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From Embodied to Disembodied Practices of Care –Discussing Welfare State Transformation in Finland

Helena Hirvonen (helena.hirvonen@jyu.fi)
Department of Social Sciences and Philosophy, University of Jyväskylä

1. Introduction

The scarcity of public resources and the rapid aging of population have forced Western welfare states to resort to new steering mechanisms regarding their service production. In Finland that represents one of the Nordic welfare states, market mechanisms are now increasingly used in the public service sector to obtain measurable results of human service work and to thereby improve the efficiency and the cost-effectiveness of health and social care services. These processes have resulted in the concurrent implementation of complex systems of control and audit in the public service sector, while the dynamics between the workers and service-users also change as the role of citizens now resembles that of consumers. Moreover, the transformation affects the universalistic ideals and the rationality behind public service production in the Nordic countries, thereby challenging public service workers' professional identities (Henriksson and Wrede 2008). The changes in the relationships between citizen and service providers raise the question of the citizens' trust toward the welfare state and public service professionals as the service providers.

The recent welfare policy shifts have implications on care work cultures and professional agency (Henriksson & Wrede 2012). Inquiries on the front-line workers' experiences of the transformation in the lower levels of professional hierarchy of public service occupations are timely in the context of Finland where nurses, social workers and care workers repeatedly report the highest levels of mental and physical strain among all occupational groups (Ylöstalo *et al.* 2010). Increase in time pressure, poor organization of work, as well as ethical conflicts due to scarcity of material and personnel resources, have also been noted in recent studies (Järnefelt and Lehto 2002, Virkki *et al.* 2012, Laine 2006: 31). In Finland, the municipalities hold the legal responsibility for the provision of welfare services, and their provision largely remains within the public sector despite the transformation of the ideals of universal coverage of welfare services toward a liberal welfare state model (Anttonen and Häikiö 2011, Julkunen 2006). Consequently, the development and organization of care occupations remain closely intertwined with the welfare state itself. As a country with a relatively extensive public service sector, Finland therefore provides an interesting case for studying

the transformation of welfare states in terms of the sustainability and innovative potential of the Nordic welfare state model.

The transformation of the welfare state has not left the public service personnel unaffected. 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, recent studies from various countries have pointed to the emergence of both ethical and practical problems among the less powerful occupational groups who have faced more challenging circumstances in the field of care work where economic values and medical expertise are now highlighted (Rasmussen 2004, Tronto 2011, Rask and Dahl 2005, Höpfl 2003). This has caused restratification of welfare service occupations in the benefit of the educated (semi-)professions with medical and technical expertise, such as registered nurses (Henriksson 2008, Laurén and Wrede 2008). Under the medico-managerial logic of care, the element of social care at the heart of many less established occupations has become regarded as a "non-professional" activity (Henriksson and Wrede 2012). This has decreased the status of occupations such as practical nursing that encompasses skills and competence to socially defined care. All in all, the workers' formal competence requirements have grown more demanding, while the value of their professional knowledge and their chances to influence the decision making in the workplace have rather decreased (Henriksson 2012, Henriksson and Wrede 2008, Laiho and Ruoholinna 2012).

Care work is traditionally understood to comprise of embodied, situational and social practices (Tronto 1993, Sevenhuijsen 1998) that are central to the workers' self-images as skilled professionals[1]. As the welfare state transformation changes the roles of the state, the care professionals, and the service-users, it calls for new mechanisms of building trust between them, thereby changing professionalism. Kuhlmann (2006) suggests the contemporary knowledge-management practices in public service organizations now call for disembodied professionalism, which is founded on information, and which is often generated with the use of ICT-devices, and with the attempt to make the results of care work transparent, evaluable and comparable. These demands have implications on the workers' professional identities and agency.

In this paper I use the interviews (n=25) of Finnish, public service workers to analyze their experiences of the contemporary management practices in the public sector in the context of nursing, care work, and early education work, and ask what kinds of practices of care emerge in their everyday work. I further discuss the results from the point of view of the transformation of the nature of care professionalism from embodied to disembodied professionalism. Methodologically, the paper relies on to the growing body of practice research (Gherardi 2006, Goldkuhl 2011) and takes local practices of care and their management as a vehicle for studying the effects of welfare state transformation on the workers' professional self-images.

