at times. This shift reinforced that the client was given opportunities for improvement and it was the individual's responsibility to exercise their freedom and choice by taking these up. At times there was evidence of techniques of discipline associated with the hospital and the attendant medical authority. It was clear, however, that if the HealthOne Camara client chose not to take up the advice and guidance offered, then they were responsible for any consequences.

By folding in these understandings of health, responsibility and self-governing, the HealthOne Camara client had the opportunity to become the expert and manager of their own health and care. For these people, however, their complex medical and physical needs weave through the various domains of their life. Thorne, Patterson and Russell (2003, p. 1337) noted the very magnitude of the challenge faced by those people who “incorporate continuous attention to a health challenge within the complexities of living a human life”.

For Keith, Frances, Iris, Maria, Clare and Arthur, HealthOne Camara’s integrated care integrated concerns of costs and burden across the multiple domains of their life. Connecting care, health, life and citizenship through these technologies of integrated care drew on the assumption that the individual can, and will, take up the advice and information offered (Kendall et al. 2011; Vassilev et al. 2011). Those who do not take up these opportunities for reform and improvement are considered as lacking an understanding of their own needs and the impact their health has on others in terms of cost and burden. Individuals who reject expert advice are understood as both disobedient and deficient (Kendall et al. 2011, p. 91), and responsible for their own failure. The analysis presented in this chapter has illustrated how technologies of integrated care work through ideas of individual responsibility (Glasgow & Schrecker 2015) and ongoing monitoring and adaptation of choice making that takes into account medical, life and economic concerns. These ways of thinking have been associated with and identified through the analysis of health promotion and programs that promote lifestyle management (Larsen 2012) and ideas of reflexive prudence (Trnka & Trundle 2014). The analysis and discussion contained within this chapter has shown how these ways of thinking about health and care are embedded within models of integrated care that target chronic illness and the life of the HealthOne Camara clients.

Chapter Six – HealthOne Camara and Spaces of Integrated Care

> ….we do not live in a kind of void, within which individuals and things might be located. We do not live inside a void that would be tinged with shimmering colors, we live inside an ensemble of relations that define emplacements that are irreducible to each other and absolutely nonsuperposable (Foucault 2000a, pp. 177–8).

Introduction

The previous chapter explored how technologies of integrated care assembled the HealthOne Camara client. This examination highlighted the influence of advanced liberal notions of choice and freedom within the assemblage of HealthOne Camara. HealthOne Camara technologies of integrated care presented a programmatic solution to the problem of the client's chronic illness, by drawing on the notion of the individual as capable of becoming a self-governing client. The analysis in Chapter Five drew out the complexity of this assemblage of HealthOne Camara and the "ongoing labour of bringing disparate elements together and forging connections between them" (Li 2007, p. 265). The alignments that were forged as the assemblage came together were temporary: "elements are drawn together at a particular conjuncture only to disperse or realign" (Li 2007, p. 265). Yet, despite the transient nature of these alignments, the assemblage cohered through the strength and reproduction of the political rationalities that ran through it.

This chapter returns to the assemblage of HealthOne Camara, to explore further how this programmatic solution unfolded as clients and local experts were gathered together through its integrated care. In presenting this analysis, this chapter takes up notions of space and heterotopia (Foucault 2000a) introduced in Chapter Two to describe an additional, complementary analysis of HealthOne Camara. This chapter shifts the focus of the analysis slightly, to examine how technologies of integrated care opened up a governable space in which the responsible client was assembled. By exploring care from this perspective, this chapter builds on the earlier analysis of HealthOne Camara's technologies of integrated care as well as connecting with the third and final research question set out in Chapter One:

> *How have the governable spaces of HealthOne Camara's integrated care assembled the subjectivities of the clients?*

The analysis and discussion that follows in this chapter argues that the HealthOne Camara clients were assembled within decentralised spaces of care that cut "across many domains of human life" (Brown 2012, p. 20). By connecting across many domains of the life of the HealthOne Camara client, integrated care opened up multiple, decentralised spaces in which the client was (re)assembled as self-governing. Chapter Two introduced links made by Foucault between power, governing and space. Recent work from the fields of geography (Elden 2007; Elden & Crampton 2007; Huxley 2007; Johnson 2006; Thompson 2011), adult education (Sandberg et al. 2016) and health (Street & Coleman 2012) has used Foucault's work on space and comments on heterotopia to (re)think contemporary, decentralised spaces of governing. Rather than the disciplinary spaces associated with the hospital or clinic, which work to divide and separate, this way of governing unfolds through configurations of "decentralised, localised self-surveillance, self-control and self-punishment" (Elm-Larsen 2006, p. 78). Such spaces of governing come into view in relation to other spaces in which *legitimate* citizens demonstrate responsible management of their health and life.

This chapter begins by turning to consider how care is assembled within HealthOne texts as a space of governing—a heterotopia (Foucault 2000a). Heterotopia has been used in recent studies of citizenship (Sandberg et al. 2016) and health and care (Hutton 2010; McGrath & Reavey 2013; Street & Coleman 2012; Street, Coleman & Brown 2012) to frame analyses of how technologies and techniques open up spaces in which different subjectivities are produced. Within such spaces, discourses, practices and material objects assemble subjectivities directed by certain programmatic logic. As demonstrated through the recent study of citizenship education (Sandberg et al 2016), such programmatic logic offers the potential for the individual to take up the subjectivity offered and move to a position of legitimacy within a broader population of responsible clients or citizens. In keeping with neoliberal rationalities of responsibility, individuals who do not take up offers of self-improvement are responsible for any outcomes. As is shown through the analysis of such spaces as heterotopias, this way of governing is riven with tensions, multiplicities and ongoing contestation.

The chapter then shifts to explore such complexity within the spaces of integrated care in which the HealthOne Camara clients (Iris, Maria, Arthur, Keith, Frances and Clare) took up this subjectivity. These spaces were referred to as care, and marked points at which the assemblage of HealthOne Camara aligned and clients and experts came together. These spaces were more complex than those represented in the policies and texts of HealthOne, and the empirical analysis of them emphasises the complexity of such attempts to govern. Data analysed in this chapter was collected during the period of fieldwork undertaken in Camara. The chapter concludes with a discussion of what some of the effects of such ways of governing may be for those individuals who cannot, or do not, take up the opportunities presented.

Heterotopia and HealthOne's spaces of integrated care

As outlined in Chapter Two, Foucault made a number of comments in which he connected notions of power and governing with space. In Foucault's 1978 and 1979 lectures, he moved from his earlier focus on how discipline worked through "enclosure and circumscription of space" to the ways in which security and self-governing sought to govern a *polity* through the "opening up and release of spaces, to enable circulation and passage" (Elden 2007, p. 30). Again in contrast to discipline, such "circulation and passage" required minimal regulation—"discipline seeks to regulate everything while security seeks to regulate as little as possible, but in order to enable" (Elden 2007, p. 30). Security, or governmentality, assembles active citizens and responsible clients as free and willing subjects who make choices to optimise life and, in doing so, become self-regulating and self-governing. The spaces in which subjectivities are assembled are multiple and decentralised and connected by political rationalities and technologies.

The technologies of integrated care that ran through HealthOne assembled spaces in which this way of governing through care was enacted. These spaces unfolded across multiple sites, places and people. Within these temporary spaces of care, the patient was reassembled as a client and given opportunities to learn about and understand their health and care. This marked a way of helping to shift the risk and burden associated with their care away from the institution of the hospital and the domain of the government to the individual. As these spaces of care expanded across sites and places, more people were pulled in. Hospital staff, GPs, social care workers were all important contributors to client care, and alignments were forged between them.

Within these spaces of care, experts such as the GPLN worked on the subjectivity of the client as self-governing: an expert in their own care. Within this space of integrated care, the GPLN functioned as a mediator (Holmes, Perron & Savoie 2006) or, as stated in the official HealthOne Camara GPLN job description, a “conduit” (Western Sydney Local Health District 2012) between the objectives of the program and the life and body of the client. In taking up this function as a conduit between the HealthOne program and the life and body of the client, the GPLN drew the client into the space of care through the processes of referral, assessment and enrolment, as discussed in Chapter Five. Through these processes the HealthOne Camara client was drawn into a space that existed in relation to something else—other spaces of legitimacy in which clients managed their own health and care responsibly. The HealthOne Camara client was set apart from others who may have had similar illnesses or diseases but who had already demonstrated responsible self-governing.

The case study of Joan, which featured in a key HealthOne text, illustrates the way in which integrated care opened up as a space of governing for clients. Reading this case study, and using heterotopia as a conceptual tool in its analysis, emphasises how integrated care came together and opened up a space of activation and reform. Within this space of integrated care, the HealthOne expert, the GPLN, worked with other service providers and Joan’s insurance company to engage her in ways that produced her as a HealthOne client and partner in the provision of her own care. Through this partnership, Joan became an expert in her own care.

> **Case Study: HealthOne NSW – improving outcomes for individual clients**
>
> Joan* is a 40 year old partial quadriplegic who weighs 115kg and has a history of refusing to go to the hospital for necessary care. Any care required in hospital needs to be negotiated with Work Cover NSW. On admission Joan must be turned every hour and there had previously been conflict about whose role it was to provide this level of care. Prior to HealthOne NSW communication with the insurer was not initiated until after hospital admission, which often meant a delay to her necessary care and a longer hospital stay from resulting pressure sores.
>
> Enrolment to the HealthOne NSW program has facilitated better care through a discussion with all stakeholders and an agreed management plan for who does what when. In partnership with Joan an agreed process was developed for an

> emerging need for hospitalisation. This has resulted in early intervention by the HealthOne NSW GP Liaison Nurse who is able to negotiate post admission care with the hospital, reducing the delay to appropriate care and ultimately resulting in a reduced length of stay. After 8 months, Joan has had 30% less hospitalisations. (*name and age have been changed) (NSW Government 2012, p. 13).

In this extract from a key HealthOne text, Joan is initially assembled as a patient with a concerning history of refusing hospital admissions. Joan's refusals to go to hospital, and the complexity of the involvement of multiple agencies in her care, have led to a deterioration in her physical condition. Consequently Joan has needed longer and more expensive hospital admissions. According to the text, enrolment with HealthOne has led to better care for Joan. This outcome of better care is described as reduced hospital stays. The care that allowed this outcome to be achieved did not relate to practices and processes associated with Joan's body. In contrast, this integrated care involved Joan becoming a partner in her own care and management. The alignments of this partnership were forged across multiple contacts between Joan and the GPLN. Joan was temporarily (re)assembled within this space of care as she engaged with the program of becoming a self-governing HO client. Once her self-responsibility was demonstrated, Joan progressed out of the temporary heterotopia and became a legitimate partner in her health and care. This movement by Joan evidenced the 'success' of HealthOne's integrated care.

This space of care was assembled through the problematisation of health and illness, as discussed in Chapter Three. The *problem* of Joan is described in ways that emphasise the costs of her care, as well as her own role in the deterioration of her pressure sores. The *solution* offered through her becoming a partner in her own care is facilitated by the intervention of the GPLN. Joan's apparent willingness to be assembled as a HealthOne client in accordance with these rationalities integrates her into her own care and activation as a "responsible, self-governing citizen" (Street & Coleman 2012, p. 13). This HealthOne text presented the case study of Joan as an example for people involved in other local programs like HealthOne Camara. It can be read as an educative text describing what is possible for clients as a result of enrolment with HealthOne. Of significance within this chapter is the linearity within this description of HealthOne's care and Joan's subjectification.

