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

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.

Keywords: place, placeism, place-based initiative, health partnerships, representational politics, inclusion, governmentality, actor-network theory.
Introduction

Normalising place, partnerships and community

Place

Place as a possible determinant of health receives considerable attention in the health literature (Cummins, Curtis, Diez-Roux, & Macintyre, 2007; R. A. Kearns & Gesler, 1998; Klein, 2004; Larsen, 2007; Pearce, 2012; Popay et al., 2003; Popay, Williams, Thomas, & Gatrell, 2008; Reddel, 2002; Stead, MacAskill, MacKintosh, Reece, & Eadie, 2001; Tabuchi, Fukuhara, & Iso, 2012; Thompson, Pearce, & Barnett, 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, Riley, & Crammond, 2012; Casey, 2003; Craig, 2003; Cummins, et al., 2007; R. Kearns, 1993; Keating & Hertzman, 1999; Klein, 2004; Petersen, 1996; Prince, Kearns, & Craig, 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, Petersen, & Lupton, 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, Bunton, & Conway, 2004; Crawshaw, Bunton, & Gillen, 2003; Larsen, 2007; Marmot & 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, Osborne, & Rose, 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 adopting these techne (Walsh, 2001) and embracing the notion of ‘place-basedness’ which, as Castle (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.

**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; Crawshaw, et al., 2003; Larner & Craig, 2005; Powell & Moon, 2001; Prince, et al., 2006; Voyle & 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 & 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 ‘centers 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 heterarchies (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).

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 ‘ethopolitical 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.

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
It also advocated that participation take 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 ten 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 argued, would not be possible without greater devolution or community engagement (Commonwealth of Australia, 2011, p. 6 & 21).

A major challenge in delivering the above policy is Australia’s systems of government which has three tiers: federal, state and local governments. This complexity is compounded by the devolution of governmental responsibility to ‘ensembles’, such as PBI partnerships and community, to marketise primary health care while at the same time addressing the limits of ‘the market’ (Jessop, 2003). There is, as a result, a multitude of sites where the policy being translated in one locale may not be translated as intended into action in another. Representation is pivotal to the democratisation of health and social policy but, as Baker (2006, p. 155) suggests, it may pose an even greater challenge to the translation of policy into action. He asks,

Before we can even consider such key questions as whether representation is normatively defensible, how to effect representation, or the representativeness of our representatives, we need first to look, then, at whether subjects can be considered capable of representation at all.

The purpose of this article is to address this question by capturing some of the complexities of representational politics as they come to bear on the emergence of a new local system of governance. It explores the effects of local governance in terms whose interests are represented in the decisions made in relation to health planning and resource allocation. It takes as its example the translation of a PBI partnership in regions of Australia identified as culturally diverse and socially disadvantaged. This study contributes methodologically, epistemologically and empirically to a growing body of literature which provides ongoing scrutiny of the effects of government through place, partnerships and community (Craig, 2003; Crawshaw, et
This article is divided into three sections. The first section outlines the methodological and epistemological assumptions underpinning the study as well as the methods used. The second section summarises the policy context within which the PBI partnership emerged and recounts ‘performances’ from the ‘fields of action’ that took place during its emergence. In the final section, ‘diagnoses’ are used to frame partnership performances. The impact these performances had on democratising health care locally, by determining who represented whom and whose interests prevailed, are also discussed.

**Research Approach: epistemological and methodological assumptions**

The complementary intellectual resources available from within the governmentality and actor-network theory (ANT) literature enable researchers to explore and describe the specific socio-material relations contributing to how social entities emerge and are performed. They were used in combination because each addresses well documented shortcomings of the other (Rutland & Aylett, 2008). Neither is confounded by complexity and thus lend themselves to studies of complex social entities such as PBI partnerships (Law, 2004; Schostak & Schostak, 2008). Foucault’s conceptualisation of the *taxonomia* framed how this study was conducted using a new taxonomy called ‘governmentality in action’. Foucault (2002, p. 127) argued that scientists responded “to the difficulty of apprehending the network [or complexity]” by establishing a taxonomy. Microscopic observations and observed facts are interwoven with what was already known and what had yet to be known to render apparent the hidden and the confused (Foucault, 2002). This new taxonomy was made up of constructs and tropes that helped to mobilise the resources available within the governmentality and ANT literature. It was used to attune to, trace through and to amplify the socio-material relations comprising the PBI partnership. Themes derived empirically were integrated with those made available using the governmentality in action taxonomy to reveal what had yet to be known about the partnership.

