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Problematizing loneliness as a public health issue: an analysis of policy in the United Kingdom

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ABSTRACT

This article presents an analysis of discourses in recent UK policy on loneliness reduction. We use Carol Bacchi's 'what is the problem represented to be' approach (WPR) to explore how the problem of loneliness produces specific solutions, subject positions, and forms of responsibility. Our findings suggest loneliness is understood as a public health threat that both emerges from and causes ill health. Using Foucault's concept of governmentality, we argue that policy discourses construct loneliness as a problem requiring governance to minimize health 'risks.' Loneliness is problematized as creating strain on health and social care systems, as well as the economy by reducing productivity. The projected 'costs' of loneliness are managed via social prescribing. Social prescribing positions GPs and link workers as guides whose role is to transfer lonely subjects away from costly healthcare settings and toward the civil sector. The policies are produced in a context of continued budget cuts which we propose may threaten the effectiveness of projects like social prescribing. Social determinants of health, closely tied to loneliness, are largely left unaddressed in favor of solutions that individualize and responsibilize lonely citizens.

KEYWORDS

Loneliness; public health policy; governmentality; Foucault; WPR

Introduction

In 2018, then Prime Minister Theresa May appointed Tracy Crouch as the UK's first minister of loneliness. Along with the creation of this new ministerial post, several policy strategies addressing the phenomenon of loneliness have been released. Loneliness has not only become a problem for policy in the UK. Norway, Japan, Denmark and the US have established ministers, strategies, policies, or reports focused on tackling loneliness as an 'epidemic'. Considering that the UK is often cited as an inspiration for these political approaches (Department for Digital, Culture, Media & Sport, Office for Civil Society, and Baroness Barran 2021; Ruud 2018), an analysis of the British case can prove instrumental.

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What about the problematization of loneliness makes it an issue that warrants a minister and multiple policy strategies? Our analysis reveals that loneliness is represented in policy as a threat to public health. This article argues that the framing of loneliness as a public health problem emerges in response to concerns about the financial strain it places on health and social care services and its impact on economic productivity. In response to this problem, public health approaches and social prescription schemes become techniques of neoliberal governmentality.

Loneliness has long figured in our social imaginaries via literature, philosophy, and art. Later, the phenomenon has become framed in terms of health, particularly in psychology and mental health discourses (Alberti 2018, 2019; Gibson 2000; Mijuskovic 2012; Snell 2017). Alberti argues that loneliness is historically and culturally contingent and that such an analysis facilitates an understanding of how loneliness becomes 'invented' as a specific health problem (Alberti 2018). Loneliness has previously been seen as an individual problem, one solved within the family, or, in only the closest of communities (Flora 2019; Ozawa-de Silva and Parsons 2020).

Conversely, we might ask why loneliness has become a problem for policy at this juncture. We pinpoint three instigating events in the 'history of loneliness' as a political problem in the UK. First, The Yorkshire Times launched an influential campaign in which it called loneliness 'the hidden epidemic' in 2014. This initial framing of loneliness as an epidemic has since taken hold amongst policymakers and other actors (UK Parliament 2016), making it a key event in the modern conceptualization of loneliness as a policy issue. Second, through a series of policy recommendations, researchers in the UK have successfully framed social isolation, and subsequently loneliness, as a medical problem in need of policy solutions. Finally, we cannot underestimate the role the tragic murder of Labour MP Jo Cox has had on the issue of loneliness in the UK. Prior to her death, Cox made loneliness reduction her mission, establishing the Jo Cox Commission on Loneliness. Following her murder, the political drive to continue the work was firmly cemented.

Theoretically, we draw upon Michel Foucault and his use of the term governmentality (Foucault 2008, 2009). We argue that loneliness has become an object of specific governmental practices and 'styles of thoughts' (Dean 1994, 2012; Rose and Miller 1992) aimed at governing loneliness as a public health issue. Methodologically, this article uses Carol Bacchi's 'what is the problem represented to be' (WPR) approach (Bacchi 2012, 2015; Bacchi and Eveline 2010; Bacchi and Goodwin 2016) to critically examine how the problem of loneliness is represented in a corpus consisting of 20 policy documents from the UK. The corpus contains documents from both the national and local level, explicitly dealing with loneliness. This article aims to explore how loneliness is represented as a problem; what underlying assumptions about loneliness can be traced in the corpus; what is left unsaid about the problem of loneliness; and what effects are produced by this representation of the problem (Bacchi and Goodwin 2016). Using Bacchi's framework, we will show how the problem of loneliness becomes productive, producing various solutions, subject positions, and forms of responsibility. We are not so much interested in why loneliness is a problem, but rather, in what happens when it becomes a problem for and in policy, and what governing practices and rationalities are enacted in the name of 'solving' loneliness. By studying problematizations of loneliness

(Barnett 2015) in policy, we are better equipped to discern what unintended consequences may arise and to give voice to silenced issues within dominant problematizations.

