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Discourses of lifelong learning: health as a governing technique in the shaping of the Swedish population

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ABSTRACT

This article focuses on how the Swedish population is shaped into desirable citizens as resources for the nation’s prosperity. The aim is to analyse how health operates as a governing technique in discourses of lifelong learning. Within such current discourses the population is today described as generally well-educated and healthy, but not educated or healthy enough. When constructed as being in need of enhancement, measures of learning are suggested for regulating certain groups of the population into becoming what is regarded as desirable. Making use of Foucault’s notions of governmentality and genealogy, white and green papers from the Ministry of Health and Social Affairs from 1930s and today (2017) are analysed. The analysis shows that although the population is described as having different problems originating from ignorance, the solutions that are suggested in the different time periods are basically the same. The relation between learning and health is described in different ways in the 1930s and the present. In the 1930s learning is explained merely as a means to achieve a healthy population while in the present health is described both as a prerequisite and as an effect of learning. Further, there is also a difference in how the governing is conducted.

KEYWORDS

Governmentality; lifelong learning; genealogy; education; health

Introduction

In contemporary western societies, the population and its qualities are foregrounded as essential for the nation’s well-being (see, e.g. WHO, 2013). One component described as of importance for gaining a proper population is education, and especially opportunities and access to lifelong learning. Discussions about lifelong learning have been intensified over the past decade and is brought forward in different contexts and at different levels, such as in policy texts and debates, but also in advertising, marketing and the everyday talk. Learning is supposed to happen all the time and everywhere, and calls for us to be prepared to learn throughout our entire life and in the different areas of life, i.e. learning should take place not only in school but also at work and at leisure time (see, e.g. Ministry of Education, 2017). Popkewitz, Olsson, and Peterson (2006) argue that discussions about lifelong learning bring about a pedagogisation of society where pedagogy and learning are written into other practices outside the educational system, for example, in public health and correctional treatment, where learning is presented as a necessity.

Further, in the ambition of shaping a prosperous nation lifelong learning has become a strategy wherein the state is presented as an enabler and regulator in fostering the good self-regulated citizen (see, e.g. Fejes & Nicoll, 2008). When talking about lifelong learning certain ideas about the
abilities and the quality of the population is displayed. One such central idea concerns the health status of the population. In this reasoning, each individual needs to learn how to manage their life to become knowledgeable, healthy and productive (cf. Simons & Masschelein, 2008a; Åkerblom & Fejes, 2017). Here, notions on learning and health become intertwined (see also EU, 2013; Ministry of Health and Social Affairs, 2011) – it seems like one must, in order to become and stay healthy, become a lifelong learner.

Thus, fostering a healthy lifelong learner is brought forth as a key in current discourses in Sweden. While the well-being of the population is put forward as generally good and improving, unequal health is raised as a concern, where certain groups are portrayed as being at risk, such as citizens with a low level of education, groups with ill-health and those who are unemployed (e.g. Ministry of Education, 2016; Ministry of Health and Social Affairs, 2007, 2011, 2016a). Such groups are at risk of being excluded, and certain measures are needed in order for them to learn to become healthy, and thus included. With such descriptions of the population and measures for improvement, we have what Foucault called a problematics of governing (see Fejes & Dahlstedt, 2013; Fejes & Nicoll, 2015), a situation in which issues regarding government are problematised. In this article, such problematics is addressed by analysing how health operates as a governing technique in current discourses on lifelong learning in Sweden.

Previous research

This article connects up to Foucault inspired research that analyses discourses on lifelong learning and how the population is shaped and fostered through such discourses (see, e.g. Edwards, 2002; Fejes, 2006; Fejes & Nicoll, 2008; Masschelein, Simons, Bröckling., & Pongratz, 2007; Simons, 2006). A common assumption among the mentioned research is that the population, in the name of learning, needs to be shaped, fostered and regulated (see, e.g. Olssen, 2006). Learning here expands beyond formal schooling, permeate the society as ‘the learning society’ (Simons & Masschelein, 2006), shaping the entire life into a life of learning (see, e.g. Fejes, 2006), may it be the ways public libraries are mobilised as places for the fostering of desirable citizens (Andersson, 2009), or how the path towards becoming a citizen in the US, by the naturalisation process, depends on the willingness and success in learning to commit to and perform the ceremony (Bishop, 2017).

