**Health Promotion in Civil Society**

**Biopolitical government of diversified cultures and communities**

During the last 20-25 year, Denmark has witnessed the consolidation of a strong emphasis on preventive health programs that purports to respect local diversity and citizens’ values. This article explores this tendency at the level of national policy programs as well as at the level of local municipalities. It demonstrates two characteristics of this multi-level preventive strategy that break with the so-far dominant approach of public health provision. First, an expansive preventive rationality is supplementing, overlaying, and to some extent challenging the domain which was conventionally delineated by medicine and diagnostic treatment. By this token the knowledge privilege of medicine is supplanted by new constellations of professional disciplines and their values, including pedagogy, therapy, socio-psychology, and anthropology. Second, the national health strategy promotes an explicitly anti-authoritative and non-tutelary approach. It embraces an ethos of involvement, participation and respect for the values represented by citizens and communities. Both national health campaigns and local initiatives seek to sway agents previously unrelated to health issues to take up the goals of preventive health promotion, thereby spanning and dissolving traditional sector boundaries. Theoretically, the article aims to demonstrate the potentials of applying a reading of Foucault which sees biopolitics as embedded within a governmentality framework in which the municipality is symbolically recoded through a fantasy of localism.

Keywords: Health promotion, biopolitics, governmentality, civil society, fantasy, localism.

**Introduction**

Across modern welfare states a growing attention has been given to preventive health care, the importance of which was emblematically stated in the XX WHO? doctrine from 197X and which contained key tenets of preventive health planning confirmed by various governments during the last two decades (xxx.xxx; Sundhedsministeriet, 1999; DHEW, 2002; xx,xx). Recent policy initiatives for preventive health have explicitly opposed a health policy that centres on public health institutions and conventional concepts of illness and cure. Instead, they wish to supplement conventional views with an attention to the ’lifestyles’ of people at risk and prioritize efforts to target the environments in which people live, including family relations, work life, eating habits, and more into the gambit of preventive health. Accompanying this governmental focus, critics have voiced concerns that the prominence of a new social agenda linking health and safety to lifestyle choices implies a seemingly limitless expansion of the logic of prevention (Holsworth, 2009). In the academic domain, critical studies have emerged of preventive policies or what has illustratively been termed ‘lifestyle politics’ inspired by concepts in the work of Michel Foucault (Larsen, 2011; xxx; xxx?).

This article aims to contribute to the discussion of how we can understand political programs targeting the life style of populations from within a Foucaultian framework. Our discussion involves some considerations of the concepts of biopolitics and governmentality and their interrelation. We place emphasis on how to avoid interpreting the proliferation of life style targeting programs as a uniform strategy for social control or a welfare state that subtly colonises civil society.

The article falls in three major parts. The first section offers a presentation and evaluation of the concepts of biopolitics and governmentality. The second section delivers an analysis of the recent development in policy programs for health promotion in the context of Denmark, demonstrating the increasing concern for life styles, diversified cultures and non-tutelary health promotion through municipal programs. Finally, the third section provides a case study of the concrete intertwinements at the level of specific preventive practices of biopolitical aspirations with governmental caution against excessive state intervention. By way of conclusion, we raise some questions of how critical policy observers may relate to the current emergence of non-authoritarian and culturally sensitive policy programs. In this way, we attempt to indicate some ways in which the developments within preventive health policies may be of relevance to the understanding of contemporary public policies more broadly.

**Biopolitics, governmentality, and civil society: A framework for analysis**

In what follows, we do not attempt to give an extensive account of the body of literature on biopolitics and governmentality, let alone excavate in greater detail Foucault’s original and diverse uses of these terms. Instead, we shall focus our presentation and discussion on a few isolated issues related to the concept of biopolitics which will be supplemented with some reflections on governmentality and the status if civil society in Foucault. These choices are made from a concern with the pertinence of these conceptual debates to our case of life style oriented health promotion.

Within the commentary literature on Foucault it is generally agreed to separate the concepts of biopolitics and governmentality, hereby emphasising the different meanings and objects of study that Foucault supposedly had in mind. A recent study by the Danish scholar Lars Thorup Larsen (2011: 203) is illustrative for this tendency since he takes biopolitics and governmentality to be “distinct theoretical perspectives”:

Biopolitics is a descriptive term for politics and technologies aiming to optimize the biological life of the population, whereas governmentality takes aim not at the population as such but at the modes of governing including forms of subjectivation. (...) One focuses on optimizing the biological life of the population, and the other reflects on the best way to govern subjects, not just in health matters but in general. (Larsen, 2011: 203).

