Geoforum 41 (2010) 930–939

Contents lists available at ScienceDirect

Geoforum

journal homepage: www.elsevier.com/locate/geoforum

Neoliberal reforms in elder care in Norway: Roles of the state, Norwegian employers, and Polish nurses

Micheline van Riemsdijk *

University of Tennessee, 1000 Phillip Fulmer Way, Burchfiel Geography 304, Knoxville, TN 37996-0925, United States

ARTICLE INFO

Article history:
Received 17 June 2009
Received in revised form 16 June 2010

Keywords:
New public management
Neoliberalism
Nursing
Elder care
Norway
Poland
Migration

ABSTRACT

After a worldwide financial crisis in the early 1980s, many states decided to implement new public management strategies. These strategies consist of private sector management practices that aim to reduce the cost of public services. The US and the UK first adopted the new public management model and other states soon followed. The Norwegian state was initially reluctant to adopt private management practices, but it eventually implemented modified reforms that suited the Norwegian socio-political context. This article investigates the ways in which the Norwegian state and Norwegian employers shape the labor force in Norwegian nursing homes through new public management strategies, and the tools that foreign-born nurses use to challenge these structures. The Norwegian state shapes the labor force through labor market policies and the rescaling of public services to local governments, and Norwegian employers reinforce the neoliberal values of the state in their hiring practices and daily operations in the workplace. In particular, this article analyzes the interweaving neoliberal institutional and personal factors that influence the working experiences of Polish nurses in a semi-private nursing home in Oslo. The city of Oslo created a unique public–private partnership with a city-owned company that manages three nursing homes in Oslo. The findings of this study indicate that Polish nurses in one of these nursing homes were negatively affected by the new public management strategies. They improved some of their working conditions over time but structural barriers still persist despite high demand for their skills.

1. Introduction

In the early 1980s, many states experienced strained budgets during a worldwide fiscal crisis, and state support for the "three pillars of social policy," namely education, healthcare, and social welfare and income security, dwindled during this time (McGregor, 2001). In an attempt to reduce social spending and to increase efficiency, many governments made the politically charged decision to implement cost-cutting strategies. The dominant trend in governance in the public sector became new public management (NPM) strategies that promote private sector management practices. The main goals of NPM are to improve efficiency and quality of service in the public sector through private sector mechanisms such as competition, entrepreneurship, contracting-out services, fee-for-service charges and downsizing (Christensen and Lægreid, 2002b; Hood, 1991). NPM strategies are based on neoliberal beliefs that market-driven competition between providers of social services will encourage a better use and allocation of resources, and lead to higher economic growth. NPM strategies were first introduced in the US and the UK in the early 1980s, and were soon adopted elsewhere.

Neoliberal strategies were initially presented by policy makers as homogenous and inevitable, famously referred to as "there is no alternative" by former Prime Minister Margaret Thatcher. Contrary to the widespread conceptualization of neoliberalism as an end-state or a "condition" (Tickell and Peck, 2003), recent studies have shown that various socio-spatial models and versions of neoliberal reforms exist. In fact, the extent and outcomes of neoliberal and NPM reforms are historically and geographically contingent and interact with institutional and social structures (Barnett, 2005; Brenner and Theodore, 2002; Brown, 2004; Staeheli and Brown, 2003). In order to better understand these nationally- and locally-specific neoliberalisms, scholars investigate various paths to neoliberalism and the specific political-economic geographies and spatialities of these paths (Brenner and Theodore, 2002; Jessop, 2002).

Neoliberalism and markets are not "natural," disembodied and external forces but are in fact actively managed, shaped and policed by the state (Peck, 2004). The state plays a central role in the organization of the labor market through regulations and devolution of state governance to local scales (Goodwin et al., 2005). However, the regulatory power of the state to implement neoliberal reforms is geographically and historically contingent. For instance, European states have social democracies that place a high

* Tel.: +1 865 307 4108; fax: +1 865 974 6025.
E-mail address: vanriems@utk.edu

0016-7185/$ - see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.geoforum.2010.06.008

value on social equality, and neoliberal reforms in Europe have been more moderate and consensual than in other parts of the world (Peck, 2004).

Employees help shape and sometimes actively transform the practices of the state. Jones (2007) has termed this process the "peopling of the state," referring to employees' active production and transformation of state forms. These transformations of the state can be achieved through social and material practices in daily life (Leitner et al., 2007; Painter, 2006) and can include active resistance to neoliberal practices. If this resistance is successful, employees sometimes rework the contours of neoliberal projects (Barnett, 2005; Laurie and Bondi, 2005).

This article investigates the ways in which the Norwegian state and Norwegian employers shape the labor force in Norwegian nursing homes, and the tools that foreign-born nurses use to challenge these structures. The Norwegian state shapes the labor force through labor market policies and the rescaling of public services to local governments, and Norwegian employers reinforce the neoliberal values of the state in their hiring practices and daily operations in the workplace. This article studies the interweaving institutional and personal factors that influence the working experiences of Polish nurses in Aurora Borealis, a semi-private nursing home in Oslo.[1] This study focuses on Norway because it has one of the most comprehensive public sectors in the world, and revenues from oil exports and high levels of taxation finance extensive public services including healthcare, education, culture and sports (Lian, 2003). These high revenues made rising costs less pressing than in many other European states, and public opposition to privatization of services contributed to slow and reluctant adoptions of neoliberal ideas in Norway.

