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Conference • NNHSH 2013 Theme: Transformations of Health Practices and Health Policies in the Nordic Welfare States

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Conference • NNHSH 2013

Theme:

**Transformations of Health Practices and Health Policies
in the Nordic Welfare States**

Time: April 24-25, 2013

Venue: University of Copenhagen, Southern Campus, Njalsgade 80, 2300
Copenhagen S. Room # 24.0.11. (See map)

The network NNHSH is supported by FAS

Anne Leonora Blaakilde, Kristofer Hansson,
Karine Aasgaard Jansen and Susanne Ådahl
Conference • NNHSH 2013

Theme:
Transformations of Health Practices and
Health Policies in the Nordic Welfare States

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Lund University
2013

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Preface

Welcome!

We are pleased to announce an exciting programme for the 2013 research conference, presented by The Nordic Network for Health Research within Social Sciences and the Humanities (NNHSH). This year's theme, "Transformations of Health Practices and Health Policies in the Nordic Welfare States", has attracted a range of researchers and PhD students from the Nordic countries. We look forward to many interesting and productive discussions during the conference!

We are grateful for the support we have received from:

- FAS: the Swedish Council for Working Life and Social Research, which provided a grant that made it possible to present the conference.
- The Faculty of Humanities, University of Copenhagen, which will hold the conference in their fine facilities.
- The Center for Healthy Aging, a research center funded by NORDEA and located at the University of Copenhagen, which provided the assistance of student helper Liv Grønnow.

We wish you a warm welcome to NNHSH 2013!

Anne Leonora Blaakilde, Kristofer Hansson, Karine Aasgaard Jansen and
Susanne Ådahl

Program

Wednesday April 24th

09.00	Arrival, registration and coffee	
10.00	Welcome and practical information	Room 24.0.11
10.15	Plenary speech, Signild Vallgård: Autonomy or obedience – change and continuity in governing technologies in health promotion	Room 24.0.11
12.00	Lunch	
1 pm	Parallel sessions 1 & 2	See catalogue
3 pm	Coffee	
3.30 pm	Parallel sessions 3 & 4	See catalogue
7 pm	Dinner at Ché Fè www.biotrattoria.dk	

Thursday April 25th

09.15	Plenary speech, Georg Drakos: Diagnosis in dialogue: How to approach new paradigms and buzzwords in healthcare?	Room 24.0.11
11.00	Parallel sessions 5 & 6	See catalogue
1 pm	Lunch	
2 pm	Session 7	Room 24.0.07
3.15 pm	Closing words	Room 24.0.07
4 pm	Departure	

Presentation of keynote speakers

Plenary speech, Signild Vallgård

Wednesday April 24th, 10.15

Autonomy or obedience – change and continuity in governing technologies in health promotion

In the paper I will argue against the idea that a radical change has taken place in the governing technologies in health promotion during the last 50 years, by some called 'late modernity'. On the other hand I will show that a great change has taken place in the governing ambitions of the authorities and apparently in the acceptance by the population of these ambitions.

Social inequality in health – three Scandinavian political problematisations

It may seem obvious what social inequalities in health are. However, studying the three Scandinavian countries reveal fundamental differences between the policies in the countries when it comes to how the problem is described and explained and in the means suggested to reduce it.

Signild Vallgård is a historian and professor of health policy analyses, Department of Public Health, University of Copenhagen. During later years her research has focused on power and ethical aspects of health promotion and on the use of social categories in policymaking.

Plenary speech, Georg Drakos

Thursday April 25th, 09.15

Diagnosis in dialogue: How to approach new paradigms and buzzwords in healthcare?

How can health research make a difference inside and outside of academia? Georg Drakos will discuss three ways of approaching new paradigms and buzzwords in healthcare: a theoretically oriented, an empirically oriented, and a practice-oriented approach. The primary focus will be on practice orientation which does not exclude the other two.

Georg Drakos is Associate Professor of ethnology at Stockholm University. His studies concern narrativity, expressive forms of culture, and ethnographic fieldwork within health research. At present he participates in the project “Collaborative research companies in the humanities and social sciences”, which aims to develop tools for the mutual exchange of knowledge between academia and public organizations. More info.: www.sf-hs.se

Parallel sessions

Wednesday April 24th 1 pm – 3 pm

Session 1: Health policies, practices and social inequalities (p. 17)

Room 24.0.11

Moderator: Karine Aasgaard Jansen, Department of Archaeology, History, Cultural Studies and Religion, University of Bergen

- Nanna Ahlmark: Diabetes interventions as social technologies: dominant health rationalities and lived experience among ethnic minorities with type 2 diabetes
- Heidi Lene Andersen: Inequality in Health – a perspective on the different welfare regimes and the different Health promotion practises?
- Britta Lundgren: Vaccination narratives – trust, fear, and fantasy
- Marita Sihto: Health policy research –the need to broaden the focus

Session 2: Vulnerability and well-being among the elderly I (p. 22)

Room 24.0.07

Moderator: Susanne Ådahl, Department of Social Research (Sociology),
University of Helsinki

- Åsa Alftberg: Health practices in old age
- Blaakilde, Anne Leonora: Migration and health management. Elderly, ill Danish migrants practising self-care
- Tenna Jensen: Food for the elderly. Dietary politics aimed at elderly in Copenhagen 1900-2012
- Anne Liveng: Paradoxical constructions in Danish elderly care
- Eva-Marie Tveit: Nursing homes in Norway – a complex and changing context for an educational intervention

Wednesday April 24th 3.30 pm – 6 pm

Session 3: Calculating and dealing with risk concerning children's health
(p. 29)

Room 24.0.11

Moderator: Kristofer Hansson, Department of Arts and Cultural Sciences,
Division of Ethnology, Lund University

- Petra Roll Bennet & Helena Bergström: Om föräldrastöd och föräldraansvar kring barns fetma och övervikt
- Gabriella Nilsson: Det självreglerande barnet? Skola, föräldrar, individ och ansvaret för barns hälsa
- Sonja Olin Lauritzen & Marie-Louise Stjerna: Parents as care providers. Responsibility and 'moral parenthood' in the case of child food allergy
- Marie-Louise Stjerna: Risk management in everyday life: young people with food allergy
- Birgitta Sandström (Round table discussion): Riskabla liv – en studie om barn och unga i spänningsfältet mellan vardagsförståelse och diskurs

Session 4: Mental health: Diagnosis, treatment and care (p. 36)

Room 24.0.07

Moderator: Karine Aasgaard Jansen, Department of Archaeology, History, Cultural Studies and Religion, University of Bergen

- Niklas Altermark: Powers of Classification: Politics and Biology in Intellectual Disability
- Kristina Eivergård: Den delaktige patienten?
- Anna Johansson: ”Att ge kritik och vägra ta skit”. Psykiatrivård och patientskap i en digital kultur
- Leena Leinonen: The Aim of Finnish Social Work in Mental Health Care – Psychological or Psychosocial Wellbeing?
- Kerstin Stenius & Tuukka Tammi: Integrated treatment as practice and as an idea: The case of integrating substance abuse and mental health care in Finland
- Maria Vallström: Det diagnostiserande samtalet

Thursday April 25th 11 pm – 1 pm

Session 5: Managing health: Medical and social technologies (p. 43)

Room 24.0.07

Moderator: Anne Leonora Blaakilde, Center for Healthy Aging, University of Copenhagen

