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Part II

Professionals in Health

Reconstructing Care Professionalism in Finland

Helena Hirvonen

Introduction

The public sector plays a special role in the Nordic welfare states through its commitment to the principle of universalism, and in relation to social security and publicly funded services in education, health and care (Rostgaard 2002). In the 21st century, the impact of economic austerity on public resources and a rapid aging of the population have forced welfare states to undergo an extreme reform. In Finland, the reform has meant streamlining the state, restraining public expenditure and recalibrating the universalistic ideals behind the Nordic welfare state model, as well as introducing new management models (Pollitt & Bouckaert 2011). The managerial reforms implemented in Finland have followed the ideology of new public management (NPM), altering the roles of the state and the clients, and influencing care work cultures, and health and social care workers' professional agency (Henriksson & Wrede 2008).

The welfare state reforms are intensified by an overlapping transition towards knowledge society. In the public service sector, this affects the professional power of public service workers. Clients and managers are now more empowered in relation to health and social care professionals, while professionals need to reassert their accountability through various audit techniques. Moreover, in 'technological societies' such as Finland, difficulties in improving the efficiency and quality of human service delivery are easily framed as technical problems that call for technological solutions (Barry 2001). Technologisation is validated by a strong optimism and hopes of more flexible service production, efficiency gains, better civic participation and improved

transparency, documentation, quality and comparability of service outputs that would result in citizens' enhanced quality of life (Doupi et al. 2007; Heichlinger 2011; European Commission 2009). Technologisation of work is therefore a process that increases efficiency and reasserts trust in public services.

In the case of health and social care work, the parallel transformations towards knowledge society and a leaner welfare state has meant the introduction of complex and manifold audit techniques that are implemented through information and communication technologies (ICTs) as practices of record-keeping and checking (Saario 2014). These are used as a means for assessing health and social care workers' professional accountability, and for evaluating the results of their work as quantifiable and comparable outputs, representing a turn towards what Power (1997) calls an 'audit society'. As the end users of ICT solutions, workers are the key players in the success of technological investments, from the point of view of public economy and the quality of care.

Previous studies on the use of ICTs in health and social care work point to workers' resistive practices and improvised use of technology, which may compromise the expected outcomes of costly investments in technology (Koivunen et al. 2008). According to these studies, workers' dissatisfaction arises from the fact technologies are produced exclusively from the vision of their developers, and appear to end users as 'the design from nowhere' (Suchman 2002). Moreover, the gendered and corporeal nature of care work – which continues to be overwhelmingly female-dominated – has often been absent from policy discussions regarding the problematic aspects of the implementation and design of ICTs in care work (Balka et al. 2009).

The growing implementation of technology in health and social care work demonstrates the transition towards the knowledge society in the Finnish welfare state. From two points of view, the transition poses particular challenges to occupation groups in the lower ladders of professional hierarchies of health and social care work, such as nurses. First, as professional work, care work and nursing involves technical and medical expertise, but also a form of personal service, bodywork and emotional orientation to the needs of another human being. Due to the holistic nature of health and social care work, its outcomes are not easily transformed into quantifiable and comparable outputs to be audited and recorded. Nevertheless, ICTs have gained a

growing role in monitoring and auditing workers' performance and care outputs (Saario 2014). Second, studies show that the occupational requirements of workers' interaction skills, emotion work and empathy are culturally essentialised as natural 'feminine skills', based on a normative cultural assumption of women's abilities in the fields of emotion work, empathy and corporeal care (Husso & Hirvonen 2012; Virkki 2008).

In this chapter, I use qualitative interview data (n=25) collected from Finnish health and social care workers to study the effects of the managerial transformation of the welfare state from two interrelated points of view: first, with regard to the overriding role that ICT-assisted practices of accountability work have gradually gained in health and social care work, and second, with regard to how this affects nurses' professional identities and agency as care professionals.

