

# Rethinking Community, Medicalization, Social and Health Care: A Foucauldian Analysis

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## Abstract

*Social care and health services are fundamental issues used to situate the aging identities that people who require such services in occidental societies. Both contain changing vehicles that arbitrate relations between older people and health and social care professionals underpinned by politics and policy and the communities they live in and the interactions with family members and friends. However, they also represent an increase in professional power that can be exerted on old age, and thus, the deep layers of meanings associated with that part of understanding aging. The article presents a analytical framework based on a critical re-interpretation of the work of critical French philosopher Michel Foucault as applied to aging, care and health in communities and impact on families and informal carers. It identifies the interrelationship between care managerialism and older people in terms of a conceptual understanding of medicalization and surveillance and the crucial point is that they are relevant in theorizing power relations between health and care professionals and older people under the rubric of new policies such as integrated care. However, health spending still dominates and social care is chronically under funded, highlighting a huge disparity in policy domains of what is said and what is delivered. Post BREXIT, it is possible it will become clear that the funding for social care from the Boris Johnson administration (2019-) in the UK will fit with the neo-liberal project of putting the emphasis on care onto families, informal carers in communities and older people themselves.*

**Keywords:** *medicalization; old age; surveillance, health and care.*

## INTRODUCTION

This paper illuminates the use of Michel Foucault's analytical theorizations for health and care power relations with older people. It is unapologetically a Foucauldian article with controversial and critical implications for professional power and aging. In a disciplinary field depicted as "data-rich but theory-poor" there would appear to be a great many researchers who might respond that there really is no need for social theory in understanding health and social care policy and practice with older people. They might claim empirical generalizations are sufficient and that broader frameworks are obfuscating and unnecessary. Judging from a content analysis of all articles published in the early 1990s in eight gerontology journals, it would appear that nearly three fourth made no reference to theory at all (Powell,

2017). Without a sound conceptual grounding and reflexive perspective, social gerontologists build little more than empirical molehills without any cumulative effect. We might go further still, without abstracting scaffolding; facts cannot exist in a perceptual sense. Facts depend on a perceptual framework, and, were they to stand alone, they would have precious little cumulative effect, amounting to little more than a pile of bricks awaiting an architect. To provide the architect, this paper can look to the work of Michel Foucault that provides "analytical toolkit" to interrogate relationship between health and social care professions and user groups and consequences for older people, communities and informal carers. Foucault's analytical frameworks are relevant for applied gerontology as he problematizes health and care professions as an instrument of state governmentality, an agent that

reproduces dominant state discourses on “old age.” The author has argued elsewhere that the power relations in health and care institutions produce user groups as “customers” (Powell, 2006; Powell 2017). Simply put, in using this language of the customer, health and care policies attempt to replace the “care” and “health” subject position with that of “consumer.” Despite personalisation, which has implications for families and communities, it is normalized through discourses and social practices such as surveillance, power, and domination despite its rhetoric. At the same time, Foucault has identified that power is both repressive and a creative relation underpinned by “resistance” practices.

The process by which older people are made subjects are related to powerful “managerial” actors in health and social care. This article provides an analytical framework critique to problematize the consolidation of managerial power primarily drawing from examples in the United Kingdom and United States. It fundamentally questions the assumption that managerialism in the post welfare state has evolved independently, in its work and social practices. Indeed, in the past several years, social policy in the United States under President Trump and under PM Boris Johnson in the United Kingdom have focused on the management of old age with particular emphasis on the reform of health and social care. In the case of the United Kingdom, the process of reform was imposed by central government backed up by exaggerated demographic arguments in communities which has a long history of the present (Phillipson, 2013; Powell, 2017).

