Political geographies of health care:

Governmentality of population health in the constitution and transformation of state spatiality

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Abstract

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Population health has been inseparable from the development and constitution of the modern capitalist state since the 19th century and particularly after World War II. Healthy citizenry, with its economic and social potential, is arguably a strategically important resource for the strength and prosperity of the state and nation. Since population health plays a decisive role in the success of the state, it is subject to political problematisations and calculations. Perceived as a wide-ranging political problematic beyond the traditional scope of medical systems, population health is seamlessly connected to the socioeconomic processes of the state. Accordingly, it has become one of the most significant objects of political power and governmental interventions.

This doctoral dissertation contributes to the multidisciplinary research on state spatial transformation through new perspectives by conceptualising and investigating political geographies of health care. This involves exploring the ways in which population health is politically problematised in relation to the prevailing social, economic and political circumstances of the state in a given spatiotemporal context. The emphasis is placed also on how population health is integrated into the spatial constitution of the territorial state through state power and related health care practices, and how the historically contingent relationship between the state and population is re-constructed through health care. This thesis is thus focused on the constitution and transformation of state spatiality through an inquiry into health care as one of the key constituents of the state associated with sovereignty and governmentality as two forms of state power. Thus, health care is seen as uniting the territorial management of state spaces and relational spaces of governing a population. In this regard, Finland provides an interesting empirical context for this research, since it can be regarded as emblematic of the state space/health care nexus characterising the Nordic model of statehood.

The thesis at hand consists of three studies, each of which focuses on the state space/ health care nexus through different theoretical-conceptual frameworks and research materials. The historical and discursive approaches applied in this thesis have been inspired and informed by poststructural theory and specifically by Michel Foucault's theorisations and analytical strategies of governmentality, *dispositif*, power/knowledge and genealogy. The research is based on empirical material consisting of 51 policy

documents associated with health care in Finland (e.g. national strategies for health care, committee reports and Government proposals to Parliament) covering the period from the mid-1960s until the present. Empirical material includes also semi-structured interviews conducted in the autumn 2016 with 14 key actors in the Finnish health care sector.

The key findings of the study indicate that health care is an important organising element of the relationship between state power, state space and population. In this capacity, health care plays a crucial role in the historically contingent constitution and transformation of state spatiality. Empirical observations highlight, in particular, that health care is concerned with specific political problematisations of population health, cooperation between sovereignty and governmentality, and the construction of the relationship between the state and citizen. The findings thus propose that the interplay between these issues results in a distinctive spatial organisation of the state during a given time, characterising specific forms of statehood. Therefore, this suggests that population health, state power and citizenship constitute the analytical elements of political geographies of health care through which spatial constitution and transformation of the state can be examined.

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Article II   Kivelä, S. (2018a). Constructing the territorial state through the mundane: Statization of everyday population health. *Geografiska Annaler, Series B: Human Geography* 100: 1, 25–41. DOI: 10.1080/04353684.2017.1368356.

Article III   Kivelä, S. (2018b). Active citizenship, public sector and the markets: Freedom of choice as a state project in health care. *Geoforum* 91, 160–169. DOI: 10.1016/j.geoforum.2018.03.006.

Foreword

For me, becoming a human geographer has not been a straightforward path. When I started my geography studies in 2008, I had been working as a RN for almost a decade. Combining work and studies was sometimes quite challenging, particularly when a night shift was followed by a morning lecture. Simultaneously, however, those times were memorable and inspiring. After graduation four years later, I was given a great opportunity to start work at the Geography Research Unit. Then, I had to close the door to the 'hospital world', which I had been part of for 12 years. I remember all those years, and in particular my colleagues of that time, with great warmth and gratitude. Our ICU team was something very special. As the title of the thesis at hand indicates, my preceding work experience in the health care sector has had a considerable impact on my geographical research work. I am glad to have been able to connect some of the previously acquired expertise with geographical spatial thinking in this doctoral dissertation.

1 Introduction

Healthy citizenry, with its economic and social potential, is arguably a linchpin of the strength and prosperity of the modern state. Since population health is an important determinant of the success of the state and nation, it is subject to political problematisations and calculations. Accordingly, population health becomes a problematic of government which necessitates health care as a governmental strategy for managing the problem. Originating from the aforementioned notions, the thesis at hand seeks to conceptualise and investigate political geographies of health care. This involves exploring the ways in which population health is politically problematised in a given historical context. The focus is also placed on how population health is integrated into the spatial constitution of the state through state power and related statist practices of health care, and how this is associated with the construction of the historically contingent relationship between the state and citizenry. Within political geography, such an approach provides a fresh insight into the constitution of state spatiality.

This thesis contributes, in particular, to the multidisciplinary research on state spatial transformation. The state has been a central concept within and beyond political geography since the end of the 19th century when the German geographer Friedrich Ratzel (1969) wrote about the state as a living organic entity. However, as pointed out by Painter (2005: 38; also Mitchell 1999) political geographers' engagement with the state has fluctuated over time: the state was at the core of political geographers' concerns in the early 20th century, but from then until the late 1970s it was either largely neglected as an object of geographical inquiry or treated in a relatively limited and simplistic way. However, since the 1980s, there has been a resurgence of political geographical interest in the formation, functions and spatialities of states. Simultaneously, the state and state space have been re-theorised and re-conceptualised primarily in terms of relational thinking. That is to say that the conventional understanding of the state (space) as a static, discrete and self-enclosed territorial container of society (e.g. Taylor 1994; cf. Agnew 1994) has been challenged by an increasing number of human geographers and other scholars within social sciences. Accordingly, the state with its distinctive spatialities has become commonly understood as a historically contingent and constantly changing product of socio-spatial processes, social practices and power relations within and beyond state boundaries (e.g. Jessop 1990; 2002a; Brenner 2004a: Jessop *et al.* 2008; Painter 2010).

The renewed theoretical understanding of the state and state spatiality has given rise to interdisciplinary studies on state spatial transformation, which focus particularly on the relation of state power to state spaces and its consequences on socio-spatial relations and spatial constitution of the state characterising specific forms of statehood (e.g. Jessop 2002a; Brenner 2004a, 2004b; Moisio and Paasi 2013a). In recent years, the emergence of neoliberal political rationalities and economic globalisation has provoked rethinking the existing configurations of state spatiality and statehood. Contemporary politico-economic

global transformation has resulted in the construction of new forms of statehood conceptualised, for example, as competition state (Cerny 1990) and workfare state (Peck 2001). These conceptualisations seek to conflate some common characteristics of the neoliberalisation (e.g. Harvey 2005), privatisation (e.g. Hibou 2004), internationalisation (e.g. Glassman 1999; Hirsch and Kannankulam 2011) or transnationalisation (e.g. Demirović 2011; Major 2013) of the state. Accordingly, new forms of statehood have challenged, replaced or partly superseded the post-World War II Keynesian welfare state as a prevalent form of statehood.

What the aforementioned indicates is that state spatial transformation occurs as a response to perceived internal and external politico-economic pressures on the state, i.e., state space is constantly reconfigured and optimised to conform to prevailing politico-economic challenges. Therefore, state spatial transformation is not a spontaneous process, but actively produced through socio-economic struggles of state power (e.g. Newstead *et al.* 2004). Such a process is non-linear and thus characterised by particular continuities and ruptures (Moisio and Paasi 2013a: 269). State spatial transformation is also a highly contextual phenomenon and therefore does not take place in a similar way in different spatial and geographical contexts (e.g. Moisio and Belina 2017: 5).

Many of the studies on state spatial transformation have drawn on historical materialism, within which state spatiality is conceived of as resulting from the circulation and accumulation of capital (e.g. Harvey 1982; Jessop 1990, 2002a; Brenner 2004a). In other words, materialist approaches perceive the historically contingent spatial structures of the state as correlating with changing modes of production (see Lefebvre 2009). I suggest that it is equally relevant to place emphasis on the relationship between state power and social practices of governing a population through which the state is constantly re-territorialised and re-spatialised (see Moisio and Kangas 2016). In this view, spatial transformation of the state unfolds in a given historically situated context through population-targeted governmental interventions which seek to reorganise spatial relations within the state (Moisio and Paasi 2013a: 269).

Premised on the above notions, my overall aim in this thesis is to provide the research on state spatial transformation with an alternative reading by conceptualising and investigating political geographies of health care. I focus particularly on the ways in which health care as a statist social practice becomes associated with spatial articulations of state power. Therefore, my primary concern is how state spatial transformation is produced in and through health care practices. I combine the existing literature on state spatial transformation with Michel Foucault's work on governmentality which provides me with a useful theoretical-methodological approach to the state space/health care nexus. By governmentality, Foucault (1997: 81) refers to a technology of power exercised by the state over a population in order to direct the characteristics and behaviour of a population (also Huxley 2008: 1637). Therefore, from the governmentality perspective, the object of analysis is not necessarily state space per se, but the government of population and the related production of governable spaces and subjects through the state (Rose 1999;

see also MacLeavy and Harrison 2010: 1040–1041). In this context, the thread of my study is the coming together of sovereignty and governmentality in health care practices. Sovereignty (territorial management of state space) and governmentality (government of population health) are regarded here as two intertwined forms of state power which cooperate in health care practices seeking to govern population health through state space and state space through population health (cf. Moisio and Paasi 2013a: 270–271), resulting in distinct territorial and spatial structures of the state.

I propose that such an approach enables stepping beyond the persistent ontological dichotomy which approaches state space either as territorial or as relational (e.g. Moisio and Belina 2017: 9). Therefore, my theoretical ambition is also to contribute to the attempts to overcome the distinction and opposition between territorial and relational understanding of state spatiality. In this context, I suggest that health care should be understood not exclusively as a territorially institutionalised system of health services, but rather as a more wide-ranging ensemble of discourses, knowledges, policies, practices, institutions, agencies, etc., through which state power is exercised over territory and population. In this view, health care constitutes a relational entity through which the territorialisation of the state takes place.

In this thesis, the state space/health care nexus is approached in three individual but intertwined research articles from different theoretical and methodological perspectives, and demonstrated empirically in the context of Finland (see Subchapter 1.1) by using policy documents and interviews as empirical materials. In order to excavate historically contingent interconnections between state spatiality and health care, the temporal context of the research covers a period from the mid-1960s (Article I; Article III) until the present (Article I; Article III). In this sense, the present research is dialectic in nature: it examines the historical processes of reconstitution of state spatiality in order to increase understanding not only of past, but also of contemporary socio-spatial transformation of the state (cf. Kitchin and Tate 2000: 14).

1.1 Empirical context of the study

As changing statehood is not universal, but rather a historically and geographically situated phenomenon, researchers have argued for better contextual understandings of spatially variegated forms of state transformation (e.g. Moisio and Paasi 2013b). In this doctoral research, Finland is employed as an empirical context in order to demonstrate the central arguments made in the thesis. Finland provides an interesting contextual case which is instructive not only on its own terms, but may be also considered to be emblematic of the state space/health care nexus characterising specific forms of statehood. That is on the one hand because of the ways in which the establishment of the national health care system was inextricably attached to the territorial and spatial construction of Finland as a Nordic welfare state informed by Keynesian welfarism that emerged in the 1960s and

culminated in the 1980s (see Articles I and II). On the other hand, health care reforms since the early 1990s have been one part of the series of administrative policy reforms within which the recent and contemporary reconfigurations of the welfare state spatialities have been and are produced (see Articles I and III). In the following, the Finnish context is discussed in order to afford an overview on the historical development of the system of public-sector health services and its present restructuring processes within the ongoing health care reform in Finland.

In Finland, like in other regimes of the 'Nordic model of health care' (see Magnussen *et al.* 2009: 3–20), the national health care system is characterised by the welfarist principles of spatial and social universalism and equity. This denotes that public authorities are obligated by the Constitution of Finland (731/1999: 19 §) and accompanied health care legislation to guarantee all residents of Finland equal access to publicly funded health services regardless of socioeconomic status and place of residence. Public-sector health services have been organised and provided by local governments, i.e. municipalities (311 in 2018 including Aland), for over 150 years. One of the special features of this so-called 'Nordic welfare municipality' (see Kröger 2011) is the principle of local self-government protected by the Constitution of Finland (731/1999: 121 §). This denotes that local authorities are entitled to levy and collect local taxes by which the public-sector health services are financed, in addition to state subsidies and user-fees.

Each municipality is obliged by the law to maintain health centres, either alone or in federation, for the provision of primary health services. Every municipality is also required to be a member of one of the 21 (including Aland) hospital districts which are responsible for the provision of specialised medical care. Hospital districts are managed and funded by member municipalities. Municipalities also have an option to purchase health services from other municipalities as well as from private service providers and organisations which both play a remarkable complementary role in public-sector health service provision. At the national level, the Ministry of Social Affairs and Health as an organ of government is responsible for the planning, guidance and implementation of health policy (see e.g. Vuorenkoski *et al.* 2008 for a detailed overview of the present health care system in Finland).

In Finland, the existing spatial system of national health care was built under strict state-orchestration that rested upon a political alliance between the Social Democrats and the agrarian Centre Party. Through the implementation of the Primary Health Care Act (66/1972) in 1972, autonomous municipalities were subjugated by law to a national spatial planning and steering system for the harmonisation of the operational principles, methods and practices of health care across the country. With passing of the Act, a regional hierarchy of primary health care was constructed by establishing the nation-wide network of municipal health centres alongside the previously developed network of maternity and child services as well as the hierarchical network of university-, central- and district hospitals. State-led development of health care had its strongest phase of progress and expansion from the early 1970s to the late 1980s.

Similarly to other Nordic countries (see Magnussen *et al.* 2009 for an overview) and the OECD sphere in general, national health care in Finland has been under constant reformation since the early 1990s when criticism of the hierarchical and centrally planned Finnish state culminated during the deep economic recession. Consequently, the conservative-centre Government launched a series of health care reforms by dismantling the state-centred planning and steering as well as by reforming the state subsidy system in order to transfer political, administrative and financial responsibility from the state to local governments (see, for example, Saltman and Bankauskaite 2006). Despite the series of reforms, the territorially institutionalised foundation of health care has nonetheless remained rather intact until the present.

The pending health care reform in Finland has been prepared since 2015 by the incumbent bourgeois Government formed by the National Coalition Party, the Centre Party and the Blue Reform (diverged from The Finns Party in 2017). According to the Government policy outlines, the primary objectives of the reform is to modernise health services, to bridge the sustainability gap of the public sector, as well as to narrow down the differences in health and wellbeing among the population (see Government of Finland 2018 for a detailed description and political objectives of the reform; note also Saltman and Teperi 2016). One of the striking issues is that health care reform is integrated with regional government reform, which entails the rationalisation of the distribution of administrative responsibilities between the state, regions and local governments. In consequence of these two tightly entangled reforms, the responsibility for organising and providing publicly funded health services will most likely be rescaled from municipalities to 18 larger, to-be-established autonomous regions (counties) from the beginning of 2020 onwards. In pursuance of this, the existing multisource financing of health care (see Saltman and Teperi 2016: 307) is going to be simplified in such a way that the counties will be financed directly by the state.

Another leading point of departure of the ongoing Finnish health care reform is to gradually extend a service user's freedom of choice (henceforth, I use the term 'health care choice' as a synonym in this context) in health care which has been at the core of health care reforms worldwide (e.g. Clarke *et al.* 2006; Nordgren 2010; Gabe *et al.* 2015). In Finland, thus far, health service users have been entitled to choose their publicly funded services primarily from public service providers. With passing of the new legislation on health care choice, service users will be entitled, gradually from 2020 onwards, to choose the provider of publicly funded primary health services and some specialised medical care services between the public, private and third sector. In this regard, the service providers, whether public, private or organisation-based, will be provided with public funding and equal operational preconditions through competition neutrality. Service providers (i.e. counties, private corporations and health organisation) will establish health centres which will constitute a new institutional basis for primary health care. Most of the specialised medical care services are going to be provided in public corporations owned by the

counties. Service providers will be funded via counties by a capitation payment based on the number of individuals listed for the chosen unit.

The present health care reform in Finland is thus a massive state-orchestrated political process seeking to fundamentally reorganise the long-established administrative, financial, institutional and spatial structures of health care. Therefore, in the case that the reform will be realised as outlined by the Government, the previously created socio-spatial structures of Finland as a Nordic welfare state are to be remarkably reconstructed through the reform. The Government bill regarding the new legislation on health care and health care choice was introduced to Parliament in March 2018. The reading of the legislation on regional government and health care will be in progress in Parliament during the summer 2018. At the moment (June 2018), it seems probable that the implementation of the new legislations will be postponed for a year.

1.2 Research questions

This research focuses on the socio-spatial transformation of the state induced by changing health policies and regenerating statist social practices of health care in and through which state space and population are governed. The thesis consists of one main research question and three sets of sub-questions. The main research question for this doctoral dissertation is as follows:

> *What are the key elements of state spatial transformation when analysing the ways in which territorial management of state spaces and relational spaces of governing a population come together in health care practices?*

By addressing the above question, this thesis focuses on the entanglement of sovereignty and governmentality of population health in health care practices. Through this, I seek to connect the territorial with the relational, which are often seen as mutually exclusive features of changing state spatiality. In addition to the comprehensive main question comprising the thread of the thesis, the research is based on three groups of specific sub-questions formulated for and answered in the three individual research articles. Accordingly, the articles contribute to the main research question and thus to the primary objective of the research by approaching the state space/health care nexus in a given spatiotemporal context from different perspectives and through various methodological choices as well as research materials. Each article takes the adopted theoretical approach forward. A summary of the three articles is presented in Table 1. In the following, the sub-questions premised on the identified needs and calls for further development of the research on state spatial transformation are presented article by article.

Article I (Kivelä and Moisio 2017)

Ia. How is it possible to overcome the persistent binary between sovereignty and governmentality in a political geographical analysis of state spatial transformation?
Ib. How is the changing state spatiality connected to the coming together of geopolitics and biopolitics?

These research questions derive from my observation that state spatial transformation has not been approached from the perspective that combines sovereignty and governmentality as two forms of state power, the former targeted at territory and the latter at population. Article I seeks to contribute to the filling of this gap through analysis of the ways in which statist health care systems are bound both to biopolitical and geopolitical aspects of spatial transformation of the state. Accordingly, the article focuses on health care as a key element of spatial constitution of the territorial state which brings these aspects together.

Article II (Kivelä 2018a)

IIa. How is everyday population health conceptualised and defined by the state apparatus?
IIb. How is everyday population health rendered statist in and through practices of health care?

Spatially, temporally and socially contingent effects of state power on the mundane life of populace have recently attracted increasing scholarly interest. However, the 'mundane' has remained less theorised and conceptualised as it often seems to be taken as an ontologically given (spatial) category of governance. Article II seeks to provide one possible way to understand how population health is constituted as a mundane political problem of government by theorising health care as a *dispositif* of state power which combines biopolitical governmentality with 'prosaic geographies of stateness' (see Painter 2006).

Article III (Kivelä 2018b)

IIIa. How does the health care choice discourse contribute to the political rationalisation behind the contemporary socio-spatial transformation of the state?
IIIb. How is state power reconstituted through health care choice?
IIIb. What kind of citizenship is sought and how can it be produced through health care choice?

Table 1. Summary of the original articles.

Article	I The state as a space of health: On the geopolitics and biopolitics of health-care systems	II Constructing the territorial state through the mundane: Statisation of everyday population health	III Active citizenship, public sector and the markets: Freedom of choice as a state project in health care
Primary conceptual issues	Entanglement of geopolitical and biopolitical aspects of state spatial transformation in the social practices of health care	Interconnections between biopolitical problematisation of everyday population health and the construction of the territorial state	Coming together of reworking of citizenship and socio-spatial transformation of the state in health care reform
Research questions	Ia. How is it possible to overcome the persistent binary between sovereignty and governmentality in a political geographical analysis of state transformation? Ib. How is the changing state spatiality connected to the coming together of biopolitics and geopolitics?	IIa. How is everyday population health conceptualised by the state apparatus? IIb. How is everyday population health rendered statist in and through practices of health care?	IIIa. How does the health care choice discourse contribute to the political rationalisation behind the contemporary reconstitution of state spaces and social life? IIIb. How is state power reconstituted through health care choice? IIIc. What kind of citizenship is sought and how can it be produced through health care choice?
Theoretical-conceptual framework	Geopolitics and biopolitics of state transformation, governmentality	Statisation, biopolitical governmentality, *dispositif*	Neoliberal governmentality, subjectification
Temporal context	1960–present	1960–1980	Present
Empirical material	Policy documents	Policy documents	Interviews, policy documents
Analytical strategy	Genealogy, analytics of governmentality	Genealogy, *dispositif* analysis	Analytics of governmentality

The role of a citizen in political restructuring processes requires more analysis in the context of state spatial transformation (see e.g. Brenner *et al.* 2010). Article III seeks to contribute to this need through an inquiry into the ways in which reworking of citizenship is entangled with the reconstitution of state spatiality in the ongoing health care reform in Finland. In this, health care reform is conceptualised as a technology of state space which is seamlessly attached to freedom of choice in health care as a twofold political technology: that of re-regulation and subjectification.

1.3 Structure of the thesis

The thesis consists of three independent but seamlessly interlinked research articles and a synopsis that serves as a compilation for the theoretical and empirical interrelations of the articles. This synopsis is organised in five main sections. After the introductory section, the synopsis continues with section two, which focuses on the theoretical and conceptual background of the research. The section considers how the state and space as scholarly concepts have been defined, theorised and conceptualised in relation to each other within and beyond geography over time. The section begins with a discussion on territorial and relational understanding of state spatiality and continues by reviewing the existing key literature on state spatial transformation relative to which this study is positioned. Section two concludes with a concise discussion on territorial/relational dichotomy.

Section three develops a theoretical and conceptual approach to state spatial transformation in the context of the state space/health care nexus. The primary aim of the section is to bring together the theoretical contribution of the three sub-studies to the understanding of health care as a key constituent of historically contingent state spatiality. The section starts with an introduction to governmentality chosen as a theoretical framework for investigation into the entanglement of sovereignty and governmentality of population health in health care. The section proceeds to suggest three territorial-relational dimensions of health care which connect the territorial management of state space with the relational spaces of governing population health.

The fourth section discusses the methodology, methods and empirical materials used in the research. The section starts by placing the thesis under a poststructuralist approach. Relatedly, this is followed by an introduction to an analytics of governmentality as a theoretical-methodological framework applied in analysing the empirical materials. The section concludes with an introduction to the research materials consisting of policy documents and semi-structured interviews. A summary of the key empirical findings of the articles as well as the answers to the sub-questions are provided in the fifth section. Also, some suggestions for future research on the state space/health care nexus are

included in section five. The section concludes with a discussion on the methodological contribution of the research called political geographies of health care. The list of analysed policy documents and the interview structure, as well as the three research articles, are included in this synopsis as appendices.

2 Geographies of state spatiality

This section deals with the key concepts of the research and the relevant literature on state spatial transformation. Since the scrutiny of spatial transformation of the state is not sensible without familiarisation with the theorisations of the concepts of state and space, this section focuses on how these have been defined, theorised and conceptualised in relation to each other within and beyond geography in the course of time. The section starts with a discussion on the shift from territorial towards relational understanding of state spatiality and continues with a review of literature on state spatial transformation on which I draw in this thesis. The section concludes with a concise discussion on dismantling the territorial/relational dichotomy to which I contribute in Chapter 3 of this synopsis.

2.1 Changing conceptualisations of the state, space and state space: from territorial towards relational understanding of state spatiality

The ways in which the state, space and state spatiality are conceptualised in relation to each other have been reliant upon the perspectives from which they have been approached at the time. With regard to the scholarly understanding of space, until the 1970's, space was given meanings by building on Euclidean geometry which suggested that space should be understood as a geometrical system of organisation. In such a view, the concept of space was to be treated analytically as an "absolute container of static, though movable, objects and dynamic flows of behaviour" (Gleeson 1996: 390). Accordingly, the majority of human geographers deemed space to be a distinctive, unchangeable and autonomous container of human activity and social relations, thus having an existence of its own (Hubbard and Kitchin 2011: 4). Likewise, the conventional conceptualisations of state space, usually elaborated in terms of territorial nature of the state, are premised on the naturalisation of space through container metaphor (see Brenner *et al.* 2003: 1–2). This kind of understanding represents state space as a monolithic entity or static territorial frame for political processes in terms of both inter-state and intra-national relations (e.g. Häkli 2013: 343).

   Perceptions of state spatiality as a pre-given and relatively static characteristic of modernity as well as the pervasive taken-for-grantedness of territoriality (Brenner *et al.* 2003: 2) are epitomised in the German sociologist, Max Weber's, famous definition of the modern state. Weber specified the relationship between state power, territory and population by conceptualising the state as "a human community that (successfully) claims the *monopoly of the legitimate use of physical force* within a given territory" (1994/1919: 310–311; emphasis in original). Weber's definition has become a widely adopted point of reference for theorising the concept of the state as well as its various and changing forms.

That is because, firstly, the state is seen to be constituted by public institutions such as administrative authorities, legislation and public services. Secondly, the state is conceived of as a territorial unit with exact boundaries. Thirdly, the state controls the exercise of legitimate power through its military forces and penal institution system (Painter 2003: 359–360).

Following Weber, the British sociologist, Anthony Giddens (1987: 120), has called the state a 'bordered power container' by which he refers to the state as a political organisation capable of using mechanisms of physical violence to sustain territorially organised rule. In this view, the state is generally understood as a social organisation comprised of institutional settings of regulative authority and state agencies through which state power is exercised over the population within a well-defined geographical space (Moisio and Belina 2017: 5–6). In a parallel line of thought, geographer Peter Taylor (1994: 152–157) has made an analytical distinction between power, wealth, cultural and social containers premised on four main functions of the state: warfare, management of the economy, maintenance of national identity and provision of welfare services. Container-based views on the state are thus largely attached to the state's capacity to exercise territorial sovereignty, that is, the state as a container results from the functions of its territoriality. Therefore, from these kinds of conventional state-centric perspectives, the state is generally conceived of as an explicitly bounded static monolith distinct from civil society that possesses the supreme authority to regulate the population within its territory (e.g. Sharma and Gupta 2006: 8).