This distinction certainly catches some important aspects of Foucault’s original elaborations where biopolitics marked the historical moment where the biological life of man became an object of political calculation as it ”passed into knowledge’s field of control and power’s sphere of intervention” (Foucault, 1984: 142). This political interest for man-as-species reached a high point in the 19th century, where “the biological came under state control”, or, as Foucault immediately qualifies, “there was at least a certain tendency that leads to what might be termed State control of the biological” (Foucault, 2003: 240). Governmentality, in its turn, was used differently by Foucault, who seminally used the term to designate the emergence of a modern rationality for the exercise of political authority that would make the freedom of the governed and the harnessing of their capacities a fundamental and indispensable prerequisite for the exercise of government (Foucault, 2007; 353).

We recognise the analytical potentials in maintaining the two concepts as separate markers for describing modern forms of power. However in the context of this article, we wish to emphasise the potentials in following a strategy in which biopolitics and governmentality is seen as intimately intertwined. Arguments for such a reading are easy to find in Foucault’s own work, for instance, when he stresses that it is “only when we know what this governmental regime called liberalism was, will we be able to grasp what biopolitics is.” (2008: 22). Or when Foucault states that the aim of the 1978-1979 lecture series was to study the way in which the “specific problems of life and population” since the end of the eighteenth century have been “constantly haunted by the question of liberalism.” (2008: 324). These statements as well as Foucault’s expansive readings of liberal thinkers during his 1979-lecture series, The *Birth of Biopolitics* suggest that it is simply not possible to analyse biopolitics without taking into account the liberal framework of governmental concerns within which the population as a bio-social reality emerged. Most importantly, perhaps, is the tensional or moderating relationship that exists between biopolitics and governmentality (Dean, 1999: 98-113). Dean observes: “(T)he imperatives of bio-political norms that lead to the creation of a coordinated and centralized administration of life need to be weighed against the norms of economic processes and the norms derived from the democratization of sovereign subject of right.” (Dean, 1999: 101). Thus, while biopolitics has a potentially limitless impetus for regulation of the life of populations, in the broadest sense of the term, governmentality is a rationality that contains a liberal scepticism against excessive regulation and thus plays a moderating or keeping-in-check function in relation to biopolitics.

For the purpose of the analysis to follow, we restrict our discussion of the two terms to merely indicate a few aspects of biopolitics and governmentality which will be helpful in exploring contemporary preventive health programs. First, we wish to emphasise that biopolitics is not restricted to targeting people’s biological existence in narrow sense, as if only distinct biological and medical problems can appear under the gaze of biopolitics, such as longevity, birth rate, genetically transmitted deceases, body mass index, and so on. Rather, modern biopolitics concerns itself with the biological life of man as it is lived out within small or big scale environments, covering an almost limitless number of factors from 19th century urban environments characterised by ‘zones’ of poverty and moral decay (Foucault, 1978; Osborne & Rose, 1999) to life style factors such as transportation systems or workplace access to exercising (McGillivray, 2005). The discovery of 18th century Western European authorities that their populace exist within a complex environment of forces influencing their strength, productivity and well-being paved the way for an expansive examination of these environments, which is today still in progress. In brief, then, biopolitics takes into account the whole life of human beings encompassing a potentially limitless number of factors that may be perceived as influential upon living humans. For this reason, studies of biopolitical initiatives should be attentive to how they transgress or bring together actors and domains that are usually separated by administrative and disciplinary boundaries. We agree with Lemke that “the categorical divisions between the natural and the social sciences, body and mind, nature and culture lead to a blind alley in biopolitical issues” (2011: 121), yet wish to emphasize that after having left this blind alley, the analytical task is studying the intertwinements and blurring of, for instance, concepts of nature and culture in concrete biopolitical programs.

Second, biopolitics marks out forms of power which are highly flexible with respect to their domains of application and with respect to the establishments of norms. Instructive is here to contrast biopolitics schematically with discipline. Here, we briefly mention the distinction offered by Foucault and many commentators between discipline which targets ‘the individual body’ and biopolitics which addresses ‘a multiplicity of men’ (Foucault, 2003: 242). What interests us in this context is not this macro/macro distinction but rather to point out the governmental logic of discipline and biopower, respectively. Emblematically, then, disciplinary power works by optimizing bodies, correcting gestures, and seeking to normalize individuals in accordance with a given standard (Foucault, 1975). A key term here is ‘normalization’ which encapsulates the process of establishing a norm (for instance by defining pathologies versus ‘normal behaviour or functioning) under which ‘deviating’ individuals can subsequently be evaluated and corrected. Moreover, discipline relied upon the construction of institutional spaces which are both functional and analytical, and rather strict demarcations of the inside and outside of institutions. Biopolitics, shares some characteristics with discipline but does not confine itself to institutions as the locus for exercising power. It takes ‘man-as-living being’ as its object and seeks to operate on individuals in all their whereabouts, actions, and social relations, thereby transgressing institutional barriers and dissolving conventional boundaries between the public and the private, the institution and its outside (Lazaratto, 2002; see also Deleuze, 1986 ). In brief, then, biopolitics does not depend upon the modern institutions (hospitals, schools, armies, factories), but operates on an, in principle, indefinite number of sites