Theoretical framework and methodological considerations

Studies on governmentality often start with the following dictum from Foucault, that governmentality is the art of 'how one conducts the conduct of men' (Foucault 2008, 186). Elaborating on this, Foucault unpacks how the word 'government' should be understood in connection to governmentality:

> This word must be allowed the very broad meaning it had in the sixteenth century. 'Government' did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or groups might be directed – the government of children, of souls, of communities, of the sick [. . .] To govern, in this sense, is to control the possible field of action of others. (Foucault 1983, 221)

Some have later pointed out that the meaning of government comes more to the fore in the French, as it can mean to direct or move forward, or 'to provide support for.' It can take on a moral meaning of 'to conduct someone' in a spiritual sense or, tangentially, to 'impose a regimen' (on a patient, perhaps) or to be in a relationship of command and control (Sokhi-Bulley 2014). In addition to signifying a method of conducting the conduct of people, governmentality also describes a way of thinking about government and managing the conduct of people; a set of 'governing rationalities', as several authors have called it (Dean 1994, 2013; Rose and Miller 1992). It is by now well-known that governmentality is a play on words, fusing the words governing and mentality into govern/mentality. Sokhi-Bulley has described governmentality as that which 'refers to both the processes of governing and a mentality of government – i.e. thinking about how the governing happens' (Sokhi-Bulley 2014). It is then both an 'art', that is, various practices concerned with governing the conduct of people, and a set of rationalities, i.e. a way of thinking about governing the conduct of people. Policies as sites of governmentality are excellent entry points for the analysis of both suggested practices of governing people and how governing rationalities are enacted.

As an extension to this more general framework of governmentality, we also engage with scholarship on various 'techniques of governmentality' which aim at governing a certain problem in a certain manner. Examples of this would be how certain 'thought styles' or 'styles of reasoning' (Amsterdamska 2004; Hacking 1994) become utilized in governing health problems in policy. A case in point when it comes to framing loneliness as a public health issue would be to look at what forms of scientific rationale or reasoning are utilized in constituting the problem and what kinds of logics underlie its proposed solutions. One example would be the utilization of what Reubi has called 'epidemiological reasoning' (Reubi 2018). Another concerns the making of 'pastors' that shepherd citizens toward responsibilization in matters of their own health through an edict of self-care (Waring and Latif 2018).

Another important governmental technique which has become key in governing public health is the increased reliance upon discourses of risk in public health policies. The turn from 'danger' to 'risk' and from 'faith/luck' to 'calculation' has been well

documented in research (Douglas 2013; Hacking and Hacking 1990; Porter 1986, 1996). This in turn has produced a stream of research on how certain groups come to be seen as being 'at risk' and the governmental aspect of the construction of risk groups within public policy (Møller and Harrits 2013; Schroeder et al. 2022). The governmentality of public health relies upon and continuously recreates a division between 'normality' and 'abnormality' in the population through various techniques and styles of reasoning, a key point both in the work of Canguilhem (2012) and Foucault (2003).

Finally, the turn toward the economization of human life and health (Kenny 2015; Murphy 2017) is another stream of analysis which fits suits our analytical lens of the governmentality of loneliness. The economization of public health can be envisioned through 'disability adjusted life years' (DALYs), 'quality adjusted life years' (QALYs), and issues around 'human capital' and productivity (Kenny 2015; Villadsen and Wahlberg 2015; Wahlberg 2007; Wahlberg and Rose 2015). We will draw on many of the insights in the above to refract our analysis and map how loneliness has predominantly become a problem of public health and economic cost to society in policy.