Political geographer, John Agnew (1994), has termed the above non-questioned integration of sovereignty and territoriality characterising the Westphalian state system as a 'territorial trap' by which he refers to an ahistorical and decontextualised view of the world as reified into fixed units of sovereign space. According to Agnew (1994: 60–71), a territorial trap results from three indivisible geographical assumptions about the modern state upon which the naturalisation of state space in modern societies is grounded (see Brenner *et al.* 2003: 2): the state is regarded as possessing sovereign control over its accurately bounded national territory; domestic/foreign polarisation is considered to be a fixed characteristic of a modern inter-state system; the territorial state is seen to be existing prior to and as a static geographical container of society. Agnew (1994: 77) thus maintains that the lack of theorisations of the historical connections between the territorial state and the broader social and economic structures has led to the territorial trap.

However, since the mid- to late 1980s, social scientists including human geographers have provided new theoretical insights into the research on state space in order to dismantle the territorial trap (see Brenner *et al.* 2003: 3–5 for a concise overview). This has taken place in the wake of the broader 'relational turn' (see Jones 2009 for a discussion) initiated in the 1970s by the historical and geographical materialism, whereby space began to be conceived of as socially produced and transformed rather than clearly bounded spatial totality (Hubbard and Kitchin 2011: 5). Therefore, as Jones (2009: 491) suggests, relational thinking denotes a paradigmatic departure from the notions of absolute and relative space. In this, relational space does not exist as an entity in and of itself, but is interconnected

with material objects and their spatiotemporal relations and extensions. In the following, I turn to discuss the literature on those relationality-inspired conceptualisations and theorisations of the state and socio-spatial relations which I consider to be the most relevant for my understanding of the relationship between state power and state space.

2.2 Relationality of state spatiality

Existing state spatiality reflects the relations between state power and state space at a given historical time. Drawing on the idea that the state as a historically contingent political form is characterised par excellence by its grounding in the territorialisation of political power, Martin Jones and Bob Jessop (2010: 1120) contend that "states comprise historically variable ensembles of technologies and practices that produce, naturalize and manage part of terrestrial space as a relatively bounded container within which political power is exercised to achieve various, more or less well integrated, policy objectives". In this view, state power is not activated by the state per se but by the political elite (i.e. politicians, state officials and other state agents) located in the state system (Jessop 1990: 366–367). Therefore, as the agent of state power, political elite is simultaneously both the producer and object of state spatial transformation (Moisio and Vasanen 2008: 29). The spatiality of state power in particular spatiotemporal situations is a manifestation of prevailing state strategies, social relations and political power struggles. That is to say that the relationship between state power and state space becomes visible as a variety of spatial configurations of the state characterising the statehood at a given time (e.g. post-World War II Keynesian welfare state) (Moisio 2009: 156–158).

   During the past twenty-plus years, state space has appeared as a widely applied conceptual approach to theorise the spatial articulations of state power. Accordingly, state spatial transformation has become one of the key research topics in human geography and in social sciences more broadly, induced by the 'crisis of the welfare state' (see e.g. Jessop 2002a; Brenner 2004a) and the resultant changing spatial forms of the political economies over the past decades. The leading argument has been that the spatialities of the state result from societal processes and practices whereby the state continues to be a key element of the spatiality. In this view, state spatiality is seen as a constitutive dimension rather than a passive outcome of societal processes (Moisio and Belina 2017: 4). Therefore, among the interdisciplinary studies on state spatial transformation, scholars have usually focused specifically on the political struggles of state power as well as territorial restructuring processes and related social practices in different temporal and spatial contexts (e.g. Brenner 2004a, 2004b; Jonas 2013; Ahlqvist and Moisio 2014; see also Antipode 2010).

   Although state spatial transformation has been discussed from a variety of perspectives and in different state contexts, the theorisations of spatial constitution of the territorial have some integrative elements (also Ahlqvist 2013: 328–329). These theorisations share the view that state space should be conceptualised as a historically situated and

dynamic ensemble of social processes and power relations rather than as a static and self-enclosed territorial frame (e.g. Jessop 2007; Painter 2010). They also collectively highlight that specific geopolitics (Roberts *et al.* 2003) and a distinctive political rationalisation (Moisio 2011; Moisio and Paasi 2013a) are increasingly being employed to merge a neoliberal mode of production to state space, resulting in re-scaling (Brenner 2004a), internationalisation (e.g. Hirsch and Kannankulam 2011) and transnationalisation of state spaces (e.g. Demirović 2011). In addition, the common point of view is that state spatial transformation is not an idiopathic process but is actively produced within social relations including political contestation and power struggles (e.g. Moisio 2008). These studies thus underline the seamless interconnections between territory and socio-spatial relations through which the modern state comes into being.

In the following subchapters, I focus on three different relational approaches through which the state and state space have been theorised by scholars within human geography and other social sciences. In this thesis, I combine these literatures with Foucauldian governmentality approach in building theoretical approaches to the state space/health care nexus (see Chapter 3). Firstly, theorisations drawing on historical materialism which focus on the processes of capital accumulation in the constitution of state spatiality is relevant to the understanding of socio-spatial relations under contemporary capitalism. Secondly, poststructuralist conceptualisations of the state provide a suitable framework for investigation of the state's relations to civil society. Thirdly, analyses of neoliberalisation of the state are useful as they include elements which build linkages between the materialist and poststructuralist perspectives (cf. Brenner *et al.* 2010).

2.2.1 Historical materialism: the state as a social relation

As a branch of Marxist approaches to the state, historical materialism focuses on the connection between capitalism and state space. Through historical materialist analyses, the French sociologist, Henry Lefebvre, has provided pioneering work on the geographies of state spatiality. In particular, Lefebvre's work is essential for the understanding of state spatiality emerging from the interaction between state power and state space. For Lefebvre (1991: 26), "(social) space is (social) product" which is produced, consumed and reproduced in and through various practices at a given historical time. In Lefebvre's thinking, the social production of space does not refer to space merely as a "physical container within which capitalist development unfolds, but one of its constitutive social dimensions, continually constructed, deconstructed, and reconstructed through an historically specific, multiscalar dialectic of de- and re-territorialisation" (Brenner 1999: 43). In his analysis of the state's relation to space, Lefebvre (2009; originally published in 1978) develops his ideas of state space (*l'espace étatique*) through spatialised accounts of the development of modern capitalism in the 20th century. Lefebvre (2009: 225) underlines the spatial dimension of the emergence of the modern state by contending that

*"As the product, the child, of a space, the so-called national territory, the State turns back toward its own historical conditions and antecedents, and transforms them. Subsequently, the State engenders social relations in space; it reaches still further as it unfurls; it produces a support, its own space, which is itself complex. This space regulates and organizes a disintegrating national space at the heart of a consolidating worldwide space (*l'espace mondial*)".*

For Lefebvre (1991: 229–291, 2009), the above denotes a transformation from precapitalist 'absolute space' to capitalist 'abstract space' of the modern state by which he refers to a qualitatively new matrix of socio-spatial organisation produced and regulated by state power. Brenner and Elden (2009: 358) interpret that "abstract space permits continuous, rational economic calculation in the spheres of production and exchange, as well as comprehensive, encompassing control in the realm of statecraft". In this view, state space becomes constantly produced and transformed for political purposes by state power, i.e., it is the political product of material-institutional practices of the state's spatial regulation (Brenner *et al.* 2003: 11; Brenner and Elden 2009: 359). In this regard, Lefebvre (2009: 226–249) uses the notion 'state mode production' to chart the historically and contextually specific spatial strategies through which the state has sought to shape and reshape the spaces of capital accumulation and commodity exchange in order to facilitate capital accumulation and to advance political domination during the course of the twentieth century.

As Lefebvre's theorisation highlights, historical materialism places emphasis on the processes of capital accumulation and changing modes of production as the driving forces of state spatial transformation (see also Harvey 1982; see e.g. Cerny 2006 for criticism). In the increasing body of literature on state spatial transformation, materialism appears as one of the most applied approaches to the connections between contemporary capitalism and state spatiality. Most of the materialist studies draw on the idea of a transition from a Keynesian national welfare state (see e.g. Esping-Andersen 1990, 2002 for a typology of the post-World War II welfare state regimes) to new spatial configurations of statehood which have since the 1990s been structured around such conceptions as the competition state (Cerny 1990, 2010), the workfare state (Peck 2001) and rescaling of the state (Brenner 2004a). According to Moisio and Belina (2017: 5), the central point of departure of the materialist perspective is the idea that the state has not retreated or been hollowed out in the face of globalisation (cf. Albrow 1996; Ohmae 1996; Strange 1996). Rather, the state is perceived as being under qualitative reconfiguring which denotes that the change has taken place in the ways in which state power is exercised over state space, resulting in new forms of state spatiality (see e.g. Peck 2004; Lagendijk *et al.* 2009: 6).

Building on neo-Marxism of Antonio Gramsci and Nicos Poulantzas, the British sociologist, Bob Jessop (1990, 2002a, 2007a), has developed a 'strategic-relational approach' to the state in which he (1990: 260) maintains that the state is a social relation that can be analysed as the site, the generator and the product of state strategies. Among the materialist spatial studies on state transformation, Jessop's (2002a) distinction between

the 'Keynesian national welfare state' (KNWS) and the 'Schumpeterian workfare post-national regime' (SWPR) may be considered as one the most influential works elucidating the changing state spatialities in the context of advanced capitalist economies. By KNWS, Jessop (2002a: 56–80) refers to Keynesian economic policies clustered around the issue of full employment through demand management and market failure compensation in the relatively closed national economy, i.e., the national was the primary scale of policymaking in KNWS. Also, the state was responsible for providing its citizenry with a minimum level of welfare rights on the grounds of social welfare as well as for economic reasons.

For Jessop (2002a: 250–254), the SWPR, which emerged in the 1980s, is Schumpeterian as it emphasises innovation policies and policies of structural and systemic competition as central public policies for managing the relatively open economy (see also Cerny [1990, 2010] for the competition state). Consequently, the national is destabilised as a primary scale of policymaking and the significance of other spatial scales is increased. At the same time, social policies and welfare service production are increasingly subordinated to economic imperatives which mirrors Jamie Peck's (2001) theorisation of the workfare state. However, Joe Painter and Alex Jeffrey (2009: 67) have pointed out that Jessop's SWPR should be understood in a broader sense than simply as a form of the state as "it involves more diffuse patterns of international policy transfer, partnership working, local solutions and governance networks".

As Jessop's theorisations indicate, state spatial transformation is inseparable from the question of spatial scale. Scholars engaged with rescaling literature often draw on the idea of state spatiality as a complex manifestation of prevailing practices and related processes of socio-spatial regulation at various scales (Moisio and Belina 2017: 6). In this regard, it has been suggested that since state spatial transformation is a multi-scalar process, it should not be seen as an erosion of the territorial state, but rather as a temporally and spatially contingent reorganisation of the state manifesting itself as a rescaling of the state and state power (see e.g. Peck 2004). However, Becky Mansfield (2005: 458–461) has criticised the rescaling debate for abandoning or ignoring the national scale and its importance. Mansfield (2005: 468) has argued that the national should be seen not as a level, hierarchy or scale, but rather as a social dimension of political economic practices in the production of space (see also Jones 1998: 27).

American urban theorist, Neil Brenner (2003, 2004a, 2004b), has made remarkable contributions to the debate on the rescaling of the state by drawing on Jessop's (1990, 2002a) strategic-relational state theory and by developing a 'strategic-relational-spatial' framework. In this, Brenner (2004a: 116, 159) argues that the development of the Keynesian national welfare state reflected a novel way to organise, produce and transform politico-economic space and the state space in particular. Brenner (2004a: 130) maintains that, as a spatial strategy and spatial project of the state, spatial Keynesianism refers to "a broad constellation of national state institutional forms and regulatory strategies designed to alleviate uneven geographical development within the national space-economy, and thereby, to promote stabilised national industrial growth". Brenner's (2004a: 176–304)

central argument in his synthesis on the 'new state spaces' emerging in Western Europe in the 1980s is that the regulative practices of spatial Keynesianism have been gradually replaced by spatial practices of a 'rescaled competition state regime' as a response to the crisis of previous forms of regulation. In Brenner's view, rescaling of the state results from the scale-sensitive political strategies aiming at the promotion of subnational spaces (i.e. local, metropolitan and regional) in the supranational capital accumulation sphere (see also Leppänen 2011: 51). According to Brenner (2004a: 204–207), this has led to the positioning of major cities and city-regions as growth engines of territorial competitiveness.

2.2.2 Poststructuralism: the state as an effect of practices

Whereas materialist perspectives approach the state as a social relation resulting from practices that obtain a certain fixity which in turn structures practices, the more poststructuralist tradition emphasises the ways in which the state comes into being primarily as an effect of discursive and mundane social practices (Moisio and Belina 2017: 2). In this regard, Timothy Mitchell (1991: 94) has contended that the state should be understood as a structural effect, i.e., "it should be examined not as an actual structure, but as the powerful, metaphysical effect of practices that make such structures appear to exist". From this angle, the state is not so much structuring, but rather "the state comes into being as a structuration within political practice" (Abrams 1988/1977: 82). In a parallel line of thought, Michel Foucault (2008: 77–78) has claimed that the modern state is nothing more than a mobile effect of the same historically contingent social practices of government that manifest themselves in other apparent structures (e.g. the economy, society, etc.).

The conceptualisations of the state as an effect of practices explicitly question the more conventional state-centric accounts of the state as a monolith. Accordingly, as Moisio and Belina (2017: 3) point out, poststructuralist views on the state acknowledge discourses about 'the state' as well as the material infrastructures and practices of state institutions but reject the concrete existence of the state as an object or thing with a particular universal and fixed essence. In this regard, poststructuralist understanding of the state seeks to abandon the persistent idea of the state as a freestanding entity and an ultimate seat of power located in isolation from and opposed to economy or society (Mitchell 1991: 95). Poststructuralist perceptions of the state thus challenge the persistent juxtaposition of the state and civil society as two separate realms of social life (see Subchapter 3.2 of this synopsis for more detailed discussion). In this view, the relationship between state power and citizenry is structured on the grounds of the practices that constitute the state (Jones 2012: 806). That is to say that the state does not exist independently of the everyday practices of social life which make up the state, but rather comes into being as a reification of social practices (e.g. health care) through which the relationship between state power and citizens is intensified (see Painter 2006).

From the poststructuralist perspective, state spatial transformation can be seen as emerging from the changing relations of the state power to civil society. Building on Foucault's analyses of power, Peter Miller and Nikolas Rose (1992, 2008; also Rose 1993) have conceptualised the restructuring of welfare state as a movement from 'social government' to 'advanced liberalism'. In this, social government refers to mechanisms of security established through Keynesian technologies of social interventions by the state "in which the health of society and the health of the economy became mutually reinforcing over the course of the economic cycle" (Dean 2010: 176). In turn, advanced liberalism, which emerged in the 1960s and 1970s, alludes to a mode of government which emphasises the expansion of market mechanisms to the sectors of formerly public provision, the employment of indirect means of regulation and the construction of multiple forms of agency through which the rule over civil society is accomplished. Also, advanced liberal government seeks to enforce individual responsibility and to privatise risk management (Miller and Rose 1992: 173–174; Dean 2010: 266). Thus, in Miller and Rose's view, transition from the Keynesian welfare state to new forms of statehood refers primarily to the reconfiguring relationship between the state and civil society resulting from the change in practices through which civil society is governed by the state and related agencies.

In terms of the territorial/relational dichotomy, poststructuralist views on the state are often regarded as representing relational thinking, whereas materialist conceptions are many times associated with the more territorial understanding of the state (Moisio and Belina 2017: 9). That is expressly because of their distinct attitudes towards the relations between state power and civil society as an object of analysis. However, it can be argued that materialist and poststructuralist approaches are brought together in the analyses of neoliberalisation of the state which I will review in the following.

2.2.3 Neoliberalisation of the state

A large number of scholars have engaged with the increasing multidisciplinary literature on the state spatial transformation under contemporary neoliberalism (e.g. Peck and Tickell 2002; Harvey 2005; Brenner *et al.* 2010; Moisio and Paasi 2013a). As Kim England and Kevin Ward (2007: 15) puts it, "neoliberalisation is, if nothing else, a process of state restructuring". The ways in which financialisation, trade liberalisation, intensification of internationalisation, individualisation, and the associated politics of entrepreneurialism, privatisation, and increasing labour market flexibility have been articulated and enacted in policymaking have been of particular interest in studies on neoliberalising transformation of the state (Moisio and Belina 2017: 5). Jessop (2002b), among others, suggests that neoliberalism has been adopted by states as a political strategy of 'survival' in response to the crisis of the Keynesian welfare state and associated political, economic and social challenges to the state. In his characterisation of the 'neoliberal state', David Harvey

(2005: 2–3) claims that neoliberalising politics aims to maximise the reach of market transactions through "deregulation, privatization, and withdrawal of the state from many areas of social provision" and "to facilitate conditions for profitable capital accumulation on the part of both domestic and foreign capital".

By employing Finland as an empirical context, Toni Ahlqvist and Sami Moisio (2014) have studied neoliberalisation of the state as a process in which a welfare state form they refer to as cartel polity is transforming towards a particular adjustment of the competition state they call corporate polity. In Ahlqvist and Moisio's (2014: 22) conceptualisation, corporate polity reflects the construction of a corporation-inspired management model for the state and represents a new state ethos "underpinned by constant concern about the state's international competitiveness in front of 'nature-like' market forces, transnational investors and highly skilled labour". Deborah Cowen and Neil Smith (2009), in turn, have conceptualised state transformation as a transition from geopolitical to geoeconomic social. Their central argument is that whereas geopolitical social is associated with the building of the national territory, society and economy, geoeconomic social is constituted through processes by which states aim at accumulating wealth through market control rather than through acquisition and control of territory. This denotes also the privatisation of the state itself, i.e., "the state becomes an entrepreneur in its own right, a player in the market first and foremost rather than a regulator of the market's 'excesses'" (Cowen and Smith 2009: 41).

Neoliberalisation of the state has been increasingly approached from the perspective of governmentality (which is discussed in more details in Chapter 3 of this synopsis). As Thomas Lemke (2007: 45) remarks, the transition from the Keynesian welfare state towards free market policies and the emergence of neoliberal political projects in Western democracies has been the primary focus of the studies drawing on the governmentality approach. Within governmentality, neoliberalism is conceived of as a political rationality related to specific technologies of power rather than, for example, as policy or political ideology (see e.g. Larner 2000; cf. Rose 1996). In this framework, state spatial transformation is premised upon regenerating political rationalities and related governmental technologies. To further develop Cowen and Smith's (2009) above-discussed contribution, Sami Moisio and Anssi Paasi (2013a) have analysed the changing geopolitical rationalities upon which the governmental interventions in Finnish state space have predicated in certain geohistorical conjunctures. Moisio and Paasi conceptualise the ongoing state spatial transformation in Finland as a gradual transition from a 'Machiavellian-Keynesian' geopolitical rationality towards a 'Porterian-Floridian' one which highlights the emergence of competitiveness (see Porter 1998) and creativity (see Florida 2003) as keywords in political discourse and spatial planning vocabularies.

However, despite many of the approaches to contemporary global change are pervaded by the narratives of 'decline' or 'erosion' of the state, most studies on state restructuring, regardless of their analytical perspectives, have accentuated that the neoliberal globalisation is in fact engineered explicitly through state power and political re-regulation. Therefore,

what has been demonstrated by a multiplicity of studies is that neoliberal restructuring of the state has been facilitated expressly through state-orchestrated reorganisation of state spatiality (e.g. Moisio and Belina 2017 5–6; see also Cerny 1997: 251; England and Ward 2007: 15). Importantly, it has been also pointed out by many scholars interested in neoliberalisation of the state and space (e.g. Peck 2001; Peck and Tickell 2002; Roberts *et al.* 2003; Harvey 2005; Castree 2006) that multiple varieties of neoliberalisation exist and that the neoliberalising processes are both historically and geographically contingent.

2.3 Towards territorial-relational understanding of state spatiality

The above-discussed conceptualisations and theorisations of state spatiality induced by the increasingly pervasive relational thinking suggest that the relationship between state power and state space should be understood in a new way. They propose that as a concept, state space refers to a multiscalar, networked and relational process rather than to a static self-enclosed territorial frame (Moisio and Paasi 2013b: 257). As Painter (2010: 1096) remarks, the growing awareness of the dynamism of state spatiality is associated with the emergence of relational approaches to theorising the state per se (see e.g. Painter 2005 for a review). Accordingly, re-theorisations of the state question the state-centricity by highlighting that the state is not located 'just there' in isolation from space and society. Rather, the state should be understood as a historically contingent and dynamically evolving spatial entity (Brenner *et al.* 2003: 11) constituted and transformed by the interactions between the territory, population, power, and transnational relations, as well as the related assemblages of social practices, discourses, rules, power, and symbolic and material forms of governance and institutions within and beyond state boundaries (Moisio and Paasi 2013b: 255).

However, while most of the present-day scholars acknowledge the relational and processual nature of state transformation and space reproduction, there is a persistent and often ontological binary between 'the territorial' and 'the relational' which has characterised much of the geographical debate on the state, territory, space and borders since the 1990s (Moisio and Paasi 2013b: 263). As mentioned, the former is often associated with the materialist perspectives while the latter is attached to poststructuralist approaches to the state and space (Moisio and Belina 2017: 9). Nonetheless, despite the pervasiveness of relational thinking and the resultant undermining of the territorial nature of the state, the transition from territorial to relational understanding of the state and space has not rendered irrelevant territory as a quintessential state space. Rather, it appears to be of increasing political and scientific importance (Painter 2010; see also Brenner and Elden 2009; Elden 2010; 2013; Murphy 2013).

Recently, by arguing that socio-spatial processes are simultaneously territorial and relational, scholars have made efforts to overcome the mutual exclusivity constructed

between territorial and relational geographies (e.g. Hudson 2007; Jessop *et al.* 2008; Harrison 2010; Allen 2011; Paasi 2012). As Jones (2010: 247) notes, relational space is often associated with the views on politics and policy-making as unbounded and non-territorial. In order to make an opposite argument, Cochrane and Ward (2012: 7; cf. Paasi 2012) propose that policy-making should be understood as both relational and territorial, i.e., simultaneously in motion and fixed or embedded in space. They continue that territorial and relational spaces are unavoidably entangled as territories are not fixed but resulting from intertwined sets of social, political, and economic relations stretching across space, which at the same time shape and limit the development of relations (see also Painter 2010; cf. Hudson 2007; MacLeod and Jones 2007; Morgan 2007). From this angle, what highlights a relational understanding of territory is that contemporary state restructuring has not resulted in a non-territorial state, but rather an 'open' state space in which increasing networking functions in conjunction with territoriality, territorial border and territorially defined political identities (Moisio 2011: 158).

Premised on the discussion in this section, my main observation is that statist social practices of governing a population deserve greater scholarly attention in the research on state spatial transformation. In the following section of this synopsis, I seek to contribute to filling this gap by inquiring into health care as a statist social practice which combines sovereignty and governmentality as two forms of state power. I propose, therefore, that this kind of approach to state spatiality brings together the territorial and the relational. In this view, social practices create territorial state spaces and likewise, territorial practices create relational state spaces. This suggests that territorial and relational spaces are not unconnected but rather co-constitutive of the spatial organisation of the state.

3 Sovereignty and governmentality of population health: health care in the nexus of territorial and relational state spaces

In this section, my primary aim is to bring together the theoretical contribution of the three independent research articles by building a theoretical and conceptual approach to state spatial transformation in the context of population health. This approach merges the issues of state space and health care; it focuses on the ways in which health care appears as a key element of spatial constitution of the territorial state at a given spatiotemporal conjuncture. In this context, health care does not exclusively refer to a territorially institutionalised setting of health services, but to a heterogeneous ensemble of power, knowledge systems, discourses, policies, practices, institutional spaces, agencies, etc., targeted at managing both population and state space (territory). From this angle, health care is understood here as a statist social practice (cf. Foucault 2003a: 321) in and through which sovereignty and governmentality, as two forms of state power, are exercised over a population and territory, resulting in a particular spatial structure of the state. In this capacity, health care is situated in the nexus of territorial and relational state spaces. Therefore, the approach developed in this section seeks to provide an alternative perspective to escape the territorial/relational dichotomy discussed in the previous section of this synopsis (Subchapter 2.3). In this regard, my determining point of departure is the idea that the territorial management of state space and the reconfiguring relational spaces of governing population health are mutually constitutive to changing statehood.

In order to develop such an approach, I combine the above-discussed key literature on state spatial transformation with the scholarship of the Foucauldian governmentality approach. I conceive governmentality of as a relevant theoretical and conceptual perspective to study the dialectical relationship between state power and the governmental objects, i.e., state space (territory) and population health (discussed in more details in the following subchapters 3.1, 3.2 and 3.3). Foucault (2007: 87–114) introduced the concept of governmentality in 1978 during his lecture series at the Collège de France. A lecture Foucault gave on the 1st February on the problematics of government has commonly become known as 'Governmentality' by which he suggested an option to conceptualise the ways in which power works within and through space and society. Governmentality thus seeks to rethink the relationship between power, space and population.