Third, the establishing of norms under biopolitics has a markedly immanent character, since it rests on the recognition of its fundamental dependency on the population and their life forces (including deviances and abnormalities existing within the population or group in question). Foucault indeed emphasized that modern power recognizes that it does not constitute the source of its effects and is thus looking for ways to mobilize energies, processes and movements inherent to the objects of government (Foucault 2009). Or, in Maurizio Lazzarato’s words: biopolitics is “a multiple and heterogeneous power of resistance and creation” (Lazzarato, 2002: 101). As biopolitics is not ultimately about correcting and harnessing individuals to match capacities predefined by expertise, since it has an openness towards the energies and (perhaps unexpected) potentials inherent to the life and the life styles of the governed. Thus, it eschews a rigid binary scheme of exclusion/inclusion, since it is prepared to discover and operate upon a multiplication of life forms, including what is considered ‘abnormal’ personalities and traits. Foucault’s comments on modern sexuality serves as the emblematic example of this mechanism in biopolitics (Foucault, 1980: 48-53; Nealon, 2008: 50-52). The reader probably recalls that Foucault wished to oppose a view of modern sexuality as repressive of some genuine, latent desire or sexual drive. Instead, he claimed that the discourse of modern sexuality has been one of proliferation and multiplication; a remarkable explosion of new categories and types of sexuality.

The biopolitical production of norms, then, do not primarily serve the function of excluding persons or acts, but rather aims to include (by examining, testing and classifying) as many aspects of human social existence as possible. This point is made by Nealon: “Foucaultian power never gains a greater hold of the body or a socius than when it intensifies, multiplies and extends its realms of application (rather than rarifying or calcifying them within a clumsy, centralized binary scheme)” (2008: 51). Crucially, therefore, biopolitical interventions are not a matter of judging the usefulness of a person or human characteristics against a pre-established, rock-hard norm, but rather of interrogating life forms (even critique and resistance) and intensifying those elements found to be productive for biopolitical objectives. However, that biopolitics has a preparedness to recognize, examine, and ultimately utilize, what is considered as abnormal individuals and behaviours does not preclude judging, in some cases, particular life forms ultimately unacceptable, since threatening the life that should be fostered (its health, hygiene, purity, racial composition etc.). Foucault (2003: 241) emphasised—and we should still be analytically attentive to this point—that the impetus of fostering life of modern biopolitics concomitantly installed a gaze that would detect those elements internal to a population that posed a biological or moral threat to its strength and unity (Lemke, 2011).

Fourth, and finally, the concept of the biopolitical helps us eschew a view of public health programs as a means of social control, implying a kind of uniform and unidirectional power originating from the state apparatus. Some contributions to the critical sociology of public health provision and preventive health promotion have drawn upon the Foucauldian framework to make interpretations in this direction. One example in this respect is the seminal work of David Armstrong that tends to portray patients as victims caught in the control of a mighty medical regime (Armstrong 1983). In other cases, the concept of governmentality is interpreted as a form of power that subtly allow authorities to carry out social control by inciting individuals to take up particular forms of self-regulation that fit broader strategies of government. Hence, Bryan Turner defines governmentality as “A regime which links self-subjection with societal regulation” (1997: xv). However, if we give emphasis to the above understanding of biopolitics as a form of power that attaches itself to the processes it seeks to govern, recognising its dependency on the governed, we achieve the analytical advantage of avoiding the view of public health as a solid and self-enclosed regime of power. Instead, we may be ready analyse biopolitics such as public health provision and preventive strategies as unstable and ongoing projects, which are never unequivocal or unidirectional.

The concept of governmentality has been widely discussed (for instance: Rose & Miller, 1992; Dean, 1999; Rose, 1999) and it has been applied in numerous empirical domains (for instance, Turner, 1997; Rose, 1996; Larsen, 2011). For present purposes, we merely indicate what we feel to be some key points that the framework of governmentality offers for a specific analysis of state organised health campaigns targeting agents of civil society. First of all governmentality analysis opens up state analysis for looking at the historically contingent forces of power struggles (see also, Jessop, 2011). Secondly governmentality analysis opens up welfare analysis to new policy arenas. We wish to eschew a reading of governmentality suggested by some governance theorists who adopt the term to substantiate the view that the modern welfare state has been decentred into policy networks, increasingly relying upon markets, quase-markets and voluntary agencies for services delivery (e.g. Torfing, 2005). It may well be that welfare states have recently delegated responsibility for some services from state bureaucracies to other actors, but our interest is Foucault’s suggestion that governmentality implies studying “the rationalization of governmental practices in the exercise of political sovereignty” (2008: 2). This means that governmentality hardly designates the collapse of sovereign state power, but rather that the exercise of political sovereignty became infused with a new rationality of government gradually emerged from the 17th century onwards through a series of transformations (Foucault, 2007). A key element in this new rationality is the discovery of civil society as a potentially self-governing domain which confronts the state and imposes a self-limitation upon the exercise of political sovereignty. Importantly, Foucault does not ascribe any substantial qualities to civil society but inserts the concept in a genealogy that explores the different functions that this domain—and the various political aspirations investing it—have served through the history of the modern European states. “We must be very prudent regarding the degree of reality we accord to this civil society. It is not an historical natural given which functions in some way as both the foundation and source opposition to the state.” (Foucault, 2008: 297). We may take this as an injunction to avoid founding concrete analysis of policies and institutional arrangements upon state and civil societies as pre-given entities (Villadsen, 2008).