In arguing that the space of HealthOne's integrated care can be viewed as a heterotopia assembled through neoliberal political and economic rationalities (White, Hillman & Latimer 2012), a particular order can be discerned. Within these spaces of integrated care, the client was reassembled and integrated into the provision of their own care as a partner and expert. As was argued previously in relation to Joan, the space of this integrated care settled across the physical body of the client as well as the various domains of their life and health. This space was assembled through the connections of HealthOne itself and so within this space, the client was assembled and "co-opted" (Street & Coleman 2012, p. 13) into its programmatic logic. The relations of the heterotopia and the way in which care unfolded was in keeping with these rationalities. Poland et al (2005, p. 174) noted the complex ways in which clients and citizens are governed through power relations and techniques associated with such "focus on the cultivations of new subjectivities of personal empowerment, participation, self-actualisation, risk management, and health and safety". Such techniques work by aligning the desires of the subject with the rationalities that assemble the program and its practices.

This co-opting and integration was evident in the case study of Joan, as well as in the spaces of care of HealthOne Camara clients Arthur and Clare. As argued in the previous chapter, Arthur took up the subjectivity of the responsible client who was willing to become a wheelchair user, and was then 'rewarded' with additional services and the possibility of being rehoused. Clare appeared to take up the advice of the GPLN to seek out the GP to improve her own ability to manage her chronic asthma. Within other spaces of HealthOne Camara's integrated care, however, clients, especially Frances, Keith, Maria and Iris, took up this subjectivity in ways that complicated and disrupted the order of the spaces of care. As Rose and Miller (Rose & Miller 1992, p. 190) observed, "[g]overnment is a congenitally failing operation: the sublime image of a perfect regulatory machine is internal to the mind of the programmers". As is evident in the following analysis of HealthOne Camara's spaces of integrated care, so too is the *sublime image* of the integrated care, as set out in the HealthOne's case study of Joan.

Heterotopia and HealthOne Camara: contested relations

Chapter Two argued that the analytic utility of heterotopia in a study of governmentality relates to its potential to identify "some of the ambiguities, contradictions and unintended effects and outcomes" (Elm-Larsen 2005, p. 82) associated with advanced liberal ways of governing. This section uses extracts from research field notes to consider the spaces of care into which Frances, Keith and Maria were drawn. These spaces—heterotopia—came into view in relation to other spaces of legitimacy. These heterotopia were also ordered by the dominant neoliberal political and economic rationalities which assembled HealthOne. The space of Joan's care was described in ways that set out an order and linearity. In contrast to Joan's space of care, however, for these HealthOne Camara clients there is evidence of displacement, multiple orderings and constant realignment (Street & Coleman 2012). The following analysis traces how these subjectivities were produced within the spaces of HealthOne Camara's integrated care, and what happened when this order was disrupted.

Keith

Within HealthOne Camara, Keith was assembled as a complex, long term and expensive client of local health and care services. Keith had no family, lived alone and, as he was a quadriplegic, could not get himself out of bed or attend to his own physical needs. As he had no next of kin, the Public Trustee managed his finances and worked with government and private sector agencies to employ carers and oversee Keith's ability to pay these people from his own money and the government benefits he was entitled to. These carers came to Keith's home early each morning to provide him with food and basic physical care. Carers returned at midday to lift him out of bed and sit him in his electric wheelchair. They returned at 5 pm to give Keith dinner and put him back to bed for the night. As part of their duties, and in a way that marked Keith's reliance upon them, the carers ensured that he could reach a straw positioned on his bed so that he could drink water if he was thirsty in the hours before the next morning's visit. Through this care, Keith's physical body was cared for and kept alive. This pattern had been repeated innumerable times over the years since Keith became a quadriplegic after falling from a tree in 1976 when he was in his early 20s.

Keith's 'life', however, involved more than just the work of the carers who tended to his physical body. Other people, places and material objects were gathered into the relations and life that was assembled around him. Keith's 'life' was full of objects that allowed him to stay alive and move around the spaces in which his life was assembled. The hoists in his bedroom were used to turn him and lift him out of bed. Once he was out of his bed he could be placed into his wheelchair. This motorised wheelchair offered him mobility and a degree of independence. For example, Keith would travel to the local shops in this wheelchair and go shopping and run errands. He was able to attend hospital appointments by himself and would sit outside his house with his neighbours who would bring him food and beer.

Within the space of HealthOne Camara's integrated care, Keith's subjectivity as a *client* was produced within the priorities of the HealthOne program and the local experts involved in his care. The techniques of this integrated care focused on Keith's compliance with the directive to take more bed rest so that his pressure sores could heal. This advice was presented as a straightforward and rationale choice. The local 'experts' wanted Keith to spend more time in bed and to use the foam wedge the occupational therapist had provided, to ensure that he did not roll on to his back while he was lying down. Keith had refused to follow this advice and was spending the same number of hours sitting in his wheelchair, despite the worsening pressure sores. Chapter Six explored some of the techniques involved in Keith's care, and noted the use of disciplinary techniques such as a 'carrot and stick' approach to encourage him to be a responsible client and follow this advice. Within the spaces of care in which these attempts were enacted, Keith demonstrated resistance as he sought to negotiate his subjectivity as a HealthOne Camara client.

For example, the GPLN had planned to visit Keith at home again to discuss concerns about his pressure sores and his reported refusal to spend more time in bed.

> The GPLN stated that she wants to talk to Keith about his wound care. He needs to spend less time in his chair, more time in bed. Keith says no. He wants to be up and doing things – *"I have a life"*. He says he is in bed until between midday and 1pm, and then in his chair until tea at 5pm. Keith restates that he won't agree to extended bed rest. Keith says the reason he won't agree to extended bed rest is because of the heat in his room – the bed is positioned against the back wall and the sun shines directly on it all day. By the afternoon it is so hot *"you could cook a piece of toast on it"*. (Research field notes 23/09/13)

The GPLN attempted here to shape Keith's subjectivity, as a compliant HealthOne Camara client, by advising him to take more bed rest so that his 'wounds' could heal. This would be a positive outcome in terms of Keith's physical health as well as his predicted need for future hospital care if the wounds continue to worsen. Keith, however, rejected this suggestion—"I have a life". Through his refusal, Keith is exercising his freedom and choice about how he lives and spends his time. He also contextualises this refusal by linking it to the heat in his bedroom. Again, by doing so he is making a choice that he does not want to lie in an extremely hot room all day. These choices contradicted the advice of the professionals involved in his care and thus Keith was viewed as a ‘problem’. Keith did not conform to the responsible subjectivity of the HealthOne Camara client but rather tried to negotiate his care.

Later in the conversation Keith suggests managing the ulcers on his legs by cutting his legs off. You don’t want your legs cut off, the GPLN replies.
The GPLN suggests that perhaps he could spend a couple of hours up in the morning then a couple more in the afternoon. Keith agrees but tells her he would need carers to come and help him more often and his hours have recently been reduced.
After further discussions Keith says to the *GPLN “I’ll cut your throat if you talk to me about a nursing home.”*
“I didn’t say anything about a nursing home.”
“That’s because I told you I would cut your throat.”
(Research field notes 23/09/13)

Through this exchange Keith demonstrated an awareness of his own resources and allocation of carer time that had not been raised by the GPLN. Importantly, Keith also seemed aware of the potential presence of the discipline of the institution of the nursing home. This awareness is significant in terms of Keith’s response to the subjectivity of HealthOne Camara client. If Keith becomes the responsible client, then he can stay at home. However, if he resists, he may need to spend time in hospital or in a nursing home. The heterotopia of integrated care is assembled as a decentralised space of governing. There is a connection from this care back to that of the institutions of the nursing home and the hospital. This is significant because, as noted by Poland et al (2005), although power and regulation are more obvious in institutions such as the hospital, a connection is maintained through the networks of experts that extend out through the “less formally regulated settings” (p. 174).

Within this space of care, attempts were made to produce Keith as a HealthOne Camara client. A successful HealthOne Camara client would agree to increased bed rest as a short term measure that reduced the long term risk of hospitalisation due to worsening pressure sores. However, Keith resisted such attempts, and in doing so made choices about his care and life that disrupted the order of the heterotopia. Keith demonstrated his ability to make choices that integrated the multiple domains of his life into his care. The advice of the

GPLN, in contrast, followed the linearity of the policies that assembled HealthOne and acknowledged the dominance of the medical authority associated with it.

Keith's choices were not 'correct choices' within the programmatic objectives of HealthOne Camara and so Keith did not move out of this heterotopia to a position of legitimacy. Keith's comment—"I'll cut your throat if you talk to me about a nursing home"—suggests an awareness that there are other spaces or sites within the assemblage of HealthOne to which he could be shifted if he is too problematic or becomes too unwell. As discussed, the assemblage of HealthOne pulled in multiple and overlapping sites. Within an institution like a hospital or nursing home in which disciplinary forms of power are prominent, Keith would be unable to do the things he has stated he wants to be able to maintain—what he referred to as 'having a life'. This life, however, does not fit easily with the programmatic objectives of HealthOne and the advice of the experts who want him to spend more time in bed. In this instance, Keith's view of what it means to "have a life" did not align with the priorities of HealthOne.

> The GPLN parked the clinic's pool car outside a low set house, got out and walked the few steps to the gate. There was a large dog out the front of the house and Keith was sitting in his motorised wheelchair while another man and a woman were sitting on upturned plastic milk crates. The GPLN approached the group and Keith turned his wheelchair to look at her – he said hello but did not offer her a seat or invite her into his house. Keith was wearing sunglasses and holding a beer can in a brown stubby holder tied on to his right hand.
> GPLN: *"You shouldn't be drinking that (beer) in front of me."*
> Keith: *"I'm not."*
> (Research field notes 23/09/13)

In this instance the GPLN had visited Keith to discuss the medical report with him in a way that acknowledges her medical authority and positions her as the holder of knowledge that Keith 'needs' in order to be able to manage his own care. Keith, however, did not comply with the expectations of a home visit from such an expert or authority – he did not greet her in a way that acknowledged her position as a local expert or invite her into his house. He did not suggest that the GPLN sit down. The visit proceeded under the tree outside the front of his house, his friends stayed and listened and the GPLN stood up the whole time. This inversion of the usual power and knowledge relations disturbs the space of this care. The GPLN can be seen to attempt to re-assert some medical or supervisory authority by telling Keith he shouldn't be drinking beer in front of her. Keith resists this authority by stating that he isn't drinking beer whilst continuing to do so.

Considering this space of care from the perspective of heterotopia, emphasises complexity and disorder. It also suggests that the relations of HealthOne Camara's integrated care are different from other spaces and sites of care. Such disorder and contestation would not be possible within the hospital or clinic, yet within these spaces of integrated care which connect life and health, clients like Keith present a challenge to authority and order.

Keith's desire to maintain his relative independence is evident in another conversation between Keith, his neighbour Jo and the GPLN. This 'independence' does not simply involve following the advice or using what he is given by experts; it involves finding ways of adapting and working around potential obstacles and also monitoring and influencing the way in which other experts work with him.

Keith was sitting by himself out the front of his house with a beer. His neighbour, Jo, calls in with a carton of beer. They say the street isn't too bad now – there used to be shootings, the church across the street was shot up. Keith said *"they all shot each other in the end and now the street is quieter"*. They talk about the state of the house – a beam was dropping and Keith had called out to a builder walking to a nearby site and asked him to fix it with some spak filler which the builder did. Jo had brought Keith some lunch but says it's too hot for him to eat – Keith tells him to put it inside for a while. They talk about switches inside the house – Department of Housing is so slow to get things fixed. The occupational therapist has brought Keith a new switch for his telephone so he could answer it independently. *"They said they could get some hooks and hang it on the bed. I said no that's no good, the bed is on that side and I can't reach it...I asked if they couldn't get me a switch. It (the telephone) is as handy as a zip in a pair of underpants."*
(Research field notes 14/11/13)

Again Keith displayed his self-governing—and his ability to be an independent, active citizen within his home. Rather than wait for the Housing Department to send someone to fix the falling beam, Keith saw an opportunity for an alternative solution and enlisted the help of someone passing by. In a similar way, Keith monitored and challenged the workers who installed a telephone he could not reach. Keith pointed out to the workers that the solution they had proposed (putting hooks on the bed) wouldn't work either.