It must also be stressed that the community care system was also in a less systemic and coherent structure; this also led to calls for it to be radically reformed (Phillipson, 2013). The personalisation reforms offered the promise of greater choice and autonomy for care workers, families, communities and service users through the intensification of marketization into areas traditionally, directly controlled by central government such as community care. Coupled with this, service industries such as professional social work have had a fundamental redefinition of their profession as managerial systems (Lewis & Glennerster, 1996; Phillipson 2013). Indeed, the nature and philosophy of such care provision for older people has been the central cornerstone in debates within the popular imagination in recent

years. The continuing resonance of this question is linked to the perceived role of the professional social worker as a bulwark against an encroaching tide of “dependency” (Hughes, 1995). A distinctive feature of the welfare state has been the systematic introduction of new managerialism throughout the public sector and introduction of new sectors such as the Third Sector. Thus, Powell (2017) points not only to the substantial increase in the number of people working in welfare organizations with the title “manager” but also to the transformation of many formerly professionalized roles, into “hybrids,” where a significant aspect of the occupational identity is managerial. This is increasingly the case, for example, with head teachers, general practitioners, and care managers. Care managerialism constitutes a move away from direct social care toward “monitoring” and “assessment” (Powell, 2017). The price to be paid, however, is that the relationship between helping professionals and older people has been reduced to one of surveillance. The surveillance role evokes a “surface” of reality as constructed as “depth,” whereby professional methods of surveillance are presented as “concern” models. This act of observation confers a uniformity that emphasizes the “protective” role of the professional rather than the substantive requirements of older people at the centre of surveillance (or “professional monitoring”). In the United States and the United Kingdom in particular, the transition from a top-down social policy that managed dependent populations through the welfare state (pensions, unemployment insurance, and healthcare) to a postwelfare or neoliberal state has gained momentum in recent years. Currently, surveillance occurs more bottom up: Central control has been replaced by local power; management systems are inspired by consumer models to welfare, there is a reliance on risk assessment. For example, at the local level in the United Kingdom, managerialism is seen to challenge “dependency” by promoting social relationships of “partnership” and “trust” between professionals and older people underpinned by drawing in families and friends in communities to provide care.

Such social relationships are supposed to have arisen because the mixed economy of welfare embodies a diversification of political agendas and multi public, private and third sectors: the control of financial resources, the improvement of services and promotion of choice, changing the role of local authorities and councils, a reduction in public sector provision, a

focus on social relationships between professionals and service users; and increasing family care. Indeed, if we recall in the United Kingdom, the Department of Health's (1991) policy rhetoric has highlighted the contradictions of the role of the British care manager: "The guiding principle of implementation should be to achieve the stated objectives of the care plan with the minimum intervention necessary. It should, therefore, seek to minimize the number of service providers involved" (Hughes, 1995, p. 94). At the same time, British care managers should be "tailoring services to individual needs and promoting wider choice" (Hughes, 1995, p. 94). Hence, the process of choice has become privatized and contingent on consumer sovereignty that has an impact on how resources are mobilized, especially in 2009 with a world-wide recession.

Comparatively, the United Kingdom, the United States, and Canada have similar policy shifts toward community care, but this has lacked sufficient integration between the funding, administrative, and ideological frameworks that support acute and long-term care (Powell, 2017).

In 2008 in the United States at the beginning of the 'credit crunch', with the Medicare D, this highlighted a shift of emphasis to a market-based, deregulated medical policy. Crucial aspects of the George W. Bush administration plan were characteristically delegated to insurance and pharmaceutical companies. Indeed, a preoccupation with the medical challenges presented by Medicare D, underpinned by privatized and insurance-driven health provisions, has resulted in what Foucault (1973) may have observed as an expansion of the medical gaze into wider areas of health and social policy. The medical gaze refers here to discourses, languages, and ways of seeing that shape the understanding of aging into questions that center on, and increase the power of, the care and health professions, and delegitimize other possibilities. A consequence is that areas of policy that may at first seem tangential to the medical project come to be reflected in its particular distorting mirror. The impingement of the medical gaze can also be seen in the policy debates concerning disadvantaged groups over a shrinking public purse. The impact of medicalized notions of aging and its construction as a "threat" to other sections of the population can also be seen in the proposed rationing of Medicare coverage in American welfare policy. Here, medical care has both come to colonize notions of old age and reinforce

ageist social prejudices to the extent that "infirmity" has come to stand for the process of aging itself and Medicare its potential policy savior. Obamacare which attempted at universal coverage of medical access was stripped away by the Trump administration on the premise that individuals pay for their own care.

