Help for self-help in elderly care – expenditure cuts and attractive workplaces for care workers?

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Abstract

A wave of policies to reform municipal elderly care services is sweeping across Denmark at the moment. Under headings such as ‘help for self-help’, ‘everyday rehabilitation’, and ‘home-training’, municipalities are working to make their elderly citizens more self-reliant, active and less dependent on municipal care services. In times of austerity, and in expectation of increasing expenses for care tied to ‘the burden of the elderly’, municipalities see help for self-help and rehabilitation programs as a means to reduce expenditure on elderly care services. At the same time though, the programmes are promoted as initiatives to improve the quality of life of the elderly, and furthermore as an opportunity for improvement of the working conditions of the social- and health care helpers implementing the programmes. Drawing on a case study in a home care unit, this paper discusses how understandings of care, care work, and care recipients, change in a Danish municipality implementing a help for self-help and rehabilitation program. The program is somewhat surprisingly welcomed by the care workers in the studied unit, despite its obvious ambitions to cut back expenses for services. Among several explanations of this apparent paradox, the analysis shows that the care workers find that help for self-help and rehabilitation makes the relationship between caregiver and care recipient more equal, and that their work takes a turn towards a more developmental understanding of care, perhaps paving the way for increased societal recognition of their profession.

Introduction

A wave of policies to reform municipal elderly care services¹ is sweeping across Denmark at the moment. Under headings such as ‘help for self-help’, ‘everyday rehabilitation’, and ‘home-training’, municipalities are working to make their elderly citizens more self-reliant, active and less dependent on municipal care services. The responsibility for implementation of the local reform programs is given to front-line workers such as social- and health care helpers, who are required to change their work-practices and to align their interactions with the elderly citizens for whom they care, to the ideals of self-reliance, activity and independence.

In times of austerity, and in expectation of increasing expenses for care tied to ‘the burden of the elderly’, municipalities see help for self-help and rehabilitation programs as a means to reduce expenditure on elderly care services. At the same time, though, the programs are promoted as

¹ The scope of this paper is limited to formal and publicly financed elderly care services carried out by professional care workers – it does not include unpaid, informal care work.
initiatives to improve the quality of life of the elderly, and furthermore as an opportunity for professionalization and improvement of the working conditions of the social- and healthcare helpers implementing the programs.

Drawing on a case study of help for self-help and rehabilitation practices in a homecare unit in a Danish municipality, this paper analyses how this apparent win-win situation plays out in practice for the workers implementing the programs. Is it possible that programs designed to cut back care-services can result in more attractive workplaces for front-line care workers?

To answer this question, first a background understanding of homecare for the elderly in Denmark is necessary. Next, drawing on Scandinavian research on care and care work, different perspectives on what home-based care work for the elderly is, and should be, are presented. Subsequently I will describe the methodology of the case study in the homecare unit, and then move on to analyzing how the understanding of care work develops in this unit under the influence of the studied help for self-help and rehabilitation program, and how the social and healthcare helpers in the unit receive the program. This analysis feeds into a concluding discussion.

**Homecare for the elderly in Denmark**

In the Danish context homecare for the elderly is a municipal responsibility, and is carried out primarily by low-wage female workers with a short education in social- and healthcare (14 months) – ‘social- and health care helpers’. The provision of publicly funded homecare for the elderly can be traced back to the 1940s, when it first emerged in the form of ‘housewife-substitution’. Families could be granted help from a housewife substitute in urgent situations such as illness on the part of the mother or childbirth. Housewife substitution could also be granted to weak, solitary elderly citizens (Dahl 2000, Petersen 2008). The scheme gradually expanded and was institutionalized along with the development of the Danish welfare state, and the principle of universalism of the latter. It became known as ‘home help’. Since the late 1950s Danish elderly care services have been carried out under the policy-heading ‘as long as possible in one’s own home’ – entailing that the home is considered the best place for care for the elderly, and that all necessary assistance should be provided here, in this way avoiding placement in a nursing home if at all possible (Petersen 2008).

Like the rest of the public sector, the elderly care sector has not avoided reforms inspired by New Public Management (NPM). In fact some argue that the elderly care sector has been the sector with the biggest drive to apply NPM-principles in Denmark (Kamp, Hvid 2012). This is not to say that the universal model of elderly care provision has been completely dismantled – Denmark still keeps a comparably high coverage level within elderly care (Rauch 2007). Even so the sector has been affected by NPM-inspired reforms both in terms of managerialism and marketization (Dahl, Rasmussen 2012, Ryberg, Kamp 2010). A number of efforts have been made in order to create a market for homecare: a split between purchaser and provider has been implemented, services have been standardized to conform to a ‘common language’ in the sector; detailed time-planning and pricing has been linked to the standardized services; extensive digitalization has been carried
out; and private providers of homecare services have been allowed – all in order to ‘modernize’, make the sector more efficient, and provide elderly citizens with a free choice of homecare services.

