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"Hard to reach" consumers: neo-liberal citizenship and cultural difference in UK health promotion policy

Angelina I. Zontine
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Increasing immigration from non-European nations is reshaping the social landscape of Europe. At the same time, economic integration and neo-liberal restructuring reshapes the relationship between European states and their citizens. Britain is one of the European states where migrants and refugees from so-called "third world" nations are settling. While previous immigration to the UK consisted of mainly British-educated post-colonial subjects, many recent immigrants are not products of an imperial educational system (Hansen 2000). They do not necessarily speak English, identify as British subjects or share dominant British ethnic identities. As in many nation-states, the entitlements of British citizenship are being extended to include "cultural rights" related to identity and heritage (Pakulski 1997, Joppke 1999). Ethnic minorities living in Britain employ universal human rights discourses to argue that their cultural practices and ethnic identities should be accommodated and respected in the public sphere (Soysal 2000).

Public health is a service provided for citizens. Public health, like other social services, is therefore a site where citizenship is demarcated and experienced. Recent policy reforms in the British National Health Service (NHS) demarcate a certain model of citizenship based on active engagement with mechanisms of the free market.
NHS policies champion market-based solutions to social problems while at the same time they seek to meet the needs of an increasingly diverse citizenry. Health polices such as

those of the NHS employ discourses of productivity and value that draw lines of inclusion and exclusion around and between bodies. Following Shore and Wright, I am compelled to ask: what new subjects do these policies construct? (Shore and Wright 1997). What social classifications do they produce and reproduce? Taking the immigrant client as a locus of analysis, I will describe the subject position into which British public health programs seek to enroll immigrant clients. I hope in so doing to shed light on the mechanisms of modern power centered on the body as well as the shifting relationship between states and their subjects.

This paper is a product of preliminary and exploratory research conducted over four months in London, England. I do not intend in this paper to represent the variety of actors involved or their views, nor can I adequately characterize the range of experiences of immigrant NHS clients. In order to explore the process by which immigrants are constructed as neo-liberal citizens, I will focus on the process of health promotion in the NHS and describe the roles of immigrant clients within this process. I will describe the tensions and disconnects NHS workers perceive between the ideal client role envisioned in these policies and the realities of immigrant clients from Bangladesh and Somalia within some health promotion projects in SE London. I will also point to directions for further research, looking at perceptions of ethnic and cultural difference and how these intersect with neo-liberal citizenship models.

The "field" of policy

In order to analyze policy and its implementation, a fundamental rethinking of traditional "field" of ethnographic research is required. Conventional wisdom in cultural

anthropology conceives of the field as a bounded, coherent whole located in a discrete space and time, and participant/observation in this "field" as the basis of anthropological knowledge (Gupta and Ferguson 1997). The "field" of policy, in contrast, is "a social and political space articulated through relations of power and systems of governance" (Shore and Wright 1997:14). The multi-sited character of policy represents fresh possibilities, but it also brings fresh challenges. One of my main challenges as an inexperienced fieldworker was recognizing and identifying the concrete, everyday manifestations of health policy. I often felt disoriented and paralyzed by the unboundedness of the "social and political space" of policy. In order to concretize my research objectives, I focused on the process of policy implementation by analyzing health communication media. I attempted to follow health promotion projects from the policies that establish health promotion goals, through people that make and distribute and use health communication media in their workshops, classes and seminars.

Health media served as a conceptual focal point that I used to delineate my field; in other words, I went to sites where health media was made and used and talked to the people involved. I combined two main ethnographic methods: observation in places that produce health promotion media and unstructured ethnographic interviews with media makers and users. My "field" included both governmental sites such as clinics and NHS agencies, and non-governmental sites such as community centres. I visited hospital waiting rooms and combed the racks of NHS media at public libraries. I conceived of these diverse sites as interlocking spaces through which policy is implemented, in recognition of the increasingly dispersed character of contemporary processes of governance (Rose and Miller 1992).

