Caring humans: how reablement programmes transform the care relationship

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Abstract

The categorisation of later life as a period of poor health and deterioration positions 'the elderly' as a high-risk, potentially burdensome, subaltern group in many Western societies. Policymakers in Denmark have long promoted a 'healthy ageing' agenda; i.e., that post-retirement citizens should be independent, active, and freely choosing consumers who are free from the need for municipal services – and that they can remain in their own homes and care for themselves as long as possible, even after they start to exhibit signs of age-related physical and cognitive decline. But there is also a political and socio-economic concern that the country's rapidly growing elderly population will develop a greater need for health and welfare services. As a result, the Danish welfare state's core aim to provide 'compensating' practical support and care to citizens in need has shifted to an emphasis on individual responsibility, self-governance, and providing 'help to self-help'. In this respect – and like many other Western countries – Denmark has begun establishing reablement programmes; the fundamental premise of these programmes is that professional training in activities of daily living (ADLs) will reduce older citizens' need for hospitalisation, medical treatment, and especially in-home care services.

Despite evaluations that have examined certain administrative and cost-saving benefits, reablement programmes are relatively new – and what actually happens in practice remains unclear. For example, what does it mean for ageing citizens who may have certain physical limitations to be presented with the choice to regain their independence and functional ability, and thereby retain their potential and value as productive citizens? Based on 15 months of ethnographic fieldwork, which included following the work of reablement therapists in a suburban Danish municipality, this paper provides a socio-cultural perspective on certain political expectations for ageing and functional ability. In particular, it presents some of the paradoxes, conflicts, negotiations, and challenges that are part of older citizens' participation in reablement programmes. The paper describes how the therapeutic work of reablement reveals the citizen as a complex person who cannot easily fit into an ideal type or the state's individualised, pre-conceived categories. The paper also explores how the politically-defined goals for reablement may create particular tensions and contradictions that have implications for the outcome of the training. The author argues that neoliberalist rationality assumes that caring responsibilities can be allocated in a particular way; however, humans cannot conform to such operating logics. Thus, as the responsibility for providing older citizens with stabilising help and support has transitioned from other health professionals to the reablement professionals, this has led to a difference in *who* cares.

Key words: reablement, everyday rehabilitation, ageing, health and welfare services, Denmark

Introduction

Denmark is often considered to be the epitome of a social-democratic, European welfare society, but this small Scandinavian country also represents a growing tendency towards health and social policies that emphasise a citizen's individual responsibility and continued productivity. Whereas the traditional Danish welfare state was built upon the idea of a citizen who is an equal part of the larger social collective, actively participates in the democratic process, 'owns' a share of the state, and has a nearly unrestricted right to state benefits (Petersen et al. 2010; Lidegaard 2009), since the 1990s, the country has emerged as a neoliberal 'competition state' (Pedersen 2011; *also* Mik-Meyer & Villadsen 2013). Similar to other European countries, Denmark's form of neoliberalism refers to the "political, economic, and social arrangements within society that emphasize market relations, re-tasking the role of the state, and individual responsibility" (Springer et al. 2016: 2). A focus on citizens' responsibilities and productivity is not unusual in many high-income, industrialised Western societies, which depend on an active and engaged workforce to ensure economic stability. But, as the Danish public sector has expanded over the past several decades, there has also been an increased focus on standardisation and efficiency, especially with regards to better managing the country's increasing elderly population.

Policymakers in Denmark have long promoted a 'healthy ageing' agenda (WHO 2012); this means that post-retirement citizens should be independent, active consumers who are 'free' from the need for municipal services – and that they can remain in their own homes and care for themselves as long as possible, even after they start to exhibit signs of age-related physical and/or cognitive decline. But, due to the government's emphasis on cost-savings in the public sector, there has also been greater political interest in supporting older citizens' ongoing productivity and activity. This has led to a transition from *providing help* and welfare services to *enabling self-help* (Petersen 2008; *also* Blom 2014) in order to reduce the financial burden of providing these services to Denmark's expanding elderly demographic. In Denmark, many governmental policies, laws, and regulations tend to be categorical and target 'the individual' with regards to the provision of welfare and health services. This reflects an "increasingly pervasive process of individualisation" (Mik-Meyer & Villadsen 2013: 4), whereby each citizen is given the freedom to make the 'correct' choices (Pedersen 2016: 37) regarding their health – rational choices that should allow the individual 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. As a result, the Danish state's core aim to provide 'compensating' practical support and care to citizens in need has shifted to an emphasis on individual responsibility, self-governance, and providing 'help to self-help' in relation to health and welfare services.

