



Empowering the elderly?

A qualitative study of municipal home-health visits and everyday rehabilitation

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Empowering the elderly?

A qualitative study of municipal home-health visits and everyday rehabilitation

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Preface

Broadly speaking, this dissertation is a qualitative study of home-health visits and training programmes directed towards elderly citizens in the Danish municipality of Gentofte. But when I began my research, I did not have much hands-on experience with elderly people. Of course, I knew some elderly people – as of this writing, my own father is 91 years young – but I had never conducted research into ageing-related issues, the provision of eldercare, or older people's practices of health. Thus, in order for me to learn about the health-related services and programmes being offered to elderly citizens living in Gentofte, the municipal leadership arranged for me to partake in a two-week introduction programme in August 2014. Each day, I went out to a different department or institution, spoke with the people who worked there, took a tour of their facilities, and made some preliminary observations. These visits ranged from a few hours to a full day.

I started by accompanying a municipal 'Visitor' to conduct an evaluation of a woman in her 80s with Parkinson's disease who had just moved into one of Gentofte's senior-housing areas. Rather than accepting the municipality's offer for help to unpack and set up her new apartment, she was more concerned about knowing whether the wigs she used to cover her extreme hair loss would be paid for. The Visitor informed the woman about her rights and the services available to her as a new resident of the municipality, and the Visitor handled the woman's concern about her wigs and hair loss sensitively and without judgement.

Next, I followed Home Help services, where I met a man in his 60s who had had a stroke and needed help getting out of bed, taking a shower, and getting dressed. The Helper joked around with him, supervising him in the shower before offering physical support as he washed, dried, and dressed himself. We then went to see another man, also in his 60s; the Helper told me he was a long-time alcoholic who stayed inside his apartment all day, every day, drinking beer and smoking cigarettes, rarely eating. The Helper sternly teased him about his drinking while she changed his adult-diaper and washed his genitals. Towards the end of the Helper's shift, we also visited a woman (age 81), a former midwife who was a trailblazer in the fight for women's rights, now wasting away in her huge, empty villa home. After ensuring that she took her medication with some food, the Helper sat and drank coffee and smoked cigarettes with the woman; it seemed to be a daily routine they both clearly enjoyed.

With Home Nursing Services, I met a woman in her 80s; while the visiting nurse sorted her medications, she asked me whether she should get the eye operation she had been contemplating.

The nurse sat and talked with her for much longer than the 20–30 minutes allotted by the government for each home visit – simply because, as the nurse told me afterwards, the woman was a hypochondriac who needed a little extra support. We then visited another woman (age 93) with painful cancerous sores on her legs that needed to be treated and dressed several times a day. The nurse painstakingly cleaned and dressed the woman’s legs, always being careful to explain what she was doing and to stop if it hurt too much; I held the woman’s hand when she cried out in pain. We also visited another woman in her 80s who had just returned home after having a stroke; I helped the nurse lift her from her wheelchair and put her into bed, while her devoted husband stood nearby and wondered aloud if he would be able to help her like this.

These are just a few of the people I met during this two-week programme. On a personal level, their stories and experiences made a huge impact on me. But as an ethnologist, I was struck by the practices of the professionals who were working with the elderly on a daily basis. I found that, rather than reducing these citizens to a civil-registration number or even just a face and a physical body to be managed and manipulated, the professionals endeavoured to make a connection and interact with each of them as a *person*. And, as I discuss in this dissertation, they were doing more than just encouraging these citizens to take responsibility for their own health – as I define it, *encouragement* is the practice of actively giving help or trying to increase someone’s confidence to the point where they are able to do something difficult; this makes it a one-way practice that takes place between defined individuals. But what I saw were social, reciprocal exchanges between multiple actors; this was an active, iterative process, rather than something linear or static. Furthermore, as I began to learn more about the work being done by the municipal health professionals, I discovered that they played a central role in linking the political ambitions for community health and translating this information to citizens in their everyday lives. Thus, after attending various community-based events, seminars, and workshops in the municipality at the start of my fieldwork, I decided to focus on the work being done by certain professional groups, particularly those who make home visits to elderly citizens.

As I delved deeper into how the work of municipal healthcare services is done, I realised that home visits to ageing citizens could be understood as social, material, and cultural encounters that are much more than simply sites of health promotion, governmentality, or the dissemination of political rhetoric. I saw this most clearly when, in June 2015, I began to follow the physical and occupational therapists who are part of the municipality’s new Cross-disciplinary Training Team. The Team’s therapists told me how motivated most citizens were to train, how willing these citizens were to undergo (sometimes multiple) courses of training despite their physical limitations, and how much it

meant to the citizens to retain their independence. But this made me wonder about the kind of rationalities involved – i.e., why do older citizens agree to participate in these municipal programmes, and why is it important for municipal health professionals to try to help those who will not, or cannot, help themselves?

My analysis in this dissertation illuminates how municipal health professionals navigate between their responsibilities to both politicians and elderly citizens, and how they use their knowledge and experience to ultimately provide a certain form of care. While policies, statistics, numbers, categories, and standardised systems play a significant role in the work of municipal healthcare (as in most governmental work), this dissertation focuses on the people involved – specifically, health professionals and the elderly citizens with whom they work – and the choices they make in response to transformations within the eldercare sector in Denmark. It is about the professionals’ role as caregivers, and about the essential personhood they recognise and acknowledge in the elderly recipients of the services they provide. And it is about the value and sense of potential that each of us hopes to retain for as long as possible.

Copenhagen, Denmark
July 2017

* * *

Introduction

According to the European Commission, the rapid development of new medical advances along with improved standards of living means that Europeans are living longer than ever before: “By 2020, a quarter of Europeans will be over 60 years of age” (European Commission 2014: 5). Although the Commission hails it as a “spectacular achievement” (ibid.: 8), this demographic trend – combined with low birth rates across the European Union – indicates that population ageing is accelerating while population growth is slowing down. This tendency has been positioned as problematic since the issue of global ageing started to outpace more general worries about a ‘population bomb’ that could destabilise financial and social institutions (Ehrlich 1968; Johnson et al. 1989). As such, population ageing has developed into a worldwide matter of concern because, if it continues unabated, it is expected to lead to significant changes in the structure of European society: according to the Commission, ageing combined with persistent low fertility rates will lead to a marked reduction in the labour force and transform the age composition of the overall European population, which would consequently alter “the economy, social security and health care systems, the labour market, and many other spheres of our lives” (European Commission 2014: 5).

These concerns have led to a shift in both expert debates about and public understandings of the potential impact of population ageing (Bülow & Söderqvist 2014); this in turn has produced a certain political discourse in many European countries, which has influenced how governments address the ‘problem’ of elderly citizens via the social policies and health initiatives they implement. As I describe in this dissertation, I was particularly interested in examining how certain political discourses attached to health programmes targeted towards elderly citizens in Denmark might shape and affect their everyday lives. Thus, in the section that follows, I first discuss how ‘the elderly’ have been constructed as a specific category; i.e., how the older, post-workforce pensioner (retiree) has become framed as a generic category of individuals who “share the same experiences and needs, and have the same interests” (Gilleard & Higgs 2000: 90) – a political categorisation that positions ‘the elderly’ as an abstract sub-group of society that has the potential to burden younger generations in the future and, as such, must be managed in specific ways. I also describe the paradox of Third Age, and how a positive discourse of ‘healthy ageing’ has emerged, which has implications for older citizens.

The construction of 'the elderly' and the paradox of the Third Age

In many societies, the human life course has long been divided into a series of distinct ages; originating in ancient Greece with writers and philosophers like Aristotle, the concept of 'the seven ages of man' became especially popular in medieval Europe, where both theologians and astrologers attached significance to groups of seven, such as the deadly sins and the planets (Burrow 1986)¹. By the 1800s, this categorisation of the human lifespan had expanded into nine or even 10 stages – from birth to 100 years – and the idea became a prominent way of thinking about the ageing process in the Western world. More recently, in the early 20th century, pension schemes formalised the mid-60s as the expected point in life that a person should retire from work, and the category of 'old age' became "a status firmly located within the institutionalised life course of white heterosexual able-bodied men" (Gilleard & Higgs 2014: vii, 115). In this sense, a man's chronological age – rather than his physical age – became the primary impetus for leaving the workforce. The life course of women, on the other hand, was typically defined by their reproductive abilities (ibid.: viii, 37). Thus, once a person reached their 50s or 60s and could no longer be productive, they were considered to be 'old'.

Such divisions have become embedded in the way people think about ageing and what it means to be elderly. In many societies, ageing – and especially older age – has been culturally defined as a distinct point of time when a person's body and mind begin to decline and decay. However, due in part to the continuing increase of life expectancy, the needs of and expectations for older people in most Western societies² began to change in the mid-20th century. For example, in the 1980s, the popularisation of 'the Third Age'³ as a specific stage of life after retirement suggested that a 'new' personal and collective identity could also be developed. The concept of the Third Age (after the 'ages' of childhood and adulthood) reinforced the perception of later life as a distinctive stage in the life course; it is usually defined as "the span of time between retirement and the beginning of age-imposed physical, emotional, and cognitive limitations; i.e., between the ages of 65 and 80+" (Barnes 2011a). According to social-gerontologists Christopher Gilleard and Paul Higgs:

¹ William Shakespeare famously wrote about the seven stages of man in his 1623 play "As You Like It" (Act II, scene vii).

² From this point, my discussion focuses on Western societies, specifically Europe and Denmark, unless explicitly stated otherwise.

³ Demographic historian and sociologist Peter Laslett popularised the term in his 1989 book, *A Fresh Map of Life: The Emergence of the Third Age*, as well as through his work as a founder of Britain's University of the Third Age in 1982.

The third age can be considered as an example of a generationally defined cultural field, where particular logics of power and influence operate that determine both the nature of the participants and the frameworks governing these practices. The underlying logic of the field is structured by consumption, a post-scarcity consumption that supports the search for distinction and that implicitly or explicitly rejects, denies or marginalises ‘old age’. [...] The logic that operates within the third age is the logic of consumption and the individualisation of society’s material surplus. (Gilleard & Higgs 2007: 25)

This focus on consumption suggests that, by the time they retire from work, the current generation of older people should be in a socio-economic position to spend their pension money on the things they were not able to do while they were actively working and/or raising children – e.g., to travel, engage in hobbies and leisure activities, spend more time with loved ones, etc. In other words, while they may not be active in the workforce any longer, this social group should still be able to contribute to society as ‘active’ consumers. The positive discourse about ageing positions the Third Age as a ‘limitless’ period of rejuvenating physical activity, consumption, and fulfilling social involvement, particularly with regards to engagement with one’s family, friends, and community.

In addition, a great deal of recent scientific research has suggested that participation in hobbies and recreational activities, both inside and outside the home, could delay mortality in older populations (e.g., Lennartsson & Silverstein 2001: S335); such research indicates that ‘active engagement’ with life after retirement could have profound health consequences as people grow older (ibid.). However, the paradox is that, if we accept the categorisation of the Third Age, this is also the time of life when people typically develop more health problems that require medical treatment, hospitalisation, and/or supportive services. In general, medical research indicates that people over age 50 have a higher risk of developing chronic diseases related to obesity, loss of muscle mass, late-onset diabetes, and cardiovascular disease, which are among the most common and costly health problems facing older adults. This often means that, as people age, they are living more years with multiple chronic illnesses (Crimmins & Beltrán-Sánchez 2010), which suggests that, rather than getting the most out of life in the Third Age, they are simply dying more slowly and entering the Fourth Age⁴ sooner. Moreover, because these health conditions and illnesses are often linked to lifestyle choices, the scientific research propounds that poor health in

⁴ The so-called Fourth Age refers to the final years of adulthood before death (Blanchard-Fields & Kalinauskas 2009; Barnes 2011b). Usually starting at about age 80 or 85, it is characterised as a period of extreme biological and functional decline.

later life can be prevented, lessened, and/or managed. Thus, there has been a “biomedically framed ‘need’ to assess and minimize the risks that...older people are exposed to, or that their functionally limited bodies, selves, and lives apparently embody” (Kaufman 1994: 435). This has positioned the social category of ‘the elderly’ as simultaneously an object of concern and a subject of care.

Traditionally, governmental social-protection systems and the formalised care of older citizens have included “a particular construction of the subject for which policies and arrangements are designed. In both political and public discourses (...) elderly people feature as subjects who are associated with particular needs, wishes and desires, and for whom care needs to be guaranteed and organised” (Weicht 2013: 188). But, as I have suggested, idealised perceptions about functional ability and vitality in the Third Age have begun to influence how many Western societies decide to manage and care for elderly citizens. In particular, government officials are increasingly influenced by biomedical research and scientific paradigms about the ageing process; these inform the health policies they implement, and work to determine the parameters for the health and everyday lives of citizens after they retire (i.e., approximately age 65 and over). Specifically, the paradigm of ‘healthy ageing’ and ‘active ageing’ is often emphasised in political legislation and social policies that target older people (e.g., Hepworth 1995; Alftberg & Lundin 2012; Elmelund 2012; Lassen & Moreira 2014; Rudman 2015). As a result, expert beliefs about the physical process of ageing and the needs of older people have been shaping the opportunities and capacities they have as citizens. I argue that this has led to the emergence of a new type of citizen – i.e., what I call the ‘limited yet limitless’ ageing consumer, which I discuss in the next section.

The emergence of the ‘limited yet limitless’ ageing consumer

There is no universally accepted definition for terms like successful ageing, healthy ageing, productive ageing, etc., but they typically refer to the individual or collective strategies that are used to optimise economic, social, and cultural participation throughout the life course. As I discuss in this dissertation, a political emphasis on active participation and being able to increase one’s resources points to a citizen’s ongoing, continued potential as a valuable, productive member of society. This emphasis is not unusual in many high-income, industrialised Western societies, which depend on an active and engaged workforce. But I argue that this discourse creates a paradox that can be seen most clearly when it targets ‘the elderly’ as a sub-set of

society. In particular, my research shows that, within many health and social policies, the categorisation of later life as ‘old age’ – which positions elderly citizens as a high-risk, potentially burdensome group – has become entangled with the positive discourse of healthy ageing in the Third Age to create a ‘limited yet limitless’ ageing consumer – i.e., a post-retirement citizen who may suffer from certain health limitations but who still has unlimited potential as a contributing member of society.

The popular conceptualisation of the Third Age includes many positive aspects – mostly in terms of social engagement (Smith 2000), knowledge and expertise (Singer et al. 2003), and adaptive flexibility in daily living (Riediger et al. 2005). It is also typically understood as a period when a person usually has fewer responsibilities (in terms of career and raising a family) and thus, when this stage is coupled with adequate financial resources, it should offer rich possibilities for self-fulfilment and purposeful engagement with life (Barnes 2011a). In this positive paradigm of active ageing, the general perception is that older citizens should want to achieve the ‘limitless’ promises of a good later life in the Third Age. Moreover, there is no mention of deterioration, disability, or death; rather, older citizens are expected to remain in a state of suspended animation, and to preserve their mental and physiological capabilities indefinitely. As such, they are positioned as interminably productive, self-helping, and independent consumers who can continue to contribute to economic growth and development, and to support the social collective.

However, some governments have decided that certain citizens – especially those with health conditions that have led to functional limitations⁵ – need to receive specific forms of knowledge and/or assistance from health professionals so that they can learn how to attain these promises by becoming more independent and self-sufficient. As such, politicians and public-health officials have developed programmes and services to provide these citizens with information and opportunities to take more control over their own lives, which will ultimately allow them to remain physically, mentally, and socially active for as long as possible. In addition, as I discuss in this dissertation, many health initiatives and programmes are offered as choices, which constitutes these citizens as consumers of health and social services. In the political discourse, if citizens can make the ‘correct’ choices and learn how to be responsible for themselves in order to achieve a long, active life with a high quality of life, then providing them with health

⁵ Here, the emphasis is on the body’s functional ability, which is not affected by cognitive limitations due to stroke, dementia, or Alzheimer’s disease. In my conceptualisation, the ‘limited yet limited’ ageing consumer may have some mild age-related cognitive decline but is generally considered to be sharp-minded and capable.

programmes, information, and supportive services to attain this goal is simply good business; in economic terms, it is a smart ‘return on investment’.

This also creates a market for other consumer-based health solutions, such as anti-ageing cosmetics, dietary supplements, and a variety of pharmaceuticals (Rudman 2015: 16; *also* Gilleard & Higgs 2000; Twigg 2013). Thus, rather than excluding older people who may have certain health problems and functional limitations – due to either chronic conditions such as diabetes or arthritis, or serious illnesses such as cancer or heart disease – some governments believe it is worthwhile to make an investment in helping these ‘limited yet limitless’ consumers take responsibility for their own health and care needs, so they can retain their value as consumers and remain part of the social collective. As such, many public-health initiatives have begun to focus on ‘activating’ and ‘empowering’ older people to (re-)master certain skills and competences, which would foster their continued participation; i.e., allow them to remain active, energetic, and take responsibility for their own health in order to benefit society and fully enjoy their lives in the Third Age – and to stave off the unmentionable decline and decay (and associated expenses) of the Fourth Age for as long as possible. But this means that, at the level of everyday life, both citizens and health professionals have to navigate the paradox inherent in the construction of the ‘limited yet limitless’ ageing consumer, which is a central focus of this dissertation.

In the next section, I discuss the development of reablement programmes in Scandinavia, starting first in Sweden and then in Denmark. These interventions are designed to manage an increasing number of elderly citizens and their expected demand for care; specifically, this form of rehabilitation should help ‘limited yet limitless’ ageing consumers re-learn certain competences, which will reduce their need for health and welfare services, and minimise and/or prevent hospital admissions. Participating in these programmes should also empower elderly citizens to be more self-sufficient and independent.

Everyday-rehabilitation programmes in Scandinavia

As I have already suggested, the matter of population ageing has become a major concern in many European countries in recent years, and most have been developing and implementing policy initiatives at both the national and local level to address this phenomenon. In response to this overall trend, the European Commission writes:

Reforms of social protection systems in Europe, particularly pensions, health care and long-term care arrangements, are considered an important component of the constructive response to population ageing. [...] Hence, one of the most important issues is how to restore sound public finance and assure the sustainability of social protection schemes without excessively burdening younger generations in the future. (European Commission 2014: 5)

This excerpt points to the challenges that many European nations are facing with regards to how they will handle new societal demands and risk in general, and adequately support their ageing populations in particular. To address the problem of population ageing (and to “assure the sustainability of social protection schemes”), specialised rehabilitation programmes are the newest “constructive response” to be implemented in many Western countries. Typically, this form of training is a “time-intensive, time-limited intervention provided in people’s homes or in community settings, often multi-disciplinary in nature, focusing on supporting people to regain skills around daily activities” (Aspinal et al. 2016: 1). In English-speaking countries, such rehabilitation interventions for the elderly are typically known as *reablement* (United Kingdom), the *active service model* (Australia), or *restorative home support* (New Zealand and USA). In Scandinavia, the Swedish version is called *hemrehabilitering* (home rehabilitation), while the term *hverdagsrehabilitering* (everyday rehabilitation) is used in both Norway and Denmark⁶.

Although physical therapy has long been a municipal offer to citizens who are experiencing a loss of functional ability, particularly after hospitalisation, the first formal ‘reablement’ programme in Scandinavia was established in Östersund Municipality (Sweden) in 1999:

The background for the decision was a need for municipal savings. But instead of cutting the budget for care and health services, the local government decided to invest 10 million Swedish kronor (over 1 million Euro) in restructuring home care. The idea was that a proactive investment could provide citizens with more quality of life and savings for the municipality in the longer term. (FOA 2017)

Maritha Månsson published the book *Hemrehabilitering: vad, hur och för vem?* (*Home Rehabilitation: What, How and For Who?*) about her experiences as a medical officer in Östersund. In the book, she explains that the rehabilitation programme is meant to increase elderly citizens’ level of activity and improve their functional ability, as well as to maintain and delay a deterioration of function (Månsson 2007). In the years since then, positive evaluations of the so-called Östersund-model have inspired local governments throughout the Nordic region to establish similar programmes. The pilot programme “As long as possible in one’s own life”

⁶ In this dissertation, I use the terms ‘everyday rehabilitation’ and ‘training’ somewhat interchangeably.

(Længst muligt i eget liv) was the first to be implemented in Denmark; it was launched in Fredericia Municipality in 2008. This project aimed to focus on the rehabilitative efforts of in-home eldercare and to strengthen older citizens' ability to "master their own lives" (Kjellberg et al. 2011; Blom 2014: 45). The Fredericia project was built around a multidisciplinary team of municipal health professionals, specifically evaluative home visitors (Visitation), occupational therapists, physical therapists, visiting nurses, social and healthcare assistants and helpers, and regional managers.

The central idea of everyday rehabilitation in Denmark is that physical training at home will reduce an older citizen's overall need for hospitalisation, medical treatment, and especially in-home welfare services – such as meal preparation, personal care, and house-cleaning – as outlined in §83 of the *Social Services Act*; this national law governs the provision of services related to personal assistance and care, assistance or support for practical tasks at home, and meal delivery. According to researchers at KORA (the Danish Institute for Local and Regional Government Research) in an evaluation report for the National Board of Social Services (*Socialstyrelsen*), the overall purpose of everyday-rehabilitation programmes is almost identical in each municipality, but the organisational framework can vary (Kjellberg et al. 2013); for example, the local leadership in a particular municipality can choose to offer training to citizens with all types of needs, or to complement Home Help and Home Care services, or combine in-home training with rehabilitation at a community-based training centre (ibid.). Each municipality can also determine the length and intensity of the training offer, which may vary from six weeks to an indefinite duration (Hansen 2013: 48).

Based on positive evaluations of the Fredericia model – and a savings of 15 million Danish kroner (over 2 million Euro) in the programme's first year (Kjellberg et al. 2011) – the Danish government decided to activate §83-A of the *Social Services Act* in January 2015. This addendum states that all Danish municipalities must now offer a short, time-limited everyday-rehabilitation programme to any citizen who has been evaluated as having decreased functional abilities and who could potentially benefit from physical training. This programme is available to anyone who is experiencing some degree of functional limitation as the result of an accident or illness and who wishes to re-gain their ability to live independently. But at the municipal level, these programmes are most often targeted at elderly citizens who are experiencing age-related functional decline and who may have other physical health issues.

The premise is that training everyday activities will improve an elderly citizen's sense of security and stability within the home setting, which should result in more self-sufficiency and less dependence on others, and thereby ensure a better quality of life with less need for in-home welfare services. According to researchers at KORA: "The goal [of reablement] is that the elderly will be more self-reliant and less dependent on help afterwards" (Rostgaard et al. 2016). Training within the home setting is important because, in general, both politicians and health professionals consider the home to be a place of familiar surroundings and routines that support a higher level of functionality and a better quality of life; thus, it is where 'a citizen functions best' and where they can most effectively 'age in place'. This is consistent with research that supports the benefits of the elderly remaining at home for as long as possible, which many consider to be "the best place to grow old" (Mahler et al. 2014: 36; *also* Wahl 2001; Oswald et al. 2007). Overall, it is believed that there is "a positive correlation between ageing in familiar surroundings with a deeper sense of satisfaction and contentment" (Wilmoth 2000 in Stones & Gullifer 2016: 450). This underlying belief has made 'ageing in place' the primary objective of eldercare in many Danish municipalities; i.e., that elderly citizens should be able to remain in their own homes for as long as possible.

National governmental agencies, special-interest groups, and local political leadership in Sweden, Norway, and Denmark have conducted a great deal of research to evaluate the administrative benefits and cost-savings potential of everyday-rehabilitation programmes (e.g., Langeland et al. 2016; Kjellberg et al. 2013; Kjellberg et al. 2011; Ness et al. 2012; Gustafsson et al. 2010; Sjögren 2007); however, the results thus far have been inconclusive, and most of these evaluations cite the need for additional research to examine the potential cost-saving benefits of such programmes as well as their short- and long-term effect on elderly citizens' health and well-being. While the framework for most everyday-rehabilitation initiatives typically underscore the importance of building equal partnerships between health professionals and those who receive training, these programmes are still nascent; as such, relatively little is known about how these programmes function in practice.

However, some qualitative research that investigates how these programmes influence and impact the everyday lives of the healthcare professionals involved, the elderly citizens with whom they work, and/or the citizen's relatives has begun to emerge (e.g., Hjelle et al. 2017; Hjelle et al. 2016; Glasdam et al. 2013; Wilde & Glendinning 2012). In the next section, I explain my ethnologic interest in studying the socio-cultural phenomena that shape how healthcare for the elderly is done, and what my work in this dissertation contributes to the academic field.

The dissertation's motivation, aim, and relevance

The design of most health and social policies does not typically take into account the lived experience of the people whom these policies affect (Twigg 2002: 427), and it is therefore often difficult to see how broader societal changes and developments influence the micro-processes of everyday life. As such, a qualitative study of the contextual framework of people's social relationships and everyday activities *in situ* is able to move from a more abstract examination of historical trends and sociological tendencies to a detailed description of everyday practices and relational interactions; it can thereby be a powerful way to investigate how culture has been and is being created and shaped, to discern the relational encounters and socio-material artefacts that people find meaningful, as well as to understand how the temporality and organisation of modern society affects and impacts people's daily lives (and vice versa).

Conducting ethnographic research is thus a way to illuminate the inherent complexities of social life, especially "the experience and interpretation of events by actors with widely differing stakes and roles" (Sofaer 1999: 1101); with regards to this dissertation, a variety of actors – such as politicians, health professionals, and citizens – may all have varying expectations for and perceptions of the same events. When I first began this project, my original research question focused on investigating how certain social, cultural, and political practices and understandings affect health in a local 'community'. But, as I describe in more detail later, I learned that particular forms of knowledge and meaning were exchanged in the contextual, relational practice between a health professional and a citizen. I thereby wanted to gain more insight into the unique social world that developed during the home-health encounter; a complex social world that was determined and defined by a particular political framework.

A classic conundrum in most public-health work is: how can programmes and services that are designed for a uniform collective reach the individual? This raises questions about how both individuals and collectives are constituted and understood. Within the fields of medicine, medical education, and in the social sciences, there has been a growing emphasis on the significance of individual behaviour, responsibility, and 'self-help' in relation to health practices (Grace 1991: 330); as I already mentioned, this discourse has been influencing health policies and the services available to citizens. These policies position both health professionals and citizens as rational individuals who should be able to make the 'correct' cost-benefit choices – especially when they collaborate in a 1:1 partnership. Through my initial research into health policies and initiatives in Denmark, I discovered that a political economy of healthcare services has developed over the past

few decades, which frames the individual citizen (or patient) as a freely-choosing consumer; this suggests that the health professional becomes re-configured as a seller of services that should meet the consumer's demand. But, as an ethnologist, I suspected that the people involved in these abstract configurations might not adhere to such capitalist rationalities. People are complex, social beings, and political initiatives that focus on a uniform, abstract individual as an agent of mobilising action and change do not always succeed when put into practice (Laverack 2006).

In addition, with a societal emphasis on universality, equality, and community, the Danish welfare state has traditionally focused on managing a homogeneous 'uniform' collective; particularly in terms of "social rights, equalized incomes, and flat-rate benefits, financed through taxation" (Lidegaard 2009: 370). But with the rise of immigration as well as globalisation in recent years, the political directive to provide universal benefits to a uniform collective has been challenged (*see* Jenkins 2011; Olwig & Pærregaard 2011). This made me wonder: What are the implications of an individualised, market-driven focus with regards to the provision of social and healthcare services? In particular, how does a focus on 'the individual' affect the fundamental purpose of health and social services (i.e., to provide a universal form of help and care), and how might this ultimately impact the larger collective? At the outset of my research, it was not clear to me how either citizens or health professionals responded to the political expectations for their individualised 'market exchange' of knowledge, services, and resources during a health encounter. Thus, my ethnographic investigation into the Danish state's eldercare initiatives and programmes prompted me to ask: how do health professionals understand the political discourse and try to empower individual older citizens to take control of their health – and what are the effects? Driven by these queries, I was curious to explore the politically-defined 1:1 relationship of a municipal home-health encounter in the situated social context of everyday life. Thus, my ambition with this dissertation is to elucidate some of the conflicts, paradoxes, and negotiations that take place during these encounters.

In particular, I attempt to describe what happens when the abstract 'state' via the municipal health professional enters older people's homes to evaluate them and to offer (or rescind) certain health programmes and care services, and how these encounters are experienced by the various actors involved. In other words, what dynamics are involved when policy meets practice at the intersection of the state, the professional, and the citizen? According to rehabilitation manager and physical therapist Louise Thule Christensen, who has been the project leader in Fredericia Municipality since 2007, the Fredericia model of everyday rehabilitation focuses on fulfilling the older citizen's "hopes and dreams" for the future (Guldager 2011). But how do the health

professionals who are tasked with this work help individual elderly citizens to achieve their hopes and dreams, and how does this potentially conflict with the political expectations and ambitions for these health services?

The Danish government's health-prevention focus has been increasingly emphasising the concept of 'help to self-help' (*hjælp til selvhjælp*), whereby citizens who apply to receive certain municipal services (i.e., assistance with activities of daily living, such as bathing, getting dressed, housekeeping, preparing meals, etc.) instead receive 'activating' help to support them in performing these tasks for themselves, thereby becoming more independent and self-sufficient. With the discursive shift from providing help to enabling self-help within the eldercare sector, the older citizen is expected to transform into a new type of 'governable' subject that can be empowered to fulfil certain objectives of the contemporary Danish state. But, as I discuss, this shift also means that the work of municipal healthcare becomes a particular kind of relational practice – a 'shared responsibility' – that also re-defines the relationship between the state, the health professional, and the ageing citizen. Thus, the question that has framed my project is:

How do the Danish state's political goals and individualised health policies influence the provision of in-home health services for the elderly, and how do both municipal health professionals and elderly citizens navigate the political discourses that frame their relational encounter?

In this dissertation, I present the real-life interactions between municipal health professionals and elderly citizens in one particular Danish municipality in order to illuminate how a 'shared responsibility' for health care emerges. By investigating how the goal of eldercare has shifted from one of providing help to enabling self-help, I examine how both health professionals and elderly citizens interpret, experience, and react to the political discourses that frame their encounter. As such, this dissertation examines the forms of power, experience, knowledge, and meanings that are generated, shaped, and co-constituted by the actors involved. In particular, my analysis highlights the effects that the Danish state's political transformation has had on both municipal health professionals and the elderly citizens with whom they work, and it makes an original contribution to the academic field related to health professionals' practices and the provision of eldercare in contemporary society.

A central component to my analysis of these home-health encounters is an exploration of the discourse around the term 'empowerment'; during my fieldwork, both politicians and health professionals often referred to the need to motivate and encourage citizens as a way to *empower*

them to make certain choices and remain independent. In general terms, the concept of empowerment is meant to give a form of power to those who are power^{less}. But from where does power emerge, and how is it operationalised in local settings? In the next section, I discuss the concept of ‘empowerment’ as an analytical frame for this project.

Examining eldercare encounters through the lens of ‘empowerment’

Many contemporary health services can be understood as “an intervention to produce compliance” (Powers 2003: 227). With Denmark’s political emphasis on ‘help to self-help’, there is an expectation that even frail, very elderly citizens will comply with governmental recommendations and manage their own lifestyle choices, act responsibly, and “acknowledge that they play an essential role in solving their own problems” (Mik-Meyer & Villadsen 2013: 4). Moreover, an “increasingly pervasive process of individualisation” (ibid.) has developed in Denmark, wherein individual citizens are given the freedom to make the ‘correct’ choices (Pedersen 2016: 37) regarding their health – rational choices that should allow them to master their lives and take more responsibility for their own health and welfare, and continue to have productive, independent lives until they die at a ripe old age. In the government’s view, the freedom to make these choices should be empowering, in terms of the older person “attaining a sense of control and meaningfulness” (Andersen et al. 2000: 14) in their everyday lives.

When the word ‘power’ is mentioned in academic circles, the immediate leap is often to the work of philosopher and social theorist Michel Foucault, especially his descriptions of power relations, biopolitics, and subjectivity. In particular, his conceptualisation of biopolitics deals with the population as a political problem (Foucault 2003: 245); i.e., biopolitics “will derive its knowledge from, and define its power’s field of intervention in terms of the birth rate, the mortality rate, various biological disabilities, and the effects of the environment” (ibid.). Foucault’s work has inspired a great deal of scholarship in a range of academic fields; notably, a wealth of recent academic research in Denmark has examined the forms of governmentality, biopolitics, and subjectification that can be recognised within the disciplinary mechanisms of the Danish state (e.g., Mik-Meyer & Villadsen 2013; Beedholm & Frederiksen 2015; Larsen 2015; Pedersen 2016; Kristensen 2016; Møller & Johansen 2016). Many of these scholars have described the ‘invisible’ forms of institutional, systemic power, surveillance, and control that an individual citizen is expected to internalise in order to “conform to existing rules, codes and mores” (Foucault 1980: 155; *see* Gordon 2002: 129).

In particular, this research has explored Foucault's ideas about neoliberal governmentality in relation to certain developments in the Danish healthcare sector, wherein capitalist market models have become "generalised to all spheres of society" (Larsen 2015: 18; cf. Foucault 2009: 145). In political scientist Lars Thorup Larsen's analysis, for example, the Danish government's establishment of a 'free choice' in relation to hospital waiting-lists in the early 2000s created a market that could be managed in a way that was meant to increase production and efficiency. Larsen argues that, as a result, the governmental ambition to strengthen the private hospital sector has also worked to convince Danes to embrace more general ideals about the benefits of individual freedom and patient choice (ibid.: 22); in this way, particular institutional leadership mechanisms have prompted patients to increase production in order to make a given market problem controllable (ibid.: 23).

Others have examined Foucault's ideas about institutional forms of surveillance and control. Specifically, anthropologist Dorthe Brogaard Kristensen describes how a political emphasis on individual responsibility, choice, and freedom has become combined with Danes' interest in health and fitness: "For the sake of competition and to live up to political goals, one's freedom to choose has increasingly become a mantra in the healthcare sector" (2016: 84). Kristensen argues that political ideals for self-responsibility, freedom, and competition – combined with citizens' desire to live a long and healthy life – are a "perfect example of Foucault's concept of the panopticon, where the person internalises power as a permanent condition in the form of constant self-disciplining and self-monitoring" (ibid.). Similarly, other scholars have pointed out that the recent political trend towards a "government of individualisation" (Foucault 2000: 330) in Denmark has worked to transform citizens into an instrument and tool of the state, whereby the body becomes a "biopolitical target" of health-promotion efforts (Otto 2013: 119). As a result, good health is seen as both a right of citizenship and an effect of government intervention (Powers 2003: 229).

There is often an emphasis on the individual's relation to the forms of institutional power that shape knowledge production. For example, in a study of Danish kindergartens, sociologist Oline Pedersen wrote that "controlling others through their freedom requires the creation of responsible individuals who, with this freedom, make the correct choices" (2016: 37). Thus, having the freedom to make the 'correct' choices means entering into a particular regime of power. Pedersen argues that the Danish government's emphasis on creating a healthy, productive population and making "good lives possible" is meant to ensure a state of good quality (ibid.: 37; cf. Foucault 2008: 95–144). She attests that this is directly related to Foucault's concept of 'technologies of

the self”, which “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (1988: 18; *also* 2003: 146).

Foucault himself wrote that such technologies or operations are the product of systems of historical inscription; specifically, the long-term development and emergence of complex social practices “which work on human conduct, moulding it and forcing the bearer of such conducts to take responsibility for them” (Foucault 1979 in Crossley 1996: 102). But, at the level of the self, Foucault also attests that – in addition to being historically produced – individual subjects/agents are constituted in and through a set of social relations that are imbued with power (1980 in Allen 2002: 135). He wrote:

What defines a relationship of power is that it is a mode of action which does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on existing actions, or on those that might arise in the present or the future. (1982: 789)

Foucault argues that the constitutive capacity of power can be beneficial and productive if it works to fabricate, manufacture, and shape interests and identities (*see* Gordon 2002: 133). But he tends to see power relations as always strategic, wherein “individuals try to conduct, to determine the behaviour of others” (1987: 18). He also argues that power is only possible in a relationship between persons with active agency, wherein each is “thoroughly recognised and maintained to the very end as a person who acts” (1982: 220); this is what contributes to the formation of the individual subject. As such, forms of institutional power that operate to control or manage the body (both collective/population and individual/citizen) require the individual subject to display an active form of agency and resistance, which thus becomes a pre-condition for the relation of power. However, once the subject is understood as an effect or product of power, then the subject “loses its capacity to act and becomes, in a sense, passive” (Gordon 2002: 134). In Foucault’s optic, the production of “docile bodies” (Foucault 1979) can be seen as the ultimate outcome of state intervention in individual citizens’ healthcare practices. Here, the process of empowerment “supports the status quo of power relations” (Powers 2003: 235), which ultimately works to reinforce the dependency of both individuals and populations.

In my study, I found that municipal health professionals are imbued with a certain form of power – via their capacity as representatives of the Danish state and its institutions, these professionals are positioned as part of the collective ‘state’ to intervene in the lives of individual citizens. As

such, they operate as a biopolitical mechanism of disciplinary control and surveillance, especially when they offer individual citizens the freedom to choose opportunities that will foster self-responsibility and self-governance. In the Foucauldian optic of governmentality and biopolitical power, the professionals' actions are meant to act upon and influence citizens' actions, especially their future actions with regards to taking responsibility for themselves and gaining more control over their bodies. By displaying agency and reacting to (or resisting) this form of power, the citizen acts and becomes a particular kind of governable subject.

With regards to ageing citizens, Foucault stated that old age is a particular area of biopolitical concern because ageing individuals "fall out of the field of capacity, of activity" (2003: 244); security mechanisms must thereby be installed to optimise a particular state of life (ibid.: 246) and improve existing life by focusing on risk prevention and eliminating accidents – "the random element" (ibid.: 248) in the life course. In this sense, the Danish state's health initiatives and its political emphasis on the concept of 'help to self-help' can be understood as security mechanisms that are meant to optimise and improve – and stabilise – a citizen's later life. Through these biopolitical mechanisms, elderly citizens' homes and bodies become areas of concern where potential risk must be reduced. At the same time, these individuals are offered the freedom to choose services that will provide them with the power to be more self-helping and independent, which positions them as freely acting subjects who may resist the political interventions.

Although many scholars have persuasively used a Foucauldian optic to describe the forms of institutional surveillance and biopolitical control to which an individual citizen may be subjected, their application of Foucault's work often overemphasises a linear form of strategic power and subsequent passivity. Moreover, much of this analysis does not account for the complex, relational interactions and micro-processes of sociality that take place between people in their everyday lives. For example, when the municipal health professional – representing the collective, external power of the state – enters the individual citizen's home, some might want to represent this as an uncontested site of governmentality; a place where an individual can be articulated as a 'citizen-subject'. However, my research suggests that, at the micro-level of everyday life, relationships are much more complicated and contingent on other factors; thus, many aspects of the encounter are constantly being negotiated, which works to transform the subjectivity of both the individual and the health professional.

My work in this dissertation specifically focuses on examining the relational encounters between people, with a particular emphasis on how bodies, homes, and forms of sociality are negotiated.

Thus, I decided that a wholly Foucauldian approach did not allow me to explore how ideas about agency and autonomy might emerge through certain social interactions; I also wanted to avoid over-emphasising linear forms of power relations. The political focus on a citizen's home as a site for health encounters thereby led me to the work of political theorist Hannah Arendt, particularly her classic 1958 book *The Human Condition*. In Arendt's analysis, she writes that, since the time of the ancient city-states of Athens and Rome, there has been a distinction between a citizen's public and private sphere of life; this corresponds to the political and household realms, respectively (1958: 28). In the classical city-state, it was understood that "a man could not participate in the affairs of the world [if] he had no location in it which was properly his own" (ibid.: 30); a citizen was not considered 'free' unless he was able to 'master' and manage his own home. Arendt avers that the appearance of power creates the public domain (see Gordon 2002: 134); thus, she describes a complex relation between public space and power, which I found compelling. As Arendt argues, forms of action become prioritised in the public domain, especially actions that are dependent on relationships with other actors: she writes, action "is never possible in isolation; to be isolated is to be deprived of the capacity to act" (1958: 188). In Arendt's view, acting together in concert with others is "constitutive of the public, political realm in which action itself takes place" (see Allen 2002: 138). For her, the subject's full agency can only be achieved through action with others in the public, political realm. Thus, the forms of action that an elderly citizen does together in concert with a health professional (representing the power of the state) constitute the citizen's home as a political realm. The actions done in this location are a pre-condition for power; as Arendt argues, when such actions are performed with others in the political space, there is a continual production of power (1958: 200–1). Furthermore, when words and deeds are shared in a space that is constituted by such power, then it is possible to articulate both subjectivity and agency, which leads to a form of freedom that is never passive. Arendt suggests that power is the capacity of people to act in concert to begin something new; she specifically points to power as that which "springs up between men when they act together and vanishes the moment they disperse" (ibid.: 200). The collective power that emerges from this form of action echoes the Danish Health and Medicines Authority (DHMA, *Sundhedsstyrelsen*)'s definition of empowerment, which is formulated as a need for "collective action to improve health outcomes, and to obtain more influence and control over shared living conditions and quality of life" (DHMA 2005: 24). The Danish government's expectations for collective action depend on the empowerment of individual citizens, but from where does an individual's source of power originate? As I describe in this dissertation, empowering citizens to take responsibility for

their own health is grounded in the work of the municipal health professionals. Thus, I point to the form of plurality that Arendt describes – i.e., an activity in which a person reveals their unique identity through their words (intentions, choices) and deeds (actions), but the validation of this identity requires the presence and acknowledgment of others. In this way, empowerment is also a relational, social practice.

Arendt attests that, since the expansion of economic forces since the 18th century, the public realm has become the central area to satisfy our private, material needs, which has destroyed the lines of demarcation between public and private (1958: 68–72; 253); I too question whether any distinction between the public and private realms exists when health professionals enter the citizen’s home to do their work. Specifically, my analysis shows how the lines of demarcation between the public and private realms have become blurred with the rise of welfare states, especially as it has become more typical for representatives⁷ of the state to enter private homes on a regular basis to evaluate a citizen’s living conditions as well as to deliver health information, services, and/or treatments. As I describe, when municipal health professionals encounter a citizen-subject within their private home, the political conceptualisation of ‘freedom’ and autonomy becomes negotiated and re-defined. I found that, somewhat paradoxically, the invisible forces of institutional control become diffuse, and the relations of power become more ambiguous and contested. This results in a new form of agency, and the citizen’s subject position as an abstract ‘individual’ with a certain relation to the collective becomes less clear.

Arendt also contends that the expansion of capitalist values in the 20th century has undermined the traditional division of essential human activities – i.e., labour, work, and action – and made them meaningless (1958: 320–5). Because all human efforts are now focused on reproducing the material conditions of our existence – particularly through capitalist forms of productivity, industrialisation, and consumption – she believes that, in the ‘modern’ Western world, we have become a society of job-holders who no longer appreciate the values of the past. But this viewpoint has become somewhat out-dated, especially as Western societies have become more globally interconnected and digitally mediated; the development and expansion of the Internet has fundamentally changed industry and commerce, and it has also generated new forms of sociality. Thus, certain social or cultural values may not necessarily have been lost or destroyed; in fact, I argue that a form of care that is based on ‘traditional’ values may be emerging.

⁷ In Denmark, these representatives have typically been Visitation plus longer-term municipal services such as Home Care, Practical Help, and Visiting Nurses; I describe these roles in more detail in Chapters 1 and 2.

Although I am certainly inspired by many of Arendt's concepts and arguments, I recognise the limitations of her perspective; in this dissertation, I use her work mainly as a point of departure rather than a strict theoretical framework. For example, while I could perhaps describe the municipal health professional in Arendtian terms as *homo faber* (he who works upon and makes/fabricates things; 1958: 136) and the citizen as *vita activa* (he who is actively engaged in the things of this world; *ibid.*: 14), such terms privilege the individual agent and become categorical. One of my central points in this work is that abstract labels and categorisations can be normative and restrictive, especially when applied to the complex social realm and micro-processes of everyday life. However, I believe that we can see traces of Arendt's description of the three forms of activity that she considers essential to the human condition – i.e., labour, work, and action – in the practice of municipal home-health visits, and I have loosely used these terms as a way to structure the dissertation. In Arendt's view, 'labour' refers to the activity "which corresponds to the biological process of the human body" (*ibid.*: 7); 'work' produces and provides "an 'artificial' world of things. (...) Within its borders each individual life is housed" (*ibid.*); and 'action' is "the only activity that goes on directly between men without the intermediary of things or matter" (*ibid.*). Here, Arendt frames action as the human ability to begin something new – to start again based on our own initiative (*ibid.*: 177), which she calls natality; this is what constitutes the individual's identity as a freely acting agent⁸. But this action can only occur within a "web of relationships" with other actors in the political realm (*ibid.*: 188).

Overall, my references to political philosophers and theorists such as Foucault and Arendt are meant to represent the 'invisible' forms of disciplinary and constitutive power generated by the institutions of the Danish state, which have become entangled in the health professionals' real-life encounters with elderly citizens. In Foucault's work on disciplinary power, he describes how certain institutions (e.g., schools, prisons) have been designed to control and organise the bodies that populate these spaces, specifically through the historical emergence of an "art of distributions" to maximise efficiency (Foucault 1979: 141). However, as I have suggested, when a citizen's private home becomes the site of political power and action in Arendt's conceptualisation, then the citizen is articulated in another type of subject position, and the individual's body cannot be negotiated and controlled in the same way to serve a biopolitical

⁸ In her later work, *The Life of the Mind* (1978), Arendt makes a distinction between an 'agent' (one who is capable of action in beginning something new) and a 'subject' (one who is capable of thinking, willing, and judging) (Allen 2002: 140). In this dissertation, I use the term 'competent social agent' to refer to the political constitution of a freely acting, individual subject.

purpose. Thus, when the collective/political state enters the individual/citizen's private home in the health encounter, both the municipal health professional and the citizen assume a certain subject position with the ageing body as a shared focus of attention and negotiation. In this way, the body is simultaneously perceiving and perceived (Coelho 1991 in Sadala & Adorno 2001: 286), especially in relation to being engaged with its cultural world.

In Denmark, the political concern – and thereby the work of municipal healthcare – is primarily focused on the citizen's physical body – i.e., evaluating it, treating it, reducing risk, and preventing disease and illness. The health professionals I followed in my study did not simply encounter an ageing individual and try to have a discursive dialogue with a certain type of 'citizen'; they also communicated with the physical body, especially in relation to its functional competence and comportment within the spatial configuration of the home. Although Arendt emphasises the relational aspects of plurality, her description of power and agency is firmly located in the disembodied individual's Will, and how the exercise of this Will can spark initiative and lead to political change. Most significantly, she tends to disregard the physical nature of lived experience, which is qualified by the body in its spatial environment.

This prompted me to include a phenomenological perspective, wherein the body is understood as part of a historical person who engages with, lives in, and experiences their world in a particular way. For example, sociologist/gerontologist Julia Twigg writes that bodies are not simply vessels to be worked upon by health professionals but are “interpreted, mediated, and in part constituted in social and cultural meanings” (2006: 25); according to Twigg, this allows us to understand how the phenomenological body can be both a generator and receptor of meanings. As I describe, the forms of meaning that the citizen-body may derive from the health encounter are politically defined, and the health encounters contain a confluence of power, space, and agency, which overlap and act upon each other in a transformative manner (Crossley 1996: 107). The municipal health professionals try to establish the individual citizen as a particular kind of subject, which can be defined by its ability to control and 'master' its home and body. But there is a dialectic relationship between a person as a body and the world in which it is located (Sadala & Adorno 2001: 286). In this sense, the conditions of a person's spatial environment may limit their body, but they do not determine it.

Furthermore, if we understand an active body as a social body (Jackson 1983: 329), then the physical training that is done in everyday rehabilitation is meant to embed a particular kind of knowledge into the body. Embodying new habits and embedding knowledge via training is only

possible when an active body-subject is engaged, and this demands a reciprocal, social relationship. In philosopher Maurice Merleau-Ponty's conceptualisation of how the body develops new habits, especially in terms of physical training, there is a flexible power of action and reaction between social actors, which may ultimately be empowering (*see* Crossley 1996: 109). I found this understanding of the flexible, reciprocal – and fundamentally social – nature of empowerment particularly relevant to how the everyday-rehabilitation therapists engaged with the bodies of elderly citizens in the context of a training session. Thus, rather than privileging the 'individual' in these encounters, I also describe the how certain actors relate to – and find power in – each other in a mutually constitutive relationship. This form of 'relational autonomy' highlights the social context of their encounter as well as the embodied aspects of the decisions they make together (Walter & Ross 2014: S16), and allows these actors to re-emerge as individual subjects who have a new relationship to the collective.

Moreover, by locating the body within the home environment, the citizen's 'messy subjectivity' can be displayed; my conceptualisation of this term refers to the complexity of the human agent as a person. More than simply a person's unique identity or sense of self, this form of subjectivity encompasses the various "modes of perception, affect, thought, desire, fear, and so forth that animate acting subjects" (Ortner 2005: 31). These modes of affect and thought can be shaped by cultural and social formations, especially in relation to how people act on the world "even as they are acted upon" (*ibid.*: 34). The display of these subjectivities makes social beings much more than the holders of certain subaltern identities, such as 'the elderly'. I describe these active forms of subjectivity as 'messy' because, when they are displayed, they can complicate – and often contradict – the docile compliance or individual rationality expected in the political context of a home-health encounter.

To summarise, my work in this dissertation explores the tacit forms of governmentality and biopolitical control that permeate certain discourses about health and activity, and how these powerful forces influence and shape the encounter between a health professional and a citizen. During this encounter, a certain type of citizen emerges, as the physical body and its functionality become a matter of concern and negotiation. But when the health professional enters the citizen's home, a shift in subjectivity also occurs, and citizens are not merely rendered passive; in this realm, the boundaries between public and private become unclear, which blurs the pre-defined lines of power and control. Locating the elderly citizen's body within the home space allows the citizen to emerge as an individual with a unique identity and Will, which the health professional is expected to engage through a particular kind of intersubjective relation that is separate from the

materiality of their corporeal body. But the health professional must communicate with this body – as well as the citizen’s phenomenological body with its history of lived experience and its ‘messy subjectivity’, which produces another form of action and agency; this form of sociality ultimately works to re-define the individual’s relation to the collective. Having established this theoretical framework, I next present a brief overview of the chapters that follow.

Overview of the dissertation’s chapters

In Chapter 1, I employ a cultural-historical perspective to discuss some of the factors that have led to the establishment of Denmark’s current public-health initiatives and eldercare services, highlighting several significant socio-economic developments from the 1890s to the present day. I trace the country’s transition from a welfare state to a competition state, and describe some of the challenges that both municipal leadership and healthcare professionals have been experiencing since widespread public-sector reforms in 2007, with a focus on how the role of the municipal health professional has been impacted.

In Chapter 2, I describe the methodological footsteps I took as I tried to discover how certain political discourses are used in the practice of home-health visits to empower individual citizens to take responsibility for their own health, and thereby improve community health. I did this by ‘following the rhetoric’ in one specific Danish municipality, which required me to position myself within certain landscapes in order to trace the social correlates and connections between, e.g., politicians at the local City Hall, health professionals in their municipal offices, and citizens in their own homes. I followed the work being done by the health professionals from three specific municipal departments: *Visitation*, *Preventive Home Visits*, and the *Cross-disciplinary Training Team*. Over the course of 15 months, I shadowed and observed the everyday work practices of these health professionals, following them on dozens of visits to elderly citizens’ homes before conducting semi-structured interviews with both professionals and citizens.

The analytical chapters are bundled into three separate parts, which are inspired by Arendt’s conceptualisation of the three central activities related to the human condition: i.e., *Labour*, *Work*, and *Action*.

