



The anti-politics of healthcare policy and its blurring effects on care work in Norway

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Abstract

The *aim* of this article is to explore discourses of public healthcare sector transformation in Norway. These discourses are part of a wider European neoliberal discursive terrain shaped by policies that focus on competition, choice and 'integration' in healthcare. The *method* applied here is a combined Foucauldian and post-Marxian discursive approach with a political theoretical focus on how issues are given meaning in specific contexts, emphasising discourse as a situated social phenomenon that encompasses a materiality constituted by and constitutive of discourse. Person-centred care has emerged as a new trend in healthcare in Western countries over the past decade, and is in Norway articulated at policy level as 'the patient's healthcare service'. This article recognises person-centredness as a valuable ideal in care relationships and practices at the individual level. However, the article *argues* that the focus of person-centredness, embedded in a broader ideological trend of individualisation, may also mask a change in the relationship between the state and its citizens that has a depoliticising effect on healthcare at the institutional and structural level of society. As a *result*, in Norway one of the effects of recent healthcare policy and intervention has arguably been a depoliticisation of care work. Depoliticisation through the trajectory of naturalisation, has the effect of re-informalising care work, clouding its socioeconomic value and making it 'invisible'. This process is discussed as representing a potential challenge to the key societal value of gender equality, since care work is thereby domesticised and re-feminised. The contribution of this article regarding *implications for practice development* is to inspire professionals to reflect critically on both contemporary discourses and policies of healthcare and some of the potential effects on care work. Finally, the article also aims to provide practitioners with a framework for understanding policy and its articulations at various levels, and thus, it is hoped, contribute to their empowerment.

Keywords: Healthcare policy, Norway, depoliticisation, analysis of discourse, care work, informalisation, critical reflection

Introduction

Over the past 30 years European states and societies have seen a 'steady narrowing of the domain of the political', a rise of the rule of experts and a transition to a situation of 'post-politics' (Kalb, 2011, p 3, 2014, p 251). Neoliberal capitalism plays a key part in this dwindling of the political, as depoliticisation can be seen as inherent to its ideology (Brown, 2006, 2015; Büscher, 2010, p 31; Blokker, 2014, p 263). Healthcare is a strongly politicised field in every Western society, yet this article will argue that we are seeing a tendency to depoliticise it. Throughout Europe, austerity policies inform healthcare policy. Reforms are set in motion by increasingly technocratic governments as the simultaneous ongoing naturalisation of capitalist relations depoliticises the economy and restricts political control (Blokker, 2014, p 263). It is within this wider contemporary context that the transformation of the Norwegian public healthcare sector is discussed as having the side-effects of an anti-politics machine (cf. Ferguson, 1994). The main argument is that recent ideas, policies and reforms produce unauthored effects. One such effect is the depoliticisation of care work through re-familialisation and re-informalisation: this kind of work is increasingly being pushed into the private (family) sphere and thus into the informal (care) economy. This effect potentially reinforces a re-feminisation of care work – the gender division of labour in the field – and, more generally, challenges the value of gender equality. It also blurs the socioeconomic value of care work and in a sense makes it (structurally) 'invisible'.

Demographic changes are bringing, among other things, a radical increase in the number of older people living with health needs of varying complexity. Throughout Europe, this trend is perceived as a major societal challenge. Reforms, brought about by state interventions, are implemented with the goal of creating healthcare systems that will be sustainable in the future. These interventions are embedded within the hegemonic discourse of integration (Glynos et al., 2014). Integration can be seen as political logic that, although articulated differently in various national contexts, carries certain prerequisites, such as a focus on each individual's autonomy and freedom of choice, and the rule of the market. In Norway, this logic is embedded in the wider discourse of public sector transformation and articulated through concepts such as the coordination of healthcare and person-centred healthcare (Norwegian Ministry of Health and Care Services, 2008-09, 2012-13, p 96). When governments across Europe reform their healthcare systems, their interventions can produce effects other than those intended, as noted above. However, these effects are crucial in the production of certain structural changes.