- Dorthe Brogård Kristensen & Matthias Bode: “I measure therefore I am”. A study of self-trackers in Denmark
- Karolina Lindh: Certifierade subject – HLR för alla
- Liz Adams Lyngbäck: The Lifeworld of People Engaging with Cochlear Implant Users: What will be gained by studying parental experience of hearing differentness?
- Anette Wickström: Improving the smile – on the construction of normality in orthodontic practice
- Susanne Ådahl: On the Biosocial Solidarity of Giving Organs to Others: An anthropological perspective

Room 24.0.11

Moderator: Gabriella Nilsson, Department of Arts and Cultural Sciences, Division of Ethnology, Lund University

- Carolina Lilja Gkogkaki: 'LeanSafety' and the government of healthcare professionals in Swedish healthcare: Normalization, Human Error and (un)professional otherness
- Heidi Haggrén: Collective interest organization of nurses and the trust in expert knowledge in Finland, 1950s and 1960s
- Kristofer Hansson: CI, leisure environments and public habilitation
- Ann-Cathrin Jönsson: Supportive counselling for persons after stroke – a disease leading to a variety of changes in the life situation
- Sarah Wadmann: Running a 'research business': studying physician-industry collaborations at the intersection between economy and morality

Thursday April 25th 2 pm – 3.15 pm

Session 7: Vulnerability and well-being among the elderly II (p. 58)

Room 24.0.07

Moderator: Anne Leonora Blaakilde, Center for Healthy Aging, University of Copenhagen

- Jessica Enevold: Gullstolen och andra makt-situationer: Ett konstprojekt för ett äldreboende
- Stinne Glasdam: Placed in homecare – Living an everyday life in dependence and monitoring
- Aske Juul Lassen: Active aging as a way of keeping diseases at arm's length

Abstracts

Session 1: Health policies, practices and social inequalities

Nanna Ahlmark, National Institute of Public Health, University of Southern Denmark, Copenhagen

Diabetes interventions as social technologies: dominant health rationalities and lived experience among ethnic minorities with type 2 diabetes

Some ethnic minority groups have a significantly higher prevalence of type 2 diabetes than the majority population. Marginalization, social position and migration related stressors may furthermore influence health behavior negatively. Public health interventions increasingly address such challenges. Yet, we have scarce knowledge about how such interventions are implemented and perceived by ethnic minority participants – especially over time. In this study we investigated the health rationalities reflected in municipal diabetes education courses for Arabic speaking immigrants and how the latter experienced the courses and perceived them 2.5-3 years later in the social context of everyday life. We employ the Foucault inspired concept ‘social technologies’ as the theoretical framework for the investigation. It suggests that it is not problems, which make us look for solutions, but already

imagined solutions, which make us define problems. The solutions represent socially constructed intentions about the good life. They, however, seldom meet the complexities of lived life of those for whom they are intended. Preliminary results show that rather than adopting the individualized approach to disease management, central in the courses' 'solutions', they become a platform for shaping socialites: as a catalyst for collectively processing traumatic life experiences and stories of distress. The findings point to unexploited potentials for health interventions if elements of social networks are prioritized.

Heidi Lene Andersen, ENSPAC, Sundhedsfremme, Roskilde Universitet

Inequality in Health – a perspective on the different welfare regimes and the different Health promotion practices?

This abstract describes different welfare state regimes and the impact the policies have on the approaches and practices in the field of health promotion. Internationally and in Denmark there is a discrepancy between the health promotion theory and health promotion practice. The general (theoretical) development in the field of health promotion is based upon the Ottawa Charter's holistic health perspective, whereas the practice field of health promotion often is based upon an individual and a physical health care perspective. The question is to which extent the different welfare regimes policies play a role in defining the practice of health promotion, and thereby

the inequality in health. The results of the findings presented in this abstract, is partly based upon 2 articles, written by Elisabeth Fosse and Signild Valgård, and partly by empirical evidence collected in several community health project in UK and Denmark. The findings indicate that the perspective of universalism in the social democratic regimes needs to be revitalized and empowered.

Britta Lundgren, Department of Culture and Media Studies, Umeå Universitet

Vaccination narratives – trust, fear, and fantasy

Epidemics are fascinating in the past, in the present and for the future. There are histories of epidemic past, like the Black Death, the yellow fever, the cholera, the Spanish flu, polio, AIDS and more. Epidemics and especially pandemics disrupt the society as we know it. An epidemic is a physical or biological event, but it is also a social and cultural crisis. There are lots of novels, artworks, movies about different epidemics and pandemics. Each epidemic also has an identity, a narrative that connects all these aspects. (Alcabes 2009: 1 pp).

Vaccination is the most common answer when it comes to fighting infectious diseases. But vaccination history is not only a story of hope and success, it is also a field full of fears, fantasies, conspiracy theories, and controversies.

As vaccine technologies reach from the global into the intimate and personal spheres this ambivalence or mistrust cannot be confronted by facts and information supply alone. There is an urgent need for dialogue to prevent mistrust and there is a need for knowledge that is culturally appropriate and relevant to different communities and groups. Narratives and stories work as a means for people to select facts and to evaluate phenomena that occurs in their lives. The analyses of narratives – from authorities and decision makers, from patient groups and from health staff - are crucial tools in this dialogue.

Marita Sihto, National Institute for Health and Welfare, Social and Health Policy, Finland

Health policy research – the need to broaden the focus

The research on health policy, especially the tradition of health services research in Finland, has often been understood as a study of health care, i.e. as a study of the operational level of health policy. Additionally the focus has been on the measurement and evaluation of outcomes. This approach disregards many aspects of the broad field of health policy such as the content of the health policy, the decisions what the policy makers do and the processes that lead to desired outcomes of the chosen policy. It has been assessed that if the outcomes are evaluated without knowledge of processes, the outcome by itself seldom produces a road map for policy makers because they do not know what produced the observed outcome. There is a need to study and evaluate policy processes in a way that would open up and explain

what happens in the “black box” of the decision-making and reveal the processes that enable to improve policies. This process-oriented approach pays attention to the question; *how* does the chosen policy have the intended effects? The *policy analysis* is used for this and it focuses on the study of the entire policy making process: the formulation of the policy content, the context of policy making environment, actors, implementation process and evaluation. There is often a significant gap in health policy research dealing with policy processes and governmental policy making related to health. The aim of the paper is first to analyse what are the basic assumptions in the policy analysis research tradition, and second discuss why process-oriented health policy research is needed.

Session 2: Vulnerability and well-being among the elderly I

Åsa Alftberg, Department of Arts and Cultural Sciences, Division of Ethnology, Lund University

Health practices in old age

The importance of a health promoting lifestyle is a normative belief directed towards all ages, but in particular old age. Ageing and old age are regarded as synonymous to diseases and disabilities, which make a healthy way of life appear as even more crucial. The ageing process - or rather the expected negative effects of the ageing process - is generally regarded as something that can be postponed, if one chooses the proper (healthy) manner to grow old.

This paper examines the intersection between old age and a health promoting lifestyle, based on the experiences of older people, aged 80 to 90 years, and displayed in my fieldwork consisting of interviews and participant observations. What is it to grow old, to feel the body change and sometimes reduce its capacity while being surrounded by the cultural ideal of an active, health promoting lifestyle? What strategies can be applied by the individual between sickness and health, meaning someone who from a medical point of view has poor health but consider him- or herself as not at all ill? The paper discusses how the notion of being active, healthy and independent shapes the practices of ageing, i.e. sayings and doings in old age. Based on ethnographic descriptions of the participants' everyday life, the analysis shows that the cultural concept of a healthy lifestyle creates situations that are morally loaded.