Notwithstanding this, managerial power then is seen as a key professional role that is fundamental to transforming social relations within a consumer-led economy. Care management has become a space for the surveillance of older people. It is argued here that such a managerial mechanism is not of instigating choice, empowerment, and social inclusion, but is a professional institution. for individual regulation and collective control of user groups: older people. Hence, there are two dimensions that are particularly important to this article on theorizing aging and professional power. First, there is the use of a Foucauldian perspective to locate the discontinuities in the relationship between health and social care professionals with older people. Second, there is the question of power itself and its relevance to the emergence of a discourse articulated by professional managers who assess, probe, and inspect a distinct populational group: an aging population.

### **A FOUCAULDIAN ANALYTICAL FRAMEWORK: MEDICALIZATION AND MANAGERIALISM**

Michel Foucault's (1977) landmark works have importance to the social analysis of old age. First, his analysis of punishment and discipline and medicine and madness have relevance to the images of older people. Foucault (1973) described how subjects of knowledge such as "criminals" and "mentally ill" are constructed through disciplinary techniques, for example, the notion of the expert "gaze" (p. 29). Old age is constructed in a similar way. Second, Foucault (1977, 1980) made it possible to analyze both the official discourses embodied in health and social care policies and those operating and implementing within society: "care managers" and "older people":

*'It was a matter of analysing, not behaviors or ideas, nor societies and their "ideologies," but the problematizations through which being offers itself to be, necessarily, thought—and the practices on the basis of which these prob- lematizations are formed.'* (1980, p. 11).

The works of Foucault (1967, 1972, 1976, 1977) have problematized issues of madness and illness,

deviance and criminality, and sexuality. Foucault has problematized the role of the medical “expert” that seems “empowering” but is a contingent sociohistorical construction. The relevance to old age is the recognition that social practices “define a certain pattern of ‘normalization’” (Foucault, 1977, p. 72). Such social practices are judged by experts such as medical personnel and care managers who problematize older people via a process of assessment for services. Care managers are pivotal to Foucault’s (1977) analysis of “panoptic technology”; they normalize judgment on older people:

*The judges of normality are everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the “social worker”-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behavior, his aptitudes, his achievements. The carceral network, in its compact or disseminated forms, with its systems of insertion, distribution, surveillance, observation, has been the greatest support, in modern society, of the normalizing power. (Foucault, 1977, p. 304)*

For Foucault (1977) normalizing power involves the dimensions of physical and biological discourses and how these are inserted on the human body. The aging individual is located in a political field saturated with power relations that “render it docile and productive and thus politically and economically useful” (Smart, 1985, p. 75). Hence, the care manager plays a role in power relations as she or he “take(s) responsibility for ensuring that individuals needs are regularly reviewed, resources are effectively managed . . .” (Department of Health, 1989, p. 21).

To examine this further, some of the conceptual tools emanating from Foucault illuminates their relevance for understanding the relationship between health and social care professionals and older people. Using Foucault’s work focuses on two interrelated areas of Foucauldian analysis: medicalization and aging, and surveillance and crucially resistance.

Jaber F. Gubrium (1998) has suggested that medicalization is an important foundation for understanding how public and professional perceptions of older people are created via truth discourse. For Foucault (1980) “‘truth’ is linked in a circular relation with systems of power which produce and sustain it” (p. 133). All strategies that attempt

to control older people involve the production and social construction of “true” knowledge. Historically and before the prevalence of managerial systems, biomedicine played a key role in articulating truths about the social condition of older people (Katz, 1996). The relevance of this to Foucault’s work is the way in which the gaze of truth constructs people as both subjects and objects of power and knowledge. In *The Birth of the Clinic*, Foucault illustrates how such a gaze opened up “domain of clear visibility” (Foucault, 1973, p. 105) for doctors for allowing them to construct an account of what was going on inside a patient and to connect signs and symptoms with particular diseases. The space in which the gaze operated moved from the patient’s home to the “hospital.” This became the site for intensive surveillance, as well as the attainment of knowledge, the object of which was the body of patients. The identities of “elderly people” have been constructed through expert discourses of “decay” and “deterioration” and the medical gaze helps to intensify regulation over older people to normalize and provide assessment and treatment for such notions (Foucault, 1977; Katz, 1996). Medical discourse, under the guise of science, was part of a disciplinary project oriented to: *create a model individual, conducting his life according to the precepts of health, and creating a medicalized society in order to bring conditions of life and conduct in line with requirements of health.* (Cousins & Hussain, 1984, p. 151)

