Social Policy & Society (2022) 21:2, 194–209
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Dividing Responsibility for Care: Tracing the Ethics of Care in Local Care Strategies

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This article analyses local care policies through the lens of the feminist ethics of care. The focus is on the normative understandings regarding care that emerge in local care strategy documents and how these understandings relate with the concept of 'responsibility'. In this article, strategies published by the municipality of Jyväskylä, Finland, between the years 2008 and 2016, are analysed using Trace analysis. The research questions are: How is the division of responsibility regarding care among different actors constructed in the strategies? How do the roles assigned to these different actors accord with the principles of ethics of care? The findings show that the documents emphasise individual responsibility in managing risks related to old age, as the norms of local societal institutions are largely detached from the principles of ethics of care. The analysis also reveals the absence of gender and human frailty from the care strategy documents. Rethinking the strategies through the lens of the ethic of care would mean reconceptualising responsibility as relational.

Keywords: Care, ethics of care, local social policy, Trace analysis.

Introduction

Due to demographic changes and the ageing of population, demand for care is expected to increase across developed welfare states. Simultaneously, many welfare states are also facing cutbacks in their social service provision. Growing care needs combined with diminishing public resources are likely to lead to a situation in the future where formal care services will only be available to the oldest and frailest (see e.g. Kröger and Leinonen, 2012), while the role of families and private care provision will increase.

This is also the case in Nordic countries, which have traditionally been characterised by universalist and women-friendly social policies (Hernes, 1987), aiming for equal access to services and a high degree of defamilialism, i.e. low levels of dependence on family-based care. However, these ideals are now being questioned. In Finland the shift has been from public to private responsibility, as both families (see e.g. Jolanki *et al.*, 2013) and the market, i.e. private service providers (see e.g. Anttonen and Häikiö, 2011; Meagher and Szebehely, 2013), are expected to take on a bigger role in solving the 'care crisis'. The role of family and community is particularly highlighted: for example, the strategic programme of the previous Finnish government (2015–2019) stated that 'the opportunities of working-age people to care for family members will be improved' and 'community spirit and intergenerational ties increased' (Prime Minister's Office, 2015: 22–3).[1]

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

Even though the field of care is facing major changes, one characteristic of the Finnish model of care provision remains: the main responsibility for the implementation of care policy continues to be situated at the local level. In Finland, local authorities play a significant role in care provision and in how care is organised in practice. With national legislation typically framed in rather general terms, municipalities have responsibility for and autonomy in organising and providing care. Due to the large number of municipalities and the uneven distribution of scarce resources, the scope and quality of available services can vary significantly among municipalities (Kröger, 1997, 2011). Consequently, in order to gain a comprehensive picture of the discursive framing of Finnish care policy and practice, it is essential to conduct analysis also at the local level.

In this article, the goal is to analyse the normative understandings related to care that emerge in local care strategies of the city of Jyväskylä, Finland. As noted by Sevenhuijsen (1998: 123), documents related to care policy can be analysed as 'vehicles of normative paradigms', and therefore analysing these often seemingly value-neutral documents can reveal something about the normative ways in which care is understood. In this article, feminist ethics of care is used as a lens through which these documents are analysed. Ethics of care can offer a fruitful analytical framework through which the values of local policy can be deconstructed, as well as tools for challenging the underlying normativities regarding care policy (Sevenhuijsen, 2004; see also Bond-Taylor, 2017).

The data of this article consists of the local care strategies of the city of Jyväskylä, Finland. The strategies analysed were published between the years 2008 and 2016. This period was characterised by the economic crisis that started in 2008, and the subsequent austerity measures in social policy. The interest in this article is in exploring the underlying normative understandings regarding care that emerge in these strategies, and how these understandings relate with the concepts of 'responsibility' (Peeters, 2013, 2017) and ethics of care. The research questions of this article are: how is the division of responsibility regarding care among different actors (the state, municipality, market, families, individuals) constructed in the strategies; how do the roles assigned to these different actors accord with the principles of ethics of care?

Contemporary cultural ideals of care in Finland

Since the 2000s, the ideal of active citizenship has had a strong presence in Finnish national care policy documents (Anttonen and Häikiö, 2011). In these documents, older people are primarily seen as responsible citizens who are willing and able to make active and conscious choices regarding the form of care they prefer. It is the responsibility of all citizens to take care of their own and their kin's care needs, and to make conscious decisions regarding the services they need. The responsibility of public actors has been increasingly directed towards enabling citizens' own responsibility (Häikiö *et al*., 2011). In these accounts, older people are seen as active consumer-citizens, and thus the ideals of individual responsibility, independence and self-sufficiency are very much present. Consequently, high-quality care is understood as supporting the independence of both carers and those with care needs (Hoppania *et al*., 2016).