In Part I (*Labour*, chapters 3 and 4), I explain how citizens’ physical bodies are assessed and managed via the municipal evaluation process and subsequent training related to the goals for everyday rehabilitation. I describe how municipal health professionals follow the political discourse as they assess the elderly physical body to discover whether it can be re-skilled to

regain its former productivity – specifically, to transition from a dependent, standardised object of attention to a ‘limited yet limitless’ ageing consumer: i.e., a post-retirement citizen who may suffer from particular health limitations but who still has unlimited value as a contributing member of society. I focus on how the professionals try to follow the state’s rhetoric “to support the citizen in living a life that is as independent and active as possible” (*municipal pamphlet*), and then how the Training Team engages a citizen’s physical body as a site of potential in which certain self-helping habits, knowledge, and competences can be embodied.

In Part II (*Work*, chapters 5 and 6), I focus on two specific cultural meanings and values traditionally associated with the home: privacy and security. These two values formed a strong pattern in my fieldwork, and my analysis outlines how the work done by the health professionals unsettles the home as a private place of everyday routines, ‘automatic’ habits, and acts of domestication. As such, I describe how municipal evaluations and the training programme work to re-configure the ways in which a citizen should be ‘at home’ with their material, physical surroundings. When the political realm enters the citizen’s private space, certain spatial understandings and everyday routines must be de-stabilised in order for the private home (and a person’s external environment) to be negotiated as a space that will allow the citizen to be more self-helping and properly ‘age in place’ according to the political agenda.

In Part III (*Action*, chapters 7 and 8), I argue that everyday rehabilitation is a relational practice that is sustained by the plurality of communicative interaction. In this form of activity, an elderly individual is expected to reveal their unique identity through their words (intentions, choices) and deeds (actions), but the validation of this identity requires the presence and acknowledgment of others. Specifically, I discuss how the health professionals try to engage in a form of relational plurality with an elderly citizen’s phenomenological body; a body that has its own sense of identity and history of lived experiences, and a body that may not always make the ‘correct’ choices or behave like a rational consumer that conforms to the logic of the marketplace. Through shared decision-making and a more general form of relational autonomy, new forms of sociality, action, and care emerge.

And finally, in Chapter 9, I summarise and reflect on the dissertation’s key analytical points, with a particular focus on how municipal health professionals navigate the political rhetoric about health and activity in their encounters with elderly citizens, as well as how they attempt to manage the paradoxes and changes of subjectivity that occur. In the concluding sections, I revisit my conceptualisation of the ‘limited yet limitless’ ageing consumer, specifically highlighting

some of the conflicts, tensions, and forms of resistance that emerge when interacting with this archetype, which can complicate the work of municipal health services for the elderly. I then discuss how my analytical insights about the discursive move from ‘help to self-help’ relate to the ongoing modernisation of the Danish eldercare sector, and I suggest how a more caring response to neoliberal conceptualisations about individualism and independence may produce an alternative form of empowerment.

* * *

Chapter 1

From help to self-help: the transformation of eldercare in Denmark

The goal is to realize an age-friendly WHO European Region, in which people of all ages enjoy supportive, adapted social environments and can look forward to high-quality, tailor-made, well-coordinated health and social services that help them to maintain maximum health and functional capacity throughout their lives.

World Health Organization's Healthy Aging Strategy for Denmark 2012

Introduction

National political decisions have had profound effects on how both municipal leadership and healthcare professionals engage with elderly citizens. In this chapter, I put the establishment of Denmark's current public-health initiatives and eldercare services into a cultural-historical context, outlining several significant political and socio-economic developments from the 1890s to the 2000s, which are central to understanding the organisation of the contemporary healthcare sector. I take inspiration from Foucault's genealogical work to create a 'history of the present' wherein he sought to uncover the discursive traces of distinct historical periods (Garland 2014: 369) in order "to grasp some of the "implicit systems which determine our most familiar behavior without our knowing it" (Foucault in Simon 1971: 201). As a qualitative researcher and cultural analyst, my aim is to provide insight into how certain invisible forces of disciplinary power and control – particularly in the form of political discourses and rhetoric – are interpreted, understood, and perhaps resisted by people in their everyday lives.

In the following sections, I describe some of the social, economic, and political developments associated with social initiatives for elderly citizens and the provision of welfare services, and how the role of the municipal health professional has emerged. But, in order to 'problematise the present', I first outline how the contemporary Danish government is currently managing its 'elder burden' in relation to health and welfare services. I start by providing an overview of how the concept of 'healthy ageing' in Denmark can be understood, with a particular emphasis on the prevention of certain chronic, lifestyle-related diseases.

1.1. Understanding 'healthy ageing' in Denmark

As of 2010, approximately 16.5 per cent of Denmark's total population of 5,550,000 was age 65 and over, and 4.1 per cent was age 80 and over. This 80+ group has been significantly expanding, from 52,000 in 1950 to 228,000 in 2010, with the figure projected to reach an estimated 545,000 by 2050 (United Nations 2010) based on current rates of population growth. This means that, by 2050, one in four Danes will be over age 65. Moreover, the median age of Danes is continuing to increase; according to the World Health Organization (WHO 2012), this led to "an old-age dependency ratio in 2010 of 27.8 dependents (aged 65 years and over) per 100 persons of working age (aged 20–64). This ratio is expected to increase sharply in the coming years, reaching 54.2 dependents per 100 persons of working age by 2100" (ibid.). At the same time, Denmark is also experiencing low national fertility rates and is currently trying to promote an increase in the birth rate in order to ensure that its working population is large enough to support its social-welfare system (Hansen 2015).

Several social-epidemiological studies have concluded that overall population health has been greatly improved by the relatively generous and universal welfare provision of the social-democratic, Scandinavian welfare model (Bambra 2011: 740; *also* Lundberg & Lahelma 2001; Lundberg et al. 2008). But, despite steady increases since the 1950s, life-expectancy rates in Denmark – which used to be among the highest in the world – have improved very little since the 1970s; its longevity rates are now the second lowest in the European Union and the lowest among the Nordic countries, averaging around age 78 for men and women combined (Nordic Social–Statistical Committee 2008: 23). This is mostly due to the country's rising epidemic of non-communicable diseases, such as cancer, cardiovascular disease, diabetes, and respiratory diseases, which together account for an estimated 70 per cent of all deaths (WHO 2012).

In order to counteract this trend and improve overall population health, many of Denmark's recent public-health programmes have focused on prevention – specifically, preventing lifestyle-related diseases in order to produce better average life-expectancy rates (Vallgård 2001) and to "improve Denmark's ranking in the global longevity competition, [which is] necessary for the common good of society" (Anderson 2011: 247). In particular, this includes an emphasis on the 'KRAM factors': Kost (diet), Rygning (smoking), Alkohol (alcohol), and Motion (exercise). This public-health focus was developed after the Ministry of Health and Prevention and TrygFonden (a private research foundation) conducted a comprehensive survey of Danes' health habits in 2007–9 (National Institute of Public Health 2009). They chose to investigate these

factors in particular because they are “important to health – for example, in relation to many lifestyle diseases and a considerable number of premature deaths” (Danish Working Environment Authority 2017).

Most of the non-communicable diseases from which Danes suffer are linked to high rates of modifiable risk factors – i.e., high blood pressure, tobacco use, harmful use of alcohol, high blood cholesterol, overweight, unhealthy diets, and physical inactivity (WHO 2012), which has prompted the Danish government to take significant steps to implement targeted public-health interventions at the national level. But, as I mentioned in the *Introduction*, many older people tend to suffer from one or more of these diseases simultaneously – and to live with them for longer – which has put additional strain on the Danish health and welfare sector. For example, the World Health Organization (WHO) states that, in Denmark:

Many older people live with the long-term effects of one or more chronic diseases, resulting in complex health care needs. As the 80+ age group rapidly expands, the rise in demand for health care is certain to be felt most in the long-term care sector. In 2007, public and private expenditure on long-term care represented 2.5% of GDP in Denmark, approximately half of which was spent on home care. (ibid.)

To manage this complexity and expected demand, many of Denmark’s national health-promotion and -prevention initiatives have been developed “to combat the social exclusion of older people by fostering their active participation in society” (Otto 2013: 131); the political belief is that remaining active should reduce their risk of developing lifestyle-related diseases and, most important, their potential need for in-home care services. As such, these programmes have become an integral part of municipal efforts to offer “citizen-oriented health promotion which aims at creating, shaping and facilitating certain ways of ageing healthy” (ibid.: 114). But, as I have already suggested, the outcome and impact of these initiatives are dependent on the work being done by the health professionals employed by local governments.

In order to better understand the underlying thought structures and historical conditions for how (and why) certain municipal programmes and services have been developed and implemented in Denmark – and how they have constituted some of the current work practices related to healthcare services for the elderly – the following sections provide a brief genealogy of the emergence of the Danish welfare system and its contemporary transformation.

1.2. Denmark's emergence as a welfare state

Traditionally, the Scandinavian welfare model of social and economic development has been characterised by “a strong emphasis on security, safety, equality, rationality, foresight, and regulation” (Gullestad 1989: 73) and, on the whole, the Scandinavian countries – i.e., Denmark, Sweden, and Norway – have consistently ranked high on global measures of economic freedom (see Henriksen 2006; Lidegaard 2009; Heritage Foundation 2017). According to annual rankings compiled by the Organisation for Economic Co-operation and Development (OECD), Denmark typically ranks among the richest global societies (OECD 2016). But Denmark has not always been rich, nor has it always been a social-welfare ‘utopia’: the country’s first publicly subsidised welfare programmes were primarily targeted towards low-wage workers, who were offered insurance policies to protect against illness (1892), unemployment (1907), and disability (1921) (Henriksen 2006; Petersen et al. 2011). Pensions for certain valued professional groups, particularly civil servants and factory workers, began to be established in the 1870s, as the country transitioned from being an agricultural society to an industrial one.

Inspired by political and economic trends developing in Germany throughout the 1880s, as well as the ‘enlightenment’ movement exemplified by the work of N.F.S. Grundtvig⁹, Danish politicians began to focus on developing social programmes to help the needy; specifically, to provide financial support for medical visits, midwives, and funerals (Aarhus University 2017a). In 1891, Denmark established the *Law on old age relief for those worthily in need outside of the poverty sector (Aldersdomsunderstøttelse til værdige trængende udenfor Fattigvæsenet*¹⁰), its first publicly funded programme to support older citizens who could not be active in the workforce (Henriksen 2006; Petersen et al. 2011). The *Old Age Relief* offer was not a pension based on income that had been earned earlier in life; rather, it was an “old-age allowance [that] could be granted to those ‘worthily in need’ who had reached the age of 60” (Nordic Social–Statistical Committee 2008: 10). This law stipulated that anyone age 60 and over could receive

⁹ Nikolai Frederik Severin Grundtvig (1783–1872) was a Lutheran pastor, hymn writer, poet, educator, politician, and social critic who made an indelible imprint on Denmark’s social, educational, and political development and cultural values. His work is a well-known example of the ‘enlightenment’ movement, which encouraged free thought, an open exchange of ideas, a strong social consciousness, and a lack of restrictions on economic activities. By emphasising the importance of social cohesion and egalitarianism, the tenets of this enlightenment vision were instrumental in how Denmark became a modern European welfare state (Lidegaard 2009: 28, 32; also www.grundtvig.dk).

¹⁰ In most of the references and archival materials I consulted, this law was simply referred to as *Loven om Aldersdomsunderstøttelse*, which is quite neutral and does not suggest that a citizen’s socio-economic status was one of the main conditions for eligibility.

financial aid from their local municipality if they were a Danish citizen, had not received poverty assistance in the previous 10 years, and were deemed by government officials to be ‘worthy’ of assistance; this support was provided without revoking their right to vote, as was the case when a citizen received poverty-sector assistance (Aarhus University 2017a)¹¹. This law was followed a year later by the *Social Insurance Act (Sygekasseloven)*, which provided all citizens with “free medical services and social assistance in case of illness” (Lidegaard 2009: 43). Taking care of sick and/or elderly citizens who could no longer work thereby became part of a wider Scandinavian tradition that prioritised the welfare of societal groups that could not participate in the labour market; it also included children and the disabled.

Following the introduction of a new parliamentary political system in 1901, the Danish state began to develop even more social programmes that were meant to support “the weaker groups in society” (National Museum of Denmark 2017). These programmes were based upon legislation to ensure that certain groups of citizens would be given comprehensive, consistent access to health care and other welfare services (Jarden & Jarden 2002). Many private social initiatives were also being established at this time; for example, in 1920, a ‘housewife-help’ corps (*husmoderhjælpens corps*) was instituted in Copenhagen, and the following year the Danish Red Cross started a ‘home help’ initiative in Hammel and the surrounding municipalities. These initiatives were followed by the formation of ‘home sick help’ (*hjemmenes sygehjælp*) services (Petersen 2008b: 44) in Copenhagen in 1931, and the Health Visitor institution (*sundhedsplejerske-institutionen*) in 1937 (Buus 2001a), which provided guidance and support to new mothers.

The establishment of such programmes reached a culmination in the 1930s, when the governing Social Democratic party introduced a large number of reforms that would ensure universal social benefits for the entire population; this included the *National Insurance Act (Lov om Folkeforsikring)* in 1933, which stipulated that, if certain standardised criteria and conditions

¹¹ With the enactment of the Danish Constitution in 1849, “all Danes were entitled to receive public support if they could not support themselves. However, having to receive government support was considered to be degrading and was long associated with a loss of rights, such as the right to marry or to vote.” *Source:* <http://danmarkshistorien.dk/leksikon-og-kilder/vis/materiale/lov-om-alderdomsunderstoettelse-1891/> (last accessed 10 June 2017)

Also, this law remained unchanged until 1922, when it became the *Retirement Interest (Aldersrente)*; this change fixed the amount of support and raised the age limit to 65 years. The law was revised again in 1937 and 1946, but the basic principles remained unchanged from 1922 until the retirement reform in 1956. *Source:* http://denstoredanske.dk/Danmarks_geografi_og_historie/Danmarks_historie/Socialpolitik/aldersrente (last accessed 12 June 2017)

were met, a citizen had the right to receive defined benefits without losing any rights (Aarhus University 2017b). With the *Insurance Act*, all citizens were granted the right to receive financial support; however, the amount of insurance coverage provided was based on how much the citizen had paid into the system. A citizen's right to these insurance benefits was based on the idea of 'help to self-help' (ibid.); i.e., that receiving assistance was a temporary support that was intended to help the citizen regain their former productivity. As a result of these initiatives, symptomatic social policy became replaced by the idea of prevention, which provided the foundation for the risk-averse, service-intensive welfare state (Petersen et al. 2012a).

During this time, the first 'old-age homes' were also being established for those citizens who were receiving the *Old Age Relief* allowance and could no longer live on their own due to poor health (Blom 2014: 43). Most of the services offered by the municipalities took place in these public institutions, but a broader offer of in-home assistance was established in 1949 (ibid.: 44) in connection with the 'housewife replacement' scheme (*husmoderafløsningsordning*). This programme was developed due to structural changes in the labour market, socio-economic considerations, and a lack of nurses following World War II (Petersen 2008b: 45). The scheme provided temporary relief to families where the housewife was unable to handle the household for a period of time, but it also included assistance for disabled elderly citizens with a need for practical help (Ringsmose & Hansen 2005: 10).

The national government continued to develop benefits programmes and pass more reforms throughout the 1950s. However, by then, Denmark was experiencing severe post-war economic fluctuations and trade deficits, which caused the governing political parties to seek a stable majority and to reconsider the role of the state (Petersen 2008b: 42). As historian and diplomat Bo Lidegaard writes:

The old socialist idea of the working class taking over the means of production was developed into the notion that the citizens now were to take over control of the state regulating both production and the foreign trade economy with a view to assuring, as Grundtvig had put it, that few had too much and fewer too little. (2009: 236–7)

Thus, the Danish state assumed more responsibility for both the collective and individual welfare of those who could not take care of themselves (ibid.). In my analysis, these protections were meant to provide security and stability to a populace that was arguably anxious about their post-war future, inducing a sense of nationalism and equal, shared collectivity. Furthermore, politicians formulated any person's need to seek assistance from the state as a fundamental right

of citizenship, and the first significant welfare reform was introduced in 1956: ‘the people’s pension’ (*Folkepension*)¹², which was part of an amendment to the National Insurance Act from 1933. Replacing earlier versions of the *Retirement Interest* scheme that were meant to help only financially disadvantaged elderly citizens (*see* footnote 11, page 37), this new pension was available to anyone age 67 and over, who was entitled to “the minimum amounts payable, regardless of the recipient’s economic conditions” (Aarhus University 2017c).

However, such a programme required funding, and politicians sought ways to increase workers’ productivity and increase taxation among the populace, which would facilitate the government’s ability to distribute more welfare benefits to more citizens. Politicians encouraged citizens to feel a sense of equality and ‘ownership’ in the state, but some welfare economists were already concerned about the potential dangers of this system; i.e., that it would lead to “taking away the sense of personal responsibility from the individual, weakening personal initiatives, creating a patronising government that takes with one hand and gives with the other, and focusing on material progress rather than the value of culture and belief” (Lidegaard 2009: 238). However, as Lidegaard writes, the electorate were not opposed to higher taxation, and most supported the equal and collective nature of the new welfare system, believing that anyone who was not able to care for themselves should have access to benefits and assistance provided by the state. Thus, due to the new political and social emphasis on the *universal* nature of benefits – which covered all citizens, was financed by workers’ taxes, and administered by local municipalities (*ibid.*: 43) – Denmark emerged as a ‘true’ European welfare state.

As the country experienced economic growth and low unemployment rates during the 1950s and 1960s, and there was a ‘golden age’ of welfare in which the public sector continued to expand. The *National Insurance Act* was amended in 1958; a new provision allowed elderly citizens with a need for support to receive permanent help from the state in their own homes, rather than being referred to a nursing home (Ringsmose & Hansen 2005: 10). During the 1960s, there was also an expansion of public health care (*folkesundhed*, ‘the people’s health’)

¹² Often used as a prefix, the word *folke-* (‘the people’) has significant meaning in many Scandinavian countries. In Denmark, the extensive use of the term in connection with government, public institutions, and social-welfare programmes refers to “something both popular and part of the nation” (Lidegaard 2009: 32), and it can be traced back to the influence of Grundtvig (*see* footnote 9, page 36). He believed that true democracy required all segments of the population to be actively involved in politics, and to have an interest in and access to basic information about the workings of society (*ibid.*: 30). Much like his contemporary Abraham Lincoln in the United States, who famously envisioned a “government of the people, by the people, for the people” in his 1863 Gettysburg Address, Grundtvig worked to build a government that promoted the social values of active participation, free thought and debate, egalitarianism, and a sense of shared community.

and public-school education (*folkeskole*, ‘the people’s school’), both of which were available to all citizens (Henriksen 2006; Petersen et al. 2012b). Politicians worked to improve existing schemes, such as health insurance and unemployment insurance, and they further expanded the public sector with new offerings and initiatives (ibid.). In my analysis, these developments produced a sense of Denmark being a citizen’s ‘homeland’, wherein each individual citizen as part of the greater collective agreed to contribute equally to the paternalist welfare system – and thereby expected to receive help, not only from the state’s welfare institutions but their fellow co-citizens (*medborgere*; see Ludvigsen 2016: 90).

During the 1960s, the industrial sector also began to develop significantly, which prompted urban mobility; for example, in 1840, nearly 80 per cent of the Danish population lived outside of urban areas, while the number decreased to 20 per cent by 1970 (Blom 2014: 29). As a result, some municipalities were faced with shrinking populations while others experienced unmanageable increases. In order to ‘equalise’ the tax imbalance and administrative work of the municipalities, the government approved major structural reforms in 1970 (ibid.: 29–30), which was a turning point for the welfare state. Specifically, it catalysed a rise of consumption values and marked “a shift away from the productionist society that underlays much of the political history of the welfare state towards a modern society that is increasingly individualistic and fragmented” (Twigg 2002: 433). I argue that, in Denmark, this fragmentation had a significant impact on the provision of welfare and care services. In the next section, I discuss the country’s transition to a competition state.

1.3. Denmark’s emergence as a competition state

As part of the 1970 reforms, the Danish Parliament implemented an ‘administrative simplification’ with a new social statute that provided considerable tax relief to citizens, and stipulated that each municipality would be responsible for its own social-welfare programmes (Villaume 2005). Expansion in the public sector continued, even during a period of social protests and an economic downturn in the 1970s in which unemployment rose from 20,000 to 220,000 between 1972–82 (Lidegaard 2009: 307). To manage this trend, the government initiated a comprehensive overhaul of the social-security system (ibid.: 297); the welfare-state protections that were meant to cover a citizen ‘from cradle to grave’ required a strong central administration and an efficient tax system, both of which were becoming victims to public-sector expansion and the bureaucratic bloat caused by an excess of regulations. In 1974, the

government also supplanted the ‘housewife replacement’ scheme (*husmoderafløsningsordning*) with a Home Care scheme (*hjemmeplejeordningen*), which offered support and care to needy citizens, providing them with short-term, ‘compensating’ help at home (Blom 2014: 44).

By the early 1980s, the Danish economy was suffering from high unemployment rates, a growing government deficit, and serious concerns over a large public debt (Lidegaard 2009: 307). As a result, the people elected a centre-right government in 1982, which initiated several significant changes to economic policy; in particular, the new Prime Minister Poul Schlüter (Conservative People’s Party) was inspired by the political and economic leadership of Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States. Thus, Schlüter’s government “sought to promote growth in the private sector rather than to enlarge the public one, or to increase public spending” (ibid.: 310).

Following a general trend within Europe at this time, political discussions in Denmark began to focus on welfare reforms and developing a more ‘neoliberal’ society, which refers to “the new political, economic, and social arrangements within society that emphasize market relations, re-tasking the role of the state, and individual responsibility” (Springer et al. 2016: 2). Whereas the traditional Danish welfare state was built upon the idea of a citizen who is an equal part of the larger social collective, actively participates in the democratic process, ‘owns’ a share of the state, and has a nearly unrestricted right to state benefits (Petersen et al. 2010), I follow the argumentation of political scientists such as Ove Kaj Pedersen, who writes that the political and economic forces that propelled Denmark’s turn towards neoliberalism in the 1980s contributed to its transition to a ‘competition state’ (Pedersen 2011; also Knudsen 2007). Here, a particular emphasis is placed on the individual citizen being a productive worker and consumer in order to promote industrial growth and development; i.e., to ensure that Denmark would be able to compete in the global marketplace.

These new arrangements had implications for the overall political culture as well as “the values¹³ upon which the Danish community is said to rest” (Pedersen 2011: 169). Due to financial developments since the 1970 reforms, which prompted a drive towards more standardisation and efficiency within the public sector, many municipal programmes began to shift from the welfare state’s fundamental focus on providing ‘compensating’ practical help and personal care to needy citizens to a more neoliberal emphasis on responsibility, self-governance,

¹³ This refers to the social values that the ‘enlightenment’ movement endeavoured to promote, such as active participation, free thought and debate, egalitarianism, and a sense of shared community; see footnote 9, page 36.

and enabling ‘self-help’ with regards to most forms of welfare assistance. For example, the first Elderly Commission (1980–82) resolved that self-determination, continuity, and strengthening an older person’s own resources should be central elements in the design of future social-care policies (Blom 2014: 44). Policymakers were also influenced by the WHO’s 1988 initiative “Health for All”, which prompted the national government to establish a comprehensive health-prevention programme with a focus on improving citizens’ living conditions and lifestyles, as well as formalising preventative health work and cross-disciplinary collaboration (ibid.: 48).

Following a long period of high unemployment from the mid-1970s to the mid-1990s, the number of welfare recipients in Denmark dramatically increased (Henriksen 2006). As a result, the prime impetus of the government was to get citizens into (or back into) the job market as soon as possible; these workers were considered to be the economy’s driving force (Pedersen 2011: 73–4), and the focus was on their potential for production, especially in relation to helping Denmark become more competitive in global markets (ibid.: 186–88). During the 1990s, national politicians began to decentralise and reform the public sector, privatising a number of state-owned companies. The government also institutionalised the work of municipal ‘Visitation’ to conduct in-home evaluations of citizens who applied to receive state assistance, and professionalised the formal education of Social and Healthcare Helpers (*social- og sundhedshjælper*) and Social and Healthcare Assistants (*social- og sundhedsassistenter, SOSU*) (Lønstrup 2008). With the establishment of Visitation as part of the municipal authorities, the political intention was “to shift the assessment of older people’s needs away from the care professions and put it into an administrative context with a broader overview. [This was done partly] to better manage the economy, and partly to ensure that the elderly received consistent help” (ibid.). This political intention has since been reinforced several times, which has worked to sediment the role of particular health professionals, as I discuss further in section 1.5.

In addition, the *Act on Preventive Home Visits to the Elderly, etc.* was enacted in 1996¹⁴. This law made it obligatory for all Danish municipalities to offer preventive home visits (PHV) twice a year to all citizens age 75 and over. According to the Danish Health and Medicines Authority (DHMA, *Sundhedsstyrelsen*), “The purpose of the home-visit offer is to prioritise health prevention and promotion for the elderly by creating security and well-being as well as to

¹⁴ *Act on preventive home visits to the elderly, etc.* Act no. 1117 of 20.12.1995 (*Lov om forebyggende hjemmebesøg til ældre m.v.* Lov nr. 1117 af 20.12.1995). Source: <http://www.sst.dk/~media/B429274719CF40B49F8A8FE82266E5E8.ashx> (last accessed 19 February 2017)

provide advice and guidance on activities and opportunities for support” (DHMA 2003). In line with the decision of the Elderly Commission in the early 1980s, these visits are meant to strengthen older people’s resources and help them towards attaining a better quality of life, and Denmark is considered a pioneer in developing such visits for the elderly (Mahler et al. 2014: 36). As the DMHA writes: “Preventing functional loss in the elderly is an important concern for both the individual older citizen and with regards to society’s finances” (DHMA 2003).

In the next sub-section, I describe a specific aspect of Denmark’s turn towards neoliberal governance as a competition state; i.e., its emphasis on the concepts of *free choice* and *empowerment* in relation to health services.

1.3.1. The neoliberal move towards ‘free choice’ and ‘empowerment’

By the early 2000s, the Danish government began to focus on avoiding the “traditional top-down imposition of welfare” (Rostgaard 2006: 444) in relation to the provision of benefits and care services. To control public-sector expenditures and improve efficiency (Petersen 2008a: 94), the government introduced a particular kind of ‘free choice’, which primarily applied to the categories of citizens who were not healthy, fully active, and contributing members of the economic workforce (e.g., children, the disabled, the elderly). Specifically, in 2003, the Ministry of Finance developed a policy document, *Free choice and quality – payment models for the municipal service areas (Frit valg og kvalitet – afregningsmodeller på de kommunale serviceområder)* to help the municipalities manage these citizens; the scheme was intended to “strengthen citizens’ freedom of choice...in order to increase the quality of and satisfaction with the services provided. At the same time, this freedom of choice must be weighed against the municipalities’ potential to appropriately manage expenditures and control capacity” (Ministry of Finance 2003: 47).

This policy document outlines the standardised choices to which citizens are allowed with regards to public institutions, such as schools and nursing homes, as well as private firms that provide in-home care services. The scheme explicitly describes the type of choices available, stating:

A freer choice weakens the possibility of referring individuals to specific suppliers or services, therefore reducing the municipalities’ ability to manage capacity and service levels. This increases the significance of other management tools; i.e., Visitation, to manage the municipality’s decision on the allocation of specific offers and services to the individual citizen. (ibid.)

This scheme was developed as part of the Ministry of Finance’s modernisation efforts to control the public sector and make it more efficient, as well as to improve quality and flexibility. It was inspired by the rise of New Public Management (NPM)¹⁵ in the 1990s, a form of management that included ideas about outsourcing, performance management, and technology. While NPM is no longer widely used in Denmark, many of its ideas continue to influence political decisions and policies to the present day (Torfing 2016; Pedersen & Andersen 2016). Some scholars have argued that the *Free Choice* scheme was also a “regime change” that was meant to alter the relationship between the market, the state, health professionals, families, and care recipients because it reinforced the state’s new definition of citizens as *consumers* of welfare services (Petersen 2008a: 94–5; *my emphasis*) – as opposed to *recipients* of care and assistance in the traditional welfare state. In addition, the government’s ‘elderly package’ (*ældrepakke*), which was first offered in 2002, outlined the municipal service options available to older citizens; being given a choice between municipal or private help thus created a market for welfare services, and constructed these citizens as “freely choosing elderly” consumers (Højlund 2006). I argue that this type of choice is in line with the logic that operates within the cultural field of the Third Age (*see* page 11); specifically, a logic that focuses on “consumption and the individualisation of society’s material surplus” (Gilleard & Higgs 2007: 25).

Shortly after these new forms of governance began to be implemented, the national health authority (DHMA, *Sundhedsstyrelsen*) also began to emphasise ‘empowerment’ with regards to community health. This was formulated as a need for “collective action to improve health outcomes, and to obtain more influence and control over shared living conditions and quality of life” (DHMA 2005: 24). In this case, ‘quality of life’ refers to the idea that all individuals should have the resources – material, social, personal, etc. – to overcome illness and adversity, and live a long life (*ibid.*: 11). This definition of ‘empowerment’ refers to changes brought on by collective action; however, despite the enlightenment vision of social cohesion and egalitarianism that benefits ‘the greater good’ (*see* footnote 9, page 36), one of the distinctive features of the modern Danish state is its focus on the needs and obligations of the individual citizen within the collective (Henriksen 2006). Moreover, in the state’s transition from a welfare state to a competition state, I argue that this citizen has been constituted in a particular way and

¹⁵ Due to a changing economic environment, many wealthy European countries – including Denmark – began “adjusting their models of welfare capitalism” (Green-Pedersen 2002: 271) during the 1980s and 1990s. These adjustments included reforms of the public sector, such as “the introduction of explicit measures of performance, decentralization, private-sector styles of management, contracting out, and privatization” (*ibid.*). These reforms generally fall under the category of New Public Management.

thereby re-defined – from a “moral member of the shared community” with compassion for their vulnerable and/or marginalised co-citizens to an “private opportunist” who has value as a tax-paying worker and consumer (Pedersen 2011; Petersen et al. 2013).

This emphasis on the individual can be seen, for example, in Denmark’s *Social Services Act (Lov om Social Service)*, a legislative document that is disseminated to all municipal health workers and available to the general public:

The purpose of assistance under this Act is to promote the ability of individuals to manage for themselves or to facilitate their daily lives and improve their quality of life. The assistance provided under this Act is based on the individual’s responsibility for himself and his family. The help is customised to the individual’s needs and assumptions in cooperation with the individual.

Ministry of Children, Equality, Integration and Social Affairs 2014: §1., 3.2 and 3.3

This policy is primarily a regulatory scheme that is meant to help the municipalities manage their expenditures and control capacity; it attests that any state-supported assistance given to an individual citizen should promote their ability to “manage for themselves”, which will ultimately help relieve the state’s financial burden to provide social-protection systems (particularly long-term healthcare services) to the collective citizen body.

Policy documents such as the *Free Choice* scheme and the *Social Services Act*, combined with the DHMA’s goals for empowerment, demonstrate how the Danish state has been transitioning from a paternalistic welfare state – wherein governmental authorities assume the responsibility for protecting equal citizens in a homogeneous shared community, and help them live “a healthy life in order to increase their well-being” (Vallgård 2014: 341) – to a more neoliberal competition state: in this type of market-based system, “individuals exert their ‘free choice’ but are at the same time guided by those who designed the incentives to induce more or less of a certain behavior” (Larsen & Stone 2015: 5; Larsen 2015). Thus, I argue that the political rationale behind the promotion of ‘free choice’ and ‘empowerment’ is to activate citizens’ potential to be more productive and self-governing, which, as historian and health-policy analyst Signild Vallgård writes, should make them “capable of choosing and responsible for their own lives, including their health-related behaviour” (2014: 341). In other words, trying to ‘empower’ individual citizens via the offer of a ‘free choice’ is a form of social regulation that should guide them towards acting as “the government wishes them to act, and adopt more healthy lifestyles” (Vallgård 2001: 387). As I describe in this dissertation, all citizens in the contemporary competition state have a responsibility to be active consumers who embrace opportunities to be productive, independent, and healthy for as long as possible.

* * *

Thus far, I have described Denmark's emergence as a welfare state, and how older people who could not be active in the workforce have historically been categorised as 'weak' and 'needy', being judged by government officials as being 'worthily in need' of social benefits, care, and support. By designating sub-groups within the general population (*see* Gilleard & Higgs 2007; Petersen 2008a), policymakers have thus attempted to specify standardised factors related to the heterogeneity of older people in terms of their social participation, mortality, morbidity, and service needs. Moreover, in order to sustain the social-protection systems that are meant to provide protection against the risks and needs associated with factors such as sickness, invalidity, and old age (European Commission 2017), many national governments – including Denmark – have regularly reformed the institutions, policies, and laws that regulate these systems. At the same time, my analysis shows that a positive discourse about 'healthy ageing' coupled with neoliberal ideals of individual responsibility, productivity, and self-governance has been dominating the political debate on how best to manage Denmark's rapidly increasing elderly population, which has in turn informed health policy and municipal decision-making with regards to welfare and health services.

From a cultural-historical perspective, the nation-state of Denmark and its social-welfare institutions have been undergoing a constantly changing set of epistemological transformations since they were first established. And particularly since the 1990s, Danish policymakers have struggled to regulate and maintain the universal and equal social benefits provided to citizens, even as they have continued to expand the public sector. Furthermore, certain political and epidemiological paradigms have come to dominate Danish public-health policies and initiatives directed towards the elderly – in particular, programmes and offers that couple functional capacity with chronological age, meaning that someone who is over a certain age is assumed to be frail, ill, deteriorating, and thus in need of certain assistance and services. The growing dominance of capitalist, market-driven ideals within the Danish government suggests that the political leadership have been trying to find the best way to manage significant economic and social changes, but reforms to the state's traditional social-protection systems have had major implications for the provision of welfare services at the local level.

The basis of public health is that government authorities assume the responsibility to identify widespread health problems, and then set an agenda for appropriate action (Vallgård 2001:

388). However, the general shift away from state-provided welfare schemes in Europe has resulted in towards more fragmented, privatised, and plural forms of governance (Twigg 2002: 422), especially with regards to the healthcare sector. In Denmark, this was first seen in the 1970 reforms – which completely overhauled the country’s social- and health-services sectors – and again during the most recent structural reforms in 2007. During both reforms, the national government decided to re-organise the country’s regions, combining and ‘equalising’ the municipalities to make them large enough to more efficiently manage their workload and responsibilities; in 2007, the number of municipalities was reduced from 271 to 98. These reforms had substantial implications for the overall healthcare system, the provision of welfare benefits, and the work of municipal health professionals, which I discuss in the following sections.

1.4. The 2007 reforms and the empowerment of the municipalities

According to then-Prime Minister Lars Løkke Rasmussen (Liberal Party), the goal of the widespread public-sector reforms in 2007 was “to create a new Denmark where a strong and forward-looking public sector solves tasks efficiently and as close to citizens as possible. The citizens of Denmark will experience an even better and more coherent public service” (Ministry of Health and the Interior 2005: 4). Prior to this reform, the municipalities were already responsible for the administration of a range of social-welfare areas, such as eldercare, childcare, schools, and other social services (ibid.: 22). But with this re-organisation, local governmental authorities (i.e., the newly formed five regions and 98 municipalities) were given more responsibility for instituting citizen-orientated initiatives in collaboration with professional experts and civic authorities. The Danish government subsidised the implementation of these projects with 200 million DKK (nearly 27 million Euro) (Iversen 2014: 104; Anderson 2011: 232–3), but the local politicians in each municipality would henceforth design and implement their own health-prevention and -promotion programmes. This has become important at the municipal level (Larsen & Stock 2011) because doing so “shows political good will, secures a local share of carefully disbursed government funding, and provides [citizens] with affordable health-promoting offers” (Anderson 2011: 233).

One of the central features of the 2007 reforms was a move towards re-financing municipal budgets, which was intended to “adjust the equalisation system to the new tasks and the new local map to ensure a fair balance between rich and poor municipalities” (Ministry of Health and

the Interior 2005: 33). The national government has periodically discussed ‘re-prioritising’ municipal budgets in this way, which would make it necessary for each municipality to supply a staggered financial contribution to the shared national economy. These monies would then be ‘equalised’ and re-distributed to the municipalities in order to standardise their budgets. The goal is to ensure a more uniform provision of ‘core’ welfare services throughout the country, but this is controversial because such equalisation takes control away from local leadership and lets the national government decide how the funds should be used.

The matter of equalisation has typically prompted debates about a need for more municipal autonomy and freedom, as opposed to a need for minimum standards and governmental accountability (Thomsen 2016). But rather than describe the details of this reform, my focus here is on its implications for health and eldercare. For example, the five new regional authorities were made responsible for overseeing the healthcare sector in their local areas, especially with regards to the management of hospitals. The aim was “to support the quality of patient care by providing a basis for grouping treatments, to expand the benefits of specialisation, and to ensure the best use of resources” (Ministry of Health and the Interior 2005: 27). In addition, government officials wanted to promote better coherence between regional and local efforts regarding health services. As such, the regions and municipalities were “required to enter into a binding collaboration to coordinate decisions regarding, for example, the organisation of health treatments, training, prevention, and care. Together, they must make health contracts that agree on the discharge procedure for frail elderly patients, and agree on plans for prevention and rehabilitation” (ibid.).

Each of the municipalities was obligated to co-finance the healthcare sector, and these local governments were given the authority and autonomy to decide which social-welfare programmes they would offer to their constituents. Specifically:

The municipalities will have general responsibility for all rehabilitation that does not take place during hospitalisation, (...and) will assume primary responsibility for health-prevention and -promotion efforts in relation to citizens. The aim is for [these efforts] to be integrated into other municipal duties in citizens’ local environments; i.e., when the municipality is in contact with citizens in day-care centres, schools, senior-citizen centres, etc.

Ministry of Health and the Interior 2005: 22

In my analysis, the national drive to minimise expenditures and improve efficiency while implementing improved services in “citizens’ local environments” (ibid.) has resulted in a

political discourse that focuses on ‘better service for less cost’. This imperative often forces local municipal leadership to make difficult decisions, the end result of which can be quite controversial: for example, a national newspaper reported that authorities in the Danish municipality of Ringkøbing-Skjern had sent a letter to all Home Care recipients, which stated that, going forward, an elderly citizen would only be able to receive these services if they “have severe dementia, are blind or paralysed in almost the entire body” (Røjle & Andersen 2016). Even if a citizen has a serious injury or chronic illness, they would now be expected to hire private services or ask their children or relatives for help. Karsten Sørensen, the chairman of the municipality’s Social Affairs and Health Committee, was quoted as saying that the decision was made due to a deterioration of service levels: “We had to lower our level of service, and it has to do with [money]. It’s a deterioration, but we stand by the decision. We can only spend the money once” (ibid.).

These dilemmas can often feel repressive to municipal leadership. For example, at KL¹⁶’s Social and Health Politics Forum 2016, Ninna Thomsen (Socialist People’s Party), who is responsible for health and care services in the City of Copenhagen, said:

In the municipalities, we’re experiencing great frustration because, on the one hand, our budgets are being cut, while on the other hand, we get criticism if we reduce the service-level of eldercare or serve vacuum-packed food. [The government] has to take responsibility for ensuring that there are consequences if you reduce spending in the municipalities. (Thomsen 2016)

In addition, a 2016 study conducted by the elderly-rights advocacy organisation DaneAge (*Ældresagen*) showed that, due to the political directive to save 1 per cent of their budgets per year, 29 municipalities were compelled to set aside less money to care for citizens age 80+ than they had in 2015 – despite being funded with a collective 1 billion DKK (nearly 135 million Euro) in ‘dignity dollars’ from the national government to strengthen municipal services and ensure better care for the elderly (Rysgaard & Prehn 2016).

With the 2007 reforms, the government intended to adjust the equalisation system and thereby ‘empower’ each municipality to offer a better and more coherent public service, but in the years since then, many municipalities have struggled to find a balance between their obligations to the

¹⁶ According to its website, Kommunernes Landsforening (KL; the National Association of Municipalities) is “a membership organisation that represents the interests of Denmark’s 98 municipalities, and it works to strengthen and develop local governments. Using a holistic perspective to problem-solving, KL’s vision is to achieve impact and results on behalf of the municipalities, in order to benefit both individuals and society”. *Source*: <http://www.kl.dk/Om-KL/Prasentation-af-KL/> (last accessed 12 February 2017)

state and their responsibility to provide care services and support to their constituents. Quite often, as the above quotes exemplify, the result is that certain decisions are made for purely financial reasons. Moreover, with the government's focus on the *prevention* of illness and injury – in its need for healthy and productive workers as a driving force of the economy – it has assumed a risk-adverse position, which has transformed all citizens into 'pre-patients' (Larsen & Esmark 2013: 6). This approach has resulted in the development of health policies and welfare programmes that function to "create the self-caring self" (Rostgaard 2006: 452), wherein older citizens should delay the inevitable and learn to master (or re-master) certain skills in order to remain self-sufficient and independent for as long as possible.

As I have already mentioned, the political transition from providing help to enabling self-help at the local level is grounded in the work of municipal health professionals, whose role and responsibilities have also undergone change as Denmark transitioned from a welfare state to a competition state; I discuss this in the next section.

1.5. The changing role of municipal health professionals

In the earlier sections of this chapter, I outlined how social programmes to help 'needy' and 'weak' citizens first began to flourish in the 1920s and '30s. At that time, Danish municipalities offered a range of services and support to elderly citizens within the public institutions (e.g., 'old-age homes') that were part of their jurisdiction until basic in-home care services were established in 1949 in connection with the 'housewife replacement' scheme (Blom 2014: 44). During the 'golden age' of the welfare state, the *National Insurance Act* allowed elderly citizens with a need for support to receive compensating help in their own homes, rather than being referred to a nursing home (Ringsmose & Hansen 2005: 10). This care was primarily provided by nurses who were employed at hospitals and clinics located in the municipality as well as by minimally trained health workers and socially motivated volunteers.

Historically, municipal health professionals in Denmark have not been physicians or members of medicine's institutions, but these workers have held an important role within the political system. This type of professional "operates using powers delegated to it by society through government action" (Cruess & Cruess 2008: 585), which grants them a privileged position in relation to the collective. Their job has required them to represent the municipality and promote its values when meeting an individual citizen, especially when discussing health practices and providing services. As such, these workers have often fulfilled a particular function in Danish

society. For example, ethnologist Henriette Buus' work has explored how the introduction of a new maternity practice in the late 1930s aimed to cultivate a population of physically healthy and socially strong citizens who, in terms of culture and civilization, would be on the same level as comparable states; she suggests that, due to this programme, Danish women's subjectivity is connected to the institutions of the state (2001a). I would argue that, in terms of in-home healthcare and services for elderly citizens during the same time, the work of the community-based health visitor was primarily meant to serve an altruistic purpose in caring for those who could no longer care for themselves, but also to stabilise certain social structures and shared values by reinforcing the egalitarianism and collectivity of Danish society – a society in which everyone contributed equally, and everyone was supported equally throughout the life course.

As I have already mentioned, certain in-home nursing and other assistive services have been available to 'needy' elderly citizens since the 1950s. Historically, municipal health professionals have typically had some degree of specialised training in their discipline, which includes a collectivity or service orientation (Freidson 1988: 77), but they have had varying amounts of authority based on how the national and local politicians have defined their job functions; thus, they have had different degrees of influence and power in relation to citizens (Højbjerg et al. 2015; *see also* Beedholm & Frederiksen 2015). Moreover, most of the work of the municipal health professional was politically formalised in the 1990s when Denmark was already well on its way to becoming a competition state. Since that time, the mandate of municipal health professionals has been to respond to a need – i.e., to evaluate, categorise, and stabilise 'at-risk' citizens via the health and welfare services they are allowed to receive.

In this dissertation, I use the term 'municipal health professional' as an umbrella descriptor that encompasses many different types of job function: Visitor, preventative home visitor, health-promotion counsellor, exercise counsellor, dietician, social and healthcare helper, social and healthcare (SOSU) assistant, visiting nurse, physical/occupational therapist, and others – not to mention the specialised job functions associated with various municipal institutions, such as activity centres, nursing homes, hospitals, etc. As I describe in later chapters, these professionals are specially educated social/healthcare workers who have often been employed elsewhere in the healthcare sector before accepting a job in a municipality. The specific professional groups I followed are defined by a shared sense of identity related to their disciplinary education and training, but their purpose and thereby their epistemology has been determined by those who govern and regulate their work; i.e., the national legislators and local politicians.

As I discuss, the transformations that have taken place (and are still occurring) in the Danish state have significant implications for the work and identity of the municipal health professionals. To promote efficiency, the contemporary competition state has categorised and standardised these professionals according to their job functions and responsibilities; this sediments their roles and affects how they interact with ‘active’ citizens in the context of an in-home health encounter (Beedholm & Frederiksen 2015). For example, in my analysis of the various policy documents that have been mentioned throughout this chapter, I determined that they presuppose a linear, reciprocal relationship between singular, independent entities, which is expressed in a triangle between the Politicians, the Professionals, and the Citizens/Individuals. This is most clearly seen in the policy document *Overall standards of quality for the care and health area (Overordnet kvalitetsstandard for pleje- og sundhedsområdet)*; see Figure 1 below.

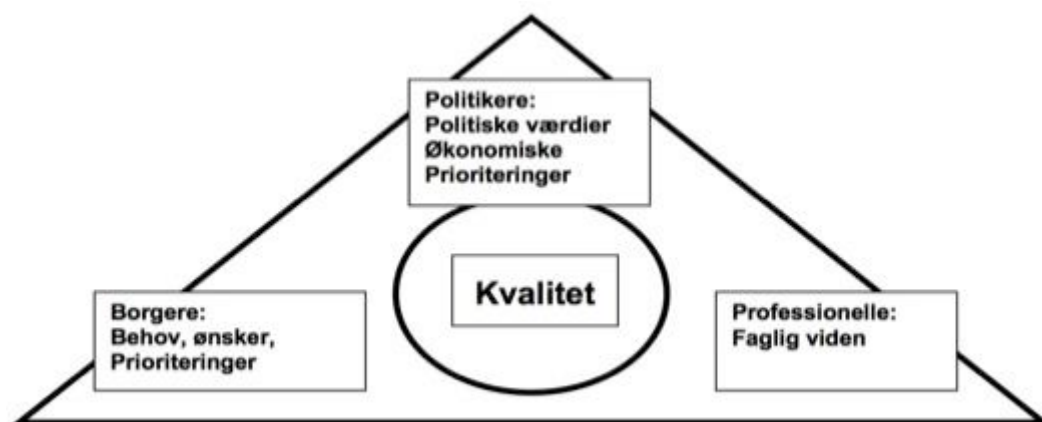


Figure 1. The national policy document “Overall standards of quality for the care and health area” states that municipal health professionals are expected to uphold a certain standard of quality when providing services to citizens. It is expressed in this triangle, with the *Politicians* (political values, economic priorities) at the top, and the *Citizens* (needs, wishes, priorities) and the *Professionals* (professional knowledge) on either side. (Gentofte Municipality 2014a: 6)

In the political configuration, all municipal health professionals are obligated to uphold a certain level of service quality in their work, and they must follow the guidelines set forth in the *Social Services Act §83*, which addresses the provision of in-home services related to practical help (Home Help, *hjemmehjælp*) and personal care (Home Care, *hjemmepleje*). Additionally, I ascertained that the triangle in Figure 1 represents the way that many municipal health programmes are designed to function – i.e., an individual is evaluated by, cared for, and/or trained by another individual. In this 1:1 reciprocal relationship, the abstract Professional, acting as a representative of the municipality, is expected to use her professional training and

experience to provide a Citizen with the highest-quality services they are entitled to receive under the law. And in exchange, the abstract Citizen is expected to express their needs, wishes, and priorities to both the Professionals and the Politicians.

Sociologist Kristian Larsen and historian Kim Esmark write that, historically, “patients and clients who had previously been constructed as the object of various social, medical, and health-related interventions and treatments are now articulated as subjects” (2013: 5). And, more recently, as I mentioned earlier (*see* page 44), ‘needy’ citizens have become re-defined as consumers of welfare services as opposed to recipients of care and compensating assistance. Thus, I agree with Larsen and Esmark that the Danish state’s ongoing transformations have created “related movements between sectors, institutions, professions, technologies, and clients, including new requirements for production and the application of knowledge related to the healthcare area” (*ibid.*: 6). They argue that this type of specialised knowledge is a social and historical product; as I contend in later chapters, it has also become embedded in the competition state’s political rhetoric, which becomes interpreted, negotiated, and challenged by both the healthcare professionals and the ‘active’ consumer-citizens it has created.

Summary

In this chapter, I have applied a historical perspective to describe certain social, political, and economic factors that have led policymakers and politicians in Denmark to implement particular public-health policies and initiatives that target elderly citizens. Throughout the emergence of the Danish welfare state, the expansion of the public sector – with its focus on the design and implementation of municipal health services – can be seen as a process of constructing uniformities across time and space via the production of standardised categories that define abstract groups of citizens according to their needs. The nature of retirement pensions, insurance schemes, welfare benefits, health programmes, and in-home services has categorised some people as ‘weak’ and/or ‘elderly’ citizens with certain needs and demands, which contributes to a form of governmentality and structured dependency, wherein “state policies, not biology” dominate and shape the lives of older people (Gilleard & Higgs 2000: 13).

By presenting a brief ‘history of the present’ in relation to how ‘healthy ageing’ is conceptualised in Denmark, I have tried to elucidate the development of specific political discourses and to trace the systemic logics that have emerged – and become embedded – over time. These ‘invisible’ structures of political power and knowledge production can normalise

certain ways of thinking and acting; as I have discussed here, Danish politicians have historically defined the provision of care and services for elderly (post-retirement) citizens, which has significant implications for both citizens and healthcare professionals in the present day. With the government's recent establishment of everyday-rehabilitation programmes for elderly citizens who have functional limitations, the intention is to increase older people's independence with regards to daily activities, and empower them "to age in place, be active and participate socially and in the society" (Tuntland et al. 2015: 1). But, as I explore in later chapters, life stages are not static and 'elderly' citizens cannot be easily categorised or standardised; moreover, people of any age and any level of functional ability can be non-dependent, valuable, and productive in a variety of ways.

As I discuss, the outcome of everyday-rehabilitation programmes depends on the skills and expertise of the municipal health professionals, who must coordinate training efforts together with the citizen, their family/relatives, and other actors in the healthcare system, and encourage the citizen to actively participate in the programme. The conventional belief is that "the management of populations is more effective when accomplished with the participation of those managed, because participation creates joint responsibility" (Powers 2003: 227). But how is this joint – or shared – responsibility done in practice? In the next chapter, I describe the methodological footsteps I took to investigate how certain health professionals and elderly citizens experience the political discourses related to health, ageing, self-help, and productivity.

* * *

Chapter 2

Generating empirical material

Gentofte citizens are a special group – there are some who are healthy, and some who aren't. And those are the ones who disappear. (...) But many citizens can manage for themselves – so what role should the municipality have?

Field notes, discussion with the (former) director of the municipality's Social & Health department; 19 February 2014

Introduction

In order to more effectively manage the health and welfare needs of its expanding elderly population, the Danish government, local politicians, and several private foundations have begun to express an interest in better understanding the health practices of elderly citizens – i.e., what is ‘the good late life’ and what does it mean to age ‘well’ in Denmark? This has prompted a drive for more local research on ageing and the life course. In particular, this PhD project was associated with the Center for Healthy Aging (CEHA)¹⁷, an interdisciplinary research centre based at the University of Copenhagen. CEHA's researchers study ageing and ageing processes ‘from cell to society’, and they consider ageing to be a lifelong process that is affected by both human behaviour and lifestyle. My project was part of a multidisciplinary research group that draws upon methods and theories from the humanities, social sciences, and public health to examine the theme of ‘Community Innovation for Healthy Aging’¹⁸.