Through this challenging of order, Keith demonstrated his ability to make choices and exercise his freedom. For Keith, the threat of being placed in a nursing home or agreeing to extended bed rest presents a potential crisis in terms of his loss of independence and freedom. However, Keith's choice to prioritise elements of his life over his immediate physical health presents a challenge for HealthOne Camara. Through practices of integrated care, HealthOne Camara seeks to reduce the risk of future care needs and hospitalisations by shaping the client's ability to manage their care in line with these economic imperatives. Although Keith is demonstrating his ability to be the active and free citizen, HealthOne Camara's practices of integrated care work to produce a different subject. Unlike Joan's care, Keith's subjectivity as a client was not produced in a linear or rational way. Keith's subjectification as client involved negotiation, refusal and reminders of disciplinary power and potential movement to an institution. Within his responses, Keith connected the various domains of his 'life' and made 'choices' that prioritised his mobility, independence and contact with his community, and in so doing drew out a tension within the connections and relations of this space. As has been argued, HealthOne Camara's integrated care sought out a simplicity and smoothness in its spaces of integrated care that was disrupted by clients who contested and negotiated their care. This contestation flowed from the multiplicity of their subjectivities. Such tension is also evident through the analysis of how Frances responds to the subjectivity of the HealthOne Camara client.

Frances

In similar ways to Keith, Frances presented with complexities in her physical and medical needs that flowed into other domains of her 'life'. Frances had been hospitalised for 18 months after a horse riding accident about three years earlier when she was in her mid-30s. After this hospitalisation Frances returned to the community to live, and now lives alone in a supported housing unit. Although she had regained some mobility in a wheelchair, since the pressure sores on her lower back had developed and become infected, Frances had been confined to her bed. From this bed Frances used the telephone and Internet to connect with the other aspects of 'life'. She managed her finances, looked after her cats and kept in touch with her four children. Her youngest two children lived interstate and via the Internet Frances would arrange and pay for them to travel and to stay with her during school holidays. From this bed Frances also attempted to manage her carers; she would ask them to go shopping and take money out from the cash machine, as well as clean her house and attend to her personal needs. The space of Frances' care incorporated this multiplicity of people, material objects and activities as she took up actions associated with 'being' the coordinator of her 'life' and care.

For Frances, her home and even her bed had become the sites from which she managed these various domains of her ‘life’. Frances had some control and choice over who came in and out of her home—she had a long plastic stick she used to operate a switch that opened or locked the front door to the housing unit. Within the space of care that settled around her, experts tried to work with Frances, shape her as a ‘responsible’ client and keep her well enough to stay out of hospital. The site of the hospital took on a significance within the HealthOne assemblage and the different spaces of Frances’ care. The hospital remained connected as she had outpatient appointments there and, at times, was taken to the Accident and Emergency department. An admission to hospital marked a crisis point for Frances and her physical needs; it meant that the infection in her pressure sores had worsened to a point where it could no longer be contained by the work done in her home. Within the space of Frances’ care, an admission to hospital represented a failure of the body and the everyday practices of care that aimed to maintain Frances in the community.

Like Keith, the space of Frances’ care spread across her home and community to the hospital, and took in the multitude of people and things that allowed her to function in her home. The transport workers, social carers and nursing staff who visited her daily were all pulled into this assemblage. In a similar way to Keith, the complexity of Frances’ space collided with the practices of HealthOne Camara’s integrated care, which sought out a simplicity and linearity. The resulting tension is evident in the extracts from the research field notes below. As indicated in these extracts, Frances is presented with clear medical information and advice, which she is encouraged to follow. In keeping with the subjectivity of the responsible, self-governing client and citizen, Frances demonstrates her ability and ‘freedom’ to make particular choices, as other domains of her life come into tension with her subject position as a HealthOne Camara client.

> The GPLN had arranged another home visit to Frances to tell her that the infection in her wounds has worsened. When we arrive at the unit a carer wearing latex gloves opens the front door and the GPLN goes into Frances’ bedroom. The GPLN and the community nurse are talking to Frances – the wound is described as smelly, offensive, red, hot, black. The GPLN and the nurse and Frances talk about calling an ambulance to take Frances to the Accident and Emergency department at the local hospital. Frances has agreed but is worried about being admitted to hospital as her children are arriving to stay with her in a couple of days. The GPLN says the hospital cannot admit Frances without her consent so she can just refuse admission if they suggest it.
> (Research field notes date 16/09/13)

Within this space of care, Frances is presented with information and advice that she can, as a responsible HealthOne Camara client, take up in order to help manage the infection in the wounds on her back and reduce the risk of needing additional and longer hospital admissions. As argued earlier, this care seeks to integrate the client into HealthOne's "bureaucratic orderings as they learn to manufacture themselves as responsible, self-governing citizens" (Street & Coleman 2012, p. 13). This co-opting is strengthened by the assumed motivation of the individual to be seen as responsible and *able* to self-govern. The heterotopia of Frances's care is thus ordered in keeping with these rationalities. As Frances' care unfolds in the exchange above, she is pulled into the heterotopia and its order. However, this order is not smooth, and the GPLN appears to recognise a tension within it. The GPLN contradicts her own previous statement about the urgency of the possible hospital admission' and informs Frances that the hospital cannot admit her with her consent: she can refuse admission. In keeping with neoliberal rationalities about freedom and choice, being given the opportunity to make decisions about health and care locates the responsibility for any associated outcomes firmly with the individual. Frances had explained that she was concerned that the hospital admission might overlap with the visit from her children, and the GPLN acknowledged this conflict. The implications of refusing admission were that the infection would worsen and Frances' care needs may increase as a result, yet she would be at home when her children arrive. There are also implications for making the other choice; if Frances chose to stay in hospital, the visit from her children would be disrupted.

Within this space of integrated care, there is a tension as these choices that affect the various domains of Frances life connect with each other. Within the spaces and relations of her care Frances has shifted to a precarious position, and needs to make choices. Complicating this even further, is the way that the GPLN in her capacity as the local HealthOne Camara expert has herself offered Frances an option—an option to refuse admission to hospital.

On a subsequent visit to HealthOne Camara, the GPLN explained that Frances' pressure sores had worsened and she had presented at the hospital A&E department and was advised to agree to an admission. Frances refused and discharged herself home. Frances didn't want to be in hospital while her children were visiting. The next clinic appointment available for Frances to have her pressure sores examined is 21st October. The GPLN says Frances *"refused medical advice, it's her responsibility now"*. Frances has been advised to re-present at A&E for a hospital admission as this will be faster than waiting for the clinic appointment. The GPLN said Frances' wounds were pretty bad and she may be in hospital for up to a month when she is admitted.
(Research field notes 23/09/13)

In this extract from the research field notes the GPLN explained that Frances *chose* to discharge herself from hospital and by doing so disregarded medical advice. Consequently, it was likely that her wounds would worsen and when she was next admitted she would have to stay in hospital for longer. As a HealthOne Camara client, these implications are Frances' responsibility. Frances was presented with opportunities to take up HealthOne Camara's integrated care in ways that experts believed would allow the crisis of the infection to pass. In this way Frances was presented with a choice but, within the "programmatic logic" (Rose & Miller 1992, p. 190) of HealthOne Camara, she did not make the *correct* choice. There was a moment in the previous visit in which the GPLN acknowledged the complexity of the choices Frances was presented with. This moment, however, passed. The words of the GPLN in the subsequent discussion suggested that the ordering of this care reverted to a simplicity in which the correct choices were limited to those which aligned with HealthOne's programmatic objectives. As a result, the responsibility for the decision to refuse admission was returned to Frances – she "refused medical advice, it's her responsibility now". This clear placement of responsibility abruptly simplified the space of Frances' care, by removing the complexities of her life that influenced her decision making. Despite the discourses of partnership and choice, and the acknowledgement by the GPLN of the potential conflict with Frances' children coming to visit, the spaces of care shifted away from Frances' life. The space and relations of care resettled in line with HealthOne Camara's programmatic logic. This logic was (re)produced through the work of HealthOne Camara's local experts and the subjectivity of the HealthOne Camara client. As Kendall et al. (2011) argued in relation to self-management, in this instance choice was not really about Frances being free to make a choice at all:

> choices are limited by hidden 'rules' about what is deemed to be a 'healthy behaviour'…the actual control over these rules are allocated to health professionals and assumptions are made about the capacity of all individuals to address the broad inequities that inherently restrict freedom (Kendall et al. 2011, p. 94).

Within the assemblage of HealthOne Camara, the only correct choice for Frances to make was to have stayed in hospital so the infection could be treated. By making the alternative choice, Frances was subjected to the disciplining techniques of those involved in her care. White, Hillman and Latimer (2012, p. 73) referred to the disciplining that unfolds as patients are divided into categories such as "good, bad, legitimate or illegitimate". Such divisions reproduce the notion of the responsible citizen and client as willing to activate the approved subjectivity: "The labor of dividing patients in such a way reproduces…orders of good citizenship; those who transgress the order become undeserving of care" (White, Hillman & Latimer 2012, p. 73).

These orders of good citizenship are, for people like Keith and Frances, potentially narrowed and tightened as they are subjected to policies and programs that seek to simplify life and health. Attempts to be active and responsible are overshadowed by the priority given to compliance with directives which can be presented as partnership and choice.

On a subsequent home visit when the GPLN left the room to take a phone call on her mobile, Frances talked about how she wanted to get a part-time job. She can't go back into her wheelchair until the infection in her pressure sores has cleared and the wounds have healed. The GPLN returns and concludes the visit and we go back out to her car. We get in the car and the GPLN realises she has left her bag in the house. She goes to the front door and rings the bell a couple of times but Frances doesn't open the door. The GPLN goes around the side of the house and climbs over a low brick wall. She stands under the window calling out to Frances explaining why she needs to come back in. Frances eventually activates the switch to open the front door and the GPLN retrieves her bag.
(Research field notes 25/10/2013)

Within the concluding moments of this home visit, Frances expressed an intention to go back to work; to become an income earner. This is a 'legitimate, responsible' goal, yet she is stopped by the implications of her pressure sores, as she cannot use a wheelchair until they have healed. In a similar way, Frances displayed 'choice' and responsibility when she refused hospital admission as she needed to be at home with children. However, within these choices that Frances made, there was a conflict with HealthOne Camara objectives. HealthOne Camara's integrated care sought to shape Frances as a responsible client who would attend hospital in order to optimise the healing of her sores. However, when Frances chose to stay at home to see her children, her choice was seen as rejecting medical advice and potentially increasing the costs of her care. Frances failed to take up the *legitimate* subjectivity that was available to her—that of the compliant and responsible client.

Maria

The complexity of Frances' care resonates with that of Maria's spaces of care. Maria also challenged the reordering of the heterotopia and sought to negotiate the subjectivity. In Chapter Five, the conversation between the GPLN and Maria's social care coordinator was used to illustrate that an element of the HealthOne Camara client's responsibility involved demonstrating an awareness of the costs and resources that they absorbed. Maria had been asking for additional hand wash and to change to a different type of surgical tape. The GPLN told the social care coordinator that it was "not her job" to get supplies and that she would explain that to Maria. After concluding the conversation with the care coordinator, the GPLN continued in to see Maria. Maria had begun displaying symptoms of a degenerative neurological disorder when she was nine years old and now, at 30 years of age, she was dependent upon a ventilator to breathe and only had movement in a couple of facial muscles. After the GPLN arrived, Maria's carer connected a pen-like device to a headband that sat around her forehead. This pen was then connected to a communication aid and computer that Maria could operate independently. Maria was able to use this computer to communicate as well as to access the Internet.

