Care policies as biopolitics
Towards a cross-national comparative framework

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- work in progress -

From the 1970’s on, the concept of care has been used as a heuristic critical tool with regards to welfare studies, especially - but not exclusively - by feminist scholars. In this contribution, we suggest using the concept of care and a Foucauldian approach of biopower to build a critique of reforms undertaken by European welfare states. By “care”, we mean the activities and relations through which various categories of dependant people (such as young children, frail elderly people and people with disabilities) are attended to. Our main argument is that the contemporary development of a care policy field can be understood as an extension of biopower. This means that care policies contribute, through the deployment of specific power mechanisms, to a process of life-governing. Obviously, there can be some debate about the meaning of this “life” concept. In this contribution, we argue that “life” does not only refer to certain “vital” characteristics of human beings – as is the case in the dominant literature on biopolitics – but also refers to a fully social and historical experience. In this perspective, care contributes to the governing of life as it addresses both the content and the course of the lives of care receivers and care-givers.

1 This definition is directly inspired by the “social care” concept of Daly & Lewis (2000). However, for the time being, we leave aside the “normative, economic and social framework within which these are assigned and carried out” – aspects, which those authors also include -- because these dimensions are part of our definition of care policy field.
Drawing on the results of comparative research on care policies in Switzerland, we show that this government of life is partly determined at the local level, by local care policies. Through a comparative analysis of local childcare, disability and elderly care policies in six Swiss regions, we identify three different types of biopolitics, that contribute to framing social inequalities with regards to life content and life course. Moreover, we show that such types of government rely on specific local configurations of discourses, instruments and modes of subjectivation.

On these grounds, there is reason to hypothesize that a transnational configuration of local biopolicies can be identified in Europe. Indeed, a large number of care policies are either currently emerging or undergoing transformations. At first glance, this phenomenon appears very disparate. Indeed, care policies are debated and implemented by a multiplicity of actors and in a plurality of territorial levels – from local to regional, national or international. Moreover, care refer to different institutional settings – like home-based care policy, health insurances – and care policies developed independently from one another. Finally, these developments address independent categories of populations – mainly children, adult disabled and dependent elderly, but also more specific ones like autistic children, people suffering from dementia or end-of-life patients. The variety of these transformation is now well acknowledged (Pfau-Effinger, Rostgaards 2012). The literature on care long reflected this diversity and still appears quite fragmented: it was organized with regards to target populations (mainly childcare or elderly care) or problematic issues (care as unpaid or paid work) (see Lewis 2000, Rostgaard 2002). More recently, the development of comparative social-care studies has generated broader research that allows for the identification of more complex national care regimes (Antonnen & Sipilä 1996, Bettio & Plantega 2004) as well as for the identification of different national trajectories in the development of care provision and services (for instance Pfau-Effinger, 2005).

Against this background, we think that mobilizing the biopower concept can help us to understand what happened in these changing and/or emerging fields of care in a new and heuristically integrated way. We will start our argument with a brief reconstruction of the concept of “care” as it has historically functioned as a critical tool in welfare studies, suggesting that an understanding of care as part of biopower can contribute to extending this critical tradition (1). Then, we will present the main features of our theoretical frame, in

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2 On rare occasions, they get integrated into an explicit holistic concept – this is for example the case when a trans-sectorial policy is framed under the new banner of “supporting the informal careers”.

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which care is understood as part of a contemporary power over life. We argue that at least three definitions of life are engaged in the way care is currently conceived and provided (2). The third section presents the main results of the mobilization of this theoretical framework at the level of local public policy, in the context of Switzerland. In these cases, we focus on the way life content and life course are governed through local care policies (3). On the basis of these first results, we will suggest avenues towards a cross-national comparison of contemporary local care policies, insisting on the importance of developing multiscalar analysis (4). In the conclusion, we will sum up our main results and questions, and return upon the heuristic potential of considering care as a new form of biopower (5).

1. The concept of care as a critical tool in the field of welfare study

The concept “care” has been traditionally used as critical tool for the study of welfare policy. In this section, we present a short, and certainly not exhaustive, overview of this critical literature in the field of social policy. We will (somewhat artificially) distinguish the use of care in the feminist critique, in the critique of State reconfiguration, and in the neo-institutionalist literature of “new social risks”.

The first and main critical stream is the feminist one. Indeed, beginning in the 1970s, feminist scholars refer to care to denounce the patriarchal dimension of welfare state, and, later, to discuss its emancipatory capacity with regards to women or to reflect on intersectionality (exploring the articulation of gender, race and class inequalities). Initially, care was conceived from the point of view of the situation of women’s life conditions (Daly & Lewis 2000). Indeed, the use of the concept contributed to shedding light upon the “invisible welfare state of care” (Wearness 1978), helping to identify family as part of welfare and, more specifically, highlighting the hidden importance of the unpaid and informal work realized by women (“housework”, Oakley 1974). Shedding light on this invisible work was a way to denounce structural domination on the heels of the second wave of the feminist movement. Focusing on childcare for instance, Oakley pointed out that “the stake that the society had on insisting in women’s natural fitness for the career of mother: the alternatives are all too expensive”.