As part of this research, CEHA has supported several long-term fieldwork projects that investigate health-promoting activities among and interventions for older people in four Danish municipalities: Copenhagen, Ishøj, Vordingborg, and Gentofte. These partnership municipalities were selected due to their differing demographic profiles, geography, economic resources, and social challenges; specifically, their “socially, demographically and ethnically contrasting

¹⁷ The Center was first established in 2009, and its present research is supported by the Nordea Foundation with a grant of 150 million DKK (approximately 20 million Euro) for the period of 2014–18. In general, the Nordea Foundation supports projects that “promote ‘the good life’ within the areas of health, exercise, nature and culture”, and it emphasises that it supports projects that “create good lives for others in Denmark” (Nordea Foundation 2017).

¹⁸ More information about this research is available at <http://healthyaging.ku.dk/research/health-promotions-innovations/>

[environments] characterized by very different organizational settings” (CEHA 2012: 25). The objective was for this research to illuminate important local dynamics regarding health and ageing; specifically, the “social differences that affect people’s ability and interest in health interventions”, such as their “health status, functional capacity, gender, education, (former) occupation, ethnicity and familial situation” (ibid.: 24). Each of CEHA’s partner-municipalities has “different organisational and institutional conditions and different population compositions in terms of social class, ethnicity, age, and health status” (ibid.).

In this chapter, I outline the methodological considerations for my study and how I researched certain municipal policies and programmes that target elderly citizens, which led to my interest in the work being done by municipal health professionals. As such, this project is comprised of ethnographic research into “the social grounds that produce a particular policy...and the situated communities such policy affects” (Marcus 1995: 100). In this sense, I tried to follow particular connections and flows – or “following the metaphor” (ibid.: 108) – with regards to municipal health discourses. As I discuss later in this chapter, I was actually ‘following the rhetoric’, which required me to position myself within certain landscapes in order to trace the social correlates and connections between, e.g., municipal politicians at City Hall, health professionals in their municipal offices, and citizens in their own homes. This prompted my interest in how the health professionals themselves follow the political rhetoric – as well as how they engage with, question, and implement it. By entering my field of study with a phenomenological perspective, I sought to gain insight into the immediacy of the deed-in-the-doing; i.e., to discover how community-based health programmes targeted at elderly citizens are experienced by people in their everyday lives.

My primary interest as a qualitative researcher was to understand how Danish politicians and health professionals use specific constructions and discourses to include and incorporate elderly citizens into local communities of practice that promote ‘good health’, and how systemic processes are used to empower them to be healthy, active citizens. Thus, the socio-cultural phenomena that I have studied are less about the defined territorial boundaries of a municipality or specific physical locations therein, and more about the connection and flow between local actors in multiple sites of cultural production. As I generated my empirical material, I tried to identify certain sites of intersection in order to define the argument of my ethnography (ibid.: 105) and to determine which patterns of social practice were most prominent. By doing so, my intention with this work has been to describe how these diverse sites of cultural production combine and interact in the relational practice of health services and empowerment.

The senior research staff at CEHA facilitated my access to the political leadership in Gentofte Municipality. In the next section, I provide an overview of Gentofte as the fieldwork site for my research.

2.1. Gentofte Municipality as a site of inquiry

The municipality of Gentofte is located about ten kilometres north of Copenhagen, the capital of Denmark. Nearly 75,000 people live in the seven districts that comprise this quiet commuter-suburb that lies along the country's eastern coast, and there are a significant number of international and/or elderly residents. A large portion of its general budget goes to the development, maintenance, or improvement of its physical environment; i.e., town planning for buildings, schools, and housing, as well as sewers and water, etc., which are necessary for basic hygiene and the support of public health (e.g., Lomas 1998: 1182; Rose 2001: 27). The budget also covers the upkeep and maintenance of parks, green areas, and shared public spaces, such as the municipality's six libraries. The municipality has long held a privileged position as Denmark's wealthiest municipality and, although it is still subjected to budgetary equalisation (*see* page 48), it has historically avoided much of the municipal consolidation caused by the national reforms. As such, it has been able to operate with perhaps more political autonomy than other municipalities that have struggled to ensure social equality and provide their citizens with access to a full range of welfare benefits and care services. In addition, the municipality's mayor Hans Toft (Conservative Party) has held this elected office since 1993. The socio-economic stability and political consistency of Gentofte thereby made it an ideal setting to study the effects of societal changes and transformations related to everyday practices of health.

In Gentofte, health initiatives have traditionally focused on early intervention and prevention, the care of vulnerable and critically ill citizens, and citizens with chronic conditions. And, after the 2007 reforms, the municipality's politicians focused even more attention on health-promotion and prevention efforts; specifically, they aimed to solve their public-health challenges by developing and implementing programmes in close cooperation with citizens, relevant professionals, general practitioners and hospital staff, volunteer organisations, local associations, and businesses within the municipality. In this way, the local leadership have endeavoured to offer evidence-based, inclusive, innovative, and targeted health promotion and prevention initiatives. This follows what could be considered a "public-health paradigm of health promotion" (Krumeich et al. 2001: 122), which seeks to include different levels of

analysis to understand the factors that affect health: i.e., which intrapersonal, interpersonal, organisational, community, and public-policy factors are involved (ibid.).

Following the national reforms in 2007, the local government's Health Promotion and Prevention unit launched a new health policy called *The Whole Person*. This policy addresses factors such as strengthening one's social capital, coping skills, and network, as well as improving and reinforcing a citizen's own resources (e.g., socio-economic, psychological, etc.). With regards to 'the whole person', Gentofte takes a broad view of health prevention and promotion that includes both physical and mental health as well as social considerations. The policy also outlines a structural strategy with "a focus on creating a healthy framework through legislation, regulation, and availability. The purpose is to make healthy choices easier for citizens" (Gentofte Municipality 2012: 4). According to the policy, the goal is "to create a municipality [that takes] both an individual and shared responsibility for [the] health and well-being [of its citizens]" (ibid.: 5), which means that each citizen should feel a balance between, on one side, a responsibility to manage their own health and, on the other side, the municipality's responsibility to provide a healthy environment and conditions (ibid.).

Both the *Social Services Act* (see page 45) and Gentofte's health policy emphasise a citizen's individual responsibility to manage their own health. Despite the municipality's economic wealth, it is not an autonomous entity and must therefore comply with the Danish state's imperative to manage municipal budgets and reduce health-related expenditures. Thus, to counteract the anticipated costs and demands of its expanding ageing population, the leadership in Gentofte have been actively promoting the national public-health agenda, which emphasises the promises of the Third Age; i.e., that older citizens should remain independent and 'free' from the need for municipal services – they should be engaged, active consumers who are able to live in their own homes and care for themselves as long as possible, even after they start to exhibit signs of age-related decline.

With regards to its elderly population, Gentofte Municipality expects significant growth in the number of residents between the ages of 65 and 84 in the coming years: officials predict an increase of 8 per cent by 2020, and 16 per cent by 2025 (Gentofte Municipality 2014b: 7); this is one of the highest rates in Denmark. Thus, at the time of my research, Gentofte's annual budget for 2014–5 was approximately 14.6 million DKK (over 1.9 million Euro), which was specially earmarked for eldercare services and programmes. A portion of this money would be used to maintain physical structures for the elderly, such as assisted-living facilities and nursing

homes (especially for citizens diagnosed with dementia or Alzheimer’s disease) as well as activity centres, which is in alignment with the international directive to provide “supportive, adapted social environments and (...) high-quality, tailor-made, well-coordinated health and social services that help [the elderly] maintain maximum health and functional capacity throughout their lives” (WHO 2012)¹⁹.

A central goal of the 2007 reforms was “to create a new Denmark where a strong and forward-looking public sector solves tasks efficiently and as close to citizens as possible” (Ministry of Health and the Interior 2005: 4); thus, I wanted to gain insight into how the political leadership in Gentofte interpreted the discourse of the national government to promote community-building among citizens. I decided to start by visiting sites where public-sector health professionals work closely with elderly citizens, which I discuss in the next section.

2.2. Municipal introduction programme and entering ‘the field’

My formal fieldwork began quite broadly. In order for me to better understand the various services and programmes offered to elderly citizens living in Gentofte, the municipal leadership arranged for me to attend a two-week introduction programme in August 2014, as I mentioned in the *Preface*. The intention was for me to go out to a different department or institution each day, speak with the people who worked there, follow their work and/or tour their facilities, and make observations; in some cases, I could also speak to any older citizens who might be interested. These visits ranged from a few hours to a full day, and included the Care & Health Authority (*Pleje & Sundhed Myndighed*; specifically, Visitation), the rehabilitation centre Tranehaven, Home Care services, Visiting (Home) Nurses, the day-centre Tværbommen, as well as several elderly residences: Rygårdcentret, the municipality’s largest nursing home; Søndersøhave, which primarily accommodates dementia patients; and Jægersborghave, a state-of-the-art ‘nursing home of the future’²⁰.

Prior to this introduction programme, I had been assigned a ‘buddy’ in the municipal leadership; I met with Hanne regularly throughout my fieldwork to discuss the progress of my project.

¹⁹ See the quote from the WHO that opens Chapter 1.

²⁰ Newly built and equipped with the latest digital technologies, Jægersborghave is described as ‘the nursing home of the future’ on the municipality’s homepage. *Source:* www.gentofte.dk/da/Borger/Seniorer/Ældre-og-plejeboliger/Modernisering-og-udbygning-af-plejeboliger/Jægersborghave-Fremtidens-plejebolig (last accessed 2 May 2017)

Because she had been working in a senior position in the municipality for many years, she also acted as a helpful resource and gatekeeper who was able to make suggestions and offer feedback with regards to the feasibility of carrying out my research. Although Hanne was not familiar with qualitative fieldwork, she understood that this form of inquiry was “a process of discovery so that its consequences can never be fully known at the outset” (Aull Davies 2008: 55), and she was always enthusiastic and supportive of what I was trying to achieve. Shortly before the approval of my request to conduct fieldwork, the political leadership in Gentofte Municipality had undergone a disappointing experience with a high-priced consulting firm that had been hired to explore future trends among elderly citizens²¹, so I was fortunate that the municipal gatekeepers were willing to grant me access to explore different facilities and institutions. Because of this close connection with the municipal leadership, I chose to start by examining how certain professional departments operate.

After my visits to the municipality’s elderly-care residences and nursing homes (especially Søndersøhave), the municipal leadership suggested that it would be too disruptive for me to study people with cognitive impairment who were living in such a facility. But moreover, at the beginning stage of my fieldwork, I was more interested in finding the ‘community’ in community-based health interventions. Who were the people towards whom these programmes were targeted? From my background research, I knew that Gentofte Municipality offered a wide range of programmes, activities, and events to all of its citizens, and that municipal staff had a long history of collaborating with several different civic and special-interest organisations, such as the Diabetes Foundation and the Arthritis Foundation, to implement community-based intervention projects. But at the time of my fieldwork (between August 2014 – February 2016), there were no specific health interventions being developed or implemented in the municipality.

From my naïve standpoint, I thought that immersing myself in the physical environment of the municipality would lead me to discover some kind of community that could be identified and defined. I wanted to organically discover where ‘regular’ elderly people went, what they did, and what they experienced. Thus, as I began my exploratory investigations, I cycled and walked

²¹ I first came into contact with Gentofte Municipality in connection with this project: my original supervisor was involved as a consultant, and I attended several brainstorming sessions and planning meetings with the steering committee throughout 2014; we thought that I might be able to follow the project’s recommendations as they were implemented in the municipality. Although these meetings did introduce me to the political leadership and provide insight into the process of political decision-making in Gentofte, I ultimately decided to conduct my fieldwork independently; thus, my participation in the other project did not significantly affect my methodological decisions or the resulting analysis presented in this dissertation.

around the landscape of the municipality, and I spent a lot of time in libraries, cafés, shops, outdoor activity centres, parks, cemeteries, and many other places, trying to locate ‘the elderly’. I also began to study Gentofte’s health policies (*see* section 2.5.3.) and attend various community events targeted at elderly citizens; I discuss these events in the next section.

2.3. Attending municipal community events for the elderly

The local leadership in Gentofte hosts a variety of community events, which are specifically targeted at elderly citizens over age 65 or 75. The designation of these persons as ‘elderly’ is not my distinction; rather, in alignment with the institutionalisation and categorisation of old age (*see* page 9), the Danish government have determined that citizens generally retire from work and take their pensions at age 67, which makes them eligible to receive particular benefits and services from their local municipality. For example, ‘Elderly Days’²² is a four-day programme that has been held at Gentofte City Hall since 1992. This annual event is intended only for citizens age 65 and over²³; it includes a series of lectures and entertainment, but the main purpose is to introduce these older citizens to the various health and social services available to them in their local neighbourhoods or at home. According to municipal officials, over 2,000 citizens attended the event in 2014.

The municipality’s Health Prevention department also hosts a series of smaller theme workshops, which are typically offered to citizens age 75 and over. For example, at the ‘Happiness in the Everyday’ event, citizens listened to health experts discuss how regular exercise helps to improve well-being. The lectures focused specifically on physical activity, including a peer-to-peer message that was meant to inspire and motivate elderly citizens to be more active; during this event, Sonja (age 86) told the rapt audience how she started to practice yoga at age 80, and now rides an exercise-bicycle five days a week at the health centre. She told the group: “It’s important to do something [active] when your friends and people around you are dying” (*field notes; 26 November 2014*). As part of the workshop, the participants were encouraged to get a complimentary measurement of their weight and body-mass index, try a

²² This event was re-named ‘City Hall Days’ in 2015, but the purpose and offerings remained the same.

²³ Citizens are sent a letter to inform them of the various community events and theme workshops; the mailing list is generated in connection with their civil-registration number (*centrale personregister*, CPR), which includes their birth date.

step-counter, and talk privately with a health counsellor or dietician. Like other municipal events, the attendees were also encouraged to be active socially – there was coffee, cake, and fruit on offer, and citizens were given opportunities to chat together and mingle.

At many of these large community events, the focus is on the benefits of physical activity, independence, and engagement with others. Like the *Social Services Act*'s emphasis on the individual being able to “manage for themselves” (see page 45), remaining ‘independent’ is a strong theme in Gentofte’s political discourse. The language of these events was also consistent with the positive discourse of ‘active ageing’ in the Third Age (see page 11); the municipal professionals consistently emphasised how being physically active can help older citizens to ‘live the life they want’ without illness, and that being more active would help them stay involved with their friends and family. At these municipal events and workshops, I spoke to many elderly citizens and tried to recruit them as potential informants, but none of them contacted me afterwards²⁴. Thus, because I had good access to the municipal leadership via my ‘buddy’ Hanne, I decided to delimit my project by focusing on elderly citizens who asked the municipality for help, support, and/or guidance – i.e., those individuals who made their presence known by expressing a need. At the time, I thought that they might contact specific professional groups to ask how they could get more involved and participate in the broader ‘community’ that was waiting outside their doors.

Furthermore, I was also interested in learning more about the kind of health messages the ‘home-going’ professionals disseminated on behalf of the municipality – as well as how they tried to engage elderly individuals to be more active in the local community (wherever/whatever it was) – so I decided to focus on the work being done by Visitation and Preventative Home Visits, which eventually led me to study the work being done by the newly established Cross-disciplinary Training Team. I discuss my fieldwork among these professional groups in the following sections.

²⁴ I typically struck up a conversation with citizens during a break or after the workshops/seminars, and told them about my project. If they expressed interest, I gave them my business card and asked them to call me so I could give them more details. However, it was difficult to make contact and begin an informal conversation at some of the larger community events, such as ‘Elderly Days’.

2.4. Fieldwork among three groups of health professionals

In order to be recognised as a ‘professional’, certain key competences – as well as particular skills, behaviours, and attitudes – must be acknowledged, valued, and embodied. According to sociologist Eliot Freidson (referring to the work of sociologist W.J. Goode), the definition of ‘professionalism’ should include two core characteristics: “a prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation” (Freidson 1988: 77). In Goode’s earlier work on medical professionalism, he described the “community within a community” (1957), which was made up of colleagues with similar training, values, and a shared sense of identity. Freidson also outlined several ‘derived’ characteristics, such as licensure, standards for education and training, and freedom from lay evaluation and control. While these factors are essential to construct a framework for practice, he argued that “the only truly important and uniform criterion for distinguishing professions from other occupations is the fact of autonomy – a position of legitimate control over work” (Freidson 1988: 82). This definition suggests that when a profession is an autonomous entity that cannot be evaluated or changed by the general public (laypersons/citizens), it thereby takes on the role of an authority with its own form of specialised, expert knowledge.

With the political transition from providing help to enabling self-help within health services, I determined that the role of ‘home-going’ municipal professionals is also changing – in this new configuration, they have to act as a buffer, conduit, and mediator between citizens and politicians, often helping to explain policies or the specific services and programmes that are available to the citizen²⁵. These professionals must use their specialised knowledge and experience to manage citizens through various aspects of the healthcare and/or treatment process while adhering to national law and municipal policies. But they also have to act as risk assessors, finding the best way for elderly citizens to remain in their own homes for as long as possible without the need for municipal help. As I discuss in later chapters, the political emphasis on efficiency, regulation, and cost-savings has also worked to structure and define the job functions of these professional groups, which contributes to their sense of identity and the epistemology that defines their interactions with elderly citizens.

²⁵ These professionals may also navigate between a citizen and his/her physician or other healthcare practitioners – for example, if a citizen is having trouble communicating with or is dissatisfied with their general practitioner (GP), the health professional may suggest solutions or alternatives. Because GPs are ultimately responsible for a citizen’s health, the health professional may also ask permission to contact a citizen’s GP if they have concerns about a citizen’s mental or physical well-being after a home visit.

Each of the groups I followed had a specific worldview and approach to their work; thus, in order to understand how they negotiated their differing levels of autonomy, power, and responsibility in relation to citizens, I had to adjust my gaze and my position accordingly. In the following sub-sections, I describe the methodological path I took to gain insight into how these health professionals ‘follow the rhetoric’ (Marcus 1995: 108) during their encounters with elderly citizens, providing an overview of my fieldwork among the three specific groups I studied: *Visitation*, *Preventative Home Visits*, and the *Cross-disciplinary Training Team*.

2.4.1. Visitation: the gatekeepers to municipal services

I had already shadowed one Visitor for a day during the two-week introduction programme. When I began my formal fieldwork with the department, which my ‘buddy’ Hanne arranged, most of the Visitors had already briefly met me. During a meeting on my first day of fieldwork, I told them that my primary interest was in observing their visits to older citizens; I hoped to establish contact with a wide variety of people. Thus, I followed the Visitation staff from October to December 2014; this also included attending internal meetings and seminars along with the other municipal employees at the Care & Health Authority. As part of the education to become a Visitor, one is expected to be able to “analyse, critically evaluate, and manage transitions between functions, departments, and sectors to ensure consistency in healthcare services; this may involve both an interdisciplinary and an organisational perspective in the analysis of actual collaborative challenges” (University College UC Syddanmark 2014). In practice, the Visitor’s job is to assess the living conditions and functional needs of any citizen who wants to receive personal care or practical help from the municipality. They must uphold and enforce laws and policies on behalf of the state, and they alone have the power to make official, formal decisions (*afgørelser*) with regards to the services a citizen is allowed to receive. As part of the municipal ‘authority’, Visitors typically evaluate citizens after they have received a formal referral from the citizen’s doctor or a request from a close relative.

During the six weeks I spent with Visitation, I went to their office two or three days each week. I spent the first week sitting at a small table in the middle of the open-office space, just observing (and listening to) the different comings and goings, conversations, interactions, and behaviours, which I scribbled in my field notebook. At this point, I was not trying to discern patterns that I could use in creating my ethnography; rather, I wanted to gain insight into how

the Visitors spoke to each other so I could learn some of their terminology and build rapport; I hoped to find out what was important to *them* in relation to working with elderly citizens on behalf of the municipality. I observed how the Visitors interacted with each other as well as staff from other municipal departments, such as Assistive Devices (*hjælpemidler*), and I listened to their side of phone conversations with both citizens and colleagues (as much as could be heard in an open-office space); I did this in order to understand their organisational culture – i.e., the unspoken understandings and tacit rules for how they conducted their work. In classic participant observation, a qualitative researcher usually spends an extended amount of time “living among the people he or she is studying, participating in their daily lives in order to gain as complete an understanding as possible of the cultural meanings and social structures of the group and how these are interrelated” (Aull-Davies 2008: 77). As a group, the Visitors included me in as much of their ‘daily lives’ as possible – e.g., coffee breaks, lunches, department meetings, workshops, and decorating their office for the Christmas holidays.

With regards to home visits, my primary method was ‘shadowing’, where I focused on studying “the ways of work and life of mobile people” (Czarniawska 2007: 17) – this allowed me to move *with* the Visitors as they did their jobs and thereby to gain insight into the phenomena that circulated with them. In this connection, I followed six Visitors on home-visits to nine citizens: three men (age 61–90) and six women (age 57–91)²⁶. Before each visit, the Visitor would usually give me a brief overview of the citizen they were going to visit, including why that person needed a visit. On the car-ride over to the citizen’s home (which became an informal ‘drive-and-talk’ interview), I would ask about the Visitor’s approach; i.e., what she²⁷ was looking for, what she expected to find, what she was going to ask the citizen about, and why. During the visits, I tried to understand their work as they did it – what was important for them to know about a citizen’s health condition in order to make an assessment and official decision? When we arrived at the citizen’s home, the Visitor would usually introduce me²⁸ and explain that I would be observing and taking notes during the visit. I would then tell the citizen that their

²⁶ For a full overview of my informants, please refer to Appendix A.

²⁷ At the time of my fieldwork, all 12 of the Visitors were women.

²⁸ Most of the municipal professionals typically introduced me as a PhD student, but sometimes as just a student or researcher, which often prompted the citizen to ask me questions about my project. And as soon as the citizen heard my American accent, they frequently asked me questions about myself – I discuss my ‘insider/outsider’ status later in section 2.6.

identity would be concealed in my notes and research materials; all of the citizens agreed that it was fine for me to attend and notate the visits.

Once we went inside the home, I usually sat next to the Visitor, writing field notes as she interviewed the citizen. This positioning aligned me with the ‘municipal official’, and these conversations became quite ‘meta’: although the Visitors had a list of questions to ask about the citizen’s activities of daily living (ADLs²⁹) and functional ability, they were in some ways conducting a semi-structured qualitative interview with the citizen. These conversations made me think of anthropologist Clifford Geertz’s 1983 paper *Local Knowledge*, which discussed how to acquire knowledge in the field. In this work, Geertz wanted to move beyond descriptions that referred to forms of knowing in dualistic terms, such as inside/outside, first person/third person, phenomenological/objectivist, and emic/etic. Instead, he believed that the researcher’s task is to consider both objective and subjective perspectives along a continuum in order to more accurately represent a native culture’s understanding of concepts, symbols, and language. He was inspired by psychoanalyst Heinz Kohut’s conceptualisation of the ‘experience near’ position, which refers to what an informant “might himself naturally and effortlessly use to define what he or his fellows see, feel, think, imagine”; and an ‘experience far’ position, which refers to the words/descriptors used by specialists “to forward their scientific, philosophical, or practical aims” (Geertz 1983: 57). Being able to consider both positions in fieldwork results in a more accurate description of the local people’s meaning-making activities and symbolic action.

Thinking about the Visitors’ interviews in this way, my impression was that their work was weighted towards the ‘experience far’ position – although they asked citizens to describe their everyday lives and experiences in their own terms, the purpose of these interviews was to determine what services the citizen needed and what they were eligible to receive; thus, they highlighted the ‘practical aims’ of the municipality. Moreover, during these discussions, the Visitors often reiterated the political emphasis on the benefits of physical activity, independence, and engagement with others. It was during these interviews that the political discourse about health practices leaned towards rhetoric; i.e., it used language meant to persuade. In particular, the Visitors’ evaluative function, which focuses on gaining knowledge about the citizen’s functional ability and living conditions, included an implicit moral

²⁹ *Activities of daily living* (ADLs) are “basic self-care tasks (...). They include feeding, toileting, selecting proper attire, grooming, maintaining continence, putting on clothes, bathing, and walking”. *Source*: www.caring.com/articles/activities-of-daily-living-what-are-adls-and-iadls (last accessed 15 February 2017)

judgement that was meant to compel the elderly citizen to “aspire to autonomy” (Rose 1998: 151) and take responsibility for their own health; I elaborate on this in the analytical chapters.

After the visit to a citizen’s home (which usually took place in the morning), the Visitor and I would have another ‘drive-and-talk’ interview on the way back to the office; she would tell me what she thought about the citizen’s condition, and what her decision would be. Once back at the office, I would typically sit at her desk as she entered some preliminary notes into the computer system; then after lunch, she would complete the file and write her decision letter. If necessary, she would also contact other municipal departments (such as Assistive Devices or Home Care) and make arrangements with relevant service providers; e.g., meal delivery, housekeeping, etc. The Visitors enjoyed a coffee break together every day from 14:00–14:30; here, they would discuss problems and issues with municipal leadership, other departments, or specific citizens as well as chat about their personal lives. Typically, their afternoons were also filled with attending formal meetings or seminars, catching up on paperwork (including casework), and implementing new ideas to improve the quality and efficiency of their work.

During this part of my fieldwork, I gained a great deal of insight into the variety of challenges experienced by elderly citizens in their everyday lives. And I learned a tremendous amount about the work of administering municipal health services. From this experience, I began to focus more on how the political rhetoric was entangled with the home encounter – and how the abstract designations of Professional and the Citizen (*see* page 52) were actualised or invalidated in the relational practice of a home-health visit. As I discuss in the analytical chapters, the role of the Visitor is to follow and enforce laws, policies, and rules; to offer citizens choices and opportunities; and to mobilise the appropriate actors within the framework set forth by national and local policymakers. Thus, in terms of professional autonomy, the Visitor’s role is both restrictive and restricted – the department is an independent, authoritative unit that manages citizens’ needs, and the Visitors are able to perform their jobs autonomously; specifically, they manage the problems that “the client cannot solve, and only the professional can solve” (Goode 1957: 196). However, their work with citizens is regulated and controlled by national legislation and local policies that promote optimal efficiency.

In addition, the work of Visitation is activated by an individual citizen who needs assistance – i.e., someone who has been experiencing more difficulty in their everyday life, or who has undergone a sudden change in their health or social condition due to an illness or injury. The Visitors are then deployed as ‘risk assessors’ to evaluate the damage that has been done to the

healthy citizen body, and then determine what can be done to fix it. Having acquired this understanding of how the politicians have constituted the Visitor's function, I decided next to look more closely at the work of health promotion in the municipality; specifically, how the elderly citizen's subject position changes when they are not in need of services but of information. Thus, I decided to follow the professionals who conduct Preventative Home Visits, which I discuss in the next sub-section.

2.4.2. Preventative Home Visits (PHV): the municipality's guidance counsellors

In her qualitative study of PHVs in Frederiksberg Municipality, ethnologist Lene Otto stated that these programmes in particular have become an integral part of municipal efforts to offer "citizen-oriented health promotion which aims at creating, shaping and facilitating certain ways of ageing healthy" (2013: 114). As she described it, in addition to promoting overall health and well-being, the purpose of the PHV is "to identify people at risk for health problems, to prevent further decline, to enhance the possibility for the individual to maintain activity and participation, to be in control of everyday life, and to experience life satisfaction" (ibid.). In Gentofte Municipality's promotional materials, the PHV offer is described as such:

...a health-promoting interview based on your needs [where we] discuss issues and options in relation to your life situation, everyday life, well-being, networks, health, housing, activities, exercise, and interests. Even if you do not have specific problems right now, we have seen that many people greatly benefit from focusing on how to maintain the quality of life they want³⁰.

This health-promoting service has a different level of contact than Visitation; it also contains a specific temporal aspect, as it is only provided to citizens age 75 and over, who are sent a letter twice a year with the offer to receive an in-home visit. Citizens who would like to obtain more information must then contact the PHV visitors to arrange a 'health-promoting interview'.

After an interesting and productive time with Visitation, I hoped to do the same type of shadowing with PHV. When I attended one of their theme workshops ("Happiness in the Everyday") in November 2014, I introduced myself to Gerthe and Benedikte, the PHV visitors

³⁰ See www.gentofte.dk/Borger/Seniorer/Forebyggende-hjemmebesøg

who were part of the Health Prevention department³¹; we arranged that I would shadow them one day a week throughout March 2015. I went to their office for a full day every Thursday, when they held a regular morning staff meeting. This also introduced me to the other members of the department (i.e., dieticians, exercise consultants, and health coaches), who allowed me to observe their work for a few hours or facilitated access to other health-promoting activities. In this capacity, I observed a private health consultation (one citizen), a smoking-cessation seminar (three citizens), a local-exercise programme for elderly people (four citizens), and a fitness test (two citizens); I wrote field notes during all of these events, and took photographs during the exercise programme and fitness test with permission from the participants. I also had an informal interview with one of the exercise consultants and the diabetes health coach. These activities and conversations helped to illuminate the overall work being done by the Health Prevention department with regards to the municipality's goals for community health, which elucidated how these professionals interpreted and engaged with the political rhetoric regarding 'active ageing', physical activity, and self-responsibility for elderly citizens.

In terms of PHVs, I shadowed both Gerthe and Benedikte on home-visits to four citizens: one man (age 77) and three women (age 74–87); the man and one of the women were a married couple. These visits functioned very much like the Visitor visits, with Gerthe/Benedikte giving me a brief overview of the citizen they were going to visit, including why that person had requested a PHV. On the car-ride over to the citizen's home, I would ask what she was going to ask the citizen about, and why. When we arrived at the citizen's home, she would introduce me and explain that I would be taking notes during the visit. And once we went inside, I usually sat next to Gerthe/Benedikte, writing my field notes as she interviewed the citizen. However, these conversations had a decidedly different tone than the Visitor visits. This was mainly because the PHV is 'on the citizen's terms' – i.e., the citizen has requested the visit because they want to learn more about what is available to them in the municipality. Most often, they do not *need* to receive welfare services (e.g., Home Care) but would like to discover what the municipality provides that might improve their quality of life, such as computer courses for senior citizens, activity centres, exercise classes, housing options, etc.

³¹ Gentofte Municipality has a central Health Prevention and Promotion department, which is based at City Hall; this part of the municipal authority is responsible for designing and implementing projects and offers that focus on promoting healthy lifestyles, as well as developing municipal public-health policies. Preventative Home Visits is part of a smaller Health Prevention department based at the rehabilitation centre Tranehaven, and it is much more service-orientated; citizens can contact the department directly to request information and/or personal counselling.

In this way, the PHV professionals act as guidance counsellors and advisors – they do not conduct an authoritative evaluation, but provide an interested citizen with information, support, and resources. The focus of their work is on helping older citizens to build their skills and competences so they can ‘take charge’ of their own lives. However, it was during these visits (and more generally in the work being done by the Health Prevention department) that the municipality’s rhetoric about the benefits of physical activity and engagement with others was most prevalent. While many of the conversations with citizens focused on giving them individual support and resources to improve their everyday lives, the larger theme workshops emphasised guidelines from the Danish Health and Medicines Authority (DHMA, *Sundhedsstyrelsen*), which included how regular exercise improved physical and cognitive function, reduced the risk of developing health problems, and gave elderly people more years to spend with their friends and family, doing the activities they enjoyed. The overall message – highlighted in the PowerPoint presentation at the “Happiness in the Everyday” theme workshop, for example – was that there was “a sea of opportunities” in Gentofte Municipality, and it was up to the citizen to “take control!” (*field notes; 26 November 2015*).

This rhetoric – which I understood as being related to the municipal discourse about ‘shared responsibility’ (*see page 58*) – seemed to treat disability and death like an epidemic that could be avoided (Foucault 2003: 244), especially if the citizen engaged in exercise to improve or maintain their physical capacity for as long as possible. In this sense, the municipal focus on physical robustness, independence, and longevity seemed to work as a security mechanism to ensure that elderly citizens had the information they needed to optimise this stage of their life (i.e., the Third Age). Although the Health Prevention staff did not have any particular authority or power over the citizen, I determined that their politically-defined function as ‘guidance counsellors’ meant that they acted as the municipality’s regulatory mechanism – meeting citizens who expressed an interest in being more active and engaged, but who lacked the knowledge, motivation, and tools to ‘take control!’ of their lives. However, because these health-promotion offers are voluntary, the professionals only encountered citizens who actively sought out opportunities to change themselves and their circumstances; they were continually trying to find new ways to track down citizens who could benefit from their counselling.

During my fieldwork with both Visitation and PHV, I noticed that these professionals were beginning to refer older citizens to the new Cross-disciplinary Training Team³², which provides home-based rehabilitation in everyday activities. As I mentioned in the *Introduction* (see page 16), this offer had just been become part of the municipal service law due to the government's interest in and emphasis on health prevention and risk reduction among Denmark's expanding elderly population; the team was a newly formed unit in Gentofte, and I became interested in understanding how these therapists engaged elderly citizens during a more direct, hands-on, and long-term process in which the political move from providing help to enabling self-help was most evident. At this point, my gaze began to shift from how the professionals delivered health-prevention messages to abstract, individualised consumer-citizens to how professionals who were directly responsible for empowering citizens to be more independent and 'self-helping' navigated the political rhetoric about health, productivity, and ageing in place. I describe my fieldwork with the team's therapists in the next sub-section.

2.4.3. Cross-disciplinary Training Team: the potential transformers

While I was in the Health Prevention department with PHV, I arranged a meeting with Pia, the manager of the Cross-disciplinary Training Team, which had its offices in another part of the Tranehaven building complex. Pia was very willing to let me shadow their work, but she stressed that the team was new; they had only existed as a municipal unit for less than a year at that point, and she said that they were still experiencing 'growing pains' and a lack of coordination/coherence as a group. This suggested to me that the team's therapists might be less influenced by the political rhetoric that I found permeating the work of both Visitation and PHV, which might mean that they negotiated and interacted with citizens in a different way. However, by virtue of the therapists' discipline and education, this was also a team that primarily focused on the body and how to improve its physical function, so I wondered whether the rhetoric of 'a better life through physical activity and productivity' would already be implicit in their work with citizens?

³² This included Lumikki (age 83), who I first met during her interview with Visitation (28 October 2014). When she was referred to the Training Team, I asked to shadow the physical therapist Janette during their training sessions (November–December 2014). Thus, I was already somewhat familiar with the work being done by the Training Team when I began my fieldwork with them. I discuss my time with Lumikki in more detail in section 2.5.2.

I started my fieldwork with the Training Team in June 2015. Pia and I agreed that I would come to their office every Monday and Thursday when they held regular team meetings (to discuss ‘information’ and ‘professional development’, respectively). Pia arranged the schedule so that I could shadow a different therapist each time I came (and, like Visitation, they were randomly selected based on availability). During this period, I followed nine members of the team (out of 12): three physical therapists, four occupational therapists, and two social and healthcare (*social og sundhed*, SOSU) assistants. This included participant observations in their office and evaluations of / training visits to 20 citizens: six men (age 54–90) and 14 women (age 54–93). The SOSU assistants also coordinated the intake of patients who were being discharged from Tranehaven and needed further rehabilitation at home. This part of my fieldwork was the most hectic because the therapists³³ were constantly on the move, and they each had slightly different approaches to their work. I usually arrived at the office early in the morning; we would go on one or two home visits (by car or electric bicycle), then return for the staff meeting and lunch, then go on another one or two visits in the afternoon. In contrast to the two other professional groups I had followed, the therapists never seemed to have a ‘typical’ day, which was similar to the other home-going service departments (i.e., Home Care, Visiting Nurses) that I had observed during the introduction programme.

However, most of these other service departments have been embedded in the municipal infrastructure for decades, whereas the Training Team had not yet developed a professional identity or coherence as a group. This was partially due to them being a new team (their ‘collectivity’ had not yet coalesced; Freidson 1988: 77), and partially because, as a collective, they were cross-disciplinary in nature. There were standards within each of their specific disciplines, but the therapists were also trying to define new standards for themselves as a team of mixed disciplines (which was a central focus of their weekly ‘professional development’ meetings). Moreover, they were still trying to determine their position within the municipal regime – once a citizen started a training programme, the individual therapist was responsible for their progression as well as coordinating other actors within the organisation who might be necessary to involve (such as Assistive Devices), which could often be confusing. The therapists also worked closely with Visitation, which made independent referrals to the team and sometimes accompanied them on joint initial evaluations.

³³ From this point on, I refer to all members of the Training Team generally as ‘therapists’, regardless of their disciplinary background and educational training.

During this month of shadowing the therapists, I gained a great deal of insight into their work processes (both within the municipal regime as well as hands-on with citizens), the tools and terminology specific to their disciplines, and the various practices related to ‘everyday rehabilitation’ in a citizen’s home. I learned about their frustrations with certain municipal rules and systems – especially computer documentation and administrative work, which had to account for 50 per cent of their work time – as well as their ‘growing pains’ as a team. With this group in particular, there were certain political expectations for what they should be able to accomplish and achieve; i.e., how their work could directly benefit the national and municipal ambition to reduce costs and improve longevity rates. In comparison to the other professional groups I observed, the Training Team had to navigate the political demands and expectations differently because their mandate was to produce specific health outcomes – i.e., to train elderly citizens to be more independent and self-helping for as long as possible. I came to understand that, although their disciplinary education focused on improving physical performance and functionality, the therapists had to do much more than simply work with an older person’s corporeal body; they had the potential to help the elderly transform themselves into a particular kind of citizen. As I discuss in the analytical chapters, the therapists were expected to help these citizens embody the habits and routines of empowered Third Agers who could continue to be active and productive consumers.

The therapists typically performed their work alone with citizens (one-on-one), but they also sometimes conducted initial evaluations together with a Visitation or brought another therapist to one or more training sessions. As a rule, they were supposed to coordinate training with the citizen’s Home Care worker, but this only happened twice during all the visits I followed (which was a particular source of frustration). The therapists had specialised professional knowledge but relied on each other (and their manager) to enhance their skills and help the citizen reach their goals. I could also see that they interacted with the citizen in a different way: they often struggled to promote the political rhetoric or found it to be an obstacle in helping a citizen achieve what they wanted to accomplish. Thus, I realised that the political move from providing help to enabling self-help was not straightforward. It seemed to me that the training encounters centred more on a certain kind of sociality and relational practice – as I discuss, a specific form of ‘caring action’ occurred between the therapist and the citizen – and I came to see their work as assuming more of an ‘experience near’ position (Geertz 1983: 57; *see* page 66).

This was compelling, and I wanted to learn more about these social relationships and gain a deeper understanding of what happened *during* a training programme. Thus, I asked Pia if I could return to follow one physical therapist and one occupational therapist through a full course of training – i.e., from initial evaluation to the end of the programme – with two citizens each. I gave Pia the names of two physical therapists and two occupational therapists who I wanted to follow; these choices were primarily based on the therapists’ pedagogical nature, attitude and outlook towards their work, and their interest and willingness to be involved in my project. Pia asked one from each discipline to participate, and I then coordinated my fieldwork directly with Sofie (physical therapist) and Katrine (occupational therapist). However, the choice of which elderly citizens to work with was completely random; it was based on whoever was referred to the team at that time.

This part of my fieldwork lasted from October 2015 to February 2016, during which I met three of my primary informants: Walther, Norah, and Ulla (*see* Appendix A for an overview of each)³⁴. Here, my observations and participation in the training programme became much more focused: I went to the Training Team’s office only to meet with Katrine or Sofie prior to each training session; there were several times when I met them at the citizen’s home³⁵. If we had time beforehand, I would ask them what their professional goals were for the session; i.e., what they expected to work on, and what they hoped the citizen would accomplish that day. And afterwards, I would ask what they thought about the session and whether things had gone according to plan. Because Sofie and Katrine were often running around to other citizens’ homes and meetings, they did not always have time to talk with me immediately before or after a training session; in those cases, we made a separate appointment (usually the next day) to discuss the citizen’s progress. I attended nearly every training session, taking field notes and photographs during each (with permission from both the citizen and therapist – *see* section 2.7.).

During my fieldwork with Visitation and PHV, I was almost always given the opportunity to ask the citizen questions myself – usually, at the conclusion of their conversation. I did ask a few clarifying questions during those home visits, but I was mostly trying to understand why the Visitation or PHV visitor asked the questions *she* asked – i.e., what kind of information was *she*

³⁴ I started to follow Sofie with a second citizen, Alma (age 95), who unfortunately became hospitalised after three sessions and had to stop training; as such, Alma’s training process is not represented in my analysis.

³⁵ Even though I spent less time in the office, I also became more a part of the team; I was included in personal conversations, birthday celebrations, and even the group’s holiday party at a private home.

trying to gain about the citizen? – and how she communicated specific health messages and discourses to the citizen. With both Visitation and PHV, the emphasis was on what the citizen *needed* in terms of municipal services or information/resources, and how they could be encouraged to be more active and self-sufficient. But with the Training Team, it had already been determined that the citizen would benefit from this form of physical training; thus, the focus was on what the citizen *wanted* to do and might be able to achieve him/herself.

With the team, I had the opportunity to learn more about what happened after the initial interview and evaluation. Following the entire course of training allowed me to get to know both the therapists and the citizens in a much more meaningful way, which provided deeper insight into the relational practice that occurred during the training encounter. I wrote field notes during each session and, if relevant, took photographs with permission from the participants. When we returned to the Training Team's office, I also took photographs of the comments that various municipal professionals (e.g., Visitators, medical personnel from Tranehaven, GPs, etc.) made in each citizen's online journal; in particular, I wanted to examine how Sofie and Katrine understood and interpreted these comments, and how they then formulated and entered their own training notes into the shared computer system.

From this fieldwork, I began to understand that the governmental apparatuses that defined the practice of health and welfare services affected not only citizens but also the health professionals who performed this work. The newly formed Training Team was not comprised of abstract Professionals, but selves of a particular type who were struggling to define their professional identity as a group; as sociologist Nikolas Rose writes, they were “suffused with an individualized subjectivity, motivated by anxieties and aspirations concerning their self-fulfillment, committed to finding their true identities and maximizing their authentic expression” (1998: 169–70). I felt that there was something about choices, freedom, and potential in the work being done by the Training Team that was important for me to try to capture and describe in my analysis. Moreover, there were paradoxes, conflicts, dilemmas, and contradictions bound up with their work, especially as they endeavoured to navigate between the political goals and rhetoric, and the individual citizen's agency and personhood; I describe this in more detail in the analytical chapters.

When the course of training with each of the citizens was finished, I conducted semi-structured interviews; I provide an overview of these, as well as the other fieldwork I performed, in the next section.

2.5. Interviews and other research: places, people, policies, and perspectives

During the course of my fieldwork, I had many informal and friendly discussions with politicians, professionals from a range of municipal departments and facilities, and citizens of all ages; these conversations elucidated their experiences with and perspectives of municipal health promotion and welfare services. But I also wanted to conduct qualitative interviews that were “set off in time and space as something different from usual social interaction between ethnographer and informant” (Aull Davies 2008: 106) in order to gain knowledge about certain social and cultural realities from these informants’ experiential points of view; i.e., their emic perspective (Parfitt 1996: 341), while also keeping Geertz’ continuum in mind (*see* page 66). My main goal with these qualitative interviews was to compare and contrast my informants’ formal ‘on the record’ viewpoints with what I had learned from my observations during fieldwork. Thus, I waited to conduct interviews until I finished shadowing and conducting participant observations with each of the professional groups and training with the citizens. I also wanted to develop rapport with my informants so they would feel more comfortable with me during the interview³⁶. I describe the interview process in the following sub-sections.

2.5.1. Interviews with the professionals

I did not conduct interviews with the professionals from Visitation immediately after my fieldwork with the department; at the time, I wanted to have the option to return to their office to perform more participant observations and shadowing if my fieldwork with the Training Team proved to be unproductive. Thus, my first interview was conducted with Benedikte and Gerthe from PHV because I knew my fieldwork with them would not be extended beyond the one-month period. With the Training Team, I arranged and conducted interviews with Sofie, Janette, Katrine, and Pia (manager) at the conclusion of all the training programmes. And, when it became clear that I was not going to carry out more fieldwork with Visitation, I conducted interviews with Brynja and Britt; I selected them because they worked in close cooperation with the Training Team and had particular insights into their work process, but also because they

³⁶ I contacted one citizen who I had met during my fieldwork with PHV; she seemed quite interested in learning more about my project. But when I met with her privately and suggested conducting a life-history interview (*see* section 2.5.2.), she declined. After experiencing a few of these refusals, I decided it was better to get to know a citizen over a longer period of time before asking them to partake in any sort of interview.

understood the political regulations and professional values related to Visitation and the overall goals for eldercare and service provision in the municipality. During my time with Visitation, I had shadowed Brynja but not Britt; this difference in familiarity provided perspective in relation to how they each interpreted and followed the political rhetoric.

I designed two sets of interview guides: one for professionals, and one for citizens. With both, I began by explaining the goal of the interview: specifically, that I wanted to gain a deeper understanding of their everyday life through their own thoughts, opinions, and experiences. I told them that the interview would be semi-structured in nature – i.e., that I had specific questions that I wanted to ask, but that I might also ask about different things that arose during the conversation or things that had happened during my time with them. I also asked for their informed consent to participate in my research (*see* Appendix C). In the guide for professionals, I specifically focused on three areas of inquiry: municipal health policies; their job function and responsibilities; and their understandings of health and ageing. These questions were meant to elicit information and explanations about their role in the municipal regime, the challenges of their work, and their experiences of and approach to working with ageing citizens. All of the interviews were conducted at the professional's workplace, and lasted between 60–90 minutes³⁷. Each interview was voice-recorded on my iPhone 5 and transcribed directly from Danish to English.

2.5.2. Interviews with citizens

As I endeavoured to recruit elderly informants to participate in my project, I first approached Lumikki (age 83), who I had met during my time with Visitation and followed through a training programme with Janette. I then contacted Alfred (age 77), a friend's father who had spent most of his life in Gentofte Municipality and had several serious chronic health issues, yet had never contacted the municipality for help or support at home. I met with both Lumikki and Alfred over the course of several months in the spring and summer of 2015 to conduct a series of life-history interviews. We would usually have coffee and cake, and discuss the trajectories of their lives; I also followed Lumikki on a 'typical' shopping day in her neighbourhood, and we ate lunch together in her home afterwards. These interviews (which were conducted in

³⁷ The interview with Pia was conducted on two separate days because she had only booked an hour in her calendar for the initial session, and we ran out of time.

Danish) focused on the major milestones in their lives – e.g., getting married, having children, moving homes, experiencing the death of their spouse – as well as a general family history and an overview of the health problems they had encountered over their life-course. Because these visits often lasted several hours, our discussions usually took the form of an informal, friendly conversation (Spradley 1979: 55–8).

With these conversations, I hoped to gain an understanding of their personal experiences living in the Danish welfare state for a long period of time³⁸, and especially during its heyday; I wanted to discover how certain social and cultural changes had affected them and perhaps influenced the health-related decisions they made now as older citizens. Because life histories can be misremembered (Aull Davies 2008: 206), their factual retelling was not as important to me as their first-hand impressions and perspectives; i.e., what past events were important for them to tell me about, and why? I also wanted these life histories to provide perspective to the rest of my research because both of them were ‘outsiders’ for different reasons: Lumikki, because she was not Danish; and Alfred, because he had never contacted the municipality for support or services. In order to keep the interaction casual and comfortable, I did not record these conversations; I took field notes and a few photographs to capture the most relevant and interesting parts of their stories.

When they wrapped up their life histories, I conducted a formal semi-structured interview with each of them. I also conducted interviews with Norah, Walther, and Ulla at the conclusion of their training programmes. At the time of these interviews, I had been following them for several weeks or even months and had established a friendly rapport with each. They knew about my project from the beginning, and were very willing to participate in an interview. In my interview guide for all of the citizens, I focused on three areas of inquiry: health policies in the municipality; their understandings of health and ageing; and health prevention and promotion, specifically related to their experience with the training programme (Alfred was the only citizen who had not been through a training programme; with him, my questions focused on his particular health issues and why he had not contacted the municipality for assistance). All of the interviews were conducted in the citizen’s home, and lasted between 60–90 minutes. Each interview was voice-recorded on my iPhone 5 and transcribed directly from Danish to English.

³⁸ Lumikki is originally from Finland; thus, she did not grow up in Denmark. She and her husband also lived in Canada for several years with their two daughters before settling in Gentofte in 1980.

2.5.3. Other fieldwork and policy analysis

In my attempt to locate the ‘community’ in Gentofte Municipality during the first phase of my fieldwork, I attended a range of events and workshops to learn more about how (and what kind of) political messages regarding health and ageing were disseminated to older citizens. These events included a special mini-conference called “Focus on your and our health” (*Fokus på din og vores sundhed*) at Gentofte City Hall (3 June 2014), the annual “Elderly Days” (*Ældredage*) at Gentofte City Hall (2–7 October 2014), as well as the Health Prevention department’s theme meeting “Happiness in the Everyday” (*Glæde i Hverdagen*) at Tranehaven (26 November 2014) and their “Theme Day for Men”³⁹ (*Temadag til Mænd*) at the Main Library (9 June 2015). In addition, I attended regular staff meetings with the three groups I followed, as well as internal professional-development workshops and seminars with healthcare professionals from many different municipal departments; for example, a full-day training module about home-health visits held at Vilvorde Kursuscenter in Charlottenlund (24 November 2014) and a large internal meeting on “Robustness” at Tranehaven (18 June 2015).

During these events and meetings, I wrote field notes and, if relevant, took photographs with permission from the participants. While attending these events provided me with a great deal of background information and knowledge about the municipality’s values and political rhetoric, especially during the early stage of my research, these events do not significantly factor into the analysis I present in this dissertation. I also attended a focus-group interview (7 March 2016) with six older women who lived in Gentofte, which was arranged by a Master’s student at Copenhagen Business School (CBS) who was writing about the implementation of §83-A of the *Social Services Act*. Although this interview was interesting, I have not included the women’s impressions of municipal health services and programmes in my analysis; at that point in my research, I had decided that the focus of my analysis would be on the relational encounters that took place during the home-health visits and training sessions that I had followed.

³⁹ In connection with a presentation given during this workshop, I subsequently met with four members of the steering committee for the Hemingway Club, “a social network for adult men aged 60 years and older. The network is voluntary and based on community.” *Source*: <http://hemingwayclub.dk> (last accessed 4 November 2016)

Towards the end of my fieldwork, I studied various documents related to both national law and local health policy, as well as a great deal of municipal health-promotion brochures, pamphlets (*pjecer*), and service descriptions. These primary source materials were critical to understanding how and why municipal health policies have been developed and implemented over time, especially since the 2007 reforms. In particular, studying printed materials is a valuable way to analyse administrative and social coordination (Giddens 1991: 24–5). Throughout my research, I attempted to evaluate such ‘official’ documents in terms of their authenticity, credibility, and representativeness (Aull Davies 2008: 198), especially if they became part of my empirical material. In general, the documents and materials that were important to my informants from the professional groups became important to me; they allowed me to analyse the effects and traces of these texts (and the rhetoric they contain) *in relation to* the connection and flow between local actors in multiple sites of cultural production. As such, the laws, policy documents, brochures, websites, etc. to which I refer in this dissertation are essential reference materials; they have provided an important point of departure and a framework for my analysis of the work of municipal health professionals and the transformation of eldercare in Denmark⁴⁰.

In Chapter 1, I presented a triangle figure from the policy document “Overall standards of quality for the care and health area” (*Overordnet kvalitetsstandard for pleje- og sundhedsområdet*; see page 52), which represents the way that many municipal programmes are designed to function – i.e., an individual is evaluated by, cared for, and/or trained by another individual. In fact, the national government has suggested that this 1:1 relationship is the most effective way to work with citizens at home; for example, according to the Danish Health and Medicines Authority, “There are several advantages to meeting the citizen in his own home. The citizen feels more comfortable with one-to-one contact in a familiar environment” (DHMA 2005: 7). During the home-visits and training sessions I observed, there were many other actors involved: spouses, children, friends, neighbours, pets, other health professionals, etc. My analysis does not seek to ignore the central importance of these actors, but because of the political emphasis on the 1:1 relationship between individuals, I made an active decision to focus on the relational practice that occurs between the health professional and the citizen during the home-health encounter. However, I must also acknowledge my own mediating presence in these encounters; in the next section, I discuss my reflexive position.