Some Foucault-inspired educational researchers have focused more specifically on how health become intertwined in discourses on lifelong learning (e.g. Berglund, 2008; Green, 2007; Österlind & Wright, 2014). Here, focus of attention has, for example, been directed towards self-help literature (Rimke, 2000) organised sports activities (Green, 2007; Österlind & Wright, 2014) and health education (Leahy, 2014; McCuaig & Tinning, 2010). Self-help literature is in such research construed as a technology of the self, a practice of self-contemplation, focusing on shaping a desirable and mentally healthy citizen. Such citizen, need to, by herself, identify her own problems, find solutions, and work on herself in order to improve. Similar work on the self is carried out through sports activities. Here the prime interest is directed towards the body. However, by shaping and moulding one’s own body, the idea is for the ‘whole’ person to become healthier, physically as well as mentally (see, e.g. Green, 2007; Österlind & Wright, 2014). Closely connected to sports activities are more formal health education practices. Leahy (2014) argues, e.g. that health education discourses serve as management tools when it comes to learning how to be healthy, i.e. create healthy subjects. In such discourse, the usual ‘neoliberal suspects’ (p. 1) emerges, together with governing strategies relating to individualisation and accountability. Such strategies might be carried out through planned health and physical education activities which contributes to the fostering of healthy citizens (see, e.g. McCuaig & Tinning, 2010).

To sum up, health has been seen as a central part of current discourses on lifelong learning, and in governing and shaping the population into what is deemed desirable. In this article, the
focus will thus expand on such arguments by focusing on how health operates as a governing technique in current discourses on lifelong learning in Sweden.

The analytical tools of the study

The analysis draws on a governmentality perspective inspired by the work of Michel Foucault (2007a, 2007b). A governmentality analysis concerns itself with practices that shape, lead and influence people’s behaviour in accordance with what the one being governed is perceived to be by its very nature (Foucault, 2003). Governmentality can be described as thoughts about how governing should be practised wherein the population is shaped and governed (Fejes, 2006). By identifying some of the figures of thought prominent today, and tracing them back in time, it becomes possible to illustrate that how we reason about the population today is not new, but simply different.

Governing can thus be seen as a broad and diverse repertoire of techniques that operate everywhere in society (Foucault, 2003). These techniques, i.e. methods and procedures for governing individuals, do not need to be regulated by law. Instead, the governing can be conducted by means of tactics that shape the conduct of the population by working through people’s desires, aspiration and beliefs (see, e.g. Dean, 1999; Foucault, 2008). In other words, it is about the ways in which modern social and political systems control, manage and govern populations and individuals (see, e.g. Behrent, 2013). Historically, the relationship between ‘governing’ and ‘governed’ changed when the exercise of power shifted from a centralised governing to a decentralised governing. These changes have meant that the exercise of power has become liberalised. In this way, freedom has become the focus of governance, which, with knowledge as a basis, organises and regulates society and has the well-being of the population as a goal, rather than, as previously, its ownership.

Biopolitics and biopower are two central notions that Foucault introduced in relation to his idea of governmentality and are also important in relation to questions about how the population should be governed. According to Foucault (1976–2004) biopower is about the power to arrange life. Power has the mission to serve, manage and control life, its security and also the well-being of the population. Biopower has two types of power technologies: discipline, which acts against the body of the individual, and regulation, which acts against the population. Although these technologies operate at different levels, they are complementary. Foucault (2014) argues that biopolitics emerged in the 1700s in the wake of perceived problems of disease and population growth, both of which needed to be explored and corrected. Based on this, constructed knowledge about the population and measures such as educational campaigns were initiated with the intention of regulating the population into healthy and useful human material. Thus, biopolitics became a politic determined and governed by life, with different techniques and power exercises that intended to regulate, control and support the population.

In order to trace figures of thought back in time, a genealogical approach (Foucault, 1984) is mobilised. Garland (2014) describes genealogy in the following way:

It aims to trace the forces that gave birth to our present-day practices and to identify the historical conditions upon which they still depend. Its point is not to think historically about the past but rather to use historical materials to rethink the present. (p. 373)

Here, focus is on historical conditions in order to identify practices upon which we still depend; what points of departure, power and knowledge has made these practices possible? Thus, by mobilising a genealogical approach it becomes possible to identify processes of descent and emergence in present practices (see, e.g. Foucault, 1984; Garland, 2014; Hultqvist & Peterson, 1995; Rose, 1999). The purpose is not on explaining certain needs or imagined problems, but rather to understand how and why certain things occur as problems at any given time (Foucault, 2007a), the way power operates and with what effects in terms of shaping subjectivities.
In a governmentality analysis questions posed concern the how, what and effects of power, i.e. what is to be governed, how should governing be enacted, with what goal and effect? (cf. Dean, 1999; Fejes, 2006; Foucault, 2007b; Rose, 1998). In this article, these analytical questions are reformulated as How come the health of the population is constructed as a problem and how is health at the same time mobilised as a governing technique? How are the solutions explained and what has made such constructions possible? With such questions in mind, in reading the documents, focus has been directed at identifying regularities of statements on how the population and its health is described, what solutions that are proposed and what knowledge is mobilised in such constructions. Thus, by visualising discourses we can see what is talked about and not, in what ways and with what ‘effects’ in terms of shaping subjectivities (see, e.g. Foucault, 2007b).