Municipal decisions regarding services such as home care and home help are regulated under §83 of the *Social Services Act* (Ministry of Children and Social Affairs 2018). In order to address the issues of an expanded public sector and to better manage a rapidly increasing elderly population, "domiciliary care for the elderly has become the political test case [for] the provision of the Danish notion of 'a free choice'" (Rostgaard 2006: 444). Specifically, citizens who are eligible for in-home welfare services – such as meal preparation, personal care, and house-cleaning – are given a choice between receiving subsidised municipal services or private help. But this 'free choice' has created a market for welfare services and constructed these citizens as "freely choosing elderly" consumers (Højlund 2006). And, after an addendum to the *Social Services Act* (§83a) went into effect in 2015, older citizens who apply to receive help from their municipality are now given the choice to participate in a specialised reablement or 'everyday rehabilitation' (*hverdagsrehabilitering*) programme. Similar to other initiatives that are now being offered worldwide, the goal of Danish reablement is to strengthen an older person's functional abilities in specific activities of daily living (ADLs) so that the elderly person can be more independent and self-sufficient at home (Vinge et al. 2011; Kjellberg et al. 2013; DaneAge 2019). While there may be a discursive emphasis on supporting an older person's social participation and improving well-being, from a political and economic perspective, reablement programmes are fundamentally being implemented to decrease older citizens' need for hospitalisation and medical treatment, and to reduce the costs related to providing in-home welfare services (ibid.).

Several evaluations have been conducted to assess the effects of these programmes (Kjellberg et al. 2011; Kjellberg et al. 2013; Petersen et al. 2017), but they are still nascent in Denmark, and the results thus far have been inconclusive. Most of these evaluations cite the need for further research to examine the administrative and cost-saving benefits of such programmes as well as their effects on older citizens' health and well-being; what actually happens in a Danish context is still unclear. However, some qualitative research has begun to investigate how reablement programmes influence and impact the everyday lives of the healthcare professionals involved, the elderly citizens with whom they work, and/or the citizen's relatives (e.g., Hansen et al. 2015; Clotworthy 2017, 2018, 2019; Bødker 2019; Bødker et al. 2019). But there remains a lack of consensus about how reablement programmes should and do function in practice, and inadequate knowledge about their impact and how they may change perceptions of ageing and the individual's responsibility for ageing well.

Based on 15 months of ethnographic fieldwork in a Danish municipality – during which I closely followed several people participating in a reablement programme – this paper examines how both municipal health professionals and elderly citizens navigate the political discourses that frame their relational encounter. In particular, traditional forms of evidence-based decision-making often contain a paternalistic approach that assumes that health experts can transfer information in an accurate and unbiased way so that individual patients can be "filled up (like an empty glass) with new knowledge and thereby transformed into informed and willing decision-makers" (Charles et al. 1999: 655). But a central aspect of reablement programmes is that they are intended to be a relational practice – i.e., a 1:1 partnership – in which the therapist and the older citizen co-determine goals together; goals that are based on the citizen's unique needs, desires, and hopes. From a political standpoint, the freedom to make these choices should be empowering, particularly in terms of the older person "attaining a sense of control and meaningfulness" (Andersen et al. 2000: 14) in their everyday lives. However, as I discuss, people are complex and do not always make rational choices – especially if they are sick, injured and in pain, or dying. In these situations, people need care. Furthermore, choices that lead to meaningful action are not made by autonomous individuals in isolation from their complex social environments; the decision-making process also requires acknowledgement and caring actions. As such, the nature of reablement programmes means that the care relationship becomes reconfigured.

An ethnographic investigation of reablement

My qualitative research was associated with the Center for Healthy Aging (CEHA), an interdisciplinary centre based at the University of Copenhagen (Denmark). Since 2009, CEHA's researchers have been studying ageing and ageing processes 'from cell to society', and they consider ageing to be a lifelong process that is affected by both human behaviour and lifestyle[1]. My project was part of a multidisciplinary research group that draws upon methods and theories from the humanities, social sciences, and public health to examine the theme of 'Community Innovation for Healthy Aging'. In this connection, I conducted ethnographic fieldwork in Tøftsby, a quiet suburb north of Copenhagen, the country's capital. Tøftsby is amongst Denmark's wealthiest municipalities, and has the highest expected increase in elderly residents over the coming years (i.e., between the ages of 65 and 84). The aim of my project was to investigate how the Danish state's political goals and individualised health policies influence the provision of in-home health services for the elderly, and to gain insight into the paradigms and processes that are involved when certain health initiatives are implemented in a municipal context (Clotworthy 2017).