Following the international trends from the European Union level, currently both care policy and public opinion in Finland are in favour of older people having the option to 'age in place' and to live in ordinary housing as long as it is considered possible. Current hegemonic discourses about 'ageing in place' and 'active ageing' emphasise the ideal of

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independence in making sense of old age and care. The neediness, infirmity and fragility that are often natural parts of old age are largely absent from the conceptualisation of Finland's national care policy (Hoppania *et al.*, 2016).

These ways of thinking about the desirability and attainability of the ideal of the independent individual has serious implications for the notion of equality, and consequently for care policy. Institutional reforms such as increasing privatisation and marketisation reflect the ideal of the 'autonomous' individual who makes his or her own 'choices' about how to act in a given situation (Trnka and Trundle, 2014: 138). In Finland, this has meant that the recipients of more extensive forms of care are either constructed as a burden and a drain on scarce public resources or are largely invisible in policy documents (Pulkki and Tynkkynen, 2016; Hoppania, 2019).

These accounts reflected in current care policy are tied up with the general individualistic ethos that is prevalent at all levels of current Finnish society. This ethos is closely linked to the broader international discourse of 'responsibilisation' (see e.g. Peeters, 2013, 2017). Through responsibilisation, the relationship between individuals and the state is constantly being reconfigured. The discourse of responsibilisation constitutes the various processes that transfer responsibility from one actor (the state) to another (the individual); it emphasises that the individual is responsible not only for the self, but also for surrounding society (Peeters, 2013, 2017). However, even though individuals are seen as having responsibility for society, societal structures are simultaneously seen as static and unchangeable, such change being beyond the reach of individuals (Lahikainen and Harni, 2016). Consequently, since changing societal structures is deemed impossible, and self-reliance is expected of individuals, the only strategy an individual can adopt is to turn inwards, focusing on care for the self and the family.

Ethics of care as a theoretical and methodological framework

Ethics of care originated as a theoretical approach that aimed to analyse and highlight the importance of the moral dimensions of care, viewing caring not only as a process and practice, but also as an ethical orientation. Later researchers such as Tronto (1993) emphasised that care should be conceptualised as not only a moral but also a political value, with significance for society as whole. In empirical research, ethics of care has also functioned as a critique of normative understandings of the ideals of independence and individual responsibility in social policy discourses (e.g. Sevenhuijsen, 2003). Feminist ethics of care particularly highlight the gendered nature of care and the need for a more democratic and equal distribution of caring responsibilities, addressing privileged irresponsibility among more powerful groups in society (Bond-Taylor, 2017).

Ethics of care focuses on the interconnectedness of individuals, and acknowledges the relational and contextual aspects of care. The ethics of care framework consists of the interconnected principles of attentiveness, responsibility, competence, responsiveness and trust (Tronto, 1993; Sevenhuijsen, 2003: 184). By using the ethics of care framework in empirical research, it is possible to analyse and deconstruct the normative understandings in current care policy.

In this article, the data is analysed using Trace analysis, generated by Selma Sevenhuijsen (2004). In Trace analysis, the aim is to use the ethics of care as a framework to analyse documents that deal with care policy. Policy texts are often constructed as representing value-neutrality and objectivity, even though values are inevitably always

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present in policymaking. Thus certain values that emerge in the texts are taken as self-evident and apolitical, while moral arguments are simultaneously concealed. Trace analysis aims to evaluate such moral arguments and normative paradigms as they emerge in policy documents, particularly in documents that deal with care policy. By normative paradigm, Sevenhuijsen (1998: 123) refers to 'a configuration of knowledge which orders the description of social problems, in order to pave the way for regulation'. In using Trace, the aim is to evaluate and renew these normative paradigms by taking the perspective of the feminist ethics of care as the main point of reference.

Sevenhuijsen (2004) divides Trace into four steps: *tracing*, *evaluating*, *renewal with the ethics of care* and *concretising*. In tracing, the focus is on deconstructing terminology and assumptions that emerge in the text and often remain unquestioned. These include the leading values of the text, such as assumptions about gender and human nature (e.g. what is considered 'normal' or 'moral' behaviour in relation to care), definitions of care, ideas about the role of the state in care provision, and the overall rhetoric used in the text. The goal is also to evaluate the political philosophy underpinning the text, the adequacy of the text, the social knowledge that informs the text, its sensitivity (or lack of it) regarding power relations, the structural axis of inequality, and the inclusionary and exclusionary aspects of the text. Hence, Trace comes close to discourse analysis in exploring how the social and moral order is (re)produced, maintained and sometimes challenged in textual documents. In tracing the aim is to introduce an alternative definition of care, to reformulate or solve dilemmas and inconsistencies that emerge in the policy documents and to bring forth alternative social knowledge. To conclude, one has to consider how the findings of the tracing might be concretised in the documents – how a particular policy might be reformed if ethics of care would be taken as the normative foundation of policymaking.

