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Whose place is it anyway? Representational politics in a place-based health initiative

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ABSTRACT

The association between place and poor health, such as chronic disease, is well documented and in recent years has given rise to public health strategies such as place-based initiatives (PBIs). This article reports on the emergence of one such initiative in Australia, in regions identified as culturally diverse and socially disadvantaged. The study draws on the intellectual resources provided by governmentality and actor-network theory to provide insights into the reasons why community actors were excluded from a new governance body established to represent their interests. Risk-thinking and representational politics determined who represented whom in the PBI partnership. Paradoxically, actors representing 'community', identified as being 'at risk', were excluded from the partnership during its translation because they were also identified as being 'a risk'. As a consequence, contrary to federal government health and social policy in Australia, it was state government interests rather than the interests of community actors that influenced decisions made in relation to local health planning and the allocation of resources.

1. Introduction

1.1. Normalising place, partnerships and community

1.1.1. Place

Place as a possible determinant of health receives considerable attention in the health literature (Cummins et al., 2007; Kearns and Gesler, 1998; Klein, 2004; Larsen, 2007; Pearce, 2012; Popay et al., 2003; Popay et al., 2008; Reddel, 2002; Stead et al., 2001; Tabuchi et al., 2012; Thompson et al., 2007; Walsh, 2001). It appears at the nexus of economic discourses and discourses of inclusion, urban renewal and public health, and permeates policy pertaining to health, social equity, inclusion and urban development (Carey et al., 2012; Casey, 2003; Craig, 2003; Cummins, et al., 2007; Kearns, 1993; Keating and Hertzman, 1999; Klein, 2004; Petersen, 1996; Prince et al., 2006; Reddel, 2002; Rose, 1999; Walsh, 2001). In Australia, convergence between economic discourses and discourses of inclusion, urban renewal and public health has been concretised within health and social policy as 'Place-based initiatives' (PBIs), which, as the evidence presented in this article shows, have produced new 'spaces of contestation', 'conflicting logics' and 'political mobilisation' (Craig, 2003; Jessop, 1999; Lupton, 1995; Petersen, 1997; Petersen et al., 1996; Prince, et al., 2006; Reddel, 2002; Rose, 1999).

PBIs represent attempts by governments to address the complex interplay of issues impacting on the health and well-being of particular populations (Craig, 2003; Crawshaw et al., 2004; Crawshaw et al., 2003; Larsen, 2007; Marmot and Wilkinson, 2006; Prince, et al., 2006; Stewart, 2001). They have been described as managing 'a place' in such a way as to mitigate the multiple and interdependent problems afflicting specific areas or communities to achieve measurable outcomes and benefits for the people from communities living in particular settings (Kickbusch, 2003; Petersen, 1996; Walsh, 2001). They represent the 'governmentalisation of place' by rendering specific locales knowable, autonomous and governable though localised decision making and by creating responsibilised, regulated disciplinary fields of action using technologies of calculation, inscriptions and other socio-technical devices. These *techne* of government assist the emplacement of boundaries within which the socially excluded and those made responsible locally, are spatially united and confined, strategically and figuratively, through the use of statistics and other forms of representation (Barry et al., 1996; Craig, 2003; Lupton, 1995; Petersen, et al., 1996; Rose, 1999). The Australian Standard Geographical Classification (ASGC) and the Governance Models for Location Based Initiatives (Commonwealth of Australia, 2011) are examples of two such *techne*. For example, the ASGC enables Australian governments to compare and contrast one geographical region with another to establish whether they are at risk while the policy document Governance Models for Location Based Initiatives articulates governmental expectations relating to how 'a place' should be governed (Commonwealth of Australia, 2009b, 2011). For example, on page 26 of that document, it is stated, "A network approach proposes a shift in relationship from a purchaser–provider relationship to an arrangement where all parties in the network are co-producers". Australian governments emulate health and social policy trends elsewhere by

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adopting these *techne* (Walsh, 2001) and embracing the notion of 'place-basedness' which, as Castel (1984, p. 245) indicates, is not new.

> In the sixteenth century, public assistance was characterised by the development of the local initiatives based on the municipality, which attempted to take on the burden of all of its less fortunate subjects, on condition that they were under local jurisdiction. Municipal assistance claimed to be protection based on domicile, which attempted to maintain community links with inhabitants that poverty, lack of work, sickness or disability threatened to dislodge.