⁴⁰ In this dissertation, I have translated all references to and citations from these documents myself; although I may have asked a Danish friend or colleague for clarification of a specific word, phrase, or term, I accept full responsibility for any misunderstanding or mistranslation of these materials.

2.6. *Gaining insight from an intersubjective, situated position*

Although I have spent the past several years of my academic career studying health and healthcare practices – primarily surgical residents working in the Danish hospital sector, and Danish doctors/nurses who had worked abroad with *Médecins Sans Frontières (Læger uden Grænser, MSF-DK)* – I am not trained or educated in the medical field. But I have always been fascinated by the work of health professionals and how they evaluate, diagnose, handle, and treat both the corporeal body and the phenomenological body. As philosopher Hans-Georg Gadamer wrote, “Treatment always involves... a certain care which must recognize the freedom of the patient. No doctor can presume to want to exercise control over the patient” (1996: 109). Furthermore, philosopher Annemarie Mol writes that good care is not a matter of trying to control people or exert authority – it is about providing counter-balance because healthcare professionals can see gaps in rationalism that patients may not be aware of. But, in turn, the patient must “engage actively in care, painfully, enduringly, and as a prominent member of the care team” (2008: 25). With these viewpoints in mind, I have long been interested in examining how health and medical professionals perform their work in order to learn more about what professionalism, autonomy, and ‘good care’ means to them – especially from a hermeneutic perspective, which demands a certain form of narrative interpretation and reflection about the Other’s lifeworld. Thus, I designed my study to explore how specific home-going professionals in Gentofte Municipality perform their work with older citizens – work that is not always autonomous and free from government authority, yet which requires them to evaluate, interpret, and navigate many diverse and emerging fields of knowledge.

As I have already described in this chapter, I primarily aligned myself with the health professionals during the home-visits and training sessions with elderly citizens. In this sense, I was quite aware of my connection to the research situation and the possible effects I might have on it (Aull Davies 2008: 7). Thus, I did not endeavour to get actively involved in the training sessions, other than to observe the therapist and the citizen from a slight distance. During the home-visits, the professionals knew that I was supposed to be a ‘fly on the wall’ and not interfere with or disrupt their work. However, it was a little more complicated with the citizens, who often talked to me during the sessions (e.g., when we were taking walks) or asked me to do

favours for them both during and after the training sessions (such as mailing letters). Sometimes, they also implicated me in their experience of training by making faces that only I could see or comments that only I could hear. In this sense, I recognised that my position as a researcher could become compromised if I began to feel sympathy for them or if I was somehow privy to ‘secret’ knowledge. This was one reason why I did not ask many of my own questions during the initial home visits, and also why I waited to conduct interviews with all of my informants until the end of the training programme; I did not want to interfere in the 1:1 relational practice that occurred between them during the encounters.

At the same time, I knew that the production of my data was a collaborative process that all of us generated together intersubjectively, and that the activities and encounters in which we were participating contributed to a shared social world. Thus, my position in the field was situated in that context because “meaning is always in the social domain in which people participate” (Unger 2005: 4). This meant that my approach to the research had to be epistemologically based in interpreting the situations in which certain actions and behaviours had meaning to the people in that particular situated context. By endeavouring to interpret these forms of social and cultural meaning, I would be better able to understand how the actors’ language and actions changed to represent their changing sense of themselves in the world (ibid.: 5). As I was trying to discover what was meaningful in the context of these encounters, one of the biggest drawbacks – and benefits – was my insider/outsider status⁴¹. For all intents and purposes, I was an outsider: I am not Danish, I do not have professional medical training, and I am not an elderly citizen; also, at the time of my fieldwork, I was not employed by a municipality, and I had never needed to receive welfare services or help from the government. As many people said to me during my research, I did not have the same ‘home-blindness’ that a native Danish researcher might have, and which might compromise my analytical position and ability to describe the social realities in which these actors were embedded.

However, my identity as either an insider or outsider was not fixed – rather, it was changeable and constructed by how the research participants saw my position. This was clear in how both professionals and citizens related to me: with a few exceptions, the professionals accepted me following their work and took me and my research seriously. I remained an outsider with both Visitation and PHV, but became more of a group insider the longer I spent with the Training

⁴¹ Despite Geertz’ continuum (see page 66), I was very aware of my vacillating status as either an insider or outsider during fieldwork.

Team. In general, the professionals considered me to be a ‘Danish insider’ in the sense that I am familiar with the systemic workings of the Danish state, have integrated into society and, even though I speak Danish with a strong accent, I can follow everything that is being said and engage in conversations. But there were times when I did not understand a word or phrase (especially if it was specialised terminology); in these cases, my outsider status was evident, but I saw it as a benefit, as I could ask them to repeat or explain something in more detail. This often prompted them to re-phrase their discourse, which was analytically interesting.

Because I have only lived in Denmark for a few years, I also did not take the same things for granted – there are certain cultural practices (routines and rituals) that I have noticed since I moved here in July 2008, and they became even more highlighted during my fieldwork; for example, the cycling culture and shared-lunch routines. But most importantly, as an American, I did not grow up with the protections and benefits of a welfare state, so gaining an ‘insider’ understanding of the development, implementation, and evolution of the policies targeting older citizens and governing the work of the professionals has been very interesting to me. In general, the experience of moving to a different country forced me to see certain cultural and social practices with ‘new eyes’, and I try to maintain this way of seeing in my work as a cultural analyst. But that being said, I realise my research has an effect on the real-life people who I have studied; I discuss my ethical obligations in the next section.

2.7. Ethical obligations and the handling of empirical material

Because I have not collected my informants’ personal data and my work does not contain any identifying information, it was not necessary to register this project with the Danish Data Protection Agency (*Datatilsynet*), the state authority that oversees the Personal Data Act⁴². Denmark does not have an Ethics Review Committee or Institutional Review Board for academic research. However, my project is in compliance with ethical guidelines for empirically-based research as outlined in the *Danish Code of Conduct for Research Integrity* (Ministry of Higher Education and Science 2014)⁴³. This means that I have endeavoured to

⁴² “The regulations of the Act on Processing of Personal Data apply to the processing of personal data if the processing is conducted for scientific or statistical purposes. *Personal data* is understood as data about a person that directly or indirectly can be identified.” *Source*: <https://www.datatilsynet.dk/english/health-research-and-statistics-projects/private-research-and-statistics-projects/> (last accessed 10 July 2017)

⁴³ “Based on three basic principles of research integrity, i.e. honesty, transparency, and accountability, the Code

conduct my research with honesty, transparency, and accountability. And, much like the physician's Hippocratic Oath "to do no harm" (National Library of Medicine 2012), I have tried to leave the field of my study in much the same way that I found it. But, at the same time, I realise that I have taken much more than I have given – although I participated in the relational practice of home-health visits and everyday rehabilitation, and thus was part of the situated intersubjectivity that these encounters contained, it was only I who collected the data and materials that I have used to develop my analysis. I can never say what short- or long-term effects my fieldwork has had on my informants (both those I followed/observed and those I interviewed) nor can I truly predict the effects my final analysis may have on these informants, on national/local policies, or on practices related to health and eldercare (although I speculate in the *Conclusion* to this dissertation).

In addition, prior to entering the field for the municipal introduction programme, I was asked to sign a confidentiality agreement⁴⁴ (*tavshedspligtserklæring*; see Appendix B), which stated that – according to local law and specifically in relation to my connection with the Care & Health Authority in Gentofte Municipality – all information regarding private citizens' economic and personal relationships would be kept confidential. Thus, during my time with Visitation in particular, I took handwritten field notes, using only citizens' first names and birth years (to calculate their age). Since many of these home-visits focused on intimate health concerns and/or private social problems, I did not audio-tape the discussions, and I did not usually take photographs; the one exception was with an older couple who both seemed quite 'fresh' and lively. In this case, I asked their permission to take photographs and to use the visual material in my research; they both verbally agreed, which I wrote in my field notes. I also took some photographs of the Visitation workers working at their computers, but we ensured that these images did not contain any identifying personal information (i.e., surnames, full birth dates, addresses, civil registration numbers, etc.) related to private citizens.

As I mentioned earlier, I went through the official municipal 'channels' to arrange my fieldwork among the professionals – in the case of Visitation, my main contact Hanne first spoke to the

presents a set of six commonly accepted standards on responsible conduct of research, a set of guidelines on teaching, training, and supervision, and, finally, a set of guidelines on how to respond to breaches of responsible conduct of research. Together, these elements are intended as guidance tools for researchers in their day-to-day work" (Ministry of Higher Education and Science 2014: 4).

⁴⁴ I also had to go to my local police station to obtain an official copy of my criminal record (*straffeattest* – see Appendix B), which stated that I had not committed any offenses; I submitted both of these documents to the Registrar in the municipality.

department's manager, who then discussed my project with her staff and gave their collective approval. When I first arrived at their office, I told them what I hoped to do and encouraged them to ask questions if they had any concerns about my research. I arranged my fieldwork with PHV and the Training Team myself, but Hanne was aware of my plans and had no objections from the municipality's standpoint. With PHV, Benedikte and Gerthe spoke to their manager and the rest of the Health Prevention department before agreeing to participate in my research; during this part of my fieldwork, I also took extensive handwritten field notes. I took a few photographs during the home-visits and exercise classes, mostly so I could remember the different elderly citizens I met; in these cases, I asked for and was given verbal permission, which I wrote in my field notes. Again, I only wrote a citizen's first name and age/birth year in my notes.

I conducted fieldwork in the same way during the first month I spent with the Training Team (June 2015). When I returned to follow Sofie and Katrine through the entire training programme, we discussed my research project with each of the citizens during the initial interview, and they each consented to my shadowing their course of training. They also allowed me to take photographs during the sessions; the vast majority of these images do not show the professional's or the citizen's face. Because I often met the therapists at the citizen's home, I knew the first and last name of these citizens as well as their address. Later, in order to arrange the interviews, I also obtained their telephone numbers (usually during the final training session) and gave them mine in case they needed to cancel or re-schedule the interview.

Prior to each interview, I would start the recording and give each informant the opportunity to provide their informed consent (*see* Appendix C), telling them that they could always refuse to answer certain questions and could inquire about why I was asking these specific questions. I also assured them that, although I would use quotes from these interviews in my research output (the dissertation as well as conference presentations, journal articles, books, interviews, teaching materials, etc.), I would conceal their identity and personal information; as such, all of the names in this dissertation are pseudonyms. I also gave them my business card and told them that, if they decided later that they did not want to be included in this project, they could always contact me to withdraw. All of the informants gave their explicit permission on the recording and, as of this writing, none of them have contacted me.

I took a great deal of photographs before, during, and after most of the public municipal events, workshops, and seminars that I attended. Very few of these images show identifying personal

information (and if they did, I obtained verbal permission and made a note in my field notes) and, as stated earlier, they do not significantly factor into this dissertation. I also held a formal presentation (28 April 2016) for my main contact Hanne and other members of the leadership group at the Care & Health Authority; during this meeting, we discussed the project's progression and my preliminary analytical insights. This group were also sent several draft chapters of this dissertation in May 2017 to review prior to submission; as of this writing, they have not expressed any objections to Gentofte being included in this research project. After the dissertation has been formally submitted, I expect to hold another presentation for the leadership group at the Care & Health Authority as well as a broader group of municipal health professionals (including those from the departments I followed).

Summary

In this chapter, I have described the methodological approach I took to generating my empirical material and gaining insight into the socio-cultural phenomena related to municipal programmes that promote 'healthy ageing' in a particular field of inquiry. I began my research by exploring Gentofte Municipality as a site of cultural production; specifically, as a place where public-health policies may affect and influence a particular situated community. In order to investigate how the politicians endeavour to "make healthy choices easier" for elderly citizens to make, according to the political discourse, I attended a municipal introduction programme, workshops, and a variety of community events targeted at residents age 65 and over. During these events, I learned that the municipal health discourse emphasises the benefits of physical activity, independence, and being socially engaged for as long as possible. However, because it was difficult to recruit informants at these large events, I thereby decided to 'shadow' certain home-going municipal health professionals in order to learn how they disseminate information to elderly citizens about being more physically active and involved in the local community.

I followed the health professionals who work with Visitation for six weeks, gaining insight into the phenomena that circulated with these authorities as they performed their work to assess an elderly citizen's functional ability and living conditions; in these evaluative interviews, they often reinforced the municipality's rhetoric about the benefits of remaining physically active and engaged, and also acted as risk assessors to determine the most efficient way for the citizen to take responsibility for their own health and reduce their need for in-home services. Next, I

followed the health professionals from Preventative Home Visits (and met many other health consultants in the Health Prevention department), which required me to shift my analytical gaze and position. Here, the political rhetoric about remaining active and engaged was most prevalent, and the work done by these professionals acted as a security mechanism to ensure that elderly citizens had the information they needed to optimise their later life. Both of these groups were beginning to refer citizens to the municipality's new Cross-disciplinary Training Team, which was established to provide 'everyday rehabilitation' to citizens in order to improve their functional ability, prevent hospital admissions, and reduce their need for municipal help. I followed certain members of the team over six months, including an entire course of training with three citizens.

As I generated my empirical material, I discovered that each of these groups encountered a different kind of citizen; in the politically-defined 1:1 encounters, there were layers of interaction and negotiation as the professionals worked to persuade and then transform older people into self-helping citizens. But in addition, I learned that the nature of eldercare services – and thereby the nature of the work done by the home-going municipal health professionals – is undergoing a transformation as the Danish state moves away from providing help and puts more emphasis on enabling self-help. As I discuss in the following analytical chapters, the state's transition to a consumer-orientated culture that prioritises efficiency, productivity, and individual self-responsibility has affected the welfare state's traditional values – such as solidarity, community, compassion for the weak, and equality for all (Beedholm & Frederiksen 2015: 153). These changes have also diminished the social prestige of certain professions and fundamentally changed the health professional's relationship to the citizen (*ibid.*). But in the social context of these in-home health encounters, new forms of care seem to be emerging.

In the chapters that follow, I draw upon ethnographic material from my field observations and interviews to describe how municipal health professionals 'follow the rhetoric' as they work to empower the ageing citizen to develop their potential to be more self-helping.

* * *

PART I

LABOUR – activity related to the biological process of the human body

The citizen should be self-helping so [the municipality] can save money. That's it. (*laughs*) In the end, there might be some benefit to society – it sounds good, right?

Interview with Britt, Visitor; 1 March 2016

Introduction

The fields of geriatrics and gerontology have long been established in Europe to conduct biological and social research into the ageing process and the life course (*see* Achenbaum 1995; Grimley 1997; Mulley 2012). Within these disciplines, the biomedical study of ageing typically focuses on the body's corporeality – i.e., its unmediated materiality and visceral physicality – in relation to age-associated diseases such as Alzheimer's, arthritis, diabetes, cardiopulmonary disease, and stroke. Some psychological research suggests that these physical conditions may play a significant role in how humans experience the ageing process, as well as the level of well-being and quality of life they are able to achieve (e.g., Steverink et al. 2001). Since the issue of population ageing has become more of a concern in many Western societies, as I discussed in the *Introduction*, the political interest has shifted from understanding ageing as a process of structured dependency to an emphasis on promoting 'active ageing', wherein good health becomes a commodity, and "agency and effort are always expected – specifically, by working on lifestyle, leisure, and consumption" (Gilleard & Higgs 2014: xii).

In this connection, Danish politicians have been trying to determine the best way to manage the country's increasing elderly population and their need for healthcare. With the political move towards efficiency, self-management, and providing 'help to self-help', this means that municipal health professionals are tasked with the job of mobilising the *bodies* of rational consumers to take responsibility for their health and comply with the government's ambitions; they must be developed into "self-mastering humans" (Tronto 2017: 29). In the following chapters, I describe how these health professionals assess the elderly physical body to discover whether it can be trained and re-skilled – specifically, to transition from a dependent, standardised object of concern to what I call a 'limited yet limitless' ageing consumer: i.e.,

a post-retirement citizen who may suffer from particular health limitations but who still has unlimited value as a contributing member of society (*see* page 12). This citizen is constituted as an active subject who should choose to (re-)produce bodily labour and adopt the paradigm of healthy ageing in the Third Age.

* * *

Chapter 3

Evaluating the body's need for help

In this chapter, I focus on the evaluation process conducted by Visitation, which is informed by the municipality's epistemology regarding the primacy of the physical body and its need for exercise and activity. I describe how, due to the government's emphasis on growth and consumption – combined with management tools such as the *Free Choice* scheme – local politicians and health professionals follow a 'logic of choice', which is "a specific mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad" (Mol 2008: 7). In the contemporary competition state, as I have suggested, the elderly citizen has been constructed as a 'limited yet limitless' consumer with the freedom to choose how to behave.

Thus, the Visitors' evaluations focus on determining whether a citizen can return to continued labour, but an emphasis on the physical body creates certain dilemmas for these health professionals, as they encounter 'rational consumers' with a particular form of mindful agency. In the next section, I begin by discussing how the municipal health professionals focus on the primacy of the citizen's physical body.

3.1. The primacy of the rational consumer's physical body

From my research into national health and social-welfare policy documents as well as Gentofte's health policy and initiatives, I determined that many of the current municipal programmes that target elderly citizens are based on biomedical research and recommendations made by the national health authority (DHMA, *Sundhedsstyrelsen*); as such, they tend to reflect a persistent normative belief that people over a certain age (usually 65) suffer from physical ailments and a degree of cognitive impairment that necessitates their need for support and assistance from governmental agencies (*see e.g.*, Kaufman 1994; Weicht 2013). This perspective works to categorise elderly bodies as inherently 'defective', 'abnormal', and 'needy' and, in Denmark, they have historically been subjected to a particular form of attention from the state's health experts and municipal professionals, who have been charged with evaluating the elderly

person's level of 'neediness' before setting certain compensating services in motion to improve his/her quality of life.

Moreover, ageing bodies in Gentofte have been constituted as needy 'objects of attention' – not only because government policies have categorised them as a monolith known as 'the elderly' based on their chronological age and post-retirement status, but also because, in terms of healthcare services, the municipality's organisational culture and epistemology emphasises the primacy of the physical body, focusing on its corporeal needs and abilities⁴⁵. For example, nearly all of the health professionals I followed as part of my research had been trained and educated as physical therapists, occupational therapists, or nurses (*see* section 2.4.) before beginning their jobs in the municipality. This professional training prepared them to have a very specific biomedical relationship to the body, and to evaluate it, approach it, and work with it in physiological terms. For example, in response to a question about how the municipality supports 'healthy ageing', the Visitor Brynja said:

As soon as the municipality gets the first referral from a citizen regarding assistive devices or something – you already begin to think, 'Could there be a need for physical activity or training that could maintain or prevent a decrease in function?' I think that's really good. (...) Maybe it's also because of my background as a physical therapist – I use this approach, and I acknowledge the things they already do, but I also suggest what else they could do, with an eye towards activity. I talk to them about that a lot – after I've heard about their everyday life – how they could fit in some activity?

Interview; 25 February 2016

In this quote, Brynja explained that, after hearing about a citizen's everyday life and the challenges that have led a citizen to enquire about receiving assistive devices from the municipality, her approach is to find out how they can "fit in some activity". She pointed to her training as a physical therapist as the reason why her first instinct is to discover if there is "a need for physical activity or training that could maintain or prevent a decrease in function" in the elderly citizen's body. This training and educational background is also reflected in how other health professionals describe the ageing process. For example, Benedikte from Preventative Home Visits (PHV) – who is a trained occupational therapist – explained:

⁴⁵ Although the municipality's health policy *The Whole Person* mentions strengthening a citizen's psychological resources, coping skills, etc., all mental-health services and counselling in Denmark fall under the domain of a citizen's general practitioner (GP), who is connected to the regional health authority and not the municipality.

Ageing is something that happens from birth... and then we start ending at some point (*laughs*). (...) 'Ageing' is much more what you think about when you're 60+. When you're younger, you talk about 'age'. If you talk about 'ageing', then it's about whether there are any functions that have been affected by getting older.

Interview; 16 April 2015

Both Brynja and Benedikte have a biomedical perception of the ageing process that is rooted in the physiological body and its experience of functional decline as it gets older and begins to lose its biomechanical abilities, such as balance, coordination, vision, and hearing. But Benedikte also made a distinction between the different perspectives of 'age' and 'ageing', which may change and develop over the life course. Her colleague Gerthe (also a trained occupational therapist) acknowledged the more subjective aspects of ageing and getting older, which may be culturally and socially defined:

It can also be the age that you *feel*. (...) There are a lot of elderly people who don't feel their age. (...) Our image of ageing has also changed over time. A number of years ago, being in your 50s was considered really, really old. Also the clothes...they dressed in a particular way. It's not that way today – I can visit an 80-year-old who is dressed in very modern, smart clothes and a new beautiful necklace, and she can look much younger than her age.

Interview; 16 April 2015

Here, the professionals discussed ageing in terms of the body's physical ability and appearance (*vis-à-vis* clothing), which reflects a form of cultural ageism wherein an ageing body is constituted by whether or not it is invisible; in other words, it becomes an object of attention due to how functionally able it may or may not be, and how 'age-appropriate' its clothes may or may not be (Gilleard & Higgs 2000: 69; Twigg 2013). Furthermore, I found that the health professionals often discussed the ageing body's physical experience in idealistic terms – i.e., that the body is still capable of achieving more, doing more, participating more – rather than simply accepting the body's current condition and the eventuality of its natural decline.

As I discussed in Chapter 1, Denmark's transition into a competition state has meant that politicians and health professionals have developed an increased focus on risk-prevention, healthy choices, and limitless productivity for all citizens. The central idea is that "societies work best when they allow rational actors to make choices in the market, and that anything that interferes with such choices reduces people's freedom" (Tronto 2017: 29). This way of thinking thereby positions the citizen as a rational consumer; i.e., an "independent, autonomous agent

that, given objective data, is capable of choosing to create a self that conforms to arithmetic averages” (Powers 2003: 231). This rationality also conforms with how the role of the Visitor has been formulated: in the state’s *Free Choice* scheme (see section 1.3.1), Visitors are specifically described as a tool to manage capacity and service levels: “[Limiting choices] increases the significance of other management tools; i.e., Visitation, to manage the municipality’s decision on the allocation of specific offers and services to the individual citizen” (Ministry of Finance 2003: 47). This framework can be understood as a remnant of New Public Management (see page 44), which emphasised a strong and uncritical belief in the rationality of management tools to benefit and improve the public sector (Pedersen & Andersen 2016). In practice, it means that the state expects the Visitor to act as a rational agent who uses biomedical evidence and her professional expertise to evaluate a citizen’s physical capabilities, and she in turn expects to encounter rational citizen-consumers who will freely choose (Højlund 2006: 43) to behave ‘properly’ to reduce their health risks, improve national longevity rates, and contribute to reducing the state’s economic expenditures.

Although the operating logic of these management tools has begun to lose much of its motivating force due to an over-emphasis on savings, documentation, and reorganisation (ibid.), the rhetoric of rationality and regulation is dominant in the municipality – I argue that it has informed the Visitors’ worldview as the authoritative gatekeepers to services, and it has structured the work that they do when they assess ageing citizens’ bodies. In particular, the body’s physical capability and functionality has become equated with good health; e.g., at the top of the standardised document that the Visitors use in their interviews to assess a citizen’s everyday life, it states, “Functional evaluation = health evaluation”.

In particular, the political move towards promoting self-responsibility, activity, and self-help can be seen in how these professionals assess the ageing body in terms of its physical functionality, which I describe in the following section.

3.2. A focus on offering ‘opportunities’

As I outlined in Chapter 1, elderly bodies in the Danish welfare state were historically categorised as being ‘in need’ of care and assistance. Although the citizen had to be eligible and ‘worthy’ of assistance, this support was framed as a collective, social responsibility wherein citizens had a right to receive stabilising assistance from the state, and such help was made available to anyone who required it. But, as Denmark transitioned into a competition state in the

late 20th century, both public services and citizenship rights were subsequently restructured. In this way, “access to services increasingly came to be seen as a right where need could be established” (Fine 2007: 7). As a result of this needs-based assessment, elderly and/or ill bodies were subjected to a particular form of scrutiny and surveillance: the state’s expert gaze, which is activated via institutions and mechanisms (i.e., Visitation) that evaluate a citizen’s level of neediness and offer appropriate services and assistance to improve their quality of life.

With regard to older people (age 65+), the national health authorities define ‘quality of life’ as the “perception of enjoyment in the absence of discomfort or pain” (DHMA 2005: 23). The Visitor’s function thereby has traditionally contained a form of pastoral power that is meant to look after “not just the whole community, but each individual in particular, during his entire life” (Foucault 2000: 333). This requires the Visitors to get to know the individual citizen and their needs in order to deliver ‘person-centred’ evaluations and services. As the Visitor Britt told me:

I need to figure out who I’m sitting across from. (...) And to get a sense of what kind of person this is. Because finding out what kind of help they can get is accomplished quite quickly. So it’s more about ‘how can you achieve this?’ so they feel like they’re getting the help they should have.

Interview; 1 March 2016

In this quote, Britt explained her approach when she goes to evaluate a citizen’s need for municipal help. Rather than describing the citizen as an abstract individual, she used language that positions the citizen as a person with needs and feelings related to “getting the help they should have”. She also said that it is important for each person “to feel like they’ve been *heard*”, thus positioning herself (and the overall role of the Visitor) as someone who is there to hear about⁴⁶ the citizen’s needs, priorities, and wishes in order to improve their quality of life. This was also emphasised by the Visitor Brynja when she explained the amount of time she tends to spend on a visit: “You can’t get hold of everything in 20 minutes. There needs to be some time

⁴⁶ This positioning of the municipal health professional as a sensitive advisor and ‘hearer’ is also prevalent with Preventative Home Visits. Benedikte told me that, in order for her to build rapport with a citizen, she often needed to “share some of myself” – her approach was to “talk about my children, husband, or whatever might be relevant to get the citizen to open up” and share information about their situation. She said, “It’s important to show the citizen that you’re a person too” (*field notes; 19 March 2015*). I saw this during her visit with Agnete (age 88) who was not eating due to a stressful family situation that involved fighting over an inheritance; Benedikte told her about a similar situation she had experienced and said, “These cases always bring out the worst in people, but we have to remember that it has nothing to do with us” (*ibid.*).

for it. So that citizens feel met, heard, understood – taken seriously” (*interview; 25 February 2016*). This type of ‘hearing’ points to the rational exchange and negotiation that is expected from the home-health encounter.

However, in the political move from providing help to enabling self-help, Visitators no longer have the universal responsibility to ensure that supportive care is available to all who need it (Fine 2007: 4), and thereby to make decisions about the most appropriate form of help and support an individual citizen should receive. As I discussed earlier, most welfare services have been constructed as a commodity that the citizen-consumer can choose, and help “no longer takes its starting point in everyday life, but instead in meticulous administrative programmes” (Højlund 2006: 47). Thus, the government’s policies and regulations have defined which services the Visitators are able to offer to citizens – a market that is controlled and regulated by the municipality with regards to service providers and quality standards – and the rational consumer is given ‘opportunities’ from which to choose. For example, Brynja told me:

I expect the citizen to want to participate in the offer that I can give them. And that’s what I think is important to do on behalf of the municipality – to offer them opportunities. So they get an idea of, ‘What are MY opportunities in my situation right now?’ So you give them some comprehensive advice and guidance – what could the opportunities be? And they’re certainly allowed to say, ‘I’d like to do that’ or ‘That’s not something for me.’ But I have an expectation that they will actively participate – they’ll be a part of it.

Interview; 25 February 2016

Here, Brynja described that it is important for her to give citizens advice and “opportunities” to participate in any municipal offers; specifically, opportunities for them to engage in physical activity and other forms of self-care that will make them more self-helping and improve their quality of life. Moreover, when elderly citizens are given an offer to receive services, the Visitators *qua* the municipality expect active participation. This is the dominant epistemology among many of the municipal health professionals, even in relation to ageing bodies in decline. Specifically, Visitators like Brynja who work under the rationality of self-governance “have an expectation” that elderly citizens will choose to “actively participate” and “be part of it”, which will allow these citizens to achieve a “perception of enjoyment in the absence of discomfort or pain” (*see* previous page). However, this conceptualisation of ‘quality of life’ can be seen as an “articulation for the goals of health care where ‘cure’ was unrealistic” (Armstrong & Caldwell 2004: 368). This means that – because ageing bodies cannot be biomedically ‘cured’ – the

Visitors can only offer an illusion of rational choice, articulating the belief that an older citizen can still choose to improve their quality of life by being more physically active.

In addition, with the discursive move from providing help to enabling self-help, Visitors can no longer simply use their professional expertise and authority to identify needs and decide which services and assistance would help a citizen; their mandate now is to encourage citizens to make rational choices; i.e., to engage in physical activity and be self-helping. I could see this change in tack when I followed the Visitor Brynja to evaluate Johanne (age 85), who suffers from osteoporosis and had recently received a diagnosis of lung cancer; she had just made an appointment to meet with her physician to plan a course of radiation treatments. In my field notes, I wrote:

Brynja and I enter the apartment, and Johanne apologises for everything being a mess; she immediately begins to cry. Brynja and I try to calm her down and comfort her – we tell her (truthfully) that her apartment is lovely, and she should not apologise. We sit down, and Brynja slowly begins her evaluation interview – she has a list of specific areas that she needs to assess, such as Johanne’s daily activities, personal hygiene, meal preparation, etc. After asking about her treatment plans and daily routine, Brynja outlines the services Johanne would be eligible to receive from the municipality. She offers several options for help with grocery shopping, cooking, house cleaning, etc. However, these services are not free – they are subsidised and organised by the municipality. In addition, they are only temporary – after three months, Johanne will have to apply again to re-new the services. But she can do this indefinitely.

Field notes; 30 October 2014

Brynja’s interview with Johanne was meant to determine what her body could or could not do in terms of its current functional ability, and what type of help the municipality might provide according to the *Social Services Act §83*, wherein assistance should “promote the ability of individuals to manage for themselves or to facilitate their daily lives and improve their quality of life” (Ministry of Children, Equality, Integration and Social Affairs 2014: §1., 3.2 and 3.3; see section 1.3.1.). As Brynja told me later, “I’m very focused on getting people to understand how important it is that they take over and not just allow themselves to get worse and worse. That you can still do something even though you’re 80 or 95 or whatever” (*interview; 25 February 2016*).

In the negotiation that occurred, Brynja suggested that Johanne would feel better if she tried to do something active every day. However, Johanne had no intention of “getting worse and worse” – on the contrary, she told us that she was going to follow her doctor’s treatment plan,

and she had just quit smoking ‘cold turkey’ 15 days prior to our visit. But she rejected the idea of being more physically active, saying, “Not all elderly people should be rehabilitated – some just can’t, and the government shouldn’t push for this” (*field notes; 30 October 2014*). Here, Johanne acted as a ‘rational consumer’ by deciding to participate in radiation treatments and quitting smoking to extend her life. But she also made it clear that she was not interested in the choice that Brynja offered with regards to “taking over” and engaging in physical activity to, perhaps, improve her quality of life.

In these situations, the mindful agency of active citizen-consumers can present challenges to the political goals for self-governance and responsibility, and a citizen’s resistance to being managed by the municipality in this way can be especially frustrating to the Visitors. As Brynja told me:

There are some [citizens] who are completely obstinate, and you can’t change much for them. (...) There are many who think, ‘I just don’t want to.’ And again, it comes down to our evaluation – should they get help, or not? And it’s a really fine balance with regards to the fact that they should get help if they actually *can’t* do something. But you can get a little annoyed if they won’t at least make an effort themselves. (...) Even if you’re in a wheelchair, you can wipe off the table next to you. Find the small, small tasks that can make someone feel meaningful.

Interview; 25 February 2016

Here, Brynja expressed annoyance with elderly citizens who “just don’t want to” because – following the rhetoric of active ageing in the Third Age and the government’s push for limitless productivity and self-help – she believed that citizens should “at least make an effort themselves” and not be *passively* needy. Rather, she expects the elderly citizen to demonstrate rationality, self-sufficiency, and a degree of control over their physical body, and to choose to be engaged with the services being provided.

Brynja also pointed out that participating in certain actions – even “small tasks” like wiping a table – “can make someone feel meaningful” despite physical limitations such as being in a wheelchair. From a political perspective, it is important for elderly citizens who receive municipal assistance to “make an effort” and choose to take responsibility for their own care; following the rhetoric, engaging in activities that might make them feel meaningful will improve their quality of life. But finding meaning in the small tasks also constitutes these citizens as a subject and creates a market value for their efforts, which benefits the competition state. This logic of choice frames self-care not only as a moral obligation but also assigns blame to citizens

who may make the ‘wrong’ choices and fail to ‘properly’ manage themselves in accordance with the municipal guidelines (Otto 2013). In addition, because municipal welfare services have been constructed as a needs-based offer and citizens have been constructed as consumers of these services, it means that they can choose to attain an improved quality of life by deciding to begin anew. According to social-gerontologists Christopher Gilleard and Paul Higgs, “The individual consumer is expected through the development of self-knowledge and self-expertise to be able to achieve a particular internal state – through his or her choices” (Gilleard & Higgs 2000: 82). Of course, this choice also means that freely acting consumers are able to question and negotiate the terms of the offers they are given, which I discuss in the next section.

3.3. The mindful agency of active consumer-citizens

Gentofte’s structural strategy for reducing health risks focuses on providing an environment that “makes it easier for citizens to make healthy choices” (Gentofte Municipality 2012: 4). By expecting and encouraging the citizen to make healthy choices – i.e., to “take over”, to “take responsibility...as long as they can”, and to not “get worse and worse”, in the words of the Visitators – this political discourse suggests that citizens are somehow inherently passive, incomplete, and not doing *enough*. Thus, as I have discussed, there is a focus on “management by activity” (Katz 2000: 148), and the state expects even elderly citizens to *choose* to engage in more physical activity in order to improve their quality of life. In contrast to the ‘golden days’ of the welfare state, in which the provision of care and supportive services was guaranteed and framed as a universal right of citizenship, older people can no longer assume that they will automatically receive long-term assistance from the municipality, despite having contributed to the welfare system for their entire lives. For example, the Visitator Britt described one of the biggest challenges she experiences in her work: “It’s when [a citizen] thinks they should have some service just because they’ve paid their taxes. It’s a classic challenge, but it’s true. It can be really hard to get them to understand that house-cleaning isn’t – well, it’s something we’d *all* like done for us” (*interview; 1 March 2016*). As a group, the Visitators often discuss how frustrating it is that citizens want ‘free’ housekeeping and then complain about the services they do receive; according to the Visitators, older citizens “just [don’t] understand” that “this is how the law is” (*field notes; 22 October 2014*), which suggests that this epistemology has become embedded in the Visitators’ worldview.

I saw this “classic challenge” enacted when I followed the Visitor Sanne to re-evaluate Dyveke’s situation. Dyveke (age 86) is a widow who lives alone; according to her journal, she was diagnosed with leukaemia 20 years ago, but has been in remission for many years. More recently, however, she had been diagnosed with depression and is having trouble managing daily tasks around the home. Dyveke was evaluated by another Visitor (Karin) several months ago, who recommended that she start a program with the Training Team. However, it appeared that Dyveke had not followed through with training after the initial visit; instead, she contacted Visitation again to receive help with housekeeping. In my field notes, I wrote:

When we arrive, Dyveke invites us to sit on the sofa in her tastefully furnished living room; she has a lovely small apartment with large windows that look out onto a quiet residential street. Sanne begins the evaluation by asking how Dyveke has been doing lately.

Dyveke: Well, I have a cancer on my back...it’s not too serious, but it needs to be removed. I also have it on my hand. [*She shows us her hand, with a small bandage covering the melanoma.*] Really, I’m just so tired at the moment – I feel a little heavier than usual. (...) I’ve always been able to manage for myself – cooking, cleaning. But I’m just so tired. I’d really like to get outside, but it’s not so nice right now. (...) I really need help with vacuuming. (*There are several small rugs on top of the carpeting, which covers the entire apartment.*) I can do it myself, but I’ve had some falls.

Sanne: Do you tend to vacuum the whole apartment all at once, or break it up?

Dyveke: Usually, I wait for a day when I feel good, and then I can manage [the whole apartment]. (...)

Sanne: I understand that you got a visit from the Training Team – how did that go?

Dyveke: Well, it’s different from how I usually vacuum – completely different.

Sanne: Do you feel like you have less energy now than when my colleague was here [in the summer]?

Dyveke: Absolutely. I’ve had leukaemia and now skin cancer, so I’ve felt very low.

Sanne: So what do you think about vacuuming with the Training Team? They were impressed by how mobile you are... I’m not sure the municipality can give you help with it.

Dyveke: Oh, I understand. I’m sure there are others my age who need the help – others with less strength. It’s just that I feel it in my back...

Sanne: Well, we could have the Training Team come out again...

Dyveke: They’ll just tell me to do it a certain way. It’s difficult to take the vacuum out of the cabinet, and they won’t move the furniture. I like to watch TV in the other room while I eat, so the furniture there in particular needs to be moved.

Sanne: But vacuuming is also exercise. You could see it as exercise...

Field notes; 20 November 2014

In this example, both Sanne and the Training Team (indirectly) consider Dyveke to be very “mobile” (i.e., active and functionally able) and thus physically capable of vacuuming her own apartment; as a result, Sanne determined that Dyveke was not eligible to receive help from the municipality, even though Dyveke was feeling exceedingly tired and depressed due to her

various illnesses. When Sanne wrote her decision letter after the visit, she noted that Dyveke was able to set daily goals for herself – she walked regularly with her walking sticks, went out to buy groceries for herself, visited her sons’ families, etc. – thus, Sanne concluded that Dyveke’s functional level was “not restricted”.

In other words, she believed that Dyveke’s body, in the temporal framework of the evaluation, was mobile *enough* to do the vacuuming herself. Sanne also made a special note in Dyveke’s journal: “The citizen can vacuum but chooses to do the whole apartment at once, rather than breaking it up (as recommended).” Even though Dyveke reported that she felt “heavier than usual” and “very low”, Sanne did not address Dyveke’s psychological or emotional state during the evaluation. To overcome feeling “low”, Sanne suggested that Dyveke should join local exercise classes and take more walks outside – and that she should even think of vacuuming as exercise – because she is “not restricted” and thus able to do so. This example elucidates the municipal epistemology of physical activity as a cure-all, and it also highlights how the citizen-consumer feels they have the freedom to question – and even reject – the services and opportunities they are being offered. There is a negotiation of power between Sanne and Dyveke, as Dyveke debates the first Visitor’s decision to send the Training Team and then points out to Sanne that she “feels it in [her] back” when she does try to vacuum. This suggests that Dyveke has an expectation to receive the services that she believes she is entitled to – that she *chooses* to receive.

However, as political scientist Tine Rostgaard writes, “the communicative logic of free choice is essentially to ensure the individual a position as a consumer in the organisation of welfare” (2006: 445), and she contends that being free to choose can present certain risks. In addition to the moral implications of making the ‘wrong’ choice, I argue that the citizen’s freedom to choose challenges the Visitors’ authority and expertise, as well as her responsibility to make rational decisions regarding a citizen’s need for services. In their evaluations of citizens, the Visitors tend to echo the political rhetoric; specifically, that choosing to “manage themselves” (*see* page 45) and being more physically active will make elderly citizens’ lives more “meaningful” and prevent them from “becoming worse and worse”. But, with the discursive move from providing help to enabling self-help, the role of the Visitors is also transitioning: they are no longer simply authoritative managers who use their professional expertise to evaluate the citizen’s present body *as is*, and then determine what a citizen needs before deploying the appropriate service providers. Now, the Visitors must shift their perspective and assess the citizen’s body in terms of its ability to *retain* functionality; as Brynja said (*see* page

91), “[When] the municipality gets the first referral from a citizen regarding assistive devices or something – you already begin to think, ‘Could there be a need for physical activity or training that could maintain or prevent a decrease in function?’” (*interview; 25 February 2016*).

Viewing the elderly citizen’s body in terms of its “need for physical activity or training that could maintain or prevent a decrease in function” suspends the body in a particular temporality – i.e., that it should be able to *remain* productive in its current physiological state while it also points to the corporeal body’s ability to continue to act in new ways – specifically, to produce labour to *regenerate* its life processes (Arendt 1958: 99) for as long as possible. During their evaluations, the Visitors offer elderly consumer-citizens a rational, moral choice to take responsibility for their own health; and, as I discuss in the next section, the Visitors’ promise of a return to productivity activates the citizen’s freedom to begin something anew (*ibid.*: 9). Being able to judge the available choices and thereby act in a particular way provides the citizen with a sense of initiative; specifically, whether or not to remain a competent, social agent.

3.4. Engaging the ‘limited yet limitless’ body

In their (usually) one-time evaluative visits, the Visitors assess the citizen’s physical body and examine the temporal dichotomy of what it is/is not capable of doing right now, as well as how it functions within its physical surroundings (most often in relation to the spatiality and materiality of the citizen’s home environment, which I explore in Chapters 5 and 6). But, as I have already discussed, the government’s focus on enabling self-help now means that a citizen’s need for care and support is no longer pre-given and, due to the operating logics that inform their work, the Visitors must assume that all citizens will choose to take responsibility for improving their own health and quality of life. Thus, the Visitors follow the political directive “to support the citizen in living a life that is as independent and active as possible” (*municipal pamphlet*), which means that an elderly citizen should no longer be a dependent, standardised object of attention. Rather, the Visitors expect to engage with what I call a ‘limited yet limitless’ consumer (*see* page 12) – a particular kind of citizen that has been constituted by political discourses and institutional thinking. As I described, this post-retirement citizen may suffer from particular health limitations but still has unlimited value as a contributing member of society. Moreover, this citizen is also constituted as an active subject who should choose to (re-)produce labour indefinitely and adopt the healthy-ageing paradigm of the Third Age.

During their interactions with elderly citizens, the Visitors often use the phrase ‘for as long as possible, which suggests that the body’s “labour power, like any other energy, can never be lost” (Arendt 1958: 133). I argue that the formulation of ‘for as long as possible’ implies a promise – not necessarily of immortality and infiniteness, but rather the promise of a fulfilling life that will continue to (re-)produce biological labour and remain active with a vague, indeterminate end. This articulation reinforces the conceptualisation of the elderly citizen as a rational consumer who has the freedom to choose how they want to act. In a market-driven society that discursively positions citizens as individual consumers, these active agents must be told how to behave and what to buy (Powers 2003: 231) among the choices available to them – and, with regards to health behaviour, they must take the production of their bodies seriously, learn how to mitigate risk, and “buy into a lifestyle that creates the kind of self that he or she desires” (ibid.). Thus, the Visitors’ evaluations focus on “why we want them to keep active”; specifically, the Visitor Brynja said that she wants elderly citizens “to understand why we don’t just throw help at them. (...) if they just sit down and get helped, they’ll only get worse” (*interview; 25 February 2016*). Here, “getting worse” signifies greater physical deterioration, disability, and decay, which will put strain on the state’s economy due to a need for more supportive services, medical treatment, and possibly hospitalisation. This idea was emphasised by the Visitor Britt, who said, “The most important thing is for [citizens] to understand that they have to – and should have the desire to! – take responsibility for their own lives as long as they can” (*interview; 1 March 2016*). In other words, citizens should be rational and *choose* to take responsibility for their health, their actions, and the ongoing production of life. Participating in self-helping activities will thereby make their lives “meaningful” (*see Brynja’s quote, page 98*), but taking (or not taking) responsibility constructs a certain moral narrative about the choices one makes.

I saw this when I accompanied the Visitor Freja to evaluate Ejvild (age 90) after he was discharged from the hospital following surgery on his lower intestine. He is almost completely deaf and also has heart problems, so his doctor recommended that a Visitor evaluate his living situation to ensure that he could take care of himself at home; he and his wife had also recently applied for a placement in an assisted-living facility subsidised by the municipality. During the

assessment, Freja asked Ejvild how he was managing various activities of daily living (ADLs⁴⁷) – these are the specific areas that she needed to assess. Ejvild could manage many of these tasks; e.g., he could bathe himself, get dressed, read the newspaper, walk with a cane, and climb the stairs unassisted. In my field notes, I wrote:

Freja: You have the right to attend free exercise sessions and activity classes offered by the municipality. The classes are held nearby, so you can get there easily.

Ejvild: Yes.

Freja: You'll also be able to get out of the house and talk with the other participants.

Ejvild: Uh-huh.

Freja (*looking at her notes*): It might also be good for you to go out for regular walks again, especially once the weather warms up. That will help [improve] your energy and allow you to sleep better at night.

Ejvild (*pleasantly but firmly*): I'm doing fine!

Freja (*nodding*): Of course, you need to decide for yourself.

Field notes; 3 December 2014

In her expert opinion (and following the political rhetoric), Freja believed that Ejvild would benefit from attending exercise classes for the elderly at a local activity centre, and she gave him the choice to participate; however, as an active citizen-consumer, Ejvild insisted that he was “doing fine!” Thus, he expressed his “needs, wishes, and priorities” (*see* Figure 1, page 52) as a citizen-consumer and made a choice among the ‘opportunities’ that Freja presented to him. She framed these opportunities – to attend activity classes and take regular walks – as a way to improve his energy, engage with other citizens, and sleep better because, as the Visitator Brynja said, “if [citizens] just sit down and get helped, they’ll only get worse” (*see* previous page). In this case, Freja gave Ejvild the choice of how he wanted to act; a decision that relates to the question ‘how shall I live?’ (Giddens 1991: 14) and the possible ways Ejvild can choose to improve his quality of life. The Visitators offer the citizen the choice to “decide for [themselves]”, which relates to whether they make the moral choice to remain productive, competent social agents. In this case, Ejvild decided that he was “doing fine!” and declined the municipal offer, thereby resisting the subject position of an ‘active citizen’.

Traditionally, when a Visitator determined that a citizen needed helping services, she would present them with two choices: either municipal services (which are free/subsidised) or private

⁴⁷ *Activities of daily living* (ADLs) are “basic self-care tasks (...). They include feeding, toileting, selecting proper attire, grooming, maintaining continence, putting on clothes, bathing, and walking”. *Source:* www.caring.com/articles/activities-of-daily-living-what-are-adls-and-iadls (last accessed 15 February 2017)

help (paid by the citizen) – and this private help must meet the same level of service quality that the municipality offers (Højlund 2006). But with the state’s need to manage its looming ‘elder burden’ and manage municipal costs, elderly citizens are now being given another choice – as I mentioned in the *Introduction* (see page 16), the national government activated §83-A of the *Social Services Act* in January 2015, and it states all Danish municipalities must offer a short, time-limited training programme to any citizen who has been evaluated as having decreased functional abilities and who could benefit from physical training at home. During the home visits I followed with both Visitation and Preventative Home Visits, I noticed that these health professionals were beginning to refer citizens to the municipality’s new Cross-disciplinary Training Team. Brynja told me that she considered this offer to be another “opportunity” for the citizen “to manage as many things as possible at home for the longest possible time” (*interview*; 25 February 2016).

As I have mentioned, the idea is that everyday rehabilitation will reduce a citizen’s overall need for in-home services – such as meal preparation, personal care, and house-cleaning – as outlined in §83 of the *Social Services Act*. The programme is specifically meant to re-skill a citizen’s functional ability, training them to remain independent and self-helping within their own homes. The offer is framed with the promise of an untapped potential: e.g., part of the text inside the promotional pamphlet says, “For Gentofte Municipality, it is valuable that you have a long and active life with a high quality of life ... We see ‘Train Yourself Free’ as an investment in you. If you become more active, you will preserve and increase your resources, so you can master your life as long as possible and avoid being dependent on others.”

This rhetoric – which emphasises remaining functional, productive, and engaged for ‘as long as possible’ – encourages citizens to choose a tantalising promise that is contained within the illusion of rational choice that the Visitors offer; i.e., the opportunity to partake in a ‘project of the self’ (Giddens 1991: 14), and to begin anew by keeping their bodies active and continuing to produce labour. In this way, they may become “seduced into dreaming of wonderful things: walking, freedom, health!” (Mol 2008: 26). Accepting this promise will benefit the competition state’s ongoing political need for active, healthy consumers, but it will also allow elderly citizens to maintain control of their physical body and thereby preserve their identity as a competent social agent. Thus, developing the citizen’s ‘potential’ is central to the political aims in establishing the Cross-disciplinary Training Team, especially as it relates to their work with an elderly citizen’s physical body; I discuss this in the next chapter.

Summary

In this chapter, I have described how elderly citizens in Denmark have been politically categorised as ‘limited yet limitless’ consumers who should be willing to take responsibility for their own health with the resources available to them in order to be more physically active and socially engaged, and thus contribute to the state’s continued growth and productivity. For the politicians, it can be problematic if an older citizen decides *not* to participate in health-promoting/-preserving activities – the main consequence being that they will be left to fend for themselves, eventually reaching a point of decline where they must receive municipal services, be institutionalised (e.g., enter a nursing home), or be hospitalised, which would have negative implications for the Danish competition state. Such an emphasis on self-governance, wherein a citizen is obligated to take personal responsibility for his own care in order to benefit society (Halse 2009: 51; Mik-Meyer 2014), combined with a focus on retaining the functionality of a citizen’s physical body as a resource to the state, thereby becomes strongly tied to morality (Taussig et al. 2013: S6). Instead of being dependent on others for help, the elderly citizen is encouraged to make the choices that the health experts want them to make; specifically, to decide to take control of their own health (Powers 2003: 232) and to engage in self-care. But this freedom to choose has implications for the authoritative power of the Visitor, as the consumer-citizen questions and negotiates her professional expertise as well as the choices and opportunities she offers.

I also described how the municipal epistemology emphasises the primacy of the citizen’s corporeal body. Thus, if the Visitor determines that a citizen is physically capable of managing more everyday activities for themselves, of preserving their functional ability, of participating in their own self-care, etc., they promise an improved quality of life, whereby elderly citizens can “increase your resources, so you can master your life as long as possible and avoid being dependent on others” (*municipal pamphlet*). If the citizen accepts this choice and responsibility, then the Visitors refer them to the Training Team, which is mobilised to re-skill the body and help transform it into an active, engaged, self-helping citizen who can become ‘free’ from the need for municipal services. By participating in the effort to re-learn or regain certain skills and a degree of control over their body, the citizen is promised the opportunity to retain their identity as a productive, competent social agent.

The practical work of the Training Team is predicated on the process of embodiment, which is meant to activate the older person’s corporeal body and develop its potential, inscribing certain

practices and actions onto it in order to make them habits. However, this training contains its own set of negotiations, conflicts, and dilemmas, as the therapists' endeavour to mediate the citizen's labour to develop the potential in their bodies; I describe this in the following chapter.

Chapter 4

Embodying potential

In this chapter, I discuss the work being done by the municipality's newly established Cross-disciplinary Training Team, which reflects the typical goals of most reablement and everyday-rehabilitation programmes; i.e., to help people “regain as much functional independence as possible following a period of ill health, an admission to the hospital, or a decline in function” (Aspinal et al. 2016: 3). Here, I focus on how the Training Team tries to follow the political rhetoric “to support the citizen in living a life that is as independent and active as possible” (*municipal pamphlet*) and approaches a citizen's physical body as a site of potential in which certain habits and competences can be embodied.

One of the meanings of potentiality is “a latent possibility imagined as open to choice, a quality perceived as available to human modification and direction through which people can work to propel an object or subject to become something other than it is” (Taussig et al. 2013: S4), and this conceptualisation is central to the therapists' approach. Specifically, their work focuses on training the corporeal body to ‘remember’ or re-learn particular actions, and the therapists act as a mediator for the practice of embodiment, communicating with the body to help the elderly citizen bypass their ‘faulty’ brain and make certain self-helping actions into habits. But this process also contains its own set of conflicts and negotiations. In the next section, I describe how the therapists try to locate and develop the ageing body's potential to be more self-helping.