Dean’s (1999) ‘analytics of government’ formed a major component of the taxonomy. Dean (1999) suggested that to conduct an analytics of government, researchers should explore how different locales and agents are brought into view, spatialised and identified and how they establish the relations of authority that determine who and what is to be governed and how these are connected and constituted in space. He also suggested examining the *techne* of government, such as the various mechanisms, procedures, instruments, techniques, technologies and vocabularies used to conduct conduct and impose limits on what can and cannot be done. Researchers are also encouraged to explore the specific ways of acting and forms the of knowledge, expertise, strategies and calculations employed through the conduct of conduct and how different entities,
routines, rituals and procedures are organised and re-organised and to what end. Finally, Dean (1999) suggests that researchers employ an analytics of government to explore the characteristic ways actors or agents are autonomised and responsibilised, including how individual and collective identities, status, capacities, attributes and orientations are assumed by those who are governed and those who are governing.

ANT extends the analytical power of governmentality by providing ways to trace through the situated relations of power-knowledge and to name the action in terms of its effects. The repository of schemes and tropes generated by governmentality and ANT studies were used as ‘reality amplifiers’, to enable the researcher to attune to and re-name, and thus render apparent, the various means by which conduct was conducted (Law, 2004; Mol, 2010). In contrast to other research approaches, ANT makes no distinction between agency and structure, people and things. Rather than creating discontinuity between the individual and aggregate, the trope ‘network’ is used to depict them as being coextensive and coconstitutive thus avoiding overly top-down or dualist analyses typical of studies that separate agency from structure. People and things are afforded equal importance during analysis. Network can be used figuratively to re-present the complex, interconnected, heterogeneous, material and non-material relations that are performed to hold networks together by way of translation. Translation is therefore an important construct within ANT. It is used to describe how meaning and action are invoked relationally across space and time and, as Rose and Miller (2010, p. 279) argued, is what enables governments to ‘govern at a distance’.

The relation between political rationalities and such programs of government is not one of derivation or determination but of translation – both a movement from one space to another, and an expression of a particular concern in another modality.

The trope ‘actor’ is used to connote people who interrelate to perform networks while ‘actant’ is used to connote the interactions between people and things that also help translate networks and both were participants in this study. Finally, devolution of governmental responsibility may occur by way of ‘obligatory passage points’ and ‘inscriptions’. Obligatory passage points and inscriptions are used to connote the actions that help to stabilise and normalise knowledge, and to facilitate the enrolment of actors into a network (i.e. the PBI partnership). They also facilitate the autonomisation and responsibilisation of actors by articulating the relations of authority and marking out specific areas of responsibility that determine who and what was to be governed (Dean, 1999).

Methods

This relatively small scale qualitative study formed part of larger participatory action research (PAR) project being conducted to evaluate the PBI partnership. Ethnographic techniques influenced by the ‘theoretical formal style’ described by van Maanen (1988) and those described by Latour (2007) and Law
(2004) were used to capture the complex ways in which the PBI partnership was enacted. When adapting these styles of ethnography to the practice research, the researcher typically places less emphasis on the observation of and engagement with participants drawing instead on a broad range of social material, as Latour (2007) pronounced, “Everything is data”. In this study, social material was aggregated from the following sources (Law, 2004).

- Transcripts of interviews and meetings with Board members, program leaders, the PBI manager, members of the research team¹ and other senior employees representing the state health department that had been generated by the research team as a whole.
- Observational notes taken during Board meetings, planning days, team building sessions and during interactions with members of the research team and PBI partnership.
- Research journal used as a log of inquiry that detailed reactions, associations and chronological ordering of events, and included ad libitum writing to ‘freeze’ moments, capture and record specific tropes and ideas and to report the effects of the research on participants (Latour, 2007).
- Ephemera, including documents and objects such as letters, meeting agendas, progress reports, surveys and information from previous surveys, interviews, proposals and submissions, expressions of interest, contracts, the strategic plan and member agreement, media releases, launches and promotions, digital media, such as websites, and archival records, such as past research proposals, submissions and business cases.
- International, state and federal health policy documents relevant to chronic disease, place-based initiatives, governance, health partnerships and health promotion.