In its broadest sense, governmentality refers to the social practices designated to direct human behaviour (Foucault 1997: 81) or more accurately to "rationalization and systematization of a particular way of exercising political sovereignty through the government of people's conduct" (O'Farrell 2005: 107). However, based on his analyses of political power and power relations, Foucault (2007: 108; note e.g. Walters's 2012: 11–13 for various interpretations) gives three distinct but interrelated meanings to the

concept of governmentality. First, by governmentality he refers to the ensemble of discursive and non-discursive elements that enables the exercise of specific power "that has the population as its target, political economy as its major form of knowledge, and apparatuses [*dispositifs*] of security as its technical instrument" (Foucault 2007: 108). From this angle, Foucault concerns governmentality as a specific technology of power exercised by the state over population (Huxley 2008: 1637). In others words, Foucault (1980a: 139–140) understands the style of exercising power in modern states as biopower targeted at a population. Therefore, the population is seen as the ultimate end of government and as a political subject-object which can be produced and governed through multiple governmental technologies (Foucault 2007: 108), for example, by affecting a population's health and distribution within a certain territory on the basis of scientific knowledge (e.g. statistics) about a population's life processes (Foucault 1980a: 141–142).

Accordingly, political economy as a major form of knowledge does not refer only to the economic government but is considered in a broader sense as management of both population and spaces in certain spatial and temporal situations (Foucault 2007: 94–95). Knowledge is therefore a means of rendering a population governable collective which is regulated through calculative technologies. The apparatus (*dispositif*) of security alludes, in brief, to a heterogeneous network of discourses, knowledges, practices, technologies and institutions through which governmental power is exercised over population and space for socio-spatial order and security. Foucault is therefore particularly interested in the ways in which (state) power, population and spaces of security are connected to each other (see Foucault 1980b: 194–196; Foucault 2007: 11), i.e., how people and spaces are governed through the state (cf. Valverde 2007). In this view, spatial organisation of the state may be seen as a result of the specific interrelation between state power, state space and population.

Secondly, Foucault (2007: 108) illustrates by governmentality the genealogy of technologies of power. According to his genealogical analyses of power, sovereign power is exercised on territory, disciplinary power on individual bodies and government (biopower) over the population as a social collective (Foucault 2007: 11). Nevertheless, Foucault does not propose a linear replacement of sovereignty by discipline and of discipline by government, but he sees these technologies of power as comprising a triangle of sovereignty-discipline-government which has the population as its primary target. Furthermore, Foucault never aimed to create a general theory of what power is, but rather to contribute to the understanding of how power works and what kind of subjectivities power produces in a specific historical situation. For Foucault, power is not hierarchical or centred around the state, but instead, power is immanent in all social relations (such as doctor-patient, teacher-student, etc.) (also Jessop 2007b: 35–36). In Foucault's thought, government is therefore conceived of as 'conduct of conducts' exercised on the self and others (Foucault 1982: 789–794). As Dean (2010: 18) aptly interprets, "government is any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to

shape conduct by working through the desires, aspirations, interests and beliefs of various actors, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes". In this regard, what is particularly emphasised in Foucault's political thinking is the productive characteristics of power, which denotes that governable subjects and spaces are produced through specific technologies of power (e.g. Rose 1999).

Thirdly, Foucault (2007: 108–109) uses the concept of governmentality to describe the genealogy or 'governmentalisation' of the state. Foucault was renowned for his reluctance to general theorisations about the state and state power. Accordingly, he chose to approach the state through his genealogical inquiries into the development of arts of government and governmental rationalities as styles of political reasoning about the purposes of the state (Foucault 2007: 87–114; also Huxley 2008: 1637–1638). Through genealogical methods, Foucault contrasts liberal art of government, emerging from the late 18th century until present, with certain other arts and practices of government (e.g. police) in Europe from around the mid-16th century. This narrative of governmentalisation of the state could thus also be understood as a genealogy of liberal art of governing the states and subjects (see Walters 2012: 12–13; Elden 2007).

In the context of the state space/health care nexus, governmentalisation of the state alludes to the emergence of population health as inseparable from the development and constitution of the modern state. Concomitant with the rise of capitalism in the 18th century, population health was constituted as a target of state power and thus an objective of government through political and economic problematisation by the state (Foucault 2003a, 2003b). In this regard, health was not the issue of a particularly fragile, troubled and troublesome margin of the population, but the question was how to raise the level of health of the population in its entirety (Foucault 2003b: 341). In particular, population health became seamlessly linked with the state-driven processes of reproducing labour. From this angle, health care was expected to provide society with strong individuals who were capable of working, and thus of ensuring the constancy, improvement and reproduction of the work force. Health care thus emerged as a biopolitical strategy for the maintenance and reproduction of the workforce and, therefore, for the various political and economic functions of modern society (Foucault 2004: 16). In this, healthy citizenry became considered as a strategically important resource for the strength and prosperity of the state and was thus to be integrated into the apparatus of production to ensure the constant increase of its utility (Foucault 2003b: 343). Accordingly, population health became inescapably linked with the economic and political security of the modern state.

The role of health care was constantly widened and strengthened in the administrative system and the machinery of state power throughout the 18th century (Foucault 2003b: 346). However, the interconnection between state space and health care began to intensify considerably only after the Second World War through complex social processes which have brought these issues together (see also Moran 2000). Firstly, as major territorially and spatially institutionalised materialisations (see Fox 1986; Article I; Article II) of spatial

Keynesianism (see Brenner 2004a) and related welfarism (see Miller and Rose 1992), health care systems of various kinds have had critical roles in the emergence of post-Second World War Keynesian welfare states. In this regard, Foucault (2004: 5–7) highlights the significance of the Beveridge Report, published in 1942 by the British Economist William Beveridge, for the spatial organisation of health care after the Second World War in Great Britain and other Western democracies. The implementation of the Beveridge Report denoted that the state took responsibility for health care. That is to say that health care explicitly became a part of the state apparatus and therefore appeared as a statist social practice. Likewise, population health emerged as an object of political struggle by entering into the macroeconomics of the state through economic calculations, financing as well as economic redistribution and equalisation.

Secondly, since the 1980s, existing welfare state structures have been reconfigured through a variety of health care reforms. In the OECD sphere, the restructurings of health care have arguably reflected the emerging presence of neoliberal political reasoning in social practices (e.g. McGregor 2001; Prince *et al.* 2006; Teghtsoonian 2009). Consequently, publicly funded health care systems have turned towards competition- and market-based solutions (e.g. Wendt and Kohl 2010; Propper 2012; Tuohy 2012). Therefore, as social entities, health care systems are neither static nor politically neutral, but rather under constant change (Barnett and Copeland 2010: 499) contributing, in conjunction with other social systems, to spatial reconfiguring of the state and social relations (cf. Saltman and Figueras 1997; also Saltman and Bankauskaite 2006). Thirdly, health is one of the sectors of social life through which state power enters into the everyday life of citizens (see Painter 2006). In this capacity, health care plays a key role in the construction of the historically contingent relationship between the state and citizenry (see Article II; Article III).

As above discussion indicates, state space and health care may be seen as inextricably linked to each other as key constituents of the territorial state. In the ensuing pages, I discuss the state space/health care nexus from three different theoretical perspectives, each of which focuses on one of the following binary relationships reflecting the territorial/relational dichotomy: territory/population, state power/civil society, the state/the market. Through these theoretical perspectives I aim to dismantle aforementioned categorical distinctions and bring the poles of each pairing together. Therefore, each approach connects sovereignty with governmentality of population health in different theoretical contexts. The key empirical findings of individual research articles contributing to each theoretical perspective are discussed respectively the in subchapters 5.1, 5.2 and 5.3.

3.1 Territory/population nexus: geopolitics and biopolitics of state spatial transformation

One of the earliest, and at the same time one of the most influential, discussion of the modern state within the sub-discipline of political geography was provided by the German geographer, Friedrich Ratzel. For Ratzel, the state was an organic, living entity primarily expressing the unity of land (territory) and people. He wrote (originally in 1896) that

> *"States are dependent both in their size and their form upon their inhabitants, i.e. they take on the mobility of their populations, as it is particularly expressed in the phenomena of their growth and decline. Some number of people are joined to the area of the state. These live on its soil, draw their sustenance from it, and are otherwise attached to it by spiritual relationships. Together with this piece of earth they form the state"* (Ratzel 1969: 18).

Ratzel's definition of the state thus emphasises the seamless connection between state territory and people in the constitution of the state. However, in the tradition of political geography, scholarly emphasis has been placed primarily on the differentiated institutional settings and the absolute spatial characteristics of the state (Painter 2005: 39; also Glassner *et al.* 2004: 65–68) rather than on the relationship between state territory and population as well as their co-constitutiveness of state spatiality (see, however, e.g. Alatout 2006; Elden 2013). Also, as Alatout (2006: 608) points out, both theories of the state and theories of governmentality tend to create an a priori distinction between territory and population and thus between sovereign power and biopower. In my analysis, these issues are united through health care.

In this thesis, I suggest that the historically situated state spatialities may be fruitfully conceptualised through a discussion on the ways in which territory and population come together in and through statist social practices related to health, combining the management of population health with the territorial formations of the state (see Moisio 2015). In this view, political governance targeted at state space involves two analytically distinguishable but intertwined objects: state territory and the population within it (Moisio 2012: 45). Accordingly, territory and population are not regarded here as separate realms but as inherently intertwined elements of the state and state space defined and governed in relation to each other (see also Alatout 2006; Elden 2013). I approach the territory/ population interface through the concepts of geopolitics and biopolitics which I see as two seamlessly interconnected forms of historically contingent political rationalisation upon which the spatial constitution of the state is predicated in particular spatiotemporal situations (cf. Jones 2008; Moisio 2008). In this context, health care is conceived of as one of the statist social practices which is bound with both geopolitical and biopolitical aspects of state space, and in this capacity brings the sovereign power and biopower, i.e., the territorial and the relational, together.

As a form of geographical knowledge and a political practice, geopolitics has been inextricably intertwined with the constitution of the territorial state since the 19th century. According to Agnew (2005: 160), geopolitical constitution has been so influential that the lived space in the modern state has been almost inescapably attached to the idea of state-territoriality, that is, the state's attempts "to affect, influence, or control people, phenomena, and relationships, by delimiting and asserting control over a geographical area" (Sack 1986: 19). Associated with specific technologies of power over territory, geopolitics can be understood as 'geo-power' (cf. biopower) referring to an "ensemble of technologies of power concerned with the governmental production and management of the territorial space" (Ó Tuathail 1996: 7). Following this view, I understand geopolitics here as referring to the territorialisation of state power over a 'national' space constituted by territory, population and social relations (cf. Cowen & Smith 2009: 23), and to the related socio-spatial practices of security and inter-state competition.

Biopolitics, in turn, represents one pole of biopower that combines the micro- and macrophysics of power. The other pole, anatomo-politics of the human body is related to the technologies of disciplinary power that seek to observe, control and optimise the behaviour of an individual and integrate it into a range of institutional systems of the state (Foucault 1980: 139). According to Foucault's analytics of power, biopolitics emerged in the second half of the 18th century as a new, macrophysical technology of power "centred upon life: a technology which brings together the mass effects characteristic of a population" (Foucault 2003c: 249) within a given (state) territory. In Foucault's thinking, 'population' refers not to a legal or political entity but to a biological corpus understood as a 'social body' that is characterised by its own internal processes and phenomena (e.g. birth and death rates, health status, etc.) (Lemke 2011: 36–37). These characteristics of population are independent from state power and are thus requiring the intervention of government by the state (Rose *et al.* 2006: 87). As a technology of power arising out of the 'discovery of population' (Curtis 2002), biopolitics therefore seeks to manage and regularise population as a collective reality in relation to its qualitative and quantitative biological features on the basis of demographic knowledge and statistics on 'life' (Foucault 2003c: 242–246). In this sense, population health becomes understood not only as a medical but also as a broader political problem, the management of which necessitates the establishment of 'an apparatus' (Foucault 2003b: 343), i.e., a statist system of health care.

Taken together, health governance is associated with geopolitics of state territory, biopolitics of a population and anatomo-politics of the body (see Figure 1). Geopolitics is commonly viewed as attached to sovereign power concerned with processes of territorialisation of the state. In this regard, the question of population remains often perceived as less important. Biopolitics, instead, is seen to be as related to the government of a population and thus seems to make the construction of the territorial state secondary (cf. Alatout 2006: 607). Rather than constructing a mutual exclusivity between geopolitics and biopolitics, one should treat them as cooperating forms of political calculation bringing together the territory and population as constituents of state spatiality. Although
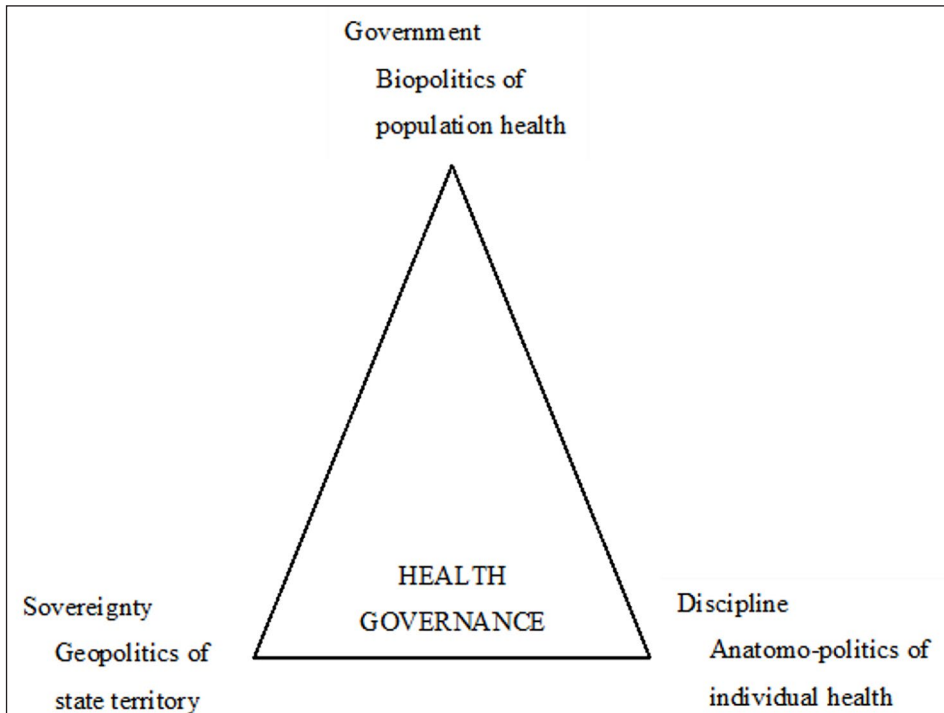
Figure 1. Powers of health governance (cf. Foucault 2007: 107).

arguing that the modern political government is more concerned with the management of the population than the management of a territory per se (Foucault 2003c: 37–39, 249–250), Foucault (1991: 350–351) points out that governmental technologies emerging from the biopolitical problematisations are to be applied also to the state territory. In this sense, population health becomes conceived of as a geopolitical problem within wider state strategies. Therefore, the management of population health results in specific spatial forms (Foucault 2007: 104–108; also Kearns 2014) and is thus connected to the territorial organisation of the state (cf. Foucault 1980: 139–140; Rabinow and Rose 2006: 196–197). At the same time, territory remains significant and is not conceptualised exclusively in terms of geopolitics, but also on the grounds of biopolitics (cf. Evered and Evered 2012: 311). In summary, the entanglement of geopolitics and biopolitics in health care practices denotes the ways in which state power, territory and population are integrated with each other, i.e., how a population is affected in order to manage (territorial) space and how the (territorial) space is to be arranged for the optimal government of population health (see also Moisio and Paasi 2013a: 270).

Premised on the above discussion, I suggest that health care materialises spatially as an effect of geopolitical and biopolitical problematisations by state authorities addressing "how best to govern the population and territory of the state" (Hindess 2005: 397). In other words, health care is not only biopolitical but also a geopolitical spatial strategy

(cf. Foucault 2003a: 321). Therefore, the constitution of the state is as biopolitical as it is geopolitical, i.e., that the spaces of population health and the spaces of territory (cf. Dillon 2007: 46) are reciprocally constituted through the merger of geopolitics and biopolitics. In this regard, health care appears as a relational system through which the territorialisation of the state takes place. This is to say that health care should be conceived of as a form of governance that establishes a link between the territorial management of the state space and relational spaces of governing population health. Relatedly, I also suggest that changes in the specific ways in which geopolitics of territory and biopolitics of population health are entangled and exercised together in a given spatiotemporal context should be understood as a transition from one systemic spatial configuration of statehood to another.

3.2 State power/civil society nexus: statisation of mundane population health through health care *dispositif*

In the context of the state space/health care interface, the second theoretical approach I suggest to territoriality and relationality of state spatial transformation stems from the persistent dualism between the state (power) and civil society (i.e. population). In geographical thinking, 'state' and 'society' have been often seen as mutually exclusive rather than as co-constitutive: they have been treated as separate objects of analysis and have thus not been commonly defined in relation to each other (Painter 2005: 37–38). This distinction is thus explicitly associated with the 'traditional' perceptions of the state as a coherent entity isolated from civil society. However, in order to overcome the state/society dualism, an increasing number of political geographers and other scholars have become interested in the relations of the state to civil society through examination of the everyday spaces of statehood. For example, Michael Mann (1984) has discussed the relations of state to society by charting 'institutional power' of the state referring to state's capacity to permeate through everyday social life in order to put political decisions into effect.

Joe Painter (2006) has taken the above-mentioned idea further by discussing 'prosaic geographies of stateness' through an analysis of the prosaic manifestations of state processes. This approach draws attention particularly to the ways in which the state enters into everyday social life through the multiplicity of mundane life practices. In a parallel line of thought, Jeff Garmany (2009) has studied how the 'embodied state' manifests itself in day-to-day social life through the governing of bodies and spaces. John Allen and Allan Cochrane (2010; also Allen 2009, 2011), in turn, have applied the topological approach to geographies of state power and the concept of 'reach' to analyse the spatially pervasive power of state authorities. Moreover, the encounters between state agents and citizens have also been discussed by Rhys Jones (2012), who has inquired into the ways in which 'state encounters' impact the daily lives of citizens and how the peopled qualities of the state are affected by its citizenry.

In order to get at the interaction between state power and civil society, I link the 'prosaic geographies of stateness' (Painter 2006) with biopolitical governmentality referring to 'the government of life' (Villadsen and Wahlberg 2015) as a distinctive form of power: knowledges, practices and techniques targeted at managing population health and regularising health-related behaviour. From this perspective, population health is conceived of as a mundane problematic of biopolitical governmentality (which I will discuss in more detail later in this subchapter). I wish to make two main arguments in this context. Firstly, whereas many of the studies focus on the state's socio-spatial effects on the ordinary social life of its citizenry, the ways in which the 'mundane' is constituted through various statist social practices of population governance have remained less analysed. In other words, the 'mundane' is often taken as an ontologically given category of governance rather than as produced through power and control. I contend that the combination of prosaic aspect of state-making and biopolitical governmentality provides a relevant approach to study how population health is constituted as a mundane political problem and rendered a governable realm. I see the statist constitution of a governable category of the 'mundane health' of population as a prerequisite for statisation of everyday social life through health care. This alludes to a process enabling state power to penetrate and intensify its involvement in civil society through dispersed statist and non-statist institutional and social networks of health care (cf. Painter 2006: 758; see also Foucault 2007: 103).

Secondly, the interconnections between state space and health care are often addressed by analysing the ways in which states re-create institutional spaces of health services in order to manage a population's existing health problems. I suggest that it is equally important to inquire into the state space/health care nexus through exploring the statist formation of everyday health problematics at the level of population. This entails analysing the ways in which the problematisations of population health are connected with the construction of the territorially institutionalised spaces of health care, i.e., how the object of government is first specified and then controlled (cf. Rabinow and Rose 2003: xvi). In other words, population health as a mundane problematic of biopolitical governmentality may be understood as a precondition for the development of the institutionalised system of health care through which the relationship between state power and civil society becomes intensified.

In order to examine the statisation of everyday population health, I conceptualise health care as a *dispositif* of state power (see also Subchapter 4.1.1 for *dispositif* analysis). The French word '*dispositif*' is often translated into English as 'apparatus' which is seen as complicated or even inaccurate by many of the scholars engaged with Foucault's work (see e.g. Pløger 2008; Bussolini 2010). In order to avoid translation-related complexities, I draw here on the original French word. Following Foucault's (2007: 108) thinking, the modern state (space) may be understood as constituted by an abundance of overlapping and interrelated *dispositifs* (of security) (e.g. health care, education, policy,

etc.) through which state power is exercised over life and spaces. In his conceptualisation of *dispositif*, Foucault (1980b: 194–196) highlights three aspects. Firstly, *dispositif* refers to a heterogeneous system of relations established between discursive and non-discursive elements. Secondly, by *dispositif* Foucault seeks to identify the spatially and temporally variable nature of connection and interplay existing between the elements. Thirdly, *dispositif* is a historically contingent governmental formation which functions strategically as a response to specific problematics of government. Foucault (1980b: 196) continues that since *dispositif* is strategic in its nature, it always consists in strategies of power relations supporting and supported by certain types of knowledge. *Dispositif* thus alludes to mutual productivity of power, knowledge and mundane practices through which the targets of government are constituted (Rabinow and Rose 2003: xvi).

As a *dispositif* of state power, health care may be conceptualised as a historically situated system of interrelations between knowledge-based and power-driven discourses on population health, health care practices, and effects (i.e. specific kinds of governable subjects and institutional settings) through which state power is exercised over state space and population (see Figure 2). As a network of discursive and non-discursive elements, health care *dispositif* is relational (cf. Bussolini 2010: 92). It is also territorial (cf. Legg 2011): it materialises as territorialised state institutions through which the state intervenes and governs the population's everyday lives and, vice versa, through which the state is recognised and experienced by its citizenry. The territorial system of health care
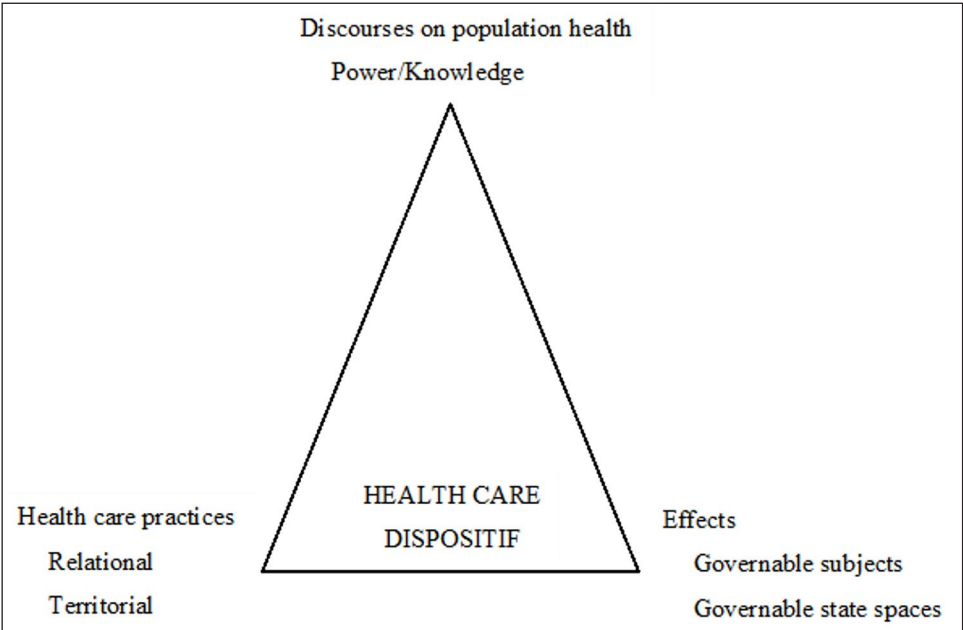

Figure 2. Discursive and non-discursive elements of health care *dispositif*.

is relational in a triple sense. First, the relational spaces of health care constitute the state as a territorial entity. Second, the relational spaces of health care bring the territorial state and population together. In the latter sense, these spaces manifest themselves in state strategies, projects, plans, etc. Third, the relationality of health care *dispositif* stands for the scientific knowledge of population health, which works in partnership with technologies of power for making population health knowable and governable. Therefore, in this view, spatiality of the state results from multiple and diverse relations between the population and the territorially institutionalised state apparatus (Lemke 2007: 44; also Jones 2012: 807–808). In this regard, as Hannah (2001) points out, the legitimacy of the state is not realised exclusively through territoriality, but also by employing social body as an equally important site of control.

Foucault's (1980b: 195) notion of *dispositif* as responding to an 'urgent need' is of great importance with regard to the statist constitution of the governable category of mundane population health. It may be argued that health care *dispositif* emerges as a strategic response to a specific problematisation of population health in a particular temporal context (cf. Rabinow and Rose 2003: xiv). Problematisation does not denote "the representation of a pre-existent object nor the creation through discourse of an object that did not exist. It is the ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought (whether in the form of moral reflection, scientific knowledge, political analysis, etc.)" (Foucault 1988: 257). That is to say that in order to govern the conduct of a population living its independent everyday life within a state territory, and to put the citizenry to productive use as a strategically important resource for the success of the state, population health needs to be translated into a calculable and governable biopolitical problem which can be acted upon (cf. Rose *et al.* 2006: 187). This is done by organising a statist health care *dispositif* around the health-related characteristics and regularities of a population in order to bring the conduct of the citizenry in line with the objectives of government (Foucault 2003b: 342–343). Health care *dispositif* thus operates strategically in response to the problematic of biopolitical governmentality by integrating the everyday population health into the territorial organisation of the state through regularisation and direction (cf. Foucault 1980a: 139–140; Rabinow and Rose 2006: 196–197).