I will first discuss the implementation of neoliberal reforms in the Norwegian healthcare system and the delivery of elder care in Norwegian nursing homes. Through a case study of Aurora Borealis I investigate the ways in which foreign-born nurses are affected by state- and employer-induced NPM reforms and how they empower themselves to improve their working conditions over time.

2. Neoliberal restructuring in Norway

Norway has an extensive public system that is rooted in a strong social democratic tradition. There is a strong consensus among Norwegian citizens that the state should take care of its citizens in times of illness, disability, and old age (Nakrem, 2004). These values run counter to neoliberal ideologies of market-driven provision of public services. However, the Norwegian state has high public expenditures that have encouraged the state to implement cost-cutting measures. The public sector is the third largest sector in the Norwegian economy (after the oil and gas industry and sea-based sectors), and costs over 40% of GDP. The public sector employs about 30% of the workforce, and this sector continues to grow (OECD, 2003).

In a study of long-term care expenditures in 19 OECD countries, Norway has the second-highest expenditure on long-term institutional care, which includes care for the elderly in nursing homes. In 2000, Norway spent 2.15% of its GDP on long-term institutional care, which was only topped by Sweden with 2.89%. These numbers are well above the OECD average which ranges between 0.5% and 1.6% of GDP. The high expenditure on long-term institutional care is partly caused by the high quality of amenities that patients receive in nursing homes in Norway and Sweden, such as high-quality housing facilities and private rooms (OECD, 2005).

Compared to other Nordic welfare states, Norway was a slow and cautious adopter of neoliberal market strategies due to four primary reasons. First, Norway has a strong tradition of statism that aims to ensure equality among its citizens. This model supports state-led governance with a strong role for the state in the provision of public services. Second, the long-governing Labor Party was against the implementation of NPM strategies, and weak minority parties had little opposition power (Christensen and Lægreid, 2002a). Third, Norway's culture, with its emphasis on promotion of the common good and egalitarian values, solidarity and high standards for social welfare, was not compatible with competition strategies (OECD, 2003). Fourth, the Norwegian government traditionally played a strong role in public affairs and was reluctant to blur the lines between state and market. These factors slowed the implementation of market reforms and eventually resulted in a distinctly modified form of market-based techniques and deregulation in Norway (Christensen and Lægreid, 2004).

Neoliberal reforms became more prevalent in Norway in the mid-1990s, after other European states had already embraced neoliberal ideologies. The increase in neoliberal thinking was evident in the Norwegian media in the 1990s when media accounts changed their focus from citizens to users, and changed their emphasis from the collective to the individual. The Norwegian word used for contracting-out services, "*konkurranseutsetting*," first appeared in the Norwegian media in 1995 (Nafstad et al., 2007). Until the early 1990s, major public domains in Norway such as railroads, telecommunication services, power companies, postal services, forestry, and public broadcasting were public monopolies with a high degree of state regulation (Lægreid et al., 2005). The first sector to be deregulated was the electricity market in 1990, followed by subsequent market liberalizations that were affected by EU regulations. When Norway became a member of the European Economic Area in 1994, it was obliged to comply with EU regulations, except with regard to agriculture and the fishing industry.[2] These EU regulations drove the liberalization of the telecommunications sector in Norway in 1998 and other reforms in the public sector (OECD, 2003). Despite these market-oriented reforms in major sectors of the Norwegian economy, the Norwegian healthcare sector remains largely publicly financed and the Norwegian government still plays a strong role in the provision and distribution of healthcare services.

Norway has the third highest per capita expenditure on healthcare in the world and these high costs place a large financial burden on the Norwegian welfare state. Healthcare systems in high-income states are facing rising costs and increasing demand for healthcare services due to an increase in elderly populations who need more medical care, advances in medical technology that require more trained medical professionals, and a generally increased demand for care (Lian, 2003; Dyer et al., 2008). In an attempt to reduce costs and increase efficiency, many states have implemented marketization strategies in the provision of healthcare (Seeberg, 2007). The costs of providing long-term care are likely to increase in the near future when the baby boom generation reaches retirement age after the year 2030. While trying to accommodate these demands, policy-makers attempt to balance the provision of quality care with cost-efficiency (OECD, 2005). In the year 2005, the US had the highest expenditure on healthcare services ($6401 per capita), followed by Luxemburg ($5352) and Norway ($4177), with an OECD average of $2759 (OECD, 2007).

[1] The names of interviewees and workplaces have been changed to ensure the confidentiality of study participants.

[2] Norway, Iceland and Liechtenstein are members of the European Economic Area (EEA), an agreement that went into effect on January 1, 1994. The agreement allows these non-EU member states to participate in the EU's Internal Market and to benefit from the "four freedoms," namely the free movement of goods, persons, services and capital. EEA member states can also participate in environmental protection and safety programs. However, EEA member states do not have the right to participate in voting in EU-related matters.