**Rationale**

The research methodology and methods were devised for three reasons. The first, was to address shortcomings in the health partnership literature. Researchers of health partnerships have complained that this area of study lacks empirical and critical accounts and is under-theorised. The bespoke methodological approach was developed specifically to address these concerns. Unfortunately, this created new conundrums which takes us to the second reason for the chosen methodology and methods. Few studies have used governmentality and ANT in combination particularly in relation to health partnerships and those that have provide little insight into the methodological issues faced in trying to merge these approaches (Edwards & Nicoll, 2004, 2006; Lockie, 2002; Rutland & Aylett, 2008; Schofield, 2002). Here I sought to address this issue by articulating how governmentality and ANT were ‘applied’ to this field of study which led to the third reason for the chosen methods which included the integrated thematic analytic approach (ILTA). ILTA was developed to reconcile tensions created by combining social material produced empirically using ANT with that derived from existing theories. For example, key proponents of ANT advocate researchers assume a
radical empiricist approach by ‘building social theory from the ground up’, to avoid ‘premature closure on the social’ and insist that ANT is not a theory (Latour, 1987, 2007). However, others argue that it is impossible for researchers to relinquish entirely their theoretical commitments and that if theories remain implicit, then they too have the power to confuse or obscure and new insights may go unnoticed (Alderson, 1998; Charmaz, 2008; Chen, 1997; A. Clarke & Dawson, 1999; E. Clarke & Fujimura, 1992; Law, 2004; Mol, 2010; Pawson & Tilley, 1997; Timmermans & Tavory, 2012). ILTA allowed for themes, already theorised in the form of a ‘start list’ (i.e. the GIA taxonomy) to be combined with ‘ground-up’ development of codes from the human and non-human social material gathered empirically. Hence this discussion conforms with suggestions made by Timmermans and Tavory (2012) and Schostak and Schostak (2008) that; researchers describe the emergent nature of their research practice and the means by which they adopt a broad theoretical base to develop specific theoretical repertoires through the research processes they employ.

Some notes on validity, quality and rigour

The following techniques were adapted from Whittemore, et al (2001) and Holstein and Gubrium (2011) to promote validity, quality and rigour of this study. They included:

- Clearly articulating how social material was collected.
- Aggregating and condensing social material from multiple sources.
- Prolonged engagement (The planning day described was just one ‘moment’ during a 2 year engagement with the partnership depicted in this study).
- Reflexive journaling.
- Analytical bracketing of discourse-in-practice to discursive practice.
- Providing verbatim transcriptions.
- Providing evidence to support representations
- Acknowledging the researcher’s interests.
- Providing dense descriptions.
- Member checking.

Limitations

A limitation of this study was that it was confined to specific regions in Australia. As a result, the descriptions and diagnoses are specific to that locale. Social material collected from Indigenous and culturally and linguistically diverse members of the community actors in regions was limited because the researcher did not have ethics approval to access this material. Ironically, this has resulted in commentary from community actors representing the above communities being under-represented in this study.
Emergence of the PBI Partnership

In Australia, the national approach to chronic disease has focused on population health, equity, health promotion and illness prevention. It built on previous federal government initiatives that began in the late 1990s which emphasised the importance of population health, life-course approaches to disease prevention, local administration of health and the need to build healthy settings and healthy communities. The national approach to chronic disease converged within health, social policy and re-invigoration of discourses of community, localisation and citizen participation that originated in the late 1940s (Reddel, 2002). The PBI partnership was established somewhat parsimoniously in response to the national approach to chronic disease. In mid-2004, following a successful bid for funding by a representative of the state health department, funding was awarded by the Australian National Chronic Disease Strategy and delivered under the auspices of the state government’s Chronic Disease Strategy (2005-2015). The funding was used to establish new partnerships between government and non-government organisations (NGOs). A Steering Committee was formed comprising an eclectic mix of actors recruited mainly from local NGOs already providing services in the regions. The State government funded administrative support which was provided by a Project Officer who assisted in the development, implementation and evaluation of the partnership and in the delivery of range of programs over which the partnership assumed control.