Data material and analytical tools

The material that this analysis is built upon consists of policy documents from the UK on the problem of loneliness from the period between 2016 and 2021. The documents represent different scales of governance, ranging from national to municipal strategies. Searches were conducted using Google, uk.gov, the Commons Library, ageuk.org.uk, and local.gov.uk to locate relevant policy documents. Policy documents were additionally discovered through a snowball methodology, by following citations from policy documents that we previously located. We should note that we did not conduct a diachronic analysis to map changes over time, nor did we trace differences based on the geographical origin of the policy documents. While the COVID-19 pandemic has indeed spurred on a renewed focus on loneliness, we did not focus on the pandemic in this article, although such an endeavor is well worth following up. Finally, we limited our empirical material to documents produced by national or local authorities, as our primary interest lies in official UK policy. While it would have been interesting to explore how other actors represent the problem of loneliness, this is not explored here due to space considerations. Therefore, we did not look at how NGOs represent loneliness, nor did we examine how different professions (patient groups, doctors, social workers, etc.) conceptualize the issue of loneliness.

Through our search, we amassed 20 policy documents. These documents were subsequently uploaded to the Sketch Engine (Kilgarriff et al. 2014) online software for semi-automated corpus analysis. Corpus-assisted discourse analysis has emerged as a viable option for combining quantitative, semi-automated analysis with qualitative close reading and analysis (Jones and Collins 2020; Mautner 2009). However, we departed from this method, instead using the software analysis as a point of entry to locate linguistic trends in the material. Thereafter, we engaged in a more classical close reading and coding of the material using thematic coding to examine what the problem is represented to be. In doing so, we wanted to ensure we could 'reveal the degree of generality of, or confidence in, the study findings and conclusions, thus guarding against over-

or under interpretation' (Baker et al. 2008, 297). Using the software as a point of departure, we first generated frequency lists to discern the most used terms. In this case, we generated three frequency lists: a list of the 300 most frequent nouns, the 300 most frequent verbs, and the 300 most frequent adjectives. In corpus linguistics and corpus-assisted discourse analysis, there are several strategies for setting a cutoff point for frequency lists. We followed Mona Baker's insights on the benefits of generating large frequency lists (Baker 2020) and then identified words that produced thematic clusters of frames. After generating the frequency list, we examined the most common collocations of the keywords using the collocation function in Sketch Engine. This was to get a sense of the context in which the keywords were used. After the collocation analysis was conducted, we next used the concordance lines function to map the co-text of the thematic clusters and their words in more detail. Concordance lines is an analytical tool in the Sketch Engine program that extracts sentences and the surrounding paragraphs containing a specific keyword.

From this, we analyzed the thematic context of the keywords. Because we were interested in how loneliness becomes a particular type of problem, we utilized Bacchi's 'what is the problem represented to be' (WPR) framework in the second and more critical analysis phase. The WPR approach 'interrogates the problematizations uncovered in public policies through scrutinizing the premises and effects of the problem representation they contain' (Bacchi 2009). Moreover, 'Bacchi maintains that problematizations are framing mechanisms, determining what is considered significant and what is left out of consideration, revealing power relations in problem representations' (Carson and Edwards 2011, 75).

Thus, our analysis and methods consist of a two-pronged approach: first using corpus analysis tools to gain an overarching familiarity with the material's predominant concerns and solutions, and secondarily, homing in on and critically analyzing the documents with the WPR approach, to discover what sort of 'problem' loneliness is represented to be in the material. The WPR approach is unique in that it focuses on what policymakers believe needs to change, encouraging researchers to begin with the solutions and work backward toward implicit beliefs (Bacchi and Goodwin 2016). Through our analysis, we determined the overarching discourse seeks to make loneliness visible as a threat to human health, first-and-foremost presenting solutions within a public health paradigm. Utilizing our two-pronged method, we focus on how:

(1) Loneliness is framed as a public health problem and what presumptions about loneliness were enacted in the policies.
(2) How 'social prescribing' becomes framed as a political and practical solution to the problem of loneliness.
(3) How the problem of loneliness is framed through risk groups and risk thinking.

In line with Bacchi, we also focus on the aspects of loneliness that are left unproblematic, as well as the discursive silences found in the texts. Finally, we examined the various 'effects' that are produced, including which subject positions are enacted in these policies when loneliness is regarded as a political problem.

Governing loneliness as a public health problem

We find several instances in the corpus wherein loneliness is clearly represented as a public health problem. For example, the following quote from the Welsh loneliness strategy states, 'We know that loneliness and social isolation can have a detrimental impact on our health and well-being and that people with poor physical and/or mental health may become more lonely and/or socially isolated because of this' (Welsh Government 2020, 36). In this representation, loneliness is represented as a public health problem linked to illness and disease. Not only can it cause ill health, but loneliness can arise from ill health, thus, the arrow of causality is said to point both ways.