**Empirical material**

The material selected consists of official documents produced by the government as these are considered important when it comes to government decision-making processes. Such documents depend on knowledge production in society, and can therefore be seen as important expressions of government’s possibilities to govern (Olsson, 1997). Accordingly, in order to rethink the present and being able to come close to the political decisions that generated and legitimised the institutional practices, the focus has been on selecting documents which make it possible to trace figures of thought back in time.

When selecting the official documents for analysis, the searchlight was directed at those in which the discussion about the need to improve the populations’ health is put in relation to learning and how these becomes arguments for certain educational measures and practices. Official texts in the present time, focusing on these aspects can be found produced by different ministries, not the least by the Ministry of Health and Social Affairs and the Ministry of Education. However, in order to avoid empirical overload, the documents from the Ministry of Health and Social Affairs were selected for further analysis. Not the least also because of these documents elaborating to a greater extent on issues in focus for analysis.

In order to trace the present discourses, historical documents from the same ministry were searched through. In such search, it became evident that discussions on the health and improvement of the population were very active during the 1930s. This was a time when the National institute for public health was created. Thus, with such distance in time (making possible a substantial genealogical tracing), as well as with such lively discussions, documents from the 1930s were chosen for further analysis. In sum, four official documents from the present time were selected for analysis (Ministry of Health and Social Affairs, 2007, 2011, 2016b, 2017) and two documents from the 1930s (Ministry of Health and Social Affairs, 1937, 1938). These six documents make up a total of 1262 pages.

When analysing the documents the interest is directed towards descriptions that become visible regarding how the discourse is built up, what the discourse do and what are the effects of the discourse (Fejes & Thornberg, 2009). In the process of analysing the following aspects, inspired by Dean (1999), was used as a guide: i) what are the problems and what is the solution to these, ii) how is the governing exercised, iii) who should be governed and what should the subject become, and iv) why do we govern or are governed. As a first step, the documents from present time was read through searching for meaning-bearing units and then continuing with the documents from 1930s. When reading the documents statements of interest are marked and re-read several times together with my first reflections and interpretations and finally, I bring this together to a coherent story.

**How to become a desirable citizen**

In the following analysis, the emphasis is on how the population is described in the policy documents in terms of what is desirable and how it is expected to behave in order to become what is described as ‘proper’. The documents from the present period are dealt with first.
**Fostering of the population – a shared responsibility**

In the contemporary policy documents, good health is constructed as important in order for individuals to be able to educate themselves and become lifelong learners. Good health is brought forward as one of the most important aspects of life and is connected to several conceptions about what it can contribute to. The documents contain different descriptions of health’s contribution to lifelong learning. The following is an example from the Ministry of Health and Social Affairs (2016b):

[..] good health is also an important prerequisite and resource for being able to do what you want to in life. In particular, this means having an opportunity to educate yourself, work and support yourself, and to participate in community life in general. (p. 13)

As can be seen, health is envisioned as crucial for an individual’s ability and possibility to educate her- or himself. Education and good health are regarded as necessary for a full life. The individual is expected to know what he or she wants to do in life, be educated, have a job, be self-supporting and play an active part in the community. Health operates as a governing technique and is described as both a resource and a requirement for freedom of choice. Being healthy and taking part in education and society enable people to choose how to live their lives (cf. Simons & Masschelein, 2008a). Health is thus put forward as an enabler that makes it possible for citizens to be what is desired. However, being able to and doing what you want in life does not mean having a carte blanche choice, but is about educating yourself, earning your living and participating in the community. In other words, people should choose in accordance with what the discourses prescribe and what is presented as good for society. In such a reasoning, education and health become techniques for self-governing (Foucault, 2008). Accordingly, education and health create the idea of a desirable individual, what the individual should be like and do, and how a desirable individual is shaped and fostered. Another approach in the policy documents is described as citizens having opportunities to take care of themselves.