Restratification of care professions in a medico-managerial welfare state

In Finland, the education and professionalisation of health and social care occupations has taken place in accordance with the expansion of the welfare state, and in close relation to the public service sector. The period from 1960s to 1990s was especially characterised by a rapid expansion in the scope of the welfare state and its service provision. This encouraged women in particular to turn to careers in the welfare service (Wrede 2008). Today, however, rapid population aging and public sector austerity policies have forced the state to re-evaluate its means of sustaining the Nordic, universalistic welfare state model. In Finland, as in many Western welfare states, this has led to a reconstruction of the welfare state according to the principles of NPM, exerting pressure upon public finances, and the quality and efficiency of health and social care services (Pollit & Bouckaert 2011).

Despite cutbacks, and the consequential retrenchment of the universal coverage of the welfare state, the responsibility for the execution of health and social care services remains in the hands of Finnish municipalities, who rely primarily on the public service sector to produce statutory health and social care services (Anttonen & Häikiö 2011; Kröger 2011). Consequently, the development and organisation of care

occupations continues to be strongly interlinked with the welfare state itself. Although welfare state reform has not led to a straightforward privatisation of welfare services, it signifies a great managerial and ideological transformation in the Nordic welfare states. According to critics, this has caused a conflict between the professional ethics of health care workers and the pressure to validate the managerial accountability and efficiency of care service work (Henriksson & Wrede 2008; Waerness 2005).

In feminist theory, care work is often analysed as a form of or in relation to biological and social reproduction (Bakker 2007). As an occupational practice, care represents a core task of health and social care work, that is cultivated through corporeal habits, emotion work and workers' occupational ethics. These require personal responsibility and commitment from individual workers to respond to the needs of another human being (Dahl & Rask Eriksen 2005; Twigg et al. 2011). The corporeal, situational and social nature of care can aid workers' imaginative ability to empathise with others. At the same time, it places care professionalism in contrast with the conventional idea of (health) professionalism that is impersonal, unemotional and science-based. Due to this, caring occupations have a complex and charged relationship with their aspirations towards professionalisation. Moreover, contemporary medico-managerial management culture prioritises medical care and emphasises workers' technical skills, further alienating workers' skills in corporeal and social care from the realm of professionalism.

Previous studies on the effects of public sector reforms estimate that established and autonomous professional groups, such as medical doctors, have fared rather well in terms of maintaining their autonomy (Kuhlmann 2006; Kurunmäki 2000). However, studies have also pointed to the emergence of both ethical and practical problems among less powerful and/or recently established occupations that are culturally more feminine and distant from the conventional idea of health professionalism (Dahl & Rask Eriksen 2005; Henriksson 2008; Tronto 2011). According to Wrede (2008), the new management culture points to both a deepening of the old and a creation of new divisions and inequalities, which build on mutually constituted, gendered and classed hierarchies in the field of health and social care work. The Finnish case, therefore, exemplifies a restratification of public professional work that Noordegraaf (2013) identifies as a key element in understanding its reconfiguration.

For one, in an effort to unite middle-grade care occupations in Finland, nine trans-sectoral study programmes in social and health care were united under the single umbrella curriculum of practical nursing in 1995. According to Henriksson (2008), the reconfiguration of occupational groups exemplifies the difficulties contemporary management culture has in associating professionalism with care service work. Moreover, practical nurses are the key occupational group involved in elderly home care services, which is an area of public care provision that is facing particularly strong pressure to streamline and rationalise. Studies show that the scope of public responsibility of elderly home care has already shifted, from a holistic to a more narrow and medical account of care work (Anttonen & Häikiö 2011; Henriksson & Wrede 2008). This deepens the social–health care divide between various (semi-)professions, and compromises the professional status and power of recently established social care occupations in particular.

All in all, health and social care workers' formal competence requirements have increased over the past 30 years, while the value of the full range of their occupational skills and their chances to influence decision-making in the workplace have simultaneously decreased (Henriksson & Wrede 2008; Henriksson 2011). Regardless of the occupational and status differences between various groups of health and social care professions, the changing cultural, political and social environment in the welfare state has affected all grades of workers. In particular, the managerial, technological and cultural transition towards a knowledge society has aimed at a disembodied and gender-neutral conceptualisation of care professionalism.