In the lecture where Foucault most directly addresses civil society (2008, lecture 13), he sees civil society as a solution of the 17th century problem of how to govern individuals who are at one and the same time both subjects of rights and economic agents. ‘A new plane of reference’ was needed that could mark out not only the space of sovereignty and economic relations “but a series of other elements in relation to which the subject of rights and the economic subject will be aspects, partial aspects, which can be integrated insofar as they belong to a complex whole. And I think it is this new ensemble that is characteristic of the liberal art of governing” (Foucault, 2008: 295). We notice a radical reconfiguration of the reference for exercising political sovereignty; it no longer refers back to the sovereign and his relation to a judicial subject, but now includes a *homo economicus* who inhabit the ‘complex whole’ of civil society. What, then, does this ensemble and its ‘series of elements’ consists of? First, echoing his biopolitical conception of the population as a living resource which possess self-regulating mechanisms, Foucault speaks of civil society as “a specific field of naturalness peculiar to man, and which (...) emerges as the vis-à-vis of the state” (2007: 349). This ‘naturalness of society’ poses, then, the principle of self-restraint upon state government implying that it should intervene less in the population by means of restriction and prohibition and more by facilitating, shaping and informing.

Second, the domain of civil society is something more than judicial and economic relations. By reading Adam Ferguson on civil society, Foucault excavates what he takes to be a modern conception of civil society and the problem of regulating it. Particularly interesting is Foucault’s emphasis on Ferguson’s idea of ‘spontaneous synthesis of individuals’ as fundamental for civil society. Civil society thus comprises “social relations and bonds between individuals which go beyond the purely economic bond, yet without being purely juridical (...) and which, in their nature if not their form, are also different form are also different from the economic game.” (Foucault, 2008: 308). Perhaps, these formulations were for Foucault an indication of the contemporary political rhetoric which portrays civil society as traversed by social relations embedded in diverse cultures that governmental authorities must attempt to know and respect.

Third, and final, we could read Foucault’s final lecture in *The Birth of Biopolitics* as a supplement to his exploration of how liberal thought turned the market into a site for the production of truth, a “regime of veridiction” for the exercise of government (Foucault, 2008: 36). The political significance of liberal political economy was that it “points to the site where government will have to look ‘to find the principle of truth of its own governmental practice’”. (Gudmand-Høyer & Lopdrup Hjorth, 2009: 112). Now it seems to us that Foucault’s last lecture could be read as summoning the emergence of civil society as the ‘site of veridiction’, a key referent for the production of truth necessary for state government, not only in terms of economic rationality, but also as a domain permeated by social bonds, cultures and allegiances irreducible to market relations. Thus interpreted, the lecture ushers the contemporary political problematic of how to arrange political programs, including health promotion, in ways that take into account the spontaneous synthesis and social bonds of civil society. In this case, Foucault invites us to be analytically attentive to political initiatives that make reference to the values, identities or instructive ethics assumed to reside in civil society.

This analytical task is to some extent taken up by Nikolas Rose in the seminal article *The Death of the Social* (1996). There, Rose suggests that since the 1980s a mutation in political rationality has been taking place across ‘advanced liberal’ welfare states, which implies that ‘the social’ is fading as a key reference for political regulation and supplanted by a government through diverse communities (Rose, 1996; see also 1999: 167-197). The analytical force of Rose’s analysis is that he convincingly demonstrates that there is not *one* civil society, but rather numerous ‘fictions’ of it each inscribed and mobilized within different, and to some extent, heterogeneous, administrative strategies. Thus, different types of experts, some located within state administration, others outside of it, would ascribe different potentials to the dormant energies of communities, including crime prevention, health promotion, neighbourhood revitalization, and more (Rose, 1996: 332). From this follows that we need to examine in detail how concepts of community, diversity, or civil society appear and which tactical function they play in specific political programs. In the analysis below of municipal preventive health initiatives, we follow this lead by attempting to explore the diverse images and hopes that diverse experts may hold with respect to the local community.

The remainder of the article consists of two case studies in a Danish context: one case analysis brings together recent national programs for health promotion, whereas another analysis explores the strategic organisation and implementation of health promotion and prevention in a Danish municipal setting. Seen in continuation the two analytical tracks opens a view on the welfare state as targeting the population in a double fashion as both a biopolitical body of subgroups and as a gouvernemntalised singulars in the sub-communities of civil society and having individual capabilities to ‘empower’ themselves in terms of lifestyle choices.