As noted earlier, the regions covered by the PBI partnership were identified by the National Place-Based Advisory Group as having “high rates of entrenched disadvantage” (Department of Human Services, 2011). Challenges to health service provision in the regions also arose from population growth, difficult environmental circumstances, changing patterns in the health workforce and a relatively high prevalence of chronic disease. Higher than the national averages of young children (<5yrs), older people (>75yrs) and people from indigenous and culturally diverse backgrounds were also represented in the regions. A business case compiled by the Steering Committee in pursuit of additional funding gave shape to the overall aims of the PBI which were to mitigate of the deleterious effects of a fragmented health care system, address issues of poor access to health services experienced by some members of the community and to build “community capacity”. More specific aims included enhancing local capacity for health promotion and early intervention in relation to chronic disease, the establishment of a patient-centered model of primary health care and implementation of a broad healthy lifestyle and supportive environment program.

A new centre of calculation

In 2007, the state health department called for Expressions of Interest (EoI) to establish a new Board to take over from the steering committee. This process, referred to hereafter as the EoI, will be discussed more extensively in the following section. Administrative support was transferred from the steering committee to the new Board to ensure the continuity of programs previously run by the state. Crucial to the establishment of
the new Board was member attendance at workshops during which they drafted the vision and mission
statements which mimicked sentiments expressed in state and federal policy on health and social inclusion.
The Board described the vision of the partnership as a “Leading edge partnership for a vibrant healthy
community” and their mission as being “Leaders in health, partners in planning – responding to the
community”. Tables 1 and 2 below depict the Board members and their representative organisations and the
program areas over which they came to govern.

**Table 1. The Board: representative organisations and member positions**

<table>
<thead>
<tr>
<th>Representative Organisation</th>
<th>Number of positions on Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisions of General Practice</td>
<td>3</td>
</tr>
<tr>
<td>Local government</td>
<td>2</td>
</tr>
<tr>
<td>State Health Department – Community Services &amp; Public Health</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary education &amp; research</td>
<td>1</td>
</tr>
<tr>
<td>Local NGOs</td>
<td>2</td>
</tr>
</tbody>
</table>

**Table 2: Program areas and key activities**

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Key Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years Initiative</td>
<td>• Facilitated developmental play-based programs</td>
</tr>
<tr>
<td>Health Promotion Initiative</td>
<td>• Health Promoting Schools</td>
</tr>
<tr>
<td>(Joint appointment with the research team)</td>
<td>• Healthy Bodies, Healthy Minds</td>
</tr>
<tr>
<td>Health Promotion Initiative (Joint appointment with the research team)</td>
<td>• Scholarship Program</td>
</tr>
<tr>
<td>Multicultural Initiative</td>
<td>• Mentoring and Support Network</td>
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<tr>
<td></td>
<td>• Eat Well Be Active</td>
</tr>
<tr>
<td></td>
<td>• Culturally competent workforce</td>
</tr>
<tr>
<td>Multicultural Initiative</td>
<td>• Culturally appropriate service delivery</td>
</tr>
<tr>
<td></td>
<td>• Community engagement</td>
</tr>
<tr>
<td>Chronic Disease Prevention &amp; Management Initiative</td>
<td>• Self-Management</td>
</tr>
<tr>
<td></td>
<td>• Nurse Educators</td>
</tr>
<tr>
<td></td>
<td>• Optimal Health Program</td>
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<tr>
<td></td>
<td>• Brokerage</td>
</tr>
<tr>
<td>General Practice Integration Initiative</td>
<td>• Co-ordination of chronic disease care between General Practice and State Health Department</td>
</tr>
<tr>
<td></td>
<td>• Timely access to appropriate care</td>
</tr>
<tr>
<td></td>
<td>• Standardisation of correspondence</td>
</tr>
<tr>
<td>Information Management Initiative</td>
<td>• Internet Health Records</td>
</tr>
<tr>
<td></td>
<td>• Electronic Discharge Summaries</td>
</tr>
</tbody>
</table>
Translating the partnership

Attempts to autonomise and responsibilise members of the new Board by state government actors were enacted through two principle obligatory passage points and concomitant inscriptions. The Memorandum of Understanding (MoU) and EoI were drafted by actors representing the state health department. Although successful at enrolling some actors, they invariably led to the exclusion of others.

Obligatory Passage Point 1: An Expression of Interest (EoI)

In June 2007, an EoI was disseminated by the state health department to enlist new actors onto the new Board. Membership criteria were formulated in accordance with ‘success factors for partnerships’ based on the findings from a literature review and a community consultation conducted by the research team. It was intended that membership of the new Board include community leaders and consumers. However, the EoI was only disseminated to actors representing local government and NGOs, reflecting prevailing views held by actors representing the state health department on ‘who’ or ‘what’ constituted ‘community’. ‘Selection’ and ‘assessment’ of ‘interested parties’ was said to have been undertaken by an ‘anonymous assessment panel’; however, it was the state employed Project Officer who actually notified applicants of their successful enrolment. During the selection process preference was given to applicants representing organisations that were able to make ‘resource contributions’ to the new partnership. As the comment below illustrates, getting the ‘right people on board’ able to bring with them skills and resources and importantly, those whose interests were already aligned with thpose of state government.