Analysis of discourses

This article is a theoretical discussion of healthcare discourses and their societal implications. The discussion is based on the analysis of discourses concerning the Norwegian healthcare system, with a particular focus on the ways the calls for transformation and planned interventions in the public healthcare sector are construed as 'problems', articulated and legitimised. Documents central to this discussion include the following Norwegian Ministry of Health and Care Services White Papers: *The Coordination Reform* (2008-09), *Future Care* (2012-13) and *The Primary Health and Care Services of Tomorrow – Localised and Integrated* (2014-15).

Public discussions by various actors, such as politicians, scholars and professionals in the healthcare sector, form a backdrop and a wider basis for this analysis. Finally, this article will make use of a number of empirical and theoretical works on the issues of healthcare policy, labour and neoliberal capitalism.

The concept of discourse has come to embody a range of different meanings in the literature, as demonstrated by the plethora of discourse theory traditions (Bacchi, 2005, p 199). One can roughly divide these into two analytical traditions: one in which the meaning of discourse lies close to the meaning of language, and a second that includes a political theoretical focus on how issues are given meaning in specific contexts (Bacchi, 2005, p 199). This article follows the second tradition, and is inspired by Foucauldian and post-Marxian approaches to discourse, such as the work of Bacchi (2005, 2009), Brown (2006, 2015), Springer (2012) and Mouffe (2013). These scholars emphasise discourse

as a situated social phenomena that should be analysed within the socio-historical context in which it emerged, and recognise a materiality that is both constituted by and constitutive of discourse; materiality and discourse become integral, where one cannot exist without the other (Springer, 2012, p 143). Healthcare policy, as part of a larger assemblage of knowledge – the discourse on public sector transformation – is thus not solely about finding solutions to perceived problems but also about ways in which problems are constructed through sets of statements ‘that brings social objects into being’ (Shaw and Greenhalgh, 2008, p 2508). A discourse is thus an assemblage of specific ways of talking, understanding and relating to a particular subject, but it is also ‘a practice, it is structured, and it has real effects...’ (Ferguson, 1994, p 18). Thus, policy papers as tools of governance with solutions to societal problems, both produce and are produced by discourses (Christensen and Fluge, 2016, p 265). Finally, in order to nuance the relativist epistemology of such a macro-level constructionist analysis with its tendency to limit, or deny, agents’ transformative capabilities, this article will draw on critical realism, which grounds its thinking in human emancipation and which to a greater degree than macro-level approaches allows a space for agents to change structures (Cruikshank, 2012, p 80; see also Bhaskar, 1975; Schiller, 2016; Williams et al., 2017). This is an important point to make in relation to one of the aims of this article – to inspire professionals to critically reflect on policy and innovation in the healthcare sector.

Depoliticisation and the anti-politics machine

Ferguson (1994) introduced the concept of the ‘anti-politics machine’ in his seminal analysis of the concept of the development discourse in Lesotho. He refers to the anti-politics machine as the processes through which political questions are converted into technical ones – that is, they are depoliticised, while ongoing political processes continue to expand bureaucratic (or technocratic) state power (Ferguson, 1994, p xv). According to Ferguson, the institutional production of certain kinds of ideas (of development) generates its own discourse as a structure of knowledge, and new interventions are based on this new knowledge structure. Interventions may ‘fail’ to achieve what they aim for, but they nevertheless have effects that are crucial in the production of certain kinds of structural changes. The effects are the twin movements of conversion and expansion referred to above, and constitute the anti-politics machine. Thus, discourses assemble into specific knowledge structures that produce real and sometimes unintended effects.