People ought to have an opportunity to themselves define their health, formulate their potential problems and be able to find solutions to them. [...] Taking responsibility for and influencing your own health should feel joyful, engaging and important. (Ministry of Health and Social Affairs, 2011, p. 10)

All this is presented in the shape of opportunities. A desire is mobilised that individuals should be able to formulate their own potential problems and at the same time find solutions, i.e. a self-disciplined subject (Foucault, 2002). It is presented positively as something that is both necessary and important and that makes people accountable for their own decisions. Giving people the possibility to describe their health also makes them responsible for it, and by formulating and describing their problems they become responsible, confessional and self-problematising health conscious learning individuals. Governing as the conduct of conduct (Foucault, 2007b) emerges. In order to assist in such governing, ‘The individual’s responsibility is supported by effective interaction between public, private and civil society actors’ (Ministry of Health and Social Affairs, 2011, p. 10). One way of helping the individual to be responsible is by interacting with others, for example experts, although there is also an expectation that individuals should be their own experts (Foucault, 2008). This logic builds further on the argument that individuals will feel involved and someone to be reckoned with.

In order to feel well people need to feel involved and have an effect on their own lives. They develop and are at their best when living in a community that is characterised by caring, responsibility and solidarity. (Ministry of Health and Social Affairs, 2007, p. 7)

The above quotation refers to people feeling well, taking responsibility and acting in a caring way. This way of reasoning assumes that people know that they need to do and be, for example, by engaging in social issues and developing community together with others. It
seems like responsibility and solidarity create healthy individuals. The quotation also highlights the need for solidarity, a logic which implies an equal distribution of resources in order to avoid health differences between citizens. This is elaborated on further in the following quotation:

The main tool that is available for counteracting different forms of inequality in health determinants is therefore the welfare state’s various institutions. Also, actions that increase knowledge, competences and human capital, and thereby people’s own abilities to create or manage the resources they have access to, often take place within the framework of welfare institutions. (Ministry of Health and Social Affairs, 2017, pp. 53–54)

Solidarity and commitment are assumed to be insufficient. Here, the argument is that the state has a responsibility to provide institutional welfare practices that aim to teach, increase knowledge, skills and human capital. If the individual has not yet reached his or her full potential, efforts are needed to help them to learn how to do this. These institutional practices are measures that, through lifelong learning, will acquaint the individual with his or her abilities and how best to manage them (see, e.g. Miller & Rose, 1990, 2008). One such institutional practice was created in 2015, when the government appointed a committee to look into closing the avoidable health inequality gap within a generation (Ministry of Health and Social Affairs, 2016b). Another example was the 2017 proposal on launching the Swedish Commission for Equity in Health (Ministry of Health and Social Affairs, 2017).

By way of a summary, the above has illustrated how the population emerges as a problem today in terms of learning and health. On the one hand, health emerges as a technology for shaping a lifelong learner. That is, one needs to be healthy to become a well-functioning learner. On the other hand, learning becomes a tool in order to become healthy, i.e. one has to learn to take responsibility for one’s own health. In sum, health here becomes both the enabler and effect of learning. The question we now turn to is how such relation is shaped in documents from the 1930s.

**Fostering of the population – a governmental responsibility**

At the end of the 1800s, discussions were held about the how the state could arrange and control medical institutions in order to preserve and promote human material (Ministry of Health and Social Affairs, 1937). These discussions resulted in a proposal from the state medical board for the establishment of a State Institute of Social Hygiene, with a focus on social hygiene measures and the prevention of ill-health among the population (ibid.). Eventually, in 1938, the National Institute of Public Health was established. At this time, public health was talked about much in terms of hygiene, and the prevention measures were exercised through controls, for example, of public hygiene, social hygiene, occupational hygiene and food hygiene (e.g. Ministry of Health and Social Affairs, 1937). However, it was not only through prevention that health could be improved. Another measure for achieving better public health was by educational interventions, which is elaborated on in the report by the Population Commission (Ministry of Health and Social Affairs, 1938).

There are different ways of improving the two principal causes [nutritional standards and family economics]. Where the cause for deficiencies is poverty, the community needs to be supportive. When the cause is a lack of insight, an enlightening and fostering activity must be organised. As the two causes are closely interwoven, the measures should also be coordinated. It is of particular concern that when society steps in with a financially supportive activity, it should be organised in such a way that it also fosters health. (p. 11)

Here, health is visualised by the description on health problems within the population. In the relation between the state and the population, the state is pictured as responsible for the population’s learning and health. Thus, the responsibility is not only to feed and nourish the population when this becomes necessary but also to foster and educate them. The population is described as having a lack of insight into both nutrition and finance and by combining financial
support with learning and fostering activities, the assumption is that health will also be fostered. In this reasoning, the individual has very little say; it is the government that has the responsibility and defines the problems and awareness of learning and health.