For medical professions, this legitimizes the search within the individual for signs, for example, that she or he requires intense forms of surveillance and ultimately processes of medicalization. This permeates an intervention into aging lives because practices of surveillance benefit older people because of the medical discourse permeation of “its your age.” Surveillance of older people enables biomedicine to show concern for their health and acquire knowledge about their condition. Hence, it constructs older people as objects of power and knowledge:

*‘This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects’ (Foucault, 1982, p. 212).*

The process of observation objectifies particular older people as “diag- noses began to be made of normality



and abnormality and of the appropriate procedures to achieve . . . *to the norm*" (Smart, 1985, p. 93). In this way, studying and examining the body and mind of older people is intrinsic to the development of power relationships between health professions and older people as users:

*"The probing technique is at the centre of the procedures that constitute the individual as effect and object of power, as effect and object of knowledge. It is the examination which . . . assures the great disciplinary functions of distribution and classification"* (Rabinow, 1984, p. 204)

The probing technique, argues Foucault, combines panopticism and normalization and "establishes over individuals a visibility through which one differentiates them and judges them" (Foucault, 1984, p. 184). Foucault (1977) argued an individual is established as a "case" and may be judged, measured, compared with others, in his or her very individuality. This individual may also have to be trained, classified, normalized, excluded.

Foucault places great emphasis on the processes of assessment and surveillance. These processes are key elements in managerial power in 2009. Despite the surface of community care policy of idealizing empowerment, the depth of community care is part of a disciplinary strategy which extended "control over minutiae of the conditions of life and conduct" (Cousins & Hussain, 1984). Paradoxically, the care manager became the "great advisor and expert" (Rabinow, 1984, p. 283) in assessing older people for care services.

In general, disciplines such as gerontology took its place alongside medical power in correcting, disciplining, and normalizing bio-medical language of "decaying" older people. Nevertheless, the managerial gaze has come to rival the medical gaze. The power of the care manager as a gerontological expert has supplemented medical power.

### MANAGERIALISM AND THE RESISTANCE OF OLDER PEOPLE

Scientific dominance may have helped shape the medicalized construction of aging identities, though it was not *economical* enough in its reach. Science has been bound up with "risk" (Beck, 1984) and what Giddens (1991) calls the process of "reflexivity": This manifests because of the loss of faith in the exercise of scientific "power/knowledge." The focus

on risk has led to a situation in which science has been slowly supplemented with financial discourses, and what we see, in relation to care provision, is an intensification toward care management models and consumerism. Hence, the pervasive move to a mixed economy of welfare has produced an extraordinarily powerful discourse and affects treatment of older people as "consumers" that has come to accompany and supplement medical discourses of old age in communities and impact on families (Powell, 2017).

Indeed, the mistrust of scientific "power/knowledge" as manifested in biomedicine is mirrored by uncertainties against care models as a means of finding a legitimized place for older people. The language of choice to erode dependency has been colonized by both medical and care discourses. Indeed, the surveillance of older people can be seen as economically productive for central and local government especially relying on Councils and informal carers in local communities. For example, social policy legislation in the United Kingdom, such as the recent integrated health and social care still centers on a "mixed economy of welfare" that highlights the incorporation of market forces to the construction and delivery of services (Clarke, 1994; Lewis & Glennerster, 1996; Phillipson, 1998). Hence, the mixed economy of welfare arguably fabricates representations of "empowerment" for older people. For example, many people's needs have not been met due to power relations and ageism (Bytheway, 1995). Allen, Hogg, and Peace (1992) quoted a manager as saying, "It is hard to listen to older people. They are slow in speech and thought" (p. 35). In this case, services provide schemes for the "conduct of conduct" (Foucault, 1976) dominated by power/knowledge and characterized by the discretionary autonomy of managers of the state:

*'It is within this disciplinary duality of power/knowledge and autonomy that power operates over older people, ultimately reinforcing the fragmentation that surveillance engenders in the broken identities of many older people at the centre of the professionals' gaze'* (Powell, 2006, p. 136).