From this perspective, the state is conceived of in Foucauldian terms as not an actor but as a way, or mode, of coordinating power relations. What follows is that state bureaucratic power is a ‘mode of power that relies on state institutions, but exceeds them’ (Ferguson, 1994, p 273), and that the expansion of this power points not to ‘the capabilities of “the state” but the extent and reach of a particular kind of exercise of power’ (Ferguson, 1994, p 274). Ferguson’s conceptualisation of the anti-politics machine is institutional and structural. To elaborate the analytical potential of the concept, this article supports Büscher’s (2010, p 33) call for a more ‘explicit political conceptualisation of anti-politics... that recognises how... interventions are subsumed under, and at the same time reinforce, the neoliberal political economy within which they function’. This article will focus on the dimension of depoliticisation (and not on the expansion of state bureaucratic power) and draw on Brown’s (2006, 2015) perspective to expand on Ferguson’s notion of depoliticisation as technocratisation and include the possible depoliticisation trajectories of personalisation and naturalisation.

Now, the concept of ‘politics’, or the political, may broadly refer to ‘the social, deliberate process with which actors make decisions that determine social or public outcomes’ (Bücher, 2010, p 34). Politics will always involve differences in values and ‘it embraces... the definition of societal problems... the elaboration of binding decisions and the establishment of its own rules. Politics delineates the realm of common affairs’ (Schedler, 1997, p 3). Political questions involve choosing between conflicting alternatives and are not technical issues solvable by experts (Mouffe, 2013, p 3). Thus, ‘politics’ describes the overall functional and formal ways in which collective affairs may be governed, while

the concept of 'public policy' refers to more specific ways of thinking and governing on a certain perceived societal 'problem'. In other words, policy is 'the translation of political values into changes in society' (Shaw and Greenhalgh, 2008, p 2506). Thus, implicit to the notion of policy is the idea that something needs to be changed. However, the 'problem', or what is in need of change, does not necessarily always become explicit in government policies. As mentioned above, 'the problem' may be given shape through policies as problematisations of a certain issue, rather than be 'addressed' by them (Bacchi, 2009, pp x-xi).

Brown (2006, p 15) analyses 'tolerance' as a discourse of depoliticisation in the US and claims that depoliticisation involves the construing of a social phenomenon, or a problem that previously called for political solutions (for example subordination or marginalisation), as 'personal and individual, on the one hand, or as natural, religious, or cultural on the other'. Accordingly, she identifies two key trajectories of depoliticisation as personalisation and naturalisation. Depoliticisation may have many layers, but it is always tied to 'the diffusion of market rationality across the political and social spheres' (Brown, 2006, p 17). Both Brown (2015, p 17) and Büscher (2010, p 34) discuss this point in relation to neoliberalism and claim that the principle of commodification – the market as a guide for all human action – fundamentally changes political conduct by discrediting alternative politics and by converting contradictory values into economic matters that are decided through the rule of competition. Thus, 'neoliberalism is an ideology that favours particular modes of political conduct, such as anti-politics' (Büscher, 2010, p 34). Regarding the US context, Brown (2006, pp 17-20) identifies as achievements of depoliticisation the legal formalism of liberalism, the importance of individual heroism and failure, the saturation of social and political life by consumer discourse, and the culturalisation of politics which subjugates conflict and difference.

Moreover, following Brown (2006, p 15), depoliticisation always involves 'removing a political phenomenon from comprehension of its historical emergence and from recognition of the powers that produce and contour it'. In addition to the eschewing of 'power and history in the representation of its subject', as discussed above, Brown (2006, pp 15-16) refers to a related meaning of depoliticisation – that it 'substitutes emotional and personal vocabularies for political ones in formulating solutions to political problems'. From the above we understand, therefore, that a process of depoliticisation may take different trajectories but will always involve a reduction, a reorientation, a conversion or a conflation of the subject in question.