It is society’s responsibility in both respects [nutrient deficiency and poverty] to take positive action. Society cannot thus entrust enlightenment and fostering activities to individual initiative. It is now generally recognised that information about nutritional issues ought to be organised as part of both the teaching in school and general education. (Ministry of Health and Social Affairs, 1938, p. 11)

When it comes to information and learning, the individual is not entrusted with taking the initiative. Rather, society has to take responsibility for organising the teaching and the information at the school and general education levels. Enlightenment and fostering on how to be healthy need to take place in institutions, and cannot be practised by or transferred to citizens. In order to reach as many people as possible, the learning and fostering should be woven into formal education, which then makes it possible to control what is taught and by whom. In this reasoning, the citizen is shaped as an empty vessel that has to be filled with proper knowledge by the right sender. In this discourse on the population and its fostering, education and health intersect. Here, health mainly emerges in the shape of social hygiene and is defined by its contribution to making good human material. As can be seen in the following quotation, the population is described as having problems that need to be corrected through education and educational measures.

There should be no doubt that the organisation of modern social hygiene requires access to an appropriately ordered and scientifically controlled and led information service. Social hygiene as a whole is to all intents and purposes a general education problem. (Ministry of Health and Social Affairs, 1937, p. 18)

In the policy documents, a shift from a medical perspective to an educational perspective is visualised when it comes to how the population’s problems should be dealt with. As people are not regarded as having the capacity to be healthy, or to benefit from such knowledge, they should be educated and fostered in order to prevent ill-health. One way of doing this is by preventive measures that are designed to by education maintain and increase the population’s health. In this context, the institution becomes an enabler which guides and teach people into behaving in the proper way. The institutional practices that emerge are based on the idea of a lack of trust in the population, and that ‘someone’ has to monitor, evaluate and control them (Foucault, 2007b). Through the emergence of institutions, intervening in people’s lives becomes legitimate. Thus, citizens are governed by ‘the correct’ knowledge, enablers and controllers.

So far, the overall discourse on how to foster a so-called inadequate population has been illustrated. This discourse is based on depictions of the population that subsequently create arguments for lifelong learning through institutional practices. However, as can be seen, there is a different relation emerging between health and learning in the present as compared to the 1930s. While in the present, health becomes both the prerequisite and effect of become a lifelong learning, in the 1930s, learning becomes a ‘mere’ means for becoming healthy. Further, in the present, responsibility for becoming and being healthy is put in the hands of the individual, while in the 1930s the State emerges as the one who should teach and foster the population.

While focus in this section has been on the relation between health and learning, in the next section we turn to questions about how certain knowledge is mobilised in order to legitimise the creation of institutional correctional practices.

**The emergence of institutional practices**

This section examines the ideas about how to govern the population as they appear in the documents and visualises how they both facilitate the various institutional practices and contribute to the fostering of the population. Although there is an interweaving between population policy, public health and educational processes in the documents from the 1930s (as well as the
present day), the population is portrayed in different ways. The section starts by describing the current ideas about the need for an institute and ends by tracing these ideas back in time.

**Contemporary ideas**

In a final report from the Swedish Commission for Equity in Health (Ministry of Health and Social Affairs, 2017), a description of what Sweden needs to do to create a society based on equality, shared interests, objectives and standards is formulated in the following way:

> [...] in order to strengthen individuals’ own possibilities to act and generate resources and in order to increase the general public’s ability to contribute resources to individuals and families in periods of life or in situations in which their own resources or courses of action are insufficient. More equal living conditions and opportunities for things like a good upbringing, a good education, a good job and a reasonable income, also result in a more equal health (p. 7)

The ambition is to create conditions for individuals so that they can contribute both to their own and the joint resources. In the above statement, education, work and reasonable income are described as prerequisites for equal health. Individuals are here regarded as in need of being strengthened in order to increase their own and society’s resources. It is about creating resources for the public and equal living conditions – creating equality in life in the end creates equal health. Here, a notion of solidarity is produced. There is also a moral dimension where, in the name of equal health, it becomes legitimate for the state to intervene in individuals’ lives. The idea is that by having resources such as an education, a job and equal living conditions, health becomes equal, as stated by the Ministry of Health and Social Affairs (2017): ‘The resources that via different welfare institutions are intended to benefit citizens are especially important for people with few own resources’ (p. 53). In addition to measures directly aimed at the individual, the idea is that equal health can be achieved by control and regulations:

> measures for more a strategic governance, follow-up and evaluation are a way of achieving more equal health. Ultimately, this will also be beneficial for the citizens, although the focus is on how different changes in the way the work is governed, functions and followed up can create better quality and greater accessibility, which in turn can contribute to improved living conditions, opportunities and health for those who need support and input from the different welfare systems. (Ministry of Health and Social Affairs, 2017, p. 9)