> The GPLN greeted Maria and her carer. She then began by saying she understands Maria would like more handwash and that she will try and get her some more.
> Maria then raised the question of trialing a different type of surgical tape – she says she wants to try a tape called Lycopore. The GPLN explains that she will have to check the costs of the tape to see which brand is more cost effective. Maria tells her she has already looked it up on the Internet and has the costs – she can pass on the details.
> (Research field notes 18/10/13)

Just as Keith's resistance disrupted the power relations of the space of his care, so too did Maria's negotiation of her subjectivity. Despite her earlier discussion with the social care coordinator, the GPLN offered to provide additional hand wash and Maria had already researched the price of the surgical tape she wished to trial. If Maria had been in hospital, the power/knowledge relations would have been harder to disrupt. But within her home, and with access to the Internet, Maria could exercise autonomy and independence, despite her very limited physical abilities. Within this space of HealthOne Camara's integrated care Maria, like Keith and Frances, disrupted the power relations. The GPLN was not the knowledge holder in this interaction—Maria knew how much the tape cost and could share this knowledge. As was noted earlier, heterotopia "is both about expressing resistance and violation of norms and about order and control" (Elm-Larsen 2005, p. 78). HealthOne Camara attempted to govern through these spaces of integrated care to achieve an order and control through the (re)production of discourses of choice and freedom. Maria's attempts to self-govern were seen as disrupting and challenging to the order and control of the spaces of integrated care.

Disrupting integrated care: shifting relations of the heterotopia

The analysis of the spaces of Keith, Frances and Maria's care reveal a complexity within the attempts to shape the HealthOne Camara client as responsible and self-governing. This integrated care seeks to engage these subjects in keeping with the programmatic priorities of self-management that will, in the future, be a cost-efficient way of managing care for such complex, long term clients. However, such attempts to shape these subjects promote 'choice' and freedom that, rather than enhancing and connecting the various domains of their lives, work to elide the complexity and tensions that emerge. For Keith to be a 'successful' HealthOne Camara, client he must 'choose' bed rest over mobility and independence. In a similar way, Frances must choose a hospital admission rather than the visit from her children. Despite her significant physical disability, Maria disrupted the relations of integrated care by seeking out additional resources and finding a freedom through her access to information and knowledge on the Internet.

Vassilev et al (2011) noted a tendency within self-care policies and programs to assume "that health behaviours and biomedically defined priorities (symptoms and measurement) are also the priorities in everyday life (which is clearly not the case)" (p. 72). The influence of such assumptions is evident in the spaces of HealthOne's integrated care. Within these spaces, the "orders of good citizenship" (White, Hillman & Latimer 2012, p. 73) are reproduced through the subjectivity of the HealthOne Camara client. Such observations resonate with the disorder and tension that can be seen within the spaces of Frances' care. The priorities for the client are derived from the advice of the experts, which (re)produces the objectives and logic of the program in relation to minimising care needs and risks of hospital admissions. Frances' priorities, however, resonate with the complexities across the domains of her life. When Frances enacts her 'freedom' and makes certain 'choices', she also challenges and disrupts the power relations of HealthOne Camara's spaces of care. Such challenge and disruption of the relations that seek out a smoothness and order is evident again in the way in which Frances delayed letting the GPLN back into her house. She would not have this capacity within the hospital, yet here in her home she can show her autonomy and independence and her power as an active citizen in unexpected ways. Similarly, Keith and Maria re-order the heterotopia of integrated care and contest the power relations that connect them within the assemblage of HealthOne.

This analysis has shown that, for these chronically ill individuals, HealthOne Camara's technologies of integrated care sought to (re)assemble them as responsible and cost efficient clients. This was done through the assembly of multiple spaces – heterotopias - of care. As Elm-Larsen (2006) suggested, heterotopia can be understood as a space that comes into view in relation to other spaces in which legitimate citizens and clients are positioned. Using heterotopia as a conceptual tool opens up a way of thinking about the rationalities and relations ordering these spaces. Within the heterotopia of HealthOne Camara's integrated care, clients were reassembled through the *activation* of their "capacities, feelings, practices and ethical ability to take responsibility for their own rational self-determination" (Elm-Larsen 2005, p. 78). When Keith, Frances and Maria activated their subjectivity, there was a tension between their priorities for their *life* and the programmatic objectives of HealthOne. Such disruption could be attributed to the way in which Keith, Frances and Maria appeared to evade the logic and rationalities of HealthOne and its experts, and the authority on which they drew. As Rose and Miller (1992) observed:

> Programmes complexify the real, so solutions for one programme tend to be the problems for another. Things, persons or events always appear to escape those bodies of knowledge that inform governmental programmes, refusing to respond

> according to the programmatic logic that seeks to govern them (Rose and Miller 1992, p. 190).

Within the spaces of this integrated care, Frances, Keith and Maria were presented with choices in relation to their (re)assembly as responsible clients. These people made choices and demonstrated responsible self-governing. However, these choices were problematic for HealthOne. HealthOne's "programmatic logic" (Rose & Miller 1992, p. 190) drew on assumptions that these people would become responsible in ways that aligned with HealthOne's objectives and thus move out of the heterotopia to a position of legitimacy. The objectives of the program were about choices that minimised costs, and these did not necessarily align with choices that maximised *life.*

As has been demonstrated in this chapter, Keith, Maria and Frances disrupted the order and relations of HealthOne Camara's care. Within the heterotopia of integrated care, the program and its techniques sought to assemble subjectivities in ways that simplified the complexity of these people's lives and the relations in which they lived. Unlike Joan, Keith and Frances negotiated and resisted HealthOne's care, and the order of the heterotopia was disrupted. Although this heterotopia was intended to be only temporary, Keith, Frances, Iris and Maria could not seem to find a way out to positions that HealthOne Camara's "programmatic logic" (Rose & Miller 1992, p. 190) deemed 'legitimate'. White, Hillman & Latimer (2011 p. 81) observed, in their study of elements of hospital care, how the presence of multiple and competing relations assemble spaces "that enact different logics whose effects are precisely to *displace,* and even exclude, figuratively or literally, those who cannot participate in turning themselves into good medical materials". As was evident within the empirical materials presented in this chapter, Keith, Frances and Maria were, however, repeatedly excluded from such positions of legitimacy, as their attempts to self-govern excluded them from participating and turning themselves into 'good' HealthOne Camara clients.

Of significance within this analysis and discussion of integrated care is the consideration of how HealthOne responded to this negotiation and resistance. Despite its discourses of freedom and choice, HealthOne Camara's techniques and technologies of integrated care responded to this disruption by shifting to become more disciplinary. Through these shifts, the connections of the assemblage of HealthOne drew in other sites and spaces, such as the hospital and nursing home. The significance of using heterotopia to examine such spaces of care connects to discussions of contemporary approaches to governing through increasingly dispersed spaces in which the active citizen is assembled. Chapter Three explored this in relation to health promotion programs that work to make responsible and healthy choices seem ‘easy’, through the provision of education and advice. Although the texts of HealthOne recognise the complexity of issues that face those individuals labelled as chronically ill, within its spaces of care clients are assembled in ways that seek out a simplicity that resonates with *making healthy choices easy choices.* In this context, making healthy and good choices is limited by “a narrow compliance view…based on a professional educative model” (Kendall & Rogers 2007, p. 140). As Keith, Maria and Frances disrupted the order of the heterotopia, they not only lingered within it but its relations shifted towards disciplinary techniques such as surveillance, regulation and the threat of institutionalisation.

Conclusion: responding to the research question

This chapter has extended the previous analysis and discussion of HealthOne by responding to the final research question:

> *How have the governable spaces of HealthOne Camara’s integrated care assembled the subjectivities of the clients?*

In doing so, this chapter has examined how technologies of integrated care assemble spaces of governing. These spaces mark out points at which the assemblage of HealthOne pulls together and coheres. Within these spaces the patient is reassembled as a HealthOne Camara client who can, in the future after education and training, take up the burden of their care and become cost effective and responsible. The texts of HealthOne suggest that this care and integration will be smooth and uncontested; the rational client will choose to take up such offers and “appropriate subjectivities” (White, Hillman & Latimer 2012, p. 69). These spaces of HealthOne Camara’s integrated care were highlighted through the notion of heterotopia, which was used in this chapter to rethink care as a temporary space of governing. These spaces are ordered by neoliberal discourses of responsibility, freedom, choice and expert knowledge. Using the notion of heterotopia situates these spaces of care in relation to other spaces - spaces in which responsible citizens are granted legitimacy through their demonstrated self-governing.

Considering these spaces through the notion of heterotopia complements the analysis of the assemblage presented in the preceding chapters. Chapters Four and Five argued that HealthOne was an assemblage of problematisations, people, discourses, places, material objects and neoliberal political rationalities. This assemblage came together as alignments were forged (Li 2007, p. 265). These alignments were temporary, but had the effect of flagging “an identifiable terrain of action” (Li 2007, p. 266). Heterotopia added to the analysis of the assemblage and problematisation, by focusing on the temporary spaces that marked points of alignment and translation as HealthOne Camara moved further from the offices of the policy makers and into the homes of the clients in Camara.

Using heterotopia as a tool in this analysis suggested that, in these spaces of care, technologies and techniques sought to activate the self-governing abilities of people in ways that aligned with the programmatic logic of HealthOne. In the extracts analysed in this chapter, the GPLN had a key role in educating, training and demonstrating to the client the moral and economic order of “good citizenship” (White, Hillman & Latimer 2012, p. 73). Although the GPLN was a registered nurse, integrated care did not, in these extracts, relate directly to the physical needs of the clients.

By opening up the examination of how the subjectivities of the HealthOne Camara clients were assembled within these spaces of care, the complexity of integrated care was emphasised. Of particular interest were the ways in which these relations and spaces responded to the challenges posed by Keith, Frances and Maria. Clients were encouraged to self-govern in accordance with the objectives of HealthOne, but when they did not, the spaces and relations of care shifted and choices were narrowed, and there were shifts towards disciplinary techniques being employed. The subjectivity of the HealthOne Camara client was not one of a citizen who was free and able to make choices about their life and care. The program’s logic sought out a simplicity by reproducing the assumption that the individual is rational and motivated to conform. However, this simplicity overlooked the complexity of life itself, and the multiple ways in which responsibility and self-governing can be displayed.

The empirical analysis presented in this chapter has suggested that HealthOne was assembled through discourses and practices that position self-knowledge as key to self-governing and the ability to make good choices. HealthOne’s integrated care was enacted across sites and places, through the relations and spaces in which the assemblage came together and engaged with the life of the client. In HealthOne Camara, such multiple and connected spaces were evident in the unfolding of care through conversations and contacts made either virtually, via email or over the phone, or in person, in homes and other sites. Within all these spaces of integrated care, techniques were employed to develop the self-knowledge of the individual; that is, to enhance their understanding of themselves and their care needs. HealthOne was assembled through multiple and connected spaces of care that settled across the individual's capacity to self-govern. Settling across multiple domains of life in this way resonated with HealthOne's stated focus as being "beyond specific conditions" (NSW Government 2012, pp. 12–3). Unlike the site of the hospital or GP surgery, these spaces were assembled through the relations and discourses that problematised chronic illness in terms of self-governing and assembled responses that worked to develop the self-knowledge of the individual.

Chapter Seven – Conclusion: Anticipatory Strings of Dots

> "My work takes places between unfinished abutments and anticipatory strings of dots. I like to open up a space of research, try it out…" (Foucault 1991, pp. 73–4).

Introduction

This study has provided new and different understandings of integrated care - an approach to managing chronic illness which has gained prominence in recent international primary health care reform. It has illustrated the value of using a governmentality perspective based on the later work of Foucault (2007) and other writers (Dean 2006, 2007, 2010; Li 2007; Miller & Rose 2008; Rose 1996b; Rose, O'Malley & Valverde 2006). Innovatively, this study incorporated Foucault's work on space and heterotopia (Foucault 2000a), drawing out the complexities and challenges of integrated care that are largely ignored by the dominant theoretical and methodological approaches taken up in primary health care research. By exploring these challenges and complexities, this research has demonstrated how discourses of integrated care and self-responsibility translate into the local practices of care in programs like HealthOne Camara.