**Case study A) National Health Promotion Strategies between 1989-2009**

Looking into the context of Danish official health policies during the last thirty years, the emergence of ‘antiauthoritarian’ health promotion programs in the late 1980s and onwards can be seen as part of a broader and long lasting critique of the welfare state’s alleged rigidity and insensitivity towards different citizens and groups (Højlund & Larsen, 2001; Larsen, 2005; Karlsen & Villadsen, 2008). A critique towards “paternalistic welfare” has been voiced from various political camps and has pointed towards welfare policies aimed at promotion and prevention allowing for the welfare state to act at a distance, one can say. Grossly speaking, the left wing has referred to the need to empower citizens through the empowerment of different communities and subcultures, while liberals have argued that the welfare state are dependent on the entrepreneurial activities from free individuals, as opposed to welfare dependents. This liberal emphasis point to a state administration that reflect the complex dynamics immanent to the self-regulating processes of civil society and the economy. Although the different camps disagreed on the means of reform, the shared the key diagnosis: health policies (and social policies in general) need to become more sensitive towards differences in individual life styles and differences in the subcultures of civil society. A view into four Danish health promotion programs (1989, 1998, 2001, 2007) will show that health promotion is:

* Anti-authoritarian. The relation between the conventional welfare expert and citizen has become suspect.
* Sensitive to its object. Self-sceptical of governmental programs’ tendency to suppress local energies and self-responsibility. User-sensitive, encourage critique.
* Normative standards are co-produced by the users.
* Critique and deviance is sought turned productive
* Cross-sectorial.
* Recognize that other forces shape the goals of health promotion.
* ’Diversity’ as key concept. The programs co-produce the ‘diversities’ that they aim to respect.

**Four National plans on health promotion**

The last thirty years of Danish health promotion policies has been marked out by especially one tendency across different reforms. In Denmark a certain ethos of the local has been pivotal to national health promotion plans from at least the 1980’s and onwards. Shifting Governments have promoted the idea of healthy living as a community ideal, where citizens are targeted in their local sites and populations. Danish health promotion have been shaped from three main pillars: Firstly, a community and setting approach have been merged with an individualized life style approach. Secondly a risk approach focusing on risk factors and risk groups have been mixed with an inequality in health-approach. And thirdly a community/municipality approach have been balanced with a partnering approach as a framework for local sector co-operations (Højlund/Larsen, 2001; Larsen 2011; Højlund, 2011). Four national plans have been central.

In 1989 a first national plan concerning health promotion was formulated by a right-wing-liberal government. The plan had the name “Government’s program for Health Promotion” (Regeringens forebyggelsesprogram”, 1989) and the plan was quite explicitly constructed from a balance approach to health, in which the idea was to give emphasis, on the one side to individuals as rational beings deciding for themselves on health risks and priorities, and on the other side intervening in a more structural manner into settings such as the family, the work place and the local community in order to build up healthy local communities.

Looking at the Governments national plan and the balance approach, the program was heavily influenced by international ideas concerning a positive and all embracing approach to health. Especially from the World Health Organisation (WHO, 1984; 1986) the idea was promoted that governmental strategies towards surrounding environments such as local communities, education, housing, safety, food, water etc. made up the structural back ground for healthy choices from citizens seen as individuals with more or less individual life styles. In Denmark a national unit of health promotion (DIKE and later SIF) was established in year 198? to form a institutional stabilisation of a broad national approach to health promotion. Numbers and measurements, whereas also ideas to strategic planning for the future were to proliferate from the new national knowledge centre.

Ten years later in 1999, a second plan was launched, this time from a Government lead by Social democrats. The plan had the name “The governmental People’s Health Program (Regeringens folkesundhedsprogram, 1999) and was a quite straight forward continuation from the first plan with a somehow changed focus. A broad life style oriented approach merged individual risk indicators with a population approach focusing on inequality in health. A preventive and promotive reorientation from individuals to communities was seen, and also a range of biopolitical measurements found their way into promotion policies, the so-called KRAM-faktorer (food, smoking, alcohol and lack of exercise) did indicate areas of governmental dedication. And also the KRAM-faktorer did indicate a differentiated knowledge interest from governmental and regional bodies towards the local. Scientific documentation on risk factors were supposed to form a scientifically aided and balanced approach in to the welfare diseases of local life.

”...forskningen er grundlaget for erkendelse…, og som sådan også en forudsætning for forebyggelsesforskning i forbindelse med udvikling af nye interventioner” (Government, 1999:105)

Together with quantitative knowledge also more qualitative sources on for example ”selvoplevede helbred” (Government, 1999:105) made up the knowledge source for intervention strategies: Objective knowledge combined with authentic knowledge, so to say.