The prosaic aspect of state-making arguably accentuates the ways in which state power and civil society are connected through everyday processes of governing population health. In this capacity, the analysis of the statisation of mundane population health enables an epistemological break from traditional structuralist accounts of the state and its spatiality (cf. MacLeavy and Harrison 2010: 1040). This kind of approach to the interface between state space and health care contributes to a more poststructuralist understanding which challenges the taken-for-granted juxtaposition of the state and civil society by viewing the modern state as a mobile 'effect' of historically contingent practices of government and continual statisations (cf. Foucault 2008: 77–78). In this view, the very existence of the state is conditioned by the discursive and mundane socio-spatial practices and related

configurations of everyday routines within which statisation occurs (Painter 2006; see also Abrams 1988; Mitchell 1999).

3.3 The state/the market nexus: subjectification of a citizen-consumer through health care choice

The third territorial-relational approach I suggest for the state space/health care interface originates from the binary relationship between the state and the market. In this, the state is often conceived of as a bounded territory in which health politics and policies are implemented (i.e. health politics is seen as a matter of the 'national') whereas the market is viewed as a more relational space of economy characterised by openness and fluidity as well as transnational flows and networks (cf. Moisio and Belina 2017: 9). The state and the market are thus often regarded as distinctive realms independent of each other; the former associated with public power and the latter attached to private power.

I approach this distinction by theorising the transformation of the relationship between a citizen, the state and the market as a key effect of health care reform. I see the contemporary restructuring of health care as associated with neoliberal governmentality which entails the infiltration of market practices and rationalities into the social processes that constitute the state (Moisio and Paasi 2013a: 269; also e.g. Larner 2000; Brown 2004; Ong 2006). This involves the reshaping of state spatiality, health care structures and individuals to conform to the prevailing market principles (e.g. Ahlqvist and Moisio 2014: 22). In this context, I understand health care reform as a state-led neoliberalising policy reform designed not only to re-territorialise and re-spatialise the state but also to create new market spaces and to produce new kinds of citizen-subjects. From this angle, health care is conceived of as a key constituent of changing state spatiality and as one of the multiple social sites of citizen-subject formation through which citizenship is defined and given meaning in particular spatiotemporal contexts (cf. Mitchell 2006; Staeheli 2011).

My main objective in this approach is to highlight the role of citizen subjectification in contemporary state spatial transformation. In pursuance of the emergence of neoliberal governmentality, the new imaginaries of 'actually existing citizenship' (Staeheli 2011, 394–395) have been conceptualised by scholars, for example, as 'active' (e.g. Rose 1999; Dean 2010), 'neoliberal' (e.g. Hindess 2002), 'aspirational' (Raco 2009) or 'consumer' (e.g. Clarke *et al.* 2007) citizenship which emphasise citizens' calculative capacities to act upon not only their security, well-being and quality of life, but also dynamic market conditions (see e.g. Peck and Tickell 2002; Brenner 2004a; Ong 2006). However, as Raco (2009: 443) points out, studies on the spatial restructuring of Keynesian welfare states have largely focused on the reconfiguration of state institutions and governance structures. With regard to the 'neoliberalisation of health' (Carter 2015), insightful literature exists on geographies of health care restructuring (see e.g. Joseph and Phillips 1984; Rosenberg 1988; Barnett and Kearns 1996; Kearns and Barnett 1997, 1999; Moon and Brown 2000;

Brown 2003; Kearns *et al.* 2003; Prince *et al.* 2006; Barnett and Brown 2006; Curtis 2008; Crooks and Andrews 2009; Curtis and Riva 2010) which is focused on the influence of neoliberalism in recasting public-sector health services, as well as on the transformation of patients into consumers.

However, not enough scholarly attention has been paid to the ways in which citizen-subjects are sought to be reshaped by a variety of neoliberalising policy reforms (see, however, e.g. Brenner 2004a; Gordon and Stack 2007; Isin and Turner 2007; Moisio and Kangas 2016) and, in particular, to the constitutive role the citizen-subject plays in health care reform and in political restructuring more broadly. By focusing on neoliberalising subject formation in the context of health care reform, I argue that the 'desirable' citizen-subject should not be seen as a passive result of changing political rationalities, but rather as an active contributor to state power in the reconfiguring of spaces of health care.

In order to demonstrate my argument, I combine the issues of state transformation, health care restructuring and citizen-subject re-formation by conceptualising health care reform as a calculative political technology of state space through which states have sought to optimise and economise the 'welfarist' state spatialities during the past 30-plus years in response to political and economic challenges towards the state (cf. Kangas and Moisio 2012: 202). In order to conform health care to the norms of economic globalisation, health care reforms have been typically designated to reorganise health policies around neoliberal political rationality (e.g. McGregor 2001; Prince *et al.* 2006; Larsen and Stone 2015). In this context, the notion of freedom of choice has appeared as a hegemonic discourse of health policies and a driving force of neoliberalism-induced health care restructuring worldwide (e.g. Clarke *et al.* 2006; Nordgren 2010; Gabe *et al.* 2015).

The emphasis of health care choice has led to rethinking the idea of citizenship as well as the 'desirable' characteristics and behaviour of citizen-subjects who are increasingly considered to be economic-rational individuals making choices in the marketplace of health services (e.g. Clarke *et al.* 2007; McDonald *et al.* 2007; Fotaki 2011). Health care choice is thus used in neoliberal governmentality to recalibrate the relationships between the state, the market and citizens (cf. Mayes 2016: 43), which arguably contributes to the shift from one systemic configuration of statehood to another. Due to its embeddedness in broader social and political systems of governing and its explicit linkages to the mutations in citizenship, health care choice is of my particular interest in this third territorial-relational approach to the state space/health care nexus. I highlight here two seamlessly intertwined, but analytically distinguishable, key dimensions of health care choice by conceptualising it on the one hand as a technology of political re-regulation and on the other as a technology of subjectification. Through these conceptualisations, I purpose to demonstrate how health care choice contributes to the state's attempts to reconstitute its internal spaces and social relations in accordance with neoliberal governmentality.

Health care choice as a technology of political re-regulation is involved in the establishment of a new kind of cooperation and interdependence between the state and the market. That is to say that health care choice is often connected with the neoliberal

problematisations of the 'welfarist' distinction between public and private power (cf. Clarke 2004). Therefore, it is commonly linked to the idea of introducing market logics into health care systems which are predominantly dominated by public authorities and governed by public funding outside the purview of the market (see e.g. Fotaki 2011; Gabe *et al.* 2015). In this sense, health care choice contributes to the attempts to create new market spaces through inter-provider competition and to transfer health service provision from the public providers to private for-profit enterprises (cf. Larsen and Stone 2015: 942). This explicitly highlights why health care should be understood as situated in the nexus of territorial and relational state spaces: it is associated with the ways in which the boundary between public and private spaces is problematised and negotiated. Thus, in this view, the territorial and the relational are brought together through privatisation of health care.

Contrary to the neoliberal views on the market as free from state regulation, I base my understanding of health care choice as a technology of re-regulation on the idea that the state/market interface is reorganised expressly through political re-regulation by the state. As the concept of the 'regulatory state', coined by the Italian political scientist Giandomenico Majone (1994) highlights, the privatisation and marketisation of health care through health care choice does not denote deregulation, but instead, an increase in state regulation (see also Helderman *et al.* 2012). Therefore, rather than rendered insignificant, the role of the state is qualitatively transformed from direct manager into one of regulator and facilitator (e.g. Jessop 2000). At the same time, state power is extended to the private sector which entails the blurring of boundaries between the state and the market. As "the markets exists, and can only exist, under certain political, legal and institutional conditions that must be actively constructed by government" (Burchell 1996: 23), the state thus continues to have a significant influence on the development of new spaces and scales of health care governance under contemporary neoliberal governmentality.

My conceptualisation of health care choice as a technology of subjectification is associated with the neoliberalism-driven reworking of citizen-subjects as 'human capital' (Read 2009: 25) and calculable resources (Moisio and Paasi 2013a: 270) recruited by the state for its operations (cf. Lazzarato 2009: 111). In this context, subjectification refers to the process in which individuals are objectified through health care choice into specific kinds of subjects (cf. Milchman and Rosenberg 2009; also Hamann 2009) whose characteristics are consistent with contemporary capitalism, the market economy and particular politico-economic objectives of the state (cf. de Koning *et al.* 2015: 122).

I therefore propose that the citizen-subject is sought to be transformed through health care choice into an active change agent making positive contributions to state power in the restructuring of health care system and thus, more broadly, playing a key role in reproduction of broader ideologies, political projects and strategies of the state (see Delanty 2006; Dean 2007). In conjunction with the growing emphasis of choice in the marketisation of health care, the citizen has become increasingly articulated as a consumer of health services (e.g. McDonald *et al.* 2007; Fotaki 2011). This arguably reflects the idea

of free and autonomous *Homo economicus*, who is capable of making calculated and rational choices in the marketplace of health services and is responsible for the consequences of their choices (cf. Brown 2005: 43; Hamann 2009: 43–44). However, as citizens exercise choice in health care markets, they become constitutive of state power not only in creation of new market spaces but also in reorganising the relationship between the state and the market through their navigation between public and private spaces. In this regard, the 'new' citizen-subject can be conceptualised as a citizen-consumer: a hybridised combination of a political construct produced in a reciprocal relationship between the individual and the state and an economic construct constituted in economic relationships (Clarke *et al.* 2007: 7). Despite the views on the notion of the citizen-consumer as inappropriate in the context of health care (see McDonald *et al.* 2007: 430–431), I find it relevant here as it epitomises the citizen-subject sought to be produced through health care choice.

This approach to the state space/health care nexus thus suggests that health care reform is an effective neoliberalising political technology designated to give rise to new forms of governing state spaces and population through health care choice (see Figure 3). Through re-regulation alluding to the redirection of state power, health care choice enables the restatisation of health care governance which accentuates explicitly that the neoliberalisation proceeds in and with the state. Importantly, successful function of re-regulation necessitates the reconceptualisation and reworking of citizenship as a spatial category. Furthermore, health care choice as a technology of subjectification should not be seen as opposite to government, but rather as a disciplinary technology targeted at
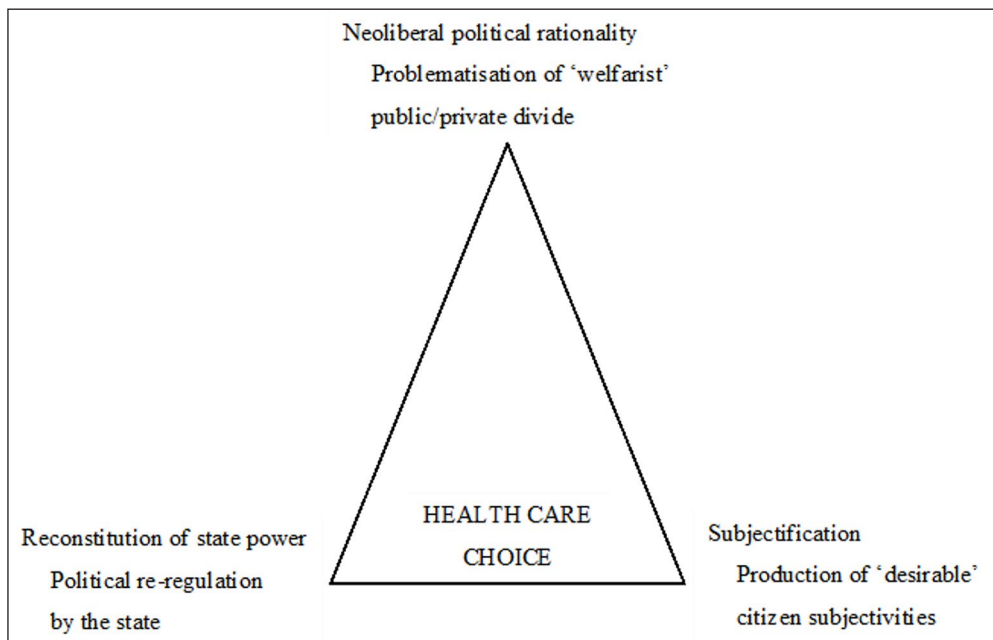
Figure 3. Health care reform as a political technology of state space.

activation and responsibilisation of the citizen through freedom (cf. Rose 1999; Rose *et al.* 2006: 91). Therefore, individual citizens are not passive ends of the government, but rather subject-objects who are on the one hand subjected to state power and related agencies. On the other hand, they simultaneously exercise actively their political subjectivity. To conclude, the reconstitution of state power and the production of new forms of citizenship arguably are mutually constitutive of the socio-spatial transformation of the state.

4 Theoretical-methodological foundations
of the research

Prior to introducing the specific methodological framework drawn upon, as well as the empirical materials employed in the research, I firstly position myself as a researcher in relation to the research field, theoretical foundations and empirical study. The present research follows the tradition of critical science and poststructuralist approach which have guided the methodological strategies chosen for the empirical study. According to Habermas (1976), types of science may be categorised into three varieties being empirical-analytical, historical-hermeneutical and critical science. Within human geography, critical science has developed since the late 1960s in connection with the 'cultural turn' as a critical response to the domination of spatial analysis and positivist research tradition (e.g. Hubbard *et al.* 2002: 33). Initially, as Johnston and Sidaway (2012: 197) highlight, a grouping of interrelated politicised critical approaches within human geography were aggregated under the rubric of 'radical geography' and later since the 1980s that of 'critical geography'. Although diverse in their ontology, epistemology and research methodologies, critical geographical approaches share the "commitment to emancipatory politics within and beyond the discipline, to the promotion of progressive social change and to the development of a broad range of critical theories and their application in geographical research and political practice" (Painter 2000: 126). In this study, I have adopted a critical political geographical approach: an interdisciplinary viewpoint combining the geographical knowledge, political sciences and social sciences in examining the spatially and temporally situated political production of new forms of statehood.

Critical science is divided, for example, by Kitchin and Tate (2000: 14–18), into postmodernism, realism, poststructuralism, feminism and Marxist approaches. As mentioned above, the present research is methodologically inspired by poststructuralist approaches which seek to provide a researcher with a perspective from which to critically examine existing socio-spatial reality and related historical, cultural and social constructions. In this view, rather than being based on one specific diagnosis of how the reality is or should be organised, poststructuralism stems from the principles of plurality and complexity which guide a researcher to make critical assessments of the phenomenon under scientific scrutiny (Wylie 2015: 373). From the poststructuralist perspective, diverse realms of (social) reality (e.g. the state, civil society, texts, discourses etc.) are not structurally locked linear systems explained in one deterministic way (cf. structuralism), but rather dynamic and non-linear ensembles open to a diversity of interpretations through which the meanings are constructed. In this regard, poststructuralist theorisation should concentrate on tracing the trajectories of change resulting from the constant processes of 'becoming' (Murdoch 2006: 14–16).

As Murdoch (2006: 22–25) claims, relationality is the core characteristic of poststructuralist geographies (see also Creswell 2013: 218–222) and, more widely, of critical

geographical rethinking of space as relationally constituted (e.g. Lefevbre 1991; Amin 2002; Massey 2005; Thrift 2006; Paasi 2011; Martin and Secor 2014). Therefore, as a concept and a body of theory, poststructuralism primarily refers to the multiplicity of meanings that arise from the constitution of relations (Murdoch 2006: 15). In this view, then, space is conceived of as relational, i.e., an open and dynamic product of competing and co-existing relations and thus as incomplete and as being under constant reconfiguration (see Massey 1998: 27–29). The key ontological and epistemological assumptions of the present thesis are premised upon the poststructuralist understanding of state space which emphasises the relational aspect of spatial constitution and transformation of the state (Moisio and Belina 2017: 9). However, although the relational approach to space draws our attention to processes in which relational spaces are produced by interactions and interrelations (Murdoch 2006: 22), I by no means see relationality and territoriality of state space as mutually exclusive, but rather as co-constitutive. That is to say that I draw on the idea that state space is not a closed and fixed container of social relations, but a dynamic effect of socio-spatial relations. Accordingly, state space is constantly reconfigured in and through a variety of discursive and social practices ranging from health to education which bring together the management of a population with changing territorial formations of the state. Therefore, the socio-spatial reality and its various constructions, such as the state and related territorial and relational spaces, are understood in this research as structured effects of these practices. In this regard, analysis of the various statist social practices contributes to the understanding of the ways in which simultaneous territorial and relational processes together produce new spatial forms of statehood.

4.1 Analytics of governmentality as a methodological framework

In this thesis, I draw methodologically on an analytics of governmentality (see also Chapter 3 for how the concept of governmentality has been employed as a theoretical approach) which has been widely applied and further developed (e.g. Rose 1999; Lemke 2007; Miller and Rose 2008; Dean 2010) as a critical methodological approach under the rubric of 'governmentality studies' especially in social sciences and also in various subfields of human geography for further development of geographical insights into the spatialities of political power (see e.g. Huxley 2008: 1647–1653 for a comprehensive review). Analytics of governmentality is not a distinct theoretical framework or strictly defined research method, but rather an analytical perspective which works best in combination with methods and concepts drawn from other areas of Foucault's work as well as other theoretical traditions (Rabinow 2003; Rose *et al.* 2006). In this subchapter, I briefly introduce analytics of governmentality as a methodological framework and give an account of how I have applied it in the research (also subchapters 4.1.1 and 4.1.2).

Originating from Foucault's genealogy of power, analytics of governmentality focuses on the entanglement of knowledge and power in specific historical contexts (e.g. Dreyfus and Rabinow 1989: 116). Analytics of governmentality is interested, firstly, in discourses and mentalities pertaining to the ways in which the truths of the aims and objects of government are constructed, i.e., the particular focus is placed on the discursive field in which the exercise of power is rationalised. Secondly, the analytical focus is also put on the actual interventionist practices manifested in specific governmental programmes and technologies through which the government is realised in accordance with specific governmental rationalities (e.g. Lemke 2001: 191). In other words, the emphasis is not on the objects, but rather on "the practices that produce those objects as their effects" (Walters 2012: 18). Rose *et al.* (2006: 84–85) note that as political power always operates through particular rationalisations, the specificity of governmentality as a style of analysing power relations is that it seeks to empirically identify different ways of political reasoning by asking questions such as who or what is to be governed, how they should be governed, and to what ends should they be governed.

Premised on the above, three central objects of analytics of governmentality may be defined (cf. Dean 2010: 39–44; also Inda 2005). The first one is political rationality which alludes to "a way of representing and knowing a phenomenon", i.e., to the "styles of thinking, ways of rendering reality thinkable in such a way that it was amenable to calculation and programming" (Miller and Rose 2008: 15–16). The existence of political rationality is thus based on the recognition and analysis of a particular problem of government (e.g. Miller and Rose 1992). Secondly, political rationality is inseparable from governmental technologies (tools, devices, personnel, etc.) which enable authorities to imagine and act upon the conduct of individuals and population as a collective (Miller and Rose 2008: 16). The third analytical element involves the subject of government (type of self, actor, agent, identity, etc.). In this context, analytics of governmentality focuses, on one level, on the processes of subjectification (i.e. subject formation) in which political rationalities and governmental technologies are associated with the will to produce and maintain specific kinds of subjects by reshaping human conduct and qualities. On the other level, focus is directed on the work that individuals perform upon themselves in order to become certain kinds of subjects (Inda 2005: 10; see also Foucault 1982: 781).

From the perspective of governmentality, state spatial transformation unfolds through governmental interventions targeted at a population which attempt to reorganise spatial relations within the state. In this view, state spatial transformation is conceived of as a historically contingent process based on changing political rationalities and governmental technologies. The process also entails reconceptualisations of citizenship and reworking of citizen-subjects (Moisio and Paasi 2013a: 269). In my work, I apply governmentality in Article I as an analytical perspective to empirically identify changing geopolitical and biopolitical rationalities upon which the emergence, maintenance and transformation of a historically contingent health care system as a specific regime of practices is predicated (cf. Dean 2010: 31). I draw on the idea that the existence of particular geopolitical and

biopolitical rationalities is conditioned by the recognition and analysis of population health as a geopolitical and biopolitical problem of government that necessitates governmental interventions. In this view, health care emerges from biopolitical and geopolitical problematisations of how best to govern population and state space (cf. Hindess 2005: 397; also Barry *et al.* 1996: 7), making it inextricably linked to the politics of knowledge and the practices of expertise (cf. Porter 2011: 18–19).

Article I also involves the analysis of governmental technologies of health care (tools, devices, personnel and systems of knowledge) through which geopolitical and biopolitical rationalities are realised. Through these technologies state authorities and related agencies are enabled to constitute conditions of governing population health (cf. Miller and Rose 2008: 16). In this capacity, technologies of health care necessitate geopolitical and biopolitical calculations and employ scientific knowledge of population health. The third analytical element examined in Article I is the materialisations of health care referring both to the institutional spaces (e.g. spatial system of health services) and to the specific kinds of subjectivities which are sought to be produced through geopolitical and biopolitical rationalities and related technologies of health care. By employing the above analytical elements, empirical analysis in Article I seeks to demonstrate that health care is seamlessly linked to the reorganisation of the socio-spatial relations of the state, and its restructuring spatial configurations disclose the changing forms of governing the economic, social and personal life of citizens.

As for Article III, I structure the analytics of governmentality around health care choice as a crucial governmental technology which enables state power to reshape and govern state space and population in accordance with the 'norms' of neoliberal political rationality. In this context, health care choice is empirically analysed as a technology of political re-regulation through which state power is qualitatively reconstituted and as a technology of subjectification for producing new kinds of citizen-subjects. In my reading, subjectification refers to the process in which individuals are objectified into subjects through a particular complex of power/knowledge, i.e., health care (cf. Milchman and Rosenberg 2009; also Hamann 2009). In this regard, the concept of subject alludes to the status of subjection "to someone else by control or dependence" (Foucault 1982: 781) associated with the government by the state and related agencies. Subjectification is thus analysed here as a form of governing which seeks to reshape individuals' characteristics and conduct to correspond to specific (neoliberal) political objectives of state power (cf. de Koning *et al.* 2015: 122). Therefore, neoliberal political rationalisation, upon which the prevailing idea of desirable citizenship rests, becomes visible through technologies of subjectification such as health care choice. However, these technologies do not determine subjectivity but are merely instruments for influencing various capacities, qualities and statuses of particular agents. In this view, governmental technologies become productive only if these agents experience themselves through such capacities, qualities and statuses, that is, if they exercise actively their political subjectivity (cf. Dean 2010: 43−44).

4.1.1 *Dispositif* analysis

Governmentality is closely concerned with the concept of *dispositif* (see Foucault 2007: 108). This subchapter focuses on how I apply *dispositif* as an analytical tool for analysing and understanding state power and its historical operations in Article II, which focuses on the statisation of everyday social life through health care *dispositif*. *Dispositif* as a theoretical concept is discussed in Subchapter 3.2 of this synopsis. As a concept, health care *dispositif* alludes to a historically and contextually contingent network of discursive and non-discursive health care practices that, in partnership with power and knowledge, are targeted at managing population and spaces as well as at producing specific kinds of subject-objects of government (cf. Foucault 1980b: 194–196; also Bailey 2013: 810). Therefore, understanding *dispositif* as an ensemble of discourses and practices permits proceeding from discourse analysis to *dispositif* analysis. Analytical focus is thus turned to discursive practices, non-discursive practices and effects of the practices (e.g. materialisations such as specific kinds of governable subjects and institutional spaces) as well as to the relations between these elements (see also Jäger and Maier 2009). In this, following Foucauldian thinking, the concept of discourse refers to "the location where power and knowledge intersect" (O'Farrell 2005: 133) and discursive practice to a "historically and culturally specific set of rules for organising and producing different forms of knowledge" (O'Farrell 2005: 134). Non-discursive practices include "institutions, political events, economic practices and processes" (Foucault 1989: 162). In other words, as Foucault relates discourse to knowledge rather than to language, by non-discursive practices he is identifying sites that are not explicitly named as knowledge formations (Bacchi and Bonham 2014: 188).

By the concept of *dispositif*, Foucault (2007: 118–119; see also Valverde 2007: 161–162, 173) attempts to free power relations from exclusive institutional spaces and to place the analytical focus on the mundane practices of government in various institutional spheres such as the prison, hospital, school and so on. Mundane practices thus create spaces of intervention and domination for the state apparatus (see Jones and Murphy 2010: 4). Therefore, *dispositif* analysis seeks to reconstruct particular strategic logic built into the processes of governing which seem to have been operative in institutionalised mundane practices at different historical junctures and according to which space is arranged in order to produce specific subjectivities (Villadsen 2008: 180). Accordingly, from this angle, health care as a *dispositif* of state power should not be analysed exclusively as a spatially located institutional space (cf. Villadsen 2008), but rather as a historically situated form of government in which discourses on population health are connected with particular statist practices of health care. The relation between these discourses and practices (i.e. power/knowledge), in turn, materialises as specific institutional spaces of health care and subjects of government. Following the idea that health policy as the politics of *dispositif* aims at first specifying the target and then controlling it (cf. Rabinow and Rose 2003: xvi), my *dispositif* analysis in Article II discusses primarily how everyday population health is

constituted as an object of government and then governed through health care *dispositif*. In this, I focus on knowledge of population health and associated technologies of health as two analytical elements of *dispositif* analysis, through which I purpose to capture the mutual productivity of power, knowledge and associated political-scientific practices of health care.

Firstly, I consider knowledge as a relevant element of *dispositif* analysis since scientifically produced knowledge and related expertise play crucial roles in specifying population health as an object of government. In other words, it necessitates that population health "can be represented, depicted in a way which both grasps its truth and represents it in a form in which it can enter the sphere of conscious political calculation" (Rose and Miller 1992: 182). In this regard, discourses on population health are of high importance. For Foucault (1980a), the concept of discourse refers to power-driven knowledge, that is, certain accepted truths that are historically constructed and together form larger regimes of truth. In this view, population health is rendered knowable and governable through discourses that are bound together with scientific knowledge production (cf. Prince *et al.* 2006: 256). Accordingly, institutionally organised health care practices emerge from the interplay between scientific knowledge and statist government of population health. In Article II, knowledge is empirically associated with the establishment of a state research institute through which the knowledge production regarding a population's everyday health was institutionalised. This alludes to a statist process by which population health was discursively problematised and constituted as a mundane governmental object with its distinctive characteristics.