4.1. Developing the body's potential for self-help

Once a citizen chooses to participate in the training offer⁴⁸, the therapists contact them to conduct an evaluation. The therapists may or may not refer to the citizen's online medical journal in the shared municipal computer system (KMD Care) in order to obtain background information written by hospital staff, Visitation, and/or other municipal departments, such as Home Care or Visiting Nurses. This process requires the therapists to interpret the texts and

⁴⁸ The initial referral can come from Visitation or the citizen's general practitioner (GP), as well as medical staff at a regional hospital or municipal rehabilitation centre such as Tranehaven.

notes written by other professionals who may have different perceptions, experiences, and epistemologies – all of which can influence the therapists’ approach to the citizen. As the physical therapist Erik told me, “I don’t like to look in the files too much beforehand – sometimes, it gives you a bad impression [of the citizen]. It’s better to go on the visit and make a ‘clean’ evaluation. Then look at the journal later for issues and inconsistencies” (*field notes; 1 June 2015*).

The everyday-rehabilitation offer is “a health-orientated effort to maintain the citizen’s functional abilities in a partnership between the citizen and [the team member] (...), where the focus is on the citizen’s everyday life and resources” (*municipal pamphlet*). Thus, in order for the therapists to train the citizen’s body to be more self-helping, they must re-skill the citizen’s ability to perform certain actions. The training typically takes its point of departure in whatever type of activity the citizen decides is important to them; e.g., going up and down stairs or taking a shower, lifting a laundry basket or vacuuming floors, putting on support stockings, etc., and the therapists emplot (Mattingly 1994) the training programme to build these specific actions. Most of the training focuses on ‘lighter tasks’ such as house-cleaning or walking to improve balance. As the occupational therapist Katrine told me, “Very often, it’s walking function or decreased strength in a leg or arm. And balance. That’s really ‘the classic’ because that’s what we see the most” (*interview; 5 February 2016*).

The therapists start their work by conducting an interview in which they meet with the citizen in their home and ask about the citizen’s everyday life (“I’d like to hear how you’re managing right now”). Depending on the citizen’s personal situation, the therapist might also go over the different municipal services that the citizen has received or is receiving, such as Home Help; during the course of this conversation, the therapist attempts to identify the ‘sites of potential’ where the citizen might be able to regain a sense of control and functionality. The therapists typically ask the citizen to show them or describe what they are having difficulty managing their everyday lives. As the physical therapist Sofie told me, “[In these conversations], I try to capture something or other that they could consider doing themselves” (*interview; 21 December 2015*). Reablement programmes typically frame the citizen as “an expert in their own life” (Aspinal et al. 2016: 2); thus, the therapists give the rational citizen-consumer the opportunity to choose the specific activities that would allow them to feel like a more self-helping, competent social agent.

Next, the therapists assess the citizen's functional ability. This evaluation typically consists of going through the 'ADL'⁴⁹ taxonomy' chart, which is widely used "to measure and describe ability related to a variety of everyday activities. The test is based on the individual patient's needs, and the measurements are done by either interview or observation"⁵⁰. The therapist usually writes her evaluation on the document (e.g., + means 'independent'; 0 means 'with help'; ÷ means 'cannot do it') during the assessment. The therapist may also take notes in order to fill out the Rivermead Mobility Index (RMI), which is a simple evaluation tool used to measure functional mobility and assess an elderly citizen's ability to independently move their own body. It was originally developed to evaluate the progress of patients who had suffered a stroke, but it is now commonly used by many physical and occupational therapists as a baseline measure for functional ability. It includes questions such as, "Can you turn over from your back to your side in bed?", "Can you manage to walk one floor up or down by yourself without help?" and "Can you get in and out of the shower/bathtub by yourself without supervision, and can you wash yourself?"⁵¹ The 15-question questionnaire is filled out with a 1 for 'yes' and a 0 for 'no'.

Similar to the Visitation evaluations, the Training Team's assessment focuses on the citizen's physical body and the temporality of what it can or cannot do *right now*. But the therapists must also try to locate the body's future-orientated potential. For example, I followed Sofie throughout a training programme with Norah (age 79), who lives by herself in a small apartment. Norah has been in the municipal system since 2009, when she suffered a stroke. In addition, she fell and severely broke her leg in 2001, which has caused her problems ever since; she also has partial sight in her left eye (caused by a work accident) as well as osteoporosis. Most recently, she was hospitalised for three days – according to the Visitor's notes in Norah's online journal, it was because she had another small stroke ("admitted after a blackout at home – blood clot in the cerebellum"). In the referral, the Visitor wrote that Norah would like to participate in physical training now to help her "regain her former skills" so she can be "freely

⁴⁹ ADLs = activities of daily living; *see* footnote 29 on page 66.

⁵⁰ *Source*: <http://fysio.dk/fafo/Maleredskaber/Maleredskaber-alfabetisk/ADL-Taxonomi/> (last accessed 15 February 2017)

⁵¹ To answer the question "If you drop an object on the floor, can you manage to walk 5 metres, pick it up, and walk back?", some therapists will drop a pen on the floor and ask the elderly person to retrieve it. Most of the therapists fill out this form at the beginning and again at the end of a course of training; however, this is usually done once they have returned to the office and not together with the citizen.

mobile and self-reliant” again, and the Visitation recommended “training everyday activities in the home, and on the street/stairs” (*field notes; 26 October 2015*).

Prior to the evaluation, Sofie interpreted this referral and told me that she expected to primarily work on Norah’s ability to walk – especially on grass and uneven surfaces outside – in order to help improve her balance function. But, following the political rhetoric (*see* Figure 1, page 52), she also had to take Norah’s own needs, wishes, and priorities into account. In my field notes from this first meeting, I wrote:

Sofie asks if Norah has any particular wishes for the training sessions; she emphasises that she takes her point of departure in what Norah specifically wants to focus on and accomplish, such as walking outside or being able to open the apartment building’s heavy front door. Norah says that, primarily, she would like to be better at walking. As things are now, she needs to look down at the paving stones on the sidewalk or hold on to furniture inside in order to keep her balance: “My greatest wish is to be more confident.” (...)

Sofie asks to see the rest of the apartment so that she can evaluate Norah’s walking ability. Norah eagerly stands up and gives us a brief tour of her small, orderly home, which – despite her having quit smoking while she was hospitalised – still reeks of stale smoke. She is especially proud of her small stepping-machine, which is placed under the large window in her bedroom. She says, “I like to look outside at the garden while I do my 50 steps. Every day!” We end up in the kitchen, where Sofie administers the ‘sit-to-stand test’⁵². After some instruction from Sofie, Norah manages eight stands.

Field notes; 26 October 2015

As Sofie and I talked in the car on the way back to her office, she told me that these introductory visits always gave her deeper insight and understanding into the reality of a citizen’s situation. In this case, the evaluation highlighted certain inconsistencies – for example, Norah told us that she had difficulty going up and down about 10 stairs in her apartment building, yet she also proudly pointed out that she could manage 50 steps on her step-machine with no trouble – “every day!” In Sofie’s opinion, this suggested that, although Norah may appear physically fragile in some ways, she was actually quite strong: “People with osteoporosis tend to have a

⁵² Known in Danish as ‘rejse-sætte-sig’ or RSS, this chair-stand test is used in almost every introductory visit; here, the elderly person is encouraged to complete as many full stands as possible from a seated position in a sturdy chair within 30 seconds while holding their arms crossed over their chest. *Source:* www.rehabmeasures.org/Lists/RehabMeasures/PrintView.aspx?ID=1122 (last accessed 15 February 2017)

fear of falling and want extra support. So, Norah's issue is more mental. (...) But she has great potential" (*ibid.*).

This example illustrates how the therapists view the body as a site of future potential when they conduct their initial evaluations of a citizen's physical function. They have to interpret the texts from other actors in the municipal system (i.e., the Visitor wrote that Norah wanted to be "freely mobile and self-reliant" again) as well as the municipal rhetoric ("If you become more active (...) you can master your life as long as possible and avoid being dependent on others"), and then, as Sofie said, "try to capture something or other that [the citizen] could consider doing themselves". But she also had to determine whether Norah's self-knowledge and self-expertise were *rational*; the inconsistencies between what Norah said and what she did suggested to Sofie that Norah's "issue is more mental". Thus, Sofie determined that she was afraid of falling and needed extra support to feel more confident in taking the stairs, and in order "to support the citizen in living a life that is as independent and active as possible" (*municipal pamphlet*), Sofie chose to focus on Norah's future potential to go up and down the stairs. In her training notes after the evaluation, Sofie wrote that Norah "walks with a wide gait and some wobbling to stabilise her walk"; she expected to train with her for eight sessions, primarily focusing on the stairs as well as walking outside to improve Norah's balance and confidence.

In order to develop the citizen's potential, the therapist has to engage in a specific form of dialogue with the corporeal body. As I discuss in the next section, the process of embodiment requires communication between the therapist and the body as they work together to develop the citizen's potential for self-help.

4.2. *The embodiment of self-helping habits*

"The body remembers." This is what many of the therapists say to the elderly citizens with whom they are working. For example, when the physical therapist Janette was showing Lumikki (age 83) how to clean the floors of her apartment without aggravating her hips and back, Janette said it specifically with regards to being physically active in order to preserve functionality:

The body remembers exercise, and the muscles need to keep being used. (...) It's especially important for women over age 50 to stay active – after that, the body starts to become tight and

inflexible and lose muscle. (...) It can cause a lot of problems, so it's good to keep moving – walking the dog, going up stairs, and such.

Field notes; 5 November 2014

Janette made the same point to Ida (age 93), who has Parkinson's disease. At the time of training, Ida was very reliant on her rollator, so the training goal was to strengthen her legs and work on her balance so she could more easily manoeuvre around her one-storey house. On the way over to Ida's house, Janette told me that Ida's mind is very sharp, but she has trouble remembering details and instructions. During the training session, I wrote:

After Ida finishes her coffee, Janette says, "Are you ready for some hard training? (...) We need to show you how to sit down in a good way." Ida agrees and stands up next to her rollator, before sitting down hard on the chair and pushing the rollator away, as she had done before. Janette gently admonishes her: "You know what should happen in theory. (...) You can hold on to the hand-rests, but it's important to set the brakes first before you sit down." Ida says, "Oh. I didn't remember how to do it."

She stands up again easily, and Janette tells her to take a walk around the living room, which is adjacent to the kitchen. When she reaches the kitchen table again (after about 30 steps), she remembers to set the rollator's brake before sitting down. Janette seems pleased and wants her to try sitting down in one of the soft, low armchairs in the living room. Ida walks in there and sits down 'properly', but Janette has to remind her again to set the rollator's brake. She gives Ida three clear instructions: "1. Feel the chair behind your knees; 2. Set the rollator's brake; 3. Turn securely and sit." Ida successfully repeats this sequence. (...)

There are only five more minutes left in the training session, so Janette says she wants to show Ida how to stand straighter at the rollator.

Janette (*as Ida stands up*): Now lift your chest...

Ida: But my balance is bad – I've fallen before.

Janette: The problem is overbalance – you over-compensate. You need to train more, and it will help.

Ida: But I forget the instructions...

Janette: The body, it remembers.

Ida: Why is it so important?

Janette: Because it can be dangerous without the brake on, and you don't want to fall again.

Field notes; 8 June 2015

Although none of the citizens I observed had significant cognitive impairment, the therapists often emphasised this type of 'muscle memory' as the best way for elderly citizens to remember exercises and instructions (Flanagan et al. 2001: 492), especially with regards to preventing falls and otherwise reducing risk. This is reminiscent of the historical policy discourse and the traditional medical paradigm that objectifies the body and its subjective, lived experiences (Twigg 2006: 83), focusing instead on the body's physical coordination and reflexes. But, for

the therapists, training the body to remember or re-learn particular movements is also a way to bypass a ‘faulty’ brain. The physical therapist Sofie explained:

With elderly people – people who have had a stroke or some type of brain injury that developed later in life – it can make the most sense to train so that the body can remember. It might be that the brain can’t remember very well, but the body knows those movements – and then you train through that.

Interview; 21 December 2015

As such, Janette was trying to help Ida master certain operations on her own body and way of being, which would ultimately allow Ida to transform herself; i.e., to gain more power and control over her body, which would reduce her risk of falling, and thereby make her more self-helping and capable of living independently. Part of the training is also focused on repetition – especially performing the same movement (setting the brakes on the rollator) in different environments (the kitchen, the living room). The therapists thereby work to help an elderly citizen embody certain practices as motor habits that are related to the physical world. In order for the training to have meaning and become a motor habit – to shift from theory to practice, or from figurative to literal meaning (Merleau-Ponty 1962: 146) – Janette worked with Ida to embody the ‘operative intentionality’ of setting the brakes on her rollator – i.e., by repeating the action of the operation with her body, Ida should eventually be able to gain knowledge of “what to do with an object without any reflexion” between her thought and action (ibid.).

However, the physical body is sometimes so compromised by age-related decline or illness that it does not remember these routine actions or habits. In these cases, the embodiment of actions does not happen easily, which can present a challenge to the therapists. For example, Ulla (age 78) has chronic obstructive pulmonary disease (COPD), which affects her breathing and circulation; she has also undergone several surgeries to her back (for a disc prolapse and stenosis), as well as a knee replacement. Prior to the initial visit, the occupational therapist Katrine told me that Ulla seemed very motivated to train; according to Visitation’s notes, Ulla wanted to maintain her current level of functionality and prevent any further loss of independence. At the time of the training, she was dependent on her rollator, but was otherwise “very well-functioning” (*field notes; 28 October 2015*) – one of the training goals was to show

her how to put on and remove her support stockings⁵³ by herself, so that she did not need a Home Care worker to do for her this every morning and evening⁵⁴.

However, Ulla was limited by constant pain. She told Katrine: “I want to walk more, but I just can’t – the pain is unbelievable. It just fills everything” (*ibid.*). During a subsequent training session that focused on the support stockings, Ulla told us that she had ordered new stockings because the old ones were too tight, which caused more pain in her legs. But she was determined to train with the old stockings, anyway. Katrine told her, “It really requires arm muscles [to put them on and take them off]. But you’ll train it in a way that’s like daily training” (*field notes; 24 November 2015*). Here, Katrine was trying to take Ulla’s attention away from her painful leg by telling her that putting on support stockings actually requires more *arm* strength. Katrine judged the level of pain that Ulla was experiencing, and then adapted her instructions to ‘re-wire the circuit’ in how Ulla approached this task – in other words, if Ulla focused on using her arms, she would not think about the pain in her leg as much when performing the action. Katrine also emphasised that it would become easier because Ulla will train every day to put on/remove the support stockings; in this way, the action will become a habit.

Embodied action or activity, which is our way of being-in-the-world, is fundamentally based in ‘habits’; i.e., acquired skills, schemas, and techniques that can be applied and modified as appropriate to promote a sense of stability (Merleau-Ponty 1962 in Crossley 1996: 101). During training, the process of embodiment requires a citizen to have the conscious motivation to act in a certain way; this experiential awareness is the “touchstone of a free act” (Arendt 1978: 26), and the anticipation of accomplishing certain actions can fuel motivation (Giddens 1991: 64). Thus, Ulla was motivated to train with her support stockings despite the pain she experienced because one of her goals was to “walk better than I do” (*field notes; 28 October 2015*), and she can only walk if she has the stockings on. However, before Ulla can master and embody any action as a habit, Katrine’s training must also work to stabilise her physical, acting body and

⁵³ Support stockings are meant to improve circulation in the body, which is vitally important to someone with a cardiopulmonary condition such as COPD. They are typically custom-measured and fit, and are extremely tight. Putting these stockings on is an arduous process that can take several minutes for even an experienced, able-bodied professional to perform, and it typically requires the use of several assistive devices (e.g., a blue floor-mat, silky white assistive sock, green plastic bag [which Ulla dubs ‘the green monster’], and special adhesive gloves).

⁵⁴ While the political rhetoric focuses on the importance of training citizens to be more self-reliant and independent, this is primarily a cost-cutting measure; one official in Odense Municipality estimated that, by training 100 citizens to put on their own support stockings, the municipality could save 1.7 million DKK (ca. 230,000 Euro) per year on staff expenses. *Source:* <http://www.tv2fyn.dk/node/38238> (last accessed 17 February 2017)

focus on it in a very specific way. Repetition and praise are central to this process, which I describe in the next section.

4.3. The importance of repetition and praise

In order to inscribe forms of knowledge on the body that will support its continued labour and regeneration, repetition and praise become important to the training process, as I saw during the next session with Katrine and Ulla. Since our previous visit, Ulla had received her new stockings, and had moved her assistive supplies into the bedroom because she wanted to be able to take off the stockings before she went to bed and put them on again when she woke up; i.e., she wanted to make this practice part of her daily routine. For Katrine, it was important to focus on establishing the habit of putting on the stockings.

Ulla: I've trained a lot since the last time you were here.

Katrine: Can you remember the steps?

Ulla: Put the white sock on... (*Katrine points, prompting Ulla to fold over the edge to 'lock' it between her toes; Ulla keeps adjusting herself on the bed while putting on the 'green monster', then she pulls up on the stocking and grunts with effort.*)

Katrine: It really takes strength!

Ulla (*breathing heavily*): Thank you – it really does. (*After successfully putting the stocking on and waiting a minute to catch her breath, she begins to take it off again.*) (...)

Katrine goes over the steps again and has Ulla keep trying: on and off, and on and off again.

Suddenly, Ulla seems to forget how to use the white sock – the stocking's seam is crooked, and the white sock is almost completely out of the stocking in the front. Ulla tries to straighten the seam by pushing her foot sideways across the mat, which just twists it further. Katrine suggests that she try to pull it up; Ulla does, and breaks a fingernail. Ulla tries to push her foot again, and Katrine suggests she use the adhesive gloves. She does and finally manages to get the stocking into the correct position. Katrine triumphantly says, "Mission completed!"

Field notes; 9 December 2015

In this example, Katrine was trying to help Ulla embody the habit of putting on her support stockings so that she could gain practical mastery over her body – as I already mentioned, the physical training is meant to inscribe a particular kind of knowledge onto the body. But Ulla's body did not easily remember the steps required to master this action; she had to actively think through the process, performing the actions again and again, which became more difficult when she experienced pain or became fatigued. Thus, Katrine had to re-direct Ulla's attention and

praise her physical efforts *while* she was performing the action – for example, by acknowledging that the action ‘really takes strength!’ and then triumphantly saying “Mission accomplished!” when Ulla succeeded. Here, the act of praising⁵⁵ accomplishments during an activity produces a flexible power of action and reaction; in this case, Ulla felt a sense of accomplishment when she finally performed the action herself.

In Ulla’s case, the goal for training was for her to acquire a practical mastery of certain skills that would make her feel more secure and competent in her everyday life, thus increasing her well-being and quality of life. But she was also expected to become a ‘limited yet limitless’ consumer – although she has certain physical conditions that limit her functionality and mobility, working in a partnership with a municipal health professional like Katrine should enable Ulla to gain mastery in the operative intentionality of particular actions and thereby become more self-helping. Katrine’s job is to provide Ulla with the necessary tools, support, instructions, and praise for these self-helping actions to become embodied over time; as a result, Ulla can be empowered to retain her subject position as a competent social agent. By investing resources into providing this form of training to elderly citizens, the municipality expects a return on its investment; i.e., that training their bodies will enable people like Ulla to remain independent and suspended in the paradigm of the Third Age, where they can continue to be rational and productive consumers.

However, like many people living with a chronic health condition, Ulla experiences a bodily struggle in that, no matter how much focused attention, experiential awareness, and willpower she invests into putting on her support stockings each day – and no matter how much praise Katrine gives – her body simply lacks the physical ability to consistently manage the action. Despite Ulla’s intellectual understanding of what she needed to do (and her active motivation to do so), her physical body still struggled with the practical action; i.e., the conduct of the operation. As such, her body is not likely to remember how to perform this action so that it becomes an intuitive, embodied habit: “A skill is finally and fully learned when something that once was extrinsic, grasped only through explicit rules or examples, now comes to pervade [one’s] own corporeality” (Leder 1990: 31). Due to the severity or complexity of their physical

⁵⁵ The type of praise given by the Training Team is markedly different from the praise and acknowledgement given by Visitation. For example, the Visitation Brynja told me, “Many [citizens] already do lots of good things, so I have to recognise that they already do. [...] I have to say] that ‘you already do lots of good things but maybe you could also do this and that’” (*interview; 25 February 2016*). This type of approach emphasises that, whatever “good things” a citizen may be doing to manage for themselves, their efforts may still not be ‘enough’ in the eyes of the municipality.

conditions, some older citizens may remain limited and unable to achieve the limitless promises of the Third Age; this creates challenges for the therapists, as they struggle to locate the body's potential. I discuss this in the next section.

4.4. When the body lacks potential

The municipal promotional materials state that the training offer will allow citizens to “regain as much of their physical functional level as possible”, and that it “will support, guide, and motivate you to be ‘master of your own life’ and manage your everyday life to a higher degree” (*municipal pamphlet*). But the training offer is time-limited, and it is simply not possible to develop the potential for continued labour and productivity in some bodies. For example, Walther (age 67) has a progressive neurodegenerative disorder known as *spinocerebellar ataxia type 1* (SCA-1). This hereditary condition affects the region of the brain responsible for muscle coordination and control, and thus causes clumsiness due to a loss of motor control, a broad gait with balance problems and a tendency to fall, erratic eye movements and double vision, as well as poor speech and trouble swallowing. The disease generally develops between ages 30–50, and Walther was diagnosed 10 years ago. During the initial visit (*15 October 2015*), he told the occupational therapist Katrine that his disease is progressive – things had been going fairly well for him, but he wanted to receive training at home in order to maintain his current level of functional ability as long as possible; they agreed that he might benefit from four or five training sessions. Among other things, they decided to focus on walking outdoors with Walther's rollator, which Katrine believed would make it much easier for him to get around and manage his daily activities.

During a subsequent visit, Walther explained that he had received some training on how to use the rollator, but he was still uncomfortable with it; he thought it had not been properly calibrated for him. He said, “My daughter and brother think it's too bad that I can't use it – I'd like to use it because I can hold on to it” (*field notes; 22 October 2015*). Katrine explained that the rollator is meant to help people who have compromised or poor balance, and she suggested that he could use it on his regular walks down to the bakery nearby. Thus, walking with the rollator was the focus of their next training session and, immediately after Katrine and I arrived, we all went outside to the parking area in front of Walther's house to adjust the rollator's settings. Walther said, “I don't have much feeling or coordination in my hands and fingers, so it's difficult for me to make these small adjustments myself” (*field notes; 27 October 2015*).

In my field notes, I wrote:

We start to walk, taking Walther's usual route down the street. His gait is quite broad with his toes splayed out to either side ('pigeon-toed'), which he tells us is characteristic of his condition, but Katrine thinks he is in danger of stepping on the rollator's back wheels. He walks quickly, and Katrine instructs him on how to use the brakes properly, and also tells him that the rollator should not be out too far in front of him; his elbows should be at more of a 45-degree angle rather than out straight. (...)

When we come back inside and sit down in the kitchen, Katrine opens her computer to update her training notes; she reads them aloud to Walther as she writes.

Katrine: Was it hard to walk like that?

Walther: No, but I can feel it.

Katrine: I'm concerned about the position of your feet with the rollator, but I'm not sure how we can make it easier for you...

Walther: I don't feel insecure with it – I don't notice one foot or the other turning out.

Field notes; 27 October 2015

However, when we arrived for the next session (17 November 2015), Walther gave Katrine a brief information sheet about his condition; it listed "causes and symptoms" and "treatment and control". His doctor had given it to him when he was first diagnosed, and he thought she might want to have a copy – he pointed out that one of the symptoms listed is a "broad, unsteady gait". He told her that there is nothing that can be done about it; he takes medication to reduce his unsteadiness, but he will never be able to walk any better with the rollator: "My body just won't do it" (*ibid.*). Although Walther desperately wanted to train his body to retain its current level of functional ability, no amount of repetition or praise would allow him to embody these physical actions; in fact, the nature of his progressive neurological illness means that his brain will become more and more unable to control his body. He had already lost his fine-motor control and coordination; eventually, he will lose his gross-motor skills, including the ability to speak, chew and swallow, urinate and defecate, and he will eventually have to use an assistive wheelchair.

This type of situation is a challenge for the therapists because the municipal regime expects them to focus on the primacy of the physical body and its potential to embody the habits and skills that will allow it to be more active and self-helping. The physical therapist Sofie said the best part of her job is "when a person discovers that they can do more. [...It's] when they experience, 'God, I can do that again!' and to see that...reflection, that little bit of spark that

comes to them again, and happiness with it. That wonderment with it, they become almost puzzled over it” (*interview; 21 December 2015*). However, as I have discussed here, the process of embodying new habits – or re-learning previously embodied habits that should result in that “spark” – is not always straightforward. In Walther’s case, he acted as a rational consumer, and repeatedly attempted to perform the actions and exercises Katrine assigned to him – i.e., the forms of labour that his body *ought to* be able to do in order to remain productive – but his physical condition prevented him from embodying these habits. Despite her best efforts to work with his limited body, Katrine’s training was unable to help Walther become limitless so that he could remain a “‘master of [his] own life’ and manage [his] everyday life to a higher degree” (*municipal pamphlet*). Thus, Katrine decided to take another approach and focus on stabilising Walther’s home, which I describe in the next chapter.

Summary

In Part I, I have discussed how elderly bodies are assessed and managed by certain municipal health professionals. I first described the evaluation process conducted by Visitation, which is informed by a political ‘logic of choice’ and the municipality’s epistemology regarding the primacy of the body and its need for physical activity. In their visits with citizens, the Visitationists amplify the political rhetoric by offering active citizen-consumers certain opportunities to be more physically active, engaged, and self-helping, but this becomes a negotiation that has implications for the Visitationists’ professional authority. With the promise of being able to care for themselves ‘for as long as possible’, the Visitationists offer rational consumers a choice – a better quality of life, and the imagined possibility of continued labour and competence as a social agent.

The ageing citizen’s future potential to be self-helping is central to the political goals for establishing the everyday-rehabilitation programme – being able to master or re-master certain skills and habits is a way to increase bodily competence, and to reduce fear and anxiety around performing actions that may put the ageing, injured, and/or ill body at risk. In the competition state, it is important to reduce risk and prevent physical conditions that might affect the citizen’s ongoing productivity. Thus, the process of embodiment that occurs during training becomes a means to an (political) end, but the therapists often struggle to work with a corporeal body that is limited by pain, weakness, and a loss of function – and that, for a variety of reasons, may not always be able to “remember” how to embody certain physical actions.

The municipal rhetoric states that this form of training should “support the citizen in living a life that is as independent and active as possible”. But when the concept of ‘potential’ enters the rehabilitation process, it means that the therapists’ work is not limited to training the corporeal body to be more self-helping. In Part II, I describe how the professionals also work to transform and adjust the materiality of a citizen’s home.

* * *

PART II

WORK – activity related to the artificial world of structures and objects

The more independent you are, the less help you need and fewer people come by [from the municipality]. Some people, some elderly people, they would really like to stay in their own homes. But there can also be limits to their autonomy there – because they're on the third floor or there are some stairs, or cat hair everywhere.

Interview with Sofie, physical therapist; 21 December 2015

Introduction

As I discussed earlier (*see* page 43), certain governmental policies emphasise the citizen's right to a 'free choice', which works to construct the citizen as a rational consumer of such care services. At the political level, some scholars believe that this free choice is the state's attempt to manage social complexity; as such, it is considered to be "the obvious answer to the massive future challenges of an aging society in which the elderly will be more demanding in relation to the provision of public services" (Rostgaard 2006: 452). Therefore, in order to address the issues of an expanded public sector and to better manage a rapidly increasing elderly population, "domiciliary care for the elderly has become the political test case [for] the provision of the Danish notion of 'a free choice'" (*ibid.*: 444).

Specifically, elderly citizens are given a choice between receiving municipal services or private help (*see* page 44); this choice is "directly related to semi-marketisation, efficiency gains, and quality improvement" (*ibid.*). In this connection, one of the goals of municipal health services in general is how the welfare system can deliver "cost-effective and sustainable care for the elderly that takes into account the citizen's wishes and goals for life" (Rostgaard et al. 2016), which is also essential in relation to reablement programmes; as I mentioned earlier (*see* page 19), the Fredericia-model for everyday rehabilitation focuses on achieving the citizen's "hopes and dreams" for the future (Guldager 2011). In order to get closer to a citizen's hopes and dreams, the home has become a central site for municipal health evaluations and various care services. According to researchers at the Danish Health and Medicines Authority (DHMA), "There are several advantages to meeting the citizen in his own home. The citizen feels more comfortable with one-to-one contact in a familiar environment and does not have to think about

arranging transportation. By experiencing the citizen in his own home, it is easier for the visitor⁵⁶ to evaluate well-being and overall functional ability as well as practical problems in everyday life” (Henriksen & Hendriksen 2005: 7).

However, when the political realm enters the citizen’s private space, I argue that the home – like the body, as I discussed in Chapter 4 – becomes marked as a site of potential. In particular, the home becomes negotiated as a place that should enable the citizen to be more self-helping and properly ‘age in place’ according to a certain political agenda. The following chapters focus on two specific cultural meanings and values traditionally associated with the concept of ‘home’: privacy and security⁵⁷. These values formed a strong pattern in my empirical material, and my analysis outlines how the health professionals unsettle the home as a private place of everyday routines, ‘automatic’ habits, and acts of domestication⁵⁸ in order to help stabilise elderly citizens who choose to become more self-helping.

* * *

⁵⁶ This refers to any health visitor, not specifically visitors from Visitation or Preventative Home Visits.

⁵⁷ While a sense of long-term familiarity in one’s surroundings can be meaningful to many elderly people, who have often spent a lifetime in the same house or apartment, it was not particularly relevant for the citizens I followed through the training programme: each of them had already moved out of the larger homes in which they had raised their children, and they were currently living alone in smaller residences. All of my central informants had sold their houses and moved after their marriages ended: Lumikki, Norah, and Ulla moved after their husbands died, and Walther moved after getting divorced from his second wife. Norah had lived in her current residence for the longest period of time (9 years), but the others were much shorter: Lumikki (5 years), Walther (2.5 years), and Ulla (1 year). Walther was the only informant who lived in a house; the others had apartments. Each of them expressed a deep connection to Gentofte Municipality with regards to place identity and a sense of belonging (Williams 2002: 145), but the physical structure in which they lived was not particularly significant to them in terms of long-term familiarity; thereby, other values and meanings traditionally related to ‘home’ – such as continuity, family, possessions, and personal history – are not addressed in these chapters.

⁵⁸ Here, I make a distinction between ‘habits’ and ‘routines’: *habits* are embodied actions and movements (see Chapter 4), whereas *routines* are a sequence of actions performed regularly in everyday life; in other words, routines may consist of a series of embodied habits. *Acts of domestication* refer to private and intimate home-based practices, such as dressing/undressing, having sexual relations, bathing, toileting, etc.

Chapter 5

Navigating public/private divisions

In this chapter, I explain how certain spatial understandings and everyday routines must be destabilised *in order for* the private home (and a person's external environment) to be negotiated as a space that will reduce risk and support the citizen-consumer's choice to remain a competent social agent. As such, I describe how home health visits and evaluations as well as the training programme follow the political rhetoric and work to re-configure the ways in which an elderly citizen should be 'at home' with their material, physical surroundings. In the following sections, I discuss what it means for the health professionals to 'meet the citizen where they are', and how the home is assessed as a setting for self-help and ageing in place.

5.1. Crossing the home's threshold

Having a sense of being 'at home' is more than simply owning property or having an attachment to a certain place. For example, when asked if there was anything that would make her move out of her apartment, Norah (age 79) said, "Why would I? (...) I like being able to do the things that I want to do – without anyone asking anything about it. (...) Here, I have free reign. I can do exactly what I want – if I want to put my legs up on the sofa, then I can do it! Right?" (*interview; 15 December 2015*). Well, yes and no. Norah's perception of feeling 'at home' is both situated and contextual – to her, it means that it is the place where she can "do exactly what [she] wants...without anyone asking anything about it". In this sense, a residential home is often considered to be a private place; a place where the occupant is free to be him/herself and do whatever they please. In addition, the home is usually a place where the occupant(s) perform their most personal, intimate acts. And, as a site of private ownership or residence, the home is typically also where a citizen has the authority and power to decide who is allowed to enter their private space.

However, in my analysis of Denmark's health policies, elderly citizens like Norah need help in learning how to 'age in place' properly. Thus, the cornerstone of the municipal everyday-rehabilitation programme is the premise that training daily activities will improve the citizen's sense of security and stability within the home setting, which should reduce risks and allow the

citizen to be more self-helping; this will prevent hospitalisation and/or institutionalisation, and thereby ensure a better quality of life with less need to receive welfare services. When a citizen's competence and functional ability within the home setting become compromised due to illness or injury, the health professionals are deployed to evaluate the citizen's living conditions – just as the body is considered a site of regeneration and limitless potential (*see* Part I), so too must the professionals assess the home's ability to support the citizen-consumer's choice to 'age in place'.

In order to conduct these evaluations, the health professionals first have to 'meet a citizen where they are'. This phrase refers to functional ability in a figurative sense; for example, as Gerthe (Preventative Home Visits, PHV) said, "We always try to talk to them about, 'What is it that you would like to do and what do you want to manage, right now with this level of function?' (...) [You have to] meet an individual where they are" (*interview; 16 April 2015*). Here, the phrase implies trying to understand what the citizen is physically capable of doing, and finding out what they want to do within that (possibly) limited framework. But 'meeting a citizen where they are' can also more literally refer to the home and the sense that the professional is entering the citizen's territory, their home field, their platform – in other words, their private 'habitat', which is the citizen's environment yet one which is hitherto unknown to the health professional. I noticed this one day when the physical therapist Sofie and I arrived at Norah's apartment for training; Norah was watching for us out of the kitchen window of her first-floor apartment (*field notes; 13 November 2015*), which emphasised the demarcation between the public and private realms. It was clear that we were entering *her* space, about to cross *her* threshold – and *she* had the authority and power to grant (or deny) us access to her private environment.

The health professionals I followed were very aware that their work was predicated on being given access to a citizen's home⁵⁹, which required a certain degree of trust. For example, when describing how she approaches a home-visit, Benedikte (PHV) explained, "When they open their doors to us in their home, many times they don't really know what it's about. It can be a bit insecure – 'What IS this? What is this offer?' (...) So [we have to be aware] that we're here on their platform" (*interview; 16 April 2015*). Gerthe (PHV) said that her primary goal was "to

⁵⁹ When I first followed various members of the Training Team (in June 2015), there were several instances where a citizen did not give us access to their home when we arrived for the visit – either because they decided at the last-minute that they were not ready to begin training, or they had forgotten about the appointment.

meet a citizen where they are...we come as a guest in their home” (*ibid.*). But she was quick to qualify what that meant: “When I say ‘guest’, I mean it in the sense of having respect that you’re coming into another person’s home – to have respect for the person’s limits – to have respect for the person we meet. Not in the sense of ‘we’re a friend visiting’. (...) They’re opening their door to a complete stranger” (*ibid.*).

However, the work done by Preventative Home Visits is usually restricted to a single visit to a citizen’s home, during which the health professional may indeed be treated as a friendly guest who has been invited to call on the citizen; e.g., the citizen will tidy up prior to the visit, offer coffee, invite the professional to sit on ‘the good chair’ in the living room, etc. But making home visits to “a complete stranger” can also be risky and even dangerous for the health professionals, which necessitates them to consider and prepare for potential harm. For example, I attended a department meeting at the Care & Health Authority where the theme was “Prevention of risks at work/related to work” (*field notes; 3 December 2014*). During this workshop, the professionals participated in small group discussions about possible scenarios they might encounter when meeting a citizen in their home. The scenarios focused on “how we can prepare for certain situations, protect ourselves, and recognise issues – what happens when the door is opened?”

In a scenario that described a home visit in which a relative was complaining about the service that her elderly mother was receiving, one professional said, “Well, the worst that can happen is that you’d be thrown out of the house.” Another participant looked at her sceptically and said, “Is that really the worst that could happen?” The probability of encountering harm is higher among the Training Team therapists, who work with citizens on a more regular basis. As the physical therapist Sofie told me, “[I have] to take care of myself because we come out to *many* ‘exciting’ people – there’s a lot to deal with sometimes. (...) There could be a citizen who is very, very angry and frustrated. It might be that they’re injured or maybe they’re scared. (...) When citizens get angry and frustrated...I become their target. I think that can be hard to deal with” (*interview; 21 December 2015*). In these situations, Sofie and the other therapists have to judge the potential risk they might encounter; if they determine that they do not feel safe working alone with a citizen, they often ask another therapist to accompany them⁶⁰.

⁶⁰ As a cross-disciplinary team, the therapists may also ask a colleague to accompany them on a visit to get their professional (specialised) input or advice regarding a citizen’s functional ability; I discuss this in more detail in Chapter 8.

Once the health professionals negotiate and cross the citizen's threshold, they then have to evaluate the home's potential to support ageing in place; I discuss this in the next section.

5.2. Evaluating the home as a setting for ageing in place

As I have already mentioned, the work of Visitation is evaluative – although they do not conduct a 360-degree evaluation of the household, one of their official job responsibilities is to assess a citizen's living conditions by performing an in-person observation that should allow them to determine which services the citizen may (or may not) require and which 'opportunities' they can offer. For example, when I followed the Visitor Jutta (a trained physical therapist) to evaluate Mogens (age 69), who had fallen several times in the past few years and consequently broken his left shoulder, wrist, and fingers; he also has an enlarged prostate that makes him incontinent and, at the time of the visit, was undergoing tests to determine if he had Parkinson's disease, which could explain his balance problems and tendency to fall. Mogens was already receiving some assistive services from Home Care and municipal help with housekeeping, but he had been having more trouble bathing and doing the laundry himself, so he contacted Visitation to evaluate his living conditions to see if he would be eligible to receive additional assistance. In my field notes, I wrote:

After inquiring about Mogens' daily activities, Jutta asks to see his bathroom; Mogens tells her that, even though he has a shower-chair, it's hard for him to get in and out of the shower because of his tendency to fall. Jutta asks him what's hard about it, and Mogens explains that he's concerned about slipping on the wet floor. They return to sit in the living room, and Jutta asks him what else is hard; Mogens answers that he has trouble washing the dishes due to his weak hand and wrist – "it's hard to put things away in the cupboard, especially" because it requires him to reach up above shoulder-height. He tells her that he has the same issue with laundry because he can't use his left arm and shoulder much: "I can pull dry things down from the clothesline, but I can't hang up the heavy wet laundry." Jutta said that it could also be "very dangerous" for him to take the stairs down to the laundry-room in the basement because of his balance issues.

Field notes; 12 November 2014

In this example, it was important for Jutta to understand the difficulties that Mogens was experiencing in relation to the spatial materiality of his home; i.e., how the space and the material items it contains were organised and configured, and why these things were presenting challenges in his everyday life. Following the political directive to experience the citizen in his

own home, it should thus be easier for Jutta to “evaluate well-being and overall functional ability as well as practical problems in everyday life” (Henriksen & Hendriksen 2005: 7).

After the visit, Jutta told me that Mogens seemed to “get by alright” with the Home Care services he was already receiving, and he did not necessarily want someone to come into his home more often. Thus, Jutta thought he would benefit most from everyday rehabilitation so that he could better manage cleaning and laundry on his own, and she referred his case to the Training Team. In this way, the Visitors assess a citizen’s well-being and functional ability in relation to their living environment; i.e., to discover “what is hard” for them to manage within the home. But I argue that this spatial evaluation is also how the Visitors decide whether the citizen has the potential to be more self-helping. For example, Jutta decided that Mogens did not need more municipal help or in-home services; rather, she determined that he had the potential to manage his home surroundings better *himself* if he received training. As a result, the private home becomes scrutinised in terms of its capacity to permit the citizen to properly ‘age in place’ according to the policy guidelines, which also marks it as a site for potential; specifically, whether or not the Training Team’s work can help a citizen to be more self-helping and independent within the home setting.

Evaluating the home as a material space related to the citizen’s potential also becomes important in the initial evaluations conducted by the Training Team. For example, I followed the social and healthcare (SOSU) assistant Louise on an initial visit to evaluate Stine (age 89), who was recently discharged from the hospital following knee surgery she received after suffering a fall at home. Since the surgery, it had been nearly impossible for Stine to manage the stairs or walk outdoors – she would like to train with her rollator but “doesn’t dare right now” because she feels too unstable. The most immediate issue was that she is having trouble getting in and out of bed because of the pain; she said, “Everything in my lower half hurts.” Louise asked to see the bedroom in order to evaluate the problems Stine was experiencing:

Stine uses her rollator to take us to the bedroom, which is at the other end of the one-storey house. Stine’s side of the bed is elevated at the top – she stops the rollator next to the messy, unmade bed, turns around, and sits down heavily. She then reaches over to hold the elevated portion, and lifts her legs onto the bed with great effort. She lies down (on top of the duvet, with her head propped on the elevated part) and tells Louise that it’s not as difficult to get into bed as it is to get out. Also, it’s fine when she lies flat on her back like this, but it’s painful to turn over.

Louise says they can train this – Stine needs to walk more to build up her leg and knee strength, but she will also give Stine some specific exercises to do in bed.

Field notes; 22 June 2015

In this example, Louise based her evaluation on what Stine told her and showed her with regards to getting in and out of bed. Louise decided that, with the proper training – specifically, walking and bed exercises – Stine had the potential to be more mobile and self-helping; i.e., that engaging in physical activity would reduce her pain and allow her to get in and out of bed more easily, thus improving her quality of life. But this demonstration of what Stine finds difficult to manage becomes what I call a ‘pantomime of everyday life’ because it is only a two-dimensional representation of reality – there may be myriad other factors involved when Stine actually goes to bed each night and gets up the following morning. Would a lower or firmer mattress make it easier for her to get into bed? Does lying next to her husband affect Stine’s ability to roll over? Does the level of pain or discomfort vary depending on how much Stine has walked during the day or whether her husband has remembered to give her a dose of pain medication after dinner? Although the evaluation takes place in the citizen’s ‘natural environment’, it is not really natural – it does not account for the extenuating socio-material circumstances of a person’s everyday life, and it does not deal with the immediacy of the deed-in-the-doing.

Furthermore, when a citizen chooses to receive certain in-home services and/or training, then the private home must become re-defined as a workplace, which may unsettle the citizen’s perception of their home as a private space. But the Training Team’s work is predicated on the political ambition to help citizens learn to re-master certain everyday habits and routines, which means that the home must be negotiated as a space that is both public and private; I describe this in the next section.

5.3. Negotiating the home as a public/private space

The physical therapist Janette told me, “In the home, it’s the citizen who has the power – we’re guests in their home. (...) Of course, we come as professionals – but I have complete respect that it’s the citizen’s home” (*interview; 5 February 2016*). Here, Janette described herself as both a guest and a professional. But I would contend that these roles are contradictory – being a guest means deferring authority to the host, which is not possible when a municipal professional comes into the private home to perform a health evaluation, help a citizen to bathe, administer medications, or provide physical training; thus, the line between guest and professional – and the

political and private realms – becomes blurred. As a symbolic and material space, the home needs to be “destabilized when care services provided by outside workers enter the home” (Dyck et al. 2005: 181) and, as such, “an individual’s ability to secure some degree of privacy is conditional” (Allan & Crow 1989: 3); thus, it must be negotiated.

I saw this negotiation when I followed the Visitator Christine to evaluate Leonore (age 80) who was undergoing treatment for bladder cancer and was also having trouble walking on and moving her leg; she had applied to the municipality to receive both Home Help (practical) and Home Care (personal) services. At the time of our visit, Leonore was also suffering from (as she described) “violent diarrhoea” which required her to wear adult-diapers. Christine – a former hospital nurse – told Leonore that this type of incontinence could be a side effect of the radiation treatments she was receiving, and the municipality would provide her with free diapers. In my field notes from the visit, I wrote:

As the interview progressed, Christine asked Leonore about her relationship with her physicians, how she was managing her pain, the importance of increasing her protein intake (which Christine said would promote healing), whether she was eating enough or able to take walks outside, and whether she had fallen inside or outside of her home. The conversation seemed to be difficult for Leonore, who expressed anger and disdain several times – she felt that she had received poor care from the healthcare system in general and her former physician in particular. Among other things, he would not approve her being allowed to get an emergency-call button, even after she had fallen and remained unconscious, lying on her living-room floor in the dark for some time. As Leonore told us about her dissatisfaction with her previous doctor, she suddenly excused herself to use the toilet. After a few minutes, she returned to the living room and said how difficult it was for her to keep getting up and down like that – both from her chair and the toilet – due to her current lack of strength. She sighed deeply as she settled back into her chair to resume the interview, and then lit up a cigarette. Christine quickly said, “Please do NOT smoke until we leave.” Leonore looked momentarily offended, but stubbed out her cigarette in the ashtray on the table next to her chair.

Field notes; 27 November 2014

In this situation, it was unclear who had authority and power in the physical space of the home setting – was it Leonore as the private citizen, or Christine as the visiting health professional? In her capacity as a Visitator from the municipal authorities who asked about Leonore’s intimate and ‘private’ matters, such as her incontinence and need for diapers – which was a source of embarrassment and shame for Leonore – Christine established a kind of dominance over Leonore, who was in a position of vulnerability. Thus, when she told Leonore not to smoke in her own

house immediately after she returned from the private, intimate act of using the toilet, Leonore became submissive and deferential, and she acquiesced to Christine's request. This solidified Christine's position as an authority with a certain form of power, which blurred the lines between guest/professional and private/public space.

However, because the government has constructed citizens as consumers who are experts in their own lives and who have the authority in their own homes, Christine expressed doubt about demanding that Leonore not smoke. After the visit, she told me, "I mean, on the one hand, it's her home and her right to smoke. (...) But on the other hand, she could easily just have waited a few minutes until we left – just to be polite to guests" (*ibid.*). This quote suggests that Christine was also unsure of the lines of demarcation between private/public because she saw herself as a guest in Leonore's home and expected Leonore to demonstrate politeness towards *her*. But Leonore considered Christine to be an external authority who was coming into her home in a professional capacity; i.e., to evaluate her vulnerable living situation *in situ*. Due to her advanced illness, she could not act as a rational consumer and competent social agent who was in control of her body; thus, she was unable to adjust her regular habits and everyday routines as she otherwise might to accommodate a guest⁶¹.

However, Christine actually has the law on her side, and Leonore's private home is legally considered to be a public workplace when a municipal employee is on the premises. According to the 2007 *Work Environment Act*⁶², Christine's right to a smoke-free working environment supersedes Leonore's rights as a private resident – i.e., someone who is free to do as she pleases in her own home. In addition, the municipality's service description *Practical and personal help and care, and training in everyday activities* (February 2016) outlines the conditions under which a citizen may apply for and receive self-helping assistance from various in-home service providers. In one sub-section, titled "When the home is also a workplace", the citizen's responsibilities are described (e.g., the front door must be well-lit with the house number visible, snow must be cleared in the winter, smoking is not allowed while the professional is present). Because certain health professionals have to enter the home to perform their work on a regular (sometimes daily)

⁶¹ In comparison, the lines of demarcation were clear during a visit I made with the Visitationer Freja to evaluate Søren (age 61) who was dying from adrenal cancer; he was completely bedridden but smoked continually while Freja interviewed him and his wife. When I asked Freja about it after the visit, she said, "He's so close to death, just let him do it" (*field notes; 18 November 2014*). Thus, Freja positioned herself as a professional who conceded authority to Søren in his own home. I describe this visit in more detail in Chapter 7.

⁶² *Lov om røgfri miljøer (Law on smoke-free environments)* §2.4. Source: www.retsinformation.dk/forms/r0710.aspx?id=11388 (last accessed 7 February 2017)

basis, that space falls under the governance of the *Work Environment Act*, a legal framework that defines the guidelines for creating a safe and healthy work environment; the citizen must ensure that their home complies with this framework.

The service description (and the law itself) is primarily directed towards professionals who provide longer-term municipal services and who work hands-on with citizens (e.g., Home Care, Visiting Nurses, etc.) – and not the professionals who make one-time visits to a citizen’s home, such as Preventative Home Visits and Visitation. With the longer-term services, the lines between guest/professional and public/private may become even more blurred; for example, when a Practical Help worker sits and drinks coffee together with a citizen each day during the visit (*field notes*; 7 August 2014). This on-going negotiation of private and public space de-stabilises the traditional meanings of ‘privacy’ in relation to the home-space; in other words, when municipal professionals enter this environment on a regular basis, the citizen loses control over this private space and, as such, the “established meanings and routinized activities that constitute the lived home [become] disturbed” (Dyck et al. 2005:175).

However, in order to help citizens become more self-helping, it is necessary for the professionals to negotiate these boundaries and divisions. In fact, there are some situations wherein the citizens welcome a lack of privacy, which I describe in the next section.

5.4. When a lack of privacy is welcome

For some citizens, the ‘intrusion’ of health professionals into their private space may be welcome if it supports their ability to receive certain helping services. For example, regular long-term services such as Home Help and Home Care have access to a lock-box with a key to the citizen’s home, which they use to let themselves in when they arrive. But as consumer-citizens who want the freedom to choose how and when to receive these services, it can also be irritating when different workers come each time. With regards to the house-cleaning service and Home Help she receives from the municipality, Ulla (age 78) said:

A new person comes every week, and it irritates me so much. Because you have a week where someone’s really good, and you think, “I’d like this person again”, but you don’t get them. And then a third one comes...there have been several different people here. And every time, I have to explain where things are, and this and that – it’s so irritating. I don’t understand why they make it so that people get the same person every time. (...) It’s really important to people – but they can’t seem to do it.

Interview; 26 January 2016

Although, like Ulla, many of the citizens I met found it disruptive or annoying to have several different professionals coming in and out of their homes *ad libitum*, most of them considered it necessary to accept such an inconvenience, and to relinquish a degree of privacy and control if it meant they would receive help that would allow them to remain in their own homes.

This was especially true in relation to emergency-call buttons – if a citizen is considered to be at risk for falls (which can be debilitating or even life-threatening for the elderly), then the health professionals can arrange for the citizen to have an emergency-call button installed in their home. This became a major part of Walther’s training sessions with Katrine; after she decided that his physical body did not have the potential to be more self-helping due to the severe and progressive nature of his neurological condition (*see* page 117), she focused on reducing his environmental risk and ensuring that he could get help if he fell. In my field notes, I wrote:

Katrine checks his files on her laptop computer, and she can see that – in addition to the indoor rollator – Walther has applied to the municipality to receive a transport-wheelchair (which he is not eligible to receive because he does not need it more than four days per week) and a personal emergency-call button. She asks him how often he falls or has fallen; he says it has been maybe once every two to three months, and he is always able to get up by himself.

Katrine: With your condition, it’s progressive, so you might need the Emergency Services in the future. You mentioned last time that you have problems with your speech...with talking. It’s your choice, but you should consider it.

Walther: Yeah...with my illness, it’s about learning what you can and can’t do. You keep doing things you’re used to doing until suddenly you can’t do them. It’s terrible. (...)

Walther goes on to explain that he “very rarely” falls, but that his ex-wife gave him a little mobile phone to use in case of emergencies. However, Katrine does not think this is a good long-term solution.

Katrine: Let’s hope it doesn’t happen for a while, but with the emergency-call button, if you can’t talk, then you just press a button and they know where you are and just come out. There’s a difference between a phone and the emergency-call button. It’s registered to your address, and they come right away if they don’t hear from you.

Walther thinks that could be a good idea – he applied for one a year ago, but was assessed at that time as not being a ‘fall risk’; Katrine updates Walther’s files with this information.

Field notes; 22 October 2015

Having an emergency-call button installed in his home is potentially life-saving for Walther. But it also meant that he must give Emergency Services access to his private space. During a subsequent visit (17 November 2015), Walther told Katrine that his ex-wife and daughter have a

copy of the special scan-card that unlocks his front door, and she said that he would have to have an extra made for the secure lock-box that would be installed by the front door (“that way, the Emergency Services won’t have to break down the door”, Katrine told him with a laugh). A two-way communication receiver must also be installed inside the house; all Walther has to do is press a button on his special wristband, and someone from Emergency Services will ask if he is all right. If he answers ‘yes’ (i.e., if the button was pressed by mistake), then they will not come; however, if he answers ‘no’ – or does not answer at all – then they will send someone out to his house right away to administer help.