In this context, one strategy of the feminist critique of the patriarchal welfare state was to focus on the specificity of the activities and of the dispositions that constituted care. Hence a number of care studies explore the characteristics of this invisible work, especially with

3 Reference to be specified (1974)
regards to its relational and emotional dimension (care as “love work”, Finch & Groves 1983, or “emotional labour”, Horschild 1983). These studies, dedicated to avoiding the traps of essentialism – helped to understand the concrete mechanisms for assigning women to their gendered roles. For instance, Folbre (2001) argues that the practice of care itself contributes to the attachment of the care-giver to the care receivers, reducing its capacity to exit (prisoners of love). In the field of social philosophy, this same strategy, beginning the 1980s, allows for a path-breaking feminist critique of the norms of social justice as they were formulated in liberal theories of justice (Gilligan 1982)\(^4\). In this perspective, the care ethic – the manifestations of which were observed in the voices of young girls, but the relevance of which was supposed to be universal – was opposed to the “standard moral voice”. Joan Tronto (1993) took over this critical stream centered on the ethic of care with the strategic ambition of using the care concept as a basis for rethinking moral boundaries and, by extension, for rethinking the field of moral and political life (Tronto 1993: 102). From this perspective, she would purge the concept of any gendered essentialism and shed light on its social and political dimensions.

A second feminist critique of the patriarchal dimension of welfare policy could be developed by focusing on care provisions and services instead of family care. This shifted the attention towards the formal dimension of care work and the development of care as a paid activity. During the 1990s, scholars focused on the public dimensions of care and on the role of the state in the reproduction of gender inequalities (Lewis 1992). This lead to various comparative studies on the provision of care services or on arrangements in welfare states, focusing on childcare or elderly care policies (e.g., Urgenson, 1990, Lewis 1992, Sainsburry 1994). These studies contributed to developing a more nuanced critique of the welfare state’s role and of social policy with regards to the position of women in society. By contrast with the patriarchal critique, Scandinavian studies pointed out the possibility for the welfare state to enhance the power of women (Women-Friendly Welfare State, Hernes 1987) while also shedding light on the reproduction on gender domination that occurred in the realm of public services, where the women constituted the huge majority of care workers (Siim 1987, 2000).

More recently, this feminist stream of critique has been enlarged, as the care concept is now able to connect gender, class and race inequalities. From this perspective, feminist works contribute to a better understanding of the working conditions in which care is realized,

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\(^4\) The Gilligan book strongly contributed to the diffusion of the “care” concept in both academic and non-academic fields, although it was mainly understood in a reduced, essentialist way, prolonging reflexion on the specificity of the women’s conditions by an emphasis of the specific value of a women’s ethic.
relating care-related work to its transnational dimension through phenomena such as migration and care drain (Graham 1991, Duffy 2005, Williams 2010) or scrutinizing in the formal development of home-based care in a feminist perspective (Parks 2003).

Apart from the feminist critique, reference to the concept of care contributes to building a critique of the state transformations that began in the 1980s, particularly in the field of social policy. Beyond the withdrawal of welfare state, the care concept allowed to develop a qualitative focus on care, in the interest of developing an deeper understanding of the transformation of the state-society relationship (Lewis 2000, Pavolini, Ranci 2007). Indeed, by explicitly referring to care as “social care”, Mary Daly and Jane Lewis (2000) intended to enhance the analytical potential of the care concept by linking it to the study of welfare states and how they are changing. In doing this, the authors further sought to break definitively with the traditional use of the care as a concept restricted to the understanding of women’s life experience. Hence, comparative research on social care first contributes to a better understanding of the influence of national regulations on the sharing of formal or informal care (Antonnen & Sipilä 1996, Bettio & Plantega 2004) or among family, state and market (Evers & Svetlik 1993; Lewis 2002, Lyon & Glucksman 2006). The influence of employment policies on care regimes has been acknowledged (Simonazzi 2009), and so has the role of national culture on the organization and development of care provisions (Pfau-Effinger, 2005). This stream of analysis contributes to developing a more qualitative critique of recent reforms towards the commercialization (Lewis 1998, Pfau-Effinger, Rostgaard 2011) or the refamiliarization (Kröger & Sipilä 2005) of care.