The welfare state, liberalisation and labour

New ideologies and reforms in Norway, as elsewhere, do not occur in a void but are influenced by global changes in the political economy. Thus, welfare models and healthcare systems are reshaped within a wider societal transformation marked by 'globalisation', which is in turn shaped by neoliberal capitalist ideologies of market liberalisation (Harvey, 2005, 2014). After World War II, the rise of the welfare state in the West led to an expansion of the public sector as the cornerstone of a social order, which facilitated better conditions for work through consolidation of labour rights and for life through social security arrangements (Breman and Linden, 2014, p 921). However, events beginning in the 1970s saw welfare states start to change.

Liberalisation has developed through a variety of trajectories of change and taken on different forms in Western countries (Thelen, 2014, p 13). Thelen describes the Nordic countries as welfare states of coordinated market economies (CMEs) characterised by social solidarity and egalitarian models rooted in 'cuddly capitalism', as opposed to liberal market economies (LMEs) characterised by less egalitarian systems based on 'cut-throat capitalism' (Thelen, 2014, pp 2, 8-9). 'Embedded flexibilisation' is described as the Scandinavian liberalisation trajectory with regard to employment, as opposed to 'deregulatory liberalisation' as in the US, or 'dualising liberalisation' as in Germany. The three ideal-types of liberalisation trajectories 'frequently proceed... through different processes of institutional change: deregulation often through institutional displacement; dualisation through

institutional drift; and embedded flexibilisation through institutional conversion' (Thelen, 2014, p 13). Embeddedness refers to new forms of flexibilisation that are based in institutions and policies that promote collectivised risk that 'protects the most vulnerable groups'. It therefore refers to processes that aim for continued high levels of equality in society (Thelen, 2014, pp 31 and 36).

The societal changes brought about by neoliberalism are many; this paper will concentrate on welfare regimes and labour. Over the past 10 years, Europe has seen a sharp decline in employment and a rise and consolidation of the economy of informality that dismantles the welfare state. The public sector has been liberalised, and in the field of labour policy the key organising principle is now flexibilisation. Breman and Linden (2014, pp 922 and 924) argue that processes observed in the global South, which were described as informalisation, are now recognisable in the West as flexibilisation. Informality has become an operative mode of employment and 'precarisation', or exploitative forms of wage work, is no longer atypical. The end of 'full employment capitalism', in combination with a sectoral shift in economic activity, away from primary and secondary sectors towards an expansion of the tertiary sector (services), has driven a process of rapid spread of precarious labour arrangements in Europe (Breman and Linden, 2014, pp 923 -926).

However, the regime of informality does not take on the same shape in all contexts, as the terms of informality are locally determined. Nevertheless, some traits are common, such as replacement of permanent and full-time employment by casualised part-time jobs, occupational multiplicity, a fall in wage levels and a move from time-rated to piece-rated employment. Moreover, outsourcing and subcontracting, a move from waged work to self-employment (mainly in the growing tertiary sector), lengthening or shortening of the working day, increased irregularity, cutbacks in secondary benefits which affect social security, and lesser control by official agencies with regard to conditions of work are all examples of new practices that may illustrate the move towards 'flexibilisation' (Breman and Linden, 2014, p 926). Some of these traits are arguably recognisable within the healthcare sector and will be addressed below.

Finally, the state has a crucial role in labour rights and social security arrangements. It has been argued that the state has been mediating between capital and labour and is still important in economic policy, but increasingly acts as a partisan to capital (Breman and Linden, 2014, p 929). Thelen (2014, p 31) argues that, in the liberalisation trajectory of embedded flexibilisation, 'the state plays a hugely important role... this trajectory of change requires more rather than less state involvement'. However, in the neoliberal era there has been an insistence on shrinking and transforming the public sector, a sector that somehow is postulated as antagonistic to individual autonomy (Breman and Linden, 2014, p 929). It is within these broader fluctuations in the political economy that the changes in both Norwegian healthcare policies and the labour arrangements within the healthcare sector must be understood. A discussion of the Norwegian context will now address how some of the trends described above are articulated, alongside their possible implications.