I concentrated on a group of policies that mark a turning point in the NHS. The policies were put in place in the mid 1990's by New Labour, though they also have political antecedents in Thatcher's administration (North 2001). These policy reforms do not seek to dismantle British social services, but to change the underlying rationality of state service provision. They intend to achieve "better return for taxpayer money" by putting in place long term projects that reduce social inequality. By reducing social inequality and thus improving health in the long run, these policy reforms intend to reduce long term reliance on state services. They try to make services more "accountable" by showing how funds are used and by using funds according to the wishes of the citizenry. The public and local managers are (ostensibly) granted increased decision-making power and "empowered" to choose services for themselves. Scholars of public health describe this shift in public health towards client empowerment in many neo-liberal states (Gastaldo 1997). In the logic of neo-liberalsm, state expenditures are reduced by the cost-cutting mechanisms of a health service quasi-market (Le Grand 1996; Milewa, Valentine and Calnan 1998). This kind of focus on increasing public participation in the NHS assumes – or constructs – a model of active, self-educating citizenship. Rather than "passively" receiving services, clients are encouraged to adopt a productive or entrepreneurial role by participating actively in NHS administration as public-sector "consumers" (Milewa et all 1998; Rose and Miller 1992). In order for these neo-liberal objectives to work, the empowered "consumers" of NHS services must educate themselves about services, choose among health service "products", and participate actively in planning boards and health promotion projects.

What subjects do the policies seek to construct?

In order to understand the role of clients within health promotion policies, I asked the NHS workers who implement these policies to identify the policy goals that inform their work, and to describe the "ideal" client who would enable these policy goals. I focused on one local chapter of a national health promotion project called Surestart. Surestart was initiated by New Labour in 1999 in areas of "high economic deprivation" as assessed by local census figures (Glass 1999). Surestart offers services for parents with children aged 0-4 in order to address health and development issues before the children begin school at age 5. I talked to Surestart workers in the SE London borough of West Bermondsey. There is vast income disparity between residents of West Bermondsey – neighborhoods or even buildings populated by young urban professionals lie right alongside subsidized or substandard housing populated primarily by recent immigrants. This Surestart chapter came to my attention because it is connected to Charterhouse, a community-based organization where I volunteered for several months. When I asked the volunteer coordinator of Charterhouse about health promotion projects for immigrant clients, she suggested I speak to the Surestart program manager, Janet. Janet is responsible for translating Surestart's national policy goals into specific programs and activities that will appeal to the parents in her administrative area. It wasn't until I came for my interview with Janet that I realized that the Surestart office is actually in the basement of the Charterhouse building, down a twisting flight of carpeted stairs.

I talked to Janet in her windowless office where she sat at a desk piled high with 3-ring binders. Periodically throughout the interview she opened one binder or another to

show me the policy documents that shaped her work. I asked her to describe the goals of Surestart. Janet said:

> I guess the policy is basically a preventative approach, so that you're trying to instill services for aught to four, *now*. I mean, research has been done. . . that proves that if you can invest a substantial amount now in services and resources, that, by the time a child gets to school in England at 5, that the levels of intervention that they require at that point is less.

At the conclusion of our interview, Janet gave me the names of several additional Surestart employees I might talk to.

As I tracked down each potential informant, the multi-sited nature of policy implementation came to complicated, tortuous life. The Surestart program, which appears so coherent on the website, is implemented by multiple employees with diverse professional training who worked out of multiple far-flung sites. They are linked through practices of information sharing and client referral, and through joint planning, and shared professional objectives. Despite the dispersed nature of Surestart implementation, workers' descriptions of Surestart policy goals struck me as fairly coherent and uniform.

Janet suggested I speak with Michelle, a "Health Visitor" who works with Surestart West Bermondsey. A 20 minute subway ride and 10 minute walk away from the Charterhouse community centre, I found the General Practitioner's surgery (doctor's office) where Michelle works. She explained to me that every child born in a London hospital is assigned a Health Visitor who contacts the new family (usually by phone) at set times during the child's first 3 years. On referral from other Surestart workers, Michelle visits families that need special attention in their homes. She explained that Surestart aims to "level the playing field and to close the gaps between haves and have-nots. Surestart provides services that should reduce inequalities by educating families

about nutrition, about playing with children, reading to children, immunization, [and] parenting skills."