Lastly, neo-instituionalist social policy studies have started to refer to the concept of “care” from a slightly different perspective, as part of a general reconsideration of the role of welfare policy in the general economy of post-industrial societies. For the purpose of modernizing the post-war welfare state, these authors conceptualize “dependence” and “care” as part of the “new social risks” (Taylor-Gooby 2004, Bonoli 2005, Esping-Andersen 2008). By contrast with the Keynesian and neo-liberal eras, they argue in favour of a new social-investment state (Morel, Palier, Palme 2014). From this perspective, the development of child-care policies is understood as a measure of the adaptation of the welfare state to new social and economic conditions. Indeed, childcare is presented as a social investment, serving to limit growing social-insurance deficits while elderly care for instance is less emphasized. This use of the care concept could be considered as part of a general critique of neo-liberal governmentality. However, as it mainly draws upon a functionalist perspective, it does not
acknowledge the issues of care policy fields and is only very loosely linked with any feminist perspective.

As Daly and Lewis put it, it may be “impossible to understand the form and nature of contemporary welfare states without a concept like care” (Daly, Lewis 2000 : 282). In this perspective, this first overview of the critical use of the care concept enhances its heuristic potential towards a better understanding of the contemporary transformation of welfare policy. However, it also worth pointing out that the general dynamique may be that the critical potentials of the concept is becoming at risk of being diluted either in a plurality of particular and segmented critical uses, or into a functionalist critique of modern governance. Indeed, we think that what is missing up to now is a critical approach which treats care policies as modes of government and, more specifically, as modes of government that both rely upon and impact the lives of those who are governed. From this perspective, the concept of biopolicy allows us to ask new types of questions: How is “good life” defined though care? What life courses, discourses and practices are framed or legitimated through care policies? What authority is drawn upon, and what techniques are used? Which categories of population bear the relevant expenses? By inviting inquiry into such questions, the biopolicy concept may help uncover clues as to how best to resist those discourses, instruments or practices which contribute to limiting life opportunities and/or increasing inequality or domination.

2. Care as biopower – a theoretical framework

According to Paul Rabinow and Nikolas Rose, the concept of biopower “serves to bring into view a field comprised of more or less rationalized attempts to intervene upon the vital characteristic of human existence. » (Rabinow, Rose, 2006 : 196-197). Indeed, western societies have undergone a radical transformation of power since the classical age (Foucault 1990): they shift from the right of death over people to a power over life. From the 17th century, this “biopower” is characterized by the institutional discipline of bodies. It manifested itself through the development of institutions (schools, asylums, barracks, and workshops) and through tactics, such as apprenticeships and education, leading to “infinitesimal surveillance”. Later, a new form of life government appears, characterized by regulatory practices which Foucault refers to as biopolitics: “The attempt, starting from the eighteenth century, to rationalize the problems posed to governmental practice by phenomena characteristic of a set of living beings forming a population: health, hygiene, birthrate, life
expectancy, race.” (Foucault, 2008: 323). More recently, contemporary biopower philosophers highlight the continuity between those Foucauldian mechanisms of life control and contemporary forms of power (Agamben 1998, Hardt/Negri 2001). However, as Paul Rabinow and Nikolas Rose put it, “little work has been done to develop Foucault’s own sketchy suggestions into a set of operational tools for critical inquiry” (Rose & Rabinow 2006: 197). Building upon the Foucaldian perspective, Rose and Rabinow therefore suggested a heuristic conceptualization of contemporary biopower aimed at grasping the diversity of the contemporary forms of biopower. As we shall see in the next section, this conceptualization of biopower can be usefully mobilized in the analysis of public care policies. From within Rose and Rabinow’s approach, biopower refers to three dimensions.

The first of these dimensions involves “one or more truth discourses about the ‘vital’ character of living human beings, and an array of authorities considered competent to speak that truth”. (Rose & Rabinow op cit : **) Indeed, when it comes to propagating care policies, discourses are seen to be spreading normative logics and prescriptive systems of values, ultimately constructing systems of “truth” about the most varied issues, such as life and care. Along with the increase of the number of elderly in European countries for instance, expectations about the quality of care are rising, while at the same time, the financial support for such care is declining. In this context, political as well as professional or lay care practitioners rely on a set of “truth discourses” to ground and legitimate their choices and practices with regard to care. These new discourses are built at the intersection of various scientific disciplines (such as medicine, sociology, nursing sciences or psychology) but may also include ethical or religious dimensions. As an example of a “good care” truth discourse, one might consider the rehabilitation, through a discourse mixing scientific and moral arguments, of the breast feeding as the best way to feed babies. This discourse is based on assumptions about life and bodies, and about “good life”.

The second dimension involves strategies for intervention “upon collective existence in the name of life and health”, interventions that may address territorialized population (like the population of a municipality) as well as emergent « biosocial collectivities ». (Rose & Rabinow op cit : **). Generally speaking, these modes of operation in the field of care will refer to the use of specific public instruments, mobilized by the public authorities in the context of a public policy, in order to adress the care relations. These instruments can target people in need of care or their family or relatives (though cash transfer for instance). But these mode of operation can also be mediated through the regulation of the care networks. The instrument here will target specific actors (like for profit care homes for elderly). Hence, as
Lascoumes and Legales explain (2004: 13) in a Foucauldian perspective, the instruments are both a technical and social mode of operation that aim to organise the social relations between public authority and its recipients. As such the instruments always carry specific rationalities and meanings.