2. The Reconstruction of Public Services in Finland

Historically, the welfare state has had a central role in in Finland in shaping social and health care occupations and their professionalization. In line with other Nordic countries, a comprehensive public services sector was established in Finland after WWII in parallel with the emergence and development of its feminine, semi-professionalized workforce in social, health care and early childhood education services. Especially the rapid period of welfare state expansion from 1960s to 1980s bound the development and regulation of the caring occupations firmly together with the welfare state and its ideology of gendered and classed equality (Wrede 2008: 28). However, the steady period of instilling the public service state was followed by a severe depression in the early 1990s. This accelerated the emerging pressures of retrenchment of the welfare state that required adaptation from its personnel. The current implementation of medico-managerial steering mechanisms and the marketization of public services have carried on the reconstruction in the 21st century. Outsourcing of public welfare services and the growing use of purchaser-provider arrangements in the provision of services further alters the institutional conditions in which welfare services are produced.

Apart from the reconstruction of the welfare state, welfare service occupations face what Evetts (2009: 261) describes a more general decrease in the cultural value of professionalism (cf. Giddens 1991). The lack of trust in the professional competence of front-line care personnel strengthens the contemporary belief in biomedical and managerial knowledge and control on professional workers in the name of the public safety (see also Hupe and Hill 2007, Brown and Calnan 2011, Banks 2004). The control and power over welfare service workers' professional agency now increasingly belongs to managerial elites and politicians in the Finnish municipalities. The everyday work in hospitals, care homes and kindergartens is subject to adapt accordingly to their requirements, which changes the practices of day-to-day care in these facilities.

3. Toward Efficiently Managed And Disembodied Care Professionalism?

Maurice Hamington (2004: 5) suggests that care can be cultivated through corporeal habits and practices, aiding our imaginative ability to empathize with others. Much of what is communicated between people is found in the subtleties of facial expressions, hand gestures, posture, inflection, and eye contact. Those who are described as caring in our society are often those who can "sense" the needs of another and respond accordingly. Sometimes these caring habits come easily, at other times, they involve sacrifice, pain, and great effort of will (ibid., 31). This empathetic component of a caring imagination is crucial in occupational caring where the workers' often have

little knowledge of the service-users.

Hamington's description of embodied care includes central elements of care professionalism, which is often understood as being embedded in embodied, situational and social practices of care (Sevenhuijsen 1998, Henriksson 2008). However, the contemporary requirements of the workers' professional competence and accountability consist not only of the expectation of appropriate medical and ethical conduct in relation to service-users, but also of the expectation of personal responsibility for efficient use of public resources. This means complying with accountability systems that give information concerning the performance of individual workers in their organizations. While trustworthiness of worker-patient relations has always been central in the ethics of social and health care work, this trust is now pursued with new forms of bureaucratic regulation and control which increases the use of technology in care work. These changes have implications on the embodied practices of care. Kuhlmann (2006) suggests that these mechanisms of checking-based trust transform professionalism so that it is no longer embodied *in* the professional, but becomes disembodied, founded on information and produced *through* the professional. As the workers spend more time on reporting and managing their activities in an effort to make care work quantifiable and transparent, they are increasingly dissociated from the actual face-to-face care with the service users. In light of this, the reconstruction of the welfare state may fundamentally change the contours of welfare service work.

4. Method And Data: Analyzing the Habitual And Social Practice of Care

I have used qualitative research methods to study welfare service workers' experiences of the contemporary practices of care. To this purpose, thematic interviews were collected in 2007-2009 by using snowball sampling and by recruiting interviewees through adverts posted in welfare service facilities. The 25 interviewees in the data are nurses and care workers from public hospitals and clinics; municipal geriatric care units, kindergartens and home care service teams (see Appendix 1). The interviewees are between 25-61 years old and the sample consists of interviews from 23 women and two men, representative of the gender distribution in social and health care occupations. The interviews were recorded and manually transcribed, lasting approximately one and half hours each. The interview themes focused on the nature of participants' jobs (duties, most/least liked elements) and their relationship with co-workers and service-users. Overall, the aim was to map their accounts of organisational life and the changes in it. The question of care management framed several interview questions, for instance those concerning the interviewees' perception on the rights and responsibilities of the workers and the service-users, and those concerning their experiences of the distribution and sufficiency of material, temporal and personnel resources in their workplaces.

In the context of this paper, I understand care as a situational and social practice that is based

on care ethics and shared occupational values among welfare service workers. In occupational sense, care involves personal service, a form of bodywork, and emotional commitment to the needs of another human being[2] (Sevenhuijsen 1998, Waerness 2005). Care practices are conceptually distinct from the individual. They are potential actions, available to be done, asserted, performed—that is, practiced—in social contexts by individuals (cf. Martin 2003: 351). As a methodological perspective, practice-based approach means analysing the situated seeing saying and doing of the interviewees, according to the shared cultural values of the field in question and embedded in society's institutions[3] (Gherardi 2006, Kuhlmann 2006: 608, Goldkuhl 2011). In the process of analysis, I focused on identifying embodied/disembodied practices of care in the interview data, and further analyzing the interviewees' experiences of these practices in terms of their professional agency. The results are presented in the two following chapters.