In the Folkesundhedsplan the most important bio-political problem was that of raising the population’s longevity (prolonged existence). International surveys had shown a dramatic going-down for Denmark. The Danish national position went down to a position as number 16 in comparative studies on peoples life expectancy (mid). This had been shown in 1994 where a governmental expert group (middellevetidsudvalget) had launched a Governmental expert report (regeringsredegørelse, check Højlund & Larsen 2001; Indenrigs- og Sundhedsministeriet 2001:7, Regeringen 1999:14). An important rationale for the gouvernemtal strategies in the Folkesundhedsplan was promoted through the bio-political numbers and populations statistics from the expert group (middellevetidsudvalg).

Another theme in the folkesunhdedsplan was the bio-political theme of “inequality in health” that had gouvernemtal implications, so to speak. In the folkesundhedsplan the theme, ”inequality in health”, was pushed to the forefront together with the theme of life style. Biopolitical knowledge on certain groups in society disclosed structural risks in combination with life styles, and these groups were turned into so called risk groups. Due to the bioeconomic and biopolitical indicators socio-economic and cultural barriers to health seemed to be important and therefor to taken in to account by gouvernemental strategies.

In a combined life style- and inequality-approach the fact of unhealthy life had two implications. One was the seemingly straightforward implication that certain ways of life caused diseases. The other implication was more intricate as unhealthy life changed status from being cause to becoming effect. Unhealthy life became a symptom on socio-economic and cultural differences such as inequality in education, income, imployment rate, and differences in ethnicity (seen for example in Regeringen 1999:16). Other factors such as geographical differenes, differences between urban/rural structure, gender differences, differences between married persons and singles. Strict medical references and socio-economic factors were blended with indicators of a more cultural and sociological kind. In such a combined approach the government had become sensitive to new risk groups and new individual life styles. A change had taken place from a individualised life style approach towards an local community approach sensitive to individuals situated in neighbourhoods, families, group of friends etc.

A third national plan on health promotion, named “Healthy the whole life” (Sund hele livet, Regeringen 2002) was launched in 2002 by a liberal government. The liberal Government had come to power one year earlier and launched the health promotion plan as part of a broader strategic catalogue naming citizens as Free choosing individuals (Regeringen ????; Højlund, ????). In the promotion plan the general tenets from the 1999-plan were continued. Risk indicators still formed a bio-political framework for localised strategies aimed at citizens in local communities and settings.

In 2009 a renewal of the national plan from 2002 has taken place as part of a broader health strategy consisting also of a strategy for direct aid (akutsygehuse), a national cancer plan, and a plan for psychiatry.

Taken together the two plans, together with a health promotion and prevention commission from 2008/2009 (Regeringen, 2009) and a renewed health law from 2005 plus a structural reform (“struktur- og opgavereform) from 2007, make up a strategic framework for Danish health promotion policies.

In the policies can be detected bioeconomic numbers:

”på de indsatser, som giver mest værdi for pengene” (Regeringen 2009:28)

And

”Danskernes forbrug af både tobak og usunde fødevarer påvirkes af prisen. Afgifter, som er indrettet hensigtsmæssigt, kan understøtte en sund livsstil. Øgede afgifter kan derfor være med til at øge danskernes incitament til at vælge de usunde varer fra og vælge de sunde til.” (Regeringen 2009:32)

Biopolitical rhetoric

”Vi skal glæde os over de gode resultater, men må samtidig konstatere at levetiden fortsat ikke er på niveau med vores nabolande Norge og Sverige” (Ibid.).

Argumentation concerning social inequality in health:

”sætte særligt ind over for ressourcesvage grupper” (Regeringen 2009:27).

Balanced responsibility arguments and ”individual in setting- arguments:

”vi skal tage ansvar for vores egen og for vores nærmestes sundhed” (Regeringen 2009:31)

Local health argument/municipalities are:

”hovedansvaret for den borgerrettede forebyggelsesindsats helt tæt på den enkelte borger” (Ibid.).

A present health promotive rationale can be seen. A governmental involvement in an anti-authority-way are formed in ”respekt for den enkelte og den enkeltes valg”. Local initiatives, promoting health in civil societal layers of society due to the government are carried forth in due respect to existing, natural communities (Regeringen 2002:7, 2009:27). Policies are guided by bio-economic numbers and carried forth by bio-political means. Strategies and initiatives produce the civil society as a place for resistance and self-balanced community as seen in the Govenrmental idea about local strength, community spirit and (sammenhængskraften). Instead of reproducing responsibility-relation between individuals and state, also responsibility-relations are talked into being in the local communities of civil society. A shared responsibility-approach is presented to re-orient the health promotive strategies towards a local level and a symbolic field called civil society (for example in Regeringen 2002:5, 2009:27).

A responsibility approach is seen in the governmental goal setting in the below.