Indeed, power relationships are still constructed around barriers of marginalization and dependency. As Henwood (1995) pointed out, pressures on resources was leading to reduced levels of service and a tightening of "eligibility" criteria for older people. The American gerontologist Estes (1979) powerfully flags this up in her pioneering book *The Aging Enterprise*:

*'Service strategies . . . and those for the aged . . . tend to stigmatise their clients as recipients in need, creating the impression that they somehow failed to assume responsibility for their lives. The needs of older persons are reconceptualised as deficiencies by the professionals charged with treating them (p. 65).'*

The point Estes is making is that such characteristics were illuminated as strategies for the service provision for older people in the United States. The use of terms such as "frailty" are being used to define "service eligibility" and power relationship processes are involved in service delivery and assessment (Estes, 1979). Hence, much discussion on the public health agenda in the UK in the past couple of years has overlooked the economic colonisation of frailty (Phillipson 2013).

Similarly, Foucault (1977) sees the assessment as central a technique that renders an individual an object of power/knowledge. In the assessment leading the opening for social services, the statement of an "aging body" is established in relation to normalized standards of rights and risks. Thus, older people will be probed for social, psychological, and economic factors such as frailty, financial resources, and expected levels of grades of supervision. This probe of assessment:

*'indicates the appearance of a new modality of power in which each individual receives as his status his own individuality, and in which he is linked by his status to the features, the measurements, the gaps, the "marks" that characterise him and makes him or her a "case." (p. 192)*

For example, following Obamacare in the United States, certain aging identities are marked out for surveillance throughout the remainder of his or her chosen service by the Trump administration. Such a service can also be difficult to access now given it is a rich cohort who can tap those services with rich resources. There is an uncertainty about what sort of entitlements medical entitlement implies under Donald Trump as President, and how permanent those entitlements might be to older people as users. Two basic approaches to reform have arisen, and neither of them work. The first is to try to fix Obamacare (universal coverage) through corporate-style management. The second is to accept that Obamacare has failed the *perceived* test of affordability and to introduce a private tier of service delivery. This service delivery process impinges on balancing budgets through managerial assessments

of older people who may or may not afford medical coverage. Heating or eating is a choice many have to choose, never mind medical care (Powell, 2017).

The relevance of this to older people is that managerial power can intensify the ordering of identities through the processes of health and social care institutions and policies of the State. In a key research study still relevant today, Allen et al. (1992) found that most older people had only one or two services in their study. In this study, few older people had much choice in what services they received, any say in the time of the delivery, the person who delivered it, or how much they received. Hence, this evidence highlights the numbing consequences are "docile bodies" (Foucault, 1977) drained of empowered energy, reinforced by the attitudes of managers to aging that it is just that, "your age," which requires an inspecting "gaze" and assessment of needs from "expert" care managers to older people as "consumers." This relational positionality implies a top down relation rather than partnership approach to tapping personalised services.

Michel Foucault (1977) has described how "techniques of surveillance" that occur in the "local centers of power/knowledge" (e.g., in the relationships between older people and care managers), have an individualizing effect:

*' . . . individualisation is "descending"; as power becomes more anonymous and more functional, those on whom it is exercised tend to be more strongly individualised . . . In a system of discipline . . . (older people become more individualised than younger people) (p. 193).*

Techniques of surveillance are calculated, efficient, and specific that "inspection functions ceaselessly. The gaze is everywhere" (Foucault, 1977, p. 195). Foucauldian ideas can identify related mechanisms of surveillance: panopticism, and normalization and the probe of assessment. These mechanisms train and organize individuals for their daily routines.

Foucault (1977) saw Jeremy Bentham's panopticon as the dominant example of disciplinary technology. Bodies of people can be made productive and observable. Foucault (1977) remarked, "*Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons?*" (p. 44). In the context of care, assessment has a preoccupation with monitoring and surveillance and this is crystallized in official policy discourse (Powell, 2006).

The perfect disciplinary apparatus, according to Foucault (1977) “would make it possible for a single gaze to see everything perfectly” (p. 173). Foucault approaches the mechanism of panopticism as both efficient, because surveillance was everywhere and constant, and effective, because it was “discreet,” functioning “permanently and in silence” (p. 177). It also provides the scope for the supervision of those who were entrusted with the surveillance of others.