The third dimension involves *modes of subjectivation*, through which individuals are “brought to work on themselves, under certain form of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole”. (Rose & Rabinow op cit : **). Hence, the issue in biopolitics is no longer that of disciplining bodies or regulating populations, but rather to persuade individuals to exercise self-control and to view their life as a type of enterprise. From this perspective, the crucial site for intervention through care is the activation of the individual autonomy. Indeed, the life government proceeds as an *indirect* form of social control – neoliberalism being an example of one such new form of governmental rationality – which does not impose conformity but which operates through the proliferation of individual difference (McNay 2009: 56). The requirement of autonomy has become part of the new government of life.

Up to now, most contemporary readings of the biopolitical point out the importance of the subjectivation process as a new form of life government and highlight the biologization of life that occurs through biothechnologies (Gottweiss 1998, Bunton & Peterson 2005, Rose 2007). Obviously, this shift has important consequences in terms of a somatization of the structuring selfhood and a re-appropriation of the living through a focus on and a remodeling of the body or its molecules. “*Selfhood has become intrinsically somatic – ethical practice increasingly takes the body as a key site for work on the self*” (Rose, 2001:16). With regards to care, we can legitimately wonder if, in different settings, the development of care technology contributes to support the growing hegemony of this definition of one’s life as a physiological site – a molecular or embodied issue – when focusing on the physical impairment of the elderly or of the disabled, and suggesting and providing technological and biomedical solutions to the dependency issues.

However, we think that the contemporary development of care policies does not only – or always – contribute to a *biologization* of life. In fact, we will argue that there are other life issues in the contemporary development and transformation of care policies that have nothing to do with its molecular or physiological dimension. We identify two of them (Lucas 2010, Giraud, Lucas 2011, Giraud, Lucas 2014). The first alternative way in which care contributes to the governing of life has to do with the ontological vulnerability of life against the
possibility of being interrupted or of never occurring. Indeed, in order for a life to be recognized as a life, it first has to become “grievable” – which also means that this life itself becomes subject to care (Butler 2009). Debates about care practice and meaning in the context of birth and end of life contribute to the redefinition of life borders, implying a struggle that is strongly linked to the attribution of different life values. Such questions about the limits of life and who is to fix the boundaries arise for instance when people are suffering from an advanced stage of Alzheimer’s disease, or when highly disabled people or dependent elderly claim the right not to live anymore.

The second alternative way in which care contributes to the governing of life is through regulating the life course of both care receivers and care-givers. We refer to the concept of life course, as “life” is understood here neither as a molecular nor as an ontological phenomenon, but as a fully social and historical experience. Indeed, care issues contribute to the construction of the individual experience of life as a socially meaningful category. As Norbert Elias recalled, the “meaning of life” constitutes a category of social order (Elias, 1985). As such, life is defined and governed through care precisely at the point where the individual and the social intersect. Hence, it is through relationships with others that life content and life course are traced in debates and policies about “dependent” children, adults or elderly. As we know from feminist literature on social and care policy, gender relations are at the heart of these definitions and regulation processes (Daly/Rake, 2003).

How life course is governed through care policies
On this basis, we argue that through different modes of government – based on discourses, instruments and subjectivation processes – care policy contributes to the definition of the life courses of both caregivers and care receivers. More precisely, we think that care policies directly address two aspects of the life course. Firstly, they frame the content of existence in relation to basic dimensions such as dependence and autonomy or the private and public spheres; secondly, they contribute to determining the main transitions of life.

Firstly, care policies frame life course content regarding two important dimensions of life. One dimension refers to the tension between dependence and autonomy, and the other refers to the tension between the private and public spheres of existence. To start with, our world has been impregnated with the ideology of individual – male – autonomy. This ideology ascribes a negative connotation to dependence (Fraser/Gordon 1997) and places autonomy as the aim of all existence. However, as the new ethics of care reminds us (Tronto 1993) that no one would be able to exist without the others; moreover, the most autonomous
adult – rich and in good health – often depends on paid and unpaid care for their success. Care policies do not escape the ambivalence between dependence and autonomy. On the one hand, care policies may actually acknowledge dependence and place a high value on maintaining the care relationship that responds to this dependence. On the other hand, care policies may seek to increase the autonomy of dependent people and/or family caregivers.