Case: City of Jyväskylä

As of 2020, Jyväskylä is the seventh largest city in Finland, with around 140,000 inhabitants. Cities in Finland are generally small in comparison with many other countries, and there has been less history of social segregation in cities than in many other countries (Lehto, 2000). In Finland, municipalities have strong autonomy in the implementation of social policy, and they have a great deal of leeway in organising services as long as they fulfil their obligations under national legislation. The relationship between municipalities and the state has been described as representing a system of 'decentralised universalism' (Burau and Kröger, 2004), as the Finnish welfare system simultaneously, and, somewhat paradoxically, emphasises both national-level universalism and local-level autonomy. This occasionally conflicting relationship between the municipal and national levels creates the core of 'Nordic welfare municipality' (Kröger, 1997, 2011).

Currently, municipalities across Finland face similar challenges. Since the 1990s, local autonomy has grown, as municipalities have been allocated more responsibilities in organising their own service production. However, this autonomy has grown simultaneously as the resources from state administration to municipalities have been cut, leading many municipalities to struggle financially. Growing leeway and diminishing resources have led municipalities to seek alternative ways of organising care services, often leading municipalities to rely to an increasing extent on private service production (see e.g. Vaara *et al.*, 2010; Hoppania *et al.*, 2016). The marketisation of care services has been a growing trend in Finnish municipalities, particularly in the bigger cities, where the expected

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market-base is more extensive than in smaller municipalities (Mathew Puthenparambil, 2019). Interestingly, this development seems to be somewhat detached from political power dynamics at the local level. Usually it is assumed that left-wing parties and politicians have more cautious attitudes towards marketisation than their right-wing counterparts do. However, the results regarding the link between the political composition of municipal councils and the level of marketisation have been mixed and recent studies do not show links between the political composition of the municipal councils and the level of marketisation in Finland (Saarinen and Forma, 2007; Hyvärinen and Lith, 2008; Fredriksson *et al.*, 2010; Mathew Puthenparambil, 2019).

There are both differences and similarities when comparing the local and national level developments in care provision between the years 2008–2016. As expected, the demand for care services in service housing as well as in home care has risen both in Jyväskylä as well as nationally. Service housing refers to the type of housing where people receive services according to their need, and pay separately for their accommodation and the services they use. Service housing is meant for people who need constant help but not institutional care – however, this line between service housing and institutional care remains blurry (e.g. Mathew Puthembarambil, 2019). Home care refers to home services, home nursing and support services, which take place in the older person's home.

The development of (non- and for-profit) private provision in service housing in the city has followed national trends between the years 2008 and 2016. In 2008, 56.5 per cent of publicly subsidised service housing with twenty-four-hour assistance were privately provided, compared to 56.4 per cent nationally. In 2016, the share of private provision had decreased both locally and nationally, from 48.3 per cent of service housing in Jyväskylä and 48.5 per cent nationally (SotkaNet, 2019)

However, differences emerge in the developments regarding home care. The use of home help has grown more rapidly in Jyväskylä than nationally. Between the years 2008 and 2016, the overall number of yearly home help visits rose 33.5 per cent in Jyväskylä and 21.5 per cent nationally. In addition, the developments in private service provision in home care have differed at national and local levels. The number of home help visits per year purchased by the city from a private provider (both non- and for-profit) increased from 30 672 visits per year in 2008 to 168 622 visits per year in 2016. In 2008, 7.4 per cent of all home help visits were privately provided – in 2016, the private share was 27 per cent. Nationally, the percentages for private service provision were 3.6 per cent in 2008 and 6.1 per cent in 2016 (SotkaNet, 2019). Jyväskylä appears to be somewhat of an outlier; according to a study by Mathew Puthembarambil (2019), less than one tenth of municipalities in Finland outsource more than 25 per cent of their total home care services.

Consequently, both the overall number of home help visits and the role of private provision in home help have been increasing in the city more rapidly than at the national level. As part of the increasing of private service provision and the use of service voucher in social and healthcare services, Jyväskylä has been hailed as a pioneer in the marketisation of care services, and held up as an example for other Finnish cities – particularly in implementing the service voucher system and thus increasing private provision of services. When using the service voucher, the service user may choose the service provider, which has been approved by the municipality based on his or her own preferences and needs. The aim of the service voucher system is to increase the freedom of choice for local residents in social and healthcare services. (Suomen yrittäjät, 2015).