Using governmentality has opened up a way of thinking about HealthOne Camara's care in terms of technologies of integrated care and multiple spaces of governing. In doing so, this study has emphasised linkages between global, national and local discourses of chronic illness and self-management and the everyday practices of HealthOne Camara's GPLN and clients. The rich descriptions of the interactions between the GPLN and Keith, Frances, Maria, Clare, Iris and Arthur emphasise the complexities of integrated care and how it seeks to govern chronic illness in particular ways.

Importantly, this study takes up a perspective that is different from the dominant analytical and theoretical approaches used in primary health care research in general and, specifically, in the body of work that connects integrated care and chronic illness. The review of primary health care literature in Chapter One illustrates that, within this field, research topics and methodologies that focus on integrated care and chronic illness show a dominant concern with the rise in incidence and prevalence of diseases, as well as policy-driven attempts to address this 'problem' (Braithwaite, Westbrook & Iedema 2005; Brown & McIntyre 2014; Kalucy 2012; Shaw, Rosen & Rumbold 2011). Much of the research uses approaches and methods that collect evidence of effectiveness and provide data that can be fed back into policy-making (Kalucy 2012; Reed et al. 2011). These instrumental and largely atheoretical approaches, evident in research from Canada, New Zealand, the UK and Australia, emphasise concerns related to costs and burdens, and what Sweeney and Kernick (2002) described as the "linear thinking" (p. 131) of policy.

In contrast to these approaches, through a governmentality perspective, this study *rethinks* chronic illness. By rethinking chronic illness in this way, the neoliberal discourses of primary health care that assemble the problem of chronic illness in terms of cost, burden and a lack of self-management are brought to the fore. Through these discourses and rationalities, chronic illness has been assembled as one of the preeminent global health problems of the twenty-first century (World Health Organization 2005, 2011, 2016). These discourses position the problem of chronic illness as an issue of cost to health care systems, disability to the individual and burden to the community. This way of thinking links with scientific and medical knowledge, which connects many chronic diseases to individual choice and lifestyle (Larsen 2012). HealthOne Camara's model of integrated care has emerged from this context. These ways of thinking and working to address the problems of chronic illness are evident in policy and literature from other countries, including Canada, New Zealand and the UK. The importance of rethinking the problem of chronic illness is derived from an international acknowledgement that, despite years of investment, only limited progress in effective health care reform has been achieved (Bate, Mendel & Robert 2008; Bennett 2013; Braithwaite, Westbrook & Iedema 2005; Cumming 2011; Degeling, Close & Degeling 2006; Gauld et al. 2012; Glasgow 2012).

This chapter draws together the key findings in relation to the research questions introduced in Chapters One and Two and examined in Chapters Three, Four, Five and Six. The chapter articulates how responding to these questions contributes unique and significant knowledge to the field of primary health care. First, this study contributes a rich, empirical study of the translation of integrated care to the field of primary health care. It traces the translation of a primary health care program from its naming in policy texts to its enactment in the homes of clients. This reveals a complexity that cannot be discerned from the more traditional methodological approaches that dominate in primary health care research, such as policy analysis or program evaluation. The analysis in this research contributes new knowledge to the field, by demonstrating the alignments, relays and connections of integrated care in ways that contrast with the dominant linear views generated through policy analysis and program evaluation.

Second, this work uses concepts and theorisations in the study of integrated care that are uncommon in current primary health care research. Using a governmentality perspective to draw out the patterns and consistencies in ways of thinking about chronic illness and integrated care highlights the influences of neoliberal discourses of individual responsibility and choice. As shown through documentary and empirical analysis, these patterns and consistencies are evident in the translation of policy texts into everyday practices of integrated care in HealthOne Camara.

A third contribution to the field is derived from the spatial analysis of integrated care. Rethinking integrated care as a space of governing highlights the complex and shifting power relations that connected local experts and clients through the enactment of this care. This spatial analysis suggests that, rather than unfolding in a linear way, as depicted in many policy texts, integrated care in HealthOne is assembled through an ongoing negotiation and resistance between experts and clients. This spatial analysis, and the introduction of the notion of heterotopia (Foucault 2000a), helps us understand this complexity. Identifying the spaces of integrated care as heterotopias shifts the focus from *what* integrated care is to the analysis of *how* this care was woven into the lives of these HealthOne Camara clients. The chapter concludes with a discussion of how all these contributions to the field of primary health care can be extended through future research.

Rethinking chronic illness and integrated care

This study has responded to the three key questions introduced in Chapter One:

1) How has chronic illness been problematised within contemporary discourses of health and responsibility?
2) How and in what ways was HealthOne assembled as a response to this problematisation?
3) How have the governable spaces of HealthOne Camara's integrated care assembled the subjectivities of the clients?

Chapter Two examined in detail the analytic tools used to explore these questions, which were then directly addressed in Chapters Three, Four, Five and Six.

The analysis presented in Chapter Three highlighted the ways in which chronic illness has been assembled as a moral and economic problem for individuals and communities. Neoliberal rationalities of responsibility and choice have positioned the optimisation of health as a moral and economic imperative. As detailed in Chapters Three and Four, this way of thinking can be traced through the texts of various international organisations and national governments. As scientific and medical advances have generated new knowledge about chronic illnesses, government concern has focused on long-term costs and management needs. This focus on costs and long-term consequences (Armstrong 2014) of chronic illness is (re)produced in policy and research texts as well as in the general media. In recent years, words such as catastrophe, epidemic and global risk (World Health Organization 2005, 2011, 2016) have been used to emphasise the urgency of the threat of chronic illness and its financial and moral implications. Chapter Four traced the translation of these discourses and ways of thinking about the problem of chronic illness through Australian health policy and into the local program of HealthOne Camara.

The (re)production of these discourses in national and local texts and practices of care was explored in Chapters Four and Five. These chapters also focused on how assembling the problem of chronic illness in terms of individual freedom, choice and responsibility opened up spaces for programmatic solutions like HealthOne Camara's integrated care. This program promoted individual choice, lifestyle and responsibility as key to addressing individuals' chronic illness. This approach also emphasised the emerging role of governments as facilitators of individual's improvement: "Governments must take action to nudge people towards health-promoting behaviour through better information, evidence based prevention and health promotion programs" (National Health and Hospitals Reform Commission 2009, p. 62). The analysis presented in Chapters Four and Five emphasises the ways in which integrated care programs like HealthOne govern populations of chronically ill citizens through pedagogical techniques and, in doing so, focus on the client's ability to self-manage, rather than on specific medical conditions.

The empirical analysis of HealthOne Camara's integrated care in Chapters Five and Six traced how the care unfolded between the local expert (the GPLN) and the clients observed. Multiple spaces of care opened up as the GPLN gave advice, information and support to these clients. This integrated care (re)produced the program's logic to promote the individual client's abilities to self-govern. In these chapters, these spaces of care were rethought as spaces of governing—multiple opportunities for the client to take up the information and support they were offered and to integrate this into their decision making and life. This empirical analysis identified consistencies and patterns in the discourses and practices of HealthOne Camara's integrated care, which both opened up these spaces and gave them a particular order.

The notion of heterotopia (Foucault 2000a) was used in Chapter Six to analyse these consistencies and patterns and to highlight how these clients contested, negotiated and resisted power relations. The analysis and discussion presented in Chapter Six also drew out the effects such contestation and negotiation can have on the 'choice-making' of the individual.

Drawing together this documentary and empirical analysis of chronic illness and integrated care in HealthOne Camara highlights how a governmentality perspective can open up different ways of thinking about the complexities of chronic illness. By considering the problematisation of chronic illness, and the programmatic 'solution' offered through HealthOne Camara, this study has shown how chronic illness has been assembled as a problem of self-governing and responsibility. Programmatic solutions, such as HealthOne Camara, seek to address this problem through programs of integrated care, which work to educate the individual about how to manage their own chronic illness in ways that are seen to be responsible and cost effective. This way of thinking highlights the strength of neoliberal rationalities of choice and freedom that frame these understandings of chronic illness and integrated care. Importantly, taking up a governmentality perspective in this study highlights how such problematisations are not marked by a beginning or ending, as such, but, rather, emerge slowly over long periods of time, through the ongoing interplay of social, political, economic and scientific factors. These insights are a valuable contribution to dominant evaluative and descriptive studies of primary health care programs such as HealthOne (Mallitt et al. 2016; McNab, Mallitt & Gillespie 2013; McNab et al. 2016).

Contribution to the field of primary health care

As argued previously, by questioning the assumptions and ways of thinking reproduced through the contemporary problematisation of chronic illness, this study offers a number of key insights to the field of primary health care. First, it offers an empirical study of the translation of integrated care, from its naming in policy to its enactment, in the daily practices of HealthOne Camara. Second, taking up the analytic perspective of governmentality offers critical and reflexive insight into how chronic illness and integrated care have been assembled as problems and programmatic solutions. Finally, this work offers a unique spatial analysis to the field of primary health care research that collates on empirical and documentary analysis and introduces the notion of heterotopia (Foucault 2000) to the field.

An empirical study of the enactment of integrated care

This research contributes a rich empirical study to the field of primary health care through analysis of the translation of integrated care, from its naming in health policy texts to its enactment in the homes of clients in HealthOne Camara. As was argued in Chapter One, dominant research approaches within the field of primary health care focus on the evaluation and description of what integrated care is and how it can be achieved in terms of restructures and the reform of processes (Valentijn et al. 2015). The dominance of these instrumental and process-driven approaches emphasises the need to find ways of working that can be evaluated, described and applied in different settings (Anderson 2011). In contrast, this study has traced how integrated care emerged as an approach to addressing chronic illness by developing the self-governing capacities of individuals. By using notions of assemblage (Li 2007) and translation (Rose 1999), this study has shown how HealthOne Camara's integrated care moved from its naming in policy texts to its enactment in the homes of clients through "fragile relays, contested locales and fissiparous affiliations" (Rose 1999, p. 51). Studying this translation of integrated care through documentary and empirical analysis highlights the complexity of contemporary understandings of chronic illness and the neoliberal economic rationalities that run through it.

Importantly, these insights highlight the ways in which dominant policy approaches to integrated care overlook the complexity and entanglement within notions of chronic illness. For example, integrated care in HealthOne aimed to reduce costs and rates of hospital admission among this group of chronically ill clients. The texts of HealthOne argued that these outcomes could be achieved by educating and advising people on how to improve their management of their own health care needs and, thus, become their own experts (see App. Two). HealthOne's practices of integrated care used education and information to analyse and improve the ability of the clients to manage their own health and life. However, as this analysis showed, *life* and chronic illness for Keith, Frances, Iris, Arthur, Maria and Clare were tightly bound together. Highlighting this complexity through critical and reflexive studies is an important addition to the knowledge generated through descriptive and evaluative research.

This study has shown that programs of integrated care like HealthOne that seek to work in linear, rational ways sit in tension with the complex 'problem' of chronic illness. Highlighting this tension is of value to the field of primary health care, as it opens up opportunities to rethink the "programmatic logic" (Rose & Miller 1992, p. 192) of integrated care. This also supports the argument made by others (Solomon et al. 2009; Unger et al. 2011) that complex and well-theorised research that goes beyond description and evaluation is needed. As demonstrated in this study, the integration of empirical and documentary analysis can pick up on the "messiness" (Sandberg et al. 2016, p. 117) of everyday enactments of practices of integrated care: "tracing their twists, turns, and localized effects" (Peck & Theodore 2010, p. 173). These insights emphasise the importance of critical and reflexive research. This type of research can question the close relationships between health care policy, funding and research topics, and extends the knowledge generated through these often atheoretical studies, to consider what the localised effects of such policies and programs may be. The analytic utility of a governmentality perspective frames the second key contribution this study makes to the field of primary health care.