Hence the concept of homecare has developed with the Danish welfare state, and has undergone neoliberal reform-attempts along with it. In this process, understandings of what home-based care work for the elderly is, and should be, have developed and shifted as well.

**Shifting understandings of care and care work**

Quite an abundant literature exists on care work in the Nordic welfare states\(^2\), concerned with both paid and unpaid care work. A very influential contribution in this tradition was made by the Norwegian researcher Kari Wærness, who coined the term ‘the rationality of caring’ (Wærness 1984). Wærness presents a feminist critique of the bureaucratization and scientification of care work and the domination of economic, technical and legal rationality in the sector (Wærness 1984, Wærness 2005). Drawing on Hochschild’s concept of ‘the sentient actor’ she argues that rationality and emotionality are not mutually exclusive concepts, and that “*both rational action, reason and feelings*” (Wærness 2005:24) are important for providing good care. Good care is dependent on the caregiver’s personal knowledge and understanding of the specific client and his/her situation – it is descriptive and contextual rather than formal and abstract (Wærness 2005), and women’s personal experiences of practical caregiving in both the public and private sphere should be valued higher (Wærness 1984). Wærness expresses concern that professionalization and socialization of care leads to an instrumental attitude towards care work at the expense of the expressive (Wærness 1984). This understanding of the threats to good care inherent in attempts to rationalize public care work has remained influential in the Nordic literature. Some have gone so far as to describe the ‘cult of efficiency’ imbedded in public sector reforms and ‘managerialist attacks’ on care occupations, as a threat to a specific ‘Nordic ethos of care’, that must be reclaimed (Wrede et al. 2008).

The Danish researcher Hanne Marlene Dahl has carried out a different analysis of the development of public care work, through a study of the development of the social and healthcare helper (formerly ‘home-helpers’) profession in Denmark. Dahl’s analysis (Dahl 2000) takes a less normative standpoint and focuses on changing constructions of care, care recipients, their needs, and the qualifications considered necessary to perform public care work. The construction of care has, according to Dahl, developed from a question of alleviating needs to one of creating welfare or quality of life for the care recipients. Additionally the understanding of care needs has moved from a need for assistance with household chores towards a need for assistance with personal care. These developments are, however, not linear and unambiguous (Dahl 2000). Simultaneously the

\(^2\) I have chosen to limit the included literature on care and care work to Nordic/Scandinavian literature - mainly because the care practices studied are so closely tied to the specific welfare regime of this region.
understanding of care workers and the qualifications needed to perform care work has changed: “There has been a move from describing the home-helpers as ‘good housewives’ within a complimentarily, gendered discourse to a more androgynous, professional discourse in the late 1960’s stressing pre-emptive measures as the core task for home-helpers” (Dahl 2005:51) Furthermore Dahl describes that: “The ideal of care is substantially rewritten in the beginning of the 1980s focusing upon the cost containment and the engineering of an active life for the recipient” (Dahl 2005:47). Dahl’s account of the development of public care work is hence not a story of decay and threats to the rationality of caring or the Nordic ethos of care, but an account of shifting and ambiguous understandings of care and care work.

An important point to make here is that even though a certain historical development in understandings of care and care work in the public sector can be described, these understandings do not eliminate or succeed each other in a linear process – they co-exist, compete and are present with different strength at different times. I find that at present three co-existing understandings of care and care work can be described and utilized as an analytical tool to understand the current developments concerning help for self-help and rehabilitation programs, and their reception among social and healthcare helpers. I wish to emphasize that I do not see three understandings as mutually exclusive.

The first understanding sees care work as a question of empathic care for a dependent. This understanding entails, in line with Wærness, an emphasis on the situational and emotional (but also the practical) sides of care, and has strong connotations to altruism, to traditional understandings of femininity and to the duties of the traditional housewife. Care recipients are understood as dependents, in need of help, understanding and sympathy.