5. Contemporary Practices of Medico-Managerial Care

The interviewees representing various occupational groups of welfare service work all recognized the contemporary call for control and transparency of their work. A care worker from a kindergarten described her experience of this control in the following manner:

> I mean, like, everything needs to be reported in writing, and it takes an awful lot of time away from the children. And I've noticed that it has increased. And my older colleagues, they're completely lost, asking whether we really need to do all this. We laugh at it sometimes, like, if I blow someone's nose, should I write and report that somewhere, too?! (12)

Her frustration with the extent to which the workers in the kindergarten are expected to report even the most menial tasks of childcare work illustrates the efforts to increase transparency of welfare service work with medico-managerial practices of care. The reporting is often done with the use of technology, which enables the gathering of standardized information from various types of care facilities.

The speed of technological advancement further challenges the front-line workers to constantly adopt new software applications. Yet, welfare service workers are the ones involved in the hands-on care of children, sick and elderly citizens. The face-to-face care of the service users is important to their self-conceptions as welfare service professionals, which was confirmed by the interviews. In this respect, a nurse questioned the purpose of the reporting practices in her unit:

> The reporting has changed from paper to electronic forms. And the daily reports we need to fill in, keep changing, too. Not all units do this, but we are required to report how many children we've kept in respirators, if we've used extra personnel from outside our unit, and so on. And they say that the reports affect the decisions regarding our resources. But sometimes it's still frustrating to fill them out. Like, does somebody really read these? Maybe the unit manager does, but she is somehow so high and mighty that she doesn't even bother to come and see how we're actually doing. So how is she supposed to make sense of these reports we fill out for her? (13)

According to Clarke and Newman (1997: 66) transparency produced through careful reporting is an important legitimating force for managerial practices (see also Dahl 2009). As public service units and individual workers in them are increasingly made accountable for the efficient use of their resources, the threat of resource cuts is a powerful argument to justify the reporting activities, as the nurse in the previous quote points out. Her thoughts further points to the difficulty with standardized reports to reveal the subtleties in '*how the workers are actually doing*'. Her criticism suggests that as the means of workers' self-assessment and self-management, the current practices leave room for improvement.

The standardized reporting practices represent only one side of the implications of medico-managerial management on care work cultures and professional agency. Another side is the change in the citizens' role from service-users to customers, which pushes public service organizations to tailor and market their services. This marketization entails an expectation of the workers' self-regulated professional development, challenging their identities as public service professionals. Coming to terms with this brings out reflections on one's personal abilities and career choices, as a kindergarten teacher explained:

> Just today, I was talking about this at work - about how we have all these new areas of responsibility, such as developing the safety of our work environment. And I feel pressured to taking more responsibility and being more involved with all these issues, although I'd rather just do the actual work. (…) I feel like this is not what I wanted. I wanted to do the job as I am, with my own personality. And now it just feels like it's not enough, like they're expecting something else of me. (15)

The contradiction between her self-image and the organization's expectations result in identity loss and experiences of insufficiency. They promote a vision of welfare service work not only as care oriented, but oriented towards competitive markets with the discourses of enterprise, quality and customer care. This vision parts essentially from the traditional discourse of public service work that

assigned individual worker's role in the workplace according to his or her occupation. According to Evetts (2009: 255) the new discourse promotes efficient organizational management and embeds the worker to their organization rather than to professional institutions. The kindergarten worker further explained how she had learnt in an in-service training that "each new child in the kindergarten represents the sound of money dropping in the cash register". To her, however, the role of such a market-minded welfare service worker was difficult to identify with.

The interviewees placed high value on the embodied, situational and social nature of care as the key to their positive self-images as welfare service professionals, and were worried that the contemporary terms of welfare service work were increasingly pulling them away from the face-to-face care of patients and clients. The key to a successful day at work, as another kindergarten teachers explained, was in the interrelationships with the service-users:

> A good day is the kind of a day during which I remember I've actually met the children. It's the most important thing. Like, last Monday a little boy said to me after his afternoon nap that "hey, Marja, you're here!". And then he looked at me and said that "you're often here but, like, not *really* here". And that's when I felt really bad because I have all these meetings and such, which is why I'm often only *sort of* present to the children at work. (7)

Her description is representative of other workers' experiences of being increasingly engaged in practices of monitoring, planning and reporting the care services their organizations produce. These practices presume and promote a disembodied form of professionalism that rests on the understanding of professional trust as being founded on information and produced through the professional, not necessarily produced in the interrelationships with the service-users. The interviewees' criticized how they do not have enough time for the embodied practices of face-to-face care in which the worker-patient trust builds on touch, communication, eye-contact and sensing of the service-users' individual needs. Next, I will further discuss the nature of care practices in terms of embodied/disembodied professionalism.