And I think you often need to have senior representation, and I think that the membership needs to be selected on the basis of representatives of organisations who have common interest…and individuals that come along just on the basis of skill can’t contribute the resources of their organisation.

Obligatory Passage Point 2: The Member Agreement (MoU)

The MoU which was also deployed by actors from the state health department proved similarly effective at enrolling new actors into the PBI partnership. Set out in a format similar to that of a business plan or abridged governance model, it is a comprehensive document which outlines the vision, mission and purpose of the PBI partnership. Congruent with state and federal health documents, ‘community’ had a significant presence in both the vision and mission statements articulated in this document. In contrast to their responses to the EoI, prospective Board members were much more circumspect about signing the MoU. The comment below is demonstrative of how the comprehensive list of rules and expectations documented in the MoU, along with an endemic mistrust of the state health department, fuelled the wariness felt by some Board members in response to signing this document.
So by signing the agreement to be a Board member you know that you’ve taken on larger responsibilities. And people are reminded of that.

… in the beginning … because of their prior experience with the, their perception I should say, of the behaviour of state health in dealing with non-government agencies, there was a distinct lack of trust.

And they invited me to be a general Board member. That was an interesting process because I think on one level it was a good strong message to say that “Think seriously about entering this” but at the same time what I was saying to them “Look, there is no sitting fees and my organization is not going to benefit in any other ways…it’s on top of what I currently do”.

The EoI and MoU had been translated by state health employed actors to help create a new network (the PBI partnership) and to strengthen associations between the state health department and local NGOs.

However, as the actor below observed, no such device existed linking the new network to ‘communities’.

I think one point is around community engagement. I don’t think there’s any formal process around that actually occurring across all the program areas and I think it needs to be standardised…I see that as being quite important to ensure that we remain responsible to the local needs.

Inscriptions such as the EoI and MoU facilitated the enrolment of actors from local government and local NGOs and were the only inscriptions used to enrol new actors. A governance model for the PBI had not been drafted at the time this study was conducted. Unfortunately, the specific ways in which these inscriptions were translated precipitated the Othering of actors representing community to whom the partnership Board had pledged to respond. These seemingly innocuous devices had helped to separate out those considered better suited to do the representing from those who were to be represented (Baker, 2006). Actors were excluded from the PBI partnership selection process because they were perceived as lacking the necessary resources and, ironically, as the actor representing state government implied, because their interests diverged too much from those of state government. The comment below indicates the complexity of the above process which also served to deter potential members.

There were problems with the tendering process, paperwork was volumes - huge - legalese and a lot of issues to work your way through and a tendering process isn’t the most appropriate for a region. It may work okay for a state, but for a region, you end up with a limited applicant pool.

Translating ‘community’ and ‘place’

How ‘community’ and ‘place’ were translated reflected the equivocal relationship some actors had with ‘the partnership’ and ‘the community’. ‘Community’ and ‘place’ were translated as being synonymous and
actors problematised both for a range of different reasons. The first of these was to do with ‘the community’s’ size, inchoateness, riskiness and complexity. The comments below are typical of how ‘community’ and ‘place’ were being represented during translations.

… 85 cultural groups in the area? – so we have 85 of those…immediately it’s unworkable.

…the multicultural community is so fragmented. The indigenous community around here is fragmented. So having a rep would really, in my view anyway, be tokenistic, because they’re not speaking for the community, they don’t represent their community.

 Refugees, particularly with immigration, that can change like that, which will potentially change the services that are out there that you partner with, or that currently support the community. And that’s a real unknown, so it is a risk.

 So really when it comes to the implementation of a program like the PBI - chronic diseases in the community - you have to deal with a lot of other issues. Issues are very much related. Language issues, cultural issues, the whole system.

 Other reasons ‘community’ and ‘place’ were problematised had to do with how they were being represented and by whom. Below, Board members and Program Leaders describe their discomfort and resentment over communities and place being spoken about in diminutive or derogatory terms.