Having a tactical grip on the institutions and controlling how they operate means that they are governed in line with the strategical goal of improving the population’s health (see, e.g. Foucault, 2007b). The measures aim to bring about an equal health that everyone will benefit from. The necessity of controlling the institutions is in turn legitimised by an expectation that this will lead to better quality, improved living conditions and greater accessibility. The institutions can therefore be seen as practices that regulate and examine other institutions in the Swedish welfare system. The institution is put forward as a facilitator that will make it easier for individuals to learn how to become healthy and, at the same time, enable other institutions to become more efficient. It is about the strategical management of society and people’s lives (Foucault, 1976–2004). The suggested measures for solving the inequitable health problems are expected to come from welfare institutions and: ‘[…] can be about generally offering education, health- and medical care, pensions and other things to help people deal with different life risks, but also in order to invest in a well-educated and healthy population’ (Ministry of Health and Social Affairs, 2017, p. 68). In reasoning like this, welfare institutions become institutional practices that are aimed at shaping the population in the name of equality and the nation’s best. It is about, under surveillance, making sure that life goes round by organising society together with and for the population (see, e.g. Foucault, 2007b). However, the governing is not only about institutionalised educational measures, but also includes disciplining tools designed to influence the population’s decision-making: ‘[… ]there are also other instruments, such as for example, through information, regulations or prices influence people’s prerequisites and abilities to make choices in different
situations’ (Ministry of Health and Social Affairs, 2017, p. 68). With strategies like this, rules and tools, such as price setting to enable and ensure that individuals learn and understand how to make the right choices, regulate the population’s decisions.

In the documents, ideas and thoughts about knowledge and how to improve it appear as starting points in institutions’ work with governance and the follow-up of the implemented measures.

In order to strengthen the prerequisites for knowledge-based work for a good and equal health, the knowledge about how political decisions and different activities affect health and its determinants in different social groups should be strengthened. This in turn requires better knowledge about mechanisms and processes that contribute to inequality in health, and better follow-up and evaluation of measures that have consequences for a good and equal health. (Ministry of Health and Social Affairs, 2017, p. 15)

Here, knowledge is pictured as the prerequisite for making influential political decisions and for describing health determinants. It is important to be able to assess the effects of measures that have been introduced so that order and control can be created and maintained. Assessment is important in order to determine whether the outcome is as expected, based on what the problem is and what is described as the needs of the nation. Further, knowledge about how political decisions are made and what effect they have on the distribution of health is needed. The follow-up and evaluation of policy decisions are suggested as being important for the development of health. In the quotation, we can see that political decisions should be evidence-based and that politicians need to be educated and controlled to ensure that correct decisions are made that benefit individuals and society based on solidarity and equality. There is also a wish for better control when it comes to the effect of the measures. One way of achieving these controls and being able to guarantee that the measures have the expected impact on the population is evaluation. One way of doing this is by creating national records (Ministry of Health and Social Affairs, 2017) that keep the population under surveillance and thereby easier to control (see, e.g. Foucault, 2017). By keeping track of the population, disarray is prevented and the population can be organised. Reasoning like the above creates arguments for interventions that target the population, which in turn legitimises intervening in individuals’ lives. In 2017, the government suggests the establishment of a council for a good and equal health with a view to ensuring that the proposed control instances would actually have some effect (see, e.g. Ministry of Health and Social Affairs, 2017).

**Tracing ideas back in time**

The documents from the early 1900s describe the launching of the Social Hygiene Institute, with ‘the character of institute of public health’ (Ministry of Health and Social Affairs, 1937, p. 26). In both the past and present documents, certain problems relating to the population’s way of living are in focus. In the long run, a concern for the nation’s existence, prosperity and the population’s well-being can be traced. The National Institute of Public Health is presented as a solution to these problems and for avoiding disarray. The discussions in the 1930s are mainly about people in general; the individual as such is not visible in the same way as in the documents from the 2000s. In documents about the National Institute of Public Health, the assumption is that sciences like medicine and sociology legitimise the measures that are directed towards the population. The described expectation is that with an institution like this, knowledge about and solutions to the nations identified health problems, e.g. diseases linked to poor housing conditions and harmful living habits, could be managed. That is, knowledge about diseases and ill-health, instead of knowledge about what is healthy, operates and becomes central in the governing of the population. Further, the Institute is also expected to deal with ‘the general preventive care of modern society’s human material’ (Ministry of Health and Social Affairs, 1937, p. 17). In other words, the discussion is about bringing order to and taking care of the population and the problems
connected with its health. Further, preventing ill-health in different social classes is brought forward in the name of equality and solidarity. Ideally, the task is to prepare and promote preventive measures that ‘are intended to preserve or improve people’s health’ (Ministry of Health and Social Affairs, 1937, p. 26).