6. From Embodied to Disembodied Practices of Care

The medico-managerial management of welfare services has brought on a requirement for the workers' self-assessment, organizational commitment and the idea of customer care. The analysis shows that these challenge the front-line workers' professional self-images and agency. A child care worker, for one, explained how the new practice of drafting individual educational plans to each

child provided her with a way to assess her own professional skills and development:

> The thing with the individual educational plans is that if I succeed in making the goals realistic for each child, the plans allows me to see the progress we've made later on, which is really rewarding. It's rewarding to see that I've succeeded, even if it's only about small steps in each child's development. So, it's a challenge to draft each plan. (12)

The care worker recognizes the potential of the written plans in terms of developing the quality of care as well as her own skills. To her, the plans are a sensible means of professional self-management that serve the good of the organization the service-users and the worker.

Similarly, a nurse from a home care service team explained how technological development and the concurrent implementation of new managerial practices worked in the benefit of her interrelationships with service-users. She described how an electronic patient register aided her to familiarize herself with her customers:

> If I don't have the time to use Effica (=electronic patient register) to read the patient files, it feels crazy to go into the customers' homes because then I can only do the necessary basic tasks. But I don't always have the time. So, if I can, 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, their life history, and 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 I can, so that it's not just separate tasks I do here and there. (25)

Electronic registers can offer valuable information and in the best case, enhance communication and help to build trust in care relationships. Having access and – more importantly – the time to use them, however, is crucial for the successful implementation of technological devices in care work.

According to Van Loon and Zuiderent-Jerak (2011), the potential of electronic registries in enhancing the quality of care is in precisely in how information can help the users to establish trusting relations with the service-users. This information also enhances the transparency of the services, a key feature of medico-managerial management. However, the disembodied practices of medico-managerial care can also result in mistrust toward the service personnel. The choice and voice given to service users as attentive consumers can create tension in the relationships between workers and service-users, as a geriatric care worker recalls:

> 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 should still

> 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've actually done 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!" (17)

The problem with the check-based, disembodied practice of care is that the workers' accountability and trust in worker-patient relationships is difficult to reduce to such standardized practices. The work of the front-line welfare service personnel largely remains hands on, situated and embodied, and relies on the workers' practical sense in creating trustful relationships with and responding to the needs of the service-users. To this end the medico-managerial practices of disembodied care alone may be insufficient as they distance the worker from the embodied practice of care.

A head nurse from a geriatric care home talked about the challenge of disembodied care practices by explaining that besides producing the official reports and files that created transparency in terms of medico-managerial management of care, she kept her office door open – to have an eye and an ear to the everyday activities in her unit:

> The residents often like to come in to say hi and sit down in my office. They don't necessarily pay much attention to what I'm doing. So, I think it's O.K. because they are safe and under my watch there. It's better than if they'd tag along one of the care workers who was busy doing her chores. Plus, the residents have their security bracelets, so they can't leave the ward without us noticing. So, if they're just looking for some company, they might as well come to my office. (Q: And it doesn't bother you?) No, on the contrary! It's very welcome. I keep the conversation light, and they often repeat the same stories anyhow, since they all suffer from memory disorder. So, them coming in my office doesn't really disturb my concentration on the paperwork. (11)

The head nurse's description illustrates how a local, social practice of care can reinforce trust between service-users and workers. Keeping the door open for the residents allows her not only to observe 'how the people are actually doing' in her unit, but to engage in their care. As a head nurse, she has more professional autonomy and leverage to control her work than most lower-level social and health care workers. She may therefore be better equipped to manipulate the medico-managerial management of care with local, situational and social practices than most welfare service workers.

The results of the analysis suggest that it is precisely the hands-on, situated, social and embodied care practices that were important for the front-line welfare service workers in terms of their professional identities. A practical nurse from a geriatric care home illustrated this by recalling the mundane act of serving afternoon coffee to one of her clients:

> If I'm able to do my job with the clients so that they're satisfied, it pleases both them and me. Last summer, I got so sick of this job. But then, one day, I was helping this lovely old lady with her afternoon coffee. She was so old and tired, like any day could be her last. So, I helped her, and she had her eyes shut as she was sipping the coffee, when she began smiling and said "a perfect coffee, thank you". And that's when I felt like I remembered again why I do this job. It's in the small things such as this. (16)

Her recent struggle to find a sense of purpose in her work is telling of the value my interviewees placed on the time and the room for the embodied, situational and social care practices. The implementation of medico-managerial management in welfare services, however, promotes disembodied professionalism, changing care work cultures and professional agency. The results suggest that from the point of view of the front-line workers, the practices of disembodied care bring about both opportunities for better self-management of one's work, and challenges to adapt to new expectations and practices.