The Norwegian welfare state model and the gendered regime of care work

Comparatively speaking, the Norwegian welfare state model provides citizens with extensive universal services. The country's system of healthcare provision is decentralised; it is the municipalities' responsibility to provide primary healthcare services (Vabø, 2009, p 346). A frequently applied description of this model is that it is 'de-familialised', which signifies that care for vulnerable citizens is a responsibility of the state, and is a quality of the healthcare system believed to promote gender equality (Christensen, 2012, pp 581 and 589; Rostgaard and Szebehely, 2012, p 101). However, over the past decade or so this model has also become de-institutionalised as the focus of healthcare service provision has turned towards community care (Norwegian Ministry of Health and Care Services, 2012-2013, pp 14-15). Welfare policies are increasingly influenced by the EU and the ethos of liberalisation tied to New Public Management (Christensen, 2012, p 582; Haukeline and Wyller, 2017, p 25). However, the decentralised municipal care regime has also shown some resistance to 'putting

grandmother out to tender' (Vabø, 2009, p 347; Jacobsen and Mekki, 2012, p 128). Yet, among the impacts of New Public Management in Norway are marketisation and 'externalisation' (privatisation/commercialisation) of (previously) public services, the introduction of a purchaser-provider model, and the establishment of a care market. On the discursive level, we have seen a reframing of 'patients' and 'users' as consumers or citizen-consumers (Christensen, 2012, pp 582-583; Anttonen and Meagher, 2013, pp 13-14; Christensen and Fluge, 2016, p 264). One might argue that this infusion of market rationality into the healthcare sector has undermined the status of professionals as experts in their relationship with patients, who become consumers in terms of the rule of choice and competition.

The Norwegian care services emerged from the so-called 'third sector' through associations of women performing voluntary care work, and were included and formalised in the public healthcare sector system in the 1960s (Vabø, 2009, p 348). This provided many women access to the wage labour market as they took up key care provision roles in these emerging women's professions (Wrede and Näre, 2013, p 57). The provision of care in Norway, as in the rest of the world, is feminised and dominated by women. Gender is thus a basic principle that organises care in most societies (cf. Fine, 2005, p 250; Esquivel, 2014). The cultural naturalisation of care work as an 'extension' of women's domesticity, and the preponderance of women in the paid/formal and unpaid/informal care economy are key factors in this feminisation. Care work is thus to a larger degree than other types of work associated with social reproduction, that is, the production of persons, rather than economic production for profit for the good of society (Haukelien, 2013, pp 196-197). Such cultural naturalisations of work have shaped gendered divisions of labour in Norway and created gender ideals that still strongly influence the labour trajectories of both sexes. Recent figures for Norway show that the unpaid/informal part of care economy is equivalent to the paid/formal part, and that women dominate both (Christensen, 2012, p 589 ; Berge et al., 2014, p 9).

The healthcare sector is labour intensive and the municipal care services have steadily grown in scale over recent decades. Thus, the ideal of equal provision of healthcare services to all citizens is costly for the welfare state and, perhaps for this reason, is a common subject of discussion in public and political debates. An emerging trend in the Norwegian – and wider Nordic – care regimes is increasing reliance on migrant labour (Wrede and Näre, 2013, p 58). Ethnicity has become an intersecting principle with gender in shaping the flexible workforce of the healthcare sector (see Fagertun, forthcoming). Work characteristics in the public healthcare sector, especially in the home-based and elderly care services, and in comparison with other public sectors, include high rates of employee turnover, high rates of part-time employment, a high level of sick leave, relatively low wages, heavy workloads, demanding hours, and difficult work-life (income-time) balance (Jacobsen and Mekki, 2012, p 132). Moreover, this work has a relatively low social regard in Norway. These are all factors that might hinder recruitment and retention to this workforce – a worrisome reality in light of recent calculations that by 2050 Norway will need double its number of full-time-equivalent care sector workers (European Commission, 2012).