Between August 2014 and March 2016, I participated in a variety of municipal programmes targeted at elderly citizens, and I followed the everyday work practices of 17 health professionals from three specific municipal departments: *Visitation, Preventative Home Visits*, and the *Cross-disciplinary Training Team*. I accompanied these professionals on dozens of visits to elderly citizens' homes, and my fieldwork included participant observations in their municipal offices as well as home visits and/or reablement training with 37 citizens between the ages of 57 and 95. In particular, I spent five months with the municipality's Cross-disciplinary Training Team, a new unit that is responsible for the reablement programme. The political leadership in Tøftsby formally established this unit in August 2014, and it is comprised of physical therapists, occupational therapists, and social–health (SOSU) assistants. Towards the end of my fieldwork, I focused on shadowing one physiotherapist and one occupational therapist through a full course of reablement training – from the initial evaluation to the final meeting – with two citizens each: two women (ages 78 and 79) and one man (age 67)[2]. Once all of these training sessions were completed, I conducted semi-structured qualitative interviews with eight

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[1] For more information, *see* https://healthyaging.ku.dk

[2] The fourth participant (a woman, age 95) was admitted to the hospital after three sessions and had to stop training.

municipal health professionals and five older citizens. These interviews were conducted in Danish, audio-recorded, and transcribed into English. All names and places have been anonymised.

A phenomenological perspective on caring actions and relational autonomy

As a concept, 'care' is a slippery term that can be defined in many different ways. Thus, the meaning of 'care' is subjective, always contextual, and thereby non-essentialist (Tronto 2017: 29, 33). In this paper, it can be understood as a way to describe how other people try to help us "to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Fisher & Tronto 1990: 40). Specifically, I use the term 'caring action' (Åström et al. 1993) to refer to the decisions that the reablement therapists make that should thereby help an older person make choices that will 'repair' their world. As anthropologist and occupational therapist Cheryl Mattingly describes, it is generally impossible to determine the outcome of any given course of rehabilitation because it is a process that must be continually adjusted and modified based on the patient's physical, emotional, and ontological limitations, which are always in flux; training therapists must therefore attempt to engage the phenomenological body of lived experience and emplot a programme that is meaningful (1994); this will enable the patient to reclaim their impaired body and articulate a new sense of self (1991: 984).

With this perspective, I suggest that the therapeutic work of reablement reveals the older citizen as a complex person and, in order to make progress with training, it is essential for them to display their 'messy subjectivity'; 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 animation 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 reablement encounter.

Moreover, in occupational therapy, there is a specific form of clinical reasoning that is directed towards action (Mattingly 1991: 981), which refers to deciding how best to achieve a certain goal. This requires narrative emplotment to determine the beginning, middle, and end of training, and it is a complex, interdependent practice that entails continual reassessment (ibid: 982). As I have argued elsewhere (Clotworthy 2017, 2019), an individual's ability to make decisions that are meaningful and lead to action require the presence of others (Arendt 1958: 201) as well as the recognition and acknowledgement of each other as complex persons (Liveng 2011: 273). Thus, reablement training also contains a form of 'relational autonomy', which refers to a "free, self-governing agent who is also socially constituted and who possibly defines her basic value commitments in terms of interpersonal relations and mutual dependencies" (Christman 2004: 143). This relational autonomy emerges in a specific social context "within which all individuals exist and acknowledge the emotional and embodied aspects of decision-makers" (Walter & Ross 2014: S16). Such an acknowledgement provides the basis for caring actions that can help 'irrational' people make specific choices that enable them to repair their worlds.

Reablement programmes typically frame the older citizen as "an expert in their own life" (Aspinal et al. 2016: 2; Rostgaard et al. 2016). As such, the therapists are supposed to give citizens the opportunity to choose the specific activities that would allow them to feel more self-helping and competent in their everyday lives. A central focus of my research was to investigate how the Training Team therapists navigate the political rhetoric about health and activity in their encounters with elderly citizens, as well as how they try to manage the conflicts, paradoxes, and negotiations that take place during reablement training. In the following analytical sections, I provide a socio-cultural perspective on certain political expectations for ageing and functional ability in relation to older citizens' participation in reablement programmes. With this, I also describe how the care relationship is being transformed.