Migration and health management. Elderly, ill Danish migrants practising self-care

Globally, the number of retirees who trespass the national border and move to other countries is increasing, and this counts also for the Danish population. In 1995, 7.039 Danes were living outside of Denmark while receiving a Danish state pension. The respective number in 2011 was 46.090 (Pensionsstyrelsen 2012). In the scholarly realm, this field of study is called *International Retirement Migration*, and the group of south-headed North-Western migrants (from the US, Canada, UK, Nordic countries and Holland) are subcategorized as *Amenity-seeking International Retirement Migrants* (AIRM). This subcategorization indicates that they are "affluent, well educated and with financial management skills" (Warnes et al. 2004). While having done ethnographies among Danes in respectively Costa del Sol and the Turkish Riviera, I found that some of these terms and categorizations may need to be developed, especially the term "amenity" and the term "retirement". Typically, "amenity" indicates pleasures, whereas "retirement" connotes elderly people. However, many of the Danish people staying in these warm areas did not reach retirement age yet (which is 65-70 in Denmark), and they are not there because of pleasure. These persons are entitled to retirement benefits in Denmark not necessarily due to age, but due to suffering from a variety of diseases, i.e. rheumatism, psoriasis, fibromyalgia and diabetes, and they learned that the warm climate is beneficial for their diseases. They are practicing health management.

However, as Danish citizens they have to perform balancing acts of great complexity between the Danish regulations concerning tax, migration, social pension and social security, which seem to be counteracting the mobility practices of a postsocietal world (Urry 2000) and the intention of the Danish Health policies of self-care in the population.

I will discuss this phenomenon by applying Anne Marie Mols terms *logic of choice* and *logic of care* (Mol 2006).

Mol, AM 2006. *The logic of care. Health and the problem of patient choice*. Routledge London

Urry, John. 2000. Mobile Sociology. *British Journal of Sociology* 51, 1, 185-203.

Warnes, A. M., Friedrich, K., Kellaher, L. & Torres, S. (2004). The diversity and welfare of older migrants in Europe. *Ageing and Society* 24(3): 307-326

Tenna Jensen, SAXO-Institute, Dept. of History, University of Copenhagen

Food for the elderly. Dietary politics aimed at elderly in Copenhagen 1900-2012

In my paper I analyse the developments of dietary politics targeted at the elderly in the municipality of Copenhagen in the 20th and 21st centuries. Over the 20th century municipal care of the elderly spread from hospitals and poor houses to nursing homes, protected housings and private homes. As care functions increased so did the need to establish dietary rules and politics in

line with both financial reality and scientific paradigms in the municipality of Copenhagen. I focus on the developments seen in the municipal dietary regulations and politics from 1998-2012. The analysis focuses on the perceptions of the elderly and the importance of diet to their health apparent in the dietary politics of 2003/04 and 2012.

I aim to place these developments in a larger historical context beginning with the introduction of Alderdomsunderstøttelsesloven in Copenhagen January 1892. I also intend to touch upon the developments in the scientific perceptions of the nutritional needs of the elderly in the 20th century.

This paper presents parts of my new postdoctoral project which aims to counteract age related loss of muscle power (begins feb 2013). It is part of the new interdisciplinary project Counteracting Age-Related Loss of Skeletal Muscle Mass: an Interdisciplinary Innovation Project on Making Lifestyle Changes through Exercise and Diet led by Ass. Prof. Tine Damsholt SAXO-Institute.

Anne Liveng, Institute of Psychology and Educational Research, Center for Health Promotion Research, Roskilde University

Paradoxical constructions in Danish elderly care

The paper discusses transformations taking place in Danish elderly care due to neo-liberal modernization processes. The transformations imply a conception of human beings as rational and autonomous; at the same time they increase the level of governance and control. They form a radical change of the

understanding of the relation between the elderly in need of support and professionals. The care relation is so to speak repealed. The critical question is raised, where this transformation leaves the elderly in need for care, where it leaves the professional care workers and where it leaves the basic ideas of a welfare state responsible for those who cannot take care of themselves?

Focus is on the impact of different philosophies of human beings; on how views of elderly people influence our ideas of which care they might need and ideas of how the professionals are to behave towards elderly in need of care. I depart from an ideal of human relations in care work which can potentially be recognizing for both parts, even though an unequal power relation is always also implied. This normative ideal I base theoretically up on care ethics, care theory and on Honneth's critical theory of recognition. Empirically it is based upon a number of analyses carried out in Danish elderly care.

The image of elderly as presented in municipal policy documents strongly puts forward the resources of the elderly, and underlines the need to live an active life in old age. The image contains a duality in constructing the elderly as autonomous *and* as people who need some kind of guidance in order to behave properly. The elderly person is constructed as being able to make meaningful, active and healthy choices for one's own life *and* to need persuasion in order to realize that he or she has to make these choices.

An evaluation carried out in activity centers for elderly is used to illustrate how the transformations pose challenges to care workers and are reflected as different logics which collide when they talk about the elderly. The elderly are seen both as people who have to be taken care of, and as independent customers, with a "free will" to choose. The employees struggle to integrate

the two logics; but as they have become economically dependent on the elderly as customers, the logic of the market tends to overturn the logic of care.

Eva-Marie Tveit, Senter for omsorgsforskning, Vest Högskolan i Bergen

Nursing homes in Norway – a complex and changing context for an educational intervention

The starting point of this abstract is an ongoing research project with the working title MEDCED hosted by the Center for Care Research at the University College of Bergen. The MEDCED study builds on an educational intervention directed at care staff to prevent the use of restraint in nursing home residents with dementia. The knowledge translation process will be thoroughly described and tested using a RCT cluster design to ensure the replicability of the study and applicability of the results, and the implementation process will be informed by the PARIHS framework.

With a background in culture studies my role as a post-doctoral researcher in the MEDCED project is work within a sub-section of the project called “Organization, culture and context”. Our study encompasses 24 nursing homes, approximately 300 patients, and staff working in the relevant wards. Nursing homes were randomly picked from four regions in Western Norway. The homes vary to a great extent when it comes to size, the economy in, and organization of, nursing homes in the respective communities, as well as demography and geography of the area. Based on interviews with the leaders

of these nursing homes and reflection notes from the facilitators that carry out the intervention, as well as contextual information informed by our visits to the homes, I would like to discuss the transformations the nursing homes are going through in the crossfire of political, structural, economical and public demands.

Session 3: Calculating and dealing with risk concerning children's health

Petra Roll Bennet, Institutionen för pedagogik och didaktik, Stockholms universitet

Helena Bergström, Barn- och ungdomsvetenskapliga institutionen, Stockholms universitet

Om föräldrastöd och föräldraansvar kring barns fetma och övervikt

I Sverige liksom i många andra länder har barns övervikt och fetma ökat. Föräldrar anses ha en central betydelse för barns matvanor och fysiska aktivitet och föräldrar till barn med fetma utpekade, både i media och i medicinsk litteratur som ansvariga för barns övervikt och att deras livsstil är avgörande. Stöd och råd till föräldrar poängterar gränssättning, uppmuntran och att föräldern ska fungera som en förebild för barnet. Matvanor och vardaglig livsstil är på många sätt en privat och familjär angelägenhet och synen på föräldrar och barns hantering av barns övervikt och fetma är alltför ensidig. I detta paper undersöks hur föräldrar och hur föräldrar och barn förhåller sig till de rekommendationer som ges. Genom intervjuer med föräldrar till barn mellan 8-12 år diagnostiserade med övervikt/fetma visas hur föräldrar hanterar råd och anvisningar i sitt dagliga liv. Det visar sig att föräldrarna står inför ett komplext dilemma som innebär att de beaktar såväl

fysisk som psykisk hälsa samt relationer i vardagliga förhandlingar mellan föräldrar och barn. Sett ur ett relationellt perspektiv utmanas idén om en rationell förälder som handlar i enlighet med kunskaper om vad som är en hälsosam livsstil och synen på barnet som passiv mottagare. Föräldraskap innebär således mycket mer än att kontrollera barnets vikt och sätta gränser.