Disembodied care professionalism in the knowledge society

Proximity between workers and service clients has traditionally been an essential requirement for the execution of corporeal and social practices of care. It transfers the 'feeling of being in good hands' and generates client trust. Consequently, the technical rationality and emergence of ICT-assisted practices of accountability affect client relations, and, in particular, the idea of client trust (Nicolini 2007). In human service work, such as nursing, trust is a mechanism through which the gap is bridged between

the client's incomplete information and need for help on the one hand, and the impossibility of controlling professional work on the other (di Luzio 2006). Therefore client trust does not simply mean trust in a person but trust in an institution the person represents. In encounters between care professionals and clients, personal feelings, emotions and values are involved, together with the general, cultural value attributed to workers as knowledgeable specialists. In these encounters, trust is a social mechanism that helps clients to overcome uncertainties about the outcome of their treatment.

Recent studies on the reconfiguration of professional bureaucracies propose that the transition towards a knowledge society has altered the relations between professionals, service users and care managers. For example, Calnan and Rowe (2008) suggest that professional trust can no longer be assumed to be embodied in the professional. Instead, it has to be earned through careful, explicit documentation of daily work that Kuhlmann (2006) describes as 'checking-based trust'. Health and social care occupations are now faced with what Evetts (2009, p. 261) describes as a general decrease in the cultural value of professionalism. Evetts (2009, p. 261) claims that the association between trust, competence and professionalism has been questioned in recent years (see also Banks 2004; Brown & Calnan 2011; Hupe & Hill 2007). According to di Luzio (2006), the situation illustrates parallel changes in attitudes towards professionals, as well as a change in knowledge production and the organisation of professional work.

Moreover, Evetts (2009) suggests that public service managers and practitioners increasingly use professionalism as a discourse of occupational control, rationalisation and motivation. For example, total quality management (TQM) and International Organization for Standardization (ISO) 9000 approaches have been widely adopted by local governments to improve service quality and workers' professional accountability in Finland (Pollitt & Bouckaert 2011). This is despite the fact that service users continue to show strong trust towards the welfare state as the provider of services and social security (Kallio 2008).

Changes in the roles of professionals and service users influence the terminology that is used in health and social care settings. The term 'patient' remains in use only in hospitals, while the term 'client' defines the relation between workers and service users in outpatient clinics and health centres for ambulatory care. The Finnish legislation,

however, continues to refer to health-care service users as ‘patients’ (Act on the Status and Rights of Patients 785/1992) and to social care service users as ‘clients’ (Act on the Status and Rights of Social Welfare Clients 812/2000). The workers interviewed for this study used both terms inconsistently when referring to service users. On the one hand, this inconsistency could be a result of the manifold expertise that many of them had in both health and social care work. On the other, it could be interpreted as a sign of their uncertainty and ambivalence towards the correct way to perceive and describe client/patient relations in the contemporary welfare state. The data extracts chosen for this chapter are faithful to the original terms used by the interviewees, while the rest of the chapter uses the term ‘client’ in reference to service users.

Besides a question of trust, feminist theorists have suggested that the ongoing technology-assisted transformation of care work cultures is a gendered process from the point of view of masculine and feminine characteristics culturally attached to work.. They claim that the parallel changes towards a leaner welfare state and a knowledge society, promote managerial and technical rationality that renders the body invisible by overlooking the corporeal social and emotional nature of care, as well as the ‘dirty work’ that caring entails (Davies 1995; Twigg 2006, p. 150). Twigg and colleagues (2011, p. 7) refers to Grosz’s (1994) pioneering work in *Volatile Bodies*, concerning the intertwining of cultural and biological issues, and claims that the binary between mind and body is still a strongly gendered construction that identifies the body with women and the mind with men. The deep-rooted cultural idea(l)s then transfer to power dynamics in societal fields, such as the working life.