Moreover, these characteristics are all recognisable traits of the move towards a regime of informality in labour, as discussed above (Bremann and Linden, 2014, p 926). In one sense we can claim that, in the main, the care workforce has historically been 'flexible', as evidenced by the period of formalisation of care work in Norway and the initiation of social welfare programmes and gender policies that supported women's part-time work (Wrede and Näre, 2013, p 58). However, demand for, and provision of, care services are expanding. The employment pattern of women has changed and the labour market has developed. The care work regime today is increasingly characterised by flexibility, and 'workforce policies are geared towards finding a flexible workforce' (Wrede and Näre, 2013, p 58). However, rather than being a convenient flexibility as in the past, it is now a flexibility often imposed on the workforce.

The predominant political logic of 'integrated care'

Today, the health and social care sectors and services are portrayed as being in constant crisis in every advanced society, something that results in unsettling processes of political crisis management at local, provincial and national levels (Fine, 2005, p 249). 'Integrated care' has emerged as a buzzword

for describing a recent trend in Western healthcare reform, and is often portrayed as a solution to fragmentation. A variety of concepts describe the same kind of reform process, including, among others, comprehensive care, seamless care, shared care or continuity of care. In the Norwegian context, this logic is articulated through the concept of 'coordinated care' (Norwegian Ministry of Health and Care Services, 2008-09). The integration trend emphasises an holistic approach that centres on the individual and the patient's perspective, and key terms are consumer choice, individual autonomy and self-governance. As Brown has observed (2006, p 16), 'One sure sign of a depoliticising trope or discourse is the easy and politically crosscutting embrace of a political project bearing its name'.

Integration can be understood as a vision with concrete meaning, for example, involving coordination and planning along the different nodes of the healthcare service chain (governance, provision, distribution and delivery). It is often explained as not just an organisational process but also as a service design principle that focuses on equity of access. However, integration can also be understood as a political logic with ambiguous content, embedded in a broader discourse of public sector transformation. As a 'master political logic', integration informs healthcare system reform, and it marginalises those who disagree with its vision and suppresses alternatives (Glynos et al., 2014, p 56). Thus, the master logic mutes resistance to 'transformation'.

In Norway, the state increasingly envisions a plurality of actors in healthcare service production. Service users and their relatives, friends and neighbours, volunteer organisations, NGOs, the private sector and local communities – all are portrayed as contributors to the production of healthcare services. Such plurality will change the sector and the labour arrangements within it. The active citizen-consumer has both the right to receive public services and the duty to contribute to their production (Christensen and Fluge, 2016, p 264). This dual role is expressed in White Papers through notions such as 'co-creation', 'co-citizenship' and 'self-governance' (Norwegian Ministry of Health and Care Services, 2012-13, pp 16 and 51; Christensen and Fluge, 2016, p 262), and is central to the new and anticipated relationship between citizens and the welfare state – or on another level, between users and providers of services. There is a call for all actors to take on their co-responsibility for societal problems, and an established 'truth' that in the future 'care community' the care chores must be shared by more actors than today (Norwegian Ministry of Health and Care Services, 2012-13, pp 21-23). In this quest, the policy discourse also specifically targets technology, innovation and person-centredness as means of transformation (Norwegian Ministry of Health and Care Services, 2012-13, pp 14, 16 and 109). Thus, the construed problem is the challenge posed by demographic changes, the justification for interventions is the sustainability of the public healthcare sector, and the solution to this complex problem is proposed to be a responsibility shared by all citizens. This dramatic shift in the state's responsibility towards its citizens indicates a depoliticisation of care along the trajectory of personalisation, and also 'that formal and informal have gone from being alternatives... to partnerships, hybrids, new forms of mixed care' (Fine, 2005, p 249). Moreover, the focus on the individual at the service level implies that greater responsibility, in terms of both time and money, will be placed on each citizen while simultaneously masking potential inequalities produced at the structural level in terms of access and means.