The Institute’s mission is described as conducting research and research activities in the field of hygiene in order to contribute knowledge about how to shape a prosperous nation. In addition, the Institute should provide education for public health officials, such as district nurses and health officers (Ministry of Health and Social Affairs, 1937). The Swedish population is here constructed as being in need of support and help, and that by giving them the opportunity to acquire scientifically based knowledge they will learn how to improve themselves and others, i.e. learn how to manage their lives in the proper way (see, e.g. Foucault, 2002, 2008). The arguments for the need for an institute is built on the idea that (scientific) knowledge about the population should be conducted and communicated here. This can be seen from at least two perspectives: the need to gather research in one place to ensure good quality, and to facilitate the research and disseminate the resulting knowledge. The intention is that the general public will be offered information and support in order to learn and align their lives with scientific facts. In other words, the knowledge that is produced within the institute will make it legitimate for the state to intervene in citizen’s lives.

At the same time, the described need to govern and refine the population has a competitive element to it.

In recent decades social-hygienic institutions have been established in a number of states, which for various reasons have not achieved the social and cultural development that characterises our country. According to the experts, the question’s solution for our country can no longer be postponed (Ministry of Health and Social Affairs, 1937, p. 23)

An important component for launching the Institute is described from a comparative and competitive perspective. In the quotation, it seems to be important for the nation that political decisions are made so that the establishment of the Institute is in the population’s best interests and preserves the nation’s reputation. The picture that is conveyed is that there is a fear of lagging behind countries that are imagined as having a poorer social and cultural development than Sweden. Another important mission for the Institute is to foster a population that can best serve society by means of public-oriented health propaganda. The Institute is further seen as educating the population to take care of itself.

An additional educational related task for the Institute is the public-oriented healthcare propaganda. […] Experience has shown that the prevention of many health-related conditions are often due to the individual’s knowledge and willingness to take care of him- or herself (Ministry of Health and Social Affairs, 1937). Even though most of the discussions do not take their starting point at the individual level, the target is, in fact, the individual. Thus, it is the will and decision-making of individuals that need to be regulated by knowledge and education.

To sum up, what we can see in the past and present documents is that some ideas are recurrent when it comes to the shaping and fostering of the population. For example, education, learning, information and propaganda appear as important and operate at all levels in society. Education and science are both assumed and described as supporting and creating the image of desirable citizens. The idea is that through educational practices citizens should learn to become useful; for their own good and for that of the nation, where a wisely planned education is assumed to awaken
a sense of responsibility for the future and nations continued existence. That is, in the 1930s, the logic was that the state had the unchallenged right to take decisions and responsibility for its citizens. The state was portrayed as ‘the great father’, with authority to manage people’s ways of living and instil the will in them to take care of themselves. In the 2000s, the state appears as an enabler that has the responsibility and ambition to foster a lifelong learner and provide the individual with education, a will and an opportunity to increase their own ability to deal with and manage life. This way of reasoning creates accountable self-governing citizens (Foucault, 2008) who continuously govern themselves in accordance with the current discourses. Thus, the state as an enabler hands over, under surveillance, responsibility and decision-taking to the individual, although this transfer depends on the fact that educational measures have already ensured that the individual is able to make the appropriate choices.

Both in the 1930s and 2000s, the governing of the population is based on an idea of minimising risks by making sure that the ‘right’ scientific knowledge is taught and that the population is supervised, controlled and disciplined. By turning to scientific knowledge (preferably about ill-health and diseases), governing is ensured and legitimised and scientific knowledge is entrusted with making reliable suggestions about an individual’s way of life. By launching institutional practices in both 1937 and 2017, learning is facilitated and made possible. Further, the idea is that accurate information is passed on by experts and that established institutional practices are ascribed with the power and right to intervene in how people live their life. In short, is it all about evaluation, evidence and control.

Discussion

In this article, it has been argued that although the population is described as having different problems which in some way stems from ignorance, the solutions that are suggested for solving the problems are basically the same. As we can see in the analysis, the assumption is that by teaching the population how to be and behave, education and lifelong learning becomes the solution. Additionally, the suggested measures to foster and regulate the population at respective period of time are not created in a void, but are enmeshed in current discourses about the kind of problems the population is attributed with (see, e.g. Miller & Rose, 1990, 2008). The population’s problems appear in a discourse in which the Swedish population is described as being deficient, or not good enough, not the least as pertaining to issues of health. The discourse on the need for improvement is linked to the construction of what is desirable and necessary in order to compete in a global market (e.g. WHO, 2013). Such a construction of the Swedish population contains a perception that there is a need for guidance, i.e. a governing problem. In this way of reasoning, certain challenges are foregrounded and certain solutions suggested. Here, measures like institutional practices can thus be seen as a biopolitical project to educate, manage and regulate the population (Foucault, 1976–2004).

