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FEATURE

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Using a historical genealogical approach to examine Ireland's health care system

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Abstract

The health of a nation tells much about the nature of a social contract between citizen and state. The way that health care is organised, and the degree to which it is equitably accessible, constitutes a manifestation of the effects of moments and events in that country's history. Research around health inequalities often focuses on demonstrating current conditions, with little attention paid to how the conditions of inequality have been achieved and sustained. This article presents a novel approach to inequalities research that focuses on examining powerful historical discourses as legitimising processes that serve to sustain unequal conditions. The use of this Foucauldian historical genealogical approach in a study of the Irish health care system is explored and proposed as a novel approach to the research of health inequities.

KEYWORDS
Discourse, Foucault, Genealogy, Health, History, Ireland

1 | INTRODUCTION

Inequities in health and health care access have become a concern for countries throughout the world (Browne et al., 2012; Burke, Thomas, Barry, & Keegan, 2014; Lynch & Perera, 2017; Marmot, 2013). While population analyses have drawn attention to the prevalence and incidence of inequities in health, such studies do not generate insights into the mechanisms (institutional policies, processes, practices attitudes and orientations) that create and sustain inequities.

Inequalities in health, in the accessibility of timely health care and in health outcomes have long been recognised both in Ireland and internationally (Burke, 2010; Graham, 2007; Kawachi, Kennedy, & Wilkinson, 1999; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Miers, 2003; Pickett & Wilkinson, 2015). The social conditions in which we are born, live and work are largely responsible for determining much of our health and our longevity. To understand health inequalities and how they can be maintained for many generations, Graham (2007) calls on us to examine the interconnectedness of *socioeconomic* inequalities and *health* inequalities. There is, therefore, a need for different theoretical and methodological approaches that can enable us to gain such understandings.

One of the conditions that confounds our understanding of these issues is that as they unfold over time, practices and the health profiles that result have been normalised and 'taken for granted'. The assumptions that underpin the acceptance of, and explanations for, inequities and their persistence are not typically held out for questioning. It is challenging to identify research methodologies that enable such scrutiny. In recent years however, a number of research scholars who have taken a critical theoretical stance have generated insights that have enabled us to begin to engage to address the conditions that underlie inequities in health (Lynam, Loock, Scott, & Basu-Khan, 2008).

The intention of the research upon which this article is based was to examine Ireland's health and welfare history, in order to understand how Ireland's social, political and economic histories have contributed to and sustained the current state of inequities in health and health care access. These present conditions, while deeply inequitable and unjust, have not emerged suddenly as a consequence of radical policy-making, but instead have gradually unfolded over many years as a result of a series of complex relations and discourses. This 'gradual unfolding' has contributed to the normalisation of current systems, practices and associated inequities (Flynn,

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2014). As such, there has been limited attention paid to addressing inequities in health. For example, there have been virtually no calls to reshape, restructure or re-examine the current systems of health care delivery, and virtually no sustained calls for universal free access to health care for the Irish population. The aim of this article is to introduce a critical methodological stance, *historical genealogy*, and to illustrate the possibilities of this approach for understanding the conditions that contribute to inequities in health.

2 | THEORETICAL FRAMING

The history of Ireland's health care policy is rich with events, developments, policy decisions, transformations, scandals and some success stories, all of which serve to form a history of the present conditions that include not only organisational structures, institutions and policies, but also the philosophical underpinnings that shape health professional education and practice. History, as Foucault (1984) has helped us to see, is not 'in the past', nor it is independent of current practices; rather, history shapes and defines what we understand to be 'real', 'true' and, in some contexts, immutable.

Foucault's theoretical perspective seeks to make visible the ways taken-for-granted practices (in the clinic, prisons, etc.) have evolved over time. His stance directs the researcher to consider the ways power (in its many forms) is manifest while examining the ways in which decisions impact (structure, shape and govern) social relationships. As the prevailing context in which the analysis was undertaken is characterised by *possessive individualism* (Macpherson, 1973), in addition to drawing upon Foucault's perspective, the analytic stance was informed by the core concepts of the *social contract* and the *gift relationship* (Boucher & Kelly, 1994; Titmuss, 1972). Thus, the theoretical stance that informs the methodology developed for this study is characterised by attention to the ways in which history and decisions made over time shape and define power and power relations (Foucault, 1982a). Each of these theoretical traditions challenges the researcher to position the problem of interest in its social and historical context in order to examine and explicate the assumptions that underlie the 'status quo' of day-to-day practices and perspectives.