Moreover, care policies directly address the tension between the private and public spheres of existence. Indeed, dependence mainly refers to life as a private experience (individual, personal and intimate). In its most diffused definition, dependence refers to the inability of an individual to take on his or her daily subsistence by themselves (Colombo 2011). From this perspective, dependent people need to be helped to varying degrees, in the most basic acts of daily life, such as moving around, being fed, or being washed. But there is an opposite pole, namely the social sphere of existence, which is expressed in the need to maintain social relationships, access public spaces (e.g. cafes, school, museum, etc.) and benefit from political citizenship.

Second, care policies frame the life course in its main transitions. Different dimensions of the life course enable care to be seen as a regulator of lives (Elder, 1994: 5-6). To begin with, the life course is subject to constraints, opportunities and expectations specific to each of its stages. These concern both the care receiver (children, disabled adults or the elderly) and the caregiver. Indeed, the life course is framed through a succession of coincidences between biological age and social roles (apprenticeship, marriage, parenthood, job, among others). Care policies are involved in constructing life courses by establishing, implementing or modifying these coincidences. Lastly, care policies contribute to the structuring of transitions: access to employment, leaving the home, becoming a couple, the birth of the first child or the onset of age-related dependence. These transitions are understood through the concept of risk (disability, job loss, illness, death of a spouse) or choice (changing a job, a spouse or a country). Today, the multiplication of life’s “crucial junctures” represents numerous new areas of regulation for the modern state (Mayer, Schoepflin 1989).

Hence, care policies can be considered as “biopolitics” because they tend to integrate various moments of the life course into a general paradigm, which includes not only a definition of life, but also a definition of its various stages and transitions. From this perspective, empirical

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5 Long term care is defined in this way: “A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are dependent for an extended period of time on help with basic activities of daily living (ADL)” (Colombo 2011).
care studies could be oriented to document and understand how concrete contemporary care policies contribute to the emergence of new forms of life-course government.

3. Diversity of local care biopolices: lessons from the Swiss case

With its cultural heterogeneity, its federal constitution, and the tradition of subsidiarity according to which the delegation of power to the Cantons, local municipalities and private organizations is always preferred, Switzerland grants us the possibility to explore a wide range of forms of biopower as exercised within and through the care domain. In previous comparative research on Swiss care policies, we explored the way local care policies contribute to a government of life, considering “life” to be a historical and social concept.

We applied our analytical framework to compare six contrasted Swiss cases (Basel, Fribourg, Sierre, Frauenfeld, Geneva and Lugano). Historically, care policies in Switzerland developed around separated social policy fields, mainly childcare, disability and elderly care policy. One of the original aspects of our approach was to consider these three categories simultaneously in each local case, in order to develop a holistic picture of life-course government.

Empirically, we first considered the modes of the government of the care itself. We characterized the diversity of local care networks and their main rules, as well as the concrete services that were provided or not. Moreover, we compared policy instruments that were mobilized, like subsidies, contracts, legislation, and incentives. Instruments form the heart of life governmentality, as they contribute to creating a specific and sustainable relationship linking the care receiver and the caregiver. Secondly, we focused on the various definitions of life that are involved in these care policies, by considering the principal dimensions of life content (autonomy vs. dependency, private vs public spheres) and by looking at its most important steps and transitions. These life definitions were reconstructed from the comparison of network rules and legitimations, policy provisions, instrument rationalities, as well as the dominant local discourses on childcare, disability or elderly care, and dependence.

As these results have been published elsewhere (Lucas 2010, Giraud, Lucas 2014), we will only insist here on the two main insights coming out of this study as they may prove useful for the purpose of developing an international comparative framework. First, we will insist on the identification of different ideal-types of local care policy that actually address the content and the life course of care receivers and caregivers. These results confirm that some of the contemporary biopolitical issues involved in care policies are actually local-level issues. Second, we will come back more precisely to the role of the concrete power
mechanisms identified in care policies which, taken together, frame the lives of caregivers and care receivers.

*Three types of local biopolicies*

While most of the comparative literature on care policies still focus on the national level (references), the analysis of local care policies in these different local contexts confirms that lives are partly governed at the level of local care policies. Indeed, the comparative analysis of local childcare, disability and elderly care policies in six Swiss regions allowed to identify three different ideal-types of biopolicy: the model of Assistance, the model of Responsability and the model of Empowerment.

Each of these types of government frames social inequalities with regards to life content and life course in specific ways (Lucas, Giraud 2014). The model of Assistance makes the traditional, gendered (female) and intergenerational self-provision of care the “natural” way of addressing care needs. In the Catholic tradition, any collective, non-familial form of care provision is suspected of threatening the legitimate privacy of the intimate family circle. This “private” dimension involves both intimacy and a mistrust towards any kind of collective life. The familial and community-based production of care frames rigid identities and social roles along the whole life course. Publicly supported care provision only targets those people who lack such family integration. Provisions for minimal, centralized and uniform public care mark the poor social, familial, local integration of the most deprived or foreign population.