As a direct correlate to the focus on morbidity caused by loneliness, the issue of mortality follows in the representation of loneliness. The English strategy states:

> Feeling lonely frequently is linked to early deaths. Its health impact is thought to be on a par with other public health priorities like obesity or smoking. Research shows that loneliness is associated with a greater risk of inactivity, smoking and risk-taking behavior; increased risk of coronary heart disease and stroke. (DCMS 2018, 18)

As we can see here, not only is loneliness tied to increased mortality, but it can also lead people to engage in behaviors recognized for their negative impact on health.

Another example can be found in the plan for South Ayrshire, where failure to maintain a healthy diet and good sleep hygiene are said to stem from loneliness: 'Additional research indicates that individuals are less likely to take care of their own health and are more likely to smoke, be physically inactive, eat less fruit and vegetables and have poorer sleep' (South Ayrshire Council and NHS Ayrshire & Arran 2018, 11). The section goes on to highlight how loneliness can be tied to dementia, depression, and death by suicide. Another strategy lists 'self-soothing' behaviors like problem drinking, overeating, gambling, falling victim to scams and abusing prescription medicine among loneliness' health (and economic) impacts (North Somerset Council 2019, 17).

Understanding how widespread loneliness is also becomes a concern, with several strategies calling for the creation of national loneliness measures among their proposed interventions. The Scottish loneliness strategy offers one example: 'One of the starting points for developing this draft strategy was therefore gaining a comprehensive understanding of the prevalence of social isolation and loneliness in Scotland' (Scottish Government 2018, 20). Here, government must acquire knowledge on how 'prevalent' loneliness is in a society, drawing from epidemiological terminology and calling for epidemiological studies of the phenomenon. Through this, loneliness becomes a public health problem inscribed with a particular logic, based on 'epidemiological reasoning' (Reubi 2018). This form of reasoning builds on a logic that sees social and health problems as objects that can be counted and made visible through practices of statistical calculations and the use of social surveys. They are then made amendable through interventions based on epidemiological surveillance information (Reubi 2018).

In the above, loneliness is represented as a problem which has the potential to drain the population of its vitality, both in terms of morbidity and mortality. As such, the governing of loneliness, or the conduct of conducts, must counteract the detrimental effects of loneliness on population health. However, biopolitics implies not only a focus

on health, disease, and illness but also how these become refracted through a form of 'economization of life' (Murphy 2017). Examples of this can be found in quotes from North Yorkshire's strategic framework, which emphasize recent research findings:

> Further research has uncovered that [sic] the financial price on what has been branded an 'epidemic of loneliness' estimating that it costs £6, 000 per person in health costs and pressure on local services. One study estimates an individual may cost commissioners £12,000 or £60 million for a cohort of 5,000 older lonely people. (The Loneliness Campaign North Yorkshire 2019, 61)

Moreover, a report from the House of Commons Library cites results from a DCMS-commissioned monetization report on loneliness which found 'the wellbeing, health and work productivity cost associated with severe loneliness (feeling lonely "often" or "always") on individuals was around £9,900 per afflicted person per year' (Simetrica in Macdonald & Kulakiewicz 2021, 21). The economization of loneliness is here represented through cost calculations and estimates of the cost of loneliness and a subsequent loss of productivity. The burden imposed on the healthcare sector also becomes part of this cost calculation. In this case, the economization of loneliness is conducted by calculating a multitude of associated costs linked to loneliness. Through this, it represents the cost of loneliness as one which goes well beyond the individual and the healthcare sector.

In another example, the Local Government Association's guidance for municipalities reports: 'a scheme to identify the most lonely and isolated resulted in savings to Gloucestershire health and social care services totaling £1.2 million, with every £1 that the scheme cost, the return on investment is calculated to be £3.10' (2018, 7). Once again, we see an economization of loneliness and how it is translated into quantitative metrics such as 'return of investment', 'accessing peoples' economic capital', and 'cost effectiveness'.

An important point in terms of the governmentality of loneliness lies in how loneliness becomes 'seen' or known as a public health problem. In the examples we shared, the governmental techniques used to represent loneliness are drawn from epidemiological thinking, economic modes of calculating cost and neoliberal notions of cost effectiveness. Through techniques such as calculations of cost estimates and the use of epidemiological data, loneliness becomes a problem at the population level. Loneliness is represented not only as an economic problem due to the cost it incurs upon the healthcare system, but also in terms of its cost due to absenteeism from work and the use of welfare programs. This leads us to the next issue: if loneliness is a public health problem in need of governing, what solutions are proposed and what forms of governmentality are needed to solve the problem as envisioned in the policy documents?