Janet also gave me the name of a speech therapist named Margaret who works with Surestart. Margaret specializes in the language development of bilingual children. She works out of multiple offices, and often conducts consultations with parents in public spaces like schools and playgrounds. After trying and failing to arrange a meeting that was convenient for her, I interviewed Margaret over the phone, frantically typing her responses on my laptop while she spoke. Surestart's main goal, she explained, is "to provide children who at risk of difficulties with the best resources that can be made available to them, to compensate for the disadvantages that they might be exposed to by dint of where they live".

These service providers agree that Surestart invests in preventive social and health services for young children in order to obviate later expenditures. But the infants and young children themselves are not the clients of the services. The clients are the parents who are encouraged to register with the program, attend parenting classes, and get their children immunized on schedule. As Margaret explained to me, "to provide for the child, they [Surestart service providers] need to provide resources to parents, carers[1], and the local community". Surestart providers describe providing resources such as information about parenting skills and childhood health issues, contacts with other parents of young children, and unlimited referrals to social and health services. The parents are then supposed to use these resources actively and appropriately. As Michelle described it, an

[1] "Carers" refers to individuals who care for others outside of their professional responsibilities. This includes parents caring for children, children caring for elderly parents, and non-biologically-related people who take on a care-taking role. The term "carers" therefore identifies a population that is recognized to have some shared experiences and concerns that is not dependant on their biological or legal statuses as parents, etc.

ideal client would "engage with you, and with other parents. We link them up with a network of friends, ideally – Surestart is really trying to make community." The Surestart workers see their role as one of facilitation: they facilitate parents' self-development and empowerment in order to combat the health inequalities that arise from socio-economic inequalities.

Surestart policy goals depend on a certain model of client participation. Surestart workers explained that parents should not simply come to activities, they should take leadership roles and become active agents in their own care.

> The whole ethos of Surestart is that it should be parents led. Its needs led, its parent led. . . How it's set up is that you have partnership boards that make all the decisions. . . probably a quarter of our group is parents. . . So, they have an important say in that, advocating for other parents. (Janet, program manager)

> We [Surestart workers] are making the family take the lead role. . . the idea is coordinating and encourage the families to take up the services. . . I always make sure that the parents are part of it, the parents have some role, you know, so that when you're not there they can do it on their own. (Abraham, family support coordinator)

> They are at the heart of it, or should be. We want them to identify the gaps in local services, and how to improve the services to meet their needs. So, parents cannot be excluded from any decisions in Surestart. They should participate at every level from top to bottom. (Cynthia, parent development officer)

Surestart exemplifies a project that intends to give NHS clients more decision making power. Parents should be included in all decision-making processes in the program. By taking active leadership roles, clients are supposed to gain confidence and self-management skills which will reduce their reliance on state services – as Abraham describes, after participating in Surestart, parents should be able to "do it on their own."

“Hard to reach” clients

The health promotion policies I observed construct subjects through the assumed role of clients within health promotion projects. However, these ideal subjects are not the only ones created through policy. In addition to the planned goals of policy makers, social policy often has powerful unplanned and unintended effects. In her ethnographic analysis of Chinese population policy, Susan Greenhalgh argues that population policy creates not only the deliberate subject of the “planned person” but also an unintended subject, the “unplanned person”. Chinese population policy intends to create a rational, quantifiable and controlled population. The unintended effect of Chinese population policy is the creation of an ‘illegitimate’ population that is not recognized by the state and so cannot be counted or rationalized (Greenhalgh 2003). NHS health promotion policies also create an unintended subject, a conceptual category that stands in contrast to the ideal client, that of “hard to reach” populations. Workers described groups of people who did not fill the ideal role of clients – groups that do not come into parenting classes, do not attend seminars and do not read, or cannot understand, the media distributed by the NHS. I will attempt to map some different uses of the shifting discursive category of “hard to reach” clients.