In what follows, we will illustrate how this theoretical stance informed the ways in which the research was undertaken and, ultimately, how it shaped the analysis. To achieve this aim, in what follows we introduce the background to health care in Ireland in the 21st century and provide an overview of Foucault's theoretical stance on discourse and power, illustrating how this stance was enacted in the particular case of Ireland's health care system.

3 | BACKGROUND TO IRELAND'S HEALTH CARE

Ireland's population is growing and living longer. The current 4.7 million population increased by 10% between 2006 and 2015 (Department of Health, 2017). An ageing population and increasing rates of chronic diseases are putting further strain on the public health system, both in acute services and in community provisions. Those without private health insurance reliant entirely on the public system are most vulnerable under these conditions.

While any person ordinarily resident in Ireland has 'eligibility' to health services, there exists a well-established two-tiered health system (Burke, 2010; McDonnell & O'Donovan, 2009). Despite numerous attempts at reform, the publicly funded health system is the subject of much criticism related to waiting times, bed shortages and overcrowded hospitals. Public health care in Ireland has therefore become synonymous with delayed provision within inadequately resourced environments. Private health care, on the other hand, is available to those whose financial means have enabled them to purchase private health insurance. The privately insured, on the other hand, may access swift consultant medical, surgical and rehabilitative services within the private system of hospitals/clinics, etc. Thus, segments of the population have timely access to a full range of clinical services while others do not. Evidence continues to mount to show that the lack of universal access to comprehensive range of health services contributes to marked inequities in health in Ireland (Burke et al., 2014) and that these conditions are worsened in the context of post-economic crisis austerity (Ruckert & Labonté, 2017).

In 2011, the *Think-Tank for Action on Social Change* (TASC) acknowledging the relationship between economic and health inequalities stated that 'Higher levels of economic inequality result in poorer health for everyone, but especially for those on the lowest incomes' (Burke & Pentony, 2011, p. v). Their report, 'Eliminating Health Inequalities: A Matter of Life and Death', identified conditions, processes and practices that contribute to the status quo and recommended changes to improve health outcomes among the most vulnerable Irish populations. As is the case in many countries, unequal social conditions are inherently unjust and align to class related lines. Using the example of the UK, Marmot (2010) points out:

> People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the "real" concerns with health—health care and unhealthy behaviours—it should become the main focus (p. 4).

However, while much international research identifies and measures health inequalities, providing important and useful data, such research fails to indicate the means by which health inequalities are created and sustained. An explanation of current circumstances therefore requires analysis of past events and their attendant discourses, a problem for which a Foucauldian genealogy offers a potential solution.

This research therefore sought not to add to the body of knowledge on the extent of health inequalities in Ireland, but to also examine how they have been maintained. For example, how has it become

regarded as 'normal' that public patients without health insurance languish on waiting lists while those with insurance purchase timely life-saving treatments? This research, therefore, looked to uncover the origins and development of societal acceptance of an unequal health care system, and its inherent health inequalities, and aimed to examine the implications of this acceptance for social solidarity in the context of the social contract. Given this retrospective imperative that was seeking to trace the foundations of current circumstances, a methodology was required that enabled a particular historical approach. Foucault's historical technique, examining as it does what has hitherto been taken for granted, was very fitting for this examination of Ireland's entrenched two-tier health care system.

Using a Foucauldian genealogical historical analysis for this research required a systematic study of the development of health care and its associated ideologies, and this was achieved through the use of four key case studies (or genealogies) from Irish health care history. This approach sought to recognise the 'continuities' and 'discontinuities' that are identifiable in the genealogy of Ireland's health care system (Salvatore, 2007). A genealogy typically starts with a question about the present and works its way backwards, and for this reason, a genealogical approach to the problem of Ireland's health care was particularly useful. Genealogy 'aims at exploring the historical development of various processes, procedures and apparatuses whereby truth, knowledge and belief are produced' (Björnsdóttir, 2002, p. 5). The historical approaches conceptualised by Foucault and his genealogical 'method' were taken up in this study. We have shown that Foucault's use of historical methods in his analyses of, for example, the criminal justice systems or psychiatric medicine serves as a useful template to examine core issues of knowledge, power and discourse, all of which feature strongly and continue to resonate in the context of health and welfare systems.