Gabriella Nilsson, Department of Arts and Cultural Sciences, Division of Ethnology, Lund University

Det självreglerande barnet? Skola, föräldrar, individ och ansvaret för barns hälsa

Det har sedan lång tid tillbaka legat i samhällets intresse att skapa självreglerande individer, men från ett nordiskt perspektiv har välfärdssamhället traditionellt tagit ett relativt stort ansvar för medborgarnas hälsa. I takt med att även Sverige successivt förändras från ett kollektivistiskt till ett mer individualistiskt, nyliberalt samhälle, ser vi emellertid en rad reformer som på ett konkret sätt flyttar ansvar och beslut rörande livsstil och hälsa från välfärdssamhället till individen själv. I en period av förändring är det rimligt att anta att det råder delade meningar bland aktörer på olika samhällsnivåer om var det här ansvaret bör placeras. Den här potentiella oenigheten är särskilt komplex när det kommer till barns hälsa, eftersom barnet, såsom varande omyndigt, inte själv kan hållas ansvarigt för sin livsstil.

Det här papret fokuserar vem som har ansvar för att barnet har en hälsosam livsstil. Utgångspunkten är två olika empiriska studier; om

barnövervikt respektive frukostvanor. I de här studierna framgår att skolpersonal har ett ambivalent förhållningssätt till elevernas hälsa och till vem som bär ansvaret för att den upprätthålls. I papret diskuteras frågor som: Hur förhåller sig skolpersonalen till, och agerar utifrån, det som de uppfattar som bristfällig omvårdnad från föräldrarnas sida? I vilken utsträckning prioriterar de ett pragmatiskt förhållningssätt, där skolan tar ett ansvar för elevernas hälsa som personalen egentligen inte anser att de borde ta, och när utövas i stället en normativ ”uppfostran” av föräldrarna och barnen? Vilka antas konsekvenserna av det här valet bli? Var beskrivs gränsen gå mellan det som uppfattas vara ett ”legitimt” misslyckande från föräldrarnas sida och ren försummelse? Hur hänger den här upplevelsen samman med vilka föräldrarna antas ”vara”, i termer av sociala kategoriseringar, likhet och skillnad?

Marie-Louise Stjerna, Department of Education, Stockholm University

Risk management in everyday life: young people with food allergy

Food allergy, a condition that ultimately can be life-threatening, is an example of an illness that involves constant risk management in everyday life as there is no other treatment than to avoid certain foods stuffs and to deal with the symptoms when they appear. Here I will draw on a study which explores how young people with food allergy manage risk related to their health, as well as social risk in how they are perceived by others, in different social arenas such as the family, the school and among peers. The purpose is to capture and shed light on various aspects of young people's views of their allergy,

understandings of risk and avoidance of ‘dangerous’ food, as well as their social vulnerability.

In order to capture these young people’s experiences of risk management, a qualitative multi-methodological approach is used, including focus groups as well as individual interviews and visual methods. During the autumn of 2012 interviews with teenagers 11-18 years old, have been carried out. It is work in progress and at present a first analysis of the individual interview material is underway. It is regarded as self-presentations, interpreted as an expression of identity formation of young people living with a hidden disability, drawing on a notion of identity as an ongoing process which takes place in interaction within social arenas and contexts. That is, the young person is seen as being right in the middle of a constant process of identity-formation, and the analysis will focus on young persons’ agency and social identity in different social arenas. In this presentation I will discuss some of the preliminary findings of the study.

Sonja Olin Lauritzen, Department of Education, Stockholm University

Marie-Louise Stjerna, Department of Education, Stockholm University

Parents as care providers. Responsibility and ‘moral parenthood’ in the case of child food allergy

Caring for a child with a chronic condition will affect parents’ lives in various ways. Child allergy conditions are ‘new’ in the sense that they have emerged through the last decades and are today seen as a major public health problem

– and parents of allergic children are expected to take responsibility for anything that can cause an allergic reaction in their children's daily lives. At the same time there is an ambiguity related to these conditions. Biomedically, allergic conditions are still not fully understood, and they are also debated as related to various aspects of 'modern life'.

This paper addresses the case of food allergy, a condition that affects up to 12 per cent of children in the Western world (depending on definition). Drawing on a focus group study carried out in Stockholm in 2009-10 with thirty-one parents of children diagnosed with food allergy we will focus on parental risk management and experiences of responsibility when living with a child suffering from food allergy. This study indicates that the management of allergy risk seems to permeate most aspects of everyday life, and that parents draw on a dominant norm of risk avoidance as well as a counter-discourse of calculated risk taking. These patterns of risk management are discussed in terms of how risk avoidance and risk taking are intertwined and balanced in the context of 'moral parenthood'.

Birgitta Sandström, Institutionen för pedagogik och didaktik, Stockholms Universitet

Round table discussion: Riskabla liv – en studie om barn och unga i spänningsfältet mellan vardagsförståelse och diskurs

”Risksamhället” är ett samhälle där människor är alltmer upptagna av att hantera risk av olika slag. Med ett sådant samhälle följer ett slags rädslokultur.

Rädslokulturer skapar i sin tur offer i form av riskgrupper som samhället på olika sätt bör skydda. Barns och ungas beroende av vuxna gör dem till mest självklara riskgruppen av alla. Vi vill presentera en projekttid som fokuserar på fenomenet risk i relation till barn och unga, och vad risksamhället gör med barns och ungas identitetsskapande.

Projektet rör spänningsfältet mellan institutionell förståelse, verksamma diskurser och vardagsförståelser av risk. Vi vill uppmärksamma hur barn och unga förhåller sig till och hanterar risk i skilda kontexter och hur deras identitetsskapande sker i relation till jämnåriga och vuxna och belysa hur föräldraskapet sammanvävs med diskurser om riskundvikande som en del av idén om det goda föräldraskapet. Samhällsvetenskaplig forskning präglas av nyfikenhet inför ett samhälle som blir alltmer besatt av säkerhet och vad det får för effekter på människors liv i form av begränsningar av människors autonomi och (rörelse)frihet. Projektet ansluter sig till ett sådant perspektiv. Det tar även sin utgångspunkt i ett barn och ungdomssociologiskt perspektiv där unga ses som sociala aktörer som både påverkas av och förändrar de världar de deltar i. Projektets fem delstudiers övergripande syfte är att problematisera och kontextualisera fenomenet risk där fokus ligger på föreställningar om barns och ungas utsatthet och agens när det gäller mat och ätande, sexualitet, hälsointerventioner och rörelsefrihet i barns vardagsmiljö.