 …that saddened me in the sense that I thought, well we're never going to change this. We're only ever going to be working on the margins if we always reinforce “this place as a place of disadvantage”, that “it's crap”, that “the people that live here are crap”.

 To me there was a missing bit, in hindsight, from our model and that was something about the meaning of living in this place and addressing that image and perception.

 Others challenged approaches taken by the so-called ‘experts’ who they claimed had not consulted adequately with ‘the communities’ and therefore had little insight into the issues affecting them or the strategies that had already been put in place to address local issues.

 …here you are having someone tell you what’s not right about you and you say well “hello”…for me this is a problem, when the expertise sits outside…it’s just a load of nonsense.

 There wasn’t good asset mapping prior to them [PBI partnership] coming on board, so there was some tension and damage done within the communities.
We [the communities] were doing all this stuff before they [PBI] came along.

A second reason why ‘community’ was problematised was their lack of representation at Board level. Some attributed lack of community representation at a Board level to the ongoing confusion over to whom Board members saw themselves being accountable, government or community. The comments below are demonstrative of the extent of the confusion felt by Board members, although some clearly rejected the assumption that they be made accountable to government, asserting instead that they remain accountable to communities. They responded to the issue of ‘accountability’ by stating,

I’m not sure who they’re [the Board] accountable to.

… I think we need [the Board] to be accountable to our community…

Without input from representatives from ‘the community’, Board members were conflicted over having to satisfy the interests of state government instead of fulfilling the mandate they had set for themselves and that set for them by the federal government; that is, that they “respond to community”. Lack of community representation at Board level was seen by some actors as a significant weakness of the PBI partnership and led to accusations of the Board being ‘closed’, exclusive and lacking credibility. When researchers asked about the Board’s processes during their evaluation of the PBI partnership, some members made the following comments,

I think that is probably one area we need [the Board] to look at, some sort of community-type representation on the Board because at present we have community type organisations and doctors and state health department are represented, I don’t think we have a community members as such…

So it’s a weakness in that it’s [the Board] really not owned by the community, not the community as in members of the community but even the community of health providers in the regions.

… in relation to the representation across the Board, I have spoken at meetings about I believe there does need to be Indigenous representation. I think that’s a weak…we have a relative large Indigenous component of the community and for them not to be represented I believe to be a real weakness, and then again affects your credibility.

As the comments above indicate, Board members were unhappy about the exclusive nature of the PBI partnership and the limited input from ‘the community’. Correspondingly, many were overwhelming in their support for greater engagement with communities, as the comments below indicate.

Engaging communities - it’s very important to engage the community. The community should trust you.
We’re trying to support a community to ensure they have good health, maintain good health, and prevent them from getting sicker. That’s the global objective I guess but ideally it’s about bringing people together to actually achieve that and creating that system change, that shift.

Irrespective of the views held by Program Leaders and Board members alike, it was the interests of state government to whom Board members ultimately responded simply because it had funded and supported the PBI partnership. Board members were reminded by one actor representing the state health department during a Strategic Planning Day that “…we have to do what’s best for the Board”.

How ‘community’ was represented was compounded further by community actors being excluded from participating at a Board level. ‘Community’ was translated as ‘a risk’ because ‘they’ lacked resources, were too big, incoherent and their interests, despite being largely unknown, were perceived as being too divergent from those of the state government. These problematisations were used to legitimate their exclusion from the network. As a consequence, associations between actors the new network and ‘communities’ remained weak. The PBI partnership had failed to meet expectations articulated in federal policy documents that policy aspirations connect with on-the-ground service delivery and that community governance mechanisms capable of representing the community be developed to drive local engagement. The implications of this for the PBI partnership and for health planning in the regions were that it was the interests of state government rather than those of community that influenced the outcomes of health planning decisions and resource allocation in the regions.