However, managing this process was not simple for Katrine, who had to arrange for the service to be installed in Walther’s home. When she returned to the office to finish updating his journal in the shared municipal system, she was not clear whether the emergency-call button should be classified as a ‘treatment’ or ‘goal’ according to his official training plan. She asked her colleague about how to best formulate it, saying, “He needs to feel secure in his own home” (*field notes*; 22 October 2015). They decided that it should be considered a treatment, but Katrine also had to be careful about how she described Walther’s needs to ensure that the other municipal departments (e.g., Visitation, Assistive Devices) interpreted this information correctly and accepted her decision; she told me that she had to write only the most basic, straightforward details of her assessment in the journal to ensure that no one would question her evaluation. She next had to check the legal rules and regulations regarding the installation, which was difficult for her to judge because Walther’s condition placed him in between the available options; i.e., “some falls” and “ambulant”. But Katrine and her colleague both agreed that Walther’s situation could change very suddenly and – particularly because he was losing his ability to speak and the fine-motor control of his fingers, which meant that trying to use his mobile phone to call his ex-wife or daughter could be problematic – it was crucial that he have the emergency-call button installed as soon as possible. Later, Walther told Katrine that the decision to have the emergency-call button installed “makes me feel more secure” (*field notes*; 27 October 2015), even if it meant giving up his privacy and control over who could enter his home. I return to the encounters between Walther and Katrine in Chapter 8.

Summary

In this chapter, I have described how the health professionals must negotiate a citizen’s home as a public/private space. The lines demarcating the difference between a guest and professional

who arrives to ‘meet the citizen where they are’ in relation to this space can often become blurred; for example, when citizens receive long-term services such as Home Care and everyday rehabilitation, then the home becomes a workplace that must comply with certain laws and regulations and, as such, the political realm enters a citizen’s private sphere. However, although homeowners were considered to be ‘free’ citizens in the classical sense, the household was “the center of the strictest inequality” (Arendt 1958: 32) because the owner was considered to be the master of all who lived and worked there. While this conceptualisation of a ‘free’ citizen has changed since the days of the ancient city-state, the contemporary competition state has defined citizens as consumers with free choice. Thus, if they purchase the commodity of in-home health services, they must pay a certain price: having their private spheres de-stabilised as a site of privacy and “free reign” (*see* Norah’s quote on page 124). I have argued that, when municipal health professionals enter the citizen’s home to perform their work, it is no longer a place where the citizen alone has power, authority, and mastery over it as a location that is “properly his own” (*ibid.*: 30), and I have described how both the citizens and the health professionals sometimes find it difficult to negotiate this shift.

I have also argued that, by accepting the municipal choice to receive assistance or training that will allow them to attain an improved quality of life for as long as possible, elderly citizens lose control over *who* enters their home and often *when* they can enter, which further de-stabilises the home as a private place. This is especially true if the citizen is receiving help (or being evaluated to receive help) with intimate and private acts of domestication; in these cases, the citizen is required by law to allow their home to become a workplace. While most citizens accept these intrusions and relinquish a degree of privacy and control within their homes in order to receive help, with regards to municipal health authorities such as Visitation, I argued that the home becomes a site of political assessment and scrutiny to determine whether the citizen’s functional ability can be improved, and thus whether the home has the potential to support ‘ageing in place’. Moreover, I explained how the professionals must also judge whether they themselves might face any potential dangers or risks when they enter a private home to meet a citizen ‘where they are’.

In the next chapter, I describe how the concept of ‘home’ as a place of meaning can be understood as “an articulation / representation of activities and actions made possible through engagement with the house” (Vacher 2010: 64). This suggests a form of work in the Arendtian sense; i.e., activity related to the artificial world of structures and objects. Adjusting this engagement is central in the design of everyday rehabilitation, which focuses on improving a

citizen's bodily competence in relation to performing familiar routines, habits, and actions within the household structure.

Chapter 6

Stabilising the home to promote ‘ageing in place’

Some qualitative research has shown that, as a material site, the home’s “specific spatial arrangements, amenities, furnishings, and location within a particular neighbourhood will be more or less enabling in the support of its occupants’ needs and desires” (Dyck et al. 2005: 175). These formulations suggest that the home is perceived as a stable socio-spatial place that should sustain the arrangement and organisation of the occupant’s daily activities. For the most part, municipal evaluations, health visits, and assistive devices are offered to make the citizen feel more secure and competent in their own homes for as long as possible. However, the work done by the Training Team also functions as a feedback mechanism to re-stabilise the citizen’s internal and external surroundings in relation to their perception of security within the home environment, which I discuss in the following sections.

6.1. Re-stabilising the home as a place of security

The home has been described as a place where ‘nothing’ in particular happens: a place where everyday life is simply *done* and where “mundane domestic activities, from routines to daydreaming, flow like hidden undercurrents” (Löfgren 2014: 82). In this sense, everyday routines are considered to be so intrinsic that they become taken-for-granted, and they are often anchored in or around the home. This ‘automatic’ functioning can only happen in a place where habits and routines have become embodied with repetition over time; as such, familiarity with the space inside the structure we call ‘home’ is part of our being-in-the-world (Heidegger 2007 in Mahler et al. 2014: 38). The Visitor Britt described how a sense of stability and familiarity in one’s own surroundings could be important for older people, even if they have health problems:

With the elderly, their functional level is often higher at home than it is in another place [like a nursing home]. I was recently out to visit a man – he was actually doing quite badly. He had had two mini-strokes, and he was doing badly. But he could function really well. He had been married and had lived in the same house for 60 years. So when he got up in the middle of the night, he turned on the same light-switch – he’s done it for 60 years. Cognitively, he was weakened. But it was the same light-switch; it was the same path to take a pee in the middle of the night. It was much easier for such

a man to be in his own home, where he knows the doorjambs and everything, than to be in a nursing home. (...) He shouldn't have to use a lot of energy to adapt himself [to new surroundings].

Interview; 1 March 2016

In this quote, Britt described the home as a place of familiar surroundings – a place where a person just ‘knows’ where the light-switch is in the middle of the night, even if one has some degree of cognitive impairment. In her professional opinion, Britt believed that this man’s functional ability would have been compromised if he needed to “use a lot of energy to adapt” to new surroundings, such as a nursing home. Thus, she thought that it could be beneficial for older people to ‘age in place’ because familiarity with – and thereby stability in – the home environment would allow them to maintain a higher level of functionality. This is in alignment with the overall political belief that remaining at home for as long as possible and not having “to adapt to new surroundings”, as Britt said, promotes well-being and a better quality of life for elderly citizens.

Therefore, feeling ‘at home’ refers to the degree of competence and mastery with which a person navigates the physical spatiality of their home. As such, the training is meant to re-orientate the biological body in relation to how it navigates its external surroundings: “the most basic of places and spatial indicators are first of all qualified by the body” (Lefebvre 1991: 174). But this functional ability is also about maintaining internal homeostasis⁶³. A citizen’s home is considered to be the basis for this kind of security – and by working with a therapist to orientate and stabilise the physical body via training (i.e., bringing homeostasis to its ‘ideal’ setting), the citizen should thereby feel emotionally *and* physically more secure in their home environment, which will enable them to be more self-helping. Pia (manager of the Training Team) emphasised the importance of training in relation to security:

I think citizens are happiest when they can keep doing things as long as possible. (...) It creates security to do these things – I can certainly understand if someone has fallen, and they say, ‘I really don’t want to do that again because I fell’. But to work through it and find security in being able to do it again – because otherwise, one becomes passive, very slowly.

Interview; 3 February 2016

⁶³ Although the words have different etymologies in English, it is an interesting coincidence that the word ‘home’ is found within ‘homeostasis’: this biological term refers to “the tendency of an organism or cell to regulate its internal environment and maintain equilibrium, usually by a system of feedback controls, so as to stabilize health and functioning”. *Source*: <http://anatomyandphysiology.com/homeostasis-positivenegative-feedback-mechanisms> (last accessed 11 February 2017)

In this quote, Pia implied that training works to re-orientate the biological body in relation to how it navigates its external surroundings, especially in areas that may feel ‘insecure’ due to an injury, illness, disability, or some other sort of physical weakness. Thus, the training is meant to re-establish internal equilibrium through a form of mechanical conditioning: “it is *mechane*, that is, the artificial production of effects which would not come about simply of themselves” (Gadamer 1996: 38). In this type of mechanical work, the therapists must re-skill the citizen in how to navigate the objective features of the man-made world (Arendt 1958: 137); i.e., the structure in which they live and its material contents.

This process could be seen when I followed the physical therapist Erik, who had just begun to train Dorthe (age 86) to use her rollator. Dorthe had suffered a stroke a few months earlier; as such, she was quite weak on her left side, incontinent, and has some mild cognitive impairment. Dorthe was very reluctant to walk outdoors, but she was motivated by the presence of her husband, Martin, who followed us throughout the session. In my field notes, I wrote:

Erik takes her gently by the arm and leads her out the front door of the apartment and up the stairs to the building’s main entrance. Dorthe’s left leg is weak and can’t bear much weight, so he helps her slowly navigate the stairs, telling her to step on each stair securely with both feet while holding the handrail. I follow behind them, carrying the rollator, and Martin follows behind me – he holds the front door open for us while Erik shows Dorthe how to step down onto the pavement. Erik then takes the rollator from me and sets it down in front of her, showing her how to release the brakes. (*After walking a short distance...*) Erik shows Dorthe how to set the brakes on her rollator, and how to turn around so she can sit down on the centre seat.

Field notes; 1 June 2015

In this situation, Dorthe was struggling to navigate the external environment and maintain her equilibrium. Thus, it was necessary for Erik to act as a feedback control that would stabilise her functional ability, instructing her on how to navigate the stairs more securely by stepping on each stair with both feet (rather than one foot on each stair) and how to use the brakes on her rollator. In this way, he helped to re-calibrate Dorthe’s mechanical, ‘automatic’ functions so that she could attain homeostasis and thereby achieve more stability in her home environment, which would enable her to be more independent and thereby self-helping.

In order to effect such changes, the therapist must first understand how the citizen navigates around their ‘natural habitat’. During the first interview, the therapists begin this process by asking the citizen what they find difficult in their everyday lives. The occupational therapist

Katrine explained that the initial observations are very important to how she decides to organise and emplot the citizen's training plan. She said:

I look at everyday activities *a lot* and ask about the things that are difficult. And if they are [difficult], then I tend to say, “Good. So let's just try that – I'd like to see what you do, and you can describe what's difficult.” Or they just do it, and I stand there and observe. And obviously, it can seem really weird to have someone standing there, watching them. But I try to explain to them that it's for me to come up with [a training plan] – before I can help them. Because I can't come up with something if I don't know what they do. So that's pretty typical for me, at least – to just look at, how do they usually do this? Could they do it another way?

Interview; 5 February 2016

As Katrine further explained, she collaborates with the citizen to set goals for training, which then focuses on the things “that prevent them from doing things as they usually do, that are a part of their everyday life – it can be anything from brushing their teeth to going grocery-shopping” (*ibid.*). Similar to the Visitor evaluations that are used to assess “what is hard” for citizens to manage within the home environment (*see* page 127), the therapists also ask the citizen to demonstrate the specific activities they find difficult in relation to their external surroundings. For example, during Katrine's first meeting with Walther, she conducted an evaluation of his bathroom because he had reported to Visitation that he felt unsafe and insecure when showering. In my field notes, I wrote:

Walther gets into the shower (fully dressed) and demonstrates how he usually holds on to one of the bath-grips when he turns on the water – because his balance is so bad, he needs to hold on to a bath-grip at all times. But this makes it difficult for him to bend over to pick up the bottle of soap or shampoo, both of which are kept on the tiled floor of the shower. Also, the showerhead is attached to a long hose mounted to the middle of the shower-wall. In order to wash his hair and body, Walther shows us how he needs to release the bath-grip to hold the showerhead in one hand while bending over to pick up the soap or shampoo; he says this makes him feel very unsteady and insecure. Katrine suggests that they train to improve his overall balance, but the best solution might be to order a bath-chair, a non-slip bathmat, and a little tray-table to hold the soap and shampoo – that way, Walther won't need to bend over at all and also won't need to hold on to the bath-grip as much.

Field notes; 15 October 2015

During these initial evaluations (and often in the subsequent training sessions), the therapists try to understand what a citizen is actually having trouble managing in his/her everyday life. In the

‘pantomime of everyday life’ (see page 128), the citizen demonstrates their challenges, which may be multiple and/or compounded by other factors, both internal (e.g., arthritic hands, emphysema) and external (e.g., high doorjambs, cabinets that are out of reach). But this starting point emphasises the spatial–temporal aspect of training, in which the therapists observe the citizen’s functional ability and their living conditions as they are *now*, but they must use their professional knowledge, experience – and often, a bit of imagination – to develop and emplot a training plan (and/or suggest assistive devices) that targets the citizen’s potential to be more competent and self-helping in the *future*. In other words, the therapist must consider the citizen’s past and current habits and routines within the home space, and then work with the citizen to re-imagine and re-establish these habits and routines in order to fulfil their training goals.

The therapists also have to determine the best way to re-calibrate the body so that it can return to homeostasis within the temporal parameters of the everyday-rehabilitation programme; the municipal politicians have pre-determined a set end-point, which means that the course of training is limited to 10 sessions⁶⁴. Within this timeframe, the therapist has to provide external feedback that will allow the citizen to maintain or attain stability in their natural (home) environment for as long as possible. In this regard, it is important for the therapist to understand the citizen’s regular, everyday routines, which I discuss in the next section.

6.2. *The significance of home-based routines*

The home – as a citizen’s main dwelling and socio-material environment – has meaning as the site in which the routines of everyday life and private acts of domestication are anchored. The occupational therapist Katrine formulated the importance of routines in terms of having stability in and control over these routines, which relates to a person’s sense of competence in their external surroundings (Williams 2002: 147). She said:

It could be that you’ve broken your arm but now you suddenly can’t do the things you used to do because they were just (*snap, snap*) driven by routine. And there are some things that are important, because it’s what we do – it’s our life, and it’s all built upon habits and routines. Get up in the morning and brush your teeth or eat breakfast or whatever you do – take a shower. There are routines. And it’s important to most people to be able to help themselves and decide themselves

⁶⁴ However, citizens can (and often do) undergo multiple courses of everyday rehabilitation if they receive a new referral from their general practitioner, hospital staff, or a municipal authority such as Visitation.

when they will stop [doing an activity]. Or if they will [continue to] do these things – but it’s about deciding for yourself.

Interview; 5 February 2016

In this quote, Katrine explained that many people find it disruptive or disconcerting if they suddenly cannot perform a formerly taken-for-granted routine, such as brushing their teeth after waking up in the morning. In this way, “empowerment is often found in the details of the mundane world. It comes from controlling access to personal space, from being able to alter one’s environment and select one’s daily routine” (Ridgway et al. 1994: 413). Having this ability to select one’s daily routine within the home was especially important to Walther, who was unable to embody certain new habits or regain mastery of already-known actions due to his progressive condition (*see* page 117). When Katrine asked him if training made him feel tired, he answered, “No – I get angry, not tired. My patience gets tired. Not being able to do some things...I get angrier and angrier if I can’t open a jar or whatever” (*field notes; 22 October 2015*). This quote suggests that, not only did Walther find it particularly frustrating to lose control of his motor functions due to his illness, his inability to perform taken-for-granted household routines made him angry and his patience “tired”.

Routine actions such as opening a jar may be done ‘automatically’ but they are also how we orientate ourselves in the world – the temporal ordering of routines provides structure and stability to our everyday lives, helping us to feel competent in relation to the world outside of our homes, which may seem chaotic and out of our control. Thus, home has a “mediating role in supporting everyday competence” (Mahler et al. 2014: 38) because it is the place where most of these ‘grounding’ routines take place. But, as Katrine made clear, most people want to decide *for themselves* when to change or stop doing their everyday routines. If a person does not feel competent within their home space – due to injury or illness, as in Walther’s case – this can produce anxiety and emotional insecurity. Walther experiences this struggle each time he is unable to open a jar – this signals that he is not in control of his body, and subsequently reminds him that he is losing the ability to manage the regular routines that work to stabilise his everyday life at home and his being-in-the-world.

In situations where a citizen feels insecure in this way, the therapists often suggest that the citizen alter their home-based routines and/or use assistive devices that will help them compensate for their lack of physical ability. For example, when Walther described how difficult it was for him to bathe due to his poor balance, Katrine suggested he get a bath-chair and a non-

slip mat for the shower. Once she helped him set up these items, she said, “A few other citizens have told me that this has helped their functionality a lot...and now you’ll feel more secure.” In addition, I wrote:

Katrine also suggests that he dry himself off while he is sitting in the chair before walking out into the main part of the bathroom. Walther says he usually holds on to the sink for support: “I need to find my balance, so I support myself by leaning my shoulder and leg against the wall.” She asks him to consider getting more grips installed in the main part of the bathroom.

Field notes; 22 October 2015

In this situation, Katrine thought it was important for Walther to adjust his regular bathing routine and rely more on assistive devices that would make him feel more secure and competent in his physical surroundings – i.e., rather than holding on to the sink for support when drying himself, Walther should do it while sitting in the bath-chair or he should use a hand-grip. Katrine later told me, “I think we occupational therapists can be quick to make compensations – where we think in terms of assistive devices to begin with” as part of the strategy for everyday rehabilitation (*interview; 5 February 2016*). While such material compensations are necessary for someone like Walther who cannot train his physical body to learn or re-master and thus embody certain habits, they also work to ‘pre-institutionalise’ the home (Kofod 2008: 48–9; *also* Buus 2001b), making it safer and more manageable for him until he can no longer live independently.

However, changing lifelong habits and daily routines can be difficult for many people and, according to the health professionals, it is one of the greatest barriers they encounter in their jobs. For example, the Visitation Brynja told me how she tried to encourage elderly citizens to participate in the training programme in order to “manage as many things at home as possible for the longest possible time”. She said:

They may just have to change their habits a little bit. [Of course,] it’s really hard to change your habits if you’re used to vacuuming three rooms at once – and now it could be necessary to do one room at a time. There are a lot of people who can’t handle having to change suddenly, and can’t understand. (...) And of course, it can be annoying to have the vacuum-cleaner sitting out for a couple of days, but it could be worse!

Interview; 25 February 2016

Here, Brynja explained how many older citizens resist changing their habits, especially when it comes to taken-for-granted household routines such as vacuuming. As she pointed out, many

citizens are accustomed to cleaning their entire apartment in one day – “vacuuming three rooms at once” – and thereby find it difficult to take the professionals’ advice to break up the task into smaller, more manageable chunks, such as vacuuming one room at a time over the course of several days.

This was the case when I met Lumikki (age 83), a widow who has arthritis and spinal stenosis, which causes pain in her back and hips; she applied to the municipality to receive help with house-cleaning, but agreed to go through a training programme to learn some new techniques. The goal was for the physical therapist Janette to show Lumikki how to clean her apartment more effectively without pain. During the initial interview, Janette asked how big the apartment is. When Lumikki said it was 100 square meters, Janette exclaimed, “That’s a lot to clean! Do you break it up?” Lumikki answered that she tried to vacuum and wash the floors on different days. This practice conformed to the therapists’ standard advice, so Janette then asked to see the equipment that Lumikki uses to clean. In my field notes, I wrote:

We all get up from the living room and go into a small bedroom at the back of the apartment. Lumikki opens the closet, leans over, and pulls out a low Miele canister-vacuum cleaner with a long hose attachment. Placing the vacuum on the floor but without turning it on, Lumikki shows Janette how she typically vacuums, pushing the hose out in front of her. Janette explains that it would be better for her to wrap the hose around her back so that she’s not pushing so much from one side – it would be better to use a centre/forward motion that doesn’t strain her hips and back. Janette says, “We tend not to think about these things, but it makes a big difference.” (...) Janette also offers to show Lumikki another type of vacuum that would be more ergonomic, but she says, “You don’t really need to replace a perfectly good vacuum cleaner if you can learn how to use this one better.”

Field notes; 5 November 2014

In this encounter, Janette explained to Lumikki that she should change the habitual way in which she vacuumed her floors. Even though Lumikki did indeed already break up the cleaning tasks into chunks, Janette still believed that she could “learn how to use this [vacuum cleaner] better” in order to be more self-helping. As such, it was not just Lumikki’s usual taken-for-granted routines that were problematic but also her technique; i.e., the habitual action that “we tend not to think about”, as Janette said.

This was especially true in relation to mopping the kitchen floor, which became the focus of the subsequent training sessions. During these sessions, Lumikki struggled to learn how to use the new ergonomic mop that Janette recommended. In my field notes, I wrote:

Lumikki: How do old people manage this? I think it's too late for me to change the way I do things...

Janette: It has nothing to do with age. There are people in their 90s who can do this – it's just a matter of learning new techniques.

Field notes; 3 December 2014

During the training sessions, Janette tried to show Lumikki that she was physically capable of managing the mop and washing the kitchen floor herself. But Lumikki was reluctant to change her routines; when Janette demonstrated the new techniques or gave instructions, Lumikki often rolled her eyes behind Janette's back or winked at me to show she was not taking the training seriously. As Lumikki told me later, "I didn't think I needed help with cleaning, but my daughter saw my house and let me know what she thought. (...) She decided I should get help" (*interview; 2 July 2015*). This suggests that Lumikki was not willing to be fully engaged in the training sessions because she herself was secure with her current household routines and techniques – it was actually *her daughter* who had a problem with them. Although Lumikki agreed that Janette "was good at explaining how I should do things without straining myself" (*ibid.*), she was nevertheless resistant to de-stabilising the way she cleaned or to use the cleaning equipment in a different way; this presented a challenge to Janette during the training sessions. Moreover, as a rational consumer, Lumikki chose not to change her routines because she already felt competent as the 'master' of her home.

In general, training everyday activities at home makes sense to the citizens. For example, Lumikki said, "It was best [to train at home] – because you could see exactly what you needed to do. It's not the same if you have to go somewhere else to be shown" (*interview; 2 July 2015*) and Walther said, "There's a difference between [training at the rehabilitation centre] Tranehaven and doing it here at home – it becomes a bit more of a habit when it's done here" (*interview; 9 December 2015*). In this sense, they both felt that training activities in the 'natural' context of their home environment helped to make them into habits. The physical therapist Sofie also agreed that experiencing citizens in the 'natural' context of their home was important to her work:

[Training] makes much more sense at home – because it's the place they know, they function at home, they know where their things are, it's where they've lived – maybe for many years. It's their home field, it's on their terms. Of course, we come in with a framework and can offer something within that framework, but it's on the person's home field. Where they, many times, feel more secure

and more themselves. (...) You see them in a greater context in their own homes. The home can also tell you a lot about how they're doing.

Interview; 21 December 2015

Although Sofie echoed the municipal rhetoric about the training taking place “on the person’s home field” and “on their terms”, the therapists also have to use their professional expertise to suggest ways to adjust the physical home-space and the material objects within it in order to develop the home’s potential to support ageing in place; I describe this in the next section.

6.3. Adjusting the home’s materiality to provide security

For many people – especially those who have lived in the same home for many years – the durability and permanence of certain material objects provides a sense of security; some of these objects may be sentimental, such as family photographs or heirlooms, while others have meaning in terms of their arrangement and placement within the home. But when the home becomes negotiated as a setting for ‘ageing in place’, certain stable objects may need to be adjusted or otherwise lose their permanent status. This could be seen when I followed the SOSU assistant Louise to evaluate Lene (age 77), who had just been released from the hospital after suffering a small fracture in her spine due to osteoporosis; she was also diagnosed with chronic pain several years ago. During the interview, Lene told us that, although she tries to do the strengthening exercises her doctor prescribed, she feels limited by her pain. With one of the exercises, she is supposed to lift her legs in bed, but the bed is too low. Also, since she returned home from the hospital, she has been fearful about losing her balance and falling in the shower. Lene said: “I tried to take a shower the day before yesterday, but it took a half-hour” because she was so hesitant to move around on the wet floor. In my field notes from the visit, I wrote:

Louise says that they will train so that Lene feels safer taking a shower by herself. Louise asks Lene to show her the other things she is having trouble with – walking slowly and hunched over, Lene shows her the too-low bed (which is nearly on the floor), the bathroom, and the kitchen. After examining these areas, Louise says that Lene might want to put a chair in the kitchen; that way, when she cooks at the stove, she can also sit down to rest. In addition, Louise suggests that she use her rollator indoors, which would give Lene more support until her balance improves.

Lene: I suppose I could, but it’s hard to control [the rollator] inside. There’s not much space.

Louise: Well, you have a lot of chairs in the living room – if we move some of them, I think you could get through more easily.

(They sit down at the dining-room table again to resume the interview...)

Louise: You're in a particular situation now, but training will help you feel more confident and secure. (...) You have challenges, but you also do a lot of things well. What would you like to work on?

Lene: I think the most important thing is bathing, and also using my rollator.

Louise: The training process will help strengthen you – we can also go outside with the rollator and see how it goes. (...) It will make you feel stronger and safer.

Lene: Yes, I can't go outside alone now.

(...) Louise also suggests that Lene ask one of her daughters to buy some non-slip stickers to place on the shower floor – regardless of the training, that will help Lene feel more secure.

Field notes; 22 June 2015

In this situation, Louise suggested it was necessary for Lene to train her physical body to improve its overall strength and balance, but she also recommended that Lene re-organise her material surroundings in order to feel more secure. By re-structuring the home environment in this way, the citizen's body becomes re-orientated in space; this is done “to facilitate the performance of a social self as well as care for the body's ‘private’ material limitations and unruliness” (Dyck et al. 2005: 181). This example shows how Louise acknowledged Lene's physical limitations and the unruliness of her body, as well as her fear of performing certain activities by herself; in order to overcome these issues, Louise suggested ways that Lene could rearrange some of the material objects in her home environment, which would provide more security and allow her to regain the ability to be a competent social agent with control over her familiar home environment.

However, when the home becomes a workplace (*see* page 134), the meaning and significance of certain stable objects may also change. For example, I followed the physical therapist Sofie on a visit to Vibeke (age 83); they were working to build her strength and improve her balance after she had been hospitalised for pneumonia. Vibeke also had severe arthritis in her knees and hands, which greatly affected her mobility and coordination, and may have contributed to her falling from the foot of the stairs a few months earlier. Since then, she has been afraid to go upstairs to the house's first floor, and has been sleeping alone in a small room on the ground floor, which was a source of frustration for her husband Klaus; he said several times that he wanted Vibeke “to get over her fear of the stairs, so she can come back to our double-bed” (*field notes; 4 June 2015*).

When Sofie and I entered their home, I could see that the furniture in the living room looked quite old – most of it was made from heavy dark wood that was popular 50 years ago, and the floral-patterned upholstery on the sofa and chairs was faded and worn thin. When we entered, Vibeke was sitting in one of the comfortable, well-worn chairs – she greeted us warmly and, after we all exchanged some small-talk, Sofie began the session by instructing Vibeke on how to grip the armrests and use her thigh muscles to stand up from the chair to her rollator. Vibeke attempted this movement a few times before her legs became tired; finally, she sat down in the chair so heavily that she hit her head on the chair’s wooden headrest. Sofie playfully said, “If you try to do it that way, you’ll need to put a helmet on”. We all laughed, and Sofie continued with the session, instructing Vibeke to walk around the dining-room table with her rollator.

In this example, Sofie assigned exercises to build Vibeke’s muscle strength and improve her balance, which would help Vibeke’s overall coordination, thus reducing her risk of falls. But the perception of being ‘at home’ is both situated and contextual, and there are often associations of stability and comfort (Mahler et al. 2014: 38). In this example, Sofie marked certain stable material objects in the home as tools and apparatuses that should support training. Thus, the comfortable, well-worn chair emerged as an exercise machine that Vibeke had to use a certain way in order to train her body to re-learn the mechanical activity of standing up and sitting down. The chair no longer held the same symbolic meaning as a place of comfort, relaxation, and security, especially after Vibeke hit her head on the headrest; suddenly, the chair became a source of potential danger and even pain. The dining-room table also transitioned from a piece of furniture associated with nourishment, family gatherings, and cosiness to an insignificant stationary object that Vibeke should “take a tour around twice a day” with her rollator.

The person-centred meaning of ‘home’ contains a complex array of factors and relations; thus, I argue that transformations to the domestic space may have implications for the health and well-being of its inhabitants. By adjusting the home’s materiality – which may also affect the relationships, objects, beliefs, and activities this space contains – the home becomes an unfamiliar, unstable place; a place that is risky, incomplete, and needs to be arranged in a particular way to support the work of training. However, training a citizen to obtain a greater sense of security in order to be more self-helping is not merely about rearranging or adjusting the home’s materiality – it also means showing citizens how to safely navigate the space outside of the home, which articulates their subject position as a particular kind of active citizen; I discuss in the next section.

6.4. *Feeling secure in the public space outside of the home*

For people who are functionally impaired, the home environment may be the place where they feel most secure – and leaving its safe confines can produce anxiety and insecurity. For example, most of my informants were extremely reluctant to leave their homes in inclement weather, due to a fear of slipping and falling on wet cobblestones or leaves, or icy walkways. Walther said he was not walking outside with his rollator “right now because it’s winter” (*interview; 9 December 2015*), and Ulla told me she had not been using her crutches outdoors “because I haven’t been to so many places here in the winter where I could do it” (*interview; 26 January 2016*). This reluctance presents a challenge for the therapists’ work, as some citizens resist being made to go outside the familiar and secure environment of their homes.

For example, the physical therapist Sofie had decided that the best way to train Norah’s balance function and “to stimulate and disturb her – in a safe way” (*field notes; 5 November 2015*) was to get her out of the security of her home-space. Sofie told me prior to the training session, “I want to see how she does outside when she’s not secure on her sofa...it’s good to push people out of their comfort zones” (*ibid.*). But Norah was reluctant to do this – and, if she had to do it, then it was going to be on her own terms. During the visit, I wrote in my field notes:

Norah asks if we are going to take a walk; Sofie reminds her that the training goal is to walk down to Strandlund, the activity centre where she attends exercise classes. But we will not go that far (approximately 1 kilometre) today. It is a horribly rainy morning (when, according to several Training Team therapists, many elderly people cancel their training appointments because they do not want to walk outside), so Sofie asks Norah if she has rubber boots. Norah pulls a pair of ankle boots out of the front closet and puts them on with difficulty; she has to hold on to something (the doorframe, her rollator) to keep her balance. When she suddenly starts to take them off again, Sofie tells her to keep them on because we are going outside; Norah protests that it is not a good day to go outside. Sofie says, “It’s autumn...you won’t get much out of the training if we don’t go outside each time. You just have to dress for it, and it’s fine.” (...)

When we go outside, Norah insists on holding Sofie’s arm to walk; she also insists that Sofie stay on her left side, due to her leg problems and poor vision on that side. Sofie convinces Norah to hold her hand rather than gripping her arm for support, and they walk about 100 yards to the end of the street. Sofie would like her to walk further, but Norah wants to go back. As they turn around, she tells Sofie again to stay on her left side.

Field notes; 5 November 2015

Here, Norah was clearly not eager to leave her warm, dry apartment to go outside for a walk on a cold, rainy day. She also felt hesitant to walk outside in the rain due to her balance problems and poor vision, which affected how she perceived the space outside her home; for her, the “point-horizon structure” that is the foundation of space (Merleau-Ponty 1962: 102) was unstable and she could not easily orientate herself. She compensated for this lack of spatial awareness by trying to hold onto Sofie’s arm, and then by insisting that Sofie stay on her (weak) left side until she felt comfortable walking. However, Norah refused to walk very far – in this sense, being ‘stimulated and disturbed’ required her to “use energy to adapt to new surroundings” (in Britt’s words; *see* page 137), and she was unwilling to exert herself for very long because being outside her home environment made her feel too insecure.

In this case, the “spatiality of situation”, which relates to the body’s “attitude directed towards a certain existing or possible task” (Merleau-Ponty 1962: 100) presented a challenge for Norah. She found it difficult to perform certain tasks – such as walking unassisted – outside the security of her home-space, and she tried to negotiate with Sofie about walking outdoors. Norah also felt the need to hold on to stable material objects – the furniture, a doorframe, her rollator – inside her home surroundings in order to navigate and feel secure in the space around her. As Sofie told me after the training session, “A lot of the things Norah does seem like habit – a physical memory or reaction – rather than something she actively thinks about or chooses to do” (*field notes; 5 November 2015*). But these embodied habits (*see* Chapter 4) – and the stable objects she used to orientate herself within her home-space – were not available to Norah when walking outdoors. As such, she did not have an automatic sense memory that would enable her to feel confident and competent when navigating the outside world.

The paradox is that, in order to obtain security and mastery *inside* the home, which will allow citizens to achieve their potential to be more self-helping, the therapists must push them to go outside the safe confines of their home and try to navigate the world beyond their sofas. For example, after training with her rollator (*see* page 138), the physical therapist Erik told Dorthe: “You can’t just sit here and drink wine and watch television. I’m going to come again next week to help you walk” (*field notes; 1 June 2015*). In this way, the citizen’s choice to ‘age in place’ is not a stationary, static process – one cannot be passive and “just sit there and drink wine and watch television”. Rather, in order to be a productive citizen for as long as possible and to be considered competent masters of themselves at home, the therapists have to encourage the citizens to have an openness to being in the outer social world and then to actively engage with it (Giddens 1991: 184).

This is why both government officials and health professionals prioritise getting the citizen ‘out on the street’; everyday rehabilitation works on the premise that being active outside the home will allow the citizen to feel more secure and thereby manage themselves more effectively overall. Citizens should not be passive, and the home should not become a place of confinement or “a signifier of a life that has been lost” (Imrie 2007: 754). In the classical sense, citizens were only truly free outside in the city; in that public place, they neither ruled over others nor were ruled themselves (Arendt 1958: 32). This sense of freedom could be seen when Ulla (age 78) received her new electric scooter from the municipality. When the occupational therapist Katrine and I arrived for training that day (*17 November 2015*), the plan had been for Ulla to try to walk outside with her crutches, but she was eager to practice driving the scooter. I wrote in my field notes:

After some trouble starting the scooter and getting it turned around in the hallway so that it’s properly angled to drive into the elevator, we make our way outside. Ulla takes a deep wheezy breath and says, “It’s lovely to be outside!” It’s a chilly day, but the sun is peeking through the clouds, and it’s not raining at the moment. Ulla wants to try to drive across the street a couple of times so she can learn how to manage the scooter’s speed and brakes, especially at traffic crossings and when going over the curbs. Katrine and I walk behind as Ulla drives down the sidewalk.

When we reach the end of the sidewalk, Ulla must go down over a small curb, cross the quiet side street, and then go up over a much larger curb to reach the opposite sidewalk; this requires her to modulate the scooter’s speed and then make a quick left turn on to the sidewalk. On the first attempt, she does not go fast enough and gets stuck on the curb. She gently puts the scooter in reverse and tries again – this time going much faster, and the effort succeeds. But it’s a little wild, and Katrine and I look around for places where the curb might be lower or more angled. Katrine points out a spot several feet further down the street, and Ulla will have to remember that location the next time she tries to cross here.

When we get to the other side, Katrine asks if she wants to try to take a few steps with her crutches. Ulla does, so we look for a wide, flat, even part of the sidewalk where she can safely practice. Ulla turns off the scooter’s power, and stands up with the aid of the crutches. Katrine walks alongside her, and together they take about 15 steps before returning to the scooter.

Field notes; 17 November 2015

In this example, Ulla found it difficult to judge the “spatiality of situation”, especially in terms of the mechanical operation of turning the scooter, modulating its speed, and crossing the street; there were few stable material objects that could help Ulla orientate herself in the external

space. As such, Ulla did not have an automatic sense memory or any of the spatial markers that would allow her to feel confident when operating the scooter and navigating the unstable world outside her home. Furthermore, she did not have physical competence in using the material assistive devices, such as her crutches and the new scooter. Thus, Katrine had to act as a mediator, judging what information would help Ulla successfully accomplish the action; she pointed out a spot where the curb was lower, which would allow Ulla to cross more easily, and she also reinforced that Ulla would have to remember that location the next time she tried to cross the street. In this way, Katrine provided spatial guidance that allowed Ulla to feel more secure in navigating the external environment.

Katrine also offered physical support when Ulla was walking with her crutches (*see cover photo*), which gave Ulla a sense of confidence in the stability of Katrine's role as a professional. As Ulla told me later, "The drive we took when my scooter was new – that was a really good experience. Because it gave me more security about driving by myself. (...) Katrine supported me the whole way, which gave me a great deal of confidence" (*interview; 26 January 2016*). Due to Katrine's guidance and support, Ulla was able to achieve a sense of independence, security, and mastery that she did not otherwise have within the spatial–material confines of her home. But this competence – and the citizen's trust in the professional's stabilising expertise – tends to develop gradually throughout the training process.

Summary

In Part II, I have described how politicians and health professionals designate the citizen's home as a setting for health prevention, evaluation, and training – i.e., a stable socio-spatial place where 'the citizen functions best', can maintain their functional abilities, and learn or re-master certain everyday activities in order to become more self-helping and properly 'age in place'. But when municipal health professionals enter a house or apartment to meet a citizen 'where they are' – especially on a long-term basis – the home as a private place must be negotiated as a public workplace. The professionals themselves must manage possible risk as they encounter the citizen's "private' material limitations and unruliness" (Dyck et al. 2005: 181) within the physical structure of their home, which can create insecurity about their own safety. Moreover, negotiating authority within the home requires trust, which tends to develop slowly during the training sessions rather than in the (usually) one-time visits conducted by Visitation, for example. But the professionals are often unclear about how to navigate their role

as a ‘guest’ or a ‘professional’, which further unsettles the citizen’s sense of authority and privacy with regards to their home space.

For citizens who have lost some degree of functional ability to care for themselves and/or their domestic space, the Training Team therapists must work on their homes and unsettle their everyday routines by suggesting new habits and techniques so they are better able to ‘age in place’. However, the body’s interactions with its domestic space “reflect a complex conjoining of physiological and social and cultural relations to produce specific, person-centred meanings of the home” (Imrie 2007: 748). I argued that, when the training re-orientates the physical body’s mechanics in relation to its ‘natural’ environment, it thereby de-stabilises the sense of security that is attached to familiar, ‘grounding’ routines within the home-space; this unsettles the citizen’s being-in-the-world. The citizen’s sense of ontological security becomes more unsettled when the therapists adjust the home’s materiality, and then ‘stimulate and disturb’ them to leave the comfort of their homes and venture outside, a space that lacks the stable material objects and touch-points that typically help to orientate them. The professionals are then often met with resistance, especially when the weather is inclement.

Throughout the process of evaluating and training a citizen’s body, and subsequently adjusting and stabilising their home, a particular kind of sociality is revealed; i.e., a certain relational practice emerges during the in-home encounters, which points to new forms of action, choice, and care. This is my focus in Part III.

* * *

PART III

ACTION – activity related to the human condition of plurality

We pull a case in from the folder and think we can help, right? And then you go out and think it could be done in two or three weeks, maybe a single visit, but then it can last months. It might seem easy to do, but then we go on a visit and a thousand other things pop up. Maybe also continuously – when there are new complications in the process.

Interview with Sofie, physical therapist; 21 December 2015

Introduction

As I outlined in Chapter 1, the goal of the 2007 municipal reforms was “to create a new Denmark where a strong and forward-looking public sector solves tasks efficiently and as close to citizens as possible” (Ministry of Health and the Interior 2005: 4), which prompted Gentofte Municipality to emphasise a ‘shared responsibility’ between the municipality and the citizen. Through its health policy, which has resulted in a wide array of initiatives, services, programmes, and informative community events that support ‘healthy ageing’, the municipality offers elderly citizens a comprehensive set of tools and resources to become more physically active, independent, and socially engaged with others. And for those citizens who may struggle to “manage themselves” at home, the municipality also provides preventative home visits, Visitor evaluations, and the everyday-rehabilitation programme, which is meant to help elderly citizens achieve better bodily mastery and functional ability so that they will be more independent and self-helping according to the Danish *Social Services Act*⁶⁵, and thereby achieve an improved quality of life at home for as long as possible.

However, as I have discussed elsewhere, the national government’s transition into a competition state has resulted in legislation and health policies that characterise citizens as individual consumers of health and welfare services who are given the choice to participate in a self-help

⁶⁵ “The purpose of assistance under this Act is to promote the ability of individuals to manage for themselves or to facilitate their daily lives and improve their quality of life. The assistance provided under this Act is based on the individual’s responsibility for himself and his family. The help is customised to the individual’s needs and assumptions in cooperation with the individual.” *Source*: <https://www.retsinformation.dk/Forms/r0710.aspx?id=161883> (last accessed 17 February 2017)

project to make themselves more active and ‘free’ from the need for municipal services. This is reflected in the municipal discourse, wherein both Visitation and the Training Team use an internal distinction to categorise citizens in relation to their goals for participating in the rehabilitation programme: ‘train yourself *free*’⁶⁶ (i.e., the citizen can do much more than before and no longer needs any municipal help), ‘train yourself *freer*’ (i.e., the citizen can do much more than before and needs less municipal help), and ‘train yourself *stable*’ (i.e., the citizen maintains a stable functional ability but still needs some municipal help). As the occupational therapist Katrine explained to me (*field notes; 22 October 2015*), ‘train yourself stable’ is mostly for citizens who live in a nursing home, while those who live in their own homes generally fall into the ‘train yourself freer’ category. This was re-iterated at a group meeting, where the Training Team’s manager Pia said, “Citizens can ‘train themselves free’ from Home Help and the municipality. (...) But ‘free/freer’ is a bit of a grey zone – some citizens who receive Home Care can also ‘train themselves free’ if it means they’re glad to be in better condition, and that [the Home Care workers] are also happier” (*field notes; 5 November 2015*).

In Parts I and II, I examined how certain municipal health professionals try to follow the political rhetoric that governs their work; specifically, how they engage with an elderly citizen and make adjustments that will allow the citizen’s body and home to support independence and ageing in place. As I described, the health professionals – particularly those from Visitation and the Training Team – are tasked with identifying whether a citizen can return to productivity, and then developing a citizen’s potential to become more self-helping. During the home-health encounter, the professionals apply their distinct operating logics and rationalities, and judge the citizen’s ability to take transformative action. In these situations – particularly in the authoritative assessments conducted by the Visitors – there is an expectation that an elderly citizen still has some degree of mastery and control over activities in their everyday life; the Visitor’s politically-defined role is to discover which resources the citizen is lacking and offer appropriate opportunities for continuing self-care.

⁶⁶ To be clear, the municipality’s rehabilitation centre Tranehaven offers a formal programme called ‘Train Yourself Free’ to its discharged patients (<http://tranehaven.gentofte.dk/da/Træning-og-rehabilitering/Træn-dig-Fri>). The therapists from the Cross-disciplinary Training Team have their home office at Tranehaven, and they regularly work with these patients under the ‘Train Yourself Free’ umbrella. But due to §83A of the *Social Services Act*, their main function is the ‘everyday rehabilitation’ of citizens who may never have been admitted to Tranehaven (<http://tranehaven.gentofte.dk/da/Træning-og-rehabilitering/Tværgående-Træningsteam> (links last accessed 17 February 2017)).

However, as I have also suggested, the Training Team therapists are not limited by the same external conditions and epistemological worldview that tend to constrict how the Visitation interact with citizens who apply to receive help from the municipality. Although certain authorities (e.g., Visitation or the physicians at Tranehaven) typically activate the therapists' work with citizens, their job responsibilities do not contain an authoritative or decisive function. Thus, working with citizens to achieve their potential to become 'free' and thereby empowered to be more self-helping requires the therapists to acknowledge the citizen as a social being and to articulate their personhood – i.e., to meet them not just as an abstract 'Citizen' but as a freely choosing subject with mindful agency – as well as unique hopes, preferences, goals, limitations, and a history of lived experience. However, encountering a citizen's lived life, active agency, and 'messy subjectivity' (*see* page 29) can complicate the therapist's work, especially in terms of efficiency (*see* the quote from Sofie that opens this section).

As I have stated elsewhere, governmental policies, laws, and regulations in Denmark tend to be categorical and target 'the individual' with regards to the provision of welfare and health services. Thus, the everyday-rehabilitation programme is intended to be a relational practice – a 1:1 partnership that is sustained by the plurality of communicative interaction (Arendt 1958: 178–9). In this form of activity, an individual person is expected to reveal their unique identity through their words (intentions, choices) and deeds (actions), but the validation of this identity requires the presence and acknowledgment of another individual. In the training encounter, the therapist is expected to co-determine goals together with the citizen, which should be based on the citizen's unique beliefs, desires, and hopes; following the Fredericia-model for everyday rehabilitation, training should achieve the citizen's "hopes and dreams" for the future (Guldager 2011). These goals should thereby become representations that activate the individual citizen's willpower and propel them to take action (Schatzki 1997: 293).

In the following chapters, I describe how the therapists attempt to engage in a form of plurality with an elderly citizen's phenomenological body; a body that has its own sense of identity and history of lived experiences, and an unruly body that may not always make the 'correct' choices or behave like a rational consumer that conforms to the logic of the marketplace. But I argue that, when the goal of municipal services changes from 'providing help' to 'enabling self-help', the choices and collaborative decisions made in the health encounter require a particular form of sociality; thus, care becomes a shared responsibility that is distributed across a range of actors, and new forms of action and empowerment emerge, which has implications for the collective.

Chapter 7

Offering free choice and empowerment

The Visitor's initial promise to the elderly citizen – of being able to return to productivity and manage themselves for 'as long as possible' – sets in motion a causal chain of therapeutic employment (Mattingly 1994: 817); this refers to outlining the 'narrative' structure of the training (i.e., its beginning, middle, end) wherein the citizen is given the freedom to choose which activities they want to train. As the physical therapist Sofie explained to me, "Despite what the referral is about, the older person completely has the opportunity to tell us and think about what they want. And what they don't want" (*interview; 21 December 2015*). In this chapter, I describe how the therapists interpret the future possibilities that a citizen chooses to imagine for themselves, which thereby sets the framework for therapeutic employment – it is here where the individual citizen's potential for continued labour is meant to be realised; where the 'limited' citizen should become 'limitless' to fulfil the political goals of the competition state. The ambition is that giving citizens the freedom to make these choices will be empowering, especially with regards to the older person "attaining a sense of control and meaningfulness" (Andersen et al. 2000: 14) in their everyday lives. But, as I suggest, giving the citizen the power to choose may complicate the progression and outcome of training.

In the next section, I describe how the therapists try to locate the citizen's motivation to participate in the training programme and become more self-helping. By encouraging the citizen to decide their own goals and tap into their willpower, this freedom to choose should activate a form of empowerment.

7.1. Locating the power of the Will

After the initial evaluation of the citizen's physical abilities, the therapist's job is to act as a physical trainer but also as a mediator and facilitator – i.e., someone who is able to "support the citizen in living a life that is as independent and active as possible" (*municipal pamphlet*) on behalf of the municipality. Thus, the Training Team's initial assessments typically focus on determining a programme for "training in daily tasks" (*Janette, physical therapist; 5 February 2016*), and how training can help "people to be in a place where they can do [activities of daily

living] more independently” (*Katrine, occupational therapist; 5 February 2016*). During the first interview, the therapists try to “capture something or other that [the citizen] could consider doing” (*Sofie; ibid.*) and then make a plan “to train them so they can master it in the end” (*Janette; ibid.*). Reablement programmes are specifically designed to include a “goal-orientated, holistic, and person-centred” approach (*Aspinal et al. 2016: 3*). Thus, the Training Team therapists have to unfold a process that moves from the realm of managing the abstract individual to encountering the citizen as a unique person with specific issues and limitations; as Janette emphasised, training “doesn’t only have to be about mastering [activities] in their everyday life – it can also be if they can’t cope with things (...) so we help them with structure and planning” (*ibid.*). Sofie also said, in reference to training with the citizen at home: “You can’t just put on blinders and only focus on...the physical level (...) focusing on a knee or whatever doesn’t function. We get much, much more into the citizen’s – the person’s life than we would if we only focused on what they could do in a training centre” (*interview; 21 December 2015*). In this quote, Sofie made explicit how her professional approach and epistemology are bound up with the individual citizen’s personhood and agency – she even changed her wording to reflect that she does not work with an abstract ‘Citizen’, but an actual person.

Although the therapists’ initial assessments do indeed focus on taking evaluative measurements of the citizen’s functional ability and physical strength with a goal towards training them to embody new or re-learn habits and routines within the home, as I discussed in Parts I and II, the therapists I followed also acknowledged the emotional and psychological factors that were necessary to consider in order for the training programme to be ‘successful’; i.e., for the citizens to attain the personal goals they choose. For example, Sofie described her job as being “almost a training psychologist – I think, what is the problem right now with THIS person in order for him to achieve what he wants, the goal we’ve discussed?” (*interview; 21 December 2015*). In this way, the therapist has to determine how to engage the elderly citizen in training so that they will continue to be able to take care of themselves – or, to echo the political rhetoric, how the therapist can provide activating help that enables self-help.

Janette formulated this in terms of locating the citizen’s energy and determination: “I need to consider their psychological condition – how much energy do they have? (...) If they don’t have any determination or mental strength or whatever, then we have to set small goals instead” (*interview; 5 February 2016*). Here, Janette pointed out the citizen’s motivation and willingness to train as an essential component – and she framed it in terms of their “determination or mental strength”, which suggests a form of power; specifically, willpower. In the political configuration,

when the citizen makes the active choice to participate in the training programme, they also exercise the power of their Will, the experiential aspect of being that arbitrates and decides between possibilities and is thereby responsible for shaping identity and character (Allen 1982: 180). For the therapists, this means that they encounter a citizen who is not merely an individual consumer with the opportunity to choose among a select few service options, or a social agent who chooses to engage in continued labour; they encounter the phenomenological body of a complex person, and they have to help this person choose how they want to be in the world. Thus, in order to emplot a course of training that can produce a certain kind of self-identity and subjectivity, the therapists have to locate this person's Will.

For training to accomplish this unique person's future goals, the therapists adopt an "experience-near" position in which they try to "see, feel, think, imagine" what others experience (Geertz 1983: 57). The physical therapist Sofie described her approach to working with citizens:

In the beginning, it's really clear that, deep down, you're sitting across from another person with full respect and the humble task of trying to know another person. So you try to ask about them – who they are, what does this mean to them right now? (...) I think that being able to clean [the house] yourself is a very small part of the whole picture, if one looks at the whole person. You have to think about the baggage they have, what about their relatives, what they've been through in their lives, how they're doing right NOW – what's their condition now, are they sick? How are they doing? So I think that's primary in describing everyday rehabilitation.

Interview; 21 December 2015

Here, Sofie explained how she focuses on "the humble task of trying to know another person", which suggests that it was important for her to acknowledge and recognise the citizen as a person (Liveng 2011: 273) before engaging with the phenomenological body of lived experience. When working with a citizen, she said she tries to consider "what they've been through in their lives" and she has to interpret this information in order to connect it to what the training might "mean to them right now". In this way, she tries to relate to them on a *personal* level, not merely on an abstract individual level, in order to locate their subjectivity. This is in contrast to how the Visitor Brynja described how she tried to "find the small, small tasks that can make someone feel meaningful" (*interview; 25 February 2016 – see page 97*). Rather than helping a citizen feel meaningful or valuable through the small tasks they perform, Sofie said she tries to determine whether training certain tasks (habits, routines) could be meaningful and valuable to that particular *person*. In other words, the training programme cannot successfully produce transformative change unless it contains individualised, person-specific meaning. Moreover, for

the training to succeed, a person's Will to act has to be present. But encountering (or trying to install) this Will in the 1:1 relation is not always a straightforward process; it often requires the therapists to use a form of clinical reasoning (Mattingly 1991) and negotiation when they encounter a citizen's messy subjectivity, which I discuss in the next section.