Birgitta Sandström, docent i pedagogik, Marie-Louise Stjerna, Post. dok., pedagogik, Petra Roll Bennet Fil.dr., pedagogik, Institutionen för pedagogik och didaktik, Stockholms Universitet. Helena Bergström, Fil.dr., pedagogik, Institutionen för Barn och ungdomsvetenskap, Stockholms universitet. Helena Hörnfeldt, Post. dok., etnologi, Institutionen för etnologi,

religionshistoria och genusstudier, Stockholms universitet. Anette Wikström,
Post. dok., socialantropologi, Institutionen för kultur och kommunikation
Linköpings universitet.

Session 4: Mental health: Diagnosis, treatment and care

Niklas Altermark, Department of Political Science, Lund University

Powers of Classification: Politics and Biology in Intellectual Disability

Intellectual disability is commonly understood as a biological state of functioning that determines the cognitive capabilities of the individuals labelled so. This article challenges this view by arguing that intellectual disability rather is a diagnosis of social deviance, which is projected onto the brain in processes of discursive biologization. Examining the classificatory systems and prominent works in the clinical literature I argue (1) that the criteria in the classification schemes are designed to detect social deviance rather than pre-discursive biology, (2) that the inscription of deviance onto the biology of the brain functions as to firmly separate 'normal' from 'deviant' forms of being, and (3) that the main rationale behind classification is to segment a part of the population that is perceived as calling for government intervention. These arguments should urge social scientific disability scholarship to approach classification and medical descriptions of intellectual disability as inherently political phenomena.

Den delaktige patienten?

I Psykiatrireformen 1995 angavs delaktighet och respekt som nyckelord för den psykiatriska vården (SOU 1992:73). I patientsäkerhetslagen står att patienten skall *göras delaktig, vara delaktig* eller *ges möjlighet* att delta i sin egen vård för att på sätt göra den säkrare (2010:659). Här läggs ett ansvar ut på den enskilde patienten som förväntas vara en aktiv deltagare i vården. Men på vems villkor? För vem säkras vården? Att som det står i lagtexten *göra* någon delaktig betyder det att det finns någon annan än patienten som skall åstadkomma delaktigheten. Det ligger en hierarkisk hållning i ett sådant ordval. Vårdpersonalen står för kunskap och förståelse av vad som skall delges, patienten ska ta emot. Innebär det att patienten på ett enkelt sätt blir delaktig i sin egen vård?

Frågan om patienters delaktighet som både begrepp och handling är viktigt att diskutera. I psykiatrin handlar det om att undersöka på vilket sätt patienter inkluderas i de sammanhang där samtalet om dem själva pågår. Får patienterna tillgång till och kan bemöta de berättelser och representationer som formuleras och ges vetenskapligt status? Vad innebär det för patienternas del att samtalet om dem själva hålls bakom stängda dörrar dit de inte äger tillträde?

”Att ge kritik och vägra ta skit”. Psykiatrivård och patientskap i en digital kultur

Sociala medier används många gånger för att sprida kritiska patientberättelser om möten med den svenska offentliga psykiatrivården. Vårdens svårtilgänglighet, resursbrist och missförhållanden är några av de teman som lyfts fram, och många skribenter ifrågasätter en syn på den psykiatriska patienten som passiv och oförmögen till självbestämmande. Sådana berättelser kan ses som en effekt av de senaste årens informationsteknologiska utveckling, vilken gör det möjligt för tidigare marginaliserade röster att ta plats i det offentliga rummet. Berättelserna bör också förstås i relation till samtida förväntningar på patienten som en aktiv och informerad konsument, vilket i sin tur kan tolkas både som en demokratisering av förhållandet patient-vårdgivare och som en transformation i linje med en neoliberal individualisering av ansvar.

Då psykiatriska patienter historiskt har haft begränsade möjligheter att göra sina röster hörda i offentligheten, är det angeläget att närmare förstå vad dessa tendenser innebär för relationen mellan psykiatri och patient. På vilka sätt kan användningen av sociala medier bidra till att omformulera betydelsen av att vara en psykiatrisk patient? Hur förhåller sig psykiatrin till detta och vilka effekter kan det få för hur de konkreta vårdpraktikerna tar form och upplevs? Dessa är de frågor som jag kommer att diskutera i mitt paper, med utgångspunkt dels i patientproducerat nätmaterial och dels i intervjuer med

personal inom psykiatrivården.

Leena Leinonen, Department of Social Sciences, University of Eastern Finland

The Aim of Finnish Social Work in Mental Health Care – Psychological or Psychosocial Wellbeing?

Social work in Finland has traditionally been strongly linked with social policy. The main task of social workers, including those in the field of mental health care, is to provide social advocacy for the patients and to take care of concrete issues in their everyday life. However, in psychiatric health care, social work is usually performed from a therapeutic starting point. Many Finnish psychiatric social workers are legalized therapists.

The aim of the study is to analyze and visualize the interface between social work and therapy, which have traditionally been separated from each other in Finland. The results show that almost one-third of Finnish psychiatric social workers have already schooled themselves as legalized therapists. This indicates that social workers believe that using therapy methods as a tool in social work makes it easier to confront psychiatric patients and their problems. However, on the basis of these results, it is justified to say that there are some major problems concerning the professional identity of Finnish psychiatric social workers and the aim of psychiatric social work. Therapy-centered social workers may totally neglect the main task of social work that is related to social policy. Should the aim of social work in mental

health care be the psychological or psychosocial wellbeing of the patients?

Kerstin Stenius, National Institute for Health and Welfare (THL), Finland
Tuukka Tammi, National Institute for Health and Welfare (THL), Finland

Integrated treatment as practice and as an idea: The case of integrating substance abuse and mental health care in Finland

Substance abuse, like mental health problems, are affected by individual factors and experiences, social interaction, societal structures and resources and cultural values. Substance abuse treatment systems are currently undergoing large reforms in many countries, in the chase for more optimal and cost-efficient mixes and coordination of services to handle widespread, often complex and long lasting problems. In Finland, there is an ongoing national attempt to integrate (the too inpatient focused) mental health care and substance abuse treatment (a non-medical and comparatively resourceful) systems, with an increased emphasis on outpatient measures. The Finnish reform is clearly of international interest; similar efforts can be found in for instance the Netherlands and Canada.

Our study uses the Finnish experiences of local differences in the integration of substance abuse treatment with mental health treatment. The paper will analyse how more or less integrated local systems officially delineate and define substance abuse problems and their proper handling in their catchment area. On the basis of interviews with local key persons and policy documents for substance abuse treatment in eight Finnish cities with a

minimum of 30 000 inhabitants, we aim to discuss the variety of reasons, interests and motives behind (re-)modeling of local care systems. In the next phase, the project will analyse how integrated or less integrated systems succeed in reaching different groups of substance abusers.