**Diagnosis**

*Avoiding the imperatives of popular representation*

This study challenges the assumptions implicit to neo-liberal governmentalities promulgated through health and social policy that local governance networks such as PBIs are able to mitigate the multiple and interdependent problems afflicting specific locales and communities (Baker, 2006; Cummins, et al., 2007; Hindess, 2002; R. Kearns, 1993; Larsen, 2007; Reddel, 2002; Stewart, 2001; Swyngedouw, 2005; Walsh, 2001). This empirical study has demonstrated that representational politics, enacted under the influence of risk-thinking, naturalises and reproduces pre-existing relations of power obfuscated by the assumption that partnerships are politically neutral and translated without bias or prejudice (Mantoura, Gendron, & Potvin, 2007; Prince, et al., 2006, p. 259). Reasons why some groups are excluded or exclude themselves from mechanisms of local governance, such as health partnerships, are well documented (Beresford, 2007; Chavis, 2001; Coaffee & Healey, 2003; Crawshaw, et al., 2004; Crawshaw, et al., 2003). The exclusion of Others in this study was legitimated by their being represented as being ‘at risk’ and ‘a risk’ because they were ill, poor, too big, fragmented, incoherent and therefore to be avoided or constrained in some way (Baker, 2006). Risk-
thinking underpinned the reasons given in health and social policy as to why certain actors from community
should have been included, while in practice rationalities of risk formed the basis of their exclusion. This
study lends empirical support to commentaries that challenge discourses of popular representation,
participation and social inclusion (Baker, 2006; Crawshaw, et al., 2003; Hindess, 2002; Prince, et al., 2006).
Hindess (2002) argued that ‘democratic deficit by design’ is brought about by the compulsion toward popular
participation. Although seen as essential to ‘good government’, it is also perceived as sufficiently dangerous
that it must be kept strictly within bounds. This study details the specific mechanisms such as the EoI, MoU
and forms of representation, that were used to keep popular participation ‘within bounds’. In addition, Baker
(2006) pointed out that subjects are often forced to betray their heterogeneity and accept artificial
homogeneous representations of themselves i.e. ‘the community’, in order to warrant inclusion or else face
being excluded. In this study, actors were excluded despite identifying as being representative of ‘the
community’ because ‘community’ itself was translated as being “too fragmented”, “too big” and “too diverse”
and because ‘their’ interests were perceived as diverging from those of state government.

Place-basedness or placeism?

This study sought to capture some of the complexities associated with the governance of a PBI and in
doing so revealed the specific ways in which they might exacerbate placeism or placial stigmatisation by
providing yet another social plane from which selected actors might be excluded (Pearce, 2012; Wacquant,
2008). Craig (2003) and Pearce (2012) alert us to the subtle interplays between negative health statistics,
place-based stigma and representational politics. Baker (2006, p. 165) describes this interplay as follows,

Representational politics…disciplines political action by offering powerful incentives to pursue
representative politics as the one way of affecting the distribution of rights and resources (and,
concomitantly, offering strong disincentives to pursue other forms of political action that will not
achieve such prizes).

In this study, incentives proved too ‘weak’ to impel Board members, who were not being paid for their role
on the Board, to pursue alternative forms of action such as engaging more thoroughly with local community
leaders. Instead, community representation at Board level and more thorough engagement with them was
actively discouraged. Board members were reminded that they “had to do what was best for the Board” which
involved managing existing state funded programs and thus maintained existing distributions of rights and
resources in favour of actors currently employed by the state health department.

The power of the state health department had been extended into ‘new territories’ and was naturalised
through the translation of the PBI partnership (Baker, 2006; Craig, 2003). However, the particular style of
governance that emerged produced a more insidious form of placeism. The PBI partnership had helped to
circumscribe a ‘place’ and all the people living within it bounds as having “high rates of entrenched disadvantage” but now also faced the ‘negative branding’ that comes with being identified as ‘at risk’, ‘pathogenic’, epidemiologically and socially.

The Janus face and fuzzy terrains of neo-liberal governmentalities

The current study demonstrates that despite being required to allow “for significant and meaningful local involvement in determining issues and solutions”, the PBI partnership was given little scope to define policy or priorities at the local level. As consequence, the possibilities for improved community engagement and innovation were constrained. State government continued to play a major role in establishing and maintaining the conditions upon which the translation of the PBI partnership depended reflecting what Garland (1997) referred to as the ‘ambiguities of the decentralisation project’. Failure to autonomise and responsibilise Board members manifested in a ‘fuzzy terrain’ (Swyngedouw, 2005) that was characterised by Board member confusion over to whom they should respond and be accountable to, community or the government? The current study found, as did Garland (1997), that the “circumscribed and conditional autonomy” imposed on the PBI partnership by state government constrained “localised freedom to act”. Board members were forced to accept the priorities and targets set by state government because they had limited means with which to represent community interests and to set alternative priorities. Crawshaw et al. (2003) reported similar difficulties in relation to community involvement with Health Actions Zones (HAZ) in the United Kingdom. They noted that methods used to engage community were often tokenistic and debates persisted over definitions of ‘community’, what constituted ‘involvement’ and identifying who it was that they should partner with. The heterogeneity of communities, representativeness, disillusionment, ‘initiative fatigue’ experienced by community members along with misalignments between the interests of community, professionals and central government also impacted on engagement practices employed by the HAZ. Such dilemmas were anticipated by Reddel (2002) and others, who foresaw engaging those under represented and lacking in social capital, yet critical to rebuilding community, as some of the major challenges to the future development of localised governance.