Norway is proud of being one of the world's most gender-equal societies, as evidenced by the enactment of multiple gender-equality policies since the 1970s. Yet, gender hierarchy persists in care work and there is a differential valuation of women's and men's work. The idea of integration or coordination must therefore not only include the care services, but also the work of care and its integration into formal structures of labour. The turn towards a 're-informalisation' and 're-familialisation' of care reveals an inconsistent state attitude and a structural change of the welfare state. The state may acknowledge the size, force and possible impact of the informal care economy and may value it as a tool of innovation (cutting costs/budgets), but it also expresses a devaluing of care work by relegating it to the fringe of formality. Therefore, this article contends that such a policy discourse, embedded in the discursive terrain of 'crisis' and 'transformation', is indicative of an increasing state reliance on the 'invisible' informal care economy. This signals a threat to gender equality and may have the

unintentional effect of a depoliticisation of care work. This article argues that these new trends are promoting informality and flexibility of the work of care, and that they might potentially reinforce the established practice of women in general taking on more care work than men (Wærness, 1984; Breimo, 2014; see also Norwegian Ministry of Health and Care Services, 2012-13).

Conclusion

This article has highlighted a tendency towards a re-informalisation and re-familialisation of care work in contemporary Norwegian healthcare policy, discussing this as a process of depoliticisation within a broader context of the global political economy, where the conditions for both work and 'the political' are changing rapidly. Policy discourses on healthcare have been considered as assembled into specific knowledge structures and as having real, and occasionally unintended, effects (Ferguson, 1994). We have seen that technological innovation, managerial reorganisation or coordination and co-creation are suggested as means to promote the sustainability of the public healthcare sector in Norway. These can be seen as technical solutions to a societal challenge that is deeply political because it concerns the state's relationship with its citizens and the state's deliberate choices and decisions concerning distribution of and access to healthcare. When reforms are driven by the managerial aim of improving coordination of services while cutting budgets, we see a tendency to convert a societal problem into a technical one. In this situation, depoliticisation works along the trajectory of technocratisation. Neoliberalism, thus, also contributes to a depoliticisation of the Norwegian economy, in common with those of other nations, through endorsing expert institutions that emphasise technocratic forms of governance. Economic policy is increasingly labelled as a field of non-political expertise where decisions 'should be grounded in objectively given economic parameters' (Blokker, 2014, p 264). It follows that formerly political matters no longer need political decision making; instead, they are either decided by budgetary factors or through the rule of the free market.

The article has more specifically discussed labour and the work of care in relation to gender equality and projected this work as increasingly 'invisible' in the context of the liberalisation of the welfare state. The strong calls for transformation, and the solutions suggested for reforming the healthcare sector in Norway, have arguably produced the unauthored effect of re-informalisation and re-familialisation of care work by way of pushing it increasingly to the informal economy and the domestic sphere. This change is a process of depoliticisation along the trajectories of personalisation and naturalisation because the subject at hand – caring for dependent members of society – is increasingly projected as a personal problem and one to be solved, in reality, mostly by women – something that masks the responsibility of the state to provide healthcare to its citizens, and removes the problem from its historical emergence. This problem is articulated at the individual level as the 'patient's healthcare service' and at the structural level as coordination and co-responsibility of all actors in society. Moreover, the process of depoliticisation through informalisation blurs the socioeconomic value of care work and thus contributes to making it 'invisible'.

This article will end by addressing the *International Practice Development Journal's* call for relevance to practice development by challenging the reader to pose the following questions the next time a new national policy for the healthcare system is introduced: is the policy, or planned intervention, in any way legitimised by economic, technical or managerial aims? Are questions regarding problems in healthcare in any way reduced, reoriented, converted or conflated into technical or personal problems, to which technical or individual solutions are suggested?

If the answer is yes to both of the above questions, the reader may try to trace a process of depoliticisation and will certainly know that the anti-politics machine is at work.

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