The second understanding sees care work as a question of service. This understanding has experienced somewhat of a boost with the implementation of NPM-reforms (Eskelinen, Hansen & Frederiksen 2006) establishing a market with a free choice of care-provider for the elderly citizens, and articulating care-tasks as services, measured in price and time-consumption. Such an understanding emphasizes the practical sides of care, and the influence and satisfaction of the care recipient. Care recipients are ideally understood as empowered, sovereign consumers, purchasing a service (Rostgaard 2011, Højlund 2006, Eskelinen, Hansen & Frederiksen 2006). Some argue that this type of relationship cannot be understood as a care relationship. Wærness for example makes a point of theoretically distinguishing care from personal service – care being when the care recipient is dependent on the caregiver and hence in a subordinate position; personal service being when the care recipient holds a superior position to the caregiver (a third possibility is caring in a symmetrical relationship) (Wærness 1984). Others have, however, questioned whether this distinction is strictly maintainable when studying actual care-practices (Eskelinen, Hansen & Frederiksen 2006).

The third understanding sees care work as a question of help for self-help and activation of the elderly. This understanding informs the above-mentioned wave of reform-programs, but is not an entirely new phenomenon. The appearance of this understanding has been traced back to the
beginning of the 1980’s (Szebehely 1995, Dahl 2000), and Swane finds that it has been a central principle in the sector since the beginning of the 1990’s (Swane 2003). The goal in this type of care is that the care recipient maintains and/or regains abilities to care for him/herself. It is embedded in an “ideology of activation and rehabilitation” (Swane 2003) focusing on the resources and not the disabilities of the care recipients. This understanding of care comes from a socio-pedagogical tradition, where the caregiver assumes an educative and motivating role towards the care-recipient (Dahl 2000, Szebehely 1995). Care recipients are understood as potentially free, independent and autonomous subjects who are in need of training, guidance and motivation to realize this potential.

With this both historical and theoretical framework established, I shall move on to describe the methodology of my case-study, before turning to the analysis.

**The case study / Methodology**

As described, the empirical foundation of this paper is a qualitative case study in a homecare unit implementing a help for self-help and rehabilitation program. The unit covers a number of small rural communities on the outskirts of the larger municipality. The unit has approximately 30 permanent staff as well as a number of social and health care trainees and temps. They cover day, evening and night shifts, with the majority working day shifts from early morning till midday/early afternoon. Furthermore the unit has one manager and two staff with administrative tasks, one of these acting as a middle-manager as well. To understand the everyday life of the unit and their practices concerned with help for self-help, I spent 2-3 days a week in the unit for approximately one month in the fall of 2012. The case-study is based on four different sources of empirical material: observational studies, semi-structured interviews, ‘chronicle workshops’, as well as documents.

The observational studies were carried out as 'shadow observations' (Czarniawska 2007) of nine care workers in the unit: Five social and healthcare helpers, two social and healthcare-students, one social and healthcare assistant, as well as a rehabilitation therapist. They allowed me to follow them through a working day, showing me their everyday practices. Furthermore, I participated in daily lunch-meetings in the unit, where the staff shared information on the day’s events with the citizens. In addition, I observed other more formal meetings on the topic of help for self-help and rehabilitation – both internal meetings in the unit and meetings with representatives of other departments of the municipality.

Moreover I conducted a series of semi-structured interviews. I interviewed all but one of the care workers I ‘shadowed’ about the events of the day, as well as some more general reflections on help for self-help and rehabilitation, and the significance of these terms in their day-to-day work. Furthermore I interviewed the unit management, the health and safety representative, a rehabilitation therapist, an assessor responsible for allocation of services to the elderly, and the central coordinator of the help for self-help and rehabilitation program in the municipality.
In addition to interviews and observational studies, I also had the opportunity to carry out two ‘Chronicle Workshops’ (Limborg, Hvenegaard 2008) with all the employees in the unit. In these workshops the employees collectively wrote and interpreted the history of their workplace and used this as a starting point for discussions about the current situation and future of their workplace.

As a final element I also studied a number of documents describing the help for self-help and rehabilitation program: a project description, newsletters, a ‘strategy card’, and the teaching materials used in courses for employees on help for self-help.

**Care and care work when implementing help for self-help and rehabilitation**

So what influence does the help for self-help and rehabilitation program have on the understandings of care in the unit, and how do the social and healthcare helpers receive the program? The analysis below is structured in five sections that all feed into a final discussion and conclusion.