Social service workers commonly used the label “hard to reach” in their explanations of how they are working to overcome the factors that make a population difficult to communicate with. In these conversations “hard to reach” functioned as a marked category that workers used to justify or explain the need for special attention. The manager of a hospital communications department explained to me that “some groups” are not reached by official NHS publications. The communications department therefore

works to tailor media to certain audiences – for example, the communications department manager suggested that I look at a series of brochures directed at young black people who are sexually active to see an example of media for "an audience that we know is specific". Health media must employ special communicative strategies to reach these "specific" audiences. Contained within this explanation is the assumption that "the general public" *is* reached by official NHS publications. "The general public" therefore serves as an unmarked category against which problematic groups stand out. The marked category of "hard to reach" was always employed in reference to populations rather than individuals. The populations described as hard to reach ranged from entire ethnic groups identified by national origin (e.g. recent immigrants from Bangladesh, Pakistan or Somalia) to sub-groupings identified by specific qualities or behaviors (e.g. Bengali first-time mothers, "African" men who have sex with men).

I heard multiple reasons why the populations so designated are difficult to enroll into health promotion projects. Minority language use was the most commonly identified barrier to service use. At a community-based health organization for Somalis in SE London, a worker said that educating her clients about the health system was important, because the language barrier prevents them from educating themselves.

> Basically, we explain to them how the NHS system works here, because if you don't know what's out there you won't be able to use it – that's one of the major problems – because of the language barriers, they don't know what's out there. They need people like us, [this organization], to explain to them what's out there, so they can use the services they're really entitled to.

An HIV/AIDS health educator at an organization for people from the horn of Africa explained that he uses both media and word of mouth to communicate with his clients about available services.

> We use them together. because . . I mean. . we try. . We use all the media possible, to reach out to the people, to make them understand. The problem is, the language barrier. Because, I told you earlier, its very multi-cultural. So many tribes, so many. . . ethnic backgrounds.

Several community health workers explained that their Bengali clients in particular are also not literate in the language they speak. Many migrants from Bangladesh speak both Standard Bengali and the Sylheti dialect, which does not have a written form. However, monolingual Sylheti speakers cannot read or understand Standard written Bengali. Health workers identified this as a barrier because educational brochures or advertisements for health classes could not reach this group. In retrospect, I am struck by the fact that no one described the illiteracy of their clients as a barrier to civic participation in the political community of the nation-state, as might have been focus in an earlier era. Rather, community workers identified illiteracy as a barrier to employment and to the active use of services – in other words, as a barrier to production and consumption in the 'marketplace' of public health.

"Hard to reach" groups become marked in part by the special efforts required to communicate with them. Many efforts used by NHS agencies to 'reach' the general public in order to promote proper service-use are increasingly high-tech and commercial-looking. I found touch-screen kiosks in public places such as library and post-office buildings with interactive menus people could use to figure out if they need to see a doctor. There are many informational websites on self-diagnosis and NHS services, and a 24-hour telephone answering service called "NHS Direct". Slick advertisements for NHS Direct hang alongside commercial advertisements for vitamin supplements and sunny vacation destinations on all commuter trains; the visual styles of commercial and NHS advertisements are virtually indistinguishable. The methods workers use to communicate

with "hard to reach" clients, in contrast, are very technologically unsophisticated. Workers told me that they go door to door to let people know about services in the area. They go to social places such as barber shops and shopping centres or events such as religious celebrations to pass out flyers. If their targeted audience is not literate, workers simply speak about services in the hope that the information will be passed on by word of mouth. Along with illiteracy and language use, not being registered with a General Practitioner (GP) was described as a barrier to clients' use of NHS services.

Hard to reach populations: GP registration

Through contact with a General Practitioner (GP), patients are screened for diseases, given preventive care and educated about health issues. People choose a General practitioner in their area and contact the GP's surgery (office) to register as a patient. Unregistered people are "hard to reach" because they are "off the grid"; they may not get care until their condition has become serious. A staff member at the Whitechapel walk-in centre indicated that too many unregistered people come into the walk-in centre, and getting clients registered with a GP is a top priority.