Social prescribing as a technique of governmentality

The most common governmental technique for governing loneliness within the public health paradigm is the practice of social prescribing. Social prescribing enables health professionals to refer patients to one of many existing of connector services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs (general practitioners) or nurses. Connector services are staffed by 'link workers' who determine the individual's needs and match them with relevant programs

in the community. Social prescribing may be initiated at the GP's office, but the treatment lies beyond the healthcare sector. It is instead found in local community services, including NGOs and private organizations, further reducing costs.

Social prescribing is represented as a solution to the problem of loneliness and social isolation in that it seeks to 'prescribe' sociality to people who suffer from loneliness. Moreover, 'social prescribing can involve a range of activities that are typically provided by voluntary and community sector organizations. Examples include volunteering, art activities, group learning, gardening, befriending, cookery, healthy eating advice, and a range of sports' (Buck and Ewbank 2020). We argue this definition of social prescription serves to represent loneliness as a public health problem, but one which presents in the clinic and is then transferred outside of the healthcare system. The initial point of departure is the GP's office, yet, by highlighting the role of the volunteer sector and community organizations, the governmentality of loneliness also involves reducing burden on the healthcare sector, making loneliness the shared domain of the volunteer sector and NGOs. In this way, the problem of loneliness becomes productive: it produces new responsibilities for diverse actors to join the cause of solving the public health problem of loneliness and opens space for new actors to intervene (and, as we might infer from this, monetize the problem of loneliness). However, while some research indicates loneliness may be reduced via social prescribing, at least in the short term (Foster et al. 2020), overall, the evidence to support social prescribing is weak (Bickerdike et al. 2017).

Citing a study from the Campaign to End Loneliness, the Healthwatch Brent[1] report highlights how 30% of GP visits stem from loneliness. Social prescribing is then described as producing opportunities:

> There is a currently a 'once in a generation' opportunity, through new Link Workers and Social Prescribers in GP practices and networks, funded by NHS England, to make a significant contribution to reducing social isolation and the related costs to the system. This can be achieved if it is carefully considered by the sector as a whole. (Healthwatch Brent 2019, 3)

In this segment, GPs and the wider healthcare sector are framed as being in a special situation because they meet people who suffer from loneliness daily. It also indicates that they have a fundamental role in healthcare cost reduction.

Moreover, we have the following narrative from a constituent cited in the Local Government Association's implementation guide:

> One day feeling my life was worthless, I visited my GP. She said she had heard about a new thing called 'social prescribing'. She did not offer me pills. This was great! [. . .] Now I have friends, I go out for meals; I've been on day trips to the coast, the animal park and other places. (Local Government Association 2018, 21)

Since loneliness is represented as a public health problem, it might not seem strange that the recommended point of delivery of services to 'solve' the problem is the GP's office. Thus, doctors are construed as frontline staff, tasked with recognizing loneliness in their patients (DCMS 2018) and referring them to NHS-funded link workers for appropriate interventions (NHS 2021).

These policies link social prescription to public health by seeing it, not only to restore social contact, but health and wellbeing, as evidenced in this quote from the Welsh strategy:

> Well-being or social prescribing services offer people a wide range of support within the community, improving emotional and physical well-being and reducing loneliness and social isolation. The services are provided often by people working and volunteering in the third or independent sector, complementing the role played by statutory organisations. (Welsh Government 2020, 22)

The quote again demonstrates how responsibility for relieving loneliness is transferred from the public to the civil sector in a strategic move to reduce healthcare costs.

Governing loneliness through risk thinking: the production of subjects at risk of loneliness

An issue to consider in the governmentality of loneliness as a public health problem is how, although anyone can fall victim, certain groups are constituted as being at increased risk of loneliness. A typical example of this is found in the Scottish strategy, which states, 'We know specific groups within the population will be at greater risk of experiencing social isolation or loneliness. We also know that it can potentially impact everyone at every age and stage of life' (Scottish Government 2018, 11). While the strategies feature a greatly expanded field of lonely subjects, some are conceptualized as being at particular risk. Some may assume that this expansion in lonely subjectivities emerged due to the COVID-19 pandemic, but this and other documents from the corpus demonstrate that the shift had already begun several years prior.