”Regeringen ønsker, at vi hver især tager ansvar for vores egen og vores nærmestes sundhed. Med ansvaret følger friheden til at træffe vores egne valg – under hensyn til andre.” (Regeringen 2009:27)

**Case study B) Partnering strategies in the municipalities[[1]](#footnote-2)**

As mentioned in the earlier discussions, a new law on health (Law no. 546) was launched in 2005. The law stipulated a general remodelling of the health system to take effect from year 2007. In the new health structure emphasis was given to the municipalities as key agents in the work on health promotion and prevention. “Health promotion in the neighbourhood”, and “healthy solutions close to citizens”, were slogans of the health system reform. A certain partnership vocabulary framed the arguments. Sharing of responsibilities was the main principle institutionalised in the political vocabulary. Framed as local hubs in partnering networks, the municipalities were supposed to act in a partnership-kind of way opening up for organisations from the private sector and civil society. Municipalities were thought of as anchorages very much in line with present management ideas (Højlund/la Cour, 2008a, Knudsen/Højlund, 2011; Hodge et al., 2005; 2010).

Looking into the municipalities and actual projects for health promotion very clearly exemplify the idea that also citizens are supposed to act as partners. Here, healthy living is envisioned and promoted as an ability to critically engage in social relations learning how to take care, how to make the right choices, and how to guide friends and families in their choices. The vocabulary is one of concomitant individualism and small-group-collectivism. A critical and self-critical attitude is formulated around a nexus of a healthy living. Key messages in the health promotion say: Do not believe in everything you hear, make up your own mind, follow your friends, if they do the right choices otherwise not, be critical towards authorities, but believe in the facilitating authority of the municipality.

An example from health promotion aimed at children. A health nurse explains about the ínvolvement of older children.

We took our starting point in a electronic survey in all the 8. classes. The concept was that the pupils was anonymously answering questions on their health behaviour. After this we tried out the concept, and established different work shops. The pupils were positive, and they experienced, the grown ups (the health profesionals) as present and attentive, not someone external to them. The pupils in particular liked the works shops on life style and abuse. No admonishing. Time for talking. It is up to the single pupil to feel what is right for him or her, what they would like to try out on the workshops. The work shops and the activities are very

Partnering for health, the health promotion projects hook up on existing real life partnerships among the young people (if we have communities for role-playing kids, for kids doing bacou; for kids scate-boarding, the health promotion has to hook up on the non conformism of these communities, talking health into the vocabularies of the outside group identities, a very intricate job of trying to create a fusion between sub group cultures and health promotion.

The partnering approach, one can say is a parasitic approach where health promotion trough partnering attempt to profit from or to ‘parasite’ upon existing civil society partnerships. Also that means, that in order to work, the partnering has to find existing partnership sub.groups to dig into. They feed of a certain intimacy when healthy values are infused into the already partnering community. Partnering also means promising to take the values of the non-conformist sub-groups seriously. That young people should decide what is best for them, is the mantra. They are under guidance of discretion. Another consequence of the partnering approach (where partnering into civil society) is partnering with sub-groups in civil society is that a lot of differentiations take place under the umbrella of the general health promotion approach. Children and young people are approached as individuals-in-sub-groups. The logic is not straight forward as it includes both homogenising, individualising and sub-sociality-promoting tendencies.

A health professional explains about partnering with the families. The overweight children and their families participate in open activities with each other, and together with food experts, in order to prepare and share meals together. In other words: The families are given the opportunity to learn from the expert, to learn from each other and to put their own fingerprints on the activities. The learning approach behind the activities is explicitly interdisciplinary.

In the first meetings several different approaches were combined. An argument has been to approach the dinner situation both as a social activity and as intake of food, something to establish knowledge about concerning the physiological aspects of being fat. Also broader aspects concerning food- and body culture have been toughed upon. Such a multiple (bred) approach has been possible only because we in the municipality have had permanent meetings in which it has been possible for different groups of proffesionals to come and exchange ideas. They have come to know each other and have become used to listen (Højlund & Wistoft, 2008)

Also the approach has an open and participatory character. The interviewee used phrases like *learning by doing* both in relation to the professionals and the families participating. The interview person finishes the example by stating “that it was from the beginning thought into the project design *that the participants were supposed to learn from each other* (Wistoft & Højlund, 2008).

The example gives evidence to a general strategy of learning evident in the municipalities (Højlund 2011, unpublished paper and paper Herlev). Learning is supposed to be reflexive and critical/self-critical, interdisciplinary and multi-participatory. Participatory projects, the open projects with a broad approach to health, but with goals framed from a more restricted risk approach in which eating is one of five main targets.

*The reflexive and critical/self-*critical participation of individual agents in a subgroup setting is promoted. This is parallel to other projects as for example in non-smoking projects:

”Kick smoke” is a new project in which older pupils are role models. We work on that project now. We really have a lot of projects with kids and adolescents as involved (Højlund & Wistoft, 2008)

The interviewee puts emphasis on the interaction between the professionals and the pupils. A learning approach is adopted where learning seems to come from dialogue.