4 | FOUCAULT, GENEALOGY AND ARCHAEOLOGY AS METHODOLOGY

Much of Foucault's approach to historical analysis represented a significant departure from that of traditional historians in a number of ways. One feature is that he does not seek to establish a 'meta-history' or an overarching total explanatory history that provides linear or progressive patterns of events in an epoch. Instead, he breaks from such a historicist view and in his archaeology emphasises what he calls the 'general history' which '…eschews the totalising theme, concentrating instead on describing differences, transformations, continuities, mutations and so forth' (Kendall & Wickham, 1999, p. 24).

Foucault's historical approach included 'archaeologies' and 'genealogies' as conceptual and methodological building blocks. In his archaeologies, Foucault sought, through his philosophical, historical approach, to explore discursive formations that indicate the origins of, for example, and medicine in *The History of Madness* (1961), of contemporary health and physical illness in *The Birth of the Clinic* (1963) and of the history of science in *The Order of Things* (1966) and an archaeology of discourse in *The Archaeology of Knowledge* (1969). Foucault's earlier archaeological work provided an alternative to the previously popular conventional approaches utilised by sociologists and instead borrowed from those of the French structuralist movement. Rather than examining the new and the unfamiliar, he sought to look at the familiar, so as to reveal our previously held assumptions (Baert, 1998).

Later, Foucault moved away from this archaeological 'method' and even went so far as to refer to these earlier works as 'imperfect sketches' of the archaeological form (Gutting, 2003, p. 4). His later work employed instead a genealogical approach in his study of punishment, Discipline and Punish (Foucault, 1977), and of sexuality in The History of Sexuality (Foucault, 1978). These genealogies are seen to have been influenced by the work of Friedrich Nietzsche in terms of the absence of a distinct intelligible world and instead the presence of what we have imposed (Moses & Knutsen, 2007). Foucault's historical and philosophical approach to examining phenomena of the present sought to identify the means by which the surrounding power, knowledge, truth and values of the phenomenon changed and evolved over time so as to create the conditions of their possibility. In this way, Foucault's writing takes on a 'Nietzschean tenor' (Flynn, 2003, p. 32).

Mukerji (2007), in an examination of cultural genealogy, relates how both Nietzsche and Foucault 'focus on the social roots and political consequences of on-going cultural forms' (p. 51). However, she differentiates their approaches suggesting that while Foucault was concerned with 'classificatory politics', Nietzsche's approach differed from Foucault's saying:

> Nietzsche, in contrast, is more concerned with memory and self-consciousness—the loss of the past entailed in the construction of historical narratives that allows traditions to carry unnamed and hence unchallenged powers into the present. Nietzsche's genealogy treats temporal change in social life as more complex and problematic; what is left unsaid and yet done over time both evades and still shapes discourse through practice (p. 52).

This interpretation is one that resonates deeply within Ireland's health system in the sense that substantially unchallenged powers have constructed particular narratives around health care, individual responsibility, state obligations and the role of charities. The history of these narratives, along with 'what is left unsaid' (Mukerji, 2007, p. 52), has shaped both practice and discourse.

5 | PROBLEMS AND CONTINGENCIES

Foucault's approach to history is distinctive from other approaches for many reasons, but one distinction of significance for this study is his focus on a *problem* for investigation rather than a particular historical period (Kendall & Wickham, 1999). This feature of Foucault's historical approach contributes to its suitability in the case of this

research having, as it does, the problem of Ireland's unequal health care system as the focus of investigation. Additionally, he described the value of examining events as 'contingencies'. However, as a champion of non-event-orientated histories, he had a very unique conception of the term 'event' which he said:

> …is not a decision, a treaty, a reign, or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once used it…
>
> (Foucault, 1984, p. 88).

Crucial relationships of force, along with the presence of power, and the use of a particular nomenclature, are fundamental features within the history of Ireland's health care, thereby providing a rich source of contingencies ripe for Foucauldian genealogy. For the purpose of this research, the 'problem' of Ireland's inequitable health care system was examined without limitations of a particular period. The contingencies to which Foucault refers were identified and examined, along with their surrounding discourses, rather than seeking to apportion causal conclusions. Kendall and Wickham (1999) interpret this technique:

> When we describe an historical event as contingent, what we mean is that the emergence of that event was not necessary, but was one possible result of a whole series of complex relations between other events (p. 5).