Offering caring actions in a relational partnership

In Denmark, the political concern – and thereby the work of municipal healthcare – is primarily focused on the citizen's physical body – i.e., evaluating it, treating it, reducing risk, and preventing disease and illness. But 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 abstract 'citizen'; they also communicated with the physical body, especially in relation to its functional competence and comportment within the spatial configuration of the home. Here, the body should be understood as part of a historical person who engages with, lives in, and experiences their world in a particular way. As such, 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" (Twigg 2006: 25); this suggests that the physical body can be both a generator and receptor of meanings, and it is important for the therapist to acknowledge the body's lived experience. Moreover, the reablement encounters contain shared decision-making, wherein both parties make an investment in the future-orientated outcome of training; the citizen because their health is at stake, and the professional because they are concerned for the citizen's welfare (Charles et al. 1999: 656).

For example, I followed the occupational therapist Katrine through a training programme with Ulla (age 78), who has chronic obstructive pulmonary disease (COPD), which affects her breathing and circulation; she had also undergone several surgeries to her back (for a disc prolapse and stenosis), as well as a knee replacement. And she would do anything to alleviate her incessant chronic pain. Prior to the initial visit, Katrine told me that Ulla seemed very motivated to train; according to the notes in her journal, Ulla wanted to maintain her current level of functionality and prevent any further loss of independence. At the time of the training, she was dependent on her rollator but was otherwise "very well-functioning" (*field notes; 28 October 2015*) – one of the training goals was to show her how to put on and remove her support stockings[3] by herself, so that she did not need a Home Care worker to do for her this every morning and evening. Katrine trained Ulla in putting on and taking off her support stockings over four sessions, but Ulla's pain was a factor each time. However, Ulla was extremely determined to manage the stockings by herself, despite how painful and difficult the process could be.

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

> **Ulla**: I don't have any more strength. (…) I don't think I can do it again.
>
> **Katrine**: No, you should just keep [the stockings] on now.
>
> **Ulla**: But I thought we needed to train more.
>
> **Katrine**: No, you've done it two times – that's enough.
>
> **Ulla**: Well, I need to at least try to do it myself. (…) I need to do it so I'm not dependent.
>
> *Field notes; 2 December 2015*

In Tøftsby, the municipal politicians and health experts have determined that the reablement programme is a "partnership between the citizen and [the team member]" (*municipal pamphlet*), and this example shows that Ulla and Katrine had entered a relational partnership to achieve Ulla's future-orientated goals. This means that, in order to make progress with training, Katrine had to acknowledge Ulla as a complex person as well as recognise the 'messy subjectivity' of Ulla's phenomenological body – her present need for reablement is based on a myriad of historical and social factors, such as her active childhood and the physical work of her past job as a cafeteria cook, which may have contributed to the weakness in her back and knees, which then required multiple surgeries; similarly, a genetic

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[3] Support stockings are meant to improve circulation in the body, which is vitally important to someone with a cardiopulmonary condition such as COPD. They are typically custom-measured and fit, and are extremely tight. Putting these stockings on is an arduous process that can take several minutes for even an experienced, able-bodied professional to perform, and it typically requires the use of several assistive devices.

predisposition and a lifetime of smoking may have contributed to her developing COPD. This combination of historical and social habits, genetics, life choices, structural determinants, and environmental circumstances have contributed to Ulla's physical pain – pain so severe that she told her physician, "if I were a dog, they would put me down" (*field notes; 28 October 2015*). This confluence of factors has also made it necessary for Ulla to strengthen her legs in order to "walk better than I do" (*ibid.*). But these modes of affect and thought also animate Ulla as an acting subject and determine how she tries to act on the world (Ortner 2005: 34). In their partnership, Katrine had to consider the various bodies that Ulla presented: the politically-defined body of the consumer-citizen; the objectified physiological, corporeal body of medical science; and the freely acting phenomenological body of lived experience and identity (Twigg 2006: 87).