**Systematization and goal-orientation of ‘what we’ve always done’**

An important question that I discussed with almost everyone I talked to in the unit, concerns whether the help for self-help and rehabilitation program actually represents anything new in their practice of home care, and if it does – what? The interesting thing is that almost everyone I have spoken to have said that it is both something new, but also something ‘we have always done’, and something ‘we were trained to do’. Help for self-help is a well-established concept and understood as an important principle for the professional care workers. The program is not understood as bringing a new type of care to the unit, but it does draw increased attention to the principle, giving priority to it in both care practice and in the professional discussions in the unit. One of the social and health care helpers described it like this: “it turned out that it was actually what we were already accustomed to doing. Now it was just put into words and some therapists became involved.” She is referring to the addition of a ‘rehabilitation therapist’ to the unit who works only with the help for self-help efforts.

Another novelty is that the help for self-help efforts are now articulated in concrete goals and plans for the development of each citizen involved – a goal could for example be: ‘Mr. Hansen would like to regain his ability to walk to the mailbox and collect his mail himself’. This goal would be agreed between Mr. Hansen and a rehabilitation therapist, who will then formulate an action plan containing the exercises that Mr. Hansen should be helped to do by the care workers visiting him, in order for him to be able to achieve his goal within a specific timespan. This type of goal-orientation of care also changes the status of help for self-help efforts in the NPM-influenced management system of the sector. If a care worker is to spend time training Mr. Hansen to collect his own mail, this time has to be registered as delivery of a specific service to Mr. Hansen. Furthermore the social and health care helpers are required to continuously document Mr. Hansen’s development according to the plan. The social and health care helpers describe that before the program, help for self-help was something they would do along the way as an integrated part of
their interactions with the elderly citizens, now help for self-help can also appear as an independent activity on their work-schedule, and they must evaluate the status and development of the elderly citizens according to the plan. Help for self-help becomes a specific and formal service, and is no longer solely a professional principle integrated into daily care practices. This on one hand creates extra and legitimate time to work with help for self-help, as it is prioritized and doesn’t just have to be ‘fitted in’ to the work schedule by the individual care worker along the way, on the other hand the formal help for self-help and rehabilitation services are always temporary. As the goal is to make the elderly citizen independent of help – ‘to make oneself redundant’ - the help for self-help effort will only go on for a limited amount of time. The social and health care helpers describe that this was not necessarily the goal earlier when working according to the help for self-help principle.

It seems that the help for self-help and rehabilitation program results in a result- and goal-orientation of care work, and more systematic and explicit articulations of the contents of the types of care understood as help for self-help. One might see this as a form of bureaucratization of care – a professional principle is turned into a formal service that can be measured and evaluated. With Waerness one might fear an instrumentalization of care, and that care workers imbued with the rationality of caring would disassociate themselves from this type of care. However, this is far from the case – the social and health care helpers in the unit generally welcome the developments stemming from the help for self-help and rehabilitation program. I will return to this later.

**Motivating and observing the elderly**

The help for self-help and rehabilitation program also gives rise to changes that are more substantial than the above described. It is not just a more systematic way of working according to the help for self-help principle.

Many of the social and health care helpers describe that they are applying their pedagogical knowledge more than they have done before. This knowledge is brought into play because they are spending more of their time motivating the elderly citizens – either to accept and enter into a formal help for self-help and rehabilitation process, or to stick with it along the way and after the end of the formal process. They describe how they have to work to ‘sell’ help for self-help and rehabilitation to the citizens, and motivate and sometimes 'lure' them to get started in becoming more self-reliant. This motivational work isn’t always easy and can be time-consuming, as a social and health care helper explained about her work with a particular citizen:

“So there was a lot of work trying to motivate her in the right way and trying to - she was kind of an unusual person - you couldn’t get her to do just anything. She had this idea that I was her maid - and that is ok, but I was trying to explain to her – in the right way, one might

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3 It is important to note that this does not mean that the social and health care helpers have stopped integrating help for self-help in other activities with the elderly.
say - that I am from the home care unit, I'm not her maid."

This citizen was obviously looking for care in the form of service from the social and health care helper, but she insisted that she was 'not a maid' and insisted on performing care as help for self-help. Another social and health care helper explained how citizens who actually want to be more self-reliant can lose their motivation along the way, and have to be kept at it:

“He himself [one of her regular citizens] had said, when we came to talk to him about it, that he would like to train and do things himself. And the rehabilitation therapist made some suggestions to him. And he said he would think about it. And then when I came back three weeks later, he hadn’t done anything, because he didn’t want to. So I said: well, then we’ll start with the cleaning. There is also training in that – doing the cleaning yourself. So we started it that way around - for example we agreed that when he was vacuuming, he would just do one room at a time and take some breaks. And then he said that he wasn’t able to wash the floors because he had to bend down to reach the rag and the bucket and all that. So I told him to buy a floor mop. And I even have one at home myself, so I could really speak well of it. He did that, and then I showed him how to use it. So he ended up washing all his floors that day, when I was actually supposed to have done it. And he could keep his balance and didn’t have to stoop. He could just stand upright, and support himself on the mop. So that went really well.”