Three health nurses for every 25 pupils, where the health nurses in a dialogue with the pupils think out activitites. The fact that the young people had the possibility to choose for them selves, and that the health nurses was attentive was important. The broad approach to health was in play. After the health days each pupil is offered individual interviews. They are prepared for the interview as they have been asked to reflect upon their experiences, two or three weeks after they are asked to come to yet another talk. The pupils have become more conscious, they come up with ideas and solutions. Much more actively than if they had just received informations. (Højlund & Wistoft, 2008)

The project is based on an open, critical learning horizon, where responsibilitation is promoted though active involvement of the children as ciritcal information users.

A lot is taking place in the schools, for example we have active health-assessments, where the children actively choose not to smoke. We do not tell them what to choose or scare them with informations that they will die as 30-year old if they choose to smoke. They are supposed to take ownership. We inform, they make the decisions. (Højlund & Wistoft, 2008)

The pupils are expected to take active part in the information processes. From critical engagement a responsibilisation is supposed to be developed. A similar approach is adopted in a project concerning drug addiction.

Our starting point was to ask the young people about their health behaviour. How is your life at the moment, do you feel lonely? The questions were related to satisfaction and self-confidence. The schemes were used by the professionals as back up for the individual interviews. Other municipalities has taken up the idea. They have changed the concept a bit. Our concept was developed by a group of teachers. Also the pupils have been involved. They have evaluated and critised part of the project, for example some pupils thought that the film, we had chosen, was to boring. Then we changed the film. We take note of what they say, and go on with some of their ideas. (Højlund & Wistoft, 2008)

In relation to both smoke and drug addiction, the young people are constituted with a double reference as being on the one side groups at risk groups and at the same time responsible self-critical and self-learners. The latter category reflects the pervasive emphasis on civil society in as far as the young people figure as sub group members that can inform and learn from each other.

A similar conclusion was arrived at in a study of health promotion aimed at children and young people (Højlund & Wistofte, 20??; Højlund, 2011). The study observed different health promotion projects and concluded that the projects were structured as partnerships, i.e. places with no definite locus of power. As the projects were meeting places for different professional environments and also for public and civil society-relationships. One example from the study illustrates well this logic. Thus, a professional from a health department in a middle range sized municipality in Denmark explained about a coming together meeting in the health promotion unit:

In the municipality there was, for example, an interest in giving more emphasis to overweight children. In relation to this, 6-7 from the staff was invited to meetings, where the intention was to gather ideas. All of the invited people had something to do with children and overweight, and all of them expressed ideas to actual projects. No idea was turned down on beforehand . The ideas had popped up locally, and they had a broad base. In relation to the later process and the more specific development of the projects the invited employees did not have an equal part, which is, by the way, not necessary. (Højlund & Wistoft, 2008)

It is important to notice the inclusive knowledge ideal, the bringing together spirit, and the poly-valens of the facilitative organ. The same interview person explains that the most visible result from the idea meetings was an interdisciplinary project on tracking down children in early stages of overweight. From the interview we learn that the cross-anchoring from the ideas phase was continued in the later phases. A multi-disciplinary and participatory approach was thus pursued. Within this framework, the domain for health promotion emerges as fluid micro-relations where citizens come together to meet professionals who should take up a non conformist attitude toward a traditional welfare vocabulary. The old rhetoric of rights and duties is left behind and increasingly substituted by another relational language that are not of the you-do/we-do-kind. The citizens and the professionals in health promotive activities are encouraged to be open minded and transformative which is visible in the broad and positive conceptualisation concerning health underpinning the activities. Yet, the goals behind the projects are formulated from a life style and risk factor approach from where a strong duty ethic (you-should) is infused into the positive and integrative we-do-pedagogy (Højlund & Wistofte, 20??).

**Conclusion**

Hvordan illustrerer vores analyse den epistemologiske dimension i community-begrebet i off sundhedsfremme: Hvad kommer vi til at se, når vi iagttager med dette begreb? Hvilke zoner, domæner, hvordan opdeles subjekter fra hinanden og inden i sig selv?

Hvad siger anlysen diagnostisk? Fremviser den konkret Foucault ‘s begreb om moderne politisk eskatologi, dvs ideologier og politiske, der drømme om en dag, hvor civilsamfundet vækkes til live og unødvendiggør staten, hvor stat og civilsamfund bliver ét? Eller fremviser analysen nogle konkrete tendenser i den offentlige velfærdsstatsregulering, der rækker udover forebyggelses-området og den danske kontekst?

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1. The case studies discussed here were gathered as part of a three year research project including an interview-survey with key actors from all the Danish municipalities, information gathered through five in depth case studies each analysing one municipal strategy including policy-planning, implementation and projects aimed at children and adolescents. The studies also draw upon information obtained in 18 focus group interviews with young people from different Danish school settings (Højlund & Wistoft et al.20??) [↑](#footnote-ref-2)