Recent studies show that the emotional burden and the ‘dirty work’ of care work continues to primarily fall on women, while men are encouraged to demonstrate leadership skills and physical strength, but also to have a restricted involvement in physical caregiving routines (Evans 2006; Korvajärvi 2004; Twigg et al. 2011). Kuhlmann (2006), on the contrary, presents a more optimistic interpretation of the technology-assisted transformation of social and health care work. She claims the transformation that highlights workers’ skills in disembodied, medical and technical care, has the potential to roll back the gendered division and expectations regarding care occupations. As a compromise, rather than liberating people from gendered workplace binaries, Adkins (2001) calls for caution and an assessment of the ways in which

contemporary flexibilities may instil new forms of power there. From the point of view of welfare service work this seems like sound advice, since the form of disembodied professionalism that the contemporary welfare state promotes, highlights first and foremost workers' medical and technical qualities, traditionally associated with masculinity and (health) professionalism.

Data and method

The data analysed in this chapter was originally collected for a PhD study (Hirvonen 2014a) concerning organisational change in welfare service work amidst the managerial, ideological and cultural transformation of the Finnish welfare state. The data includes qualitative interviews (n=25) from welfare service workers. It was collected during the period 2007–2009, using snowball sampling and by recruiting interviewees through adverts posted in welfare service facilities. The interviewees were registered and practical nurses, social care workers and early education workers. They worked in public hospitals and clinics, municipal geriatric care units, home care service teams and kindergartens. Together, the aforementioned occupations represent the relatively highly educated welfare service workforce of the Finnish public service sector. The interviewees were between 25–61 years old and the sample consisted of interviews with 23 women and 2 men, representative of the gender distribution in social and health care occupations. The interviews, which had a semi-structured form, were recorded and manually transcribed, and lasted approximately one and half hours each (Corbin & Morse 2003, p. 340). Specific themes were introduced using key questions and prompts when necessary. Interview themes focused on the nature of the participants' jobs and their relationships with co-workers and clients, as well as the changing nature of care professionalism and public management. Overall, the aim was to map the respondents' accounts of organisational life and work practices in various locales within the contemporary public service sector.

The analysis used practice research as a conceptual and methodological vantage point to address professional and organisational transformation of care service work (Gherardi 2012). Health and social care work involves personal service, a form of bodywork, and emotional commitment to the needs of another human being. From this point of view, care is understood as a situational, social and embodied professional

practice that is based on shared occupational ethics and values among various health and social care occupations. Practices are the ‘organisational memory’ of work that represent its persistent institutional knowledge and order (Schatzki 2001), and incorporate occupational values that are difficult to standardise, such as human dignity and compassion (van Wynsberghe 2011, p. 11).

Welfare state transformation affects these practices. Care work cultures are subject to various logics that predispose workers to cultural and structural change, such as the logic of patient choice, the logic of e-governance and managerialism, the logic of economy and the logic of care (Mol 2008, p. 84). These intersecting logics can generate innovative practices of care, but also moral dilemmas and contradictions concerning the appropriate use of scarce resources, such as time and money, in front-line care service work (Hirvonen & Husso 2012). In analysing the interview data, I have focused on the nature of the association between workers, the structural conditions of the labour market, and the ways in which the technical, socio-material artefacts, such as computers and mobile phones, are used in the interviewees’ descriptions of their daily work practices. The excerpts were selected for this chapter to give an overview of the interviewees’ responses regarding their professional accountability and practices of accountability work, and in relation to their reflections on care professionalism and gender. The results are presented in the following section.

Results: Towards a hybrid form of care professionalism

The results are presented in two parts. The first part deals with health and social care workers’ perceptions of professional accountability in relation to the managerial reform of the welfare state and the parallel technologisation of health and social care work. The second part demonstrates workers’ ambivalence towards the contemporary conceptualisation of care professionalism.

Practising accountability in care professions

To a growing extent, the everyday work of health and social care professionals, such as nurses, is framed by practices of ‘accountability work’. This entails assessment, monitoring, budgeting and taking responsibility for administrative work (Banks 2004, p. 184; Hirvonen 2014a; Saario 2014). Health and social care work is subject to various audit techniques and systems that are defining professional practice to a growing extent. Many of the interviewees’ accounts of the everyday practices of care work described an intensification of managerial control over care work and the novel practices it generated. A nurse with 20 years of work experience described her professional accountability as follows:

There are demands from every direction, like we have these national requirements, EU regulations, instructions by STAKES,¹ and many from the Ministry of Social Affairs and Health. And then we have the municipal level guidance; how much money can be allocated to certain activities. So that, too, regulates to a great extent the work that we can do. So it has changed a lot, really. Like, now we have to report everything and compile statistics and (...) It takes an awful lot of our working time. (RN18, Acute Rehabilitation Unit, 53 yrs)

Assessment of workers’ performativity according to impersonal and objective criteria relies on workers’ willingness and ability to adopt practices of accountability work that subject them and the outputs of their work to various audit techniques. Accountability work produces quantifiable, comparable data, and extends the fiscal and managerial responsibility of the efficiency and transparency of care services to the level of the individual worker. Accountability work may improve the transparency of the daily work of care professionals and bridge the information gap between workers and managers. However, it can also increase a sense of distance between the latter. A paediatric nurse explained how the alienation of her unit’s chief nursing officer from the rest of the care staff weakened the information flows between staff and management, and how this had a deteriorating effect on the atmosphere in the unit:

It feels as if there are more administrative personnel than ever, and fewer of us others, but it’s not clear to us what their roles are. So, it almost feels like the

chief nursing officer is afraid to visit us at the ward, since we don't see her much. So, our unit's head nurse is then there as the mediator who surfs between the chief nursing officer and us. But our head nurse can't always answer to all our questions. So it would be nice to somehow know the chief nursing officer ourselves, even if only by her face, or to have her visit us regularly to see how we're doing, and to see if we need help with something or if something is troubling us. And regarding the various projects we carry out, it would be nice to have meetings together with her instead of only receiving orders on a piece of paper. (RN13, Paediatric Intensive Care, 45 yrs)

Care managers' dissociation from front-line workers was a recurrent theme in the interviews. Medico-managerial management produce practices of accountability work to demonstrate workers' organisational accountability. However, practices of accountability work as such do not seem to meet workers' need for informal one-on-one communication and dialogue with the management. The extract just quoted illustrates the fact that asking the question of how to manage managerialism in the field of health care is as timely in Finland as it has been elsewhere (Dent et al. 2004; Carvalho 2012).

Another recurrent theme in the data concerned the use of technology as a social practice in care service work. As the end users of ICT-assisted audit techniques, care professionals are often excluded from decision-making concerning the development and introduction of technology into their workplaces. Previous studies suggest that this complicates the implementation of ICTs as a vehicle for accountability work, and may compromise the desired outcome (Koivunen et al. 2008). The interviewees' descriptions supported these findings, suggesting that one explanation for workers' resistance could be found in poor management of parallel tasks, that end up making care work more fragmentary. As a paediatric nurse explained:

Since this year, we've used electronic patient records, and it's taken a lot of time to learn to use the software. It's taking time away from patient work. Moreover, I now need to monitor a fragile child in a respirator that constantly sounds an alarm while at the same time reporting other tasks on a computer. So, I'm bouncing back and forth from the computer to the respirator, and both tasks suffer from it. At the time when we were filling reports on paper it wasn't

that difficult, or at least it didn't disturb my work as much. (RN13, Paediatric Intensive Care, 45 yrs)

Her explanation shows that it is not the technology-assisted practices per se that cause workers' resistance, but the poor management and planning of the use of technology as a social practice in care service work. Other interviewees described similar dilemmas regarding their need to prioritise one task over another, often meaning the prioritisation of accountability work over face-to-face client work.

The analysis shows that care professionals do recognise the benefits of using electronic records in terms of the good of the clients, the management and themselves, in particular when technologies are mobile and easily available. Nevertheless, workers are often at a loss with regard to the relevance of and the extent to which their work is being audited and recorded. A nurse from a municipal home care service team recalled the pros and cons of electronic records as follows:

We've recently begun to also report all the indirect tasks that are not part of our official job descriptions, such as phone calls and references. But I'm not convinced that this is good use of our time and skills (...) Then again, if I don't have the time to go to the electronic patient record to read the patient files, it seems crazy to go into the clients' homes because then I can only do the necessary basic tasks. I don't always have the time, but when I do, I try to read their files the day before, to check who I'm supposed to see the next day, to go through their medical history and their life history, to get an overall picture. It feels meaningful to be able to piece together their life situations. It allows me to help them the best way I can, so that it's not just separate tasks I do here and there. (RN25, Home Care Services, 43yrs)