7.2. Encountering a citizen's 'messy subjectivity'

Although the therapists talk about pushing people outside of their comfort zones – i.e., that they have to “stimulate and disturb [them] – in a safe way” (*see page 148*) – the therapists' politically-defined function is to support the citizen as they work together in a partnership to achieve the future goals the citizen envisions for themselves. By making these goals realistic, the therapists help citizens make choices that will fulfil the promises to which they have agreed; i.e., to be more productive and self-helping. This ultimately helps the competition state, but it should also provide the citizen with a sense of initiative and personal accomplishment. The therapists' focus on determining training goals *together* with the citizen is an opportunity for the citizen to express their unique hopes and preferences; in doing so, the therapists must try to understand not only the citizen's physical condition but also their psychological status, as well as the history of lived experiences that form the citizen's identity and sense of self. In this way, the project of rehabilitation requires a form of practical reasoning; specifically, “deliberation about what an appropriate action is in this particular case, with this particular patient, at this particular time” (Mattingly 1991: 981).

In the 1:1 relational practice of training, the therapists attempt to transform the power of the individual citizen's Will to a sense of ‘I-will and I-can’, a process that cannot be present-bound because it shapes projects that are orientated towards the future (Arendt 1968: 151). Sofie framed this collaborative project in terms of work and effort: “We come to do some work together – to make an effort that will hopefully reduce their need for some of the services” (*interview; 21 December 2015*). By saying “will hopefully”, Sofie points to the future uncertainty that is involved in this endeavour – for both her and the citizen. As anthropologist and occupational therapist Cheryl Mattingly described, it is generally impossible to determine the outcome of any given course of rehabilitation because it is a process that must be continually adjusted and modified based on the patient's physical, emotional, and ontological limitations, which are always in flux; the therapists thereby attempt to engage the phenomenological body and emplot a

programme that is meaningful in order to help the citizen reclaim their impaired body and articulate a new sense of self (1991: 984).

For example, I followed the occupational therapist Katrine through a training programme with Ulla (age 78), who has chronic obstructive pulmonary disease (COPD), which affects her breathing and circulation; she has also undergone several surgeries to her back (for a disc prolapse and stenosis), as well as a knee replacement. And she would do anything to alleviate her incessant pain⁶⁷. When we sat down at Ulla's kitchen table for the initial assessment (28 October 2015), Katrine began the interview by asking her how things were going. Ulla answered bluntly, "I'm really tired of everything with my leg. The doctor should prescribe more painkillers. (...) I've told him that if I were a dog, they would put me down." Their discussion then focused on Ulla's physical pain and what she was presently able to manage. In terms of functional ability, she was unable to walk very far, even with the support of her rollator – "I couldn't manage without that", she told us. She explained that the pain "fills everything", but that it is the only thing that limits her; other than that, "the desire is there". When Katrine asked about her goals for training, Ulla answered that, in addition to getting "refreshed" on how to put on her support stockings:

I want to be able to go down to [the main street] and grocery-shop...I know it doesn't seem far, but it's far for me. (...) I want to gain more strength in my left leg and get more painkillers from my doctor – they're just not effective enough. Also, to lift my right leg – I have many goals (*laughing*) – and to walk better than I do.

Field notes; 28 October 2015

During this first meeting, Katrine had to make sense of the things that Ulla wanted to be able to do – i.e., to locate Ulla's Will and identify her unique choices regarding who she wants to be in the future – and then emplot them in a way that the random activities are "understandable as part of a coherent whole, one which leads compellingly toward a particular ending" (Mattingly 1994: 812). The ability to decide future actions that contain a sense of freedom regarding 'how I want to show myself in the world' is thus a form of Will-power; they contain a sense of 'I-will and I-can'

⁶⁷ In two subsequent training sessions, Ulla told us that she was planning (and then had been) to visit a Chinese-medicine practitioner to receive therapy and pills. She said, "Maybe it's illegal, I don't know – but I'll go and find out. (...) I'll try anything possible – I've spent a lot of money trying new things for the pain" (*field notes; 5 January 2016*). She later told us that she had been to the practitioner three times, and "it was lovely with a massage and needles (...) but I didn't notice a difference, and it's too expensive" (*field notes; 20 January 2016*). She also told us that her grandson had gone with her to buy cannabis oil, which she hoped would provide some relief (*ibid.*).

(Arendt 1978: 214–5; *see* Jacobitti 1998: 55). In the collaborative plurality of this encounter, Ulla expressed in words *who* she wanted to be – i.e., a person who has less pain, and who can go grocery-shopping and walk better – and Katrine had to acknowledge the intentions (words) Ulla articulated, and then help her perform these deeds (actions).

However, in order to proceed with training, Katrine also had to acknowledge the ‘messy subjectivity’ of Ulla’s phenomenological body – her present need for rehabilitation is based in a myriad of historical and social factors, such as her active childhood and the physical work of her past job as a cafeteria cook, which may have contributed to the weakness in her back and knees, which then required multiple surgeries; similarly, a genetic predisposition and a lifetime of smoking may have contributed to her developing COPD. This combination of historical and social habits, genetics, life choices, structural determinants, and environmental circumstances have contributed to Ulla’s physical pain – pain so severe that she told her physician, “if I were a dog, they would put me down”. This confluence of factors have also made it necessary for Ulla to strengthen her legs now in order to “walk better than I do”. But these modes of affect and thought also animate Ulla as an acting subject, and determine how she tries to act on the world (Ortner 2005: 34). Katrine thereby had to consider the various bodies that Ulla presented: the politically-defined body of the consumer-citizen; the objectified physiological, corporeal body of medical science; and the freely acting phenomenological body of lived experience and identity (Twigg 2006: 87).

Taking this into consideration, Katrine used her clinical reasoning to determine that achieving all of Ulla’s ‘I-will and I-can’ goals were likely more ambitious than what they could accomplish within the training timeframe of 10 weeks⁶⁸. She told Ulla, “Training needs to be connected to an activity you want to do, but I don’t think it’s realistic for you to do a big, heavy grocery-shop. So let’s start smaller and try just walking to the store” (*ibid.*). Here, Katrine helped Ulla choose goals that were realistic based on what she could do *now* and what was possible in the *future* (I-will and I-can), and she acknowledged Ulla’s personhood and the future self she envisioned for herself. Furthermore, by saying “let’s start smaller”, Katrine framed the goal in terms of the activities they would work on together, which affirmed their partnership and plurality; i.e., they made a mutual promise to do this work and these actions together, which validated both of their social identities and subject positions. Katrine’s identity as an occupational therapist with a certain

⁶⁸ This timeframe is set by the municipality’s policy. If a citizen cannot reach their goals within 10 training sessions, they must get a new referral from their general practitioner or a municipal authority.

epistemology and worldview was bound up with Ulla's identity as an active agent who needed Katrine's help to walk "better than I do".

In order to engage the citizen in the training programme, the therapists must recognise the citizen's self-identity and unique personhood, and the citizen must recognise the therapist's expertise and professional identity. In this 1:1 relational practice, the therapists acknowledge them as unique, freely acting subjects, and citizens are allowed – even encouraged – to exhibit their 'messy subjectivity' and their phenomenological bodies with a lifetime of lived experience. But, as I have already mentioned (*see page 108*), everyday-rehabilitation programmes emphasise citizens being 'experts in their own lives'. Thus, in a health encounter, the professional is expected to relinquish their expert role in order for the citizen to develop their own intrinsic power (Andersen et al. 2000: 14). But allowing citizens to freely choose can create complications for training, which I discuss in the next section.

7.3. Empowerment through free choice

The municipal politicians and health experts have determined that the training programme is a "partnership between the citizen and [the team member]" (*municipal pamphlet*). But rather than recognising and accepting the essential plurality of this partnership, some citizens consider the training offer to be yet another service option, wherein they as consumers can freely choose (Højlund 2006: 43) the forms of action they do together with the therapist. For example, during the introductory visit with Norah (age 79), Sofie asked if she had any particular wishes for the training sessions; she emphasised that she takes her point of departure in what Norah specifically wants to focus on and accomplish. Norah said that, primarily, she would like to be better at walking. She told us that she needed to look down at the paving stones on the sidewalk or hold on to furniture inside her apartment in order to keep her balance; thus, in this regard, she said, "My greatest wish is to be more confident" (*field notes; 26 October 2016*).

When I arrived at the Training Team's office prior to the next session, Sofie told me that Norah had acted very strange when she called to confirm the appointment: she greeted Sofie like an old friend and was extremely energetic and happy. Sofie said, "It sounded like she'd had some 'morning juice'" (*field notes; 5 November 2015*), which is a local expression referring to someone who drinks alcohol early in the day. We discussed that, in the hospital's rehabilitation notes, Norah was described as "a woman known to have osteoporosis and alcohol abuse" (*online journal; 16 October 2015*). Norah had also told us during the introductory visit that she likes to

relax with “a glass of red wine with dinner”⁶⁹ every evening (*field notes; 26 October 2015*); thus, taken altogether, Sofie suspected that Norah was an alcoholic. As Sofie told me, the thick skin and broken capillary veins on Norah’s nose, watery eyes, and being very underweight pointed to a long-time drinking problem (*field notes; 5 November 2015*). Sofie also believed that some degree of Norah’s strange behaviour was due to the fact that she had suffered a mild brain injury (*see page 109*). In her estimation, Norah was simply unable to make certain connections: “She doesn’t understand the ‘red thread’ of training and how each session connects to the long-term goal...she just thinks about each time and wants to get through it” (*ibid.*). Sofie said that she thought Norah “had gotten used to doing things a certain way for a long time” (*ibid.*), which complicated the potential outcome of training.

During the initial evaluation, Sofie and Norah had agreed together that a training goal would be to walk down to Strandlund, a municipal facility less than one kilometre away from Norah’s apartment, and where she had previously taken exercise classes twice a week. Since her latest hospitalisation, Norah said she was not “back on my feet yet” (*field notes; 26 October 2015*), and she generally struggled with balance due to her poor eyesight and damaged leg, so they also agreed to train with Norah’s new outdoors rollator. When we arrived for a subsequent training session, Norah was watching out her kitchen window, waiting for us to arrive. I wrote in my field notes:

We come upstairs to the apartment, and Norah opens the door before we knock. She shakes our hands (suddenly very formal⁷⁰), and immediately asks if we were going to go out for a walk. Sofie answers that we’re going to go down to Strandlund. But Norah says that she wants to go to the corner store: “I need to get some cash and buy avocados.” She seems very definite and determined to go out; also, because it is a sunny (but cold) day, she wants “to get some fresh air”. (...) After agreeing to try walking with her large outdoors rollator, which Sofie tells her is “more supportive and stable”, we walk down to the main street. Norah and I chat while Sofie walks behind us and to the side to observe Norah’s gait. When we get to the intersection, Sofie suggests we go over to Strandlund.

⁶⁹ When I asked Norah later about her drinking, she said: “I drink white wine almost every day. And I enjoy it! I was told in the hospital ‘you drink too much’. But I don’t have more than two glasses of white wine every day, and I can’t see that there’s anything wrong with it! (...) I also love a little glass of whiskey once in a while. In the winter, if you come home and it’s really cold, it’s lovely to have a little snaps-glass of whiskey. Whup!” (AC: *Do you ever drink in the morning?*) “No! No! I couldn’t dream of doing that!” (*interview; 15 December 2015*).

⁷⁰ At the end of the previous visit (*5 November 2015*), Norah had acted overly familiar and gregarious, blowing kisses to both of us when we left her apartment.

Norah: No! We're going to the corner store.

Sofie: Yes, we can go there afterwards.

Norah: No, not today. Next time!

Sofie (pause): Yes, the next time we go out, we're going to Strandlund.

We continue to walk a short distance and go into the small store; Norah greets the manager, who is unloading some boxes, and he greets her by name in return. Norah puts a package of three avocados in the front bag of the rollator, and then goes to the back of the store. Norah takes a container of berry-flavoured yogurt out of the refrigerated section, and then goes up to the cashier. She asks me to get her a bottle of whiskey from a high shelf; I do so, and she puts it in the rollator's bag along with the avocados and yogurt. (...) On the way back to the apartment, Sofie gives Norah a lot of encouragement and praise, telling her that was "well done" and "so awesome", and commenting on everything she bought except the whiskey.

Field notes; 13 November 2015

While we waited (out of earshot) for Norah to pay for her items, Sofie told me not to help her with her bags because "she needs to know we're not her assistants". This seemed to be a reaction to Norah asking me to pull down the bottle of whiskey for her; especially because I am not much taller than Norah, and she could have asked the cashier to do it for her. I had also helped Norah take the outdoors cover off her rollator before we left. In addition, this was a way for Sofie to reinforce both her professional position and mine – it seemed as though she wanted to remind Norah that we were all there "to do some work" (*interview; 21 December 2015*). Later, as Norah was locking up the rollator in front of her apartment building, she struggled to put the rollator's cover on while also managing her shopping bag. Sofie held me back and told Norah, "We're not trying to be unhelpful – it's just important to see how much you can manage on your own" (*field notes; 13 November 2015*). When Sofie and I spoke on the way back to the office after the session, she acknowledged Norah's physical limitations in managing the rollator, saying that "her brain isn't sending messages to her body properly" and that "her wobble and balance problems seem to be alcohol-related, not due to her bad leg. (...) I have a feeling that her issues are mental, not physical" (*ibid.*).

In this example, Sofie attempted to locate and transform the power of Norah's Will to focus on her future-orientated sense of 'I-will and I-can'. She did this by recognising Norah's personhood (with all of its 'messy subjectivity' in her desire to buy alcohol) as well as her ability to make choices for herself, in alignment with the political discourse about the citizen's 'free choice'. Hence, Sofie relinquished her expertise and allowed Norah to dictate the course of the training

session; i.e., walking to the store instead of Strandlund. Norah thereby refused to acknowledge Sofie's expertise and professional identity as a physical therapist, instead resisting and negotiating the therapeutic actions in which Sofie tried to engage her. Sofie tried to find a way to make the training meaningful for Norah by basing it on activities Norah said she wanted to do (i.e., being "better at walking", going to Strandlund), but Norah's articulated intentions and actions were contradictory. Although Norah said that her "greatest wish is to be more confident" (*field notes; 26 October 2016*) when walking, she would only walk outside if she could set the terms. In a long-term perspective, it is doubtful that the goal of being "better at walking" in order to purchase alcohol will make Norah feel "more confident". But in this example, Norah assumed the identity of a freely-choosing consumer of services; thus, she wanted to decide when and how to participate in training, and she expected both Sofie and me to be her "assistants" – a role that Sofie immediately rejected and then reinforced by telling Norah "we're not trying to be unhelpful".

Furthermore, Norah's lack of narrative understanding complicated the process of therapeutic emplotment because she could not envision the outcome of training; rather than the future-orientated 'I-will and I-can', her Will contained a temporal component that was firmly grounded in the present. In the plurality of the training process, Sofie and Norah are supposed to imagine future possibilities together, and then work in partnership to achieve Norah's goals; with regards to the political aspirations, this collaboration should activate the citizen's potential for continued labour, action, and self-care, and thus be empowering. Although Norah initially seemed motivated to train, Sofie determined that Norah "has "gotten used to doing things a certain way for a long time" and thereby "just thinks about each time and wants to get through it" (*field notes; 5 November 2015*). Here, Sofie pointed to aspects of Norah's personality as the reason why they could not engender plurality and collaborative action, believing that Norah "just wanted to get through it" and thereby did not see the training as a way to begin anew.

Norah later told me in an interview, "[Sofie] directed me just so I could get started. That's what she directed me in – just to get started. (...) What she showed me was common-sense. And she showed me that I could do more than I thought I could" (*interview; 15 December 2015*). This suggests that Norah could only understand the purpose of training in the immediacy of the deed-in-the-doing; even two months after working with Sofie, Norah remained present-bound and did not comprehend the *future*-orientated value of training or its meaning in her everyday life. Instead of being empowered by the choices she could make and realising her future potential, Norah chose to engage in training as a strategy to "get started" and achieve her unarticulated goal, which

was to be able to do exactly what she wanted to do *today, right now*. Although Norah said that Sofie “showed me that I could do more than I thought I could”, this confirms the contradiction between her words and deeds because, during training, she was only willing to engage in actions that fulfilled her own immediate desires, not her future goals. Thus, despite providing a presence and acknowledgement, Sofie was unable to enter into a collaborative partnership with Norah and use her clinical expertise to emplot a training plan that would propel Norah towards these representations and empower her to take future-orientated action.

During my fieldwork, the therapists did not work with any citizens who had significant cognitive limitations and could not articulate their goals and identities through words or deeds; the training programme is not intended for citizens who have been cognitively affected by a severe stroke, Alzheimer’s disease or advanced dementia, for example. In order for the programme to succeed, citizens are expected to have an active Will that allows them to make choices. But I observed that some citizens chose to relinquish their right to a ‘free choice’ altogether, which seemed to give them a sense of stability and ontological security; I discuss this in the next section.

7.4. Relinquishing free choice

The municipality considers “training to be a part of everyday life, where all of our staff members must support citizens in being active” (*municipal pamphlet*). As I have already described in this chapter, this means that the therapists give citizens the opportunity to choose the specific activities of daily living that they want to train. But in the collaborative relational practice of everyday rehabilitation, the therapists also determine actions that will give the citizen a sense of assurance about their ability to remain a competent social agent; to help them stabilise their world so they can live in it as well as possible (Fisher & Tronto 1990: 40). Here, the therapists recognise the elderly citizen as someone who can envision their own potential as a person and make choices about how they want to be in the world. In the plurality of training, the therapists bind themselves to the citizen “in the face of the essential uncertainties of the future” (Arendt 1968: 164), so that smaller – yet altogether successful – accomplishments will become part of their ‘I-will and I-can’, and thus their everyday lives.

For example, I followed the physical therapist Sofie to train Colborn (age 94), who had been the director of medicine and molecular biology at a large hospital in Copenhagen. Colborn had recently been in palliative care at a hospice, and when he returned home, he started a training programme with Sofie to improve his physical condition. Colborn seemed mentally sharp, very

strong-willed and energetic, and he had a wonderful sense of humour. He only stopped playing tennis when he became ill with lymphoma. Colborn and Sofie had been working together for a few weeks, and they seemed to have developed a very friendly relationship with lots of joking and teasing. And Colborn did not hesitate to ‘show off’ his medical knowledge to impress Sofie, such as when she suggested he take ginger to alleviate the nausea he was experiencing as a side effect of prednisone, an immunosuppressant drug. With disdain, Colborn said, “People who take things like that are so stupid. There’s no scientific evidence – no journal articles about these alternative, so-called ‘health’ treatments. People who take them need to take responsibility for it, because no doctor would tell them to do it” (*field notes*; 4 June 2015). And during the session, when his nose started running, Colborn said it was because his “parasympathetic system and autoimmune system are being stimulated by these exercises”. Nevertheless, he deferred to Sofie’s professional knowledge, and insisted that she choose which exercises he should focus on in that day’s training session:

Sofie: What would you like to work on today?

Colborn: You’ve come to give help, and I sit here to get help. So it’s your choice.

Because he was suffering from pneumonia and a broken arm at the time, Sofie adjusted the amount of exercises they usually did together, which Colborn said was “logical and rational”. Instead, she instructed him through a series of chair-stands and stair-training to strengthen the large muscles in his legs, which would, as Sofie said, “keep the neurons firing” and ultimately help him manage the stairs by himself. After the session, Colborn sat and rested on a small bench between the front door and the kitchen; Sofie suggested that he have some protein after training. Colborn’s wife brought him a large glass of milk and, after he took two big gulps, Colborn told Sofie he was “grateful for the exercises to build more strength”. Then he winked at me and said, “My palliative team didn’t think that training would help – but I know it does.”

In all of the health encounters I observed, there was never an open discussion about dying or death – the mortal end all living beings must face – even with citizens like Colborn, who were in advanced old age and/or the late stages of a terminal illness. Rather, the emphasis in each visit was on what a citizen could or could not still manage to do themselves, and thus how they could continue “to be among men” (Arendt 1958: 7). In this example, Colborn seemed to want the presence and acknowledgement of a professional like Sofie to support his goal to remain a productive and ‘limitless’ social agent. For a person who may feel insecure about the future, the freedom to make choices can produce a particular form of anxiety or dread – “anxiety is the dizziness of freedom” (Kierkegaard 1844: 61) – which refers to the existential awareness of the

possibility of *being* able to make a choice. The human Will can be affected by the act of choosing: “until I finally act, I cannot be certain what I will do or how what I attempt will turn out” (Arendt 1978 in Jacobitti 1998: 55).

Thus, even though Colborn is a trained physician with scientific knowledge about the human body and the cellular changes that accompany the ageing process – he is highly educated, had a long and (presumably) distinguished medical career, and has all the resources (financial, material, social, etc.) available to him – he did not devise a training programme for himself or ask a colleague to help him. Instead, he decided that it was important that someone from the municipality come to his home to provide training. Being positioned as a rational, ‘limited yet limitless’ consumer who has the freedom to choose how he wants to act, Colborn accepted the municipality’s promise that training would help him remain a competent, social agent by engaging in a form of labour that would keep his body active and productive – and perhaps defer the decay of the Fourth Age and death – for as long as possible. As he said, “My palliative team didn’t think that training would help – but I know it does.”

In this situation, one could argue that Colborn displayed the Will-power and the sense of ‘I-will and I-can’ to act, but he felt more ontologically secure if Sofie made the choices for him; her presence and acknowledgement seemed to validate him as a person who still had value and the potential to be productive. As such, the training encounters may not always follow the government’s logic of choice, wherein a citizen-consumer is expected to be an ‘expert in their own life’. Instead, as could be seen in this example, even when an ‘expert’ citizen is given the opportunity to make choices for themselves, they may rationally choose to defer to the therapist’s professional expertise. This, of course, validates Sofie’s social role as a professional with a particular form of knowledge about the human body and its physical functionality. But I argue that it also reinforces Sofie’s role as a *care* professional – she does not have the same level of medical education or experience that Colborn does, as he playfully reminded her. However, she – as a representative of the welfare state – may provide him with a particular form of ontological security (Giddens 1990: 92); i.e., an assurance that the municipal institutions of the welfare state will continue to care about him. But, more important, the form of care and attention that Sofie gave Colborn seemed to reassure him that he still has value as a person – not just as a citizen.

Summary

In this chapter, I have described how the therapists approach and encounter a citizen's phenomenological body of lived experience. Because the therapists' job is to emplot a narrative course for the training programme that unfolds in multiple therapeutic sessions over a period of time, they must recognise citizens as persons who have agency as freely choosing subjects as well as persons with 'messy subjectivity' and unique lived histories, preferences, and hopes for their future selves. In contrast to Visitation, which requires a focus on the citizen's present needs and their ability to return to their former productivity to benefit the competition state, the Training Team's therapeutic work reveals the citizen as a person with specific issues and limitations. The process of setting goals together is where new beginnings and future possibilities are meant to be envisioned, and the citizen is given the opportunity to choose activities and actions that contain a sense of freedom regarding 'how I want to show myself in the world'.

I also discussed how, in order to emplot the temporal, narrative structure of the training programme, the therapists use a form of clinical reasoning that targets not only the individual citizen's physical condition but also tries to locate their agency, particularly the power of their Will and its sense of 'I-will and I-can'. As I argued, 'successful' training is predicated on a plurality between individuals –i.e., the presence and acknowledgement of others – which should create particular forms of meaning and action, and a "new kind of assurance" (Arendt 1958: xix, 200). In this plurality, the citizen is expected to articulate a form of Will-power that is orientated towards the future, which is then acknowledged by the presence of the therapist; this should reinforce their social roles and partnership, and thereby enable them to exercise power collectively (ibid.). However, there is often a disconnect between the citizen's articulated intentions and their deeds in the doing, which challenges the therapist's professional expertise.

As I have described in this chapter, training is meant to activate the citizen's potential for continued labour, productivity, and action. According to the political logic that governs and defines their work, the therapists' task is to help elderly citizens make the 'correct' choices so they can 'master' their everyday lives and achieve a better quality of life – i.e., to 'train themselves free' from the need for municipal services. But, as I have suggested, the form of plurality in this partnership is still a 1:1 relation between defined individuals, which has been politically constituted. Furthermore, a focus on potential, goals, and a sense of initiative through free choice places responsibility on the individual and prioritises action; in this way, it ties "the identity of particular actions to properties of the individuals who perform them" (Schatzki 1997:

286). This means that, conversely, the actions that individuals *cannot* (or *will* not) choose to do also become tied to their identities. A political emphasis on an elderly citizen's potential to remain active and self-governing – combined with a discourse that prioritises their choice to become more independent and autonomous – promises a new, open-ended beginning while it simultaneously implies that they lack something essential if they fail.

However, as I describe in the next chapter, these encounters are never truly 1:1 interactions between defined individuals. In the context of a training encounter, other forms of sociality, action, and care emerge. Specifically, a form of shared decision-making and caring action takes place, which becomes distributed among other actors in the social collective.

Chapter 8

Producing a ‘shared responsibility’ for care

In general, everyday-rehabilitation programmes are being established as a solution and a “constructive response” (*see* page 15) to the competition state’s market problem of a rapidly growing elderly population that is expected to demand more care services. But, despite the ‘hyper-individualist’ political conception of independence and autonomy (Christman 2004: 147) that is present in many health policies, humans with their ‘messy subjectivity’ are not always rational and cannot achieve self-mastery on their own (Tronto 2017: 31). Thus, as I argue here, the state’s transition from providing help to enabling self-help also contains a specific distributed aspect that constitutes a different form of care. Training in particular includes a form of shared decision-making⁷¹ wherein both parties make an investment in the outcome; the citizen because their health is at stake, and the professional because they are concerned for the citizen’s welfare (Charles et al. 1999: 656).

In this chapter, I discuss how the Training Team therapists engage in shared decision-making and caring action (Åström et al. 1993) during their encounters with elderly citizens, and how care thus becomes a social responsibility that is shared between a variety of actors. As a concept, ‘care’ is a slippery term that can be defined in many different ways. It can be understood as a way that others help us “to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible” (Fisher & Tronto 1990: 40); I use the term ‘caring action’ to refer to the decisions that the therapists make that consequently help the citizen make choices that will ‘repair’ their world. But this process also contains a form of ‘relational autonomy’, which refers to a “free, self-governing agent who is also socially constituted and who possibly defines her basic value commitments in terms of interpersonal relations and mutual dependencies” (Christman 2004: 143).

⁷¹ Within medical practice, there is a model for ‘shared decision-making’, such as that described by Charles, Gafni, and Whelan (1997, 1999). In this model, both patient and doctor try to “build consensus on the appropriate treatment to apply” (Charles et al. 1999: 781). My use of the term here does not refer to any type of clinical medical treatment but rather to the collaborative, interactional decisions made in relation to the training encounter and the citizen’s care.

This relational autonomy emerges in a specific social context “within which all individuals exist and acknowledge the emotional and embodied aspects of decision-makers” (Walter & Ross 2014: S16). That is to say, as I describe, decisions are not made by autonomous individuals in isolation from their complex social environments. In order to highlight how these forms of sociality can be seen in the Training Team’s work, I first discuss how the role of the Visitor has changed in relation to how they are allowed to care for citizens who are unable to make rational choices regarding their health or how best to ‘master’ their everyday lives.

8.1. Encountering ‘irrational’ citizens

As I have outlined elsewhere, in the contemporary Danish competition state, municipal health professionals are expected to find ways to help citizens remain independent and self-helping for as long as possible, which should improve their quality of life and reduce their need for welfare services. But when a person is experiencing a health crisis or some kind of significant change that unsettles the embodied habits and familiar routines that typically stabilise their everyday lives, they often need to find a more “bearable way of living *with*, or *in*, reality” (Mol 2008: 46). It is therefore the health professional’s job to help them manage this upheaval, so they can cope with the loss of control they may be experiencing and regain some form of equilibrium, which will thereby allow them to remain competent social agents. As such, “sickness, and loss of equilibrium, do not merely represent a medical-biological state of affairs, but also a life-historical and social process” (Gadamer 1996: 42). When the health professionals provide this form of stabilisation to ‘irrational’ citizens, the burden of care becomes more equally distributed.

For example, I followed the Visitor Freja to evaluate Søren (age 61), a former accounting executive for a large Danish bookstore chain, who was dying from adrenal cancer. When we arrived, his wife Rikke brought us into their cozy living room, where Søren was lying on a makeshift bed, surrounded by pillows, blankets, empty soda bottles, and cigarette packets. I wrote in my field notes:

I introduce myself, and his hand is like a feather when I shake it – he’s all skin and bones. His body looks really bad, but his mind is sharp, and his eyes are bright and mischievous. (...) Søren has just started another 14-day round of chemotherapy, and tells Freja that he doesn’t have much energy or appetite. She begins her evaluation by saying, “Tell me a little about your daily life so I can find out what you need.” Søren explains that, in addition to the Visiting Home Nurse, he’s just started receiving Home Help services in the morning, but it’s been difficult to get used to different people

coming in and out. Rikke begins to cry, and says she just can't lift him up to move him or help him walk. A special lift has been ordered, which will be installed tomorrow. Freja says to both of them, "It's so important that you have the assistive devices and help you need."

Field notes; 18 November 2014

Here, Freja's job as a Visitor was to decide which services would improve not only Søren's quality of life, but also Rikke's life as his spouse and primary caregiver. The evaluation focused on what both of them needed to make their daily lives function optimally under the circumstances, and Freja was responsible for approving and then coordinating the various service providers to manage Søren's care⁷². After the visit, Freja explained to me that a citizen with a terminal diagnosis is eligible to receive whatever services they might need, which are provided by the municipality at no additional cost. Freja said that, in this case, she "took things slowly and carefully", and did not actually suggest everything the couple was entitled to because she did not want to overwhelm them; she determined that both Søren and Rikke were in denial about his condition being terminal, so she decided that "they're just not ready" to receive so much information all at once (*ibid.*).

In this situation, Freja had to interpret the regulatory framework of the *Social Services Act*, and then make certain judgements and decisions – not only regarding which services she was legally able to offer Søren, but also how much information to give both him and Rikke, and when. Because of Søren's diagnosis, Rikke in particular seemed to feel a sense of uprootedness, an instability, and a loss of equilibrium – at the time of Freja's evaluation, she was unsure about how she would manage both her present and future life. Freja had to judge the specific contextual situation, use her professional expertise as a trained nurse to evaluate Søren's physical condition, and then make stabilising choices *for* the couple. In this way, Freja resolved that they were *not rational* due to feeling overwhelmed by the severity of Søren's terminal illness. She used her professional judgement to determine that they were unable to make choices for themselves, and then ensured that both Søren and Rikke received the most appropriate form of care and help they could receive from the municipality. And Rikke was grateful for Freja's reassurance, which supported her need for stabilisation, and thereby improved her quality of life.

This type of evaluation, decision-making, and coordination has been the predominant function of the Visitor as a municipal authority. Traditionally, the role of the Visitor and other health

⁷² Once Freja set these providers in motion, the responsibility for coordinating Søren's ongoing care would be allocated to the Visiting Home Nurse.

professionals has been to stabilise society (Beedholm & Frederiksen 2015: 157) by providing a form of ontological security (Giddens 1990: 92) to needy citizens whose daily routines have been disrupted due to illness, injury, or some level of functional decline; the Visitation entered the home as an expert who ‘knows what’s best’ for the citizen, assuring them that the welfare state’s institutions would help them regain a sense of order and continuity in their daily lives. However, due to the state’s transition towards self-governance and self-help, Visitation now only have the freedom and authority to offer such help and reassurance in the case of terminally ill patients or those with extreme cognitive limitations (e.g., Alzheimer’s disease, brain injuries, certain mental illnesses); as I have already discussed, all other citizens are considered to be rational, competent consumers with the ability to make individual choices regarding their health. This consumer-orientated configuration “emphasises patient sovereignty and patients’ rights to make independent, autonomous choices” (Quill & Brody 1996 in Charles et al. 1999: 657). Thus, the Visitation’s role has developed an emphasis on providing rational consumer-citizens with opportunities to reduce their health risks, regain their productivity, and be more active.

In the rhetoric of ‘shared responsibility’, the promise of an individual citizen’s potential to be more self-helping to benefit certain political goals has been formulated as a *mutual* intent to act towards future opportunities and goals – i.e., ‘we will help you as long as you help yourself’⁷³. As political scientist Joan Tronto argues, neoliberalist rationality assumes that self-mastering humans can be developed, and that caring responsibilities can be allocated in a particular way (Tronto 2017: 29, 33); however, she attests that humans do not conform to these operating logics, and care is an essential part of human sociality. Thus, care is contextual and, as a result, non-essentialist (ibid.). In a similar vein, I argue that humans find a way to care for each other. As the responsibility for providing citizens with stabilising help and support has transitioned from Visitation to the Training Team, there is simply a difference in *who* cares. From my fieldwork with the therapists, I could see that a form of caring action and shared decision-making was a central component of the training programme, which I describe in the next section.

⁷³ For example, Denmark’s *Social Services Act (Lov om Social Service)*, which states: “The assistance provided under this Act is based on the individual’s responsibility for himself and his family. The help is customised to the individual’s needs and assumptions in cooperation with the individual” (Ministry of Children, Equality, Integration and Social Affairs 2014: §1., 3.2 and 3.3).

8.2. *Caring action and shared decision-making*

In occupational therapy, clinical reasoning is directed towards action (Mattingly 1991: 981), which refers to deciding how best to achieve a certain goal; this narrative emplotment is a complex, interdependent practice that often entails continual reassessment (ibid: 982). But, as I describe, it also requires caring action to help ‘irrational’ citizens make the choices that will enable them to repair their worlds, and such caring actions may also be distributed among other actors. For example, the occupational therapist Katrine worked to train Ulla with putting on and taking off her support stockings (*see* page 114) over four sessions, but Ulla’s pain was a factor each time. Prior to a subsequent session (24 November 2015), Ulla told us that her pain medication (4 milligrams of OxyContin per day plus paracetamol/acetaminophen) did not work well enough. Katrine said, “If I had a button I could push to help you, I’d do it”.

However, Ulla was extremely determined to manage the stockings by herself, despite how painful and arduous the process could be. Prior to the next training session (2 December 2015), Ulla told us that she had been feeling “up and down today. I’m having a lot of pain in my left leg”. When they began and Ulla succeeded in getting the first stocking on, Katrine told her, “You managed that well – really good”. But after practicing with the stockings several times, Katrine noticed that Ulla was breathing heavily and getting tired; she encouraged her to take breaks if she needed to, giving her a chance to catch her breath. As they continued, Ulla repeatedly said, “This is really hard work” – and, after each rest-break, Katrine asked, “Do you have the strength to take them off and put them on again?” and “Do you have the courage to try it again?” Ulla persevered until Katrine decided to end the training:

Ulla: I don’t have any more strength. (...) I don’t think I can do it again.

Katrine: No, you should just keep [the stockings] on now.

Ulla: But I thought we needed to train more.

Katrine: No, you’ve done it two times – that’s enough.

Ulla: Well, I need to at least try to do it myself. (...) I need to do it so I’m not dependent.

Field notes; 2 December 2015

By ending the session – even though Ulla said she thought they “needed to train more” – Katrine understood that Ulla could no longer produce the biological labour power (Arendt 1958: 99) necessary to conduct the operation. Katrine’s professional knowledge and experience allowed her to see the physical pain and exhaustion that Ulla was experiencing. She also knew how determined and motivated Ulla was; after an earlier session, Katrine told me that Ulla was

“tough”, adding, “There are some people who would give up, but she won’t” (*field notes; 17 November 2015*). Thus, Katrine realised that Ulla might feel discouraged if she did not succeed in doing everything she wanted to do during the training session. But using caring action, Katrine adjusted the training session to accommodate what Ulla was able to manage that day.

In this example, Ulla and Katrine had made a promise to act together to achieve Ulla’s future goals. But during a session that was especially difficult and painful for Ulla, the awareness of her lack of physical power prompted a sense of uncertainty, and she said, “I don’t think I can do it again”. In addition to her physical body being tired and in pain, Ulla’s willpower was also fatigued from the training effort. Katrine recognised that, even if Ulla said she did not want to stop the training, she should make the choice for her and end the session to preserve Ulla’s physical energy. In the relational partnership of the encounter, Katrine’s presence allowed Ulla to keep her promise to do the training – and Ulla articulated her intentions by saying that she knew she had to “at least try to do it myself. (...) I need to do it so I’m not dependent”. But Katrine made a judgment about how much activity Ulla could realistically handle that day; with this caring action, Katrine acknowledged the hard work that Ulla had already done and helped her modulate her choices, which gave Ulla a sense of assurance that she would be able to continue working to reclaim her body and eventually transcend her physical limitations (Mattingly 1991: 984).

Ulla continued to seem motivated and optimistic after every training session; she and Katrine would sit down at the kitchen table and discuss how things went that day while Katrine made notes in her computer files, and they would often chat and laugh. This was also a way for Katrine to track Ulla’s progress in relation to her goals, as well as to plan out and emplot the next sessions. But Katrine’s care for Ulla’s welfare was not limited to the training encounter – in order to help her, Katrine had to interact with many other actors in the municipal system. For example, over the course of training, Katrine repeatedly tried to coordinate the sessions with Ulla’s Home Care worker (who helped her put on and take off her support stockings every day); one of the political goals for the training programme is for the therapists to work with *both* the citizen and other municipal professionals, such as Home Care and Home Help, in order to reduce the citizen’s need for services. Katrine told me, “It’s *super-cool* when it succeeds (*laughs*), but those times when it doesn’t work out, then it can be a bit heavy. You have to be gracious and say, ‘No problem – we’ll just try again’” (*interview; 5 February 2016*). But the logistics of coordinating Ulla’s training presented a challenge to Katrine because the Home Care worker often came late in

the evening after Katrine's work hours. At that hour, Ulla also tended to be very tired and experience more pain, which affected her strength.

In addition, Katrine was frustrated that she was unable to make therapeutic progress to improve Ulla's walking function, telling me, "If she had more support, I think she could do it – she has the strength to get through it" (*field notes; 21 December 2015*). Thus, Katrine decided to enlist the help of her colleague, the physical therapist Sofie, telling me, "She's good. She can give [Ulla] some advice about how to walk better with her crutches" (*ibid.*). When we all arrived for the next session (*5 January 2016*), Katrine explained why Sofie was there, telling Ulla, "She has a lot of good ideas about how you can walk better with your crutches – that will help you when you go shopping with your electric scooter." As we sat together at the kitchen table, Sofie asked Ulla several questions about her level of pain and the type of surgeries she had undergone in order to get a better idea of how these factors impacted Ulla's walking function. In my field notes, I wrote:

Sofie: Do [the crutches] fit you properly?

Ulla: Yes, I think they're fine. Do you want to see them? Would one of you get them for me? (*Katrine goes into the entryway to get the crutches, which are propped by the front door next to Ulla's electric scooter. Ulla stands up from the table and begins to walk with the crutches, going slowly from the kitchen to her bedroom on the other side of the apartment.*)

Sofie (observing): I think they're too high for you. (*She makes an adjustment to the elbow piece, and Ulla tries walking again.*) You're walking fine! You seem very secure. But you're also in your own home. Remember to take breaks if you need to.

Ulla: It feels quite secure to walk with them.

Sofie: Looks good – well done! (*Ulla crosses the apartment several times, as Katrine follows behind her and watches.*)

Field notes; 5 January 2016

In this example, Katrine realised that she alone did not have the expertise to help Ulla walk better with her crutches, so she asked her colleague Sofie to provide her professional advice. As a cross-disciplinary team, this type of collaboration is a central feature of the training programme. But this also highlights that that the training encounters are not a 1:1 relation between defined individuals; by engaging in shared decision-making and collaboration with others, care for the citizen becomes an *interactional*, social relation between multiple actors. In this example, Katrine did not only rely on Ulla's own 'expertise' about her health condition, her level of functional ability, and her limitations; by inviting Sofie to attend the session, Katrine made her part of the care team that was responsible for Ulla's welfare; as such, they all had an investment in the

therapeutic outcome. Like physical therapy itself, I argue that such caring actions and shared decisions are contextual and situated – they must thereby be flexible and based on multiple forms of input from a variety of actors.

In this way, the training encounters I followed were not isolated sessions that were set off in time and space; there were also other forms of collaboration, partnership, and shared decision-making that occurred before and after each session, which I describe in the next section.

8.3. The social co-production of decisions

Traditional forms of evidence-based decision-making often contain a paternalistic approach that assumes that health experts can transfer information in an accurate and unbiased way so that individual patients can be “filled up (like an empty glass) with new knowledge and thereby transformed into informed and willing decision-makers” (Charles et al. 1999: 655). This is reminiscent of the 1:1 relation I have described, which puts undue pressure on both the professionals and the patients to behave as autonomous, rational agents. As I have already suggested, people are complex and do not always make rational choices – especially if they are sick, injured, or dying. In these situations, people can be overcome by emotions that may compromise one’s self-control as well as their “rational agency” (Walter & Ross 2014: S18). Moreover, the experts themselves are people who may have doubts or insecurities about their knowledge and the ‘best’ way to proceed to reach the desired outcome. In these cases, as I described in the example with Katrine, Sofie, and Ulla in section 8.2., it is important for the therapists to involve other actors in how they decide to care for a citizen. Although consumer-citizens are given the ‘free choice’ to make decisions for themselves, especially in terms of their goals for training, the evaluative process that goes into these choices is also not limited to the training encounter. I argue that neither health professionals nor citizens make decisions alone as individuals – they each have to consider a multitude of factors, both past and present, and often consult with others before articulating their choices. In this way, decisions are co-produced and constituted through social relations.

For example, Walther (age 67) is a retired pharmacologist who lives by himself in a modest house behind a large hospital. It is a one-storey house with hand-grips near the front door, which help Walther manage the single step into the front entryway. He has a progressive neurodegenerative disorder known as *spinocerebellar ataxia type 1* (SCA-1), a hereditary condition that affects the region of the brain responsible for muscle coordination and control, and thus causes clumsiness

due to a loss of motor control, a broad gait with balance problems and a tendency to fall, erratic eye movements and double vision, as well as poor speech and trouble swallowing. When Katrine and I arrived for the initial interview (15 October 2015), Walther used a special key-pad to open the front door, and greeted us warmly with a smile. During the interview, Walther told Katrine that he had previously participated in both individual and group physical training at the ambulant-clinic to work on ADL⁷⁴ skills such as using a computer and buttoning shirts, as well as speech therapy. He said, “It was fine, but not particularly helpful in terms of practical things like picking up papers and turning on the TV”. He told us that he would like to receive training at home in order to retain his current level of functional ability as long as possible.

Katrine assessed his living conditions, and together they determined a plan for training, which would primarily focus on showering and walking outdoors with his rollator. When we talked in the car after the evaluation, Katrine told me that Walther was much more mobile, self-sufficient, and talkative than she had expected from what she had read in Visitation’s notes – it was not clear how often he had fallen, but she had been led to believe that the progress of his neurological condition was much more serious. However, she said that, if Walther’s main goal was to maintain his functional ability, then he would probably benefit more from private physical therapy – those trainers work much more intensely than what she can offer in the course of a few weeks, and it would be better than him having to go to and from a rehabilitation centre like Tranehaven.

During the next visit, Katrine asked Walther how often he falls or has fallen; he answered that it has been perhaps once every two or three months, and he is always able to get up by himself. However, he says, “With my illness, it’s about learning what you can and can’t do. You keep doing things you’re used to doing until suddenly you can’t do them” (*field notes; 22 October 2015*). Despite Katrine’s efforts to help make the shower more secure and to walk with his rollator outdoors, Katrine found it difficult to emplot a training plan for Walther. Thus, they decided to focus on stabilising his home environment by having an emergency-call button installed. Walther had applied for one a year ago, but was assessed at that time as not being a ‘fall risk’. But his situation had changed since then, and he said it now seemed like a good idea. During the next visit (27 October 2015), Katrine asked if he wanted to go ahead with it.

Walther: I spoke to my oldest daughter about it – she’s a nurse at a nursing home. I have a problem with using my mobile phone in an emergency because I can’t control my fingers so well.

⁷⁴ ADLs = activities of daily living; *see* footnote 29, page 66.

Katrine: The difference is that the emergency-call button is a two-way communication – you can always tell them if you’ve called them by mistake. (...) But it’s better to call them one time too much than too little.

Walther: I also talked to my younger daughter who’s a SOSU assistant, and she also thought it could be a good idea. I don’t have the reflexes if I fall – I just fall straight down. One time, four or five years ago, I fell down and hit my chin. (...) My mother had the same illness, and she broke her leg when she fell in the kitchen and had to use a wheelchair afterwards. My daughter says that if you break something during a fall, you can’t get back up again. So I need to find out who to contact to get the emergency-call button.

Katrine: I decided after our last visit that, if you wanted it, then I’d set the process in motion. That was my evaluation. (...)

Walther: I’m really happy to hear that. That makes me feel more secure.

Katrine: It could be that you hit your head – there are some cases where it can’t save you. (...)

Walther: I think about my mother...she managed fine until she broke her leg.

Field notes; 27 October 2015

In this example, Walther and Katrine decided that it would be best for him to get an emergency-call button installed in his home. But they did not reach this decision in isolation, and it was not based solely on rational evidence or by Katrine trying to ‘fill’ Walther up with information about the best way to care for himself. Rather, they both consulted other people in order to collectively make a decision – Walther spoke to both of his daughters, who also happened to be health professionals, and they “thought it could be a good idea”. One daughter even reminded him of the potential danger of falling and not being able to get back up again, which seemed to influence the decision he articulated to Katrine. In particular, Walther expressed a fear of falling like his mother had; in this way, his mother’s past experience informed his present decision of how to manage his condition in the future.

Although Katrine did not know the extent of the impact this personal experience had on Walther, she recognised that he was affected by it. Thus, she decided that it was important for him to feel secure in his home, and she told him, “I decided after our last visit that, if you wanted it, then I’d set the process in motion.” But this was a decision that she also did not make alone or in isolation; after reading about Walther’s condition in his online municipal journal prior to their first meeting, Katrine decided to conduct some Internet research to learn more about his condition (*field notes; 15 October 2015*). She also spoke with a colleague who had worked with ALS⁷⁵ patients before to better understand how she as an occupational therapist could help him (*ibid.*) –

⁷⁵ *Amyotrophic lateral sclerosis* (ALS), also known as Lou Gehrig’s disease, is related to the form of ataxia that Walther has.

based on this information, she told Walther that he might benefit more from private physical therapy because those trainers work much more intensely than what she can offer in the course of a few weeks. In this way, she expressed her own doubt about her ability to help him maintain his current level of functional ability.

Furthermore, Katrine's decision to "set the process in motion" involved a number of different actors. As I mentioned in section 5.4., she was initially not clear whether the emergency-call button should be classified as a 'treatment' or 'goal' according to his official training plan. She asked her colleague about how to best formulate it, saying, "He needs to feel secure in his own home" (*field notes; 22 October 2015*). They decided that it should be considered a treatment, and they both agreed that, because Walther's situation could change very suddenly, it was crucial that he have the emergency-call button installed as soon as possible. In this way, the decision-making process was not a 1:1 relation between Walther and Katrine – it was a form of care that involved multiple actors, from Walther's daughters and his previous physical therapists to Katrine's colleagues, both in the office and their virtual representations in Walther's online journal.

In this way, the responsibility for making choices regarding a citizen's welfare becomes distributed and shared, rather than individualised. This positions both Walther and Katrine not as individual agents working together in an isolated partnership, but as subjects who are part of a larger social collective. The collective nature of this shared responsibility is important, as the effects of the therapists' caring actions and shared decision-making with the citizen can also impact social actors outside of the training encounter; I discuss this in the next section.

8.4. Care as a shared responsibility

During the home visits and training sessions I observed, there were many other actors involved: spouses, children, friends, neighbours, pets, other health professionals, etc. I have intentionally not included the mediating presence of these actors in my dissertation because, as I mentioned earlier (*see page 80*), I wanted to highlight the politically-defined 1:1 relation between the health professional and a citizen. But it is important for me to mention a few of these actors in relation to the effects of the therapists' caring actions. Even though many of the citizens I encountered lived alone in their own houses or apartments, none of them lived alone in their social environment – each of them had a broad network of friends, family, former work colleagues, neighbours, and other people in the local community whom they met regularly; people in their everyday lives who they cared about, and who cared about them. For example, Lumikki told me:

I talk with [the woman at the shop] – she’s really good to ask about me if I haven’t been there for two days. “I’ve thought – what’s happened that I haven’t seen you in two days?” We can tease each other a little bit...she also checks on me in the long term – “where have you been that I haven’t seen you?” (AC: *Is it nice that someone worries?*) I think it’s lovely. We can also just talk – it goes so quickly...but she always takes the time. If there aren’t other customers, then we’ll stand there and talk a bit longer. She also knows many others, some who are also widowed – those who I also know well. So sometimes we actually meet there in [the store] and just stand there and talk. It can also happen in Copenhagen – in the smaller businesses where one can talk. If there aren’t any customers, then we’ll talk a long time – she’ll tell me about her kids or if she has pain somewhere in her body. So it’s great.

Interview; 2 July 2015

In this quote, Lumikki described how she and the shopkeeper at her local grocery store check in on each other, discussing their children and their various aches and pains. She expressed appreciation that the woman worries about her if she does not see Lumikki for a few days; in this way, the shopkeeper seemed to care about Lumikki’s welfare. As I have discussed elsewhere, the political ambition is that everyday rehabilitation will allow citizens to remain independent and self-helping at home, but just as ageing in place is not a static process, I argue that people are not abstract, autonomous individuals – we are social beings who have an interconnected relation to each other as part of our shared social environment.

Thus, an important outcome of the training programme may be that the therapists’ caring actions enable citizens to continue to care *about* – not just care *for* – other people in their everyday lives. In addition to caring for and about the welfare of their family members, especially children and grandchildren, many of my informants also cared about their neighbours. For example, Ulla told me:

I have a good relationship with my neighbour – last night, we watched handball together, and tonight we’ll watch “X-Factor”. We watch that together. (...) I try to be responsible for my neighbour’s health. She doesn’t eat anything – she doesn’t eat properly, or very little. And sometimes, I’ll make her food and take it to her, and she’ll eat it. I’m a little worried about her, because she lives really unhealthily if someone doesn’t cook for her. She’s 81 years old, and she’s been to the hospital twice because she has it so bad.

Interview; 26 January 2016

Here, Ulla explained how she tried to help her neighbour who does not eat much. Even though the woman is just two years older than she is, Ulla considers her to be in much worse condition; thus, she said that she has been “a little worried about her”. Ulla also said she felt a sense of

responsibility about her neighbour's welfare, often making her food so that her health would not get worse. This suggests how individuals are entwined in a diversity of social relationships that imbue their lives with meaning (Walter & Ross 2014: S23), and how the responsibility for health becomes distributed among multiple actors in their shared social environment.

This distributed social responsibility for health is not just limited to others in a person's immediate environment. For example, Walther expressed this shared responsibility in terms of the community, which is reminiscent of the social values that constituted the 'golden age' of the Danish welfare state:

I really can't imagine that an individual or someone should manage things or pay for things or organise things. I think, truly, [health] is a shared thing. Because I was brought up in Denmark and I've lived here my whole life – I think it's the only correct way to think about it – to take responsibility for each other, to help each other – that everyone has access to opportunities. I know I'm bad at helping people, I have no money, but I think that fundamentally, everyone should have some good opportunities. (...) For me, it's always been about the community.

Interview; 9 December 2015

In this quote, Walther described how he felt it was important for citizens to share the responsibility for taking care of each other, and to have equal access to opportunities and services. He went on to say, "I think we pay taxes so that we can share things with others, to be able to offer things to people – and to know that every single time that there's a need, you can be referred and get help" (*ibid.*). In Walther's opinion, having a shared responsibility for health means that any citizen who needs help can receive it when they need it, and that the system should make services available to everyone equally.