Maria Vallström, Historiska institutionen, Uppsala universitet

Det diagnostiserande samtalet

I det här paperet vill jag se på hur diagnoser ställs och uppfattas ur ett patientperspektiv. Med utgångspunkt i några ”diagnostiserande samtal” i samband med framförallt sinnesundersökningar för straffria intagna på Salberga sjukhus, Sala i Sverige under 1930-talet är tanken att spåra hur diagnostiseringen gick till i mötet mellan läkare och intagen, men också hur de intagna själva såg på den egna situationen och deras egna sjukdomsbeskrivningar. I viss mån kommer jag även att gå in på hur de beskrev andra intagna, sinnessjuknämnden och personal på sjukhuset. Slutligen vill jag också undersöka hur anhöriga och aktörer i lokalsamhället beskrev de intagna. Det blir en fråga om att utröna vilka beskrivningar som byggde upp diagnoserna och vilka förhandlingar som ägde rum mellan intagen, läkare och anhöriga. Mitt fokus (och mina kunskaper) ligger inte inom det dåtida medicinska diagnostiserandet utan jag vill ge en bred bild av hur de intagna kategoriserades och själva kategoriserade. För att kunna fånga även det ”utommedicinska” ordnandet kommer jag att utgå från vilka kategoriseringar som gjordes i vid mening, vilka de tillskrivna egenskaperna var och hur de

relaterade till diagnoserna och eventuellt förändrade dem. För att behålla fokus på patienterna så kommer dessa kategoriseringar att vara viktiga i analysen: de som beskriver den upplevda och tillskrivna belägenheten som intagen – patientens position – och förhandlingarna som konstruerade den. I likhet med Beverly Skeggs vill jag fokusera på hur individen blir till i relation till andra, i sociala sammanhang och i relation till övergripande maktstrukturer. Det blir därmed en fråga om subjektivering som en kollektiv process, under ständig förändring, snarare än något som sker enbart på en individuell nivå.

Presentationen ingår i projektet ”Patientens mening- om handlingsutrymmen och alternativa subjektiveringar inom den anstaltsbundna sinnessjuk-och sinnesslövrården 1870-1970”, som bedrivs under åren 2011-2013 på historiska institutionen, Uppsala universitet, finansierat av Vetenskapsrådet.

Session 5: Managing health: Medical and social technologies

Dorthe Brogård Kristensen, Institut for Marketing & Management, University of Southern Denmark

Matthias Bode, Institut for Marketing & Management, University of Southern Denmark

“I measure therefore I am”. A study of self-trackers in Denmark

This paper presents the result from an ongoing research on self tracking among Danish consumers. The study is based on participant observation and phenomenological interviews among self quantifiers and focuses on how the practice of using health numbers and technologies becomes a platform for construction of subjectivity and sociality. The “Quantified self” is a social network that focuses on self-tracking, and is associated with mobile health, sensor-network, smartphones, social medias, etc. The Danish group of Quantifiers was initiated as a digital platform in May 2012 and recruits its members through internet and social networks. Active participation in the group takes the form of participation in meetings where the members share their experiences with technologies.

We see the phenomena of self tracking in a context of self-help where consumers actively seek to manage their health. etc. Overall the focus is on the reemergence of science in an individualized self-help role. As argued by Norah Cambell (2010), the notion of the human has changed radically, as technology has replaced religion and psychology as the main model for how

mind, body and universe work. Furthermore, recently we have witnessed major changes in society that call for further analysis of the relationship between health, science and forms of sociality. The emergence of new technologies has increased the possibility for lay people to access, evaluate and manage their own health. This goes hand in hand with a moral imperative and a public discourse that encourages citizens to self-responsibility and self-management, e.g. to stay informed and to make the right choice, to evaluate health risks, and to navigate in the complex of authoritative voices (Henderson & Peterson 2002, Fox et al 2004). As a consequence, 'health' is perceived less as a concern of the state and more as a preoccupation of autonomous individuals who are able and willing to act responsibly and rationally in order to make 'healthy' choices in their lives (Rose 1999).

In the paper we focus on notions of technology and self (Cambell et al. 2010; Giesler & Venkatesh 2005, Latour 1991, 2010) the role of science and numbers (Porter 1995, Espeland & Steven 2008) and performance and optimization (Ehrenberg 2010, McKenzie 2001). In this case, health has primarily become a self help issue, an anchor for solving social and individual issues as liberation from the anti-enlightenment forces of superstition, religion, mysticism etc, as from traditional authorities.

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Karolina Lindh, Department of Arts and Cultural Sciences, Lund University

Certifierade subject – HLR för alla

Hjärt- och lungräddning (HLR) beskrivs som så enkelt att alla ska kunna lära sig. I Sverige har sedan 1981 uppemot 3 miljoner personer deltagit i någon form av HLR-utbildning. Riktlinjerna för HLR är standardiserade och följer riktlinjer från internationell och nationell medicinsk expertis. Trots omfattande utbildningsinsatser, på arbetsplatser, i skolor och av frivilligorganisationer visar statistik att chansen att överleva ett hjärtstopp utanför sjukhus är låg.

I presentationen utforskas HLR som en form av *governmentality*. HLR-utbildningar har starkt stöd hos myndigheter, frivilligorganisationer och andra samhällsinstitutioner som skolor och arbetsplatser. Instruktioner och riktlinjer för hur man ger HLR finns idag tillgängliga i flera format, förutsatt att du har tillgång till Internet via dator eller telefon kan du när som helst ta reda på hur man ger HLR. Utöver de rent instrumentella instruktionerna berättas känsloladdade historier under kurser och i media. Dessa berättelser kan handla om vardagshjältar som räddat en anhörig eller en arbetskamrat eller om plötsliga dödsfall som kunde ha förhindrats om personer kring den drabbade

hade haft kunskaper i HLR. Det ofta uttalade syftet med kurserna att det ska leda till en känsla av trygghet kontrasteras i observationerna med den oro och de rädslor som deltagare ger uttryck för i samtal under kurserna. Riskmedvetandet flyttar från instruktioner och myndigheter till kursdeltagares kroppar. HLR-kurser skapar subjekt som kan ingripa. Studien bygger på observationer under HLR-kurser som vänder sig till allmänheten och på intervjuer med deltagare på kurserna.

Liz Adams Lyngbäck, Department of Education, Stockholm University

The Lifeworld of People Engaging with Cochlear Implant Users: What will be gained by studying parental experience of hearing differentness?

The advancement of cochlear implant technology over the past 20 years has changed how perception through sound is contemplated and has brought about new questions in regard to language, communication, identity and distribution of resources in education. Hearing has been redefined to include a biotechnical extension of the body that is said to provide the use of CI technology to 95% of children born deaf or with a severe hearing impairment in Sweden (Karolinska Institutet, 2007). These biomedical practices influence attitudes and beliefs about sign language use and bilingualism. Due to the fundamental value that language use has for interpersonal relationships and socialization, I propose that the experiences of people who interact closely with CI users need be studied from a phenomenological perspective. Interdisciplinary research in education, informed by exploring the lifeworld

focuses on taken for granted experience can help us understand the recurring rhetoric at the societal level of individual solutions for hearing problems framed in technological and economic terms. Guardians of candidates for CI surgery engage in making the decision for a corrective measure which determines potential perceptual experiences and existence. This involves managing new technology, negotiating how to use services and therapies offered to families and making choices about language environment. Findings from a pre-study include a survey of the research on child cochlear implantation, ethnographic field work and a pilot interview. This work in progress will study the first person perspective accounts of people engaged in communication with CI users who initially experience the world differently (deafness/hearing impairment) and then use a technically aided acquisition of spoken language and/or sign language. People close to CI users also experience going in and out of ways of being in the world when they are directed and engaged with them as they go through these changes. The initial interest for this research will come from the accounts of people who are parents or guardians of CI users. Its focus will be on investigating experience of interpersonal relationships under newly forming linguistic circumstances and how people understand changes in ways of being in the world, their own as well as that of others'.