This story the social and health care helper told me as her ‘success-story’ – it was a long haul, but in the end they did it – the motivational efforts worked and the citizen became independent of her help.

Another element that is highlighted as a change by the social and health care helpers is the need for a greater awareness of and focus on observing what the citizens can actually do - they cannot take anything for granted and they have to be able to describe what citizens can and cannot do. One might say that their approach to the citizens and their needs is developed in a more observing and analytical direction:

“The difference is that you have to be more aware of what the citizen can do. So you really have to observe what the citizen is able to do. And then you have to describe it, and the rehabilitation therapist will come up with some suggestions for what you might do differently. Because sometimes you can get 'locked in' when you're with a particular citizen.”

Being 'locked in' in your understanding of what a citizen can and cannot do means that you are not able to focus on the resources and potentials of the citizen. The introduction of the program means that you cannot take anything for granted and that you should be very aware not to perform tasks that the citizens might be able to do themselves, as another social and health care helper explained:

“In the past we may have taken some things a little more for granted and thought: well, we are here to help, so we should do it. Now, perhaps, we look at it more like we are a helping
hand, and not the ones providing help. The citizen must provide his own help.”

One of the social and health care trainees in the unit explained the way you are supposed to view and think of the citizens like this:

“When you do something with the citizens, they have to do everything they can themselves, instead of us taking over. For example, you might think: she has broken a leg, so I will help her get her clothes on - but she does actually still have some arms up here, that she can use, right? This is what you have to think of.”

The understanding of care as a question of help for self-help and activation is strengthened in the everyday practice of the social and health care helpers with the introduction of the program. The principle of help for self-help is in no way unfamiliar to them, but they increasingly have to activate their pedagogical knowledge in long processes of motivation with the citizens, and they are also required to change their view of the citizens to become more analytical, searching for resources and potential instead of needs and disabilities.

### A more equal and developmental relationship

Another change that some of the social and health care helpers have pointed out, is that the emphasis on help for self-help and activation results in a change in the relationship between citizens and care workers. One aspect of this change is that they can develop more equal and symmetrical relations with the citizens.

The idea of ‘not taking over’ and doing things that the citizen might be able to do him or herself, is something that is highly appreciated by many of the social and health care helpers. ‘Taking over’ is seen as a form of disempowerment of the citizen – drawing on Wærness one can see this as placing the caregiver in a superior position to the care recipient. Another reason for not doing things the citizen might be able to do him/herself is not wanting to assume the role of ‘the maid’ as described above. In this case the caregiver would be in a subordinate position to the care recipient.

The social and health care helpers describe that there is a different atmosphere when they are working with the citizens according to the understanding of care as help for self-help and activation. One explained the change in her relationship with the elderly citizens like this:

“I actually think they see us more as equals than they have done in the past. In the past, you were kind of a ‘helping spirit’ or something. I think we can talk to each other more equally now. Instead of me standing, bent over them or ... I prefer it as it is now, (...) I actually think it’s good, I think it’s really good. (...). It’s like we are ‘sparring’ with each other - it’s like a partner instead of me doing all the work. And someone like XXX [a citizen’s name] right, who can wash his upper body, and then I can wash him on his back right. I think that is just better.”

In my observations I also saw many of the other social and health care helpers working to establish relationships with the elderly based on cooperation and a ‘division of labour’ between themselves
and the elderly citizens. Gaining a more equal and cooperative relationship with the citizens is considered a benefit of the program.

Another central point is that with the goal-orientation of care many of the social and health care helpers describe that they feel that they now have a kind of common project with the elderly citizens – they are working together towards a goal, and they share the ‘victories’ when the elderly citizens regain abilities and achieve their set goals, as one explained:

“I think it's probably because you share some tasks with the citizen. You have some goals with the citizen that you are trying to reach together. And when you are there, then it's a victory, we can sit and smile, right - because we have reached that point.”

These common goals and the process of working towards them together also feeds into an appreciation of working with development – that elderly care can be about something else than slow bodily decay and increasing dependency. One of the social and health care trainees explained why she likes working with help for self-help and rehabilitation:

“The good thing for me is to have the pleasure of doing a good deed. To show that it is not only about coming and wiping people’s ass all the time. Showing that they can have a zest for life. That they develop themselves, even if they have been down in the dumps - that they actually come out on top again - and sometimes you just think: wow, I never thought they would get there. So it’s great to see.”

