

AMY CLOTWORTHY

EMPOWERING THE ELDERLY?

HOW 'HELP TO SELF-HELP'
HEALTH INTERVENTIONS SHAPE
AGEING AND ELDERCARE
IN DENMARK



From:

Amy Clotworthy

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How ›Help to Self-Help‹ Health Interventions Shape Ageing and Eldercare in Denmark

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Health programmes that offer ›help to self-help‹ are meant to empower ageing adults to remain independent and self-sufficient at home for as long as possible. But what happens when the private home becomes a political realm in which state intervention and individual agency happen simultaneously? Based on 15 months of ethnographic fieldwork in a Danish municipality, Amy Clotworthy describes how both health professionals and elderly citizens negotiate the political discourses about health and ageing that frame their relational encounter. By elucidating some of the conflicts, paradoxes, and negotiations that occur, she provides important insights into the contemporary organisation of eldercare.

Amy Clotworthy holds a Ph.D. in ethnology and a Master's degree in applied cultural analysis, both from the University of Copenhagen. In her position at the interdisciplinary Center for Healthy Aging (CEHA), she teaches and conducts research on how health and social policies targeting older people influence the sociocultural dynamics of later life. With an emphasis on everyday health practices, her research also investigates how the Danish healthcare sector, hospitals, and municipal authorities can improve professional practices by recognising the complexity of older people's life histories as well as the individual needs and priorities they express in their personal narratives.

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Abstract

In this book, I provide an in-depth look at the real-life encounters between municipal health professionals and older 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 older 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 current public-health initiatives and eldercare services. This includes the recent implementation of specialised reablement or 'everyday rehabilitation' programmes, a form of 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 different departments, following them on dozens of visits to older 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 older citizen in the situated context of a home-health visit or during training. But I also include a phenomenological perspective, wherein the body – which the health professionals must assess, evaluate, and try to engage – is understood as

part of a complex historical person who engages with, lives in, and experiences their world in a particular way.

The book 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 older citizens in their homes, and I elucidate how home-health visits and reablement programmes for older 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.

This book contributes new insight into how the Danish state's emphasis on individual responsibility impacts both municipal health professionals and older people. 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, on other social actors and society at large.

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Preface

Broadly speaking, this book presents a qualitative study of home-health visits and reablement programmes targeted at elderly citizens in the Danish municipality of Gentofte. But when I began my research, I did not have a great deal of experience studying older people. Of course, I knew some older people – as of this writing, my own father is 94 years young – but I had not conducted much 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 member of the municipal Visitation staff (known as a 'Visitor') to conduct an evaluation of a woman in her 80s with Parkinson's disease; she had just moved from another municipality into one of Gentofte's senior-housing areas. Rather than accepting the municipality's offer of help to unpack and set up her new apartment, she was more concerned about knowing whether the municipality would pay for the wigs she used to cover her extreme hair loss. 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 enjoyed.

When I went out with a visiting nurse from Home Nursing services, I met a woman in her 80s; while the 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 emotional 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 had 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 introduction 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 book, they were doing more than just encouraging these older 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 citizens¹.

1 I am well-aware that the word 'elderly' has become a derogatory term, particularly within cultural gerontology and ageing studies. However, this word is a very direct translation of the Danish 'ældre'. I also use the word 'elderly' intentionally throughout the book to indicate

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 were part of the municipality's new Cross-disciplinary Training Team. The Team's reablement 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 some older people 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 book 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), my work here focuses on the people involved – specifically, health professionals and the older people 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 ageing 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.

* * *

the pervasive institutionalisation and categorisation of old age (which I describe in more detail in the book's *Introduction* and Chapter 1), and I frequently use the term 'elderly citizen' to emphasise the political perception of older people.

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 healthcare 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 (Bülöw & 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 book, 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,

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.

emotional, and cognitive limitations; i.e., between the ages of 65 and 80+” (Barnes 2011a). According to social-gerontologists Christopher Gilleard and Paul Higgs:

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 scientific research has indicated that participation in hobbies and recreational activities, both inside and outside the home, could delay mortality in older populations (e.g., Avlund et al. 1998; Lennartsson & Silverstein 2001; Paganini-Hill et al. 2011; Tomioka et al. 2016); this research indicates that ‘active engagement’ with life after retirement could have profound health consequences as people grow older. 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, biomedical 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

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.

often linked to lifestyle choices, the scientific research propounds that poor health in 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 later, 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 (as defined by the Organisation for Economic Co-operation and Development, International Monetary Fund, World Health Organization, and the United Nations), 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 people 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); 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, and which will ultimately allow them to remain physically, mentally, and socially active for as long as possible. In addition, as I discuss later, 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 programmes, information, and supportive services to attain this goal is simply good business; in economic terms, it is a smart 'return on investment'.

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.

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 more 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 should 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 book.

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.

Reablement or ‘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, healthcare 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 so-

cial 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 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 have similar service models and are typically called *reablement* or *re-ablement* (United Kingdom) and the active service model or restorative home support (Australia, New Zealand, and USA). In Scandinavia, the Swedish version is known as *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 any citizen who is 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 this 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” (*Längst möjligt i eget liv*) was the first to be implemented in Denmark; it was launched in Fredericia Municipality in 2008. This initiative aimed to focus on the rehabilitative efforts of in-

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

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 (*social- og sundhed*, SOSU) assistants and helpers, and regional managers.