During the training sessions, Katrine and Ulla were both invested in the future-orientated outcome of the reablement programme, and Katrine's stabilising presence enabled Ulla to stay focused on her training goals; e.g., with regards to putting on the stockings, Ulla articulated her intentions by saying that she knew she had to "at least try to do it myself. (…) I need to do it so I'm not dependent". But, during a session that was especially difficult and painful, Ulla's awareness of her lack of physical power prompted a sense of uncertainty, and she said, "I don't think I can do it again". Katrine recognised that, even if Ulla *said* she did not want to stop the training, she should make the choice for her and end the session to preserve Ulla's physical energy. In addition to her physical body being tired and in pain, Ulla's willingness to continue was also becoming fatigued from the training effort. In such situations, people can be overcome by emotions that may compromise their self-control as well as their rational agency (Walter & Ross 2014: S18). As I observed during many reablement sessions, an older person's 'unruly body' with its 'messy subjectivity' may not always make the 'correct' choices or behave like a rational consumer that follows the political discourse or conforms to the logic of a market economy.

However, in this case, Ulla did make the 'correct' choice, saying that she thought they "needed to train more". This highlights how the political discourse about being more self-helping and independent – or at least being a citizen who is 'not dependent' on welfare services – has permeated Ulla's perception of why she needs to train. Following the political and cultural discourses that shape her everyday life, Ulla freely chose to train more, even though she was in pain and exhausted. But Katrine recognised that Ulla could no longer produce the strength necessary to conduct the physical operation of putting on her stockings. And *she* made the decision to end the session, telling Ulla "that's enough". There was no individualised moral judgement here – in this situation, Katrine did not push Ulla to do *more* to become self-helping. This is because, in the relational partnership that had developed between them, Katrine did not encounter Ulla as an individualised elderly citizen who had been given the opportunity to choose among a select few service options. Instead, she encountered Ulla as complex person who needed support and caring actions to set reasonable limits for herself. Katrine was there to do a job, but as a *care* professional, she also had to make a judgment and a decision about how much activity Ulla could realistically handle that day; with this caring action, Katrine acknowledged the hard work that Ulla had already done and helped her modulate her choices. This in turn gave Ulla a sense of reassurance and hope that she would be able to continue working to reclaim her body and eventually transcend her physical limitations (Mattingly 1991: 984), which would enable her to repair her world.

Negotiating with a citizen's 'messy subjectivity'

In Danish health policies and initiatives, 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 (Højlund 2006: 43); this suggests that the health professional has become re-configured as a seller/provider of services that should meet the consumer's demand. Such policies position both health professionals and citizens as rational individuals who should be able to work together to make the 'correct' cost-benefit choices. But rather than recognising and accepting the essential interpersonal relations and mutual dependencies of the reablement partnership, some citizens consider this offer to be yet another service option, wherein they as consumers can freely choose the actions they do together with the therapist. This can complicate the reablement process because, in order for the therapist to emplot a course of training that will lead to a productive form of self-identity, subjectivity, and relational autonomy, the older citizen must be willing to enter into the partnership and act towards future-orientated goals. However, the therapists do not always encounter docile compliance or complete willingness; in fact, some older citizens may actively resist their caring actions.

This could be seen when I followed the physical therapist Sofie through a training programme with Norah (age 79), a widow who lives by herself in a small apartment. Sofie later explained to me how her approach to reablement focuses on "the humble task of trying to know another person. So, you try to ask about them – who they are, what does [training] mean to them? (…) You have to think about the baggage they have, what about their relatives, what they've been through in their lives" (*interview; 21 December 2015*). Thus, to prepare for their first meeting, Sofie learned that Norah had been in the municipal system since 2009, when she suffered a stroke. In addition, she fell and severely broke her leg in 2001, which has caused her problems ever since; she also has partial sight in her left eye (caused by a work accident) as well as osteoporosis. She had also recently been hospitalised for three days – according to the notes in Norah's online journal, it was because she had had another small stroke ("admitted after a blackout at home – blood clot in the cerebellum"). The referral said that Norah chose to participate in reablement so that she could "regain her former skills" and be "freely mobile and self-reliant" again, and it recommended that she receive "training in everyday activities in the home and on the street/stairs" (*field notes; 26 October 2015*).