So care understood as help for self-help and activation definitely has many positive implications in the experience of the social and health care helpers interviewed and observed. But the picture is not only rosy.

Both 'lighter' and more challenging work

The changed relationship between citizens and care workers appears quite ambiguous, involving both positive and difficult aspects. One view of the changed relationship, put forward by some of the staff, is that the help for self-help and rehabilitation efforts make their work as social and health care helpers easier or lighter. First of all the physical burden of the work is lessened if the citizens are able to perform most tasks themselves and can move around their house with little or no assistance. Moreover, in a more figurative sense, work also becomes lighter, a social and health care assistant explained:

“It is not as heavy for us - it's easier to enter their homes, when they can do a certain number of things themselves. Compared to the citizens who sit and can't do anything. So it's often for our own benefit that we teach them to do so much.”

Some, however, also state that work became more difficult or challenging when working with help for self-help and rehabilitation. The pedagogical work in motivating the elderly can, as described above, be a lengthy process, and some citizens are easier to convince and motivate than others. You have to be patient and make sure that the elderly citizens have a sense of security in the pro-
cess:

“You have to take it slowly with them (...). You have to show them that they are safe, it is quite important to show that (...). The relationship with citizens, when you are rehabilitating them, you have to find the right way in with them. That’s really what counts. If you approach them the right way, it usually helps.”

The social and health care helpers quite often have to deal with elderly citizens being afraid of losing their services from the municipality when they start to speak of help for self-help and rehabilitation. Quite tellingly on my first day of shadowing in the unit, the social and health care helper who was taking me along for the day, started out by asking me to agree that I wouldn’t mention help for self-help or rehabilitation while we were with the citizens, because: “If they think you have something to do with help for self-help and rehabilitation, they will just worry if they are going to lose their services”. We agreed to say that I was just a student studying the work of social and health care helpers, to avoid complicating things or upsetting anyone. So it seems to be quite a delicate subject, making it important for the social and health care helpers to tread cautiously. Some have also experienced resistance in the form of sarcastic remarks from citizens.

It also seems that motivation can be quite transient. One thing is approaching the elderly the right way so that they become motivated and agree to participate in a help for self-help and rehabilitation process, another thing is maintaining this motivation along the way. Some citizens will resist along the way and not wish to cooperate; in this situation the social and health care helpers experience a dilemma between respecting the wishes of the elderly citizens in the specific moment, and providing the type of care that, from a professional point of view, they find is best for them. One of the social and health care trainees told me about her training with one particular citizen. There was an agreement that she should walk to the local elderly center for lunch every day, and the trainee would come and walk with her. On the trainee’s days off, this agreement would sometimes be forgotten and her colleagues would take the citizen to the elderly center in her wheelchair – it was after all quicker this way. And the citizen wouldn’t object to this:

“She didn’t say anything out loud – she just enjoyed being driven there. She was not that motivated to do things herself. So I had to pull her ears once in a while and say: today you have to walk. ‘But I didn’t have to walk yesterday’, she would say. No, but that just means you have to walk farther today.”

Asked how it feels to put pressure on the citizens to do things themselves, the trainee answered:

“You get something positive out of it afterwards - but while it’s going on, it’s not so nice. But when you know that something good comes out of it afterwards – that they will be proud of themselves and think: ‘I actually did it’. You also become proud of yourself inside - it was good that I was tough - if I had not been so tough, then she wouldn’t have done it. So sometimes you have to be tough and straightforward – kind of be the boss or the mother, or whatever you call it. You sometimes have to say: ‘you have to’.”
So sometimes the motivational work turns into a type of pressure to make the citizens keep with the help for self-help and rehabilitation process. The social and health care helpers have to be able to change between different roles to carry out care as help for self-help and activation.

Most of the time the social and health care helpers do not see themselves as exerting pressure on citizens – they are very aware of the citizens’ wishes and self-determination. Many did, however, reflect on the possibility that sometimes they themselves, and the home care system as such, were transferring their own standards, of for example cleaning and personal hygiene, to the citizens. One social and health care helper described a situation where she thought that they had crossed the line:

“There is for example a citizen who had a brain hemorrhage. He is a former drunkard and lives in a mess. And now we have to go out and help him learn to clean - that's not his need - that is ours. (...) Here I have to say no - it's his life and not mine – we shouldn’t do it at any cost. Some say that I am square – but then I like being that, because I have my opinion about it. He does not want it - he does not want to bother with it. He wants to be allowed to live as he has always lived. But we run out there at all costs (...) and I think: damn you shouldn’t do that. That would also be to go beyond my boundaries.”