In the model of Responsibility, the central value is individual autonomy and life-course responsibility. Individuals should be able to surmount any situation of dependency, be it their own dependency or that of someone for whom they are considered responsible (usually ascendants and descendants). Since the desired (financial) autonomy and responsibility is in most cases acquired on the labor market, all forms of care provision enabling responsible adults to find jobs are welcome. But this model is gender-blind and does not accommodate concrete inequalities in life courses. Hence, it generates new kinds of inequalities, for instance between rich and poor women. Privacy, in terms of preserving familial intimacy, is not very relevant in this context. Rather, the private, small-scale, non-public provision and financing of care are systematically prioritized.

In the model of Empowerment, the state seeks to empower civil society in order to develop a sustainable, diversified, democratic and professional service supply in the domain

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6 Exception…
of care. This pluralistic service provision, ideally generated by civil society, should enable (empower) everyone to freely opt for a provision, a solution in the domain of care, that would best match their own view of what a care relationship should be. In this model, care is not gendered, as it concerns both men and women. This freedom of choice attributed to individuals in need of care is a further development of forms of self-construction and self-subjectivation of individual social actors, regardless of their gender.

Table 1. Three models of biopolicy in the care policies of Switzerland

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<th>Assistance</th>
<th>Responsibility</th>
<th>Reflexivity</th>
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<tbody>
<tr>
<td><strong>Care responsibility</strong></td>
<td>Family, community, informal solidarity</td>
<td>Market; responsible adults</td>
<td>Societal, Civil-society organizations</td>
</tr>
<tr>
<td><strong>State’s role</strong></td>
<td>Residual, assistance, paternalist</td>
<td>Quality control, Rules and sanctions</td>
<td>Information, incitation coordination</td>
</tr>
<tr>
<td><strong>Dependency/autonomy</strong></td>
<td>Naturalization of dependency as biological part of the life course</td>
<td>Child dependency as a natural and non-political issue; adult dependency as an interruption</td>
<td>Dependency as a normalized life-course risk</td>
</tr>
<tr>
<td><strong>Public/private spheres of life</strong></td>
<td>Private sphere, life as intimacy</td>
<td>Public life, active citizenship private care</td>
<td>Mix space (public-private). Intimate- social life</td>
</tr>
<tr>
<td><strong>Age &amp; social roles</strong></td>
<td>Naturalization of roles regarding ages</td>
<td>Adult-centered</td>
<td>Ages and social roles disconnected</td>
</tr>
<tr>
<td><strong>Life course</strong></td>
<td>Rigid, Gendered</td>
<td>Formal “Free choice”</td>
<td>Opportunities for empowerment; Deconstruction of gender norms</td>
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Biopower mechanisms in care policies: the example of childcare policy

Secondly, the Swiss case shows how various power mechanisms in local care policies, taken together, address the content and the course of the lives of care receivers and caregivers. More specifically, we can now observe in more detail how those local modes of governmentality rely on particular configurations of care provision, discourses, and instruments (we will only briefly mention the subjectivation process). In order to illustrate this point, we will compare these modes of government focusing on childcare policy in the cities of Sierre, Frauenfeld and
Geneva. Sierre provides us with an example of the Assistance model, while Frauenfeld illustrates the Responsability model and Geneva illustrates the Empowerment model.

Network and care provision: The different kinds of welfare mix, and the various forms of care provision they entail, contribute to the framing of life content and of life course in significantly different ways in the three cities. In Sierre, the appearance new dependency situations generally impacts close family members, often the women, who are supposed to provide care and whose life choices are therefore reduced. Every form of extra-familial care provision is minimal, mainly private, and is concentrated and organized by the local government. These provisions mainly deal with social situations of dependency that are aggravated by economic precariousness. While the city of Sierre does assure rudimentary public infancy care, this service is however completely lacking in the more populated rural areas situated in the larger Sierre district. In Frauenfeld, the local schools take care of children from the age of four, but parents with younger children must call on a private network of “day mothers” explicitly requested and supported by the town. In Geneva, the welfare mix is notable for its broad spectrum of actors and services. Hence, infant care services appear to be diversified, although private daycare centers are de facto almost totally controlled by the Geneva Local Authority.

Instruments: the mobilization of different types of instruments, with their specific rationalities, contributes to the valorization of different types of life and life course. In Sierre, care provision is governed in a restricted way via centralized and even hierarchical instruments: service contracts, controls, indicators and centralized management control. Public and private services are centralized by local authorities, allowing for a more restricted, controlled and highly administrative implementation of care tasks. In the context of scarce public provision of care, those who request help (e.g. foreigners, poor, etc.) are then subject to stigmatization. In Frauenfeld, the intention of the cantonal government with regards to care is to rationalize the use of community means and structures and to stimulate and organize private initiatives. State action is based on the model of the individual being capable of obtaining support for his or her well-being from the market. The principle of subsidiarity regulates the relationships within the network of services, as well as the relationships between the services and their beneficiaries. Individuals are seen firstly as autonomous people, then as members of family communities, and finally as communities sharing a destiny. In Geneva, the instruments used are direct provision of services or subsidy. Moreover, the municipality controls childcare centers through service contracts (and next through their full municipalization). Lastly, the public sector invests in public information and cognitive
instruments (commissions, research and evaluation). Through these instruments, the government attempts to politically recognize a large diversity of life styles and life courses and to rectify the inequalities.