Improving the smile – on the construction of normality in orthodontic practice

In Sweden, more than every fourth adolescent undergoes treatment with fixed appliances. Aesthetical reasons and enhancement of life are the main reasons. This ethnographic study aims to understand how aesthetical norms are discussed and negotiated, how deviation of the bite is evaluated, and how adolescents, parents, orthodontists and material representations interact when young people's smiles are improved. The study is based on video-recordings and participant observation of the interaction between adolescents, parents, orthodontists and assistants during activities that precede a possible treatment. Moreover, eight young patients have been interviewed.

A combination of theoretical perspectives from Science and Technology Studies and medical sociology/anthropology are used in order to understand clinical practice as collaboration and interaction as well as meaning-making processes. I use Goodwin's concepts *coding*, *highlighting* and *producing material representations*, as well as Gilman's and Davies' theories on *surgical passing*.

The initial analyses show that, when the divergence is visualized in front of the computer, the focus is moved from the children's lived experience and knowledge of their bodies, to the orthodontists' gaze and authority. The orthodontists are experts on appearances and the young patients strive to become ordinary, to escape being ashamed. Moreover, they strive for better potentialities and the "aesthetic labour" is an investment in life. Team building

is crucial for the process. Parents, adolescents and orthodontist together agree on creating the “exceptional normal”.

Susanne Ådahl, Department of Social Research (Sociology), University of Helsinki

On the Biosocial Solidarity of Giving Organs to Others: An anthropological perspective

The starting point of my presentation is the Finnish term used by the National Federation of Kidney and Liver Diseases to describe organ recipients; *elinsiirron saanut henkilö*, which literally translated means ‘person who has received a transplant’. The term itself signals the centrality of the social relationship in question, that it is one of exchange. It is also a rather neutral and restricted way of describing the lived experience of transplant reciprocity and the various relationships of exchange that evolve between citizens and the welfare state. The tried and tested metaphor of giving ‘the gift of life’ used in organ donation campaigns has recently in Finland been changed into a more imperatively formulated phrase; ‘say yes to organ donation’. This indicates that a change has taken place in how the motivation to give is perceived. It is thus interesting to ponder what social force underlies the practice of giving (through deceased donation) and how it linked to a term, ‘biosocial solidarity’, that I am in the process of developing. Using philosopher Larry May’s definition of solidarity and ethnographic examples my aim is to discuss the nature of altruistic giving when the tie sign creating the social bond between

giver and receiver is a biological object that has once been part of someone else. How is citizenship and sociality intertwined in the practice of giving and receiving body parts? What is the role of this solidarity in the giving practices of (deceased) organ donation and reciprocity? The presentation is based on ethnographic research conducted on kidney transplant recipients in Finland 2010-2012.

Session 6: Public health: Professionals, interventions and agency

Carolina Lilja Gkogkaki, School of Economics and Management, Department of Business Administration, Lund University

'LeanSafety' and the government of healthcare professionals in Swedish healthcare: Normalization, Human Error and (un)professional otherness

In January 2011 the Patientsafety Law was enforced in Sweden (Patientsäkerhetslag 2010:659). The law and its related regulations (Socialstyrelsen, SOSFS 2011:9 – The National Board of Health and Welfare) brought healthcare providers under the obligation to achieve the two-pronged quality objective of patient safety and efficiency through process-oriented management systems. Drawing on Foucauldian ideas and the Governmentality perspective my doctoral project aims to investigate how 'LeanSafety', as a combined Lean- and Patient safety discourse come to inform how professional subjects ought to be governed; how they ought to govern themselves and their relations. The purpose of my presentation will be to present some of my current ideas around the complexities of 'LeanSafety' and discuss its possibility to operate as a certain type of normalizing technology.

Collective interest organization of nurses and the trust in expert knowledge in Finland, 1950s and 1960s

This paper studies the collective interest organization of Finnish nurses in the 1950s and 1960s with the focus on the role of scientific knowledge. The collective organization of nurses was in the post-war years characterized by strengthening labour-market logic. This reflected a wider societal and labour market change as well as the changes in the health care system. The Finnish health care system expanded rapidly after the war as the pre-war ideas on public health were realized and building of a nation-wide hospital network took place. Development of medicine and technology, introduction of new personnel groups, and hierarcization and specialization of nursing personnel changed the landscape thoroughly. At the same time the health care policies provided space for nurses' professional projects and opened a way to improve their social and economic status. Education is one of the most important ways for lifting the status. The paper focuses on nurses' efforts to develop nursing education and research and create expert knowledge on the field. These are discussed in relation to the collective bargaining strategies. The paper points to the balancing between labour market interests and rationalities, professional strategies and work-related loyalties. Special emphasis is placed on the ways in which nursing organizations engaged in defining nursing, care and the common good.

CI, leisure environments and public habilitation

This paper presents parts of a new research project that study the experiences of people with cochlear implants (hereafter CI) when exercising in varied environments ranging from football, swimming, or, for example, chess club meetings. An established discourse today is that we should all be able to participate in active recreation in our leisure time, and that this is essential for good health and general wellbeing. At the same time, many leisure environments are noisy and not always adapted to people using CI. In this project I want to develop an understanding for the cultural practises that are created in different sound environments where people are spending their leisure time.

Professionals working in public habilitation are interviewed about their knowledge of which sound/leisure environments can be problematic for people using CI. Central in the interviews is a discussion about the hearing strategies they learn, and how these strategies are related to a discourse about participation, as it is defined in the “International Classification of Functioning, Disability and Health” (ICF). In this paper I present some of my findings from these interviews.

Health promotion – a neglected perspective in health care

The health care system has been proposed to be a “sick care” system that focuses predominantly on treating disease rather than promoting health. Some critics worry that ineffective preventive services are only adding to, rather than reducing, unnecessary health service utilization.

Health care has more and more been directed towards an industrial way of organization. This way of thinking has led to health care personnel being urged to be more efficient by using examples from the construction industry, thus “running” faster and spending less time with each patient, and to focus mainly on physical factors. The present health care organization with repeated cutbacks has led to a decreasing number of days in acute hospital care for persons needing health care, which, in turn, leads to an increasing need for re-hospitalisation. Decision makers ruling on health care do not seem apt to consider evidence-based knowledge on different ways of organising health care. The development of competence among different disciplines active in health care is also neglected in health care organisation. Today, health care organization is strongly built on the person needing health care specifying what the needs are. It seems obvious that a person with health problems cannot easily specify all aspects of the individual health problems and cannot interpret the exact symptoms and the reasons behind the symptoms. Even when it comes to diseases with National Guidelines specified by the National

Board of Health and Welfare, there are reports that health care is not following these guidelines.

Stroke is the disease that causes the largest number of hospital care days in Sweden. This presentation aims at giving an overview of different organizational factors in health care, but also an example of secondary prevention by following up different aspects of health status among persons with stroke after discharge from acute hospital care.

Sarah Wadmann, Centre for Healthy Aging and Centre for Medical Science and Technology Studies Health Services Research, Department of Public Health Faculty of Health Sciences, University of Copenhagen

Running a ‘research business’: studying physician-industry collaborations at the intersection between economy and morality

A characteristic of current health policies in Denmark is a merger between health and growth agendas often put forward as a call for public-private partnerships. Physicians’ involvement with pharmaceutical companies and the ensuing political debate sparks, however, paradoxical ideas. While collaborations between academic researchers and private companies are portrayed as strategic means to ensure innovation and economic growth, physicians who engage in such collaborations risk seeing themselves pictured as corrupted or biased. Building on ethnographic fieldwork undertaken in Danish hospitals in the capital area of Copenhagen during 2009–2011, this paper explores how such conflicting political expectations interact with

everyday practices in clinical hypertension research. In contrast to the political rhetoric, this study indicates that publicly employed physicians experience a need to form financial ties to pharmaceutical companies *in order* to feel independent and undertake the research they find important. Moreover, it shows how the physicians must undertake ‘moral work’ to engage in industry collaborations, and suggests that this ‘moral work’ shapes the organization of public-private research production at the Danish hospitals. In conclusion, this study suggests that financial exchanges in physician-industry research collaborations cannot be understood separately from the moral agency they evoke.