The strategy from North Yorkshire again draws on the Campaign to End Loneliness, stating that there are 'wider societal risk factors for older people too: a lack of public transport; physical environment (e.g. no public toilets or benches); housing; fear of crime; high population turnover; demographics and technological changes' (The Loneliness Campaign North Yorkshire 2020). Similarly, the London Borough of Hammersmith and Fulham strategy states:

> Social isolation is a health inequalities issue because many of the associated risk factors are more prevalent among socially disadvantaged groups [. . .] deprived areas often lack the adequate provision of good quality green and public spaces, creating barriers to social engagement, exacerbating efforts to adopt and sustain healthy behaviours and prevent further deterioration of health and wellbeing. (London Borough of Hammersmith and Fulham 2017, 7)

Special consideration is also given to unemployment as a risk factor for loneliness, citing research which pinpoints that 'unemployment increases the risk of social isolation' (London Borough of Hammersmith and Fulham 2017, 4). The document goes on to stress that unemployment is higher among those of minority background and those facing long-term illness or disability. This again ties the issue to socially disadvantaged groups. A surprising finding was that although tight budgets resulting in the loss of public infrastructure and public spaces are addressed, only rarely is direct mention of austerity made in British political discourse on loneliness.

Other key risk groups in the policies include older adults, young people, carers and the recently bereaved. Through such governing, the policies produce boundaries between those deemed at risk and those deemed not at risk of loneliness. As Foucault has argued (Foucault 1983), such processes of boundary drawing between different population groups can be seen as a form of subjectification effect. In this sense, the governmentality of loneliness relies upon the social construction of 'target populations' (Schneider and Ingram 1993).

By drawing a dividing line between the above-mentioned groups and the 'normal population', the risk discourse produces population groups understood as being at risk of loneliness. These groups subsequently become 'target populations' for interventions aimed at governing loneliness. Moreover, as Møller and Harrits state:

> [E]ven though we are dealing with a policy of 'help' – as preventive policy is at least in contrast to punitive policies – to help someone is also to intervene in someone's life, and the discourse on help thus implies a construction of risks and problems as a legitimization of state interventions in the lives of certain social groups. (2013, 158)

Through their perceived risk of loneliness, these at-risk populations become transformed into target populations in need of governmental practices to reduce the effects of loneliness. As we have previously seen in examples on social prescribing, this represents an effort to guide them out of loneliness and reintegrate them into the social sphere.

Discussion: silences, effects and alternatives

The literature on governmentality shows how the governing of public health has expanded to include a broad range of health issues; from the governmentality of obesity (Powell and Gard 2015) to the governmentality of epidemics (Bashford 1999) and drug use (Fischer et al. 2004). Our study shows how this expansion subsumes what was before seen as an intra-personal state, (re)producing it as an object of policy and strategy. Loneliness, now understood as a public health problem, firmly locates the phenomenon within a paradigm of biomedical and psychological knowledge. Thus, loneliness is increasingly understood as a biopolitical problem (Foucault 1990, 2008), rather than as an emotion for the individual to confront through various 'technologies of the self' (Foucault 2012). Such a discursive turn produces subjects who not only *feel* lonely but who also *suffer* from loneliness. The phrase not only means to metaphorically suffer emotional anguish, but also to suffer physically, as loneliness harms the very body and health of the individual.

We have shown how loneliness is not only argued to drain the population of health; it is also problematized as incurring a financial cost to society, depleting health and social care services. These representations of loneliness imply that the state must act to reduce loneliness in the population as an economic necessity. However, this also implies a form of economic thinking that plays on 'the self as an entrepreneur and the state as a firm and prescribes the conduct for both according to a logic of optimizing future rates of return on investment, especially through practices of self-investment' (Kenny 2015, 14).

Indeed, the cost calculations found in the various documents represent loneliness as a problem not only of public health, but of productivity and the economy. This representation of loneliness is in line with scholarship which focuses on the 'economization of

life' (Murphy 2017). It also demonstrates the ways in which practices of quantification have come to influence policies, and even how we understand value and what it means to live a 'valuable life' (Wahlberg 2007; Wahlberg and Rose 2015). Refracted through governmentality, the onus is on governing the behavior of people, guiding them toward making healthy choices that will reduce the 'burden' of loneliness, here associated with various costs to society. This also redistributes responsibility, making it paramount for individuals who suffer from loneliness to partake in mitigating activities.