> We encourage people to register with a doctor – we've got – its this service called Find a Doctor, "Find a Doc". So, I mean, whoever's not registered, who comes to the front line staff, we tell them 'you need to register with a doctor, here's a leaflet, contact them'. We've also got – when we're booking in patients we've got a section where [it asks], 'is this the second multiple visit by a patient who's not registered" so we keep track of this. (FahMaria, administrative assistant)

I asked her why so many recent immigrants who live in Tower Hamlets are not registered, and she explained that "there are not enough GPs for this area, for the population. Many are full up – they try [to register] but the GPs are full up." I took this statement at face value until I read several NHS guides to services in Tower Hamlets.

These guides described the unusually high population density of the borough and explained that additional GP surgeries have been opened to meet this need. GPs are given a lot of latitude in accepting or rejecting prospective clients, and I wondered if recent immigrants were discriminated against in the registration process.

I got a chance to follow up on this question several weeks later. I attended a meeting of the immigrant-advocacy group Committee to Defend Asylum-Seekers (CDAS), and while I waited for the meeting to start, I described my research to one of the group's organizers. He gave me the name and number of a CDAS member who also works for the state as a refugee benefits advisor. Teresa turned out to be a very valuable informant because she combines a critical perspective with an insider's understanding of the social service system. She explained:

> GPs don't exclude immigrants per se; really the exclusion is of the mobile poor. GPs are paid per patient, they're also paid for meeting certain targets set by government – for example, that a certain percentage of their patients will have had pap smears each year. But if patients are always moving because they are at the mercy of the housing market, they are maybe on the books at the GP but they are not coming in, and so cannot be part of meeting targets.

Because of the structure of the NHS quasi-market, GPs are disinclined to accept patients that will not help them meet policy targets. Recent migrants to the UK often arrive with scant economic resources and are thus at the mercy of the competitive housing market. Although GP's do not intend to discriminate against immigrants *per se*, immigrants in SE London constitute the majority of "the mobile poor" – people whose economic situation renders their housing unstable.

Legal/ Immigration status

Immigration status itself was recognized to complicate people's lives and therefore interfere with consistent, appropriate service use. In particular, people who have applied for asylum but not yet received it, whose cases are under review, were seen as undependable clients because the complication of their legal status makes it difficult for them to have a stable routine. Margaret, the Surestart speech therapist, explained that the workers who implement Surestart policy use special measures to reach these people:

> Our aim is to involve hard to reach groups – people who are having trouble with their immigration status, housing, et cetera and so miss their appointments. We experiment with ways to do this that go beyond the normal mode – conventionally, a family with a child with problems is referred to services, but if they don't make it, they receive a letter saying that they will get cut off from care if they don't come to their appointments. Surestart is trying to get them into the system through other ways. . other strategies.

Margaret uses strategies such as recruiting clients at neighborhood community-centres where many immigrants live, or meeting with parents in spaces where they will already be, such as playgrounds and parks. She tries to involve voluntary and self-help organizations in her work so they can steer recent immigrants and refugees towards her services.

Several workers also explained that some recent immigrants from countries that offer only minimal state health services do not trust state-provided health services. One Surestart caseworker explained that "when I go to the immigration office there are a lot of people – you know there are a lot of immigrants in the catchment area, but they hardly take up any of the services. . . it's a trust thing". Michelle, the Health Visitor who works with Surestart in SE London, told me that "they are referred but then don't remember to use services. They have never experienced anything like this. . .they are suspicious of anything free". This perceived inexperience or distrust stands in stark contrast to the

attitude of "the general public" towards the NHS. Most service workers I spoke with, while admitting shortcomings in the NHS, also expressed varying degrees of loyalty and pride in their nationalized system which guarantees health care to all. Martha, the manager of a hospital communications department, explained that people are trying hard to implement an increasingly business oriented model of service provision without losing the essence of the NHS, because it is important to all Britons. The NHS wants to give people more choice, but "people don't want to see the system go belly up."