A case for critical analysis

The ambitions articulated in Australia’s federal policy documents on health may go unfulfilled without critical examination of the strategies deployed to address the negative health outcomes of social disadvantage. In Martin’s (2008) discourse analysis of policy documents on participation in the UK, he concluded that one key question remained: that is, how are public participation initiatives are played out in practice? He proposed that focus shift by exploring the discursive effects of technocratic and democratic ideals on individual characteristics and material consequences for those involved, as this study has done. Governmentality and ANT provided ways to challenge the assumption that local governance networks such as the PBI partnerships
depicted in this study are capable of facilitating meaningful local involvement in determining issues and solutions to poor health and social disadvantage in specific locales. Governmentality and ANT allow researchers to trace through the ‘messy actualities’ of how PBI partnerships are performed to reveal the unintended consequences of everyday practice. The current study has emphasised that how local governance networks are translated influences whether they fulfil their intended purpose i.e. “responding to community”. Importantly, the implementation of PBIs is premised on the assumption that measurable benefits to local communities can and will be brought about through the development of local governance networks and are capable of representing the interests of community. These assumptions were not borne out in this study because the PBI partnership lacked the means and will with which to elicit and then represent those interests. Attempts to autonomise and responsibilise actors by way of inscriptions such as the EoI and MoU largely failed, curbing Board member impulses towards more thorough engagement with actors representing community. Translations by actors wanting to align more closely with communities were negated by actors representing state government. As a consequence, the interests of actors wanting to engage more thoroughly with communities were subjugated to those of actors who were more interested in managing the actuarial risk the PBI partnership posed to state government. Opportunities to ‘calibrate’ the outcomes of health planning decisions, in ways that more closely reflected the interests of community had been lost due to misalignments between actors representing state government, the Board and community. The connection between ‘social policy aspirations with on the ground service delivery’ (Department of Human Services, 2011) had been broken due to incomplete and competing translations of the PBI partnership.

Conclusion

The current study highlights the complexities of PBI partnerships and serves as a cautionary tale to policy writers reliant on representation and popular participation for securing more effective distribution of health resources. As the title of this article implies, PBIs produce highly contested spaces where the outcomes cannot always be predicted. Contestations played out during translations of the PBI partnership in this study resulted in the interests of some actors being privileged over those of others. In answer to the question posed at the beginning of this article which asked whether or not ‘subjects can be capable of representation at all’, it must be concluded that actors most in need of representation may not always capable of being represented because of ‘risk-thinking’. ‘Risk-thinking’, which transcends the local, melded with translations of seemingly benign devices such as the EoI and MoU and local politics of representation. These were played out through representations of ‘community’and led to some actors being excluded from the local governance structure from which they were intended to benefit. The current study makes visible one of the more pervasive paradoxes of neo-liberal governmentalities: that is, the antimony that sometimes exists between its utopian intent and its dystopian effects. The merits of having combined governmentality and ANT, using the governmentality in action taxonomy, was that it provided ways to trace through and describe the complex
performances that constitute the *techne* of government and to critically examine their effects. The diagnoses imply that attentiveness to the aforementioned paradoxes, along with alternative translations of ‘community’, the EoI and the MoU, are needed to produce different outcomes for the PBI partnership depicted in this study.

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References


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1 Contrary to ‘standard’ ethnographic approaches, some members of the research team were included as participants in this study and correspondingly, the standard consenting processes were applied. Law (2004) argued that researchers are complicit in creating realities through their depictions of them. The actions of the research team were integral to how the PBI Partnership was being translated. However, not all members of the team participated as some took umbrage over being identified as a ‘participant’ in ‘their own’ research.

2 The emergence of the PBI partnership and Board was generally not well documented making a more thorough genealogical examination of the partnership somewhat difficult. The information that follows was translated from documents produce during its emergence by way of business cases, annual reports and verbatim accounts.