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The role of Jyväskylä as a marketisation 'pioneer' can offer a lens onto the broader picture of where Finnish national care policy might be headed in the future, as municipalities are encouraged to find alternative ways of organising their services instead of relying on public service production. Thus it could be expected that, in the future, more and more municipalities will also seek alternative ways in organising their care services – which, up until this point, has usually meant relying more on private service production.

Data

The data for this article consists of local-level strategies that deal with care policy. These local care strategies are part of the making of local care policy in the city of Jyväskylä, Finland. The data comprises six strategies published between 2008 and 2016. The documents were originally written in Finnish, and I have translated the passages cited in the analysis. The documents are listed in Table 1.

The strategies analysed in this article were collected from the records of the municipal board for social and healthcare services. Such municipal boards have a rather invisible yet essential role in municipal decision-making. According to the administrative regulations of the city, municipal boards have responsibility for monitoring and taking care of operations, finances, internal inspection and risk management in their branch of administration, as well as for directing the public provision of services (Hallintosääntö, 2018: §15). The strategies analysed in this article were used as guiding documents for the board's decision-making. These documents inform local policymaking, and are used, for example, when decisions regarding municipal finances are made, or when new practices are being developed (Ahosola and Henriksson, 2012).

Like all decision-making regarding policy, the planning and reform of policy that takes place at the local level is politically and ideologically charged (Vaara *et al.*, 2010). Consequently, local care strategies have the complex task of trying to fit together differing social and political interests, goals and ideologies (Ahosola and Henriksson, 2012). As local policy documents contribute to policy preparation and agenda-setting at the local level, they are well suited for Trace analysis (Sevenhuijsen, 2004: 17). Local care strategies include the vision regarding the direction care policy should be taking, and the arguments that are considered sufficiently plausible to guide future care policy (Lähteinen, 2004).

The strategies analysed in this article have been written by different actors, representing consulting firms (Conceptualisation of service production, 2015, Service network report, 2016) and those working in the field of elder care in the city (Regional care services 2008, Welfare plan 2014, Social and healthcare reform plan 2016). For Service strategy 2010, the author(s) of the strategy remained unknown. Consequently, it could be expected that there would be some tensions or differences emerging in the texts according to who has been responsible for formulating them, even though also the strategies that have been authored by consulting firms have been written in close co-operation with the city. Even though the documents cannot be read as descriptions of 'the way things truly are', they do participate in shaping reality. As pointed out by Sevenhuijsen (2003), texts that deal with care policies are not mere describers of reality, but also participate in constructing the reality of care. Therefore it is essential to examine the kinds of reality and the visions regarding the future that are created in and through local care strategies.

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

Table 1 Data

Name of the document	Reference in the text	Year of publication	Author
Seudullisten vanhuspalvelujen strategiset linjaukset vuoteen 2030 ja toimeenpano-ohjelma (Strategic alignments of regional care services to 2030 and programme of implementation)	Regional care services 2008	2008	11 municipalities in the Jyväskylä area
Sosiaali- ja terveyspalveluiden strategia 2011–13 (Strategy for social and healthcare services 2011–13)	Service strategy 2010	2010	Unknown
Ikäystävällinen Jyväskylä: Ikäihmisten hyvinvointisuunnitelma 2014–16(–20) (Age-friendly Jyväskylä: welfare plan for the aged 2014–16(–20))	Welfare plan 2014	2014	City of Jyväskylä
Vanhuspalvelujen palveluverkkoselvitykseen liittyvä palveluntuotannon ja -mallien konseptointi (The conceptualisation of service production and models related to the elder care service network)	Conceptualisation of service production 2015	2015	Nordic Healthcare Group
Keski-Suomen Sote 2020: Keski-Suomen ikäihmisten palvelujen järjestämissuunnitelma vuonna 2020 (Social and healthcare reform in Central Finland 2020: plan for organising services for older people in Central Finland in 2020)	Social and healthcare reform plan 2016	2016	City of Jyväskylä
Jyväskylän kaupungin sosiaali- ja vanhuspalvelujen sekä perheiden ennaltaehkäisevien sosiaali- ja terveyspalveluiden palveluverkkoselvitys (Service network report on social and elder care services and preventative social and healthcare services for families in the city of Jyväskylä)	Service network report 2016	2016	Haahtela Group

Tracing local care strategies

The analysis in this article is constructed following the steps of tracing which were most relevant to the research questions, as it would be impossible to analyse the documents fully in detail in the space of one article. First, the normative frameworks are established, the care strategies are situated in their societal, local and temporal context, and the strategies' leading values are explored. Next, the terminology used in the strategies is evaluated, with particular emphasis on how the term 'responsibility' is constructed in relation to care, how responsibility is seen to be divided among different actors and how the roles assigned to these actors accord with the principles of ethics of care.