The history of Irish health care is strewn with examples of historical events, or contingencies as Foucault refers to them, which were significant in the manner in which discourses continued thereafter. These events can be seen as watershed moments that altered the circumstances in which various discourses emerged. Our analysis illustrated ways subsequent discourses, thus altered, provided the conditions for current circumstances. Thus, Foucault's genealogical approach was appropriate for this research as it does not seek to necessarily search for origins, but rather, recognition of the accidents and contingencies that have resulted in the present conditions (Galvin, 2002). Foucault refers to this approach as a *History of the Present*, the value of which he makes clear when he said (Kritzman, 1988, p. 37):

> …recourse to history […] is meaningful to the extent that history serves to show how that-which-is has not always been; i.e., that the things which seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history
>
> (Kritzman, 1988, p. 37).

6 | HISTORY OF THE PRESENT

Foucault advocated the use of history, therefore, to 'diagnose' the present circumstances. He suggests that we should seek to 'use it, deform it, to make it groan and protest' (Foucault, 1977, p. 10). By examining phenomena through a historical Foucauldian lens, we have the opportunity to question what has been familiar to us, as Kendall and Wickham (1999) argue 'History should be used not to make ourselves comfortable, but rather to disturb the taken-for-granted' (p. 4). Foucault's methods emphasise an archival examination of *l'ensemble* of discourses that provide the evidence of the conditions that prevailed and the relevant power relations within. Somers (2008) also endorses the use of a Foucauldian genealogy in this way as it 'aims to take up "minor" or repressed knowledge—not to reproduce dominant mythologies' (p. 9). The challenging of dominant assumptions is undoubtedly an attractive defining characteristic of the genealogy. Gutting (2003) refers to this disruptive feature of the approach stating that:

> Foucault simply identifies genealogy with history of the present, regarding it as any effort to question the necessity of dominant categories and procedures. More narrowly, genealogy is a history of the present specifically concerned with the complex casual antecedents of a socio-intellectual reality (p. 12).

This approach applies well to health care as the discourses surrounding health and health care are deeply embedded not only in biomedical but also in social and political assumptions and are inherently linked to power, powerful actors and identifiable power relations. For example, given the indivisible relations seen in Ireland's past between church and state and between church and health care, and the more contemporary relations between health care and the market, there exists a fascinating amalgam of acknowledged and unacknowledged power relations. It is within their particular discourses that power relations can be seen to have emerged. However, it is only by 'stepping back from this discourse that we can interrogate some of its underlying presuppositions' (Fraser & Gordon, 1994, p. 310).

7 | POWER

A genealogical approach has been usefully applied to a wide range of research problems (Björnsdóttir, 2002; Doan, 2013; Fraser & Gordon, 1994; Mukerji, 2007; Walker, 2002), which required a genealogical method because of the manner in which researchers seek to challenge commonly held assumptions and wish to define the conditions that enabled these assumptions to take hold. Research areas typically utilising a genealogical approach are related by virtue of the strong role that power plays within their subject matter. Power is a central feature in much of Foucault's writing, to the extent that in 1977, he said in an interview: 'When I think back now, I ask myself what else was I talking about in [The History of Madness] or The Birth of the Clinic, but power?' (Foucault, 1980, p. 115). Foucault never goes so far as to define power but describes it as 'action upon the action of others' (Foucault, 1982b, p. 790), and he broadens the use of the concept to beyond its use as negatively pejorative (Flynn, 2003). Walker (2002) explains that '…power for Foucault was understood as a net or web of

relationships, as something which 'comes from everywhere', productive of truths, and requiring analysis its local configurations' (p. 19).

In other words, Foucault's account of modern power is, as Fraser (1989) suggests, 'productive rather than prohibitive' (p. 18). Foucault was clear on the role of power in his work when in 1982 he said:

> The goal of my work during the last twenty years [...] has not been to analyze the phenomenon of power, nor to elaborate the foundations of such an analysis. My objective, instead, has been to create a history of the different modes by which, in our culture, human beings are made subjects... Thus it is not power, but the subject, which is the general theme of my research (Foucault, 1982a, p. 208).

This quote underscores that the relevance of power to Foucault's research is how it is used in relation to the process of subjectivation. Foucault's concern with power was the manner in which it is used, over time, to achieve the domination and subjectivation of the citizen. His analyses illustrated the ways the citizen has become subject to powers and structures that, to a large extent, they are not conscious of. For example, as Baert (1998) explains: '...structures tend to be taken for granted by the individuals who are subjected to them, and these structures are therefore unlikely to be visible to them' (p. 122).