Religion

Muslim religious values and practices were also identified as a barrier both to service use and to health education projects, especially HIV/AIDS education. I spoke with an NHS health promotion specialist named Maria who works with African community groups to organize events that will educate their clients about sexual health. In her work, Maria helps community groups educate their clients through religious and community events and traditional media of communication such as drama and dance. She described her role as that of an advocate for African community groups, but she expressed frustration about what she saw as the disinclination of African Muslims to 'face the facts' about HIV/AIDS and other sexual health issues. Maria said:

> Many Muslims say – well, these behaviors are forbidden. It's not an issue for me, a Muslim, because these things are forbidden. But I tell them, look, lots of things are forbidden many people, but they still happen. Muslim men still have sex with other men, with prostitutes, et cetera. I shows them a world map marked with AIDS rates, and I points to Somalia – look, it is dark red – and then they see.

A health educator at a community-based organization serving African immigrants echoed Maria's frustration when he explained that "there are some cultures who don't want to

know. Like the Somalis. I mean because of their religion and everything – I mean, I'm Muslim, but . . . Somalis, they don't want to know what you know."

Service workers brought together ethnic markers such as language use, religion, legal status and perceived cultural values in complicated ways in their descriptions of why some populations are hard to reach. The populations most often marked as "hard to reach" because of these qualities – language, mistrust of state services, religion – are recent immigrants from predominantly Muslim countries such as Bangladesh and Somalia. They were perceived as difficult to communicate with because they maintained and expressed a collective ethnic identity through religious practice, language use and perceived social insularity. The label "hard to reach" is clearly an effort to identify structural barriers to participation. In contrast to a label such as "non-compliant", the label "hard to reach" implies that things get in the way of reaching these clients. The label suggests that barriers to service-use are external to the client's own behavior or characteristics.

Sometimes workers explained that barriers to appropriate service-use are extrinsic to the client and therefore potentially fixable. Other times the barriers were perceived to be so intrinsically connected to clients' collective ethnic identity or cultural practices that they are difficult or impossible to change. After describing the many ways in which immigrant parents deviate from the model of good parenting she tries to teach as a Health Visitor, Michelle indicated her frustration in the face of her immigrant clients' 'intractability': "A health visitor can only recommend, and give out information. My role is to empower them to do the right thing, but if they decide it's not the right thing for them, we can't put them in jail." I observed that the circumstantial, structural bases of

"hard to reach-ness" were sometimes elided by essentialist perceptions of ethnic identity that assumed a strong, natural correspondence between national origin and clients' attributes and attitudes toward health services. "Hard to reach clients" can be seen as a discursive category created by policy initiatives that assign 'ideal clients' an active, rational role in policy implementation. This discursive category has real material effects when it is applied to and used to create populations because it differentially orders clients in the realm of health services.

Although "community" in the sense of a neo-liberal investment in "community-regeneration" is enthusiastically promoted by NHS policies, workers also expressed another, more ambivalent sense of community as a barrier to immigrants' participation. I noted this ambivalence when workers described minority languages – the non-English languages that represented a barrier to communication through 'normal' routes – as "community languages". Although language was clearly identified as a barrier, the community itself also seemed to be implicated. As I mentioned earlier, my conversations with the refugee benefits advisor named Teresa were invaluable because of her critical perspective on refugee health policy. Yet she was also deeply enmeshed in her job, and often moved between critical and sympathetic descriptions of the policies that shaped her work.

Teresa described how the bureaucratic processes required of asylum seekers exclude them from social processes. While they are awaiting status, she explained, they are just wasting time – "they are not learning English, they are not working at their professions, they are being excluded." She then explained to me that "new arrivals to London fall prey to sharks within their community. They don't trust the government that

they realize just wants to get rid of them, and they become insular rather than connected with services". The process of asylum application "pushes people back into the community"; they are "driven back into those kind of networks". "I try to help them become engaged with community", she told me. I was struck by the contradiction between the two senses of "community" Teresa expressed. On one hand is the positive sense of "community development" achieved through policies that promote small-scale entrepreneurial initiatives, adult education classes and healthy eating clubs. On the other hand is a kind of community that articulates with social exclusion, promotes intra-ethnic insularity and erects barriers to communication between the state and its subjects.