Situating local care strategies

The strategies analysed in this article consider economic austerity and demographic changes taking place at the national level as their starting points – demographic changes are seen as shaping 'all levels of society' (Welfare plan, 2014: 3). Even the oldest strategy document (Regional care services, 2008), written before the economic crisis hit Finland, includes a section on financial preparation for the growing need for care services. Even during times of economic upturn, Finnish social policy since the 1990s has adapted to a state of 'permanent austerity' (Hiilamo, 2014: 306), which can be read from the ways in which all the documents, even the oldest one, is written. The discourses in this document that relate to the economic situation are similar to the discourses in strategies published later. Even in the 2008 strategy, the emphasis is on limited resources and the accelerating use of public funds.

In all the strategy documents analysed here, the amount of resources directed to care services are expected to stay at current level, despite the expected increase in the number of service users. In Conceptualisation of service production (2015: 12), the services targeted at the oldest segment of the population are seen as facing three major challenges in the future. These challenges concern (1) the potential growth in the number of service users, (2) strict economic preconditions following the increasing dependency ratio and (3) the decreasing availability of personnel. Strict economic preconditions are illustrated in the same strategy document (12), by stating that 'current resources will be used to care for an increasing number of service users', which entails the 'need to significantly increase the productivity of services'. The reasons behind the decreasing availability of personnel are not addressed as questions related to care service workers' working conditions (e.g. Kröger *et al*., 2018) or wage levels (e.g. Koskinen Sandberg, 2016). Instead, the decreasing availability of personnel is discussed only in terms of older workers retiring from their jobs in the care services, and the workforce deficit that care services consequently face.

As resources are limited and the number of users growing, the question of who is seen as the one most needing or deserving the services offered by the public sector becomes a moral question in itself. In Regional care services (2008: 8), the optimal way of dividing scarce public resources is described as 'balancing the common and the individual good', followed by the principle that 'as many as possible would be helped within the limits of existing resources' (Regional care services, 2008: 8). This can be seen as implying that some will have to find other ways to cope than by using publicly provided services. If the aim is to 'help as many as possible', this would imply that the emphasis would be especially on those whose care needs demand less resources, instead of those who are in

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need of heavier forms of care. Consequently, the focus is shifted away from the most vulnerable people who need heavier forms of care, as they are discursively diminished in the strategy documents (cf. Anttonen and Häikiö, 2011; Häikiö *et al*., 2011; Hoppania, 2019).

One of the focuses in local care strategies is improving and maintaining the functional capability of older people. Tied together with this focus is the explicitly stated aim to reduce the use of services funded by the public sector. In the local strategy documents, citizens are guided to be responsible and reasonable when consuming publicly funded services and using the already scarce resources (cf. Clarke, 2005: 451). In Conceptualisation of service production (2015: 6), it is stated that 'the goal is to increase communication and guide service users to more actively take care of their own well-being and make use of other services than those funded by the public sector'. Thus, individuals are encouraged to use private services, but the responsibility of market as provider of care is not explicitly stated – instead, private provision is addressed through negation.

As pointed out by Sevenhuijsen (2003, 2004), the text in policy documents is usually framed as value-neutral. However, in the local care strategy documents analysed here, there are also explicit discussions of the 'values' and 'vision' of local care policy. It is even explicitly recognised that 'values are the basis of all decision-making' (Regional care services, 2008: 7). In the broader strategy for social and healthcare services in Jyväskylä (Service strategy, 2010), the main values guiding the organisation of social and healthcare services fall into five categories: (1) human rights and equality, (2) equity and individuality, (3) openness and trust, (4) safety and readiness for change, and (5) solidarity and inner entrepreneurship.

In the strategies, there are several expressions regarding values that can be seen as fitting with the Nordic welfare state ethos, and with ethics of care. Values such as solidarity, parity and self-determination are mentioned. However, in Service strategy (2010), for example, the concept of 'solidarity' (grouped together with 'inner entrepreneurship') refers to 'supporting and promoting the well-being of residents in the municipality' and 'increasing individuals' responsibility for themselves and their communities'. Thus, solidarity refers to individuals' responsibility for themselves and their communities, instead of e.g. wider societal solidarity, or public actors' solidarity with citizens.