The central idea of everyday-rehabilitation programmes in Denmark is that physical training at home will reduce an older person'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 older people who are experiencing age-related functional decline and who may have other physical health issues.

The premise is that training certain 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 some experts consider to be “the best place to grow old” (cf. 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 many 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. Some international literature has even indicated that there is insubstantial evidence to suggest that older adults’ participation in a reablement programme consistently reduces costs over the long term, prevents inappropriate hospital admissions, facilitates hospital discharge, and prevents premature or avoidable admissions to long-term care (Nancarrow et al. 2005) or improves death rates (Cochrane et al. 2016).

While the framework for most reablement initiatives typically underscores the importance of building equal partnerships between health professionals and those who receive training, these programmes are still nascent and these relationships remain under-investigated. Some qualitative research has begun to examine how these programmes may influence and impact the everyday lives of the healthcare professionals involved, the elderly citizens with whom they work, and/or the citizen’s relatives (e.g., Hjelle et al. 2017; Hjelle et al. 2016; Glasdam et al. 2013; Wilde & Glendinning 2012). In the next section, I explain my ethnological interest in studying the socio-cultural phenomena that shape how healthcare for the elderly is done, and what this book contributes to the academic field of ageing studies.

The book’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 the research I conducted for this book, 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 my Ph.D. project, the 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 discourses and then 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. My ambition with this book 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 everyday activities 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, older people are 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 framed my Ph.D. project was:

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 book, 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 healthcare 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 book examines the forms of power, experience, knowledge, and meaning 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; thus, it makes an original contribution to the academic field by illuminating 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 *powerless*. 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 my 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).

In this scholarship, 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 writes 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 describes such technologies or operations as 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 writes, "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).

However, 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 precondition 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 states 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 Ph.D. project specifically focused 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 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. Arendt argues that forms of action become prioritised in the public domain, especially actions that are dependent on relationships with other actors: as 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 discuss later, 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

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.

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 outdated, 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 suggest that a form of care that is based on 'traditional' values may be emerging.

Although I am certainly inspired by many of Arendt's concepts and arguments, I recognise the limitations of her perspective; in this book, 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; I have loosely used her terms as a way to structure this book. 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.*: 183–4).

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

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 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 health-care – 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

of thinking, willing, and judging) (Allen 2002: 140). In this book, I use the term ‘competent social agent’ to refer to the political constitution of a freely acting, individual subject.

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 reablement 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. As such, I drew inspiration from anthropologist and occupational therapist Cheryl Mattingly’s narrative approach. In particular, she argues that clinical reasoning is a tacit form of professional expertise which often requires the therapist to “improvise a treatment approach that addresses the unique meaning of disability as it relates to a particular patient” (1991: 979). As she writes, there is a “human world of motives and values and beliefs – a world of human meaning” (*ibid.*: 983) that the therapist must acknowledge in order to transcend the patient’s physical limitations. Thus, the work of occupational or physical therapy is not simply a matter of helping a ‘disabled’ patient achieve an improved degree of physical mastery – rather, the therapist must help them make sense of their change in functionality and reclaim their body, and thereby articulate a new sense of self. In this way, the therapists work with the phenomenological body; a body that has its own sense of identity and history of lived experiences (Twigg 2006: 87) that the therapists must engage in a process of active, reciprocal, and social collaboration.

Mattingly also points out that human actors essentially try to “make certain things happen, to bring about desirable endings, to search for possibilities that lead in hopeful directions” (1994: 813) and, in particular, to work “towards an ending that we care about” (*ibid.*). Thus, her conceptualisation of therapeutic emplotment – in which the therapist attempts to “set a story in motion that is meaningful’ to the patient as well as herself” (*ibid.*: 814) was central to my understanding of how the Training Team therapists approach their work with older citizens. Their ability to establish a collaborative partnership – and a ‘successful’ therapeutic trajectory – is grounded in emplotting a specific therapeutic narrative (*i.e.*, a beginning, middle, and end) that should be meaningful to the older person as a complex human actor. But the therapist’s process of narrative reasoning must also point to a future story beyond the training – a future that is informed by the older person’s intrinsic motivation (their “‘inner world’ of motives and desires”; 1998: 284) to attain certain goals and key actions, and a future that is activated by their human “urge to appear, to see and be seen” in the public world (Arendt 1978: 21 in Mattingly 1994: 817). In this

regard, the reablement programme focuses on offering “sufficient hope to the patient so that the struggle to overcome obstacles becomes meaningful and bearable” (ibid.: 819).

A person’s ability to overcome such obstacles often starts with adjusting certain mundane and ‘insignificant’ habits or learning to develop new ones. 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 reablement 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), which 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 analyses in this book explore 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 predefined 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 book'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 the 'everyday rehabilitation' programme. 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 therapists from the Training Team engage a citizen's physical body as a site of potential in which certain self-helping habits, knowledge, and competences should 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 an older 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 the 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.

Finally, in Chapter 9, I summarise and reflect on my 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 take a wider perspective to discuss how my analytical insights about the discursive move from 'help to self-help' relate to the ongoing modernisation of the eldercare sector, and I suggest how a more caring response to neoliberal conceptualisations about

individualism and independence may produce an alternative form of empowerment.

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