During Norah's initial evaluation, Sofie asked if she had any particular wishes for the training sessions; she emphasised that she takes her point of departure in Norah's everyday life and what she specifically wants to accomplish. Norah said that, primarily, she would like to be better at walking: “My greatest wish is to be more confident” (*ibid.*). Sofie and Norah therefore agreed that a training goal would be to walk down to Drikkelund, a municipal facility less than one kilometre away from Norah’s apartment, and where she had previously taken exercise classes twice a week. Since her latest hospitalisation, Norah said she was not “back on my feet yet” (*ibid.*), and she generally struggled with balance due to her poor eyesight and damaged leg, so they also agreed to train with Norah’s new outdoors rollator. When we arrived for a subsequent training session, Norah was looking out of her first-floor kitchen window, waiting for us to arrive. I wrote in my field notes:

> We come upstairs to the apartment, and Norah opens the door before we knock. She shakes our hands, and immediately asks if we were going to go out for a walk. Sofie answers that we’re going to go down to Drikkelund. But Norah says that she wants to go to the corner store: “I need to get some cash and buy avocadoes.” She seems very definite and determined to go out. (…) After reluctantly agreeing to try walking with her large outdoors rollator, which Sofie tells her is “more supportive and stable”, we walk down to the main street. Norah and I chat while Sofie walks behind us and to the side to observe Norah’s gait and balance. When we get to the intersection, Sofie suggests we go over to Drikkelund.
>
> **Norah**: No! We’re going to the corner store.
>
> **Sofie**: Yes, we can go there afterwards.
>
> **Norah**: No, not today. Next time!
>
> **Sofie** (*pause*): Yes, the next time we go out, we’re going to Drikkelund. (…)
>
> During the shopping trip, Sofie tells me not to help Norah with her bags because “she needs to know we’re not her assistants”. (…) Afterwards, as Norah is locking up the rollator in front of her apartment building, she struggles to put the rollator’s cover on while also managing her shopping bags. Sofie holds me back and tells Norah, “We’re not trying to be unhelpful – it’s just important to see how much you can manage on your own”.
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> *Field notes; 13 November 2015*

In this example, Sofie attempted to locate and transform Norah’s willingness to act in relation to the future-orientated goals that Norah had articulated. Sofie tried to use caring actions to learn about Norah as a person; she wanted to make the training meaningful for Norah by basing it on her everyday life and the future-orientated activities Norah said she wanted to do (i.e., being “better at walking”, going to Drikkelund, being more self-reliant). Sofie also acknowledged Norah as a complex person with her own form of ‘messy subjectivity’, which manifested in her insistence on going to the store and her refusal to walk to Drikkelund. Moreover, in alignment with the political discourse about the citizen’s ‘free choice’, Sofie recognised Norah’s ability to make choices and decisions for herself. But, rather than fully entering into a relational partnership with Sofie, Norah was animated by her fear of being controlled and acted upon. Thus, her ‘messy subjectivity’ limited her choices; she refused to acknowledge Sofie’s expertise and professional identity as a physical therapist, and she resisted and tried to negotiate the therapeutic actions in which Sofie tried to engage her. Although Norah told us that her "greatest wish is to be more confident" when walking, she would only walk outside if she could set the terms.

Norah also expected both Sofie and me to be her "assistants" – a role that Sofie rejected and then tried to reinforce by telling Norah "we're not trying to be unhelpful". However, because Sofie needed to conform to the political regulations and expectations that frame her work, she had no choice but to allow Norah to dictate the course of the training sessions; in this case, walking to the store instead of Drikkelund. Because the reablement programme is politically defined as being based on the citizen's choices and the therapist's position as a service provider, this example shows how Norah assumed the identity of a freely-choosing consumer of services; i.e., she wanted to decide exactly when and how to participate in training. Throughout the course of her reablement programme, Norah was only willing to make decisions and engage in actions that fulfilled her own immediate desires – to do what she wanted to do *today*, *right now*. This presented a challenge for Sofie because she was unable to locate Norah's future-orientated willingness to train; Norah was simply not invested in the therapeutic outcome. Thus, Sofie was unable to use caring actions to emplot an effective training plan or support Norah in making meaningful choices that would repair her world.

Conclusion

Denmark's transition to a competition state has meant that politicians and health experts have developed an increased focus on risk-prevention, healthy choices, and limitless productivity for all citizens. The central idea is that "societies work best when they allow rational actors to make choices in the market, and that anything that interferes with such choices reduces people's freedom" (Tronto 2017: 29). This form of neoliberal rationality assumes that 'self-mastering' humans can be developed, and that caring responsibilities can be allocated in a particular way (ibid.: 29, 33). Thus, in the contemporary Danish competition state, municipal health professionals are expected to find ways to help citizens remain independent and self-helping for as long as possible, which should improve their quality of life and reduce their need for welfare services. However, humans do not often conform to such operating logics. Despite the 'hyper-individualist' political conception of independence and autonomy (Christman 2004: 147) that is present in many Danish health policies, humans with their 'messy subjectivity' are not always rational consumers who can achieve self-mastery on their own (Tronto 2017: 31). People are complex humans who need support and recognition from others in order to make choices that may lead to meaningful action.