By highlighting the human cost of loneliness in terms of mortality and morbidity, as well as the financial loss and reduction in productivity, loneliness policies make the case for investing in programs that reduce loneliness. However, they also must do so in a cost-effective manner. This investment relies upon a governmental practice in which people must be made to take action, investing in their own health and behavior to reduce 'risks' associated with being lonely. The loss of productivity and life-years due to loneliness can be read such that the state seeks to avoid the cost of caring for people who suffer from loneliness, while simultaneously seeking to maximize the number who are productive. Health then becomes a form of commodity (Kenny 2015), and loneliness represents a risk to the 'human capital' embedded in the bodies of the lonely. Kenny states:

> [W]ith health imagined as a form of human capital, the length of one's life becomes the result of investing, or failing to invest, in one's own health. Death is no longer a disease outcome, it is rendered a decision outcome; a decision outcome that the future-oriented, risk-minimizing economically maximizing rational actor should, obviously, avoid through self-optimizing practices of investing in one's own health. (2015, 21)

Loneliness is then placed within the frame of individual risk, personal responsibility, and the construction of risk groups, a framing which is well-described within the research literature (Lupton 1993, 1995; Schiller, Crystal, and Lewellen 1994). Thus, the governmentality of loneliness in policy calls not only for investments at the state-level, but also investments made by the individual via behavioral change to abate the risk of loneliness.

In the policies, we see how subjects are divided and made into governable subjects: those who are at increased risk of loneliness and those who are not. This process can be seen as producing what Foucault called 'dividing practices' (Foucault 1982). These dividing practices act within the analytical framework of governmentality (Gordon, Burchell, and Miller 1991; Lemke 2002), to 'separate groups of people from one another and [. . .] produce "governable subjects divided within themselves"' (Bacchi and Goodwin 2016, 23).

Despite its benevolent intentions, governing loneliness as a public health problem introduces individualizing interventions into the lives of people deemed to be at risk of loneliness. Because loneliness is represented as a biopolitical problem of both health, and subsequently, the economy, social prescription can be seen as a governmental practice that reduces state expenditures on the ill health loneliness causes.

The illustrative quotes we presented offer powerful examples of how loneliness becomes implicated in a specific form of governmentality. This governmentality provides prescriptive instructions to restore social contact, directing the conduct of those who suffer from loneliness so that they become reintegrated into the community. As such, the governmentality of loneliness is also contingent upon a certain form of pastoral power (Foucault 1983). Foucault locates his genealogy of pastoral power in

the Christian world, where its core function lay in the pastor's power to guide the flock and the individual toward salvation in the afterlife. However, within the modern era, salvation was not to come in the next world. Instead, salvation became a secular enterprise, not so much of the soul, but of various secular aspects of living. In the modern regime, salvation comes to take on different meanings: health, well-being, security, and protection against accidents (Foucault 1983, 215). In our case: protection against the harms of 'chronic' loneliness.

No longer just confined to the pastor, pastoral power is now exercised by the state apparatus, the police, private ventures, welfare societies, medicine, and public institutions such as hospitals and healthcare systems (Foucault 1983, 215). Pastoral power functions by providing guidance, offering counsel for the sustenance and betterment of lives in the here and now, rather than in the afterlife (Foucault 1983; Howley and Hartnett 1992). Social prescription can be understood as a form of pastoral power, as well as an extension of the GP's dominion. The governmentality of loneliness, as enacted through social prescribing, makes GPs responsible for guiding and counseling people toward sociality and reintegration into the community. This is to both alleviate suffering and reduce the burden on the hospital sector in the name of cost effectiveness. It additionally produces subjects who are encouraged to 'confess' their loneliness to the GP-cum-pastor to receive salvation.

We might infer that at a higher level that social prescription is also about ensuring people are kept in *productive social circulation*. It this way, the governmentality of social prescribing implicitly states that by reintegrating lonely people into the community, they will become productive bodies, or at a minimum, bodies that do not represent an economic burden upon the state. This burden, as we have seen, is enumerated through a broad range of cost calculations. Social prescribing is represented as counteracting the loss of productivity and reducing the mortality and morbidity associated with loneliness. With its focus on integrating lonely people into various activities, social prescription seems very much focused on producing productive bodies through the social activities that are prescribed. Patients are essentially expected to progress from being 'docile sheep' to responsibilized, 'proactive' agents of self-care (Waring and Latif 2018).