Using governmentality to rethink chronic illness and integrated care

This study further contributes to the field of primary health care by taking up an analytical approach that is uncommon within the field of primary health care. As was discussed in Chapters One and Two, Foucault's governmentality perspective asks different questions to those of the evaluative and instrumental research approaches, which dominate the field of primary health care. Rather than asking what chronic illness *is* in medical terms, this analysis has considered *how* chronic illness has been assembled as a type of problem that can be managed through 'solutions' such as integrated care and HealthOne. When reconsidered in this way, the problematisation of chronic illness indicates shifts in thinking about the optimisation of life through responsibility and self-governing. Rethinking chronic illness in this way provides an opportunity for critical and reflexive analysis of how HealthOne's program of integrated care assembled its clients in ways that reproduced these discourses of health and responsibility. This analytic perspective, and the integration of documentary and empirical analysis, is a unique contribution to primary health care research.

A governmentality perspective provides insights into how contemporary understandings of chronic illness are assembled through knowledge from the diverse fields of epidemiology, medicine and demographics and woven with neoliberal political and economic rationalities into current understandings of chronic illness. This knowledge is (re)produced through discourses of health and responsibility that assemble chronic illness as an issue of lifestyle and self-governing. Problematising chronic illness opens up a space to assemble programmatic solutions such as integrated care and HealthOne, which emphasise techniques in which *clients* take responsibility for self-governing their chronic illness. This study offers knowledge, drawn from empirical research, into how integrated care uses technologies and techniques to translate this way of thinking into everyday practices of care. These patterns and consistencies can be seen within the policy texts analysed in this study, as well as in the everyday practices of care observed in HealthOne Camara. Significantly, and as was noted in Chapter One, the close relations between primary health care policy priorities and dominant research topics and approaches (Kalucy 2012; Unger et al. 2011) work to (re)produce particular 'truths' and ways of thinking.

By using a governmentality perspective, this study makes an important contribution to the field of primary health care, by highlighting how HealthOne's integrated care assembled the clients as self-governing. HealthOne's technologies of integrated care worked as instruments of regulation by (re)producing neoliberal rationalities of choice, self-governing and cost minimisation. The focus on responsibilisation and individualisation (Glasgow & Schrecker 2015) highlighted within HealthOne Camara's integrated care resonated with more general approaches taken within health promotion programs. Although the clients of HealthOne Camara would never be physically *healthy*, they could still aspire to be responsible, and to optimise their health and care management by demonstrating a "reflexive prudence" (Trnka & Trundle 2014) in their decision making that integrated multiple demands and sources of information.

Rethinking integrated care in this way makes explicit the rationalities embedded within contemporary understandings of chronic illness and integrated care. This knowledge is of value to the field of primary health care, as it questions the dominant approaches to integrated care that reproduce the ‘truth’ that integrated care promotes a sort of autonomy and responsibility that is *good* for the individual and the community. Importantly, it also questions the assumption embedded within these programs that *good choices* can be *easy choices* for individuals. Highlighting the relays and connections that made up HealthOne Camara’s integrated care showed the contestation, negotiation and resistance within daily practices of care. Highlighting these complexities is important in relation to considering the effectiveness of recent reforms to policy and care services. As discussed in Chapter One, despite decades of investment and reform, rates of chronic illness and the associated costs have continued to rise. Although evaluative and process-driven research can make and measure such failings, by rethinking chronic illness and integrated care this study has identified the fragility of the connections and relays that make up such care practices. The fragility of these relays and connections draws out the multiplicity of points and moments in which integrated care can be disrupted. As was shown in this study, HealthOne Camara’s integrated care responded to disruption by taking up disciplinary practices while simultaneously drawing on discourses of choice and responsibility.

The knowledge generated by rethinking chronic illness and integrated care in this way has significant implications for primary health care policy makers and practitioners. It is of relevance to policy makers, as it highlights the complexity within the very idea of integrated care itself. Policies and programs of integrated care present cohesive plans, ideas and ways of teaching and educating individuals to make ‘good’ and responsible decisions in relation to their health and care. As shown within the analysis of HealthOne, local practitioners are positioned at the interface with clients and, through daily practices of care, work in ways that are consistent with the rationalities embedded within the program itself. As these plans and practices unfold, they are subject to constant revision and negotiation rather than the cohesion and linearity depicted in policy. The fragility of the relays and connections revealed through the analysis of the translation of integrated care open up a way of thinking about why, despite decades of reform and investment, rates and costs of chronic illness continue to rise. This study has exposed the fragility and complexity of integrated care as it unfolds through constant revision and negotiation rather than in the linear, cohesive way that is predicted in policy. Identifying this tension, and the multiplicity of points at which integrated care can be disrupted, presents a more complex view of the limitations of policy-led reform that aims to achieve change through translation into everyday practices of care.

Analysing spaces of integrated care using heterotopia

This study contributes a unique spatial analysis of integrated care to the field of primary health care, by taking up Foucault's notion of heterotopia (Foucault 2000a). Identifying the multiple and connected spaces of HealthOne's integrated care as heterotopias shifts the focus from *what* integrated care is to the analysis of *how* this care was assembled as a space of governing. The analytic value of introducing heterotopia to the empirical study of primary health care and integrated care lies in its capacity to analyse the connections between the multiple spaces of care in which clients are assembled as potentially self-governing. As has been argued throughout this thesis, as chronic illness has come to be understood as a problem of lifestyle and choice, care has been reconfigured through neoliberal discourses of risk and responsibility, and relocated from the hospital and clinic to the community and, increasingly, the domestic space of the home. This spatial analysis drew out a complexity and ambiguity that is absent from the dominant approaches taken to the study of integrated care, which focus on structures and processes (Goodwin et al. 2014; Valentijn et al. 2013; Valentijn et al. 2015). Additionally, space as an analytic remains underutilised in primary health care research (Kitto et al. 2013), and this study contributes to developing this area of work.

This spatial analysis further emphasises how integrated care unfolds through ongoing negotiation and revision across multiple spaces of governing. Rethinking integrated care in this way highlights the complex and moving relations which connect experts and clients in care that unfolds across dispersed sites, places and people. These insights are of significance to the field of primary health care as international reform initiatives seek to address the problem of chronic illness through models of care that move away from the institution of the hospital or clinic and into the homes and lives of clients and their support networks. As discussed in Chapter One, reforms outlined in policy texts from Canada, New Zealand the UK and Australia have shifted the work of care across multiple sites as well as into the virtual, through initiatives such as tele-health, electronic health records and digital health initiatives (Lupton 2013, 2015). These reforms suggest not only a shift in the physical location and enactment of care but also changing ideas of what care for chronic illness entails. As the research has highlighted, local experts, like the HealthOne GPLN, are assembled as coaches, facilitators, mediators and conduits of care, as they act as the interface between policies of care and clients who are active and integrated into their own care. This study has argued that these linkages were made in the spaces in which technologies of integrated care sought to develop the self-governing abilities of the client through surveillance, education, information giving and advice. Rethinking integrated care as a space of governing highlights the complex technologies of integrated care that have, and are continuing to, reconfigured the relations that connect 'experts' and clients.

This analysis of heterotopias of integrated care has also opened up a way of thinking about how these spaces worked to include and exclude people, the processes of entry and exit and the order of the relations which structured these spaces (Elm-Larsen 2006; Foucault 2000a; Sandberg et al. 2016). The analysis of these processes of entry and exit drew out the influence of neoliberal political and economic rationalities that ordered the heterotopia through practices that worked to enhance self-governing. Openings to these heterotopias emerged through processes of referral, but also in more subtle ways, such as the moments in which the client was suddenly prompted to demonstrate their responsibility. Taking up the notion of heterotopia offered a way of thinking about these multiple spaces of care in which clients were governed—spaces that cannot be seen and that are not connected to physical sites like the hospital or the prison. Spaces that are, instead, configurations of the relations through which power is enacted and contested. This rethinking of integrated care, as multiple and connected spaces of governing, suggests that chronic illness becomes an ongoing process of self-governing.

Extending the contribution of this study: future directions for research

The insights into the complexities of integrated care and chronic illness provided by this study can be usefully extended in a number of ways. Two important opportunities for future research are discussed below. These draw on the acknowledgement that, as ideas of care continue to develop and change, the jobs of health care practitioners will diversify and new spaces and practices of care will open up and diversify further.

Reconfiguring practices of primary health care practitioners

This study has focused on the subjectivities, techniques and technologies of HealthOne Camara's integrated care that have emerged from recent Australian policy reform. This analysis and the insights derived from it could be extended further by focusing on how the care work of practitioners such as the GPLN functions as a *conduit* between programs of health care and technologies of governing. Such research would be timely as international health care policies continue to introduce new and different practices aimed at promoting self-management and integrated care. As discussed in Chapter One, similar patterns of reform are evident in policy from Canada, New Zealand and the UK. Primary health care programs derived from this reform have seen the introduction of new primary health care practitioners, such as integration nurses (Hutchison et al. 2011), care navigators, 'expert patient' tutors and trainers (Glasgow 2012), and support workers such as the *kaitautoko* (Carswell 2015). The introduction of such workers acknowledges that the integration of care and the balance of life and chronic illness is complex and requires often individualised support (Jeon et al. 2010). The significance of these practitioners is acknowledged within existing research within the field of primary health care (Mallitt et al. 2016; McAdam 2015; McNab et al. 2016; Struijs, Drewes & Stein 2015). Liaison practitioners have been the subject of research in the fields of mental health and acute care (Van der Watt 2010), but as noted by McNab et al (2016), little is known about the work of such practitioners in primary health care. Recent studies have focused on the description and qualitative evaluation of the impact of such practitioners (Carswell 2015; Goodwin 2015; Kelly et al. 2015; McNab et al. 2016). However, as has been demonstrated, critical and reflexive research approaches are an important and complementary addition to the field of primary health care, as the knowledge opens up space to ask questions about the effects and implications of contemporary attempts to govern.

Governmentality has been taken up in related health and care fields to analyse subjectivities such as family practice nurses (Thompson 2008) and specialist nurses in mental health and prison services (Holmes 2005; Perron, Fluet & Holmes 2005). These studies have provided useful insights into how nursing care has contributed to social regulation in often unexpected ways (Perron, Fluet & Holmes 2005). Taking up a governmentality perspective in the future study of new types of primary health care practitioners opens up ways of exploring in detail the complexities of the practices that support integrated and patient-centred care. Such research is internationally relevant as ongoing policy-led reform introduces such job functions as an important elements of helping people become "activated patients" (Dawda et al. 2015) ,yet the practices of such care remain under theorised in the primary health care field (Connell & Walton-Roberts 2016).

Well theorised research into the practices associated with these emerging models of 'care' has implications for both policy-makers and practitioners. This type of research can generate knowledge about how the subjectivities of 'expert' practitioners are shaped through training and education and how they, in turn, (re)produce the "programmatic logic" (Rose & Miller 1992, p. 190) embedded within integrated care initiatives in everyday practices. That is, if programs of integrated care 'train' practitioners through discourses of responsibility and cost effectiveness, how is this (re)produced within everyday 'care' practices? What consistencies and patterns can be discerned across sites and programs? The continued emphasis on crisis, escalating costs and the importance of personal responsibility underscores the need to examine what "unintended effects" (Elm-Larsen 2005, p. 82) such approaches to 'care' may have. Everyday practices of care provide an important 'site' for such analysis.