In precisely this manner, this analytic stance enabled our research to uncover the powerful disciplinary structures in Ireland's health system to which Irish citizens and patients have become subject. Much of this power is identifiable within the related discursivities, as much as it is in the equally telling silences that have succeeded in constituting a discourse in themselves. Powerful silences have been identified in Ireland's history surrounding revelations of institutional child sexual abuse, clerical child abuse, the Magdalene Laundries, forced adoption and other abuses by powerful actors. Discourses and silences such as these were submitted to Foucauldian genealogical analysis in this research.

8 | DISCOURSES

If we are to use this approach to examine health and health policy, what discourse will constitute our data? Foucault's attention to the richness of discourse as a site of power is a unique feature of much of his work. Discourse can encompass 'what can and cannot be known and said about a particular issue—what counts as knowledge and 'truth' in specific social and historical contexts' (Walker, 2002, p. 18).

In contrast to linguistic researchers' use of the term, Foucault's conception of discourse was as a more potent site of power relations or as regimes that impact on human conduct (Björnsdóttir, 2002). Such histories have a perpetual nature and are thus not bound by periods of time. He described discourse as '...the general system of the formation and transformation of statements' (Foucault, 1969, p. 146). So, in effect, he regards discourse not only as a site for examination of power relations, but also as an instrument of power wielding, an action and an outcome, so to speak. The historical approach involves the process of investigating the archives of such discourses (Kendall & Wickham, 1999). Power (2011) describes these discourses very clearly:

> Statements or propositions (énoncés) are the basic units of discourse, and their totality comprises discursive formations that are the conditions of possibility of thought and hence of action. Specific discursive formations, or epistemes, create positions for subjects to occupy and in which they may be authorized to speak... (p. 38).

Discourses surrounding health care, for the purpose of this research, represent the corpus of organised and diverse spaces that have enabled the appearance of an understanding of the very concept of health care. This is made up of formal and informal knowledge from numerous domains. Discourses relating to the aetiology of illness, health behaviours and 'responsibilisation' (Brown & Baker, 2012) are discursive formations that provide useful models of power. Authoritative attempts to attribute poor health to 'cultural' practices and traditions rather than to the poverty of minority groups and the structural inequalities to which they are subject fail to acknowledge the circumstances of history and racialising practices (Browne et al., 2012; Lynam, 2007). Neglecting these truths so as to instead engage in responsibilisation of the individual shifts attention away from the systemic structural issues that constrain some groups and privilege others (Browne & Reimer-Kirkham, 2014; Lynam & Cowley, 2007).

Pertinent discourses on health care have emerged from a broad range of sources, both formal and informal, for example health care policy efforts, health care legislation, letters and commentaries in media, opinion polls and surveys, mission statements of charitable organisations, private hospitals and public hospitals, commercial advertising of health care products. All of these constitute powerful discourses. Furthermore, the political thinking of those in power is evidenced in government reports, political materials, submissions by lobbyists, statements made in the houses of parliament, and opinions expressed by policy-makers. More informal sources include statements and opinions of health care users, publications and websites of health care activist groups, and opinions expressed in informal online fora relating to health care and related politics. Such a wide range of discourses, constituting the 'data' for analysis, chronicles the emergence of influential contingencies (Foucault, 1969), and all contribute to a rich tapestry of social and professional opinion which enables the distinction of the early shoots of the contemporary situation.

9 | DISCONTINUITIES AND CONTINGENCIES IN IRISH HEALTH CARE

In a genealogical analysis, the 'data' for analysis takes the form of particular key 'events', 'contingencies' or points of 'rupture'. In the case of this research, these are events in Irish health care, which have

forever altered interpretations and knowledge within both the formal (*connaissance*) and the informal (*savoir*) domains of concept formation. For the purpose of this research, a limited number of contingencies were chosen so as to allow sufficient depth of examination. These events, which have been instrumental in the transformation of the subject of Irish health care into its currently individualised form, were considered systematically so as to illuminate the core research questions posed. Some of these events have become almost metaphorical instruments in illustrating the failures of Ireland's health care and, more specifically, the manner in which the discourse has validated Irish conceptions of justice and fairness, of reciprocal social relationships and of solidarity through a social contract.