Secondly, population health is governed, i.e., scientific knowledge of population health is put into effect through calculative technologies of health that denote "all the diverse means, projects and devices through which the impossible dream of a healthy population has been made an object of realization" (Osborne 1997: 181). These technologies can be seen as specific state technologies by which various state authorities act upon the health-related characteristics and behaviour of a population (cf. Legg 2005: 146). In this capacity, technologies of health are inescapably linked with the politics of knowledge and practices of expertise of health professionals and other state agencies (cf. Porter 2011: 18–19). In my work, the second element of *dispositif* analysis relates empirically to health education. In this context, I regard health education on the one hand as a pivotal facet of the institutionalisation of knowledge production, and on the other hand as a statist technology of health through which population is governed at a distance via health professionals. Health education is thus concerned with the 'conduct of conduct' (see Foucault 1982: 789–790) by the state and related agencies.

The above elements of *dispositif* analysis may be conceived of as comprising a power/knowledge which not only involves the constitution of the national population as a calculable and governable subject, but also the emergence and restructuring of the territorially institutionalised health care system for the purposes of governing a population in relation to its health. These together are crucial constituents of the historically

contingent spatiality of the territorial state, as well as the intensification of the relationship between state power and citizenry.

4.1.2 Genealogy

Despite Foucault often explicitly framed his analyses of governmentality in terms of an array of methods and precepts he called genealogy, analytics of governmentality is commonly detached from genealogical methods (Walters 2012: 113; however, see e.g. Valverde 2007; Bevir 2010; Dean 2010; Bröckling *et al.* 2011; Walters 2012 for the governmentality/genealogy interface). In order to explore the historically contingent state space/health care nexus, I combine analytics of governmentality with genealogy, a variant of which I utilise in Article I and Article II as a unique method of historical inquiry (see Saar 2002: 232–234). Foucault's genealogical approach, influenced by Nietzschean notions of genealogy (see Foucault 2003d), is commonly understood as originating from his later works after, and as a replacement of, his approach to archaeology. Thus, Foucault's archaeological and genealogical phases are often treated as distinct. Elden (2001: 104; also Dreyfus and Rabinow 1983: 104), however, argues that genealogy and archaeology should be seen as existing together as two sides of the same coin: "archaeology looks at truth as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of [discourses], whilst genealogy sees truth as linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and it extends". In this view, then, Foucault's archaeological studies on discourse pave the way to more materialistic studies of power/knowledge in the genealogical period (Murdoch 2006: 30).

By genealogy, Foucault (2000: 118) refers to "a form of history that can account for the constitution of knowledges, discourses, domains of objects, and so on, without having to make reference to a subject that is either transcendental in relations to the field of events or runs in its empty sameness throughout the course of history". In this, genealogy alludes to a methodological process concerned with narrating how discursive and non-discursive practices are reciprocally constituted and how a set of these practices come into being and interact to form an ensemble of political, economic, moral, cultural, and social institutions which determine the limits of acceptable speaking, knowing, and acting. Genealogical analysis thus focuses on the historical emergence of certain epistemological structures and associated discourses (e.g. on population health) constituted and reinforced by the interaction between power and knowledge (Anaïs 2013: 125).

Genealogy is therefore concerned with an inquiry into the historical manifestation of objects of knowledge and intervention, and the 'regimes of truth' that grow up around them in a given spatiotemporal context (Foucault 1980c: 131). In this regard, what is essential is that genealogical analysis is based on a problematisation of the present: "I set out from a problem expressed in the terms current today and I try to work out

its genealogy. Genealogy means that I begin my analysis from a question posed in the present (Foucault 1988: 262)". As a diagnostic of the present (Dean 2010: 3), genealogy is interested in how the past manifests in our present by asking when, why and how a given practice, behaviour or characteristic (e.g. health of a population) became to be seen as a political problem and an object of governmental intervention and calculation (cf. Foucault 2003d). For Dean (1994), genealogy is "a 'critical and effective' history which is critical in that it engages in the restive interrogation of what is taken as given, natural, necessary and neutral, and effective to the extent that it upsets the colonisation of knowledge by those trans-historical schemas and teleologies which claim to be able to account for the truth of our present" (Dean 2010: 4). By problematising taken-for-granted assumptions of the present, genealogy thus challenges the idea of linear or progressive history.

In this thesis, genealogical analysis is targeted not only at the historical processes of welfare state construction, but also at the ways in which the present spatial structures of a welfare state are problematised in order to legitimise the transformative processes, such as health care reform, through which new forms of statehood are produced. In other words, the understanding of contemporary socio-spatial change necessitates the genealogical understanding of the past. In Article I, I apply the genealogical method to trace particular ruptures and continuities within which geopolitical and biopolitical rationalities, associated technologies and resultant materialisations of health care are consolidated into a distinguishable ideational and spatial configuration of the state, characterising a specific form of statehood. Premised on a specific problematisation of population health, these political rationalities are discursive constructions, betraying particular knowledge structures and implemented through power, which constitute the state as a space of health in a given historical context.

In Article II, I utilise genealogy to disclose particular historically contingent processes of power/knowledge and related statist practices in and through which the discursively constituted problematic of everyday population health becomes integrated into the emergence of a territorially institutionalised health care system. In these two articles, genealogy is concerned primarily with the ways in which truths about and problematisations of population health as a spatial phenomenon are produced through conflicts and struggles over knowledge and power. Therefore, through the genealogical approach I aim to challenge taken-for-grantedness of the state space/health care nexus and disclose the complex social processes that bring these issues together and into existence as mutually constitutive elements of state spatiality.

4.2 Research materials

In this thesis, the empirical study is based on four ensembles of research materials: three different but partly overlapping sets of policy documents considered as relevant to the study as well as 14 semi-structured interviews of key actors associated with the health

care sector and ongoing health care reform in Finland. I regard the collected material as constituting an assemblage of political texts which is attached to particular political rationalities and governmental technologies in geographically and historically situated discursive transformation of Finnish state spaces. I have analysed the research materials by adopting diverse theoretical perspectives employed to interpret the materials (cf. Ma and Norwich 2007: 212–213) and through utilisation of different analytical perspectives discussed in the preceding subchapters of this synopsis.

I have therefore applied methodological triangulation as a 'meta-method' for both collecting and analysing research materials. This has also involved the use of theory triangulation, i.e., I have drawn on multiple theoretical and conceptual frameworks in conducting the research. Triangulation as a method has been initially developed in the context of positivist tradition and quantitative data analysis to increase the validity of a study through the use of multiple methods (Campbell and Fiske 1959; Ma and Norwich 2007: 11). In the case of qualitative research, triangulation refers not to a validation strategy, but rather to the diverse, systematic and dissimilar uses of methods, theories, research materials or researchers (Denzin 1989) in order to gain a fuller picture of the research target (Ma and Norwich 2007: 212). In this study, triangulation has been used primarily to capture a more comprehensive and holistic understanding of the phenomenon being researched as well as its various dimensions: that is, of health care as a socio-spatial phenomenon, which unites sovereign power with governmentality of population health in historically situated political processes in which state spatial transformation is produced.

4.2.1 Policy documents

Policy documents (Appendix I) were employed as a primary empirical material in Article I and Article II. With regard to Article I, the research material is comprised of relevant policy documents covering the period 1965–2012. The material consists of 26 national health care strategy documents (1972–1999), two target and action plans for social welfare and health care (2000–2007) and two national development programmes for social welfare and health care (2008–2012). Also, two committee reports from 1965 and 1969, one strategy for health care for the years 1975–1979 and six Government proposals to Parliament for legislation on health care from the period 1971–2010 are included. The selection of the policy documents for an analysis was based on a view that as formulated by state authorities and related state agencies, they can be considered as relevant indicators of the statist biopolitical and geopolitical rationalisation of population health in particular spatiotemporal contexts.

The empirical analysis in Article II is premised upon another array of policy documents covering the period from the mid-1960s up to the early 1990s. The material consists of 12 national health care strategy documents (1972–1984) and 13 official policy documents (e.g. committee reports and Government proposals to Parliament) from the years 1965–1987

concerning health education and the establishment of a National Public Health Institute in Finland. The chosen documents are thus associated with the institutionalisation of knowledge production on population health and the development of health education as a statist technology of health for directing a population's everyday health behaviour. These documents were selected for an analysis on the grounds of two main criteria. First, they date back to an era during which Finland was constructed and expanded as a Nordic welfare state. In the context of Article II, this primarily denotes a process in which the biopolitical governmentality of population health and the territorial management of the state resulted in a specific kind of relationship between state power and citizenry, one which consolidated in a distinguishable ideational and spatial configuration of the state. Second, since the selected documents have been formulated by state authorities and related state agencies, they are conceived of as presenting official statements relative to statist health care practices in Finland.

With regard to Article I and Article II, policy documents were treated as governmental programmes (Gordon 1980) in which the discursive aspects of political power are embedded. Accordingly, I regard documentary research as an appropriate research method not only due to the temporal contexts of these articles but also because the documents embody the political processes and practices of government which produced them (Freeman and Maybin 2011). In this view, documents have a performative role in politics and are mirroring a certain historical context in which they come into being (Weisser 2014: 53). That is to say that policy documents can be seen as resulting from particular political processes which are characterised, inter alia, by competing discourses, negotiations and power struggles. Documentary research thus provides a relevant method for the analysis of the historically contingent discourses and knowledge systems as well as related political reasoning through which population health is rendered thinkable and amenable to political calculation and programming in a given spatiotemporal situation (cf. Rose and Miller 1992).

In Article III, a minor set of key policy documents concerning the pending health care reform and related extension of health care choice provided supplementary research material which primarily contributed to the understanding of the political background of the reform in a broader sense (cf. Bowen 2009: 30). The material consists of two Government proposals to Parliament for the new legislation on health care, freedom of choice and regional administration. These documents were used as complementary material to semi-structured interviews which I discuss in the following subchapter.

4.2.2 Interviews

I chose personal interviews as the method for collecting research material that contributed to Article III, which focuses empirically on health care reform and related health care choice. Personal interviews are often made use as sources of information

on individual experiences, opinions, objectives and thinking (e.g. Kitchin and Tate 2000: 213). Therefore, I regarded interviews as a purposeful method for providing research material on the underlying rationale of the pending health care reform in general, as well as the political reasoning and interpretations related to the idea of extending health care choice, in particular. Initially, I contacted 24 persons selected from Parliament, research institutes, health organisations and private health companies first via email and then by phone. I justify the selection of interviewees for this research by their close association with the pending health care reform in Finland due to which I conceived of them as relevant sources of adequate information required for conducting the study. I conducted altogether 14 face-to-face interviews with six key political actors and eight other key persons, including specialists and researchers, from the public, private and third sector. The collected interview material may thus be characterised as stemming from an 'elite' perspective (cf. Smith 2005; Kuus 2016): the interviewees represent specific (political) elite that not only interpret the rationale and ideas behind the health care reform but also participate in the struggles concerning the production of state spatial transformation through health care reform (cf. Moisio and Vasanen 2008: 29).

I designed the interviews in accordance with the thematic semi-structured interview procedure. I structured the interview framework beforehand by organising the questions around three main themes (Appendix II) directed by the research design and research questions. The interview structure proceeded from more general to more detailed issues. Therefore, in order to get a broader overview of the topic, the first theme concerned health care reform and associated extension of health care choice on a more general level. By the set of questions included in the first theme, I sought to encourage interviewees to reflect on the challenges and problems of the present health care system on which, in their view, the necessity of the prospective reform rests. The first theme also contained questions aimed at charting justifications for the introduction of the idea of more extensive health care choice.

The second theme focused on health care choice, the markets and the relationship between the public, private and third sector. The questions under this theme aimed at persuading the interviewees to consider the interplay between the extension of health care choice and the creation of health care markets. The idea was also to make interviewees ponder the effects more extensive health care choice may have on the relations between the public, private and third sector in the forthcoming health care system. The third theme combined the issues of health care choice and citizenship. By citizen-related questions, I sought to chart the interviewees' perceptions on the impacts more extensive health care choice would presumably have on a citizen's role in a future health care system in relation to the state and the markets. Relatedly, the questions were aimed at encouraging the interviewees to discuss what kind of requirements the new model of health care choice would place on the behaviour and characteristics of a citizen. All three themes were discussed in each interview but the order of questions was reliant upon the interview. Also, different questions and themes may have been given more emphasis in some of

the interviews depending on the position of an interviewee and related characteristics of discussion. Supplementary questions were posed in accordance with the course of each conversation.

I conducted the interviews between the late August and the early October 2016. I sent the interview structure to interviewee beforehand on request. The majority of the interviews took place in the interviewee's office or corresponding private space. All the interviews were conducted in interviewees' and researcher's native language, Finnish. The duration of the interviews varied from 20 minutes up to 70 minutes, being on an average approximately 45 minutes. Each of the 14 interviews was digitally recorded with the interviewee's permission. Recording allowed me not only to direct my full focus on the discussion but also enabled the analysis based on the exact responses of the interviewees rather than on my possibly insufficient notes and memories (cf. Kitchin and Tate 2000: 218). I transcribed the interviews verbatim and analysed them as a discursively produced textual material (cf. Fairclough 2010: 131) by applying analytics of governmentality as an analytical framework (see Subchapter 4.1 of this synopsis). In the analysis, I searched for contemporary discursive ways of addressing health care and health care choice, which are connected to the political efforts to produce socio-spatial transformation and new formations of citizenship. I secured the anonymity of the interviewees by using codes in the analysis. I have taken into account the other ethical issues related to the interviews and to the conducting of qualitative research in general by following the guidelines for the responsible conduct of research compiled by the Finnish Advisory Board on Research Integrity (2012).

5 Summary of the key findings of research articles: towards political geographies of health care

Health care arguably is a linchpin of spatial constitution of the state in a given historically situated context. The three individual research articles of this thesis demonstrate empirically that health care is associated with problematisations, political rationalisations, governmental technologies and knowledge systems through which governable subjectivities and spaces within a territorial state are constituted and sought to be controlled, regulated and reshaped to cohere with changing societal, political and economic circumstances. In the Finnish context, empirical observations accentuate that health care practices emerging and becoming prevalent at a given time are connected with the prevailing political rationalities. Therefore, health care practices are constitutive of historically contingent (geo)political constitution of the Finnish state as a territory of wealth, power and belonging (cf. Moisio 2018: 41).

According to the empirical findings, health care explicitly is in many ways a statist social practice which blends the territorial and relational aspects of state spatiality. In this thesis, the coming together of the territorial and the relational denotes the ways in which sovereignty and governmentality unite in health care, i. e., how the territorialisation of the state occurs through health care practices, institutions, discourses, etc. Therefore, the connecting thread of the research articles is that the territorial management of state space and the changing relational spaces of governing population health are mutually constitutive of state spatial transformation.

In this section, I firstly review the main empirical observations and conclusions of the three articles by answering the research questions posed in each individual paper (subchapters 5.1, 5.2 and 5.3). I also bring up some suggestions for future research raised by the articles. I conclude the section and the synopsis with Subchapter 5.4, in which I discuss the methodological contribution of the thesis by providing the answer to the main research question formulated for this synopsis.

5.1 Geopolitics and biopolitics of health care in the constitution of state spatiality

Article I aims to demonstrate the seamless connection between sovereignty and governmentality by focusing on the geopolitics and biopolitics as mutually constitutive of state spatial transformation. The key empirical findings of Article I suggest that the peculiar ways in which population health becomes integral to the historically contingent spatial constitution of the territorial state should be understood as a movement from one systematic spatial configuration of statehood to another. Accordingly, the way in which geopolitics and biopolitics come together in health care practices characterises

the existing form of statehood. The inquiry into Finland indicates that health care plays a crucial role in restructuring processes which seek to transform the prevailing state spatiality, including citizen subjectivities, into new forms with the aim to respond to politico-economic pressures towards the state. Research questions Ia. and Ib. are answered briefly in the following.

Ia. *How is it possible to overcome the persistent binary between sovereignty and governmentality in a political geographical analysis of state spatial transformation?*

Article I addresses the question through a discussion on the entanglements of geopolitics (associated with sovereignty) and biopolitics (attached to governmentality) as two forms of political calculation (see Elden 2013) upon which the spatial formation of the state is predicated at a given historical conjuncture. Article I provides the existing literature on state spatial transformation with a fresh empirical focus by analysing the ways in which biopolitics and geopolitics are brought together in the practices of health care. The analyses of geopolitical and biopolitical rationalities associated with the problematic of population health, and the related governmental technologies, as well as the materialisations of health care practices, suggest that the history of health care might well be written as a history of biopolitical and geopolitical problematisations of population health. This indicates that a statist health care system should be regarded as one of the key constituents of the territorial state which is bound to both the geopolitical and biopolitical dimensions of state spatiality.

Article I highlights that an analysis of the coming together of the geopolitical and biopolitical in statist health care practices opens up new avenues to investigate the ways in which the territorial management of state space and the changing relational spaces of governing a population are mutually constitutive of reconfiguring forms of statehood. Article I thus suggests that an inquiry into the relations between geopolitics and biopolitics in the context of health care offers new insights into the study on state spatial transformation and the diverse processes of neoliberalisation of the state. Therefore, since the article develops a more general approach to the sovereignty/governmentality interface by exploring the territorial dimension of health care and the health system as a specific form of biopolitics, it serves as a foundation for the remaining two articles.

Ib. *How is the changing state spatiality connected to the coming together of geopolitics and biopolitics?*

At the more specific level, Article I focuses on how spatial constitution of the state is produced through the merger of geopolitics and biopolitics at given historical conjunctures. The empirical study on Finland highlights two particular turning points within which the geopolitical and biopolitical rationalities, governmental technologies and materialisations of health care were consolidated into a distinguishable spatial configuration of the state. The first turning point took place in the early 1970s when

population health, as a strategically important resource, was given higher priority in relation to the central targets of the geopolitical calculus at that time: societal order, economic growth and national development. Accordingly, arising from a specific problematic of population health, geopolitical and biopolitical rationalities were entangled in a way that they became attached to spatial Keynesianism (see Brenner 2004a) and welfarism as modes of social government (see Miller and Rose 1992) upon which the construction and expansion of Finland as a welfare state was predicated in the 1970s and 1980s.

In terms of state spatiality, the coming together of geopolitical and biopolitical rationalities in the early 1970s materialised as a four-tier regional and spatial hierarchy of health care institutions ranging from a handful of university hospitals situated in major cities and central hospitals located in provincial centres, to district hospitals in smaller towns, and finally to municipal health centres. This kind of hierarchical regionalism (see Fox 1986) of health services may be seen as denoting the state's efforts to regionalise and territorialise the lives of its citizenry in state space through health policies: non-polarised distribution of the population within state territory was achieved by securing accessible and publicly funded health services throughout the state territory. In this capacity, the spatially organised national health care system played a pivotal role not only in maintaining the dispersed spatiality of the welfare state but also in generating a new, growth-oriented citizen-subject capable of contributing to the national economy and security. In other words, state-led development of the health care system was to enhance economic progress of the state, regional and socioeconomic cohesion, and population health by managing citizens' health behaviour through broad social rights. Thus, rooted in the principles of universalism and equality, a statist health care system may be seen as symbolising the spatiality of Finland as a Nordic model of statehood characterised by "a specific type of consensual democracy, a combination of state socialism and market capitalism, and the universality of welfare programmes as an integral part of state management" (Moisio *et al.* 2011: 243).

According to the analysis in Article I, the criticism of the hierarchical and centrally planned Finnish state characterised by dispersed spatiality culminated during the economic crisis in the early 1990s. This presents another turning point in geopolitical and biopolitical rationalisation signalling a gradual shift from welfarist spatial Keynesianism towards advanced liberal forms of governing (see e.g. Rose 1996) state space and a population. This transition has materialised in Finland through a series of health policy reforms directed towards producing 'updated' state spaces and new citizen subjectivities (cf. Moisio and Paasi 2013a: 275−277). In other words, the spatial forms of the state and the characteristics of a citizen are to be adjusted to the prevailing global politico-economic realities through new geopolitical and biopolitical discourses and practices of governance. The decreasing role of the discourse of territorial integrity in contemporary state projects, and the related emphasis on internationalisation, productivity and economic competitiveness, comprises a new geopolitical setting through which the present individualising biopolitics works. That is to say that biopolitics of population health is increasingly structured around

entrepreneurial citizen subjectivity and 'individual health' rather than 'national health' (cf. Rose 2001: 17−20). Health behaviour and the qualities, as well as the economic potential of citizens, are shaped by technologies of activation and responsibilisation in order to produce increasingly resilient individuals portrayed as calculating entrepreneurs of a novel 'productive state'.

In the above context, the empirical observation that is of particular significance is that although the geopolitical and biopolitical technologies of the territorial management of state space (e.g. the local government grant system) have been qualitatively reworked, the territorial foundation of the health care system has proven to be a rather entrenched structure of the state in the face of neoliberal rationalities. Likewise, the welfarist principles of universalism and equality continue to be central discursive elements of the policies combining the issues of state space and health care. Nevertheless, equally important is that the territorial structures of health care have become a useful spatial testing ground for neoliberal experimentation and economic calculation. In this sense, there appears to be a particular duality built into the contemporary system of health care: the inherited geopolitical spaces of the welfare state on the one hand hinder, but on the other hand enable the neoliberalisation of the state by facilitating health care-related socio-spatial practices that connect welfare rhetoric with policy reforms aimed at dismantling the previously created territorial structures of the state. This is what Ahlqvist and Moisio (2014: 48) call the capillary form of neoliberalisation which rather grows out from than replaces the spatial Keynesianism and the related geopolitical calculus. Therefore, in conclusion, Article I highlights that the broadly 'economic-strategic' nature of spatial Keynesianism in Finland – which brought together territorial integrity, economic growth and the idea of a politically loyal 'useful' citizenry – has provided legitimation for a variety of health care reforms predicated on advanced liberalism.

As for future prospects for research in the context of geopolitics and biopolitics of state spatial transformation, particularly the question of how biopolitics functions through inherited geopolitical state structures merits further scholarly attention in diverse spatiotemporal contexts. This might provide a fruitful framework for investigation of the multiple ways in which contemporary neoliberal governmentality manifests itself in different geographical contexts. Such an approach is applicable not only to health care but similarly to many other social practices of governing a population (e.g. education).

5.2 Statisation of everyday population health through knowledge production and technologies of health

In the field of the 'prosaic geographies of stateness' (Painter 2006), the relations of state power to the everyday life of the population has not been often conceptualised by analysing how the 'mundane' is constituted as a governable category through various statist social practices of population governance. In order to contribute to the filling of

this gap, Article II combines the mundane aspects of state spatiality with biopolitical governmentality through an inquiry into the statisation of everyday population health. The analysis focuses on how the population health is constituted as a mundane problematic of biopolitical governmentality and integrated into the geopolitical calculus of state space through statisation, resulting in a distinguishable spatial articulation of state power. The empirical context of Article II is situated in the period from the mid-1960 up to the early 1990s, during which biopolitical governmentality of population health was integrated with sovereign power in such a way that characterises the construction of Finland as a Nordic welfare state. The analysis thus seeks to demonstrate the historical development of a social democratic form of Keynesian biopolitics and its seamless connection to the territorial sovereignty of the state. As for Article II, the detailed research questions and the answers are as follows.

IIa. *How is everyday population health conceptualised and defined by the state apparatus?*

According to the *dispositif* analysis (see subchapters 3.2 and 4.1.1) applied in Article II, the key mechanism for problematising and constituting population health as a mundane governmental object is the scientific knowledge production on population health and health behaviour. In the Finnish context, knowledge production was institutionalised as a statist practice by the establishment of a state research institute which was to provide state authorities with actionable knowledge of the interconnections between everyday health behaviour and the major national diseases affecting a population's capabilities to contribute to national development. Problematisation of mundane population health was thus related to the wider politico-economic views on a healthy population as a vital resource for 'national survival' in the geopolitical context of the Cold War era. As a strategic resource of knowledge, a territorialised state research institute enabled state authorities to translate everyday population health into a calculable and governable statised object of biopolitical governmentality and empowered the state apparatus to act upon the population's daily life through health. In this regard, the 'mundane' should be understood as a specific form of knowledge production through which the everyday population health is conceptualised and defined by the state.

IIb. *How is everyday population health rendered statist in and through practices of health care?*

In this regard, the empirical findings of Article II highlight that population health as a mundane problematic of biopolitical governmentality is connected with the spaces of scientific knowledge production through statist technologies of health. In other words, statisation of everyday population health and the concomitant intensification of the relationship between state power and civil society are realised through health-related technologies and practices. In the Finnish case, particularly the health education, which was an intrinsic part of the above-discussed institutionalisation process of knowledge

production, functioned as a central institutionalised state technology of health in directing the mundane health behaviour of the population. Health education enabled state power to reach and govern the population's everyday life at a distance through health professionals who acted as state agencies by putting state power into effect in their daily work. In this capacity, health education may be seen as a scientific power/knowledge which plays a dual role in the statisation of mundane population health.

To put together the empirical findings of Article II, the Finnish example epitomises the ways in which the discursive political problematisations of population health are connected with the construction of territorially organised spaces of health care (cf. Rabinow and Rose 2003: xvi). In this regard, everyday population health should not be understood as a given category of governance, but rather as a constituted problematic of biopolitical governmentality upon which the construction of particular spatial structures of the territorial state are predicated. In other words, state spatiality characterising a specific form of statehood in a given historical context may be seen as a strategic response of state power to the political problematics of how best to govern the state territory and the population within it in relation to each other (cf. Hindess 2005: 397).