Although many contemporary Danish health policies and programs emphasise self-governance and individual responsibility, defining ourselves as individuals requires us to relate to *others* in the social collective. As I have described in this paper, it is essential for both the reablement therapists and elderly citizens to exchange a social acknowledgement (Liveng 2011) that confirms their identities as competent professionals and complex persons, respectively. This recognition forms the basis for their relational partnership, which – together with shared decision-making – may thereby enable the older person to gain a sense of relational autonomy that propels them to act towards meaningful, future-orientated goals. With this foundation, the therapists can use caring actions to emplot a training plan that helps the older citizen repair their world. However, as I have discussed, this process is not always straightforward. The therapeutic work of reablement reveals older citizens as complex persons with different forms of 'messy subjectivity' that influence and determine the choices they make; these complicated social agents cannot easily fit into an ideal type or the state's individualised, pre-conceived categories, and they may resist or negotiate the therapists' interventions.

Reablement programmes are being established in many Western countries as a solution to the market problem of a rapidly growing elderly population. But too often, reablement programmes are being offered as a cost-savings measure that emphasises individual self-governance, functional (i.e., physical) ability, and limitless productivity. Specifically, there is a political discourse that expects elderly citizens to be physically capable of managing more everyday activities for themselves, of preserving their functional ability, of participating in their own self-care, etc. – and this *requires* them to do a certain form of work in order to maintain their inclusion in the collective and thus their value to society. A political expectation that citizens should take a more active part in and responsibility for their own health thereby makes good health and longevity a moral obligation; i.e., older citizens have a personal responsibility to achieve a specific outcome that will benefit the state. But such an obligation can become divisive, forcing a separation between those who can and those who cannot conform to and comply with the political requirements to make the 'correct' lifestyle choices. Thus, an individual who cannot take proper care of themselves and who is dependent on others for assistance and support may be judged as a failure and a social burden. From a socio-cultural perspective, the institutionalisation of an older citizen's moral obligation to remain productive and independent for as long as possible is likely to fundamentally change perceptions of ageing; in particular, a greater emphasis on an individual's personal responsibility for remaining healthy and ageing well could eventually marginalise those who cannot (for whatever reason) achieve the political goals.

In theory, reablement programmes have the potential to challenge negative discourses about ageing and the age-related loss of physical and/or cognitive function. By emphasising "an individual's continuing ability to participate in, contribute to and be productive and valued in society" (Mishra & Barratt 2016: 25), the establishment of reablement programmes for older people could be an opportunity for governments to promote a more inclusive and balanced discourse about 'healthy ageing'. Rather than an implied expectation that everyone over age 65 is destined to become an economic burden, this discourse could promote a belief that people of any age and any level of functional capacity can be non-dependent, valuable, and productive in a variety of ways. With a greater focus on an older person's continued inclusion in a social collective and their essential human value to society, reablement programmes could also enable older citizens to continue to care about and take a shared responsibility for the well-being of others around them. This is reminiscent of the values that defined the ‘golden age’ of the Danish welfare state: i.e., there is no ‘individual’, only the ‘community’ of which everyone is equally a part, and to which everyone equally contributes.

During my fieldwork, I came to appreciate the many forms of caring action and inclusion that the municipal health professionals demonstrated in their encounters with older citizens, despite the neoliberal rationality and the political regulations that frame their work. As I observed, caring means taking a collective responsibility (Tronto 2017: 30) for both a positive or negative outcome of the health encounter as well as the long-term effect it may have on the individual citizen’s welfare. It also means helping ‘irrational’ people make the necessary choices that will enable them to repair their worlds. Fundamentally, we humans need care, human connection, recognition, security, and inclusion in a social collective. As I have discussed, caring for and about others (and being cared for and about ourselves) is an essential part of what makes us human, social actors. This means that, as the responsibility for providing older citizens with stabilising help and support has transitioned from other health professionals to the reablement therapists, there is simply a difference in *who* cares.

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