What the social and health care helper is questioning here is a role of ‘expert on the good life’ that she feels she is pressured to assume. She is very much oriented towards the citizen’s wishes, corresponding with both the understanding of care as something empathic and situational (“that would also be to go beyond my boundaries”), and perhaps also with the understanding of care as service where the influence, wishes and satisfaction of the citizen is prioritized. One might say that these understandings of care revolve around the care worker doing something for the care recipient, where the understanding of care as help for self-help and activation revolves around influencing the care recipient to do something. And this something is determined by professional understandings of the good life. This dilemma was present as a consideration for many of the social and health care helpers, but in the general picture they rarely found themselves about to ‘cross the line’.

When something other than help for self-help is necessary

It is very clearly the policy in the Municipality that as a principle all citizens should be included in the help for self-help and rehabilitation program, and this was also very clearly the position of the unit-manager who was very enthusiastic about help for self-help and rehabilitation. Most of the employees were also quite enthusiastic about the principle – at one meeting I attended, one of the social and health care helpers even said that he thought that it should be every citizen’s right to receive care as help for self-help and rehabilitation. So I was presented with very little criticism of the program and the type of care that it represents. The social and health care helpers did, however, often make assessments that something other than care as help for self-help and activation was necessary.
These assessments were always based on the situation of the individual citizen – and were often made on a day-to-day basis – e.g. if a citizen seemed confused or ill, they might not do care as help for self-help just that day. Many also made the point that it was very important to know the citizen well – ‘to be under their skin’ – before you could start working with help for self-help and rehabilitation. They considered it the task of each citizen’s regular helper to take the lead in these efforts.

The staff were clearly averse to making general statements about who should be included in the program and who should not – this was always an individual assessment. They did, however, give me examples of situations where either they themselves, or the municipal assessor had decided that help for self-help and rehabilitation was not appropriate. Some elderly citizens were deemed too frail and perhaps too affected by dementia to be candidates for help for self-help and activation. Some were deemed psychologically unable to cope with the demands of a help for self-help and rehabilitation process – for example citizens suffering from depression or another mental health disorder – the social and health care helpers were afraid that such a process would just make these citizens worse off – that they would ‘topple’. This concern that some citizens might topple if they were helped to help themselves and rehabilitated, was shared by many. In some cases the unit had decided to maintain just a short daily ‘drop by’ visit with citizens who were largely self-sufficient, but who they considered in danger of toppling. They had decided not to let completely go and keep an eye on the citizen.

Another group of citizens often mentioned as not considered fit for rehabilitation and help for self-help were the very ill, the terminally ill, and citizens with illnesses that made physical training redundant (e.g. muscular dystrophy). One social and health care assistant explained:

“Everyone is supposed to be included - even terminally ill citizens - but I don’t do that - they shouldn’t be spending their final hours on us rehabilitating them! Getting them out of bed, or even learning to get up on the toilet chair themselves or something - we must look at what citizens can do and then help them (…). We are there for them 100% when they come home from the hospital.”

Several times I was presented with the statement that what a patient needed was just ‘good and loving care’ – and not rehabilitation or help for self-help. In some cases it seemed to be considered an imposition or almost a form of abuse if you were to give that type of care.

Another, almost contrary example was also given when a social and health care helper was telling me about her relationship with one particular citizen:

“Helper: ... But we spoil her a little as well.

Me: Ok, how is that?

Helper: Well we probably don’t use help for self-help as much with her.

Me: Ok?

Helper: I think we just pamper her a little more. Perhaps we think she deserves it. I don’t
know, it’s probably just because you come there every day.

Me: Yes. And she deserves it because she …?

Helper: Because I feel that she gives something back.”

Here the citizen is considered able to do things herself, but is ‘spoiled’ by the social and health care helpers who chose to do things for her instead of trying to make her do them herself. Not receiving help for self-help and rehabilitation was kind of a prize for the citizen, because they enjoyed a good relationship.