In the past and present documents, the population is described as not good enough. Certain groups appear as being more insufficient than others, and this is presented as a public education problem. The attempts to smooth out the differences have certain similarities. Despite the fact that the population problems are partially described as having different origins (e.g. malnutrition, overweight), the conclusion in the texts from both decades is the same, namely that scientific knowledge and educational measures enabling learning are the solution. By providing the population with knowledge-based information and propaganda, which is produced in order to offer solutions to problems that are created within a given discourse, the population can learn, be corrected, regulated and moulded into something that they not yet have become (see Foucault, 2003). The argument that is put forward is that both decades’ problems originate from and are based on the population’s misleading insights, which through educational efforts will be regulated to make the population fit into the required template. Further, knowledge should be acquired through autonomous learning activities, a kind of self-care, where the institutional practices
become an enabler to lifelong learning. In this logic, one can say that power is imbued and exercised in lifelong learning through self-discipline.

In the discourse of improvement of the population, health operates as a governing technique for shaping well-functioning citizens. The analyse shows that the techniques are not new, but have been a tool for fostering the population for a long time, however, expressed in different ways. Today, health is presented as a prerequisite for shaping a well-functioning learner but becomes also an effect of learning as educative measures are expected to teach the citizens how to become responsible for their health and thus, become healthy. In the 1930s, however, health becomes ‘just’ a tool for the state to unchallenged govern the population to become what is asked for, i.e. a well-functioning learning citizen. Thus, the governing relation has changed as the governing of the population in the 1930s is conducted by the state, whereas in the 2000s the governing is conducted by the individuals themselves (cf. Rimke, 2000). In addition, in both sets of documents, techniques such as surveillance through, e.g. evaluation and experts are recurrent but do not necessarily operate in the same way. In the name of educational need, health, solidarity and equality, incentives are created to map the population. The population is thus visualised, measured, weighed and calculated, i.e. knowledge is produced about the population that can be used and reused to create more knowledge and interventions directed at it. Thus, selected knowledge is mediated to the population as information or propaganda that contributes to bringing order and at the same time responds to the possible problems within the given discourse.

The shift of relation between the state and the citizen connect up with changing ideas of how governing should be conducted. As Foucault (2007b) as well as others who have developed his work (e.g. Edwards, 2002; Fejes & Dahlstedt, 2013; Rose, 1999) governing today is shaped within a neoliberal notion of how governing should be conducted. In such notion, the state becomes an enabler where citizens are expected to shape and govern themselves. The state has become ‘distanced’ to the governing practice. This is exemplified through the way good health today is seen as emerging if people take responsibility to learn how to become through guidance and support. This is different as compared to the 1930s, where the state was rather shaped as the ‘visible great father’ who, through regulative measures would increase the health of the entire population.

In both sets of documents, the idea of lifelong learning is brought forward as of great importance when it comes to governing the population (cf. Fejes & Nicoll, 2008). The described connection between education and health creates and legitimises a need of institutional practices, which in turn legitimises the governing of the population into, in this case, a continuously learning population. Further, this logic thus creates a need for learning and knowledge control. As the implemented educational measures are imagined to foster a constantly learning population the measures become biopolitical arguments which appear and reappear in the techniques in different periods.

As mentioned above, the solution for gaining a proper population in both decades appears to be to educate the citizens. In the analysis, we can see that the relation between learning and health is expressed in different ways. In the 1930s, learning is described only as a means to achieve a healthy population, i.e. an enabler for citizens to become healthy. However, in the present health is described both as a prerequisite and as an effect of learning. That is, for having the possibility to become a lifelong learner you need to be healthy and by being a lifelong learner you also become healthy.

In one way, such argument is in line with previous research that has focused on how health becomes an important idea within current discourses on lifelong learning (see, e.g. Green, 2007; Österlind & Wright, 2014; Rimke, 2000). However, this article contributes further by offering a genealogy of such discourse. Through genealogy, it is possible to illustrate how current discourses are shaped through ideas present previously, although differently. As described above, the population as a problem in terms of health is not new, nor is the use of educational measures in the name of learning. However, what is new is the way the relation between the state...
and the individual is shaped, where today, citizens should learn to govern themselves in the name of freedom (see, e.g. Fejes & Dahlstedt, 2013; Rose, 1999). Rather than direct intervention in people’s lives as in the 1930s, the intervention today is subtler. Thus, the healthy citizen of today is different compared to the healthy citizen in 1930.

The genealogical analysis provided here proves space for further discussion and debate about our present and how lifelong learning discourses shape us as certain kinds of citizens. Such shaping is not neutral nor unproblematic, and thus, it deserves further attention.

Disclosure statement

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