2. Partnerships

Another important constituent of PBIs are intersectoral partnerships. Intersectoral partnerships between providers of health and welfare services are integral to the implementation of PBIs in Australia and elsewhere, such as the United Kingdom and New Zealand (Craig, 2003; Crawshaw et al., 2004, 2003; Larner and Craig, 2005; Powell and Moon, 2001; Prince et al., 2006; Voyle and Simmons, 1999). Mandatory partnering was introduced into Australia during the late 1980s, signalling new ways of working and marked a shift in the delivery of public health measures. Intersectoral partnering brought together the range of public and private providers that were needed to respond to the complex issues impacting on particular populations in designated locales (Kickbusch, 2003; Lupton, 1995; Petersen, 1996, 1997; Petersen et al., 1996). Partnerships imply notions of efficiency by providing ways to diversify, secure and execute more prudent dissemination of increasingly scarce health resources. Partnering is underpinned by the assumption that more can be achieved by organisations working together than if they were to work alone. In health, the imperatives to partner are driven by the need to address multiple determinants of health, many of which reside outside the health care sector (Lin in Bloom, 2000; Kickbusch, 2003; Larsen, 2007; Peck and Tickell, 1994). Governmentalities under the influence of neo-liberalism encourage the deployment of technologies such as partnerships to manage the health risks associated with social disadvantage. These ensembles or 'centres of calculation' (Latour, 1987, 2007) assist in the identification of those at risk of poor health and are expected to fulfil the objectives of governments wanting to be seen as self-limiting, frugal and reflexive. The actors that make up these partnerships are the 'new risk managers' who must work within an environment of economic restraint to manage and 'make scarce' those perceived as being 'at risk' (and, by implication, also an economic risk). These heterogeneous, biopolitical networks or heterachies (Jessop, 2003) are comprised of 'experts' who are deputised by government through the dual process of autonomisation and responsibilisation to manage risk by conducting the conduct of others for their better health. In Australia, health partnerships have become integral to the efficacy of government and indispensable to government being able to 'govern at a distance' (Commonwealth of Australia, 2009b; Dean, 1999; Jessop, 2003; Lupton, 1995; Marinetto, 2003; Petersen et al., 1996; Rose, 1999; Schofield, 2002; Shamir, 2008).

3. Community

Community is another important constituent of PBIs. According to Rose (1999) communities provide additional fields of analysis and intervention that have become indispensable to neo-liberal governmentalities. Communities are objectified and instrumentalised to constitute new forms of authority upon which successful economic governments have come to rely for their localness, trust, collaboration and good governance (Lupton, 1995; Petersen, 1997; Rose, 1999). They are constructed within neo-liberal governmentalities as sites of veridiction and intervention which governments seek to mobilise and reference to establish whether governmental practices are correct or erroneous (Foucault, 2008; Rose, 1999). Rose (1999) describes community as being both the target and object of political power while at the same time remaining external to government and, sometimes, operating counter to it. 'Government through community' manifests wherever new opportunities and obligations are created through which economically disadvantaged or culturally diverse others are enlisted to challenge the basis of their exclusion or marginalisation. Importantly, participation is contingent upon citizens being able to aggregate and bond through a shared 'ethico-political identity' commonly referred to as 'community' (Crawshaw et al., 2004; Jayasuriya, 2006; Lupton, 1995; Petersen et al., 1996; Rose, 1999; Smedley, 2000). Voyle and Simmons (1999) provide a detailed account of a community development partnership between a health group and an urban Māori community in New Zealand. Key themes to emerge from their study were issues of trust following years of colonisation, prioritisation of health issues and establishing appropriate research paradigms. Voyle and Simmons (1999) recall how Māori partners eventually assumed control over the health promotion groups and programs but emphasised that the devolution of power had been critical to the success of the partnership.

4. Democratising health care: techniques of representation and popular participation

A growing reliance on intersectoral partnerships and the deputisation of communities can be seen in a range of key Australian health policy documents (Commonwealth of Australia, 2009a, 2009b, 2009d, 2011). Australian policy documents relating to health reform, primary health, prevention and social inclusion are replete with references to partnerships and community (Commonwealth of Australia, 2009a, 2009b, 2009c, 2009d). For example, in the report A Healthier Future for All Australians (Commonwealth of Australia, 2009b, p. 196), it is stated that, "The health system of the future needs to work at these multiple levels to promote health and wellbeing with many and varying agencies and partnerships". In the same report it was recommended that national health targets be developed through broad community consultation (Commonwealth of Australia, 2009b, p. 5). It also advocated that participation takes place at a regional level to enable communities to influence and shape the way local health services are delivered. These sentiments were echoed in the aforementioned document, Governance Models for Location Based Initiatives. It was recommended in this document that local engagement be driven by local governance structures in priority locations and include mechanisms for coordinating services and representing the community across all levels of government, including the non-profit and business sectors. The National Place Based Advisory Group operates as a sub-group of the Australian Social Inclusion Board. It is responsible for implementing a range of place-based initiatives in 10 Local Government Areas (LGAs) noted for their high rates of entrenched disadvantage, one of which is the object of this study. Significantly, the Advisory Group emphasised the importance of connecting social policy aspirations with on-the-ground service delivery and economic opportunity (Department of Human Services, 2011). Principles for place-based initiatives were articulated by the Australian Social Inclusion Board in 2011. Among these, was a call for "meaningful devolution of responsibility" to allow "significant and meaningful local involvement in determining issues and solutions". The importance of "capacity development at both the local level and in government", it