The genealogical approach offers an alternative to a traditional research approach thus necessitating different approaches to sampling. Genealogies are purposefully selected as they offer appropriate exemplars for an analysis of the phenomenon in question. Each genealogy represents a discontinuity in the history of Ireland's health care system, and it is as a result of the layering of the attendant discourses that Ireland has the health care system that it has today. The nature in which Irish people were historically considered and conceptualised by those in power (the church, the medical profession, the government, the policy-makers) has, it is hypothesised, contributed significantly to the public's understanding of what it is that a health service should be, what it is that Irish people are entitled to, the actuality of a social contract between citizen and state and, ultimately, what value is placed on health and health care in Ireland.

In this study, four specific paradigmatic genealogies were examined: first, an event from the 1950s, when the Minister for Health Dr Noel Browne attempted to introduce free health care for mothers and children ('The Mother and Child Scheme') but his efforts were met with vigorous and coordinated opposition from the Catholic Church and the medical profession. The second case involved the contamination with Hepatitis C of blood products, specifically the 'Anti-D' product given to women after delivery, the consequent scandal and the subsequent mistreatment of the infected women between 1994 and 1997. The third genealogy related to the government's decision to expand the market of Irish private health provision beyond that of the 'Voluntary Health Insurance' (VHI) scheme which had enjoyed a monopoly in this area until the passing of the Health Insurance Act in 1994. The final emblematic event used was the high-profile case of a woman called Susie Long, a patient who went public about the critical delay in the diagnosis of her bowel cancer, which would not have happened had she been a patient with private health insurance. Her cancer was not treatable by the time the diagnosis was made, and she subsequently died in 2007 leaving a young family behind. It is beyond the scope of this paper to elaborate on each of these as this paper focuses instead of methodological matters.

10 | GENEALOGICAL INSIGHTS

A number of writers have provided excellent accounts of Irish health care in an empirical sense (Burke, 2010; Wren, 2003); however, this research differs from these accounts in that it sought to emphasise the way in which Irish health care became constructed from the discourses surrounding it. This research also differs in that it illuminates the implications of Irish health care's configuration in the context of a social contract and the gift relationship. Furthermore, this examination identified the interrelationships between contesting discourses of policy, state, church, charities and people. Distinct hegemonic influences can be seen to have been influential in the creation of Ireland's health care system. The current construction of health care in Ireland is frequently described as being unique and thereby incomparable to neighbouring systems. However, it is the very establishment of this unique situation that warranted deep and systematic examination from a genealogical, Foucauldian perspective, revealing as it does critical sources of power and their discourses.

While Ireland's health arrangements are unique, they are also exceptionally unsatisfactory, and yet they go unchallenged and largely accepted as normal despite gross inequities. Read (2009) sees the need for a challenging examination of the process of normalisation in his Foucauldian analysis of neoliberalism stating that '…the actual process by which it [neoliberalism] became hegemonic, to the point of becoming common sense, is not examined' (p. 25). Similarly (and in a not unrelated way), the ideology of individualisation and privatisation of health and social needs in Ireland has become dominant. By using genealogy, this research explored '…the historical development of various processes, procedures and apparatuses whereby truth, knowledge and belief are produced and impact on everyday practices' (Björnsdóttir, 2002, p. 5).

The disruptive potential of a genealogical approach is described by Power (2011), referring to its characteristics as '…precommitted to a kind of critical defamiliarization of the authority of the present via accounts of rupture and discontinuity' (p. 47). Such accounts can be found in the discourse surrounding health and health care in Ireland, and thus, the processes by which assumptions within these discourses have become so familiar as to be normalised and accepted were revealed in this research.

These cases served as critical examples of the use, misuse and appropriation of language, thereby demonstrating the power of particular discourses. Politicians, for example, can be seen to have taken over the language of universality in their vociferous promises in Ireland of 'universal health insurance', a term that merges what some might regard as disparate concepts. Baert (1998) describes the role of the genealogist in identifying such a process of appropriation, which he suggests occurs through the allocation of new meanings due to power struggles or contingency. With the appropriation of such discourse and vocabulary comes the usurpation of their related power.

The examination of these historical events demonstrates the long-established loci of control in Ireland, as well as what can be now seen as significant power shifts. Most significantly, the arguments, understandings and perceptions of issues surrounding health and health care in Ireland will be seen to have evolved and erupted as a consequence of the layering of each of these discontinuities and their discourses. This genealogical approach is therefore entirely appropriate here as it:

> ...facilitates a recognition of social contingence through continuities and discontinuities, while acknowledging the importance of identifying points of origin and rupture via an attentive analysis of the mythical and symbolic language through which they are formulated and narrated
>
> (Salvatore, 2007, p. 26).