The previous excerpt shows that the purposefulness of accountability work with regard to the core tasks of care work is a defining feature in the acceptance of technology-assisted management practices. On the one hand, when directly related to workers' job descriptions as care professionals, technology becomes a meaningful social practice. It can benefit workers' professional development and client relations in line with the normative value systems and ethics of care work, such as in the case of familiarising

oneself with clients' histories through electronic patient records. On the other hand, more often than not technology as a social practice has little to do with direct client relations. It primarily serves managerial needs to audit and quantify care, instead of supporting workers' professional self-management in client work.

From embodied to disembodied professionalism

Further analysis revealed that technology-assisted accountability work has significant consequences for how trust and communication are built through everyday practices of care, especially in terms of how this affects client trust. Previous studies suggest that the rise of the knowledge society, together with the readjustment of power between bureaucratic authorities and citizens as informed consumers, have led to the diminishing of the professional power of front-line care workers in Western welfare states (Henriksson 2008; Van Loon & Zuiderent-Jerak 2011). The results here confirm that the growing choice and voice of clients as attentive consumers readjust the balance of power between care professionals and clients. A geriatric head nurse described this readjustment as follows:

You need to be sensitive towards patients, sure, and to listen to them in as many ways as possible. But you also need to stay strong somehow. As I tell all our nurses, our work is truly under the microscope nowadays. Like, when you ride the bus or go to a hairdresser's, you don't begin to ask them if they're really sure they know how to ride a bus or how to give a haircut. But our skills and know-how constantly get questioned this way by patients and their families. (RN11, Head Nurse Geriatric Care, 38yrs)

The extract highlights the growing consumer power in the Finnish welfare state. In a knowledge society, consumer power obliges public service organisations to tailor and market their services to citizens, and to rely on rational criteria and visible markers in creating transparency in the practice of care work so that they become assessable (Kirkpatrick et al. 2005; Kuhlmann 2006; Noordegraaf 2007). However, accountability work enacted from a distance and through disembodied professional practice does not

necessarily contribute to the establishment of client trust, as a practical nurse from a geriatric care unit recalled:

With some people it's like 'because we pay for this, we should get this and that', and no matter how much you try to explain that you don't always have the time, you are still expected to do more. And if you forget to write down or tick a box in some chart that states that you've given them the eye drops, it's like the end of the world to them – even when you actually carried out the procedure and only forgot to write it down. So, we joke about it, like 'Always remember to tick the box, even if you don't give them the eye drops!' (RN17, Geriatric Care Unit, 36 yrs)

Her account reveals the difficulty of generating client trust through disembodied and standardised practice of accountability work. Moreover, the analysis of the interview accounts showed that workers need to master a variety of skills in order to establish trustful relationships in face-to-face encounters with clients. Interviewees' descriptions of their everyday work showed how this embodied face-to-face accountability work takes place through the deceptively mundane acts of touch, talk and closeness, which manage to convey the feeling of 'being in good hands'. The results suggest that for workers, establishing client trust often requires employing a variety of skills, some of which may seem insignificant for the judgement of workers' professional accountability from a managerial point of view, such as physical closeness. From managerial point of view, workers' accountability, legitimacy and effectiveness are evaluated on the basis of standardised care outputs that detach care as a professional practice from closeness and corporeality. The transforming and somewhat conflicting image of care professionalism represents the shifts management of care as paid labour, but also larger societal shifts in understanding professionalism. In light of the results, it seems that 'digital relocation' – and sometimes dislocation – of public professional work (Noordegraaf 2013) is a key factor in evaluating the professional reconfiguration. A majority of the interviewees described how the intimacy, empathy and responsibility involved in care work were crucial for workers' motivation and well-being. A nurse from an acute rehabilitation unit explained her motivation in the following way when asked what aspects of nursing brought her professional satisfaction:

Well, it [satisfaction] comes from – I know it sounds naive and stupid – but it comes from seeing that someone clearly begins to feel better when you’ve performed a procedure. Or sometimes it’s just your presence there, if they ask you to stay with them for a little while and just be there with them. That’s where it comes from. And that’s also when you know you’ve reached some kind of a trustful relationship with them, and the patient feels that you’re worth their trust. (RN14, Acute Rehabilitation Unit, 29yrs)

It is telling that the interviewee is belittling the importance of social, emotional and corporeal practices of care as a source of her professional satisfaction. Changes in the conceptualisation of care and care work also signify a transformation in professional values and ethics. As workers spend a growing proportion of their time reporting and managing care from afar, they are, paradoxically, increasingly dissociated from the face-to-face care that gives clients the chance to assess workers’ trustworthiness, and, at the same time, reasserts workers’ professional agency. Instead of managing the body, Twigg (2000) suggests, care work is now more concerned about managing the information concerning the body. As a consequence, workers’ professional responsibility becomes defined on the basis of how they handle this information, rather than how they respond to clients’ needs as they arise.

Furthermore, the analysis of front-line workers’ accounts suggests that the transition from management of bodies to management of information should be understood in light of the gendered and corporeal nature of care work. Professionalism is commonly associated with culturally masculine attributes such as scientific knowledge, emotional distance and reason, rather than the culturally feminine, less systematic and more abstract skills that nursing and care work entail (Davies 1995). Moreover, contemporary management styles are culturally associated with ‘masculine’ discourses of competitiveness, instrumentality and individuality (Thomas & Davies 2002, p. 390). Berg, Barry and Chandler (2012, p. 317) further suggest that pursuing these qualities in health and social care work could encourage female workers to behave in ways that challenge gender stereotypes in the field. Embracement of masculine, managerial management styles may empower individual workers, but simply submitting to masculine styles of management them does not resolve the question of the cultural misrecognition and disregard of the value of workers’ corporeal and emotional skills as

a part of their professional agency. Yet foregrounding the corporeality of care, Twigg (2006, p. 152) suggests, does not solve the problem either. On the one hand, it enables a recognition of the full range of nurses' professional skills in care work. On the other hand, it risks reproducing the idea that female workers' professional skills, especially, are natural (see also Calnan & Rowe 2008), making femininity a contested and ambivalent resource for identity work (Hirvonen 2014b).

Recognition is therefore a double-edged sword from the point of view of workers' empowerment. It exposes the nature of care work in ways that can erode rather than enhance the status of welfare service occupations, many of whom already have limited resources and professional power to defend their occupational status (Hirvonen 2014b). The interviewees' responses showed plenty of ambivalence towards the gendered cultural idea(l)s care work entails, particularly in relation to professionalism. A registered nurse recalled her thoughts about the societal value of care as follows:

I feel that during nursing school I ... it sort of just gave me some tips on how to do the job, but working has taught me these things, really. Maybe it's because this is the kind of job that's sort of like being a stay-at-home mom in the sense that it's not really valued. And the work, it only gets noticed when somebody hasn't done it. Sometimes even I myself find it hard to respect my work because of that! And it's only when I or one of my close ones gets sick that I realize that, yeah, somebody's running this show and taking care of them. (RN21, Geriatric Care Unit, 27)

The interviewee's reflection on the valuation of her work is telling with regard to the manifold ways in which the full range of welfare service workers' occupational skills are either misrecognised as 'natural' abilities, or otherwise neglected because they do not fit the predominant understanding of professionalism. Based on the results in this study, it seems that the conflict concerning contradictory values, goals and means of providing good quality care has been left to be resolved at the street level where front-line workers operate. As a consequence of the growing emphasis on ICT-assisted accountability work and related technical-skill requirements, the culturally feminine side of nursing and care work is further neglected as a domain of non-professional knowledge.