7. Conclusions

In this paper I have analysed welfare service workers' experiences of the contemporary medico-managerial management of care in the Finnish public sector. The results suggest that workers' accountability is asserted in a complex network of practices that promote a form of disembodied professionalism in welfare service work. The results suggest that workers' accountability is now being asserted in a complex network of practices – both embodied and disembodied, relational and objective –which have both positive and negative consequences to workers' professional images, to their professional growth and satisfaction at work, and last but not least, to the quality of care as it is experienced by the service users in the face-to-face contact with welfare service personnel.

In terms of welfare service workers' agency, the results point to the significance of embodied practices of care to the workers' to the workers' imaginative ability to empathize with service-users and to their ability to create trust in the worker-patient relations. Embodied practices are therefore important in terms of their self-images as skilled professionals. In the lower levels of the occupational hierarchy of welfare services, however, the shortage of control of one's own work can hamper individual workers' chances for embodied practices of care. Yet, the results also point to the workers' ability to adopt disembodied practices of care in a manner that enforces the idea(l) of

interrelational care, thereby contributing to their agency.

In the Nordic welfare states, care work cultures and professional identities are subject to change in line with the principles according to which the welfare state itself transforms. As the public sector remains the primary employer of social and health care workers in the Nordic countries, it plays a key role in reconstituting not only public service production, but the contours of welfare service professionalism. Further still, the welfare service occupations in the lower levels of public sector hierarchy enjoy relatively limited professional autonomy. The challenge in the transformation therefore lies in the workers' ability to adapt to new professional requirements while finding their work professionally and personally satisfying. In the case of welfare service workers I interviewed, these challenges are experienced through personal achievements and failures in the situational and social practice of care in the everyday encounters with service users. Therefore further understanding of the opportunities and risks of the contemporary management solutions are needed to assure the wellbeing of both the workers and the service users.

[1] I follow Laiho & Ruoholinna's (2012) definition of professional identities in welfare service work that comprises of the person's self-conception as a professional agent based on his or her life history, how they see themselves, what they want to become, what they relate to and identify with, what they value and what their professional commitments are, including the values and ethics of the work. The venue of constructing professional identities is the socio-cultural context of the workplace.

[2] The caring rationality that emerges in the practice of care is a "system of action" that is institutionalized and widely recognized but also dynamic, emergent, local, variable, and shifting.

[3] The practical knowledge that individuals invest in their ordinary activities is often tacit and understood by the French sociologist Pierre Bourdieu as their *symbolic capital* (Bourdieu 1984). Differences in practices are therefore also symbolic differences that constitute a set of distinctive signs for individuals' position in a societal field such as the field of welfare service work.

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Appendix 1: table of interviewees

	Occupation	Workplace	Age & gender
1	Psychiatric nurse	Psychiatric outpatient clinic	52, woman
2	Social worker	Psychiatric open ward	61, woman
3	Paramedic/ Emergency medical technician	Emergency ambulance service	27, man
4	Mental health nurse	Psychiatric open ward	51, woman
5	Registered nurse	Acute rehabilitation unit	37, man
6	Care worker	Social care agency	52, woman
7	Kindergarten teacher	Day nursery	44, woman
8	Kindergarten teacher	Day nursery	45, woman
9	Registered nurse	Geriatric nursing home	53, woman
10	Public health nurse	Geriatric home care unit	58, woman
11	Head nurse	Geriatric nursing home	38, woman
12	Care worker, BA	Day nursery	27, woman
13	Registered nurse	Pediatric intensive care unit	45, woman
14	Registered nurse	Acute rehabilitation unit	29, woman
15	Care worker, BA	Day nursery	33, woman
16	Registered Nurse	Geriatric nursing home / chronic care	30, woman
17	Care worker, BA	Geriatric home care unit	36, woman
18	Assistant head nurse	Acute rehabilitation unit	53, woman
19	Registered nurse	Home care agency	45, woman
20	Care worker	Home care agency	50, woman
21	Registered nurse	Geriatric care unit	27, woman
22	Registered & public health nurse	Home care unit	25, woman
23	Kindergarten teacher	Day nursery	45, woman
24	Kindergarten teacher	Day nursery	35, woman
25	Registered nurse	Home care unit	43, woman