Extending and diversifying the analysis of spaces of care: e-health and virtual health care

Along with further consideration of the reconfiguration of care practices, future research could usefully extend this study's spatial analysis of integrated care. As has been demonstrated through the use of heterotopia (Foucault 2000a), rethinking care as a space of governing assembled by particular rationalities contributes to new and different theorisations of care. Further spatial analysis of integrated care is important, as self-management of health increasingly incorporates tools derived from e-health initiatives. Although e-health is a broad category (Oh et al. 2005), notable developments across countries relate to tele-health, electronic health records and health informatics (Jolly 2011). E-health initiatives are connected to objectives of enhanced safety, cost efficiency and clinical effectiveness (Gaby & Henman 2004). E-health has been described as emerging from the interface between "medical informatics, public health and business….not only a technical development, but also a state-of-mind, a way of thinking, an attitude" (Eysenbach 2001, p. 1). Just as policies of deinstitutionalisation moved care into new domestic spaces (Milligan 2000), e-health initiatives such as patient controlled electronic health records and web-based information and advice have moved some practices of care into *virtual* spaces. Within such virtual spaces, clients and consumers can access, monitor and distribute information about their health and care in new and different ways. The significance of the digitisation of health promotion has been highlighted in recent studies (Lupton 2013, 2015), which have demonstrated how electronic and technological innovations create new and different ways of self-monitoring. Writers have noted the impact e-health has on traditional expert–patient relationships as professional autonomy and authority are challenged (Gaby & Henman 2004) in new ways, but limited work has focused on how practices of care unfold in virtual spaces. Research into the new and different spaces of integrated care would offer an important opportunity to ask questions about how e-health initiatives are reconfiguring care itself and the implications this has on the practices of practitioners and clients.

Various e-health initiatives would be appropriate for extending the spatial analysis of this study into virtual spaces of integrated care. For example, recent policy reform in Australia has introduced personally-controlled e-health records and web based service delivery for GPs (Australian Health Ministers Conference 2008; Australian Medical Association 2010; Department of Health 2013; Department of Health and Ageing 2010). New Zealand's *Better, Sooner, More Convenient Health Care in the Community* policy gave examples of self-care in patients checking their own weight and blood pressure and accessing test results and prescriptions on the internet (Ministry of Health 2011). E-health developments including health records, prescribing and appointment scheduling have also featured in recent health care policy in Canada and the UK (Burns 1998; Protti 2008; Van Dijk, De Vries & Bell 2011).

As has been argued, the practices of integrated care are complex and difficult to describe and measure (Dawda et al. 2015; Shaw, Rosen & Rumbold 2011; Struijs, Drewes & Stein 2015). Rethinking care as spaces of governing offers a way of discussing and describing practices of care in ways that are complex and insightful. In-depth spatial analysis of virtual spaces of care would provide important opportunities to think about the practices involved in taking up such offers of care—how this is facilitated and how power relations shift and change as this care progresses. These are vital considerations at a time when health inequalities continue to rise. As has been shown in this study, programs that reconfigure spaces of care open up opportunities for both inclusion and exclusion. It is imperative to consider which individuals and populations may be unable or unwilling to enter into these virtual spaces of care, and what the implications may be.

Concluding comments

This study has highlighted the tensions and complexities of the practices that connect chronic illness and integrated care. The analysis of this tension has opened up a new way of thinking about integrated care as an attempt to govern the self-knowledge and self-governing abilities of people in ways that promote the individual's ability to self-manage the costs and burdens of their care. However, as was shown through in-depth analysis, attempting to work in this linear way elided the complexity of life itself. By exploring such complexity, this work and its contributions to the field of primary health care draw on both the critical and optimistic nature of Foucault's approach, which he described as 'critical ontology':

> The critical ontology of ourselves has to be considered not, certainly, as a theory, a doctrine, nor even as a permanent body of knowledge that is accumulating; it has to be conceived as an attitude, an ethos, a philosophical life in which the critique of what we are, is at one and the same time the historical analysis of the limits that are imposed on us and an experiment with the possibility of going beyond them (Foucault 2003d, p. 56).

Such an attitude and ethos is significant at a time in which the crisis and burden of chronic illness is repeatedly emphasised in the public and political media. As the profile of and political concern for health and illness continues to rise, it is imperative that research asks questions to challenge the self-evidence of the problems presented as well as the programmatic solutions assembled.

The *Remaking Practices* project (Solomon et al. 2009, p. 2) argued that the significance of the need for innovative research approaches was emphasised by the consideration of "what is at stake, that is, a sustainable health care system that will provide quality health care for its population". This drive for improvement is repeated throughout the extensive body of policy and research associated with primary health care. So, too, is the acknowledgement that, despite investment and reform, impact on costs and outcomes remains limited. This study makes a significant contribution to the field of primary health care, by demonstrating the important contribution of critical and reflexive research that asks questions about how contemporary configurations of care unfold through the complex lives of real people.

Appendices

Appendix One: Information and Consent Forms

PO Box 123, Broadway, 2007
UTS HREC Ref No 2011-029R

CLINICIAN INFORMATION STATEMENT

Remaking practices: learning to meet the challenge of practice change in primary health care

You are invited to participate in a study about the development of an innovative primary health care service, *HealthOne NSW,* an initiative of the NSW Health Department. This Australian Research Council funded project will research the remaking of health service and professional practices in two *HealthOne NSW* sites. The research team will work closely with *HealthOne NSW* staff and stakeholders to develop new understandings and practical insights about how health professionals from different professional backgrounds work with each other, with patients, and with other stakeholders to achieve the aims of *HealthOne NSW*. The research will add significantly to understandings of how service innovation and change is accomplished in local workplace settings. The research findings will be useful in policy development, service redesign, workforce development and professional learning and development.

Research aims are:

1. To produce detailed descriptions and analysis of how innovation is negotiated and achieved in the two *HealthOne NSW sites*
2. To develop learning activities and service improvement resources that will be utilized during the research
3. To investigate the role and possibilities of existing and emerging technologies, in particular, information and communication technologies, in shaping professional practice and change
4. To contribute to the development of more adequate understandings of learning and change in the area of health service redesign.

There are a number of ways in which you can participate. You can nominate your areas of participation on the consent form:

1. Participate in an interview about your experiences in working within the *HealthOne NSW* initiative. In particular, you will be asked to reflect on key questions of interest, in particular how practices have changed and what learning has occurred. During the interview you may choose to use visual representations to aid discussion.
2. Participate by being shadowed during parts of your working day. We are interested in understanding the daily practices of *HealthOne NSW* staff.
3. Participate in the recording of key staff meetings where clinical or service development matters are discussed.
4. Participate by recording key events using written or digital diaries.

5. Participate in the audio or video recording of some your consultations with patients.

Members of the research team will conduct the interviews, focus groups, recordings and collaborative review groups.

We cannot guarantee that you personally will receive any benefits from this study, but the study does aim to improve the safety and quality of patient care in the health system.

Voluntary participation:
It is important for you to know that your choice to participate is entirely a matter for you. You are not required to participate unless you wish to do so. You are free to withdraw your participation from this research at any time without giving a reason. Such withdrawal will not affect your current or future relationships with the health service. If you have any difficulty or concerns about the research you can contact Professor Nicky Solomon (9514 1334). Professor Solomon is the Chief Investigator in this research.
If you are being recorded and wish the recorder to be turned off, you can ask for this to happen without any reason being given.

Confidentiality:
Any information about you that is obtained in connection with this study will remain confidential. Data gathered from the interviews and from the recording of interactions will be used for publication, training, workforce, doctoral research purposes and professional development purposes. When such data is used it will be completely de-identified. The names of patients, clinicians and health services will be removed from all reports and publications.

All information obtained in the course of this research will be securely maintained in accordance with university data security policies, and will not be made available to anyone outside the research team, unless this is required by law.

Financial and in-kind support to cover the costs of carrying out this study is being provided by the Australian Research Council; the University of Technology, Sydney; and NSW Health.

You will be given a copy of this form to keep.

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0309.

The conduct of this study at HealthOne ***Camara*** has been authorised by the Western Sydney Local Health Network. Any person with concerns or complaints about the conduct of this study may also contact The Secretary, WSLHN Human Research Ethics Committee (Westmead Campus) Telephone No 9845 8183 or email researchoffice@swahs.health.nsw.gov.au and quote SSA reference SSA/11/WMEAD/105.

NSW GOVERNMENT Health Western Sydney Local Health Network

UNIVERSITY OF TECHNOLOGY SYDNEY

PO Box 123, Broadway, 2007
UTS HREC Ref No 2011-029R

PATIENT INFORMATION STATEMENT

Remaking practices: learning to meet the challenge of practice change in primary health care

You are invited to participate in a study about the development of an innovative primary health care service, *HealthOne NSW,* an initiative of the NSW Health Department.

HealthOne NSW aims to support different groups of health professionals – doctors, nurses and allied health professionals – to work more closely with each other and with patients to deliver high quality health care that is effective and sustainable. *HealthOne NSW* is particularly interested in delivering services in partnership with patients and the local community.

Talking to patients is a critical component of understanding how *HealthOne NSW* services are developing.

The purpose of the research is not to evaluate *HealthOne NSW*, rather we are interested in understanding how *HealthOne NSW* has developed and ways in which it is different from other health services. To hear about your views and experiences will help us in understanding these matters and will assist with the development of improved health care services in NSW and nationally.

Your participation in this research would be greatly appreciated.

There are three ways in which you can participate in the study – you can nominate one or more of these ways in the consent form:

1. Participating in one or two interviews about your experiences in attending *HealthOne NSW* services. The interviews will last approximately 30 minutes and will be conducted in a private space at *HealthOne NSW*. We will also ask if you are agreeable to having your interview recorded and transcribed. The interviews will involve the researcher asking you a few questions about your experiences of *HealthOne NSW*. You will also have the opportunity to participate in some simple activities in which you can construct pictures of your experiences. You may also choose to take some photographs of things or places that you would like to use to discuss your health care experiences.
2. Having your consultation with a HealthOne NSW clinician audio or video recorded.
3. Participating in a small focus group for patients discussing their experiences of HealthOne NSW.

Members of the research team will conduct the interviews and recordings. If you are being recorded and wish the recorder to be turned off, you can ask for this to happen without any reason being given.

We cannot guarantee that you personally will receive any benefits from this study, but the study does aim to improve the safety and quality of patient care in the health system.

Voluntary participation:
It is important for you to know that your choice to participate is entirely a matter for you. You are not required to participate unless you wish to do so. You are free to withdraw your participation from this research at any time without giving a reason. Such withdrawal will not affect your current or future relationships with the health service. If you have any difficulty or concerns about the research you can contact Professor Nicky Solomon (9514 1334). Professor Solomon is the Chief Investigator in this research.