Our own philosophical stance is one that views inequities as unjust. We find ourselves seeking an analytic perspective that not only guides the examination of the contexts that accord power and resources to particular groups, but one that could also illustrate how the resulting tacit and manifest structures (including discourses of individualism, and responsibilisation) could be made visible and thus redefined to address inequities. We sought to ask the following: Why, and how, have we compromised on the ideal state, distorting the social contract that provides for its weakest members? How is the collective conceptualised in contemporary societies? How has the discourse of politics and policy influenced conceptualisations of the collective in the context of health care?

11 | METHODOLOGICAL CHALLENGES

It has been suggested by some that it is notoriously difficult to 'apply' Foucault's approaches to contemporary research, not least because he repeatedly refused to refer to archaeology and genealogy as research 'methods' per se. Furthermore, interpretation of Foucault's work is often challenging as his thinking is abstract, dense and complex requiring repeated reading (Scheurich & McKenzie, 2005). There are, therefore, many traps that a Foucauldian approach might seek to avoid. The temptation to explain or provide causality would appear to be the primary risk for a researcher new to Foucault's methods and more used to empirical research. This approach should not seek to explicate contingencies, so much as to explore the historical development of the related discourses and practices. Kendall and Wickham (1999) advise the Foucauldian scholar to 'break the habit' of looking for causes and instead to consider contingent relationships.

Walker (2002) also outlines the challenge of using Foucault's concepts in her genealogy of equality, and she identifies the '...risk of oversimplifying his approach and of selecting one part of his work to the neglect of other aspects' (p. 17). However, evidence from the literature would suggest that his genealogy has proven to be more popular among scholars as an adopted approach than his archaeology, despite the fact that a more substantial portion of his writing referred to an archaeological approach than to a genealogical method. Scheurich and McKenzie (2005) suggest that genealogy appeals more to scholars as it 'is more like a set of critical tools that can be used', whereas the archaeological method 'is dependent on a highly structured, highly interrelated set of constructs, all of which need to be deployed together to actually do an archaeology' (p. 857). In his lecture series at the College de France, published together as 'Society Must Be Defended', Foucault encourages us to use 'disorderly and tattered genealogies' (Foucault, 2003, p. 10) to explore hierarchies of knowledge and subjugation. Despite the challenges of this methodological approach, a Foucauldian genealogical approach should be considered appropriate, particularly where powerful voices are at risk of dominating the discourse and establishing inadequately challenged 'truths'.

12 | CONCLUSIONS

The adoption of a genealogical method to this research provided a novel approach through which an examination of the historical origins of Irish health care was performed. The manner in which genealogy seeks to challenge that which has been taken for granted, and to question long-held assumptions that have been repeatedly represented as fact in lasting systems of discourse, strengthens the selection of this approach. Having employed Foucault to examine this health system, the manner in which power sustains inequity is revealed.

Contemporary public perceptions and conceptions of health are not without origin. It is hypothesised that the current tolerance of, or acquiescence to, an unjust and unequal health care system has its roots in the archive of neoliberal discourse and other influential discourses of power that have sought to individualise issues surrounding health in Ireland. Individualised approaches to public health and health promotion can be seen to be a consequence of neoliberalised discourses within the domain of health care. An understanding of the origins of powerful discourses, such as these, is vital to a deeper understanding of health inequalities and is instrumental in equipping researchers and practitioners with appropriate critical skills towards addressing inequities and challenging the status quo. For example, this analysis enables Irish health care to be conceptualised outside of the traditional framework that individualises responsibility for health.

A further benefit of this approach to understanding the origins of a health system is one that should be used to broaden the perspective of health professionals' education. Those who will work within a health or social system should have an opportunity to develop critical insights into these systems and should be encouraged to question the prevailing assumptions that serve to sustain injustices through an endorsing discourse.

Other researchers in the field of health can similarly take up and examine particular moments of critical importance to health care and can identify them as critical junctures. This approach will reveal moments when a critical perspective can emerge and when opposing discourses can be seen to exercise power in crucial relations. The wide range of robust literature drawn upon in this article serves to demonstrate the substantial suitability of the genealogical approach for research of contemporary problems within health care that relate to issues of power, and the attendant discourses awaiting a rich illustrative analysis.

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