All in all most agree that in principle everyone should be included in the help for self-help and rehabilitation program, but there will always be individual and situational assessments of the appropriateness of carrying out care in this manner. These assessments seem to be closely linked to the understanding of care as empathic and situational and care recipients as weak and dependent. Some are ‘spared’ the activation and empowerment efforts because they are considered too weak and dependent to obtain any benefit from them, and others are ‘pampered’ because they enjoy a good relationship with their social and health care helper. The help for self-help and rehabilitation program thus does not determine all the care practices of the unit – there seems to be room for assessments that other types of care are more appropriate. However, it does seem that the understanding of care as help for self-help and activation has become the norm in the unit – if you find other types of caregiving more appropriate in specific situations, you have to be able to argue why that is. Care as help for self-help and activation has become the default-option one might say.

Discussion and conclusion

So to return to my initial question: how do expenditure cuts and the promise of more attractive workplaces for public care workers go together? In this particular case I would say: surprisingly well. Somewhat paradoxically it seems that the social and health care helpers generally are enthusiastic about the help for self-help and rehabilitation program – even though it has been clear from the very beginning that the program was designed to reduce expenditure on elderly care – meaning working hours for social and health care helpers. A number of explanations must be considered when trying to understand this paradox. Some of them are related to the local implementation of the program, some are more general and related to the development of the social and health care helper profession as such.

One, quite local, explanation of the acceptance of the program is that there has not (yet) been any real threat of lay-offs or reduction of working hours in the unit. There has been a reduction in the total number of hours ‘delivered’ to citizens, as more citizens are performing more tasks themselves, but the unit management has been able to avoid layoffs by a combination of not filling vacant positions (due to retirements or the likes), and a policy of hiring new staff in temporary positions only, until the unit-management is completely sure they ‘have the hours’ for a permanent position. Furthermore there was a pronounced ‘crisis-consciousness’ among the staff – it was generally accepted that the municipality had to cut expenditure – so too much resistance would seem
futile.

Another reason that the program has been accepted to such a large extent seems to be that the help for self-help principle was already widely accepted and an integrated part of they way care work is understood – in the unit, and more broadly in the social and health care helper profession. The program also adds new aspects to the work of the social and health care helpers. It systematizes and goal-orient their work with help for self-help and activation. Furthermore it changes the power-relations between care workers and care recipients, so that the care workers are able to avoid both a position as superior and subordinate to the care recipient – they are able to move towards a more symmetrical relationship, which is valued highly. They find that they are working towards a common goal with the citizens when they are in a help for self-help and rehabilitation process, and they share the citizens’ victories. Work becomes ‘lighter’, both in a physical sense and in a more figurative sense, in terms of the atmosphere in the homes of the citizens. However, it also becomes more challenging as motivational work takes up more time, and not all citizens are equally cooperative.

One might have expected a certain skepticism towards the program given that its understanding of care is somewhat one-sided – leaning heavily towards the understanding of care as help for self-help and activation, and pushing both the empathic situational and service-oriented understandings of care into the background. The social and health care helpers still carry these understandings with them, but in most situations they do not seem to have a problem combining them with the help for self-help understanding that is dominating the picture. They seem to be able to combine these understandings though they can seem contradictory – for example in this passage, where a social and health care helper explains her feelings about the program:

“Helper: I love to rehabilitate - I really do!

Me: Yes, but what is it about it - why is it so great for you?

Helper: Well it’s when you enter a house and the citizen is active and in a good mood, not sitting and waiting, and being dependent on us – that makes me really happy. Because I don’t like to see people who are lying down, and are in a bad mood because I was a little late and they had to wait – if they are hungry - I don’t like that, I really don’t. (...) So what the citizen can do himself, that also makes me happy.”

Here the empathic understanding of the care recipient’s situation is very clear – she is happy if the citizen is happy, and sad if he/she is sad, hungry or otherwise in need. The answer to making the citizen happy, however, is not to be there on time to satisfy his or her needs, it is understood to be rehabilitation and help for self-help.

Yet another explanation of the fact that the program is generally embraced is that it represents an opportunity for the social and health care helper profession to achieve a higher status and develop the contents of their work in a direction that might lead to more societal recognition. The social and health care trainee put this quite clearly when she stated that she wanted to show that her
work was more than wiping people’s backsides. Dahl has elsewhere pointed out that such societal recognition might be gained through the increasing focus on the developmental aspects of care work (Dahl 2005).

A final, and quite crucial, point is that, so far, the social and health care helpers have been able to make professional assessments, and decide that something other than care understood as help for self-help and activation can be necessary in certain situations. Few experience having ‘crossed the line’ to pressuring instead of motivating citizens, or having to rehabilitate and provide help for self-help in situations where they find it inappropriate or futile. Maintaining these boundaries, and this openness in the understanding of what type of care a citizen might need, is important – even though the help for self-help and rehabilitation program states that all citizens should be included.

References