The emphasis on individual responsibility, and the need to reduce the use of services offered by the public sector, reflects how the rhetoric used in local strategies has shifted from the ideal of universalism, which has traditionally been seen as characteristic of Nordic countries, towards a more neoliberal understanding of the division of responsibilities among the state, municipalities, families and individuals regarding care (cf. Vaara *et al*., 2010). Likewise, the emphasis is not only on individual responsibility for the self, but also on how individual responsibility will solve the problems related to macro-level societal challenges regarding the ageing of population. If individuals rely more on self-care and purchase private services, they will use fewer of the services provided by the public sector, and questions related to the sustainability of public finances will be resolved (cf. Lahikainen and Harni, 2016).

In situating the care strategies, the expectation before starting the analysis was that differences would emerge between the analysed strategies, as the strategies have been written during a span of eight years and authored by both consulting firms and those working in the field of elder care services in the city. However, all the documents analysed reflect similar discourses related to 'permanent austerity' and

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

individual responsibilisation. Some of the documents give more specific instructions for the individuals than others, but the broad, overarching theme in the texts is how the role of the public sector is described as diminishing in the future, which ultimately leads to growing emphasis on individual responsibility as well as private provision of services. Even though the strategies analysed in this article cannot be read as a straightforward description of the current reality of care, local strategy texts are powerful devices, through which certain values, objectives and ideologies are promoted, legitimated and brought to local decision-making, whereas others are silenced (cf. Lähteinen, 2004; Vaara *et al*., 2010). Consequently, it is important to ask what are the consequences for the future of care in the discourses promoted in the local care strategies. Next, the focus turns to how these broader discourses are reflected in how the distribution of responsibility for care is seen in the strategies.

Evaluating the distribution of responsibility among different actors

In all of the local care strategies analysed in this article, one of the leading values is 'responsibility', which is one of the core principles of ethics of care. In the local care strategies, 'responsibility' particularly concerns individuals and the family: the provider and organiser of care is primarily the ageing individual who, via self-care, leads an active, independent and autonomous life. If care needs emerge, family, kin and community should first respond to these needs (cf. Murray and Barnes, 2010). In this way the discourse of responsibility becomes responsibilisation (Sevenhuijsen 2003: 24; cf. Peeters, 2013, 2017), where 'responsibility' is often synonymous with 'obligation'. Consequently, individuals are not only supposed to voluntarily behave in responsible ways, but they are also obliged to make the 'right' kind of choices and decisions in relation to care.

Previous studies (e.g. Jolanki *et al*., 2013) have shown that Finnish care policy increasingly relies on care provided by families and kin, and that informal care is even understood as the main or most important form of caregiving. In the laws regarding care for older people, there exists 'a functional and economical loyalty assumption' (Kalliomaa-Puha, 2017: 232) regarding the role of family and kin as providers of care – i.e. that when the ageing person has care needs, those needs will be met by their spouses, children, other relatives or friends. This assumption hides the fact that not everyone has these social resources to draw on in times of need, making people in the most vulnerable situations disappear from the documents (cf. Hoppania, 2019).

In the local strategy documents, families, family life and kin are described in gender-neutral terms (cf. Sevenhuijsen, 2003). The assumption about the strong caring role of family is also connected to an implicit 'gender assumption' (Kalliomaa-Puha, 2017) – that the assumed gender of a carer is often female, even though gender is not addressed in the documents analysed here. This absence of gender is not surprising, as several previous studies (e.g. Ahosola and Henriksson, 2012; Autto, 2016; Sihto, 2018) have revealed the absence of gender from local policy documents, as well as lack of gender impact assessments done in local decision-making in Finland (Elomäki, 2014). Also the wider overall discourse on gender equality in Finland relies on the paradoxical idea that the best way of promoting gender equality is to stay silent on issues related to gender (e.g. Ylöstalo, 2012). However, as care and gender are historically and socially tightly interlinked, the seeming gender-neutrality in terms of care often functions in ways that hide the gendered nature of both professional and informal care – that care work is a

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heavily female-dominated field of work and that women continue to carry a bigger share of informal care than men do.

In the local strategy documents, families and kin are simultaneously discussed in administrative and moral terms, both as 'service producers' and as those 'morally responsible' for care. The care provided by families is simultaneously understood both as part of the entirety of public care services and as a private matter, dependent on 'morality'. As in the analysis by Sevenhuijsen *et al*. (2003), care among family members is constructed not only as social, but also as a moral practice and obligation. Interestingly, not only the responsibility of the family but also one's own responsibility for self-care is explicitly based on a 'moral sense of responsibility'. In Social and healthcare reform plan (2016: 9), the division of responsibility between public and private actors in care is addressed as follows:

> The responsibility for welfare is divided among public authorities, individuals and families, and other actors such as businesses, organisations and volunteer associations. Public responsibility is defined in legislation; the responsibility of individuals and families is mainly based on a moral sense of responsibility.