As she was a vocal critic of nativist politics and policies, I don't think Teresa meant that immigrants to the UK should assimilate. But she did not see the proper use of services as cultural or ethnic assimilation. Teresa did not view appropriate, active use of health services as cultural practice, but as the neutral, rational behavior of a modern subject. I see an internal contradiction in NHS policies that promote "community-building" for immigrant groups and encourage the use of culturally specific modes of communication such as drama and musical performances to educate immigrants about health, while on the other hand they insist on a certain model of engagement with health services, with state structures, and with the mechanisms of the free market. This seeming contradiction points at some important questions about ethnic identity, assimilation and neo-liberal reforms.

Many scholars argue that, in the context of European integration, a new (or renewed) cultural racism is emerging in Europe. European nation-states are working to form a collective identity based on shared history and cultural values (Shore 2000).

Immigrants from non-European nations are increasingly viewed as possessing "incommensurable cultural difference" which represents a threat to the supra-national culture of EU 'European-ness' (Stolcke 1995). The "cultural difference" of non-European immigrants may not be given a strictly biological basis as with traditional racism, but it is nonetheless viewed in essentialist terms (Angel-Ajani 2000) and may articulate with sociobiological models in some contexts (Balibar 1991). How do these essentialist or quasi-biological conceptions of cultural difference intersect with shifting models of citizenship in European states such as the UK?

In her ethnographic study of the "subject-ification" of Cambodian immigrants in the US through welfare provision, Aihwa Ong analyzes the ways that immigrants from different Asian countries are hierarchically ranked according to an existing racial conceptual framework that contrasts white masculine productivity and self reliance with feminized Black dependence and "laziness" (Ong 1996:739). Ong argues that citizenship functions as a gatekeeping device that articulates with existing racial and ethnic logics to differently order immigrants within the social field of state services. An analysis of shifting concepts of citizenship in the arena of public health can therefore illuminate shifting discourses of inclusion and exclusion. In the context of neo-liberalism, an analysis of the way concepts of citizenship are constructed and applied to recent immigrants might reveal important new understandings of "culture", "difference" and "incommensurable cultural difference". In the context of the UK, I would also like to analyze how citizenship concepts are shaped by the policies that drive EU harmonization and supra-nation building.

Directions for further research

The NHS policies on which I focus aim to promote health and reduce health inequalities by reducing social inequality. The goal of reducing social inequality is a great one. By recognizing multiple determinants of ill health, these policies seek to address root causes and enact long-term solutions, implemented with the involvement of those most affected. I am, however, critical of the way these polices reproduce and reinforce neo-liberal hegemony and marginalize alternative political rationalities.

Many scholars are noting the construction of neo-liberalism's active citizen (Gastaldo 1997, Heelas and Morris 1992, Hyatt and Callo 2003, Rose 1993). Through her work on German and French citizenship in the context of globalization and European integration, Yasemin Soysal also finds that citizenship is increasingly decoupled from the nation state. Especially for ethnic minorities in Europe, citizenship rights are increasingly argued in relation to universal human rights discourses and decreasingly dependant on nation-state territorial discourses (Soysal 2000). Paradoxically, Soysal notes that the political mobilization of immigrant ethnic minorities is increasingly based on particularistic ethnic identities (Soysal 2000). In my preliminary analysis, one of the most interesting and important themes that emerges is the tension between these bounded, particularistic ethnic identities and neo-liberal models of citizenship. I would like to investigate how this I intend to bring together theoretical work on neo-liberal subjectivity and ethnographic research on the shifting logics of ethnicity and "cultural difference" in the context of European enlargement. I want to look at the new and re-

worked lines of stratification at the intersection of neo-liberal citizenship and "cultural difference". As neo-liberalism becomes increasingly hegemonic, it is important to explore how the values of the NHS "enterprise culture" articulate with racial and gendered thinking, and with an emerging cultural racism. I am driven to ask, how much "difference" is neo-liberalism willing to accommodate, and to what end?

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