In the Finnish context, the statist constitution and management of mundane population health as a political problem necessitated the establishment of the health care *dispositif* which materialised as territorialised state institutions of knowledge production and health services. Inflation of state space by a territorially institutionalised state apparatus thus extended the state's institutional capacity and infrastructural power (see Mann 1984) throughout the territory and therefore enabled state power to intervene and govern the population's everyday social life through health care (cf. Jones 2012: 807–808). Consequently, the abstraction called territorial sovereignty of the state appeared as a locally visible phenomenon (Moisio and Paasi 2013a: 270). In this regard, health education and institutionalised knowledge production on the population's everyday health, in conjunction with an institutionalised system of health services, constituted a relational ensemble which contributed to the territorialisation of the state that united the nation with the state. This underlines the coming together of the territorial and the relational through health care as a *dispositif* of state power.

As Article II indicates, statisation of everyday population health within the construction and expansion of the welfare state resulted in a specific kind of relationship between the state and citizenry which consolidated in a distinguishable spatial form of the state. However, although the neoliberalising restructuring of health care has sought to reshape previously constructed state spatialities and citizen subjectivities, the transition from one mode of statehood to another does not necessarily denote destatisation of social life. Therefore, more scholarly attention should be directed to the interplay between the processes of de- and restatisation through which the contemporary socio-spatial transformations of the state are produced (see Jessop 2000).

5.3 Health care choice in the reconstitution of state power and forms of citizenship

As changing statehood concerns also the citizenship, the role a citizen-subject plays as a contributor to the political restructuring processes of the state requires more consideration in the scholarship on state spatial transformation (e.g. Brenner *et al.* 2010). In order to demonstrate how the reconfiguration of the idea of 'desirable' citizenship is connected with the spatial transformation of the state, the empirical focus of Article III is particularly on the ways in which the actually existing citizenship and the previously developed state spatiality are discursively problematised within state-led health care restructuring. The main empirical findings of the article suggest that reconstitution of state power and forms of citizenship are mutually constitutive of socio-spatial transformation of the state produced in health care reform. Research questions posed in Article III and the answers are:

IIIa. *How does the health care choice discourse contribute to the political rationalisation behind the contemporary socio-spatial transformation of the state?*

In the Finnish context, the empirical analysis brings forward two clearly distinguishable and contradictory facets of the choice discourse which are primarily structured around the problematisation of what kinds of political objectives and transformations are pursued by establishing a new model of health care choice. According to the critical views mirroring the 'traditional' social-democratic political reasoning, contemporary health care choice discourse contributes above all to neoliberal ideals of privatisation of health services and extension of private power in the health sector. Opposite to the transnational mainstream of the political rationalisation behind corresponding reforms, critical views perceive market logic as inappropriate for health care (cf. Fotaki 2006; Gabe *et al.* 2015) and emphasise the public responsibility for providing the citizenry with equal access to health services. By contrast, 'approving' perceptions portray health care choice and the associated competition between public and private service providers as making positive contributions to the cost-effectiveness and customer-orientation of the public sector and the overall quality of health services. 'Approving' views are thus consonant with neoliberal political thinking upon which the ongoing reorganisation of existing welfare state spatiality is predicated. What the analysis highlights, however, is that despite the prevalence of health care choice discourse indicating a strengthening of neoliberal rationalisation in and through health care governance, the welfarist principles of equality and universalism continue to be persistent discursive elements of policies which obstruct the full-scale introduction of choice-based market mechanisms into the health care sector.

IIIb. *How is state power reconstituted through health care reform?*

Empirical discussion on the Finnish example reveals that the ongoing health care reform is emphatically directed towards the restatisation, that is, the consolidation and redirection of state power in health care governance. On the one hand, the regional government reform transfers the monetary power over health care from local governments expressly to the state by which the counties and thus the service providers will be financed and steered. On the other hand, as the state will be the financier of both public and private health service providers, the extension of health care choice enables the state to expand its power to the private sector and potentially beyond state boundaries through the involvement of multinational health companies in the market. In this sense, health care choice functions as a technology of political re-regulation by the state: the state redirects its monetary transactions to cover both the public and private sector and therefore facilitates the creation of new market spaces in health care premised on inter-provider competition. Moreover, the private sector becomes responsibilitised to share the risks related to population health and to 'tune' the public sector through inter-provider competition.

Hence, what the aforementioned highlights is that, contrary to the prevalent contentions, the state has not ceded its power to the market in the face of neoliberalism. By contrast, as many scholars have underlined, the state per se should be seen as the engineer of neoliberalising reconfiguration of its spatialities. This denotes a qualitative shift in the ways in which political power is exercised rather than a reduction of state power. In this sense, the introduction of consumerist freedom of choice to health care arguably is a state project: the idea of extended health care choice should be seen expressly as coming from the political elites rather than from citizens, although the extension of health care choice is often legitimised on the grounds of citizens' increasing willingness to choose (e.g. Clarke *et al.* 2007).

IIIc. *What kind of citizenship is sought and how can it be produced through health care choice?*

Article III highlights that health care choice should be understood also as a technology of subjectification for producing 'desirable' citizen-subjects. In other words, the extension of health care choice is associated with the will to transform a state-dependent 'submissive citizen' made passive by the welfarist government into a rationally calculating citizen-consumer whose economic potential is encouraged by broadening the right to choose between health service providers. In this context, health care choice becomes conceived of as a central mechanism for increasing a citizen's power of decision with regard to not only individual health but also customisation of health services. In this, the principle of 'money follows the patient', by which the service providers will be funded in Finland, appears to be essential: it transforms the unwanted patient into a sought-after consumer who contributes through active exercise of choice to the promotion of inter-provider competition and prods the providers into high-quality service production. Therefore, the state-led creation of the health care market necessitates the activity and choices of the citizens (cf. Rose 1999: 165). In this sense, a citizen-consumer produced through health

care choice should be understood as an active change agent contributing to state power in optimising state spatiality to conform to perceived politico-economic realities. However, as each individual is not equally well equipped to make choices (see McDonald *et al.* 2007: 438), health care choice may be seen as distancing contemporary health policies from the welfarist principles of universalism and equity characterising the Nordic model of statehood.

In conclusion, the key empirical observations of Article III suggest that health care choice explicitly contributes to the neoliberalisation of the state. That is that it functions as a central statist governmental technology for neoliberalising reorganisation of the relationship between state power, the market and individual citizens (cf. Mayes 2016: 43). In this capacity, health care choice is inextricably linked to the blurring of the boundaries between public and private power and therefore brings the territorial and relational state spaces together through privatisation of health care. In this, the citizen-subject plays a crucial role through active exercise of health care choice provided by the state. Accordingly, citizenship should be understood as a spatial category associated with restatisation and marketisation of health care through freedom of choice.

As Article III indicates, reworking of citizenship cannot be detached from the study on state spatial transformation. In this thesis, I have inquired into subjectification as a process in which individuals are objectified into subjects through health care choice. I suggest that further scholarly attention should be focused on related resistance and governmental counter-conducts, i.e., the forms of struggle or revolt "against the processes implemented for conducting others" (Foucault 2007, 201–202; also e.g. Cadman 2010). Under contemporary neoliberal governmentality, subjectification entails a diverse array of governmental technologies (e.g. responsibilisation, activation, freedom of choice) that enable not only the reconfiguration of citizen-subjectivities but also the emergence of new technologies of (care of) the self and self-government. With regard to neoliberalism-driven health care restructuring, it would be fruitful to inquire into the self-configuration of one's identity "by a conscience or self-knowledge" (Foucault 1982: 781), denoting the work that individuals perform upon themselves in order to become certain kinds of subjects.

5.4 Concluding remarks: political geographies of health care as a triad of population health, state power and citizenship

In this thesis, I have focused on the interconnections between state space and health care by exploring the ways in which health care appears as a key constituent of the spatiality of the territorial state in particular historically situated contexts. The historically contingent state space/health care nexus has been conceptualised and empirically examined in three separate, yet interrelated research articles in which I have approached the topic through different methodologies, methods and empirical materials. I have conducted the study

within a theoretical framework which entangles sovereignty and governmentality of population as two forms of state power. Through this, I have aimed to demonstrate the ways in which health care brings together the territorial management of state space and the relational spaces of governing population health. In terms of the theoretical contribution of the articles, Article I is the first attempt which theorises statist health care systems as bound to both the biopolitical and the geopolitical aspects of state spatial transformation; Article II conceptualises population health as a 'mundane' problematic of biopolitical governmentality which is associated with the construction of the territorial state through health care as a *dispositif* of state power; Article III conceptualises health care choice as a technology of political re-regulation and as a technology of subjectification which co-contribute to socio-spatial transformation of the state. With this theoretical framework, I have aimed to contribute empirically to the understanding of how sovereignty of the state and governmentality of population health work together through health care, resulting in a distinct spatial structure of the state.

I have based my arguments in this doctoral research on two main observations about existing multidisciplinary literature on state spatial transformation. Firstly, changing statehood has been commonly approached through materialist perspectives which place emphasis on the processes of capital accumulation in the reorganisation of social relations and state spatiality. That is to say that more scholarly attention should be directed to social practices of governing a population which bring state power, state space and population with its distinct characteristics (health is only one of them) together as co-existing constituents of the modern territorial state. Secondly, the calls for overcoming the mutual exclusivity constructed between the territorial and the relational has not been often responded to through research into the intertwining of territorial and relational state spaces in state-related social practices. Health care as a statist social practice of governing population health is thus regarded here as representing a profitable empirical research focus for analysing the territorial-relational aspects of state spatiality. The above research gaps have been formulated in this thesis into one comprehensive research question which puts together the thread of the original papers:

What are the key elements of state spatial transformation when analysing the ways in which territorial management of state spaces and relational spaces of governing a population come together in health care practices?

I answer this question by proposing a methodological approach to state spatial transformation which I call political geographies of health care. I start by stating that this approach necessitates a specific kind of understanding of health care. Health care is often understood in a simplistic way, for instance, as an institutionalised system of health services or as a policy sector. As I have highlighted throughout this thesis, health care should be perceived in a much broader sense as a statist social practice which consists of an ensemble of discourses, knowledge systems, policies, practices, institutions, agencies,

etc., through which state power is exercised over population and state space. In the context of state spatiality, as this study has proved, health care is a connective factor between population health, state power and citizenship. Accordingly, political problematic of population health, sovereignty and governmentality as well as the idea of citizenship are intertwined in such a specific way that materialises as distinct spatial formations of the territorial state in a given historical situation. I regard these three issues as distinguishable but intertwined analytical elements when analysing the coming together of territorial management of state spaces and relational spaces of governing a population in health care practices. Therefore, I suggest that population health, state power and citizenship constitute a triad of political geographies of health care (see Figure 4) through which spatial constitution and transformation of the state can be examined.

This study has underlined that the emergence and restructuring of health care as a statist social practice is premised upon specific political problematisations of population health at root (Rabinow and Rose 2003: xiv). Therefore, within political geographies of health care, the critical point of departure is how population health is politically problematised, i.e., constituted and defined as a problematic of government (cf. Rose and Miller 1992) at a given time. In other words, attention is to be paid to the particular political meanings population health and healthy citizenry are given in relation to the prevailing social, political and economic circumstances in the state and the challenges towards the state. The analysis
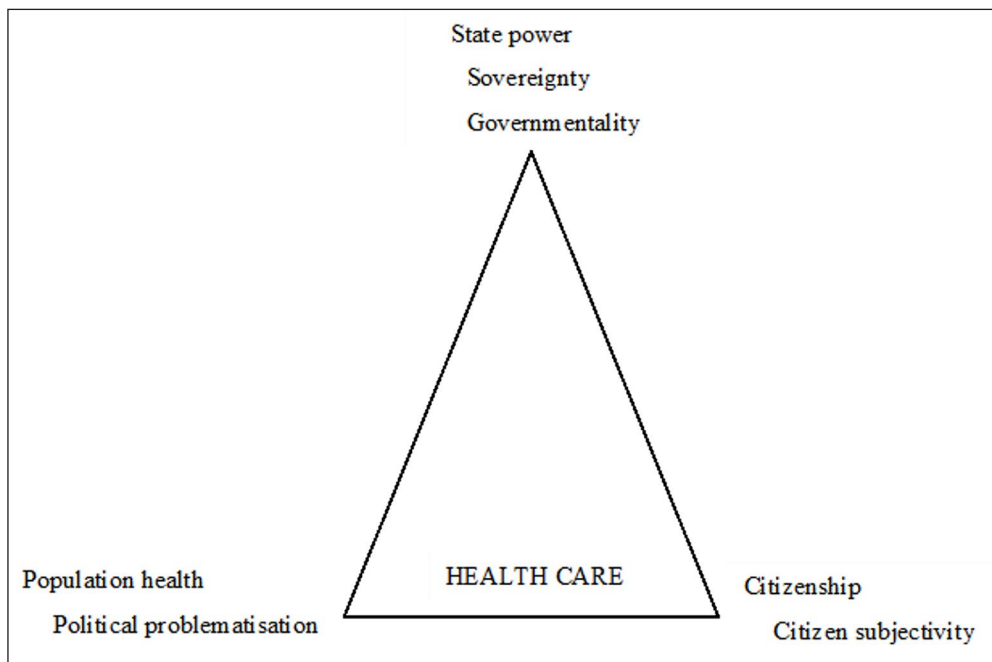

Figure 4. Political geographies of health care.

of why and how population health appears as politically important in certain historical contexts contributes to the understanding of prevalent political reasoning and the ways of governing population health at the time.

In the Finnish context, two distinctive historical contexts and ways of problematising population health can be pointed out. The population's poor health status in comparison with other Nordic and Western countries in the 1960s and 1970s was problematised by the state authorities as a wide-ranging threat to national development, national security (in terms of both internal and external relations) and economic growth. Due to ill health, citizenry was not regarded as capable of putting its social and economic potential into productive use for the state and nation (Article I; Article II). In other words, a healthy population was conceived of as a strategically important resource for 'national survival' in the geopolitical context of the Cold War era. Consequently, the national health care system was established in order to improve not only the population's health but also the social and economic potential of citizenry. By contrast, since the 1990s, population health has become increasingly problematised in terms of the norms of the global economy. In this view, governing population health through previously established systems is seen as a risk for cost-effectiveness, productivity and economic competitiveness of the state (Article I; also Article III). This has led to restructuring of health care and responsibilisation of citizens who are supposed to contribute to the creation of cost-effective state spaces. The Finnish case thus indicates a change in the political thinking of the ways in which citizenry is expected to serve through health as a resource for the prosperity of the state and nation.

As indicated above, problematisations of population health do not concern exclusively health, but more wide-ranging social, political and economic issues. In this sense, it can be argued that population health is not only a problematic of governmentality but also that of sovereignty. Hence, political geographies of health care is particularly interested in how sovereign power and governmentality of population health, as two forms of state power, come together in and cooperate through health care practices in order to manage both the territory and population. In this regard, the triad of powers of health governance (see Figure 1 in Subchapter 3.1) is of great importance since it suggests that historical shifts in the dominant mode of power should not be seen as linear transitions from one mode to another. Rather, the triad of sovereign power, disciplinary power and governmentality expressly is the field of power within which population health is managed (cf. Foucault 2007: 107; note also Schlosser 2008: 1624–1625). Therefore, the rise of governmentality does not denote a shift from a sovereign state defined by its territoriality to a 'population state', but rather to a "state of government which essentially bears on the population and calls upon and employs economic knowledge as an instrument, [that] would correspond to a society controlled by apparatuses of security" (Foucault 2007: 110). This is epitomised by O'Farrell's (2005: 107) conceptualisation of governmentality as "rationalization and systematization of a particular way of exercising political sovereignty through the government of people's conduct".

In Finland, the most obvious materialisation of the coming together of sovereignty and governmentality of population health arguably is the territorially and spatially organised system of health services established in the 1970s (Article I; Article II). State space was thus reorganised in order to govern the population in a new way. However, the national health care system was not created exclusively for governing population health but it should be perceived also as a territorial strategy for economic and political security of the state. As health care system was institutionalised throughout the state territory, it facilitated the state in localising its sovereign power and increasing its visibility in citizenry's everyday life (see also Moisio and Paasi 2013a: 270–271). The population was thus integrated with the territorial state through governmentality. As this study has brought forward, the territorial structures of health care have remained rather intact in Finland thus far. However, the ways in which governmentality of population health works through these territorial structures have changed (Article I). If the ongoing health care reform will be realised as outlined, the connection between sovereignty and governmentality of population health will be arguably reconfigured (Article III). Nonetheless, this study has indicated that health care as a statist social practice is arguably situated at the crossroads of territorial and relational state spaces as it connects the territorial management of state space with relational spaces of governing population health which constitute the state as a territorial entity. Political geographies of health care thus offers an escape route from the persistent dichotomisation towards territorial-relational understanding of state spatiality.

This study has proved that health care plays a crucial role in the construction of the historically contingent relationship between the state and citizen. In other words, 'good' citizenship is politically articulated and acted upon through health. In the Finnish context, two distinguishable forms of citizenship can be identified: social citizenship (Article I; Article III) and consumer citizenship (Article III; also Article I). Social citizenship (e.g. Dean 2010: 255–256) becomes evident concomitant with the construction of Finland as a Nordic welfare state. Social citizenship was produced by providing the citizenry with extensive state-guaranteed social rights (e.g. universal publicly funded health services) which brought social citizen subjectivities into being as a facet of state power. The aim was to bring into existence a healthy national population as a collective of loyal and productive citizen-subjects who make positive contributions to the national economy and national security.

Since the 1990s, 'desirable' citizenship has become gradually rearticulated. This has become evident through the will to transform the state-dependent citizen-subject into an active and responsible customer who is portrayed as a calculating entrepreneur of a novel 'productive state' (Article I). Accordingly, this has marked a shift from 'national health' towards 'individual health' (cf. Rose 2001: 17–20). However, as Article III has brought up, the production of consumer citizenship (e.g. Clarke *et al.* 2007) has become apparent in pursuance of the recent rise of health care choice discourse. That is to say that the qualities and behaviours of citizen-subjects are sought to be reshaped through new technologies of subject formation in order to enable the maximum use of the population's economic

potential in the changing politico-economic situation. If the new health care choice model will come into effect in Finland, the relationship between the state and citizen will be explicitly rethought as the citizenship is going to be increasingly defined in relation to the market and private power rather than to the state and public power.

With the proposed methodological framework, I wish to highlight the importance of health care as a key constituent of state spatiality. Through the analytical triad of population health, state power and citizenship, political geographies of health care has disclosed in this thesis a gradual transformation of state spatiality characterising Finland as a Nordic welfare state towards a new spatial configuration of statehood. Therefore, political geographies of health care provides one alternative methodological framework for the investigation into state spatial transformation. However, more geographical research is needed on the ways in which state power, state space and population are intertwined in statist social practices of health care (and in other social practices as well). In other words, the historically situated spatial constitution and transformation of the state deserves to be further theorised and conceptualised from the perspective of population health.

References

Abrams, P. (1988/1977). Notes on the difficulty of studying the state. *Journal of Historical Sociology* 1: 1, 58–89. DOI: 10.1111/j.1467–6443.1988.tb00004.x.

Agnew, J. (1994). The territorial trap: The geographical assumptions of international relations theory. *Review of International Political Economy* 1: 1, 53–80. DOI: 10.1080/09692299408434268.

Agnew, J. (2005). *Hegemony: The new shape of global power*. 284 p. Temple University Press, Philadelphia.

Ahlqvist, T. (2013). Potential governmentality and the state transformation in Finland. *Geopolitics* 18: 2, 328–342. DOI: 10.1080/14650045.2012.723286.

Ahlqvist, T. & S. Moisio (2014). Neoliberalization in a Nordic state: From cartel polity towards a corporate polity in Finland. *New Political Economy* 19: 1, 21–55. DOI: 10.1080/13563467.2013.768608.

Alatout, S. (2006). Towards a bio-territorial conception of power: Territory, population, and environmental narratives in Palestine and Israel. *Political Geography* 25: 6, 601–621. DOI: 10.1016/j.polgeo.2006.03.008.

Albrow, M. (1996). *The global age. State and society beyond modernity*. 246 p. Polity, Oxford.

Allen, J. (2009). Three spaces of power: Territory, networks, plus a topological twist in the tale of domination and authority. *Journal of Power* 2: 2, 197–212. DOI: 10.1080/17540290903064267.

Allen, J. (2011). Topological twists: Power's shifting geographies. *Dialogues in Human Geography* 1: 3, 283–298. DOI: 10.1177/2043820611421546.

Allen, J. & A. Cochrane (2010). Assemblages of state power: Topological shifts in the organization of government and politics. *Antipode* 42: 5, 1071–1089. DOI: 10.1111/j.1467-8330.2010.00794.x.

Amin, A. (2002). Spatialities of globalization. *Environment and Planning A: Economy and Space* 34: 3, 85–399. DOI: 10.1068/a3439.

Anaïs, S. (2013). Genealogy and critical discourse analysis in conversation: Texts, discourse, critique. *Critical Discourse Studies* 10: 2, 123–135. DOI: 10.1080/17405904.2012.744321.

Antipode (2010). November 2010, 42: 5, 1037–1307. Wiley Online Library.

Bacchi, C. & J. Bonham (2014). Reclaiming discursive practices as an analytic focus: Political implications. *Foucault Studies* 17, 173–192. DOI: 10.22439/fs.v0i17.4298.

Bailey, P. L. J. (2013). The policy dispositif: Historical formation and method. *Journal of Education policy* 28: 6, 807–827. DOI: 10.1080/02680939.2013.782512.

Barnett, J. R. & R. A. Kearns (1996). Shopping around? Consumerism and the use of private accident and emergency clinics in Auckland, New Zealand. *Environment and Planning A: Economy and Space* 28: 6, 1053–1075. DOI: 10.1068/a281053.

Barnett, J. R. & L. J. Brown (2006). "Getting into hospitals in a big way": The corporate transformation of hospital care in Australia. *Environment and Planning D: Society and Space* 24: 2, 283–310. DOI: 10.1068/d363t.

Barnett, R. & A. Copeland (2010). Providing health care. *In* Brown T., McLafferty, S. & G. Moon (eds.): *A companion to health and medical geography*, 497–520. Wiley-Blackwell, Malden.

Barry, A., Osborne, T. & N. Rose (1996). Introduction. *In* Barry, A., Osborne, T. & N. Rose (eds.): *Foucault and political reason: Liberalism, neo-liberalism and the rationalities of government*, 1–18. Routledge, Abingdon.

Bevir, M (2010). Rethinking governmentality: Towards genealogies of governance. *European Journal of Social Theory* 13: 4, 423–441. DOI: 10.1177/1368431010382758.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal* 9: 2, 27–40. DOI 10.3316/QRJ0902027.

Brenner, N. (1999). Beyond state-centrism? Space, territoriality, and geographical scale in globalization studies. *Theory & Society* 28: 1, 39–78. DOI: 10.1023/A:1006996806674.

Brenner, N. (2003). Metropolitan institutional reform and the rescaling of state space in contemporary Western Europe. *European Urban and Regional Studies* 10: 4, 297–324. DOI: 10.1177/09697764030104002.

Brenner, N. (2004a). *New state spaces. Urban governance and the rescaling of statehood*. 351 p. Oxford University Press, Oxford.

Brenner, N. (2004b). Urban governance and the production of new state spaces in Western Europe, 1960–2000. *Review of International Political Economy* 11: 3, 447–488. DOI: 10.1080/0969229042000282864.

Brenner, N., Jessop, B., Jones, M. & G. McLeod (2003). Introduction: State space in question. *In* Brenner, N.,Jessop, B., Jones, M. & G. McLeod (eds.): *State space: A reader*, 1–26. Blackwell, Malden.

Brenner, N. & S. Elden (2009). Henri Lefebvre on state, space, territory. *International Political Sociology* 3: 4, 353–377. DOI: 10.1111/j.1749-5687.2009.00081.x.

Brenner, N., Peck, J. & N. Theodore (2010). Variegated neoliberalization: Geographies, modalities, pathways. *Global Networks* 10: 2, 182–222.

Brown, T. (2003). Towards an understanding of local protest: hospital closure and community resistance. *Social & Cultural Geography* 4: 4, 489–506. DOI: 10.1080/1464936032000137920.

Brown, W. (2005). *Edgework: Critical essays on knowledge and politics.* 159 p. Princeton University Press, Princeton.

Bröckling, U., Krasmann, S. & T. Lemke (2011). *Governmentality. Current issues and future challenges.* 331 p. Routledge, New York.

Burchell, G. (1996). Liberal government and techniques of the self. *In* Barry, A., Osborne, T. & N. Rose (eds.): *Foucault and political reason: Liberalism, neo-liberalism and the rationalities of government*, 19–36. Routledge, Abingdon.

Bussolini, J. (2010). What is a dispositive? *Foucault Studies* 10, 85–107. DOI: 10.22439/fs.v0i10.3120.

Campbell, D. T. & D. W. Fiske (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin* 65, 81–105.

Carter, E. D. (2015). Making the blue zones: neoliberalism and nudges in public health promotion. *Social Science & Medicine* 133, 374–382. DOI: 10.1016/j.socscimed.2015.01.019.

Castree, N. (2006). From neoliberalism to neoliberalisation: Consolations, confusions, and necessary illusions. *Environment and Planning A: Economy and Space* 38: 1, 1–6. DOI: 10.1068/a38147.

Cerny, P. G. (1990). *The changing architecture of politics. Structure, agency, and the future of the state.* 267 p. Sage Publications, London.

Cerny, P. G. (2006). Restructuring the state in a globalizing world: Capital accumulation, tangled hierarchies and the search for a new spatio-temporal fix. *Review of International Political Economy* 13: 4, 679–695. DOI: 10.1080/09692290600839931.