The technique of panopticism was incorporated into health and social care relationships recently so that older people could be observed by professional surveillance (Phillipson, 2013). Social service provision for older people has elements of this kind of surveillance. Supervision is hierarchical in the sense that older people are accompanied by management discretionary power that embraces monitoring, assessing, and calculating older people even in the given out of resources for personalisation, ie, personal budgets for social care. Councils need to kept informed of progress of clientele to communicate this at formal review meetings to establish resource allocation to service spending planning on personalisation. Surveillance however of older people does not stop at this point, as a network of reciprocal power relationships has been created:

*‘This network “holds” the whole together and traverses it in its entirety with effects of power that derive from one another: supervisors, perpetually supervised’ (Foucault, 1977, pp. 176-177).*

Older people who require personalised services are the objects of scrutiny within society, but for such clients requiring further health financial services, the gaze reaches further; it evidences a strategic shift toward the surveillance of health and away from the postwar consensus relationship to respecting old age.

Importantly, the question of resistance to professional power and its relationship to wider debates around autonomy is important in this article. Foucault (1976, 1977) pointed to the different forms of opposition that have emerged in Western societies to challenge the imposition of power. The importance of consciousness and domination within care settings has formed the basis for group struggles for recognition and a badge of citizenship (Phillipson, 2013). As Clarke, Hall, Jefferson, and Roberts (1976) point out, there exists dynamic relations between different groups:

*‘Negotiation, resistance, struggle; the relations between a subordinate and a dominant culture, whenever they*

*fall within this spectrum are always intensely active . . . Their outcome is not given but made’ (1977, p. 44).*

The question of consciousness and resistance to professional domination has been tied to understanding and explaining social reality from older people through “history from below.” In the United States, techniques of resistance to managerial power was found by Callaghan (1989) who claimed older people “were particularly adamant that they did not want to be ‘cases’ and no health and social care professionals needed to ‘manage’ their lives” (p. 192). They wanted to be *in control* over their own lives.

### CONCLUDING COMMENTS

The momentum for this Foucauldian analytical framework of health and social care and impact on care derives from the view that older people bear the indention of principal modes of surveillance both in terms of medicalization and managerial discourses and the decrease in resources to sanction in advanced capitalist societies and then the impactful emphasis on local communities, families and informal carers which creates new tensions of resources. Crucial queries have been raised as to the social relationships between professionals and older people and contract culture. To converse about social relationships in terms of “contracts”, for example, disguises the wider, often very hidden power relationships that underpin and shape observable reality.

Defining power relationships in discourses of consumers of services is problematic; it limits the power of the consumer and subtly alters the feasible grounds of complaint from collective concerns to the shortcomings of an individual transaction (the hallmark of neo-liberalism) and managerial power in the United Kingdom. Governments in the United States with President Donald Trump and the United Kingdom with PM Boris Johnson have focused on the management of old age with particular emphasis on the discourses of neo-liberalism into politically neutral and customer-safe questions with the service on offer from paying for medical coverage to UK councils and care managers with a focus on informal caring as the key to unlock saving the State resources. Following Foucault’s (1977) analysis of the relationship between power and knowledge, this change can be seen as the development of a matrix in which to speak seriously about professional power and older people the employment of discourse of surveillance would have to be entailed. The powerful language of surveillance

offers a form of universalism to health and care policy that has been subject to utter fragmentation. Rather than recognizing patterns of social diversity all are now equal under the monitor of care policy and practice. Contentiously, under such conditions, terms such as care manager and user have worn out their analytical usefulness except as a rhetorical disguise for those with legitimate power. They simply supply the masquerade whereby both health and social care professionals and older people would come to regulate themselves in the panoptics' theatre of surveillance. Further, families and friends in communities will also be entrusted with the care of older people as informal care saves the NHS billions of pounds every year in the UK. How do we know where we are going, until we know where we are coming from? A positioning of aging as requiring social care away from the State and a startling continuity of family and community care reinforced by medicalization, surveillance by professional power which has gone un-challenged for a long time under the aegis of power should be critically reflected on without giving up the hope of resistance for active aging from the real experts society should be listening to and learning from: older people themselves.

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