Discourses: In Sierre, childhood and childcare are understood and valued in the context of a maternalist approach. Childcare is primarily considered as part of the private sphere, the family and the local community and hence, the public provision of childcare is minimal. Traditional modes of living such as marriage and a gendered division of tasks, as well as intergenerational synergies of care (grandparents taking care of their grandchildren) and community care are valued. In Frauenfeld by contrast, the only visible and valued stage of the life course is adulthood. Dependency situations are only tackled indirectly and are subject to relegation to the private or market sector. Accordingly, very young children are not recipients of state action, which places a high value on individual responsibility and on positive individual contribution to society. Like in Sierre, but with different implications, infants “naturally” depend on their caring mothers. Gender differences are not mentioned, as they are not seen as relevant to defining the individual rights and obligations. In Geneva, the explicit goal of public policy is autonomy throughout the various ages and regarding diverse aspects of life. This discourse addresses both caregivers and care receivers. In the case of infants, collective care must not only enable parents to be self-sufficient, but should also enable very young children to benefit from early socialization. The valued policy options are those that offer diverse life opportunities to both the caregiver and the care receiver (for a parent, “staying at home” has the same value as “full time work” or as “sharing care and work with the spouse”).

In the next section, we consider the opportunity to develop an international comparative framework with regards to contemporary rescaling processes, considering the methodological challenges of such a perspective. We will use our two recent comparative studies on elderly care policies in Switzerland, Scotland and Germany to illustrate the pertinence that our theoretical and analytical strands at a transnational level.

4. Towards an international comparative framework

Inspired by a Foucauldian approach of biopower, we have proposed using the concept of “care” to build a critique of reforms undertaken by European welfare states. From this perspective, and drawing on our experience from the Swiss case, we will now suggest some avenues for developing a cross-national comparison framework of contemporary local care policies. We
argue that the diversity of models which we could describe, and which we partly explain in
the Swiss case, can also be found in more centralized countries and sometimes in more
culturally homogeneous countries. We think that intranational diversity is mostly to be
explained by the rescaling processes that the domain of care has undergone in the last
decades.

In order to come to terms with these reconfiguration processes, we propose here the
preliminary sketch of a multiscalar comparative analytical framework that we will present in
two main steps. We will first shed light on the recent dynamics of rescaling in the domain of
care and explain how this rescaling process might give way to increased intranational
diversity and, eventually, to transnational similarities. Secondly, we will consider which
specific comparative methodology we may use to fruitfully analyze the diversity of local care
regimes, understood both as a multiscalar and as a biopolitical form of governance. We will
illustrate our main argument using two of our recent international comparative studies on
elderly care and dementia care in Switzerland, Scotland and Germany. Although these recent
studies focused on innovation processes in domiciliary care services (Giraud and al. 2014)
and did not explicitly refer to the biopolitical theoretical frame, some of their data and results
can nevertheless be used to illustrate the heuristic potential of this approach.

Rescaling care policies: towards transnational forms of biopower?
First, most of the care regimes in Europe have undergone a major rescaling process, involving
transformation in the regulation capacity of the various levels of government, as well as
transformation in the actors located at different policy scales. In a more horizontal dimension,
these rescaling processes also concern the re-allocation of regulation capacity between state
actors, the market, associations, or the individuals and their families. Population aging, the
transformation of family patterns, and women’s increased participation in the labour market,
are various factors that have increased the social, political and financial importance of care.
As a result, various conflicting discourses have prospered in the domain of care. Care policy
systems are in most countries traditionally rather anchored at the local scale. However,
because of increases in need, most centralized states have, over recent decades, increased their
intervention to ease the financial burden of local authorities. This has for instance been the
case in Germany in the mid-1990s for elderly care in the mid-2000s for child-care. During the
same period, global actors such as the UN, the WHO or important financial institutions such
as global players in the private-insurance market have become influential in the domain of
care as well.
Local, national, and global actors and institutions advocate for discourses of “truth” that combine scientific expertise and moral positions about care, and that also promote concrete policy instruments and modes of subjectivation that match their views on what care should be. As a result, the implementation of care is subject to various combinations of elements that can be related to diverse policy scales. Such implementation may draw upon models provided by global actors or institutions, which must be reconciled with national policy frameworks and with local political traditions, politics or social mobilizations. The importance of global discourses might give way to strong similarities beyond national borders.