This sentiment was echoed by the occupational therapist Katrine; when I asked her whether we should be responsible for our own individual health, she said: "I don't think anyone should stand alone...we all should contribute to each other's welfare" (*interview; 5 February 2016*). And, in response to my question about why the municipality should offer health and social services to citizens, the physical therapist Sofie said, "Because it's the right thing to do. Sometimes, it can feel like we pay too much for this and that – but imagine if it were your [family member]? Sometimes, one's precious tax money should be used on 'lost causes'. It's good that Denmark has these offers because no one is lost" (*interview; 21 December 2015*). These quotes suggest that certain 'traditional' Danish values are still important. Having a sense of ownership in the state, knowing that one's fellow citizens will help and care about your welfare, having equal access to

welfare services – despite the political turn towards consumerism and individualised self-governance, it may be that the social values of a community that takes a shared responsibility for collective health can still be found in the Danish competition state.

Summary

In Part III, I have described how the Training Team therapists try to locate an elderly citizen's motivation to participate in training that will enable them to become more independent and self-helping; the therapist is expected to locate the individual citizen's Will and then transform it into a future-orientated sense of 'I-will-and-I-can'. In order to emplot a course of training that is meaningful, the therapists must recognise and acknowledge the citizen's unique personhood; in this relational exchange, both of their identities and subject positions are confirmed. But the therapists also attempt to engage in a form of plurality with the elderly citizen's phenomenological body; a body that has its own sense of identity and history of lived experiences, and which displays a form of 'messy subjectivity' that can complicate the outcome of the training programme. The collaborative partnership of training should activate the citizen's potential for continued labour, action, and self-care, and thus become empowering. But some citizens display the identity of a freely-choosing consumer who questions the 'service offer' of training, and thereby tries to negotiate the therapeutic actions. Conversely, some citizens may choose to relinquish their free choice altogether, deciding instead to receive a form of attention and care in their encounters with the therapists.

When the goal of municipal services changes from 'providing help' to 'enabling self-help', the choices and collaborative decisions made in the health encounter foster a particular form of sociality; thus, care becomes a shared responsibility that is distributed among a range of actors, and new forms of action and empowerment emerge. Specifically, training contains a form of caring action and shared decision-making, wherein both parties make an investment in the outcome of the training encounter. With their caring actions, the therapists make adjustments and decisions that help the elderly citizen 'repair' their world; these realistic micro-decisions produce a sense of accomplishment and fulfilment, which may ultimately be empowering. But the therapists also include other colleagues in the act of care, and I described how decisions are socially co-produced. Neither the therapists nor the citizens make decisions in isolation as autonomous individuals within the context of the training encounter; rather, the overall responsibility for an individual citizen's welfare becomes distributed and shared with other

actors in the social collective. The result of training is that both the citizen and therapist can continue to care about and take a shared responsibility for others in the greater community.

In the next and final chapter, I summarise and reflect on the dissertation's key analytical points, with a particular focus on how municipal health professionals navigate the political rhetoric about health and activity in their encounters with elderly citizens, as well as how they try to manage the paradoxes and changes of subjectivity that occur. In the concluding sections, I revisit my conceptualisation of the 'limited yet limitless' ageing consumer, specifically highlighting some of the conflicts, tensions, and forms of resistance that emerge when interacting with this archetype, which can complicate the work of municipal health services for the elderly. In particular, a political discourse that focuses on 'shared responsibility' and 'empowerment' contains an entangled complexity that has implications for all of the actors involved. I then discuss how my analytical insights about the discursive move from 'help to self-help' relate to the ongoing modernisation of the Danish eldercare sector, and I suggest how a more caring response to neoliberal conceptualisations about individualism, self-responsibility, and independence may produce an alternative form of empowerment.

* * *

CONCLUSION

Chapter 9

Transforming eldercare in Denmark

When you get as old as I am, once in a while, you can see that things are going the wrong way [in society]. (...) I think there's something wrong with saying that most things are the state's fault – and you have to be careful about saying that people can just get themselves together and do certain things, and then there would be no problems. Things are complicated and vary much more than that. (...) You can't completely blame the individual person if they can't do something.

Interview with Walther; 9 December 2015

Summary of the dissertation's main points

From the outset of my research, I have had the contention that 'old age' is a social and cultural construction. Of course, there are physiological factors involved in the human ageing process that ultimately lead to physical deterioration and natural death – cellular senescence, DNA damage, genetics, etc. – but how and when we are considered 'old' is greatly dependent on our social environment. And, as the matter of population ageing continues to be a worldwide concern, how we grow old is also being politically defined. As such, there are particular sociocultural systems that shape and affect how we grow older – specifically, discourses that inform both the public mindset and everyday practices, and which contribute to how we become positioned as different types of subjects. By investigating how the goal of eldercare in Denmark has shifted from one of providing help to enabling self-help, I have sought to examine how both health professionals and elderly citizens interpret, experience, and react to the political discourses that frame their encounter.

In this dissertation, I have presented the real-life interactions between municipal health professionals and elderly citizens in one particular Danish municipality in order to illuminate how a 'shared responsibility' for health care emerges, and my analysis has examined the forms of power, experience, knowledge, and meanings that are generated, shaped, and co-constituted by the actors involved. In particular, my intention with this work was to investigate how the Danish state's political goals and individualised health policies influence the provision of in-home health

services for the elderly, and how both municipal health professionals and elderly citizens navigate the political discourses that frame their relational encounter.

To address this problematic, I began by outlining some of the cultural-historical factors that have led the nation-state of Denmark to establish certain programmes and services for elderly citizens. These political developments worked to organise and constitute the subjectivity of ‘the elderly’ as a sub-group of society, and the management of their care became part of the collective identity of the ‘classic’ Danish welfare state. As an equal and shared community, the foundational idea was that everyone should contribute to the system so that everyone would have access to healthcare and social services throughout their lifetime; i.e., ‘from cradle to grave’. However, with Denmark’s political transition towards neoliberalism in the 1990s in order to better manage the expanding public sector, the role of the state was re-defined, and new political, economic, and social arrangements began to emphasise market relations and individual responsibility.

This prompted a need for more standardisation and efficiency within the public sector, as well as a political drive towards consumption and productivity in order for the state to remain competitive in the global market. Social programmes also began to shift from the traditional welfare state’s fundamental focus on providing ‘compensating’ help to a more neoliberal emphasis on self-governance, independence, and strengthening the citizen’s own resources. Rather than providing universal access to welfare assistance equally to all citizens, the government began to establish more standardised frameworks to evaluate an individual citizen’s need for help. The role of certain municipal health professionals became formalised during this time, and I argued that their function and identity became entrenched in an epistemology of rationality and efficiency.

I also described how citizens were increasingly being given the right to a ‘free choice’, which refers to a pre-determined set of institutions and service providers from which they may choose; the controlled number of options is intended to help local governments manage expenditures and control capacity. But this move further transformed the relationship between the state, the market, health professionals, families, and care recipients. With an emphasis on citizens being able to choose, the government’s *Free Choice* scheme created a market for welfare services and constructed citizens as active, freely choosing consumers of health services. This – combined with a growing political emphasis on self-governance and individual responsibility – meant that citizens were expected to exercise a certain kind of personal and political freedom. In the context of a health encounter, rational health professionals were expected to provide rational consumers with rational choices to become empowered, and thereby take responsibility for their own health.

The goal of these encounters was for the health professional to identify/reduce risk and foster stability, which would provide the conditions for the citizen's ongoing productivity. As such, the invisible forces of the government's disciplinary power were designed to act upon the actions of both the health professionals and the citizens.

With the 2007 public-sector reforms, the government's political ambition was to solve tasks "efficiently and as close to citizens as possible" (Ministry of Health and the Interior 2005: 4). As such, municipalities (in the form of their budgets) were subjected to more standardisation, and citizens (in the form of their health practices) were subjected to closer scrutiny and surveillance. For example, the newly formed 98 municipalities were given more responsibility for the administration of social-welfare services and the implementation of new public-health initiatives, which was meant to be empowering. At the same time, they were expected to equalise their budgets in order to provide a more uniform provision of 'core' welfare services throughout the country, which many municipalities found restrictive. The economic drive to reduce expenditures led to a greater focus on risk prevention among the populace – in particular, a public-health emphasis on the prevention of certain illnesses and injuries – which thereby produced a moral discourse about making healthy lifestyle choices. Many of the municipal health programmes and services that have been implemented since the 2007 reforms have focused on self-care, independence (i.e., not being dependent on others), and self-sufficiency. Some municipalities also promote a discourse about the empowering benefits of physical activity, which is believed to improve the individual citizen's well-being, strengthen their resources, and provide a better quality of life.

In my analysis, beginning with Chapter 3, *Evaluating the body's need for help*, I discussed how these political frameworks and discourses have influenced the work of the municipal health professionals, as they approach an older citizen's physical body as the central focus of biopolitical concern. The scrutiny and evaluation of these bodies is conducted by the authoritative Visitors, who are deployed to assess the citizen's functional ability in their home environment and determine the services they may be eligible to receive. In these politically-defined 1:1 encounters, the individual citizen is expected to rationally articulate what they need in the temporal immediacy of the present, and the Visitor either coordinates certain services (such as Home Care) or offers opportunities for the citizen to be more active, independent, and self-helping. Specifically, the assistance they receive should "promote the ability of individuals to manage for themselves or to facilitate their daily lives" (Ministry of Children, Equality, Integration and Social Affairs 2014). In a biopolitical context, both individual parties are expected to behave as rational

actors who can mutually agree upon certain pre-defined choices that will assist the citizen in returning to productivity.

At the same time, the political leadership have begun to recognise that some citizens – especially those with certain health conditions or functional limitations – may need to receive specific forms of knowledge, tools, and/or assistance from the health professionals so that they can become more independent and self-sufficient. Rather than excluding such citizens from the collective, the municipal authorities have chosen to make an investment in helping these ‘limited yet limitless’ citizens take responsibility for their own health and care needs, so they can retain their value as consumers and remain socially engaged for as long as possible. In the political move from providing help to enabling self-help, the establishment of an everyday-rehabilitation programme has become central to the political ambition to train these citizens.

In Chapter 4, *Embodying potential*, I described how, when the therapists from the municipality’s Cross-disciplinary Training Team begin their work with an older citizen, they focus on training the corporeal body to remember certain physical actions. This process contains a variety of temporal shifts – the therapist must evaluate the citizen’s body as it is now in the present, and then determine what it was previously capable of doing in the past in order to emplot a course of training that will develop its future potential. This process relies on a certain form of dialogue with the body, wherein the therapist must determine what the body ‘remembers’ and then communicate certain instructions so that the citizen can embody these habits again. The communicative interaction within the encounter primarily relies on verbal instruction and realignment of the body, but a combination of repetition and praise is a central component to the act of embodiment. By blending these, it may be possible to inscribe new forms of knowledge on the body, which will support its continued labour and regeneration.

However, as I explained, some bodies may not have the potential to develop new forms of competence, practical mastery, and physical ability. Citizens have been given a politically-defined free choice that is meant to be empowering, but when they invest power in their bodies during the conduct of the operation, they may simply lack the physical coordination and control necessary to embody certain habits. As a result, even though they have entered the political regime and agreed to be managed as a certain type of citizen, their corporeal bodies still struggle to become more self-helping. This complicates the therapists’ practical work as well as their purpose in fulfilling the municipal goals for the training programme; i.e., to transform the physically limited ageing citizen into a limitless consumer. Hence, if the therapists cannot inscribe certain forms of

knowledge into the body, then these citizens may not retain their position as a proper, valuable member of the collective. Furthermore, these citizens will continue to be at risk for falls and other dangers, which could lead to hospitalisation or death. If the therapists cannot help these citizens to develop their ongoing potential as governable, self-helping citizens, they will continue to pose a potential risk and future expense, and thus remain a burden on the state's welfare institutions.

In order to mitigate this risk as much as possible, the health professionals have to assess the citizen within the spatiality of their home environment. In Chapter 5, *Navigating public/private divisions*, I discussed that both politicians and health experts consider the home to be a place of familiar surroundings and routines that support a higher level of functionality and well-being. This underlying belief has become a central objective of eldercare in Denmark; i.e., that elderly citizens should be able to remain in their own homes for as long as possible. But when a municipal health professional enters a citizen's home environment to perform an evaluation or provide physical training, the private realm is judged in terms of its capacity to become a place that will support self-help and productive, continued agency. In particular, the Visitor – representing the institutional power of the state – is tasked with assessing whether the home is a 'proper' setting for ageing in place, which marks it as a site of future potential to optimise a particular state of life. The home thus becomes a site for governmentality and a biopolitical area of concern, and the Visitor defines the citizen's subject position by their ability to manage and control this space. But I argued that, when the political realm crosses the threshold of this private sphere, the lines of power and control become diffuse and negotiable; this re-defines the relation between the citizen as an abstract 'individual', and the professional as an abstract representative of the 'collective' state.

In Chapter 6, *Stabilising the home to promote 'ageing in place'*, I discussed how the activity and action involved in everyday rehabilitation transforms the domestic space of the home into a workplace and part of the public domain; here, the therapists' job is to re-configure and adjust the ways in which citizens are 'at home' with their physical, material surroundings. In this negotiation, the citizen loses authority and control over their home as a private, secure place. This means that their perception of themselves as autonomous agents – and their home as a symbolic and meaningful material space – becomes unsettled. In particular, the training works to destabilise certain everyday routines and habits related to how the citizen engages with the physical structure of their house and its material contents. Adjusting the materiality of the home – and the body's relation to this space – thereby transforms it into a political realm, where the conditions for action and power can be actualised.

However, it is also important for the professionals to articulate the citizens as freely acting subjects outside of the familiar structural confines of their house or apartment. In order to activate their potential as limitless consumers, the therapists have to stimulate and disturb the citizen's stability as passive individuals; this means encouraging them to venture into the public sphere. Going outside to train with their rollators, to improve their balance when walking on a slippery sidewalk, or to learn how to steer their electric wheelchair is meant to provide these citizens with the tools, resources, and skills to remain physically and socially active as both consumers and competent agents. In this way, I argued that 'ageing in place' is not a static process. But this process also contains negotiations, as the therapists meet resistance to their attempts to train these individuals in how to remain recognised as active citizens who have limitless potential.

During the home-health encounters, the professionals apply their distinct operating logics and rationalities, and judge the citizen's ability to take action to become more self-helping. These encounters are politically framed as a 1:1 relation and a partnership between defined individuals, but they also contain a specific social dimension. Thus, in Chapter 7, *Offering free choice and empowerment*, I discussed the relational plurality that is expected to emerge during training; in this process, the citizen's potential for continued labour and action should be realised. But this requires the therapists to locate the individual citizen's Will – the sense of determination and mental strength that provides them with the power to do the work of training. In order to locate this intrinsic Will (or to install it, if the citizen does not seem engaged enough), the therapists have to articulate the individual as a person. This means encouraging them to display their 'messy subjectivity', which refers to their complexity as a human subject.

Training is a process that is future-orientated towards a specific goal that must be meaningful to this particular person and who they want to be in the world. However, if the therapists cannot locate a citizen's Will amid their messy subjectivity, then they cannot get to know them as a complex person, which limits what they can accomplish together. In addition, citizens who have been constructed as freely-choosing consumers and 'experts in their own lives' often challenge the therapists' authority and expertise, questioning and debating certain therapeutic actions. These subjects are not docile, and they cannot be easily managed or manipulated by the therapists. In this way, citizens who display their Will by resisting the therapists' power show themselves as a kind of authentic self that cannot or will not change; as a result, they do not have the potential to become governable citizens. Also, when the citizen's active Will negotiates and resists the therapeutic action, then the therapist and citizen cannot mutually confirm each other's identity and subject position within the encounter.

Although the training programme has been framed as a partnership between the therapist and the citizen as rational, individual actors, the encounters between them often contain other forms of sociality that produce relational forms of collective power. Thus, in Chapter 8, *Producing a 'shared responsibility' for care*, I described how the therapists (and formerly, the Visitors) often encounter irrational citizens – not just people who display their messy subjectivity as complex human actors, but people who have experienced a change in their health status that disrupts their daily lives and produces a loss of equilibrium. These citizens cannot behave as rational individuals and consumers who can be managed by the institutional power of the state; nor can they assume the responsibility for their own care. Often, they find it difficult to make rational choices or abide by certain rules of conduct because they may be sick, scared, and/or in pain; this compromises their freedom to act.

However, a form of caring action and shared decision-making emerges, and care becomes distributed among a variety of actors. Here, all parties make an investment in the outcome, which is centred on the citizen's overall welfare. The therapists' caring actions during training recognise and accept the citizen's physical and emotional limitations – they acknowledge the citizen's frustrations about the lack of control they have over their physical bodies, and often modify the training programme to include less demanding exercises that will produce a greater sense of accomplishment. The therapists may also involve other actors in caring for the citizen as a person; for example, by consulting with colleagues about how to produce the best possible outcome based on the citizen's unique limitations. Both the therapists and the citizens often consult with others – friends, family members, colleagues, etc. – to determine the best way to care for the citizen. I argued that, in this way, the individual citizen becomes socially constituted in relation to other actors in the collective.

Moreover, I described how the shared decisions and actions made within the training encounter are not constrained to the health professional and the citizen in that time and space – the relational autonomy and collaboration in which they engage suggests that they are social creatures who seek out the company of others to achieve a sense of interconnectivity. Both the citizens and the therapists need to be *needed* in some way, and to share the responsibility for care with others in order to constitute themselves as subjects who are part of a larger social collective. This collaboration and connectivity produces an alternative form of power, as care becomes distributed among other actors in their shared social environment. In this way, I argued that a form of empowerment comes from being helped by *and* by helping others.

It is important to note that the professionals never fully locate the individualised ‘limited yet limitless’ ageing consumer in the home-health encounters that I have presented; I revisit my conceptualisation of this archetype in the next section.

9.1. Revisiting the ‘limited yet limitless’ ageing consumer

The categorisation of later life as ‘old age’ within many health and social policies positions elderly citizens as a high-risk, potentially burdensome group that must be politically, economically, and socially managed in particular ways. However, as a positive discourse about healthy ageing in the Third Age grew in popularity during the 1980s and became a cultural ideal in many Western societies, it also coincided with the promulgation of political ideas about neoliberalism in the 1990s, wherein there was a greater emphasis on market growth, productivity, and individual responsibility. Thus, I have argued that a new type of post-retirement citizen became conceptualised – specifically, an ageing individual who may suffer from certain physical health limitations but who still has unlimited potential as an active, contributing member of society. As a result, this sub-group of ‘the elderly’ category has been constituted as what I call ‘limited yet limitless’ ageing consumers.

The positive paradigm of active ageing suggests that older citizens should want to achieve the fulfilling, limitless promises of the Third Age – which means that they should remain physically fit, socially active, cognitively sharp consumers who “have the desire to take responsibility for their own lives as long as they can” (*interview with Britt, Visitor; 1 March 2016*). By articulating this desire and making the ‘correct’ choices regarding their health, this consumer-citizen becomes positioned as an active subject of the state, and these citizens are expected to behave as autonomous and rational agents. However, as I have explored throughout this dissertation, the health professionals often struggle to navigate the political rhetoric and negotiate the citizen’s changing subject position during their encounters, which results in conflicts, tensions, and forms of resistance. Citizens who have been constructed as freely-choosing consumers challenge the choices and opportunities that the professionals offer; in particular, a citizen’s display of mindful agency can complicate the authoritative work of the Visitors, who are tasked with categorising and standardising these elderly subjects into a certain institutional framework.

As I have described, Denmark’s political emphasis on providing ‘help to self-help’ produces an expectation that even frail, very elderly citizens should be able to govern their own lifestyle

choices, act rationally and responsibly, and remain independent and productive. An older citizen's potential to remain self-helping is central to the political goals for establishing the everyday-rehabilitation programme – being able to master or re-master certain skills and habits is a way to increase bodily competence, and to reduce fear and anxiety around performing actions that may put the ageing, injured, and/or ill body at risk. In the political discourse, it is important to reduce risk and prevent physical conditions that might affect the 'limited yet limitless' consumer's ongoing productivity. By offering certain forms of assistance and support that are meant to empower this citizen, a particular kind of governable subject emerges.

With their *re-* prefix, words such as 'rehabilitation' and 'reablement' imply a *return* to something – a *reclamation* of an intrinsic characteristic or ability that had been lost or taken away. This suggests that, perhaps, an elderly citizen who has certain physical limitations or health conditions that affect their mobility can simply choose to participate in an everyday-rehabilitation programme and thereby *regain* (or at least *retain*) a sense of control over their life. As I have discussed, these programmes target the citizen's potential to begin anew – to demonstrate the initiative to continue labour and indefinitely maintain their subject position as a competent (yet governable) social agent. However, a political discourse that expects elderly citizens to be physically capable of managing more everyday activities for themselves, of preserving their functional ability, of participating in their own self-care, etc. also *requires* them to do a certain form of work in order to maintain their inclusion in and value to society. In the discourse of neoliberal market exchange, 'you can't get somethin' for nothin'.

The promise is that, by moving backwards to regain their former strength and capability, elderly citizens can look forward to a limitless sense of independence and freedom. Making active choices about the activities of daily living that they would like to do 'better' is meant to be empowering, but I argue that this illusion of choice is a false promise. As I have discussed, many elderly citizens – especially those with multiple chronic conditions – may not ever be able to regain their former physical skills. And citizens who *are* able to regain or retain some degree of mobility and functional ability may only experience this improvement temporarily, as their ageing bodies continue to decline – particularly if they develop other health issues.

In the encounters I observed, citizens often questioned and resisted the forces that tried to make them into 'good', docile subjects of the state, and some of the professionals perceived these citizens as 'difficult'. But I would argue that a certain degree of resistance is also a natural part of the social exchange between *people*. Political rhetoric and forms of power are never linear or

monolithic – there are shades of grey, nuances, and negotiations in every relational encounter. And, for the most part, what I saw were social, reciprocal, complex exchanges between multiple actors. Thus, I have tried to illuminate that the political discourses and frameworks that may structure people’s everyday lives do not necessarily determine or define them.

Although the health professionals are expected to operate under a particular rationality and epistemology in their encounters with elderly citizens, they never actually locate a ‘limited yet limitless’ ageing consumer. Rather, they encounter a citizen who is a complex person with specific health problems that have unsettled their daily lives, and who has articulated a need for help and care in order to regain stability and equilibrium. Thus, I believe that the political emphasis on ‘help to self-help’ has particular implications for the role of the health professionals, which I discuss in the next section.

9.2. Revisiting the changing role of municipal health professionals

As I described in Chapter 1 (*see* section 1.5), the traditional welfare state’s attempt to improve an elderly citizen’s quality of life was based on a local health worker providing certain care services and practical assistance at home. But, as I have discussed in this dissertation, developments to health policies and programmes since the 1990s have changed how many municipal health professionals do their work; their role has transitioned “from diagnostic caseworker to care manager, from applied social scientist to service coordinator” (Howe 1996: 77). In particular, with the rise of New Public Management and the competition state’s neoliberal goals for productivity, standardisation, and efficiency, municipal health professionals have been increasingly tasked with the job of giving elderly citizens encouragement, support, ‘free choice’, and training to remain active and self-helping in their own homes for as long as possible, which should improve their quality of life and allow them to feel empowered.

Because these professionals must disseminate political discourse and health-related information in their meetings with citizens, they too must interpret and navigate each policy and programme that the politicians decide to offer; in the Danish state’s ongoing drive for efficiency and cost-savings, new offers are continually being developed. And the political leadership are always trying to find new ways to increase efficiency. For example, at the time of my fieldwork, there was some discussion in the municipality about when and how Visitors should conduct their evaluations, especially of elderly citizens who had applied to receive help with housekeeping. As the Visitor Brynja told me:

We've been thinking that sometimes, like if a citizen has called to ask for cleaning help, that the Training Team should go out first to make an evaluation. And look at what they can train, and maybe go through a programme – and then decide whether the citizen can vacuum or not. And if they can't, then we can come out and see what help is needed. That's what we're considering now⁷⁶ – should we think about training *first* before help?

Interview; 25 February 2016

Although Brynja framed this shift in responsibility as a way to increase productivity and improve efficiency, thereby reducing municipal costs, the change could also have implications for the Visitor's placement in the municipal hierarchy: the amount of authority, autonomy, and professional prestige (Beedholm & Frederiksen 2015: 157; *also* Freidson 1988) they currently have could be compromised if another professional group is given the power to evaluate a citizen's health status and make authoritative decisions regarding their need for assistance.

During my fieldwork, I observed that a change to the Visitor's authority and power is already starting to occur with the establishment of the Training Team. Both the national government and municipal leadership have certain expectations for the outcome of their work and, as such, other professional groups are referring more and more citizens to them, making the Team's therapists almost wholly responsible for helping these 'limited yet limitless' ageing consumers achieve their potential to be more self-helping. The municipality is also increasingly emphasising the importance of elderly citizens being more physically active, independent, and robust, which suggests that the work of everyday rehabilitation to help citizens achieve these goals will become an even greater priority in Gentofte. There will undoubtedly be a greater political expectation that the Team's therapists should be able to produce very specific, measurable results.

It is also likely that the national government will decide to reform and re-organise the public sector again, which will affect the provision of healthcare services and programmes. But where does it end? One of the hallmarks of capitalist forms of production is that they are often near-sighted, focusing on short-term profit first and long-term outcome/impact second. As I have argued in this dissertation, a political and economic emphasis on helping older citizens achieve better physical functionality so they can continue to take care of themselves at home for as long as possible already seems to have created difficulties for both the health professionals and the citizens, and it may ultimately work to marginalise those who cannot achieve the political goals. Thus, I argue that an

⁷⁶ At the time of my fieldwork, Visitation almost always conducted a separate evaluation first before mobilising the Training Team, who conducted their own evaluation.

investment of resources (time, money, manpower, etc.) into trying to empower the individual ‘limited yet limitless’ ageing consumer to take more responsibility for their health may have particular disadvantages for citizens, which I discuss in the next section.

9.3. The entangled complexity of individual responsibility and empowerment

Political ideals about the productive worker and sovereign consumer are nothing new – they have been part of economic theory since the rise of capitalism in the late 1800s, which also coincides with the development of individualism during the Enlightenment in Europe, especially as it arose in response to religious oppression (Foley 2017: 2). In the traditional conceptualisation of the Danish welfare state, which grew alongside these ideals, certain social protections, benefits, and services were provided universally to any citizen who was in need of assistance and support. These political decisions were not made in a vacuum; rather, it was a collective democratic decision that was made based on shared consensus among the general populace. At the time, there was no ‘individual’, only the ‘community’ of which everyone was equally a part, and to which everyone equally contributed. In this framework, health professionals working in the municipality provided help that was meant to stabilise the structures of society in the face of uncertainty and change, which also worked to reinforce the collective nature of the Danish welfare state.

However, as the public sector in Denmark continues to modernise, there seems to be a growing emphasis on individualised personal responsibility. For example, according to researchers at KORA, the Danish Institute for Local and Regional Government Research:

...the future of health care will be more proactive than reactive. It will have an increased focus on prevention and keeping people healthy. Citizens will place greater demands on the healthcare sector; thus, they will have a much more central role in their own treatment. There will be an expectation that citizens who are particularly resourceful will take an active part in and responsibility for their own health. (Højgaard & Kjellberg 2017)

This quote demonstrates how the competition state’s market orientation is characterised by identifying problems and developing solutions that require productivity (Petersen 2008a: 93) from active, engaged citizens. It also suggests that, by default, health professionals will have to assume more responsibility for encouraging citizens to make the ‘correct’ choices regarding their health and empowering them to be more self-helping. But I would argue that the need for healthcare services is not a market problem that can be easily solved by individual citizens being more “resourceful”, taking more responsibility for their health, or being ‘empowered’ by health

professionals to make certain lifestyle choices. This kind of ambition is likely to put undue strain on both citizens and health professionals, who will continue to be expected to locate the individual citizen's potential to transform themselves into a 'limited yet limitless' ageing consumer. As I have already suggested, such a political expectation also makes good health and longevity a moral obligation, which assigns citizens with a personal responsibility if they fail to achieve a specific outcome. This means that any health professional who provides care, services, or training to a citizen who does not (or cannot) fulfil the political ambition is thereby complicit in this failure.

The individualised market logic contained within the expectation that citizens should take a more "active part in and responsibility for their own health" reinforces a moral discourse that is divisive, forcing a separation between those who can and those who cannot conform to and comply with the political rhetoric regarding activity and the 'correct' lifestyle choices. Within this moral discourse, an individual who cannot take proper care of themselves is considered to be a failure or a burden, and depending on others for help or care is seen as a personal (individual) shortcoming. For example, Pia, the manager of the Training Team, said:

As soon as you begin to get help, you become dependent on others – when they come, what they do, what *may* they do or not do, if you like the employee who comes or not, employees change – you suddenly become dependent on the whole system, which impacts having an independent life. I think, the longer you can postpone it, the better it is for the citizen. I don't think it's a good idea to get a Home Help worker for cleaning just because someone is a little lonely – then I think there should be some other offers. You should think about a day-centre or Elderly Help or Visiting Friends – there should be other offers if it's about loneliness more than about getting Home Help. I really think it's empowerment for the citizen. I think that's important – as long as it's possible.

Interview; 8 February 2016

Here, Pia discussed the implications of being dependent on others – i.e., that an elderly person would become passive and "dependent on the whole system" if they received help via the municipality. She also suggested that if someone is lonely, they should make use of other services and find ways to be more independent. During my fieldwork, this discourse was prevalent among both the politicians and health professionals in the municipality. It also seems to be a significant cultural value in Denmark – in my view, there is a narrative that it is somehow a sign of weakness to be dependent on others. But my work in this dissertation shows that the organisation of municipal healthcare is in fact grounded in a type of structured dependency; if citizens were truly expected to be wholly self-sufficient and not-dependent on others, there would be no municipal services and programmes available to them at all.

Providing universal benefits and services to all citizens in the collective was once considered a central characteristic of the social-democratic Danish state, but as the public sector continues to emphasise efficiency and cost-savings, this may not be sustainable. However, as Walther pointed out (*see* the quote that opens this chapter), it is not particularly productive to blame *either* the state or the individual for everything that may be wrong in society. Rather, as I have suggested in this dissertation, it may be more beneficial to cultivate a shared responsibility for care that is empowering to the collective; I discuss this possibility in the next section.

9.4. Care in relations: an alternative empowerment?

The preponderance of free-market, neoliberal values in many Western societies in recent years has started to produce greater inequalities among citizens, and the rise of right-wing populism in many countries can be traced to a political ideology that prioritises individual rights over the common good. Moreover, in many industrialised, capitalist countries, an individual citizen's personal freedom and freedom of choice is often only available to those who have the monetary resources to afford it. In this way, infinite choice – and the potential to become a limitless consumer – may ultimately produce a freedom that is less liberating and more of a burden (Foley 2017: 4). This can already be seen to some degree in Gentofte, which is Denmark's wealthiest municipality; although the national government continues to equalise local budgets, I have no doubt that my analytical insights in this dissertation would be very different if I had conducted my fieldwork in a less resourceful, homogenous area of the country. But my experience in Gentofte suggests that we can already begin to question the limits of neoliberal individualism, rationality, efficiency, and capitalist development – as well as the archetype of the 'limited yet limitless' ageing consumer (or the 'rational, transformative health professional') that has been constituted by the Danish competition state.

As I have suggested in this dissertation, defining ourselves as individuals requires us to relate to *others* in the social collective. During the home-health encounter, it is essential for both the health professionals and elderly citizens to exchange a social acknowledgement (Liveng 2011) of their subject positions, which confirms their identities as professionals and persons. This form of recognition, together with the relational autonomy and shared decision-making that I have described, are what may ultimately lead to an improved quality of life. In this way, the human condition does not merely consist of labour, work, and action – it also contains care, both for and about others in our shared social environment. Fundamentally, my analysis suggests that we

humans need care, human connection, recognition, and inclusion in a social collective much more than we need individualised free choice; caring for/about others and being cared for/about ourselves is an essential part of what makes us human, social actors. During my fieldwork, I came to appreciate that many forms of care and shared responsibility that were demonstrated by the municipal health professionals I observed, despite the political regulations that framed their work. In this sense, caring means taking a collective responsibility (Tronto 2017: 30) for both a positive or negative outcome of the health encounter as well as the long-term effect it may have on the citizen's welfare.

If a citizen is only valued for their individual productivity – i.e., their ability to work and contribute to society as a consumer – then they may lose a sense of their identity as a social being, and may ultimately feel oppressed and experience a lack of personal freedom. But when the responsibility for care becomes shared and distributed among others in the social collective, the individual person becomes articulated as a different type of subject; a subject who is interconnected and included as part of a whole. Being valued in this way transforms the individual's relationship to the collective, and my work suggests that this may be what produces empowerment at both the individual and collective level. Thus, I argue that the form of collaboration and connectivity that I observed during the health encounters produces its own form of relational power, as different types of care become distributed among other actors in the shared social environment. In this sense, the freedom and agency that is produced by the act of caring is potentially infinite.

* * *

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APPENDIX A

Overview of participants

Preventative Home Visits (PHV)

Benedikte: trained as an occupational therapist; has worked as a PHV visitor in Gentofte since 2003.

Interview: 16 April 2015 (conducted together)

Gerthe: trained as an occupational therapist; has worked as a PHV visitor in Gentofte since 2008.

Interview: 16 April 2015 (conducted together)

Cross-disciplinary Training Team

Janette: trained as a physical therapist; has worked with the Training Team in Gentofte since September 2014.

Interview: 5 February 2016

Katrine: trained as an occupational therapist; has worked with the Training Team in Gentofte since September 2014.

Interview: 5 February 2016

Pia (manager): trained as an occupational therapist; has worked with the Training Team in Gentofte since August 2014.

Interview: 3 February 2016 and 8 February 2016

Sofie: trained as a physical therapist; has worked with the Training Team in Gentofte since October 2014.

Interview: 21 December 2015

Visitation

Britt: trained as an occupational therapist; has worked as a Visitor in Gentofte since August 2012.

Interview: 1 March 2016

Brynja: trained as a physical therapist; has worked as a Visitor in Gentofte since August 2012.

Interview: 25 February 2016

Citizens

Alfred: age 71; has lived in Gentofte Municipality off/on his entire life (second generation). Widowed; has three children, five grandchildren.

Interview: 20 October 2015

Lumikki: age 83; has lived in Gentofte Municipality since 1980. Widowed; has two children, three grandchildren.

Interview: 2 July 2015

Norah: age 79; has lived in Gentofte Municipality off/on her entire life (since age 2). Widowed; has one child, two grandchildren.

Interview: 15 December 2015

Ulla: age 78; has lived in Gentofte Municipality since 1995. Widowed; three children, four grandchildren.

Interview: 26 January 2016

Walther: age 67; has lived in Gentofte Municipality since 1975. Has two ex-wives, two children, three grandchildren.

Interview: 9 December 2015



Tavshedspligtserklæring

Undertegnede erkender herved at være gjort bekendt med følgende:

Som værende tilknyttet Pleje & Sundhed i Gentofte Kommune har du efter forvaltningsloven tavshedspligt med hensyn til oplysninger om privatpersoners økonomiske og personlige forhold, hvis hemmeligholdelse ifølge lov eller sagens natur er påkrævet eller bliver dig pålagt.

Tavshedspligten vedvarer selvom du ikke længere er tilknyttet institutionen.

Dato: 29. juli 2014 Underskrift:

Ann B. Cothey

29. juli 2014

Station Bellahøj

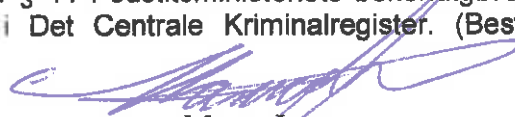
STRAFFEATTEST

For

| | |
|------------------------------------|--------------------------------|
| Fulde navn Clotworthy, Amy Beth | |
| F-- 2 | Fødselsregistreringsted Usa |

findes i Det Centrale Kriminalregister ingen tilførsel.

Udstedt i medfør af § 11 i Justitsministeriets bekendtgørelse om behandling af personoplysninger i Det Centrale Kriminalregister. (Bestemmelsen er aftrykt nedenfor).



Marco Inauen
politibetjent

Underskrift

Uddrag af Bekendtgørelse om behandling af personoplysninger i Det Centrale Kriminalregister.

"§ 11. Politiet udsteder straffeattester for private personer, når de pågældende fremsætter begæring herom. For personer under 18 år udstedes straffeattester dog kun, når forældremyndighedens indehaver eller den pågældendes værge har givet samtykke.

Stk. 2. I straffeattester efter stk. 1 optages alene afgørelser, som er tilført afgørelsesdelen, og som omfatter overtrædelse af straffeloven, lovgivningen om euforiserende stoffer eller udenlandske afgørelser med følgende begrænsninger:

- 1) Tiltalefrafald medtages ikke, hvis der er forløbet 2 år fra datoen for tiltalefrafaldets godkendelse i retten.
- 2) Bødestraffe medtages ikke, hvis der er forløbet 2 år fra datoen for den endelige afgørelse.
- 3) Andre afgørelser medtages ikke, hvis der er forløbet 3 år fra datoen for den endelige afgørelse. Hvis den, som afgørelsen vedrører, har været indsat til afsoning, medtages afgørelsen dog, hvis der ikke er forløbet 5 år fra den endelige løsladelse.
- 4) Retsfølger efter straffelovens §§ 68-70 medtages ikke, hvis der er forløbet 5 år fra retsfølgens endelige ophævelse.

Stk. 3. Er der tale om overtrædelser begået af unge mellem 15 og 18 år, gælder endvidere følgende begrænsninger:

- 1) Tiltalefrafald med vilkår om ungdomskontrakt medtages ikke, hvis det er første gang, den pågældende modtager en afgørelse, der omfatter overtrædelse af straffeloven eller lovgivningen om euforiserende stoffer, og der er forløbet 1 år fra datoen for tiltalefrafaldets godkendelse i retten.
- 2) Bødestraffe medtages ikke, hvis det er første gang, den pågældende modtager en afgørelse, der omfatter overtrædelse af straffeloven, og der er forløbet 1 år fra datoen for den endelige afgørelse.

Stk. 4. De i stk. 2 og 3 nævnte tilførsler medtages ikke, hvis den pågældende straffebestemmelse senere er ophævet.

Stk. 5. Rigspolitichefen kan efter ansøgning fra den registrerede i særlige tilfælde meddele dispensation fra de i stk. 2 og stk. 3 anførte tidsfrister".

P 358DK (01/07)



APPENDIX C

Informeret samtykke – kommunale personale

Før hvert interview med kommunens sundhedsmedarbejder vil jeg kort introducere interviewets formål, projektets foreløbige forskningsspørgsmål og bede om deres informeret samtykke for at deltage.

Indledning

Du måske vil opleve, at jeg stiller spørgsmål, som du tror, jeg kender svaret allerede på grundet min tid i kommunen (med Visitationen, Træningsteamet, m.fl.). Men her vil jeg bede dig om at uddybe. Jeg er interesseret i at høre om dit synspunkt, og jeg er oprigtigt interesseret i at lære om dit arbejde, dine tanker og erfaringer.

Denne interview vil være halvstruktureret i form – det betyder, at jeg har nogle bestemte spørgsmål at stille, men jeg også kunne spørge om forskellige ting, der dukker op under vores samtale (dvs., jeg følger ikke altid rækkefølgen af disse spørgsmål). Jeg skal fremhæve, at du altid må sige fra undervejs, hvis jeg stiller spørgsmål, som du ikke ønsker at svare på – og at du meget gerne må spørge ind til baggrunden for mine spørgsmål eller andet ved undersøgelsen, som du måtte være i tvivl om.

Derudover vil jeg sige, at jeg vil sløre din identitet i alle forskningsrelateret materialer (dvs., konference oplæg, kommunale seminarer, undervisningsmateriale, afhandlingen og relateret artikler, mm.). Jeg vil anonymisere alle mine informanter ift. navn, adresse, osv. Men hvis du beslutter, at du ikke ønsker at deltage i dette projekt, kan du altid sige fra. Forstår du det hele? (*svare ja eller nej*)

Informed consent – municipal personnel

Prior to every interview with the municipality's health employee, I will briefly introduce the purpose of the interview, the project's preliminary research question, and ask for their informed consent to participate.

Introduction

You may find that I ask questions that you think I know the answer to already because of my time in the municipality (with Visitation, Training Team, etc.). But here, I would ask you to elaborate. I am interested in hearing about your point of view, and I am genuinely interested in learning about your work, your thoughts and experiences.

This interview will be semi-structured in form – that means that I have some specific questions to ask, but I may also inquire about different things that pop up during our conversation (i.e., I may not always follow the exact order of these questions). I must emphasise that you may always object if I ask questions that you do not want to answer – and you are very welcome to ask about the reason for my questions or anything else about my study that you may have doubts about.

In addition, I will conceal your identity in all research-related materials (i.e., conference presentations, municipal seminars, teaching materials, the dissertation and related articles, etc.). I will anonymise all my informants in relation to name, address, etc. However, if you decide you do not want to participate in this project, you can always refuse. Do you understand everything? (*answer 'yes' or 'no'*)

Informeret samtykke – borgere

Før hvert interview med en borger vil jeg kort introducere interviewets formål, projektets foreløbige forskningsspørgsmål og bede om deres informeret samtykke for at deltage.

Indledning

Du måske vil opleve, at jeg stiller spørgsmål, som du tror, jeg kender svaret allerede på grundet min tid hos dig. Men her vil jeg bede dig om at uddybe. Jeg er interesseret i at forstå din verden (dit hverdagsliv) fra dit synspunkt, samt at vide, hvad du ved, på den samme måde som du ved det. Jeg er oprigtigt interesseret i at lære om dine tanker, meninger og oplevelser. Jeg har allerede stillet mange spørgsmål under vores tidligere møder. Så jeg vil sige, at jeg måske vil gentage mange af disse spørgsmål i interviewsituationen, og at det måske vil virke mærkeligt, men at jeg gør dette med et formål.

Denne interview vil være halvstruktureret i form – det betyder, at jeg har nogle bestemte spørgsmål at stille, men jeg også kunne spørge om forskellige ting, der dukker op under vores samtale (dvs., jeg følger ikke altid rækkefølgen af disse spørgsmål). Jeg skal fremhæve, at du altid må sige fra undervejs, hvis jeg stiller spørgsmål, som du ikke ønsker at svare på – og at du meget gerne må spørge ind til baggrunden for mine spørgsmål eller andet ved undersøgelsen, som du måtte være i tvivl om.

Derudover vil jeg sige, at jeg vil sløre din identitet i alle forskningsrelateret materialer (dvs., konference oplæg, kommunale seminarer, undervisningsmateriale, afhandlingen og relateret artikler, mm.). Jeg vil anonymisere alle mine informanter ift. navn, adresse, osv. Men hvis du beslutter, at du ikke ønsker at deltage i dette projekt, kan du altid sige fra. Forstår du det hele? (*svare 'ja' eller 'nej'*)

Informed consent – citizens

Prior to every interview with a citizen, I will briefly introduce the purpose of the interview, the project's preliminary research question, and ask for their informed consent to participate.

Introduction

You may find that I ask questions that you think I know the answer to already because of my time with you. But here, I would ask you to elaborate. I'm interested in understanding your world (your everyday life) from your point of view, as well as knowing what you know, as you know it.

This interview will be semi-structured in form – that means that I have some specific questions to ask, but I may also inquire about different things that pop up during our conversation (i.e., I may not always follow the exact order of these questions). I must emphasise that you may always object if I ask questions that you do not want to answer – and you are very welcome to ask about the reason for my questions or anything else about my study that you may have doubts about.

In addition, I will conceal your identity in all research-related materials (i.e., conference presentations, municipal seminars, teaching materials, the dissertation and related articles, etc.). I will anonymise all my informants in relation to name, address, etc. However, if you decide you do not want to participate in this project, you can always refuse. Do you understand everything? (*answer 'yes' or 'no'*)

Abstract

In this dissertation, I provide an in-depth, ethnologic look at the real-life encounters between municipal health professionals and ageing citizens in a Danish municipality in order to describe how the Danish state's political goals and individualised health policies influence the provision of in-home health services for the elderly. By investigating how the goal of eldercare in Denmark has shifted from providing help to enabling self-help, I describe how both municipal health professionals and elderly citizens navigate the political discourses that frame their relational encounter. Specifically, I examine how municipal health professionals are expected to transform elderly citizens into a new type of subject; an individual that can be empowered to fulfil certain objectives of the contemporary state.

I apply a cultural-historical perspective to highlight several significant political, socio-cultural, and economic developments from the 1890s to the present day, which have contributed to the establishment of Denmark's contemporary public-health initiatives and eldercare services. This includes the recent implementation of specialised 'everyday rehabilitation' programmes, a form of physical training that is designed to reduce elderly citizens' expected demand for in-home care, supportive services, and medical treatment, as well as prevent hospitalisations. In order to gain insight into the provision of health services and programmes for the elderly, I conducted 15 months of ethnographic fieldwork in a Danish municipality. During this time, I shadowed and observed the everyday work practices of health professionals from three departments, following them on dozens of visits to elderly citizens' homes as well as during training sessions. I then conducted semi-structured interviews with both the professionals and citizens.

My analysis of the empirical material is largely influenced by the work of philosopher Michel Foucault and political theorist Hannah Arendt. This approach allowed me to examine the tacit forms of governmentality that permeate certain political discourses about health, activity, and independence in Denmark, and how these forces may affect and shape the encounter between a health professional and an elderly citizen in the situated context of a home-health visit or during training. I also include a phenomenological perspective, wherein the body is understood as part of a historical person who engages with, lives in, and experiences their world in a particular way.

The dissertation contains nine chapters; the six analytical chapters are bundled into three main parts, which are inspired by Arendt's conceptualisation of the central activities related to the human condition: i.e., *Labour*, *Work*, and *Action*. Within these parts, my analysis focuses on the politically-defined 1:1 encounters between municipal health professionals and elderly citizens in their homes, and I elucidate how home-health visits and 'everyday rehabilitation' programmes for ageing citizens can be understood as social, material, and cultural interactions that are more than simply sites of health promotion, governmentality, or the dissemination of political rhetoric.

A central claim in my work is that the categorisation of later life as a period of poor health and deterioration positions 'the elderly' as a high-risk, potentially burdensome sub-group of society. But I argue that this perception has simultaneously become entangled with a positive discourse about healthy ageing and active social engagement to constitute a specific type of citizen: a 'limited yet limitless' ageing consumer. My conceptualisation of this term refers to an older person who may be *limited* by certain physical afflictions yet still has *limitless* potential and value as a productive member of society. The analysis highlights how municipal health professionals try to engage this ideal type, as well as how they interpret and experience the political discourses that frame the health encounter.

My work in this dissertation contributes new insight into how the Danish state's emphasis on individual responsibility impacts both municipal health professionals and elderly citizens. Based on my investigation, I suggest that a political discourse that focuses on individual responsibility, physical activity, and independence contains an entangled complexity that has implications for all of the actors involved. I conclude that a more caring response to neoliberal conceptualisations about individualism and self-responsibility could produce an alternative form of empowerment; a form of collaboration and connectivity that could have a positive effect on both ageing citizens and health professionals – and ultimately, perhaps, Danish society.

Resumé

I denne afhandling giver jeg et dybtgående etnologisk indblik i konkrete møder mellem kommunale sundhedsprofessionelle og aldrende borgere i en dansk kommune, med henblik på at beskrive, hvordan den danske velfærdsstats politiske mål og individualiserede sundhedspolitikker påvirker udførelsen af sundhedsydelser for ældre i eget hjem. Ved at fokusere på, hvordan målet for ældrepleje er skiftet fra at yde hjælp til at fremme selvhjælp, undersøger jeg, hvordan både de sundhedsprofessionelle og de borgere navigerer i de politiske diskurser, som danner rammen om deres møde. I særdeleshed beskriver jeg, hvordan det kommunale sundhedsarbejde er baseret på en forventning om, at ældre borgere skal indtage en ny subjekt position, i kraft af hvilken de individuelt kan udfylde en bestemt rolle i nutidens stat.

Jeg anvender et kulturhistorisk perspektiv for at fremhæve væsentlige politiske, sociokulturelle og økonomiske udviklinger fra 1890'erne til i dag, som alle har bidraget til etableringen af nuværende folkesundhedsinitiativer og den danske ældrepleje. Herunder hører også den nylige gennemførelse af specialiserede 'hverdagsrehabiliteringsprogrammer'. Disse fysiske træningsprogrammer har til formål at reducere ældre borgeres forventede behov for hjemmepleje, hjemmehjælp, hjælpemidler og medicinsk behandling, samt at forebygge hospitalsindlæggelser. For at få indsigt i udførelsen af sundhedsydelser og ældreprogrammer udførte jeg i 15 måneder etnografisk feltarbejde i en dansk kommune. I løbet af denne tid iagttog jeg den daglige arbejdspraksis hos sundhedsprofessionelle fra tre kommunale afdelinger og fulgte dem på deres besøg hos ældre borgere og under træningsforløb. Jeg gennemførte derefter semistrukturerede interviews med både professionelle og borgere.

Min analyse af det empiriske materiale er i høj grad inspireret af filosofen Michel Foucault og den politiske teoretiker Hannah Arendt. Denne tilgang har tilladt mig at undersøge de stiltiende former for statsstyre (*governmentalitet*), der gennemsyrrer bestemte politiske diskurser om sundhed, aktivitet og uafhængighed i Danmark. Helt konkret forklarer jeg, hvordan disse kræfter påvirker og former mødet mellem en sundhedsprofessionel og en ældre borger under et hjemmebesøg eller en træningssession. Jeg inkluderer også et fænomenologisk perspektiv, hvor kroppen forstås som en del af en historisk person, der beskæftiger sig med, lever i og oplever sin verden på en bestemt måde.

Afhandlingen er inddelt i ni kapitler. De seks analytiske kapitler er samlet i tre tematiske hoveddele inspireret af Arendts begreber for de centrale menneskelige aktiviteter, nemlig *Labour*, *Work* og *Action*. Inden for disse overordnede temaer fokuserer min analyse på de politisk definerede én-til-én møder mellem kommunale sundhedsprofessionelle og ældre borgere. Jeg belyser hvordan hjemmebesøg og hverdagsrehabiliteringsprogrammer for ældre kan forstås som sociale, materielle og kulturelle interaktioner, der indeholder mere end blot aspekter af sundhedsfremme, *governmentalitet* eller udbredelsen af politisk retorik.

En central påstand i mit arbejde er, at kategoriseringen af alderdom som en periode kendetegnet ved dårlig sundhed og svækkelse, positionerer de ældre som en potentielt byrdefuld højrisikogruppe. Men denne opfattelse er samtidig vævet sammen med en positiv diskurs om sund aldring og aktivt socialt engagement. Jeg argumenterer for, at dette tilsammen skaber en bestemt type af ældre borger: en 'begrænset, men ubegrænset' aldrende forbruger. Min begrebsliggørelse af dette udtryk refererer til en ældre person, der *kan være begrænset* af visse fysiske lidelser, men stadig *har ubegrænset* potentiale og værdi som et produktivt medlem af samfundet. Analysen fremhæver, hvordan sundhedsprofessionelle forsøger at interagere med denne idealtipe, og hvordan de tolker og oplever de politiske diskurser, der danner ramme om deres møder med ældre borgere.

I denne afhandling bidrager jeg med nye indsigter i, hvordan den danske stats fokus på individuelt ansvar påvirker både de kommunale sundhedsprofessionelle og ældre borgere. Baseret på min etnologiske undersøgelse af disse møder fremhæver jeg, at en politisk diskurs, der fokuserer på individuel ansvarlighed, fysisk aktivitet og uafhængighed, indeholder en iboende kompleksitet. Jeg konkluderer, at et mere omsorgsfuldt bud på neoliberale forståelser af individualisme og individuelt ansvar muligvis kan producere en alternativ form for *empowerment*; en form for samarbejde og forbundenhed, som kunne have en positiv påvirkning på både borgere og sundhedsprofessionelle – og i sidste ende måske det danske samfund.