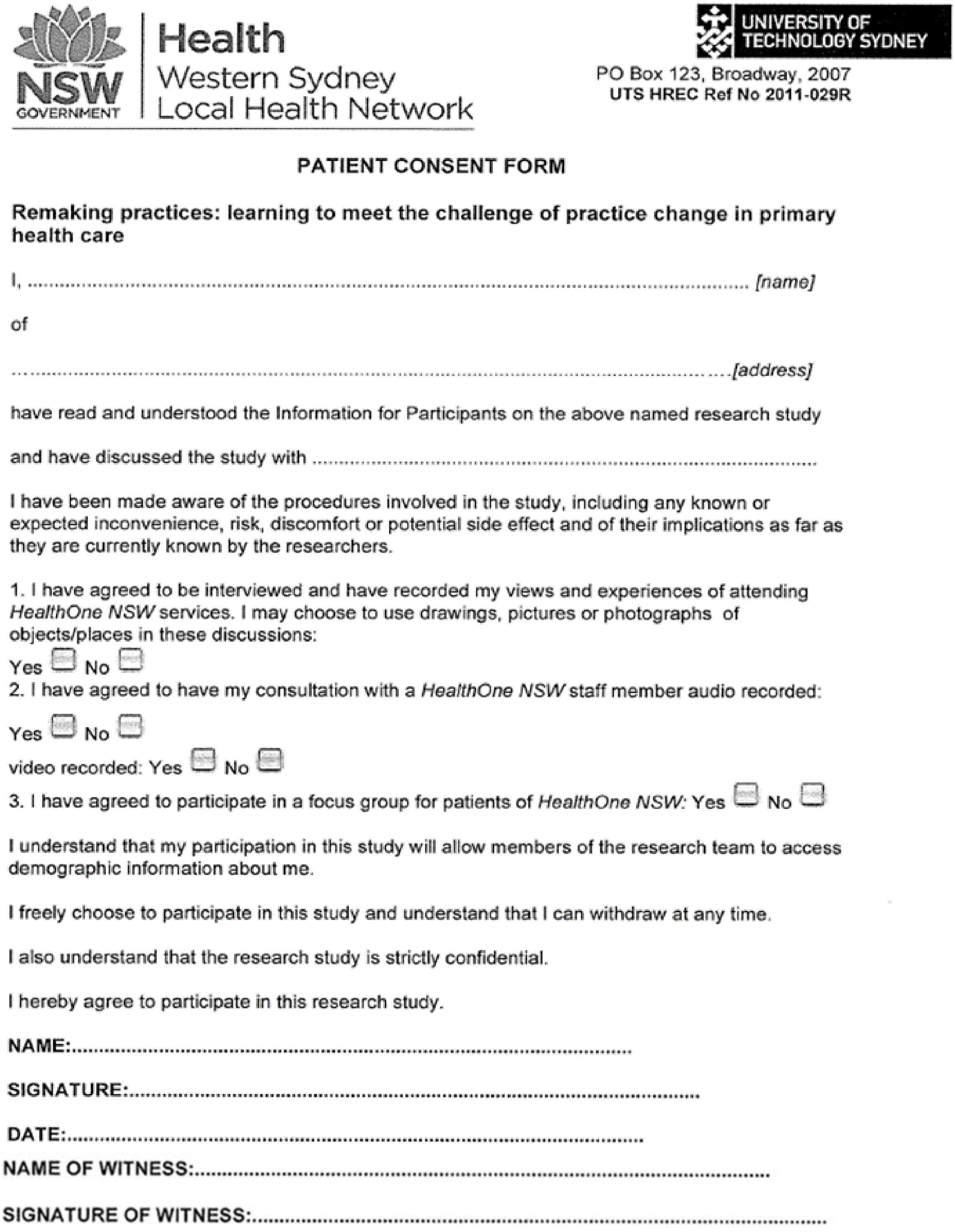
Confidentiality:
Any information about you that is obtained in connection with this study will remain confidential. Data gathered from the interviews and from the recording of interactions will be used for publication, training, workforce, doctoral research purposes and professional development purposes. When such data is used it will be completely de-identified. The names of patients, clinicians and health services will be removed from all reports and publications.

Financial and in-kind support to cover the costs of carrying out this study is being provided by the Australian Research Council; the University of Technology, Sydney; and NSW Health.

You will be given a copy of this form to keep.

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0309.

The conduct of this study at HealthOne ***Camara*** has been authorised by the Western Sydney Local Health Network. Any person with concerns or complaints about the conduct of this study may also contact Ms Jillian Gwynne Lewis, Westmead Hospital Patient Representative, (Contact details: Telephone No 9845 7014 Email address: jillian.lewis@swahs.health.nsw.gov.au) and quote SSA reference SSA/11/WMEAD/105



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UTS HREC Ref No 2011-029R

PATIENT CONSENT FORM

Remaking practices: learning to meet the challenge of practice change in primary health care

I, ... *[name]*

of

.... *[address]*

have read and understood the Information for Participants on the above named research study

and have discussed the study with ....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

1. I have agreed to be interviewed and have recorded my views and experiences of attending *HealthOne NSW* services. I may choose to use drawings, pictures or photographs of objects/places in these discussions:
Yes ☐ No ☐
2. I have agreed to have my consultation with a *HealthOne NSW* staff member audio recorded:
Yes ☐ No ☐
video recorded: Yes ☐ No ☐
3. I have agreed to participate in a focus group for patients of *HealthOne NSW:* Yes ☐ No ☐

I understand that my participation in this study will allow members of the research team to access demographic information about me.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME:..

SIGNATURE:..

DATE:..

NAME OF WITNESS:..

SIGNATURE OF WITNESS:..

Health
Western Sydney
Local Health Network

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PO Box 123, Broadway, 2007
UTS HREC Ref No 2011-029R

CLINICIAN CONSENT FORM

REMAKING PRACTICES: LEARNING TO MEET THE CHALLENGE OF PRACTICE CHANGE IN PRIMARY HEALTH CARE

I, ...*[name]*

of

....*[address]*

have read and understood the Information for Participants on the above named research study
and have discussed the study with

....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

- I have agreed to be interviewed about my experiences in working within the *HealthOne NSW* initiative. I may choose to use drawings, pictures or photographs of places/objects to aid discussion: Yes ☐ No ☐
- I have agreed to be shadowed during parts of my working day Yes ☐ No ☐
- I have agreed to participate in staff meetings that will be audio or video recorded Yes ☐ No ☐
- I have agreed to record key events using a written or digital diary Yes ☐ No ☐
- I have agreed to participate in audio or video recorded consultations between *HealthOne NSW* clinicians and patients Yes ☐ No ☐

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

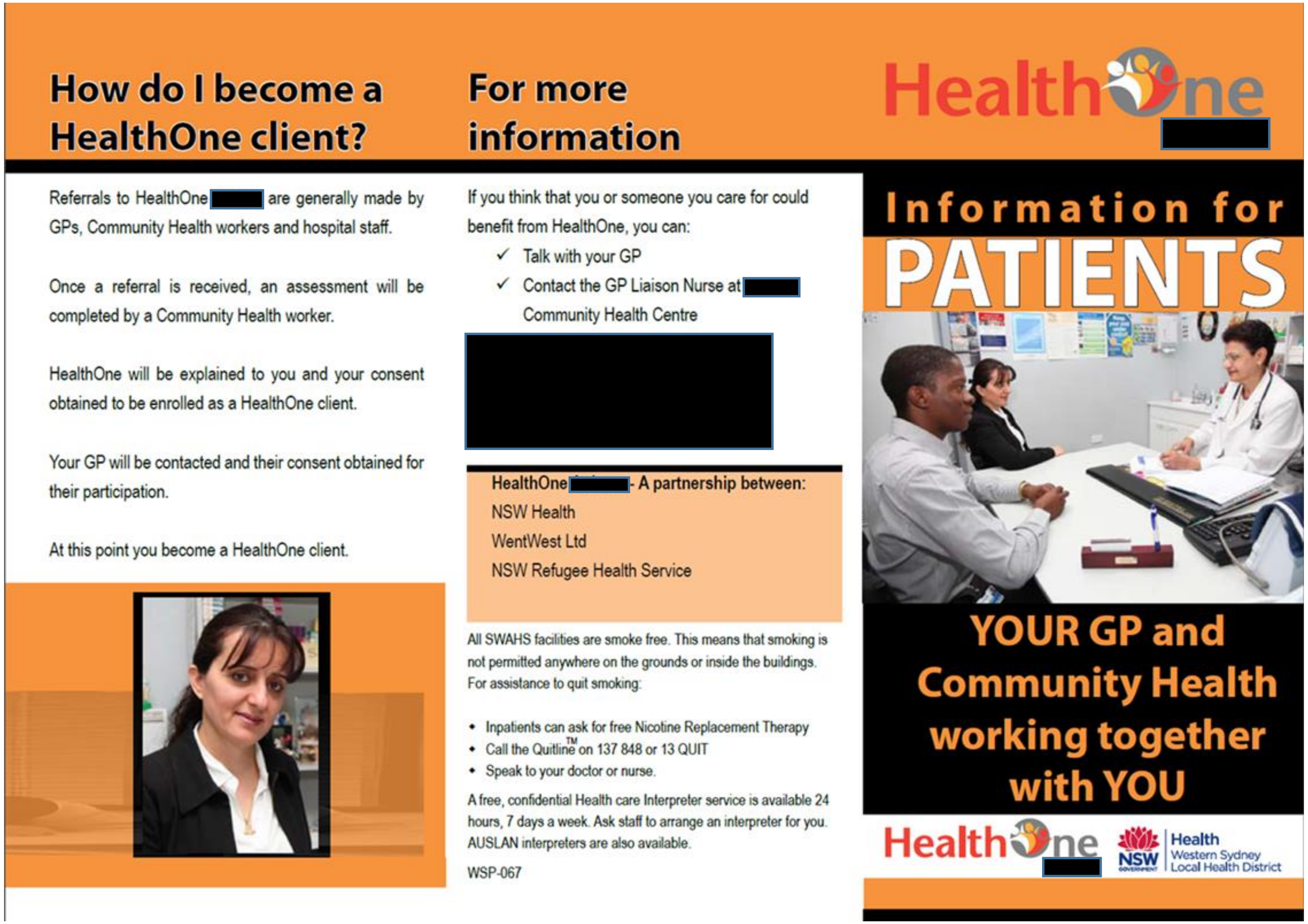
NAME:..

SIGNATURE:..
DATE:..

NAME OF WITNESS:..

SIGNATURE OF WITNESS:..

Appendix Two: *HealthOne Camara: Information for Patients* Brochure



How do I become a HealthOne client?

Referrals to HealthOne [redacted] are generally made by GPs, Community Health workers and hospital staff.

Once a referral is received, an assessment will be completed by a Community Health worker.

HealthOne will be explained to you and your consent obtained to be enrolled as a HealthOne client.

Your GP will be contacted and their consent obtained for their participation.

At this point you become a HealthOne client.

For more information

If you think that you or someone you care for could benefit from HealthOne, you can:

- ✓ Talk with your GP
- ✓ Contact the GP Liaison Nurse at [redacted] Community Health Centre

[redacted]

HealthOne [redacted] - A partnership between:

NSW Health
WentWest Ltd
NSW Refugee Health Service

All SWAHS facilities are smoke free. This means that smoking is not permitted anywhere on the grounds or inside the buildings. For assistance to quit smoking:

- Inpatients can ask for free Nicotine Replacement Therapy
- Call the Quitline™ on 137 848 or 13 QUIT
- Speak to your doctor or nurse.

A free, confidential Health care Interpreter service is available 24 hours, 7 days a week. Ask staff to arrange an interpreter for you. AUSLAN interpreters are also available.

WSP-067

HealthOne [redacted]

Information for PATIENTS

YOUR GP and Community Health working together with YOU

HealthOne [redacted]

NSW Health
Western Sydney Local Health District

What is HealthOne?

HealthOne is a NSW Health funded initiative that aims to improve your health and your access to health services.

HealthOne will ensure your Community Health Worker, your GP and other service providers involved in your care are working together in coordinating your health care.

HealthOne will also ensure that you have access to appropriate services to meet your health needs.

HealthOne will also assist you to manage your own health.

Who is HealthOne for?

HealthOne is for:

- ✓ People with complex health needs or chronic illnesses who are living at home

- ✓ People who are frail and elderly and living at home

- ✓ Refugees who:
  - ➢ are pregnant and need support
  - ➢ have young families (under the age of 3 years have priority)
  - ➢ young people with difficulties accessing health care
  - ➢ require coordinated health care

- ✓ Disadvantaged communities within the [redacted] area with specific health needs and/or limited access to health services.

What will HealthOne do?

HealthOne links together all the providers involved in your health care to:

- ✓ identify your health care needs
- ✓ identify other services that you may need to help you
- ✓ manage your health and your daily living needs
- ✓ share information about your care between providers (with your consent)
- ✓ coordinate health services that you need
- ✓ provide you with access to specialist clinics and services through HealthOne
- ✓ support you to monitor your own health and access services you might need to manage your changing health needs
- ✓ provide you with a single contact person to speak to about your health
- ✓ provide you with written information on your care for you to keep and show other providers who may not be part of HealthOne.

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