For instance, among our recent local case studies focused on the analysis of local care regimes for the elderly, we found a high level of similarity between Hamburg in Germany and the local authority of Fife in Scotland. The former has introduced a cooperative and participative instrument of governance of the domain of domiciliary care services – the care conferences -, while the latter has long supported a structure of beneficiary implication in the evaluation of the domiciliary care services they receive. Both those localities have mobilized a repertoire of values centered on democratic participation and cooperation, which makes these two initiatives much more similar than other initiatives carried out by cities belonging to the same national context, but oriented by a more or less strict form of liberal rationalization for instance.

Suggestions towards a multiscalar approach of biopolices
Second, from these first insights about the importance of rescaling in the domain of care, we draw a few preliminary thoughts about a possible cross-national comparative methodology. In the first place, we will continue to choose the local as the relevant scale of analysis. As a matter of fact, discourses, instruments as well as modes of subjectivation might be observed both through discourses on care as well as via observable practices of care.

Secondly, we find it useful to understand the position of the various local cases within their national context, as well as their possible relations with other relevant policy scales (Giraud, Lucas 2014b). This analysis of the embeddedness of each case in its environment stands to capture the signification of each case’s dynamics and the respective scalar influences to which each case is exposed. This kind of analysis can also enable us to identify the concrete mechanisms of change in a multiscalar policy domain, including professional networks, cultural influences, financial or technical incentive systems, etc.
Thirdly, we might want to look for coherence in the domain of care seen as a biopolicy both across the type of population in need of assistance – small children, disabled and frail elderly people – and within each type of care. The cross-population dimension would enable us not only to elaborate stimulating models, eventually of transnational character, but would also allow us to test for the importance of discourses about care that would be able to influence care practices and modes of subjectivation across the board. Furthermore, from our previous comparative research, we have learned that there might be contradictory elements or at least tension between care as a discourse about life and about what good care practice should be, and care as it is concretely practiced. For instance, in the case of Edinburgh the introduction a few years ago of a measure of “reablement”, advocated for at the public-discourse level as a way to foster the autonomy and the well-being of older people discharged from the hospital. However, this intensively publicized measure, which was the clear concretization of a specific view of what good care should look like, was related to a much less publicized effort to privatize the bulk of Edinburgh’s social work department. This latter decision also had a huge influence on care as a practice, as it resulted in increased segmentation in the quality of care delivered.

5. Conclusion

In this contribution, we have presented some reflections about social care as a field of power and suggest some avenues towards a new understanding of the development of care policies. More precisely, we argued that the contemporary field of social care can be understood as an extension of biopower. In stating this, we mean that what is at stake in the contemporary reform of care policies – child care, disability or elderly care – is the very definition of a “good life” and of the legitimate «life courses» for both caregivers and care receivers. By considering child care, disability and elderly care in the same frame, we are able to show how, in the Swiss case, local care policies fall into three different types of biopolicy.

There are three main theoretical claims for which such an approach may contribute to supporting with empirical evidence. First, up to now, most contemporary readings of the biopolitical focus on the biologization of life through biothechnologies. None of them has considered care as a field of biopower. Refering to care as biopower, we enlarge the definition of life from a strictly biological frame to a more historical and social one. Second, beginning in the 2000s, the critical potential of the care concept has become blunted. The feminist critique of patriarchal welfare is dulled by fragmented use of the care concept, whereas the
transversal gender equalization process in social policy suggests the need to shift to intersectorial analysis capable of appreciating the complexity of contemporary power relations. Meanwhile, the social care concept is at risk of becoming diluted into a functionalist critique of modern governance, through its inclusion in discourse associated with the social-investment state. In this context, applying the biopolicy concept to care could contribute to providing an integrated critical framework for analyzing contemporary changes in social policy, keeping the role of the state and of power relations at the center of the picture but considering its changing grips. Third, up to now, most of the theoretical and empirical comparative research on care (but also on biopolitics) have been centered on national levels. In the context of a rescaling of care policies in Europe, we have argued for the importance of considering the local as a significant level of analysis, as biopower is now defined at the intersection of a plurality of scales.

From an empirical point of view, this contribution mainly has a programmatic aim. Building on our initial, and still exploratory, results from the Swiss cases, we try to argue that we need international comparative analysis and that this analysis may be achieved by mobilizing a multiscalar method. Ultimately, the aim of this theoretical and empirical strand is to suggest bringing care mechanisms into view and analyzing the ways in which contemporary care policies, beyond their apparent diversities, impact the life content and life course of various categories of population. If the transformation of care policies implies redrawing the map of life differentiation and hierarchization, then one has to be able to understand this process in order to identify the points of resistance as well as alternative possible modes of government, and therefore in order to contribute to a constructive and normative critical discussion of contemporary care reforms in Europe.

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