All in all, the results in this chapter suggest that care professionalism is increasingly assessed based on workers' medical and technical knowledge and skills in ICT-assisted accountability work. It is unlikely that a more holistic understanding of care professionalism will gain ground in the near future, despite its significance for workers' professional motivation and for the creation of client trust. Since the 1990s, welfare service reform and the parallel transition towards a knowledge society have had a significant impact on practices of care and on the societal understanding of care as a professional skill. On the one hand, the results suggest that medico-managerial management styles and application of technology as a social practice can support workers' professional growth and self-management. They enable a comprehensive utilisation of a variety of workers' professional skills and turn technology into a meaningful social practice in care work, as other studies have also suggested (Leppo & Perälä 2009; Carvalho 2012; Van Loon & Zuiderent-Jerak 2011). On the other hand, optimistic propositions tend to disregard the comprehensiveness of the consequences of technological transformation from the point of view of gendered cultural ideals and values related to care, and to the fundamentally corporeal nature of care work. The results suggest that disregard for these aspects may have negative consequences for workers' professional self-image and client trust.

Conclusions

In this chapter, I have discussed the consequences of the Finnish welfare state reform, and the technological and organisational transformation of the public service sector from the point of view of care work and care professionalism. The doctrine of NPM has brought economic rationality and 'management by numbers' to the public service sector. Through the quantification of the inputs and outputs of welfare service work, the goal of medico-managerial management is to increase transparency of and trust towards public service work. In contemporary welfare states, ICT-assisted accountability work has become the cornerstone that ensures the legitimacy of public service bureaucracies (Ferraris & Davies 2013). To a growing extent, acts of registration and documentation validate individuals' life histories and workers' organisational accountability in health and social care institutions.

The results of the analysis in this chapter suggest that, in the case of the Finnish public sector, medico-managerial management not only affects the institutional environment of service provision, but also remodels the practices of care and the cultural understanding of care professionalism. Care workers have become subject to the requirements of self-regulated professional development. To a growing extent, workers commit to the goals, ideals and efficiency targets of their workplaces, instead of the more universal, occupational values and principles that they acquire through education and training. In this sense, professionalism is defined by the needs of the organisation rather than the state.

According to Henriksson (2011, p. 120), the Finnish welfare state implicitly continues to rely on the gendered division in the society, according to which women in general, and welfare service workers in particular, are called upon to respond to care needs because they are considered to be ‘natural carers’ and flexible workers. Despite the hopes of generating a more gender-neutral idea of care professionalism, the contemporary promotion of disembodied and technical professionalism does not liberate care service workers from gendered cultural representations regarding care. Instead, it produces a hybrid form of disembodied care professionalism, as identified by other studies (see e.g. Carvalho 2014). In the case of Finnish health and social care staff it refers to professionalism that is explicitly gender neutral and technical, but implicitly gendered. It reproduces gendered expectations of workers’ natural gendered skills in a way that leaves the question of gender and power unresolved in the labour market. In line with a conventional understanding of (health) professionalism, the ongoing transformations in the Finnish welfare state highlight workers’ technical and medical competence as opposed to a more holistic understanding of care professionalism that is culturally gender sensitive. The narrow account of care professionalism may hamper workers’ efforts to build positive professional self-images, and instead reaffirm the societal disregard of care as a professional skill.

In this chapter, I have also contemplated the welfare state reform and the turn towards a knowledge society from the point of view of client trust and workers’ professional accountability. In the case of the Nordic welfare states, care professionals play a key role in reasserting the legitimacy of the welfare state. As front-line workers, they are the first to experience, and the ones to execute and arbitrate, the changes in the

principles and values of service production to service users. Maintaining an empathetic attitude and conveying the experience of 'being in good hands' to the clients, while at the same time trying to adapt to these changes, can be a strain for workers. Improving client trust through manifold audit techniques and ICT-assisted accountability work do not, however, make up for the physical distance these methods tend to generate between managers, workers and clients. Making care more transparent consequently seems to increase the distance between actors. In care of the young, the old and the sick, ICT-assisted accountability work does not seem to make up for the benefits of physical proximity. Promotion of the corporeal and social aspects of care should, therefore, not be taken as a repetition of an outdated feminist agenda, but as a reminder of the challenges that the holistic nature of care poses in contemporary societies. This perspective is crucial in health and social care work for promoting care workers' well-being, and for the success of costly technological investments that are easily taken as a panacea in economic austerity policies concerning such work.

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