Cerny, P. G. (2010). The competition state today: From raison d'État to raison du Monde. *Policy Studies* 31: 1, 5–21. DOI: 10.1080/01442870903052801.

Clarke, J. (2004). Dissolving the public realm?: The logics and limits of neo-liberalism. *Journal of Social Policy* 33: 1, 27–48. DOI: 10.1017/S0047279403007244.

Clarke, J., Smith, N. & E. Vidler (2006). The indeterminacy of choice: Political, policy and organisational implications. *Social Policy & Society* 5: 3, 327–336. DOI: 10.1017/S1474746406003010.

Clarke, J., Newman, J., Smith, N., Vidler, E. & L. Westmarland (2007). *Creating citizen-consumers: Changing publics and changing public services*. 192 p. Sage Publications, London.

Cochrane A. & K. Ward (2012). Researching the geographies of policy mobility: Confronting the methodological challenges. *Environment and Planning A: Economy and Space* 44: 1, 5–12. DOI: 10.1068/a44176.

Constitution of Finland 731/1999 (1999). Ministry of Justice of Finland. <*https://www.finlex.fi/fi/laki/ kaannokset/1999/en19990731?search%5Btype%5D=pika&search%5Bpika%5D=constitution%20of%20 finland*> Accessed 8.1.2018.

Cowen, D. & N. Smith (2009). After geopolitics? From the geopolitical social to geoeconomics. *Antipode* 41: 1, 22−48. DOI: 10.1111/j.1467-8330.2008.00654.x.

Creswell, T. (2013). *Geographic thought. A critical introduction*. 290 p. Wiley-Blackwell, Malden.

Crooks, V. A. & G. J. Andrews (2009). *Primary health care: people, practice, place*. 296 p. Ashgate, Farnham.

Curtis, B. (2002). Foucault on governmentality and population: The impossible discovery. *Canadian Journal of Sociology*, 27: 4, 505–533. DOI: 10.2307/3341588.

Curtis, S. (2008). How can we address health inequality through healthy public policy in Europe? *European Urban and Regional Studies* 15: 4, 293–305. DOI: 10.1177/0969776408095106.

Curtis, S. & M. Riva (2010) Health geographies II: complexity and health care systems and policy. *Progress in Human Geography* 34: 4, 513–520. DOI: 10.1177/0309132509336029.

Dean, M. (1994). *Critical and effective histories. Foucault's methods and historical sociology*. 237 p. Routledge, London.

Dean, M. (2007). *Governing societies*. 228 p. Sage Publications, London.

Dean, M. (2010). *Governmentality. Power and rule in modern society. 2nd edition*. 294 p. Sage Publications, Thousand Oaks.

de Koning, A., Rivke, J. & M. Koster (2015). Citizenship agendas in and beyond the nation-state: (En)countering framings of the good citizen. *Citizenship Studies* 19: 2, 121–127. DOI: 10.1080/13621025.2015.1005940.

Delanty, G. (2006). The cosmopolitan imagination: Critical cosmopolitanism and social theory. *The British Journal of Sociology* 57: 1, 25–47. DOI: 10.1111/j.1468-4446.2006.00092.x.

Demirović, A. (2011). Materialist state theory and the transnationalization of the capitalist state. *Antipode* 43: 1, 38–59. DOI: 10.1111/j.1467-8330.2010.00810.x.

Denzin, N. K. (1989). *The research act. A theoretical introduction to sociological methods. 3rd edition*. 306 p. Prentice Hall, Englewood Cliffs.

Dillon, M. (2007). Governing through contingency: The security of biopolitical governance. *Political Geography* 26: 1, 41–47. DOI: 10.1016/j.polgeo.2006.08.003.

Dreyfus, H. L. & P. Rabinow (1983). *Michel Foucault: Beyond structuralism and hermeneutics. 2nd edition*. The University of Chicago Press, Chicago.

Dreyfus, H. L. & P. Rabinow (1989). What is maturity? Habermas and Foucault on 'What is enlightenment?'. *In* Hoy, D. C. (ed.): *Foucault. A critical reader*, 109–121. Basil Blackwell, Oxford.

Elden, S. (2001). *Mapping the present: Heidegger, Foucault and the project of spatial history*. 232 p. Continuum, London.

Elden, S. (2007). Governmentality, calculation, territory. *Environment and Planning D: Society and Space* 26: 3, 562–580. DOI: 10.1068/d428t.

Elden, S. (2010). Land, terrain, territory. *Progress in Human geography* 34: 6, 799–817. DOI: 10.1177/0309132510362603.

Elden, S. (2013). How should we do the history of territory? *Territory, Politics, Governance*, 1: 1, 5–20.

England, K. & K. Ward (2007). Introduction: Reading neoliberalization. *In* England, K. & K. Ward (eds.): *Neoliberalization: States, networks, peoples*, 1–22. Blackwell Publishing, Malden.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. 248 p. Polity Press, Cambridge.

Esping-Andersen, G. (2002). Towards the good society: Once again? *In* Esping-Andersen, G., Gallie, D., Hamerijck, A. & J. Myles (eds.): *Why we need a new welfare state*, 1–25. Oxford University Press, Oxford.

Evered K. T. & E. Ö. Evered (2012). State, peasant, mosquito: The biopolitics of public health education and malaria in early republican Turkey. *Political Geography* 31: 5, 311–323. DOI: 10.1016/j.polgeo.2012.05.002.

Fairclough, N. (2010). *Critical discourse analysis. The critical study of language. 2nd edition*. 591 p. Pearson Education, Harlow.

Finnish Advisory Board on Research Integrity (2012). Responsible conduct of research and procedures for handling allegations of misconduct in Finland. Guidelines of the Finnish Advisory Board on Research Integrity 2012. <*www.tenk.fi*>.Accessed 20.2.2018.

Florida, R. (2003). *The rise of the creative class : And how it's transforming work, leisure, community and everyday life*. 404 p.Basic Books, New York.

Foucault, M. (1980a). *The history of sexuality. Volume 1: The introduction*. 168 p. The Harvester Press, Brighton.

Foucault, M. (1980b). The confession of the flesh. *In* Gordon, C. (ed.): *Power/Knowledge: Selected interviews and other writings 1972–1977*, 194–228. Harvester Press, Brighton.

Foucault, M. (1980c). Truth and power. *In* Gordon, C. (ed.): *Power/Knowledge: Selected interviews and other writings 1972–1977*, 109–133. Harvester Press, Brighton.

Foucault, M. (1982). The subject and power. *Critical Inquiry* 8: 4, 777–795. DOI: 10.1086/448181.

Foucault, M. (1988). The concern for truth. *In* Kritzman, L. D. (ed.): *Michel Foucault: Politics, philosophy, culture. Interviews and other writings 1977–1984*, 255–267. Routledge, New York.

Foucault, M. (1989). *The archaeology of knowledge*. 218 p. Routledge, London.

Foucault, M. (1991). Space, knowledge and power. *In* Faubion, J. D. (ed.): *Power. Essential works of Foucault, 1954–1984*, 349–364. The New Press, New York.

Foucault, M. (1997). On the government of the living. *In* Rabinow P. (ed.): *Ethics: Subjectivity and truth. Essential works of Michel Foucault 1954–1984*, 81–85. The New Press, New York.

Foucault, M. (2000). Truth and power. *In* Faubion, J. D. (ed.): *Power. Essential works of Foucault 1954–1984*, 111–133. The New Press, New York.

Foucault, M. (2003a). The birth of social medicine. *In* Rabinow, P. & N. Rose (eds.): *The essential Foucault. Selection from essential works of Foucault, 1954–1984*, 319–337. The New Press, New York.

Foucault, M. (2003b). The politics of health in the eighteenth century. *In* Rabinow, P. & N. Rose (eds.): *The essential Foucault. Selection from essential works of Foucault, 1954–1984*, 338–350. The New Press, New York.

Foucault, M. (2003c). *Society must be defended. Lectures at the Collège de France 1975–1976*. 310 p. Picador, New York.

Foucault, M. (2003d). Nietzsche, genealogy, history. *In* Rabinow, P. & N. Rose (eds.): *The essential Foucault. Selection from essential works of Foucault*, *1954–1984*, 351–369. The New Press, New York.

Foucault, M. (2004). The crisis of medicine or the crisis of antimedicine? *Foucault Studies* 1, 5–19.

Foucault, M. (2007). *Security, territory, population. Lectures at the Collège de France 1977–1978*. 417 p. Palgrave Macmillan, New York.

Foucault, M. (2008). *The birth of biopolitics. Lectures at the Collège de France 1978−1979*. 346 p. Palgrave Macmillan, New York.

Fotaki, M. (2006). Choice is yours: A psychodynamic exploration of health policymaking and its consequences for the English National Health Service. *Human Relations* 59: 12, 1711–1744. DOI: 10.1177/0018726706072871.

Fotaki, M. (2011). Towards developing new partnerships in public services: Users as consumers, citizens and/or co-producers in health and social care in England and Sweden. *Public Administration* 89: 3, 933–955. DOI: 10.1111/j.1467-9299.2010.01879.x.

Fox, D. M. (1986). *Health policies, health politics*. Princeton University Press, Princeton.

Freeman, R. & J. Maybin (2011). Documents, practices and policy. *Evidence & Policy* 7: 2, 155–170. DOI: 10.1332/174426411X579207.

Gabe, J., Harley, K. & M. Calnan (2015). Healthcare choice: Discourses, perceptions, experiences and practices. *Current Sociology Monograph* 63: 5, 623–635. DOI: 10.1177/0011392115590061.

Garmany, J. (2009). The embodied state: Governmentality in a Brazilian favela. *Social & Cultural Geography* 10: 7, 721–739. DOI: 10.1080/14649360903205132.

Giddens, A. (1987). *The nation-state and violence. Volume two of a contemporary critique of historical materialism*. 399 p. Polity Press, Cambridge.

Glassman, J. (1999). State power beyond the 'territorial trap': The internationalization of the state. *Political Geography* 18: 6, 669–696. DOI: 10.1016/S0962-6298(99)00013-X.

Glassner, M. & C. Fahrer (2004). *Political geography*. 619 p. John Wiley & Sons, Hoboken.

Gleeson, B. (1996). A geography for disabled people? *Transactions of the Institute of British Geographers* 23: 2, 387–396.

Gordon, A. & T. Stack (2007). Citizenship beyond the state: thinking with early modern citizenship in the contemporary world. *Citizenship Studies* 11: 2, 117–133. DOI: 10.1080/13621020701262438.

Gordon, C. (1980). Afterword. *In* Gordon, C. (ed.): *Power/Knowledge: Selected interviews and other writings 1972–1977*, 229–259. Harvester Press, Brighton.

Government of Finland (2018). Regional government, health and social services reform. <*www.alueuudistus. fi/en*>. Accessed 18.6.2018.

Habermas, J. (1976). Tieto ja intressi. *In* Tuomela, R. & I. Patoluoto (eds.): *Yhteiskuntatieteiden filosofiset perusteet I*, 118–141. Gaudeamus, Helsinki.

Hamann, T. H. (2009). Neoliberalism, governmentality, and ethics. *Foucault Studies* 6, 37–59. DOI: 10.22439/fs.v0i0.2471.

Hannah, M. (2001). Sampling and the politics of representation in US Census 2000. *Environment and Planning D: Society and Space* 19: 5, 515–534. DOI: 10.1068/d289.

Harrison, J. (2010). Networks of connectivity, territorial fragmentation, uneven development: The new politics of city-regionalism. *Political Geography* 29: 1, 17–27.

Harvey, D. (1982). *The limits to capital*. 478 p. Blackwell, Oxford.

Harvey, D. (2005). *A brief history of neoliberalism*. 247 p. Oxford University Press, Oxford.

Helderman, J.-K., Bevan, G. & G. France (2012). The rise of the regulatory state in health care: A comparative analysis of the Netherlands, England and Italy. *Health Economics, Policy and Law* 7: 1, 103–124. DOI: 10.1017/S1744133111000326.

Hibou, B. (2004). *Privatising the state. 2nd edition*. 261 p. Hurst & Company, London.

Hindess, B. (2002). Neo-liberal citizenship. *Citizenship Studies* 6: 2, 127–143. DOI: 10.1080/13621020220142932.

Hindess, B. (2005). Politics as government: Michel Foucault's analysis of political reason. *Alternatives* 30: 4, 389–413. DOI: 10.1177/030437540503000401.

Hirsch, J. & J. Kannankulam (2011). The spaces of capital: The political form of capitalism and the internationalization of the state. *Antipode* 43: 1, 12–37. DOI: 10.1111/j.1467-8330.2010.00809.x.

Hubbard, P., Kitchin, R., Bartley, B. & D. Fuller (2002). *Thinking geographically. Space, theory and contemporary human geography*. 275 p. Continuum, New York.

Hubbard, P. & R. Kitchin (2011). Introduction: Why key thinkers? *In* Hubbard, P. & R. Kitchin (eds.): *Key thinkers on space and place*, 1–25. 2nd edition. Sage Publications, London.

Hudson, R. (2007). Regions and regional uneven development forever? Some reflective comments upon theory and practice. *Regional Studies* 41: 9, 1149–1160. DOI: 10.1080/00343400701291617.

Huxley, M. (2008). Space and government: Governmentality and geography. *Geography Compass* 2: 5, 1635–1658. DOI: 10.1111/j.1749-8198.2008.00133.x.

Häkli, J. (2012). State space – Outlining a field theoretical approach. *Geopolitics* 18: 2, 343–355. DOI: 10.1080/14650045.2012.723285.

Inda, J. X. (2005). Analytics of the modern. An introduction. *In* Inda, J. X. (ed.): *Anthropologies of Modernity. Foucault, Governmentality and life politics*, 1–20. Blackwell, Oxford.

Isin, E. F. & B. S. Turner (2007). Investigating citizenship: An agenda for citizenship studies. *Citizenship Studies* 11: 1, 5–17. DOI: 10.1080/13621020601099773.

Jessop, B. (1990). *State Theory: Putting the capitalist state in its place*. 413 p. Polity Press, Cambridge.

Jessop, B. (2000). The crisis of the national spatio-temporal fix and the tendential ecological dominance of globalizing capitalism. *International Journal of Urban and Regional Research* 24: 2, 322–360. DOI: 10.1111/1468-2427.00251.

Jessop, B. (2002a). *The future of the capitalist state*. 330 p. Polity Press, Cambridge.

Jessop, B. (2002b). Liberalism, neoliberalism, and urban governance: A state theoretical perspective. *Antipode* 34: 3, 452–472. DOI: 10.1111/1467-8330.00250.

Jessop, B. (2007a). *State power: A strategic-relational approach.* 301 p. Polity Press, Cambridge.

Jessop, B. (2007b). From micro-powers to governmentality: Foucault's work on statehood, state formation, statecraft and state power. *Political Geography* 26: 1, 34–40. DOI:10.1016/j.polgeo.2006.08.002.

Jessop, B., Brenner, N. & M. Jones (2008). Theorizing socio-spatial relations. *Environment and Planning D: Society and Space* 26: 3, 389–401. DOI: 10.1068/d9107.

Johnston, R. J. & J. D. Sidaway (2016). *Geography and geographers: Anglo-American human geography since 1945. 7th edition*. 520 p. Routledge, New York.

Jonas, A. E. G. (2013). City-Regionalism as a contingent 'geopolitics of capitalism'. *Geopolitics* 18: 2, 284–298. DOI: 10.1080/14650045.2012.723290.

Jones, A. & J. T. Murphy (2011). Theorizing practice in economic geography: Foundations, challenges, and possibilities. *Progress in Human Geography* 35: 3, 366–392. DOI: 10.1177/0309132510375585.

Jones, K. T. (1998). Scale as epistemology. *Political Geography* 17: 1, 25–28. DOI: 10.1016/S0962-6298(97)00049-8.

Jones, M. (2008). Recovering a sense of political economy. *Political Geography* 27: 4, 377–399. DOI: 10.1016/j.polgeo.2008.03.003.

Jones, M. (2009). Phase space: Geography, relational thinking, and beyond. *Progress in Human Geography* 33: 4, 487–586. DOI: 10.1177/0309132508101599.

Jones, M. (2010). Thinking space relationally. *International Journal of Law in Context* 6: 3, 243–255. DOI: 10.1017/S1744552310000145.

Jones, M. & B. Jessop (2010). Thinking state/space incompossibly. *Antipode* 42: 5, 1119–1149. DOI: 10.1111/j.1467-8330.2010.00796.x.

Jones, R. (2012) State encounters. *Environment and Planning D: Space and Society* 30: 5, 805–821. DOI: 10.1068/d9110.

Joseph, A. E. & D. R. Phillips (1984). *Access and utilization: Geographical perspectives in health care delivery.* 228 p. Harper and Row, London.

Jäger, S. & F. Maier (2009). Theoretical and methodological aspects of Foucauldian critical discourse analysis and dispositive analysis. *In* Wodak, R. & M. Meyer (eds.): *Methods of critical discourse analysis*, 34–61. 2nd edition. SAGE, London.

Kangas, A. & S. Moisio (2012). Creating state competitiveness, re-scaling higher education: The case of Finland. *In* Aalto P., Harle, V. & S. Moisio (eds.): *Global and regional problems: Towards an interdisciplinary study*, 199–224. Ashgate, Farnham.

Kearns, G. (2014). Governing vitalities and the security state. *Environment and Planning D: Society and Space* 32: 5, 762–778. DOI: 10.1068/d13002p.

Kearns R. A. & J. R. Barnett (1997). Consumerist ideology and the symbolic landscapes of private medicine. *Health and Place* 3: 3, 171–180. DOI: 10.1016/S1353-8292(97)00011-7.

Kearns R. A. & J. R. Barnett (1999). To boldly go? Place, metaphor, and the marketing of Auckland's Starship Hospital. *Environment and Planning D: Society and Space* 17: 2, 201–226. DOI: 10.1068/d170201.

Kearns R. A., Barnett, J. R. & D. Newman (2003). Placing private health care: Reading Ascot hospital in the landscape of contemporary Auckland. *Social Science & Medicine* 56: 11, 2303–2315. DOI: 10.1016/S0277-9536(02)00229-0.

Kitchin, R. & N. J. Tate (2000). *Conducting research in human geography: theory, methodology and practice.* 330 p. Prentice Hall, Harlow.

Kröger, T. (2011). Retuning the Nordic welfare municipality. *International Journal of Sociology and Social Policy* 31: 3/4, 148–159. DOI: 10.1108/01443331111120591.

Kuus, M. (2016). Diplomacy and audit: Technologies of knowledge in Europe. *Geoforum* 68, 39–47. DOI: 10.1016/j.geoforum.2015.11.014.

Lagendijk, A., Arts, B. & H. Van Houtum (2009). Shifts in governmentality, territoriality and governance: An introduction. *In* Arts B., Lagendijk, A. & H. Van Houtum (eds.): *The disoriented state. Shifts in governmentality, territoriality and governance*, 3–10. Springer, Dordrecht.

Larner, W. (2000). Neo-liberalism: policy, ideology, governmentality. *Studies in Political Economy* 63: 1, 5–25. DOI: 10.1080/19187033.2000.11675231.

Larsen, L. T. & D. Stone (2015). Governing health care through free choice: Neoliberal reforms in Denmark and the United States. *Health Politics, Policy and Law* 40: 5, 941–970. DOI: 10.1215/03616878-3161162.

Lazzarato, M. (2009). Neoliberalism in action. Inequality, insecurity and the reconstitution of the social. *Theory, Culture & Society* 26: 6, 109–133. DOI: 10.1177/0263276409350283.

Lefebvre, H. (1991). *The production of space*. 454 p. Blackwell Publishing, Oxford.

Lefebvre, H. (2009). *State, space, world. Selected essays*. Edited by Brenner, N. & S. Elden. 330 p. University of Minnesota Press, Minneapolis.

Legg, S. (2005). Foucault's population geographies: Classifications, biopolitics and governmental spaces. *Population, Space and Place* 11: 3, 137–156. DOI: 10.1002/psp.357.

Legg, S. (2011). Assemblage/apparatus: Using Deleuze and Foucault. *Area* 43: 2, 128–133. DOI: 10.1111/j.1475-4762.2011.01010.x.

Lemke, T. (2001). 'The birth of bio-politics': Michel Foucault's lecture at the Collège de France on neo-liberal governmentality. *Economy and Society* 30: 2, 190–207. DOI: 10.1080/03085140120042271.

Lemke, T. (2007). An indigestible meal? Foucault, governmentality and state theory. *Distinktion: Scandinavian Journal of Social Theory* 8: 2, 43–64. DOI: 10.1080/1600910X.2007.9672946.

Lemke, T. (2011). *Biopolitics. An advanced introduction*. 145 p. New York University Press, New York.

Leppänen, L. (2011). Changing statehood: The spatial transformation of the Finnish state. *Annales Universitatis Turkuensis AII*: 260.

Ma, A. & B. Norwich (2007). Triangulation and theoretical understanding. *International Journal of Social Research Methodology* 10: 3, 211–226. DOI: 10.1080/13645570701541878.

MacLeavy, J. & J. Harrison (2010). New state spatialities: Perspectives on state, space, and scalar geographies. *Antipode* 42: 5, 1037–1046. DOI: 10.1111/j.1467-8330.2010.00792.x.

MacLeod, G. & M. Jones (2007). Territorial, scalar, networked, connected: In what sense a "regional world"? *Regional Studies* 41: 9, 1177–1191. DOI: 10.1080/00343400701646182.

Magnussen, J.,Vrangbæk, K. & R. B. Saltman (eds.) (2009). *Nordic health care systems. Recent reforms and current policy challenges*. 339 p. Open University Press, Maidenhead.

Magnussen, J., Vrangbæk, K., Saltman, R. B. & P. E. Martinussen (2009). Introduction: The Nordic model of health care. *In* Magnussen, J., Vrangbæk, K. & R. B. Saltman (eds.): *Nordic health care systems. Recent reforms and current policy challenges*, 3–20. Open University Press, Maidenhead.

Majone, G. (1994). The rise of the regulatory state in Europe. *West European Politics* 17: 3, 77–101. DOI: 10.1080/01402389408425031.

Major, A. (2013). Transnational state formation and the global politics of austerity. *Sociological Theory* 31: 1, 24–48. DOI: 10.1177/0735275113477083.

Mann, M. (1984). The autonomous power of the state: Its origins, mechanisms and results. *European Journal of Sociology* 25: 2, 185–213. DOI: 10.1017/S0003975600004239.

Mansfield, B. (2005). Beyond rescaling: Reintegrating the 'national' as a dimension of scalar relations. *Progress in Human Geography* 29: 4, 458–473. DOI: 10.1191/0309132505ph56Ooa.

Martin, L. & A. Secor (2014). Towards a post-mathematical topology. *Progress in Human Geography* 38: 3, 420–438. DOI: 10.1177/0309132513508209.

Massey, D. (1998). *Power-geometries and the politics of space-time.* 112 p. Department of Geography, University of Heidelberg, Heidelberg.

Massey, D. (2005). *For space.* 222 p. SAGE, London.

Mayes, C. (2016). *The biopolitics of lifestyle: Foucault, ethics and healthy choices.* 156 p. Routledge, New York.

McDonald, R., Mead, N., Cheraghi-Sohi, S., Bower, P., Whalley, D. & M. Roland (2007). Governing the ethical consumer: Identity, choice and the primary care medical encounter. *Sociology of Health & Illness* 29: 3, 430–456. DOI: 10.1111/j.1467-9566.2007.00493.x.

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies* 25: 2, 82−89. DOI: 10.1111/j.1470-6431.2001.00183.x.

Milchman, A. & A. Rosenberg (2009). The final Foucault: Government of others and government of the self. *In* Binkley, S. & J. Capetillo (eds.): *Foucault for the 21st century: Governmentality, biopolitics and discipline in the new millennium*, 61–71. Cambridge Scholars Publishing, Cambridge.

Miller, P. & N. Rose (1992). Political power beyond the state: Problematics of government. *British Journal of Sociology* 43: 2, 173–205. DOI: 10.1111/j.1468-4446.2009.01247.x.

Miller, P. & N. Rose (2008). *Governing the present. Administering economic, social and personal life.* 246 p. Polity Press, Cambridge.

Mitchell, K. (2006). Neoliberal governmentality in the European Union: Education, training, and technologies of citizenship. *Environment and Planning D: Society and Space* 24: 3, 389–407. DOI: 10.1068/d1804.

Mitchell, T. (1991). The limits of the state: Beyond statist approached and their critics. *American Political Science Review* 85: 1, 77–96. DOI: 10.1017/S0003055400271451.

Mitchell, T. (1999). Society, economy and the state effect. *In* Steinmetz, G. (ed.): *State/Culture: State-formation after the cultural turn*, 76–97. Cornell University Press, Ithaca.

Moisio, S. (2008). Towards attractive and cost-efficient state space: Political geography of the production of state transformation in Finland. *World Political Science Review* 4: 3, 1–34. DOI: 10.2202/1935-6226.1053.

Moisio, S. (2009). Suomen valtion aluerakenteen muuntautuminen: teoreettisia merkintöjä ja empiirisiä havaintoja. *Politiikka* 51: 3, 155–173.

Moisio, S. (2011). Beyond the domestic-international divide: State spatial transformation as neo-liberal geopolitics. *In* Aalto, P., Harle, V. & S. Moisio (eds.): *International studies: Interdisciplinary approaches*, 149–177. Palgrave Macmillan, Basingstoke.

Moisio, S. (2012). *Valtio, alue, politiikka. Suomen tilasuhteiden sääntely toisesta maailmansodasta nykypäivään.* 357 p. Vastapaino, Tampere.