In care strategies, older people are encouraged to take responsibility and plan their own futures. When they retire (if not earlier), people are encouraged to make 'an ageing plan' for themselves. In Social and healthcare reform plan (2016: 9), this ageing plan is divided into five subcategories: (1) participation in society (e.g. through voluntary work), (2) relationships with family, kin and friends, (3) future housing needs, (4) physical, mental and social ability to function (paying attention to e.g. physical exercise, diet, use of alcohol), and (5) how one's care and interests will be organised and supervised in the future. These five categories of responsibility can be understood as risk management – as measures that aim to prevent, or at least postpone, the emergence of care needs. Thus, being a responsible individual is realised through techniques of self-surveillance and self-assessment. Responsible individuals must weigh their actions in relation to the potential effects of those actions, and must design their lives so as to avoid harm and risks, not only for themselves but also for the surrounding society (Trnka and Trundle, 2014: 138).

In addition to the responsibilisation of individuals who are using care services and their kin, the role of those working in care services is also under scrutiny (cf. Juhila and Raitakari, 2016). In the local care strategies, care workers are, to an increasing extent, responsibilised for the outcomes of their work and for the structural flaws in the organisation of care work. In Conceptualisation of service production (2015: 63), several of the biggest weaknesses of home care listed are related to the attributes of the home care workers, such as (wrong kind of, or lack of) 'know-how and attitude', 'doing the work in a performance-oriented way' and 'lack of rehabilitative manner and target-orientedness'. Again, these perceived weaknesses are not addressed as structural issues, such as problems in care service workers' working conditions (e.g. Kröger *et al*., 2018) or low wages (e.g. Koskinen Sandberg, 2016). Instead, these are seen as characteristics of care workers themselves.

In contrast to the responsibilisation of care workers, the overall responsibilities of municipalities are addressed in rather narrow terms. In Social and healthcare reform plan (2016), municipalities' responsibilities are divided into ten subcategories. None of these explicitly concerns access to social or healthcare services; rather, they involve issues such as mobility, participation in society, and the accessibility of various spaces. Thus all these

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categories presume an older person who has a fairly high functional capacity. In this strategy document, the responsibility of the public sector is only addressed as being 'defined in legislation'.

Renewal of the documents analysed here with the ethics of care would mean reconceptualising 'responsibility', as seeing 'responsibility' in individualistic terms is insufficient in order to achieve high-quality care. Often it also means unequal distribution of caring responsibilities along, for example, gendered lines. In her later work on ethics of care, Tronto (2013: 35) added another principle to the framework of ethics of care – *caring with*, which encompasses plurality, communication, trust and respect; solidarity. Instead of seeing 'responsibility' pessimistically as individual responsibilisation, Tronto (2013) points out that emphasis should be on responsibility as relational, as it would help to create a wider societal responsibility in order to build more democratic policies, which would bring care and care needs to the heart of how societies are organised. If societies fail to do this, some groups of people can live in a state of 'privileged irresponsibility' in which they are dependent on care given by others, but can 'pass on' their caring responsibilities to others.

Conclusions

The aim of this article was to analyse the normative frameworks of care policy documents and how the distribution of responsibility is constructed in these documents. The strong normative discourses present in the local care strategies emphasised the ideal of the independent individual, and the responsibility of individuals and families for solving the 'care deficit' (cf. Sevenhuijsen and Švab, 2004). The ideal is that older people should live active and independent lives, and if care needs emerge the family will form the main arena of care provision (cf. Sevenhuijsen *et al.*, 2003). The data analysed in this article emphasises familialist notions of care, and positions self-reliance in opposition to dependence on care provided by the public sector (cf. Sevenhuijsen *et al.*, 2003). Consequently, individuals, families and care workers are expected and encouraged to follow the principles of ethics of care, and to be attentive, responsible and responsive to changes in their own as well as to their kin's or customer's health conditions, as well as cautious when consuming publicly funded services. However, in the local care strategy documents, the norms of societal institutions are increasingly detached from the principles of ethics of care: as pointed out by Juhila and Raitakari (2016), the increasing responsibilisation of individuals is often linked to the 'irresponsibilisation' of state and public government, leading to the ignorance of the structural roots of problems.