Session 7: Vulnerability and well-being among the elderly II

Jessica Enevold, Department of Arts and Cultural Sciences, Division of Ethnology, Lund University

Gullstolen och andra makt-situationer: Ett konstprojekt för ett äldreboende

Denna presentation redovisar idén och arbetet med installationen och konstprojektet "Gullstolen" - en rullstol som byggts om till en gyllene tron i samarbete med och som kommer att återföras till ett äldreboende i Västra Götaland som en semi-permanent utställning/resursmaterial för verksamhet som bestäms i samarbete med äldreboendets två chefer och aktivtetskoordinator.

Projektet "Gullstolen" tar sin utgångspunkt i stolen som symbol för makt och förmåga (power and ability) - den vill vända på den klassiska situationen som ofta uppstår då man i vården och i livet sätter sig ned och i motsats till någon som sätter sig på en ny post eller tron, förlorar makt och status. Projektet leker med och understryker lekens betydelse och legitimitet högt upp i åldrarna - grundtanken är att det ska vara ok att bära guldkrona, gila ballonger och vara födelsedagsbarn även vid 80-årsålder, sittande i en rullstol. Att föra in mer kultur i vården generellt och äldrevården specifikt är en aktivitet som har ökat runtom i Sveriges kommuner de senaste 10 åren efter utvärderingar av bland annat Folkhälsoinstitutet (FHI Rapport 2005). Kulturrådet fick i uppdrag av regeringen att från 2012 fördela 28

miljoner kronor till landsting, kommuner och privata vård- och omsorgsgivare (se "kultur för äldre" på www.kulturtrradet.se och "kultur i vården", på samma websajt). Detta projekt sällar sig till många nu genomförda projekt i olika kommuner i Sverige, se exempelvis "PlayMakers" i Södertälje, som försöker införa mer lek bland annat genom datorspel för äldre. Gullstolen vill i konsten och kreativitetens tecken återföra både makt och lek till de äldre.

Stinne Glasdam, Health Sciences Centre, Lunds University

Placed in homecare – Living an everyday life in dependence and monitoring

Through a sociological single case study this paper analyses how everyday life is lived in dependence of healthcare professionals. The case is seen from a relational perspective and the analysis is inspired by Michel Foucault. The results show how the healthcare professionals' working day and the everyday life of the client (and family) in dependence are solidly structured and disciplined by a neoliberal logic of time allocation and time scheduling that rules the homecare system. The life of the client seems to be a solid, structured everyday life with minimal private time. Work in the home, alias household chores and personal care, resembles a disciplining strategy. The client lives under conditions of monitoring and control comparable with the conditions of imprisonment. The client seems to be subject to the will of and the social intercourse with other people in his own home. All in all, homecare service performs as a disciplinary practice in modern society.

Active aging as a way of keeping diseases at arm's length

Active ageing has increasingly become the ideal of how to live later life. Concepts of activity, participation and independence are central to how elderly see themselves and practice aging (Katz 2000). The elderly are encouraged and expected to stay active and independent. This is believed to be good for their quality of life, health, functionality and the economy (Sundhedsstyrelsen 2008, EC 2006, WHO 2002).

At the same time active aging is inscribed into a general health care focus, which individualizes the responsibility for health and disease. This requires subjects ready to engage in self-care, by paying attention to the signals of the body and leading healthy lives (Rose2001). However, active aging seems to contain an ambiguity in this aspect, as the practice of active aging is often a way for elderly to keep diseases at arm's length, and not a way to sense the possible abnormalities in the body. Through ethnographic fieldwork at two activity centres, the author has studied the role of activity and practice of active aging in the everyday life of the elderly users of the centres. There seems to be a fundamental difference between how active aging is thought of at policy level – as a part of a health regime of prevention and sensing the body – and how these elderly use activities to distance the sensations of the body. Activity in this way becomes a way to maintain disease at arms length.

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About NNHSH

The Nordic Network for Health Research within Social Sciences and the Humanities aims at strengthening the cooperation between researchers of both doctoral and post-doctoral level, in the Nordic countries. The common area of research has evolved as a result of the countries' shared history of public organization and financing of care services and health promotion. Hence, the common contemporary and historical features of the Nordic countries and the development of new models of welfare constitute an important basis for the joint research interest in Nordic health policies and how the illnesses and disabilities of Nordic people are practised, interpreted, and managed in the context of a Nordic welfare model. Within this broad area we want to draw attention to crossroads between, on the one hand, health care service and health promotion and, on the other hand, the everyday life and health practices of people in the Nordic countries. This refers both to direct encounters between patients/users and professionals, but also to encounters between different discourses or interpretive frameworks of health and illness. This complex of problems address questions about how the body and embodiment can be problematized, as well as how the experience of illness, disability and suffering can be explained and is assigned meaning by people, be they ill patients or professionals. The aim for the network is to develop cooperation and exchange of knowledge between academic work and various professional practitioners in health care and health sectors. FAS supports the network. **Homepage: <http://nnhsh.org>**

How to find the conference venue

The main campus (KUA)

Faculty of Humanities
University of Copenhagen
Njalsgade 80
DK-2300 Copenhagen S

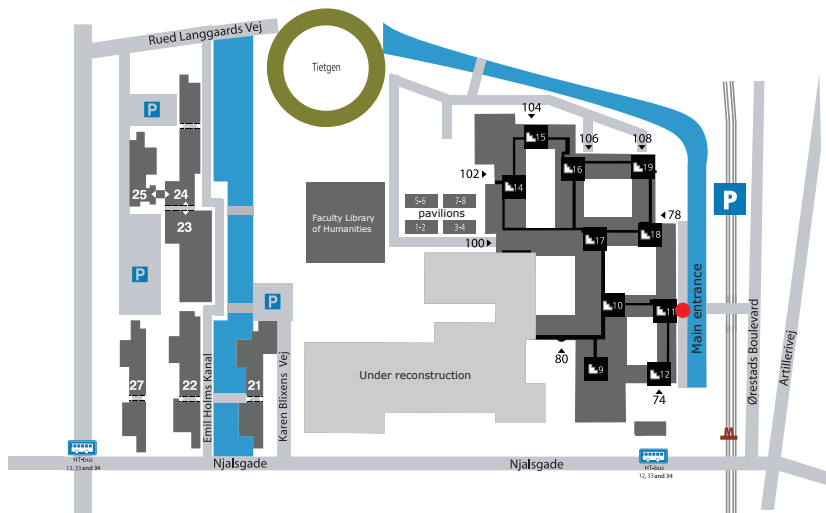
Web: humanities.ku.dk

By car: You can park at the guest parking lot on Ørestads Boulevard.

By bus: Bus number 12 (from Vesterport Station and the town hall square) and number 33 (from the town hall square).

By metro: Take the metro to Islands Brygge Station. From the station you have a 5-minute walk to the campus area.

How to read room numbers: 24.0.11 means room 11 on the ground floor in building 24.



<http://nnhsh.org>