Moisio, S. (2015). Geopolitics/critical geopolitics. *In* Agnew, J., Mamadouh, V., Secor, A. & J. Sharp (eds.): *The Wiley Blackwell companion to political geography*, 220–234. Wiley Blackwell, Oxford.

Moisio, S. (2018). *Geopolitics of the knowledge-based economy.* Routledge, London.

Moisio, S. & A. Vasanen (2008). Alueellistuminen valtiomuutoksen tutkimuskohteena. *Tieteessä tapahtuu* 25: 3–4, 20–31.

Moisio, S., Stokke, K., Sæther, E., Larsen, H. G., Ek, R. & A. Lund Hansen (2011). Interventions in Nordic political geographies. *Political Geography* 30: 5, 241–249. DOI: 10.1016/j.polgeo.2011.04.005.

Moisio, S. & A. Paasi (2013a). From geopolitical to geoeconomic? The changing political rationalities of state space. *Geopolitics* 18: 2, 267–283. DOI: 10.1080/14650045.2012.723287.

Moisio, S. & A. Paasi (2013b). Beyond state-centricity: Geopolitics of changing state spaces. *Geopolitics* 18: 2, 255–266. DOI: 10.1080/14650045.2012.738729.

Moisio, S. & A. Kangas (2016). Reterritorializing the global knowledge economy: An analysis of geopolitical assemblages of higher education. *Global Networks* 16: 3, 268–287. DOI: 10.1111/glob.12103.

Moisio, S. & B. Belina (2017). The state. *In* Richardson, D., Castree, N., Goodchild, M., Kobayashi, A., Liu, W. & R. Marston (eds.): *The international encyclopedia of geography: People, the Earth, environment, and technology*, 1–11. John Wiley & Sons Ltd., Chichester. DOI: 10.1002/9781118786352.wbieg0651.

Moon, G. & T. Brown (2000). Governmentality and the spatialized discourse of policy: The consolidation of the post-1989 NHS reforms. *Transactions of the Institute of British Geographers* 21: 1, 65–76. DOI: 10.1111/j.0020-2754.2000.00065.x.

Moran, M. (2000). Understanding the welfare state: The case of health care. *British Journal of Politics and International Relations* 2: 2, 135–160. DOI: 10.1111/1467-856X.00031.

Morgan, K. (2007). The polycentric state: New spaces of empowerment and engagement? *Regional Studies* 41: 9, 1237–1251. DOI: 10.1080/00343400701543363.

Murdoch, J. (2006). *Post-structuralist geography: A guide to relational space.* 220 p. Sage Publications, London.

Murphy, A. (2013). Territory's continuing allure. *Annals of the Association of American Geographers* 103: 5, 1212–1226. DOI: 10.1080/00045608.2012.696232.

Newstead, C., Read, C. & M. Sparke (2010). The cultural geography of scale. *In* Anderson, K., Domosh, M., Pile, S. & N. Thrift (eds.): *Handbook of Cultural Geography*, 485–497. Sage Publications, London.

Nordgren, L. (2010). Mostly empty words – What the discourse of "choice" in health care does. *Journal of Health Organization and Management* 24: 2, 109–126. DOI: 10.1108/14777261011047309.

O'Farrell, C. (2005). *Michel Foucault*. 184 p. Sage Publications, London.

Ohmae, K. (1996). *The end of the nation state: The rise of regional economics.* 214 p. HarperCollins, London.

Ong, A. (2006). *Neoliberalism as exception: Mutations of citizenship and sovereignty*. 292 p. Duke University Press, Durham.

Osborne, T. (1997). Of health and statecraft. *In* Petersen, A. & R. Bunton (eds.): *Foucault, Health and Medicine*, 173–188. Routledge, London.

Ó Tuathail, G. (1996). *Critical geopolitics: The politics of writing global space*. 314 p. Routledge, London.

Paasi, A. (2011). From region to space, Part II. *In* Agnew J. A. & J. S. Duncan (eds.): *The Wiley-Blackwell Companion to Human Geography*, 161–175. Wiley-Blackwell, Chichester.

Paasi, A. (2012). Regional planning and the mobilization of 'regional identity': From bounded spaces to relational complexity. *Regional Studies* 47: 8, 1206–1219. DOI: 10.1080/00343404.2012.661410.

Painter, J. (2000). Critical human geography. *In* Johnston, R. J., Gregory, D., Pratt, G. & M. Watts (eds.): *The dictionary of human geography*, 123–124. Blackwell, Oxford.

Painter, J. (2003). State and governance. *In* Sheppard, E. & T. J. Barnes (eds.): *A companion to economic geography*, 359–376. Blackwell, Oxford.

Painter, J. (2005). State: Society. *In* Johnston, R. J. & P. J. Cloke (eds.): *Spaces of geographical thought: Deconstructing human geography's binaries*, 37–49. Sage Publications, London.

Painter, J. (2006). Prosaic geographies of stateness. *Political Geography* 25: 7, 752–774. DOI: 10.1016/j.polgeo.2006.07.004.

Painter, J. (2010). Rethinking territory. *Antipode* 42: 5, 1090–1118. DOI: 10.1111/j.1467-8330.2010.00795.x.

Painter, J. & A. Jeffrey (2009). *Political geography. An introduction to space and power. 2nd edition.* 236 p. Blackwell, Oxford.

Peck, J. (2001). *Workfare states.* 414 p. The Guilford Press, New York.

Peck, J. (2004). Geography and public policy: Constructions of neoliberalism. *Progress in Human Geography* 28: 3, 392–405. DOI: 10.1191/0309132504ph492pr.

Peck, J. & A. Tickell (2002). Neoliberalizing space. *Antipode* 34: 3, 380–404. DOI: 10.1111/1467-8330.00247.

Pløger, J. (2008). Foucault's dispositif and the city. *Planning theory* 7: 1, 51–70. DOI: 10.1177/1473095207085665.

Porter, D. (2011). *Health citizenship. Essays in social medicine and biomedical politics.* 302 p. UC Medical Humanities Consortium, San Francisco.

Porter, M. (1998). *On competition*. 485 p. Harvard Business School Press, Cambridge.

Primary Health Care Act 66/1972 (1972). Ministry of Social Affairs and Health of Finland. <*http://www.finlex.fi/en/laki/kaannokset/1972/19720066*>. Accessed 8.1.2018.

Prince, R., Kearns, R. & D. Craig (2006). Governmentality, discourse and space in the New Zealand health care system, 1991−2003. *Health & Place* 12: 3, 253−266. DOI: 10.1016/j.healthplace.2004.09.003.

Propper, C. (2012). Competition, incentives and the English NHS. *Health Economics* 21: 1, 33–40. DOI: 10.1002/hec.1804.

Rabinow, P. (2003). *Anthropos today: Reflections on modern equipment*. 176 p. Princeton University Press, Princeton.

Rabinow, P. & N. Rose (2003). Introduction. Foucault today. *In* Rabinow, P. & N. Rose (eds.): *The essential Foucault. Selection from essential works of Foucault, 1954–1984*, vii–xxxv. The New Press, New York.

Rabinow, P. & N. Rose (2006). Biopower today. *BioSocieties* 1: 2, 195−217. DOI: 10.1017/S1745855206040014.

Raco, M. (2009). From expectations to aspirations: State modernisation, urban policy, and the existential politics of welfare in the UK. *Political Geography* 28: 7, 436–444. DOI: 10.1016/j.polgeo.2009.10.009.

Ratzel, F. (1969). The laws of the spatial growth of states. *In* Kasperson, R. E. & J. V. Minghi (eds.): *The structure of political geography*, 17–28. University of London Press, London.

Read, J. (2009). A genealogy of homo-economicus: Neoliberalism and the production of subjectivity. *Foucault Studies* 6, 25−36. DOI: 10.22439/fs.v0i0.2465.

Roberts, S., Secor, A. & M. Sparke (2003). Neoliberal geopolitics. *Antipode* 35: 5, 886–897. DOI: 10.1111/j.1467-8330.2003.00363.x.

Rose, N. (1993). Government, authority and expertise in advanced liberalism. *Economy and Society* 22: 3, 283–299. DOI: 10.1080/03085149300000019.

Rose, N. (1996). Governing 'advanced' liberal democracies. *In* Barry A., Osborne, T. & N. Rose (eds.): *Foucault and political reason: Liberalism, neo-liberalism and the rationalities of government*, 37–64. Routledge, Abingdon.

Rose, N. (1999). *Powers of freedom: reframing political thought*. 321 p. Cambridge University Press, Cambridge.

Rose, N. (2001). The politics of life itself. *Theory, Culture & Society* 18: 1, 1–30. DOI: 10.1177/02632760122052020.

Rose, N., O'Malley, P. & M. Valverde (2006). Governmentality. *Annual Review of Law and Social Science* 2, 83–104. DOI: 10.1146/annurev.lawsocsci.2.081805.105900.

Rosenberg, M. W. (1988). Linking the geographical, the medical and the political in analysing health care. *Social Science & Medicine* 26: 1, 179–186. DOI: 10.1016/0277-9536(88)90057-3.

Saar, M. (2002). Genealogy and subjectivity. *European Journal of Philosophy* 10: 2, 231–245. DOI: 10.1111/1468-0378.00159.

Sack, R. (1986). *Human territoriality. Its theory and history.* 267 p. Cambridge University Press, Cambridge.

Saltman, R. B. & J. Figueras (1997). *European health care reform: An analysis of current strategies*. World Health Organization, Regional Office for Europe, Copenhagen.

Saltman, R. B. & V. Bankauskaite (2006). Conceptualizing decentralization in European health systems: A functional perspective. *Health Economics, Policy and Law* 1: 2, 127–147. DOI: 10.1017/S1744133105001209.

Saltman, R. B. & J. Teperi (2016). Health reform in Finland: Current proposals and unresolved challenges. *Health Economics, Policy and Law* 11: 3, 303–319. DOI: 10.1017/S1744133116000013.

Schlosser, K. (2008). Bio-political geographies. *Geography Compass* 2: 5, 1621–1634. DOI: 10.1111/j.1749-8198.2008.00163.x.

Sharma, A. & A. Gupta (2006). Introduction: Rethinking theories of the state in an age of globalization. *In* Sharma, A. & A. Gupta (eds.): *The anthropology of the state: A reader*, 1–41. Blackwell, Malden.

Smith, K. E. (2005). Problematising power relations in 'elite' interviews. *Geoforum* 37: 4, 643–653. DOI: 10.1016/j.geoforum.2005.11.002.

Staeheli, L. A. (2011). Political geography: Where's citizenship? *Progress in Human Geography* 35: 3, 393–400. DOI: 10.1177/0309132510370671.

Strange, S. (1996). *The retreat of the state: The diffusion of power in the world economy.* 218 p. Cambridge University Press, Cambridge.

Taylor, P. (1994). The state as a container: Territoriality in the modern world-system. *Progress in Human Geography* 18: 3, 151–162. DOI: 10.1177/030913259401800202.

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine* 69:1, 28−35. DOI: 10.1016/j.socscimed.2009.03.037.

Thrift, N. (2006). Space. *Theory, Culture & Society* 23: 2–3, 139–146.

Tuohy, C. H. (2012). Reform and the politics of hybridization in mature health care states. *Journal of Health Politics, Policy and Law* 37: 4, 611–632. DOI: 10.1215/03616878-1597448.

Valverde, M. (2007). Genealogies of European states: Foucauldian reflections. *Economy and Society* 36: 1, 159–178. DOI: 10.1080/03085140601089911.

Villadsen, K. (2008). Doing without state and civil society as universals: 'Dispositifs' of care beyond the classic sector divide". *Journal of Civil Society* 4: 3, 171–191. DOI: 10.1080/17448680802559768.

Villadsen, K. & A. Wahlberg (2015). The government of life: Managing populations, health and scarcity. *Economy and Society* 44: 1, 1–17. DOI: 10.1080/03085147.2014.983831.

Vuorenkoski, L., Mladovsky, P. & E. Mossialos (2008). Finland: health system review. *Health Systems in Transition* 10: 4, 1−168.

Walters, W. (2012). *Governmentality: Critical encounters*. 188 p. Routledge, New York.

Weber, M. (1994/1919). The profession and vocation of politics. *In* Lassman, P. & R. Speirs (eds.): *Weber. Political writings*, 309–369. Cambridge University Press, Cambridge.

Weisser, F. (2014). Practices, politics, performativities: Documents in the international negotiations on climate change. *Political Geography* 40, 46–55. DOI: 10.1016/j.polgeo.2014.02.007.

Wendt, C. & J. Kohl (2010). Translating monetary inputs into health care provision: A comparative analysis of the impact of different modes of public policy. *Journal of Comparative Policy Analysis: Research and Practice* 12: 1–2, 11–31. DOI: 10.1080/13876980903076161.

Wylie, J. (2015). Poststructuralist approaches: Deconstruction and discourse analysis. *In* Aitken S. C. & G. Valentine (eds.): *Approaches to human geography: Philosophies, theories, people and practices*, 373–384. Sage, London.

Appendix I

Analysed policy documents

General Plan for the Development of Health Education for 1984–88 (1983). Publications of National Board of Health, original reports 2/1983. National Board of Health, Helsinki. [Terveyskasvatuksen kehittämissuunnitelma vuosiksi 1984–88 (1983). Lääkintöhallituksen julkaisuja, tutkimukset 2/1983. Lääkintöhallitus, Helsinki.].

HE 98/1971 (1971). Government proposal to Parliament for legislation on public health work. [Hallituksen esitys Eduskunnalle kansanterveystyöstä ja sen voimaanpanosta annettaviksi laeiksi.]. <http://www.edilex.fi/he/arkisto/kaikki/1971?perpage=50&offset=101.

HE 101/1981 (1981). Government Proposal to Parliament for Reformation of Legislation on Social and Health Care Planning and State Subsidy System. [Hallituksen esitys Eduskunnalle sosiaali- ja terveydenhuollon suunnittelua ja valtionosuutta koskevan lainsäädännön uudistamisesta.]. Valtiopäivät 1981: A 2. Valtion painatuskeskus, Helsinki.

HE 155/1981 (1981). Government Proposal to Parliament for Legislation on National Public Health Institute. Parliament of Finland, Helsinki. [Hallituksen esitys Eduskunnalle laiksi Kansanterveyslaitoksesta. Valtiopäivät, Helsinki.].

HE 214/1991 (1991). Government Proposal to Parliament for Legislation on State Subsidies for Municipalities. [Hallituksen esitys Eduskunnalle kuntien valtionosuuslaiksi ja siihen liittyväksi lainsäädännöksi.]. < http://www.edilex.fi/he/19910214>.

HE 216/1991 (1991). Government Proposal to Parliament for Reformation of Legislation on Social and Health Care Planning and State Subsidy System. [Hallituksen esitys Eduskunnalle sosiaali- ja terveydenhuollon suunnittelua ja valtionosuutta koskevan lainsäädännön uudistamisesta.]. <http://www.edilex.fi/he/19910216>.

HE 155/2006 (2006). Government Proposal to Parliament for Legislation on Reformation of Municipality Structure and Service Structure [Hallituksen esitys Eduskunnalle laiksi kunta- ja palvelurakenneuudistuksesta sekä laeiksi kuntajakolain muuttamisesta ja varainsiirtoverolain muuttamisesta.] <http://www. finlex.fi/fi/esitykset/ he/2006/20060155>.

HE 90/2010 (2010). Government Proposal to Parliament for Legislation on Health Care. [Hallituksen esitys Eduskunnalle terveydenhuoltolaiksi sekä laeiksi kansanterveyslain ja erikoissairaanhoitolain muuttamiseksi sekä sosiaali- ja terveydenhuollon asiakasmaksuista annetun lain muuttamiseksi.]. <http://www.finlex.fi/fi/esitykset/he/2010/20100090)>.

HE 15/2017 (2017). Government Proposal to Parliament for the Establishment of Counties and for the New Legislation on Organisation of Social and Health Care. [Hallituksen esitys eduskunnalle maakuntien perustamista ja sosiaali- ja terveydenhuollon järjestämisen uudistusta koskevaksi lainsäädännöksi sekä Euroopan paikallisen itsehallinnon peruskirjan 12 ja 13 artiklan mukaisen ilmoituksen antamiseksi.]. <https://www.eduskunta.fi/FI/vaski/KasittelytiedotValtiopaivaasia/Sivut/HE_15+2017.aspx>.

HE 47/2017 (2017). Government Proposal to Parliament for Customer's Freedom of Choice in Social and Health Care. [Hallituksen esitys eduskunnalle asiakkaan valinnanvapaudesta sosiaali- ja terveydenhuollossa sekä valtiontalouden tarkastusvirastosta annetun lain 2 §:n muuttamisesta.]. <https://www.eduskunta.fi/FI/vaski/KasittelytiedotValtiopaivaasia/Sivut/HE_47+2017.aspx>.

Health Care Programme for the Course of Life (1987). Working group memorandum 1987: 3. Ministry of Social Affairs and Health, Helsinki. [Terveydenhoito-ohjelma koko elinkaareksi (1987). Työryhmämuistio 1987: 3. Sosiaali- ja terveysministeriö, Helsinki.].

Health Policy Report by the Government to Parliament (1985). Ministry of Social Affairs and Health, Helsinki.

National Development Programme for Social and Health Care 2008–2011 (2008). Publications of the Ministry of Social Affairs and Health 2006: 6. Ministry of Social Affairs and Health, Helsinki. [Sosiaali- ja terveydenhuollon kansallinen kehittämisohjelma 2008–2011 (2008). Sosiaali- ja terveysministeriön julkaisuja 2008: 6. Sosiaali- ja terveysministeriö, Helsinki.].

National Development Programme for Social and Health Care 2012–2015 (2012). Publications of the Ministry of Social Affairs and Health 2012: 1. Ministry of Social Affairs and Health, Helsinki. [Sosiaali- ja terveydenhuollon kansallinen kehittämisohjelma 2012–2015 (2012). Sosiaali- ja terveysministeriön julkaisuja 2012: 1. Sosiaali- ja terveysministeriö, Helsinki.].

National Plan for Organising Public Health Work in 1972–1976 (1972). National Board of Health, Helsinki. [Valtakunnallinen suunnitelma kansanterveystyön järjestämisestä vuosina 1972–1976 (1972). Lääkintöhallitus, Helsinki.].

National Plan for Organising Public Health Work in 1974–1978 (1973). National Board of Health, Helsinki. [Valtakunnallinen suunnitelma kansanterveystyön järjestämisestä vuosina 1974–1978 (1973). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1975–1979 (1974). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1975–1979 (1974). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1977–1981 (1976). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1975–1981 (1976). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1978–1982 (1977). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1978–1982 (1977). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1979–1983 (1978). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1979–1983 (1978). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1980–1984 (1979). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1980–1984 (1979). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1981–1985 (1980). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1981–1985 (1980). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1982–1986 (1981). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1982–1986 (1981). Lääkintöhallitus, Helsinki.].

National Plans for Organising the Functions of Public Health Work and Hospitals in 1983–1987 (1982). National Board of Health, Helsinki. [Valtakunnalliset suunnitelmat kansanterveystyön ja sairaanhoitolaitosten toiminnan järjestämisestä vuosina 1983–1987 (1982). Lääkintöhallitus, Helsinki.].

National Plans for Organising Social and Health Care in 1984–1988 (1983). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1984–1988 (1983). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1985–1989 (1984). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1985–1989 (1984). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1986–1990 (1985). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1986–1990 (1985). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1987–1991 (1986). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1987–1991 (1986). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1988–1992 (1987). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1988–1992 (1987). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1989–1993 (1988). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1989–1993 (1988). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1990–1994 (1989). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1990–1994 (1989). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1991–1995 (1990). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1991–1995 (1990). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1992–1996 (1991). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämisestä vuosina 1992–1996 (1991). Sosiaali- ja terveysministeriö, Helsinki.].

National Plans for Organising Social and Health Care in 1993–1996 (1992). Ministry of Social Affairs and Health, Helsinki. [Valtakunnalliset suunnitelmat sosiaalihuollon ja terveydenhuollon järjestämistä vuosina 1993–1996 (1992). Sosiaali- ja terveysministeriö, Helsinki.].

Programme of Health Care for 1975–1979 (1974). National Board of Health, Helsinki. [Terveydenhuollon ohjelma vuosille 1975–1979 (1974). Lääkintöhallitus, Helsinki.].

Report of the Commission for Public Health (1969). Committee report 1969: A 3. Ministry of Social Affairs and Health, Helsinki. [Kansanterveystoimikunnan mietintö (1969). Komiteanmietintö 1969: A 3. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Committee for Development of Public Health Laboratory (1974). Committee report 1974: 91. Ministry of Social Affairs and Health, Helsinki. [Kansanterveyslaboratorion kehittämistoimikunnan mietintö (1974). Komiteanmietintö 1974: 91. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Committee for Health Care Planning (1971). Committee report 1971: B 4. Ministry of Social Affairs and Health, Helsinki. [Terveydenhuollon suunnittelukomitean mietintö (1971). Komiteanmietintö 1971: B4. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Committee for Health Education (1976). Committee report 1976: 94. Ministry of Social Affairs and Health, Helsinki. [Terveyskasvatustoimikunnan mietintö (1976). Komiteanmietintö 1976: 94. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Committee for Public Health (1965). Committee report 1965: B 72. Ministry of Interior, Helsinki. [Kansanterveyskomitean mietintö (1965). Komiteanmietintö 1965: B 72. Sisäasiainministeriö, Helsinki.].

Report of the Committee for Public Health Laboratory (1969). Committee report 1969: B 77. Ministry of Social Affairs and Health, Helsinki. [Kansanterveyslaboratoriotoimikunnan mietintö (1969). Komiteanmietintö 1969: B 77. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Committee for Social Welfare I: General Principles (1971). Committee report 1971: A 25. Ministry of Social Affairs and Health, Helsinki. [Sosiaalihuollon periaatekomitean mietintö 1: yleiset periaatteet. 1971. Komiteanmietintö 1971: A 25. Sosiaali- ja terveysministeriö, Helsinki.].

Report of the Working Group Exploring the Goals of Health Policy (1971). Economic Council, Division for exploring goals of social policies and their measurement, Helsinki. [Terveyspolitiikan tavoitteita tutkivan työryhmän raportti (1971). Talousneuvosto, Yhteiskuntapolitiikan tavoitteita ja niiden mittaamista tutkiva jaosto, Helsinki.].

Target and Action Plan for Social and Health Care 2000–2003 (1999). Publications of the Ministry of Social Affairs and Health 1999: 16. Ministry of Social Affairs and Health, Helsinki. [Sosiaali- ja terveydenhuollon tavoite- ja toimintaohjelma 2000–2003 (1999). Sosiaali- ja terveysministeriön julkaisuja 1999: 16. Sosiaali- ja terveysministeriö, Helsinki.].

Target and Action Plan for Social and Health Care 2004–2007 (2004). Publications of the Ministry of Social Affairs and Health 2003: 20. Ministry of Social Affairs and Health, Helsinki. [Sosiaali- ja terveydenhuollon tavoite- ja toimintaohjelma 2004–2007 (2004). Sosiaali- ja terveysministeriön julkaisuja 2003: 20. Sosiaali- ja terveysministeriö, Helsinki.].

Targets and Operational Principles of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1994–1997 (1993). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet ja toimintaperiaatteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1994–1997 (1993). Sosiaali- ja terveysminiteriö, Helsinki.].

Targets and Operational Principles of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1995–1998 (1994). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet ja toimintaperiaatteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1995–1998 (1994). Sosiaali- ja terveysminiteriö, Helsinki.].

Targets and Operational Principles of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1996–1999 (1995). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet ja toimintaperiaatteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1996–1999 (1995). Sosiaali- ja terveysminiteriö, Helsinki.].

Targets of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1997–2000 (1996). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1997–2000 (1996). Sosiaali- ja terveysminiteriö, Helsinki.].

Targets of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1998–2001 (1997). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1998–2001 (1997). Sosiaali- ja terveysminiteriö, Helsinki.].

Targets of Municipal Social and Health Care: National Plan for Organising Social and Health Care 1999–2002 (1998). Ministry of Social Affairs and Health, Helsinki. [Kunnallisen sosiaali- ja terveydenhuollon tavoitteet: Valtakunnallinen suunnitelma sosiaali- ja terveydenhuollon järjestämisestä vuosina 1999–2002 (1998). Sosiaali- ja terveysminiteriö, Helsinki.].

Appendix II

Semi-structured interview themes and questions (translated from Finnish)

Background information:

Name, working title, working years in current position, other related work experience
Main duties in current position

Themes and related questions:

1. Health care reform and freedom of choice

In your opinion,

- What are the central problems and challenges of the existing health care system necessitating the current restructuring?
- Why is the more extensive freedom of choice needed in public-sector health care?
- Which are the key prerequisites for implementing health care choice?
- Which are the most appropriate means to realise health care choice in the Finnish system? Why?
- What kinds of positive aspects and difficulties are related to the extension of health care choice?

2. Health care choice, the market, and public / private / third sector

In your view,

- What are the central prerequisites for creation of competition and the market in Finnish public-sector health care?
- What kinds of advantages and disadvantages, as well as anxieties, are associated with competition and the market in public-sector health care?
- Does the ongoing health care reform and the concomitant extension of health care choice have effects on the 'traditional' sectoral division and the relations between sectors? Compared to the present situation, what roles will each sector play after health care reform?
- Does health care reform and the extension of health care choice have an effect on the role of state power in health care governance? How?

3. Health care choice and citizen(ship)

To your mind,

- Does the extension of health care choice change the role of the citizen in health care in comparison to the present situation? How?
- What does the more extensive health care choice require of the citizen?
- Does the extension of health care choice have an effect on the equality among citizens? Does each citizen have an equal chance of exercising health care choice?
- With what methods can the citizen be supported to implement in his/her health care choice?
- What are the most important prospects and challenges related to health care reform and more extensive health care choice from the citizen perspective?