Loneliness is closely tied to social determinants of health in the corpus. Other authors have pointed out that one consequence of social prescribing is that it individualizes social determinants of health (Mackenzie, Skivington, and Fergie 2020). 'Downstream solutions' to 'upstream social issues' create solutions that place the onus on individual behavioral change (Scott-Samuel and Smith 2015). Several scholars have argued that programs encouraging individual change cannot solve the core issues at play in social determinants of health and therefore amount to wishful thinking (Jones 2018; Mackenzie, Skivington, and Fergie 2020; Scott-Samuel and Smith 2015). Individual interventions like social prescribing easily gain cross-party support. They also show results within an election cycle, making them appealing for politicians. However, they do not offer the fundamental societal change that may be required (Scott-Samuel and Smith 2015). They may also lead healthcare workers to see population-wide issues as matters of self-discipline. This can cause some to blame the victim for failure to comply without recognizing the broader socioeconomic issues at play (Jones 2018; Mackenzie, Skivington, and Fergie 2020).

Although rarely mentioned in the documents, austerity policy has had profound effects on the effectiveness of social prescription services. Continued budget cuts to the statutory and voluntary sector mean link workers have fewer options in terms of programs accepting referrals (Foster et al. 2020; Skivington et al. 2018; Wildman et al. 2018, 2019). Furthermore, the additional stream of referrals may overwhelm already underfunded programs (Skivington et al. 2018). For social prescribing to succeed, a trusting relationship with link workers must be built over time. However, low pay (or no pay in the case of volunteer link workers) and short-term funding mean that patients often change hands, impeding the quality of services (Foster et al. 2020; Wildman et al. 2018, 2019).

Social work has long been in decline in the UK (Lloyd et al. 2014). Research on social prescribing seems to indicate that link workers are taking up the role social workers used to play (Wildman et al. 2018, 2019), albeit with lower pay and considerably less training (Wildman et al. 2018). Social prescribing can also create dependence on link workers, which may be experienced negatively once support ends (Wildman et al. 2019). Lastly, structural issues, such as a lack of transport, not being able to afford the referred activities, or inaccessible venues have been shown to prevent participation (Foster et al. 2020). Although these structural issues are addressed in loneliness policy, previous policymaking decisions that have enhanced already-existing structural issues are seldom discussed.

Additional unforeseen challenges to social prescribing may include how physicians themselves see the intervention and their role in it. Due and colleagues found lonely patients often slipped through the cracks because of GP misconceptions, for example, believing a patient was more socially active than was the case (Due et al. 2017). Jovicic and McPherson found that GPs had no time to address loneliness in their short appointment allotments, held medicalized views of loneliness and were reluctant to address the issue due to stigma. Some did not believe that loneliness was a cause in which doctors should be involved (Jovicic and McPherson 2019). Feasibly, GPs who resent the extra time social prescribing requires or who deny it is their mandate to screen for loneliness, may refuse to adopt this form of pastoral subject position. Some patients may share the view that GPs have no place in what they perceive as non-medical issues, thereby not bringing their loneliness to the attention of GPs (Kharicha et al. 2017). All of these issues may inadvertently set up social prescribing for failure. While some studies claim that social prescribing is a cost-effective way of handling social issues like loneliness (see Foster et al. 2020), such programs may have the unintended effect of producing waste if they fail to deliver results or if the impact is only short-term.

A limitation of this study is that our corpus only extends through the beginning of the COVID-19 pandemic. A future avenue of research could be to explore if policy approaches changed following the pandemic. Another limitation is that we explore only policy from the UK here, while loneliness has increasingly emerged as a policy field in several international contexts. However, given that many countries have followed the UK's lead in the production of policy responses to loneliness, it is feasible that this study could prove illuminating in other contexts. Additionally, the UK was an early adopter of social prescribing as a remedy for loneliness. Considering that other countries have begun to adopt this approach; it will be important to understand the potential effects of social prescribing in this context when applying it to others.

Conclusion

In this article, we have shown how loneliness is represented in UK policy as a problem of public health, viewed through a lens of epidemiological thinking that divides the population into risk groups. We also demonstrated how, due to the burden its impact has on healthcare systems and productivity, it additionally becomes a problem for the economy. The governmentality of loneliness is predicted by both biopolitics and pastoral power by establishing practices that produce new forms of responsibility and behaviors. GPs are to perform as pastoral agents, guiding lonely patients toward social prescribing interventions that transfer loneliness from the realm of healthcare to the voluntary sector in the name of cost reduction. Although policymakers recognize the role of social determinants of health in loneliness, they nevertheless produce individual solutions for population problems.

Note

1. Healthwatch is an independent statutory body attending to the public's NHS experiences.

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