The question of gender was absent from the local care strategies that were analysed here (cf. Ahosola and Henriksson, 2012; Bond-Taylor, 2017; Sihto 2018). Even though both professional and informal care are persistently gendered, the local care strategies never elaborate on exactly who is expected to bear heavier care responsibilities in the future, nor on how or under what circumstances this will be done in practice. As noted in previous research (e.g. Leitner, 2003), the promotion of the role of the family in organising care usually leads to a reinforcement of the current gendered nature of care, since promoting the role of families does not take into account the existing division of care responsibilities within the family. If policy fails to address these concerns regarding the familial division of care, it risks strengthening gender inequality (see e.g. Bond-Taylor, 2017), leaving women to carry out increasing amounts of unpaid care in families. The ties between gender and care need continual deconstructing and awareness on how gender

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

processes operate in practice (Sevenhuijsen, 1998). However, currently in Finland, the gendered impacts of policies and policy changes at the local level are rarely analysed (Elomäki, 2014).

The emphasis on the individual, families and communities reflects the neoliberal ideal of citizenship which requires the individual to engage in life management, have the ability to anticipate and control risks, and adapt to changing societal and personal circumstances. Thus the expectation is that the ageing person has the ability to manage the risks related to old age, and to postpone or even prevent frailty via self-care. This focus on the self and the family as providers of care hides the fact that not everyone has societal sources to draw on. In addition, it makes the most vulnerable people disappear from the documents, as the emphasis is on the ideal of the active, independent and self-sufficient individual (cf. Anttonen and Häikiö, 2011; Häikiö *et al*., 2011; Hoppania, 2019).

The findings of the analysis are, to some extent, in accordance with previous findings done at the Finnish national level (e.g. Anttonen and Häikiö, 2011; Häikiö *et al*., 2011; Hoppania, 2019), indicating the increasing emphasis on the responsibilisation of older people for their own well-being, growing role of family and kin in care provision as well as the discursive diminishing of the public sector in organising care. This is not surprising, as the developments taking place at the municipal level inevitably reflect national level laws and policy alignments. However, paying attention to developments taking place at the municipal level is essential; as the national laws and policy alignments that deal with care policy are implemented into practice by municipalities it is at the local level where the everyday care is organised, (re)negotiated and lived. This study contributes with a more nuanced reading on how the different responsibilities regarding care are constructed in local policy-making. In Jyväskylä, the responsibility of individuals is emphasised, the responsibility of municipality is narrowed down to being primarily the facilitator of independent, active living of older people.

The idea of the strong welfare state can be seen to be based on the premise that there are certain risks, such as unemployment or illness, which are beyond the control or responsibility of the individual. Therefore, there is a need for social policy systems that offer collective insurance and social security. However, as responsibilisation has become a powerful discourse, the responsibility for reducing risks is increasingly thought of as an individual matter. Peeters (2017) argues that there has been a shift from a solidarity paradigm to a preventative paradigm: while the solidarity paradigm emphasised collective forms of insurance offered by the welfare state, the preventative paradigm suggests that individuals should act in ways that prevent a particular risk from being realised. Traces of this can also be found in the strategies analysed in this article. These strategies offer guidelines for ageing people regarding how they can take better care of their own physical and mental health, while simultaneously encouraging less reliance on services offered by the public sector.

As a method, tracing aims to bring care policy and ethics of care together. The process of doing this is not straightforward nor without frictions, as the (local) economic situation is constructed as the main concern in the strategies. Thus, it is not surprising that the principles of ethics of care often seem to be relatively invisible, as economic concerns are considered as more pressing. It is also important to note that, as in the documents analysed in Bond-Taylor's (2017) study, the documents analysed here do not claim to follow principles of ethics of care.

The emphasis on the independent individual can be seen as contradictory to ethics of care, which is based on a relational ontology (Sevenhuijsen, 1998) that highlights

https://doi.org/10.1017/S1474746420000585 Published online by Cambridge University Press

interdependence as characteristic of human life (Sevenhuijsen and Švab, 2004: 10–11). Rethinking the strategies through the lens of the ethic of care would mean more emphasis on relationality: for example, the informal care provided by families, kin and friends would be recognised, and there would be more forms of support available for those doing the caring. However, this support should be constructed in ways that would democratise rather than reinforce the genderedness of care. The notion of care in itself is taken as rather self-evident and naturalised in the local care strategies – the assumption is that everyone knows what caring is without further explanations, knows how it should be done, and that care among family members is something that just 'happens' by itself. Instead of taking care for granted, care should be made visible as 'a cognitive, reflective, and moral practice' (Sevenhuijsen, 1998: 32). The viewpoint of the ethic of care would also make the (inter)dependence of individuals more visible, instead of the focus being on self-care and self-monitoring in order to prevent the risks related to old age.

Acknowledgements

This study has received funding from: 1) Central Finland regional fund and 2) the Centre of Excellence in Research on Ageing and Care (CoE AgeCare), Academy of Finland (project number 312303).

Note

1 As of 2020, the last parliamentary elections were held in 2020, leading to the change of the composition of the government from the previous right wing–centrist government to the current left wing–centrist government.

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