Disembodied care: Articulations of care in municipal policy regarding welfare technologies in eldercare

Anna Samén
PhD Student, Department of Social Work, Umeå University, Sweden
anna.samen@umu.se

Jens Lindberg
Associate professor PhD, Department of Social Work, Umeå University, Sweden
jens.lindberg@umu.se

Katarina Andersson
Associate professor PhD, Department of Social Work, Umeå University, Sweden
katarina.andersson@umu.se

Abstract
The increasing size of the elderly population has been described as a major challenge for Western eldercare. In light of such demographic changes, welfare technology has been presented as a solution. It has been claimed, in both international and Swedish government policy, that digital technologies can improve how care is given and received. However, there is limited knowledge about what happens to articulations of care when national goals filter down to municipal local level where the actual care is practised. The aim of this article is to analyse how care and welfare technology are described in municipal strategy documents, and to discuss potential consequences of such articulations for everyday eldercare. A critical policy analysis, building on theories about articulation, was conducted on a selection of 19 policy documents (N = 19) from 18 municipalities. The key analytical results show that care tends to be articulated as an organizational matter and that care is transferred into the future of older people’s lives, through self-care and prevention. Interdependence, frailty and alternatives when welfare technology fails to create independence, are not brought up in the documents. Overall, such rearticulations of care indicate a more disembodied eldercare in the future.

Keywords
eldercare provision, welfare technology, articulations of care, policy analysis, disembodied care

Introduction
The development and implementation of welfare technology (WT) and digitalization has been a central national goal in the Swedish eldercare and healthcare sector for the last decade. Pivotal governmental actors, such as the National Board of Health and Welfare (NBHW), have defined WT as digital technology that aims to maintain or increase the security, activity, participation or independence for a person who has or is at increased risk of having a disability (NBHW, 2019). An increased use of WT is described as a way to strengthen individuals’ own resources and facilitate people’s access to good and equal...
health and welfare (NBHW 2020a). Furthermore, using welfare technology is considered an important way to manage and remedy the recruitment problem within the Swedish public eldercare sector. A recurring argument put forward for the introduction of WT is that it gives more time for care staff to provide care for older adults (SOU 2020:14). There is a consensus in governmental visions within the Nordic countries that the use of WT is a prerequisite for meeting the increasing proportion of older people's needs for care, specifically during times of difficulties in recruiting competent workers within eldercare organizations (Ministry of Health and Social Affairs, 2016; Kamp et al., 2019). In this article, the focus is on technologies that are supposed to replace or partially replace care staff, such as video communication, webcams and other surveillance technology, and medical dispensers.

According to the NBHW (2021), an important factor for the successful use and organization of WT is local guidance documents. Currently, approximately 70% of Sweden's 290 municipalities have documents to guide the development and organization of digital care for older people (NBHW, 2022). The aim of this article is to analyse how care and WT are described in municipal policy documents and to discuss the potential consequences of such articulations for everyday eldercare. To accomplish this objective, our theoretical framework builds on critical approaches to policy analysis (e.g. Bacchi, 2009; Bacchi & Goodwin, 2016) and theories about ‘articulation’ (e.g. Laclau & Mouffe, 2014; Laclau, 2005). A pivotal theoretical stance is that the concept of ‘care’ is historically contingent (Laclau, 2005; Foucault, 2012) and that the articulations used in policy documents help to arrange – but also transform – relations between care recipients, caregivers, municipal eldercare and digital technologies.

According to Laclau and Mouffe (2014), articulation is the political process of linking together potentially dissimilar elements in order to create a specific totality. Based on this line of thinking, how care is described and thus ‘constructed’ in policy documents depends on which concepts are (or are not) used together to give a particular meaning to ‘care’, ‘welfare technology’ and other concepts, in the context of municipal eldercare. From this perspective, policy documents are not neutral. Following Bacchi (2009; Bacchi & Goodwin, 2016), they should instead be considered as active players in the construction of certain social relations. Because of their centrality in public administration, the ways in which care and WT are described and presented in policy documents contribute to the institutionalization of specific representations of care, as well as to defining which problems these representations are supposed to resolve. Given this, the theoretical framework for this article can help to identify which ideological assumptions underpin municipalities’ strategies in relation to care and WT. Furthermore, it can also help to reveal aspects of care and WT that are downplayed and ‘silenced’ in policy (Bacchi, 2009; Bacchi & Goodwin, 2016), and to discuss the potential consequences of that.

**Background**

Welfare technology in social eldercare – policy and practice

In Sweden, there are three main policy actors at the national level that govern and guide the municipalities in organizing their eldercare services. These prominent policy actors are the Government, the National Board of Health and Welfare (NBHW) and the Swedish Association of Local Authorities and Regions (SALAR). The goals of WT that are often put forward are described in terms of facilitating older people to become more independent and autonomous, and providing increased security in their homes. Within the policy documents constructed by these actors, there are also representations of the problems that digitalization and technology are supposed to solve (e.g. Germundsson, 2022). An explicit problem described at the national level of policy is the shift in demographics that is
anticipated to threaten the capacity of the Swedish welfare state, including eldercare (SOU 2020:8; Ministry of Health and Social Affairs, 2016, 2020). In a Nordic context, as in most European countries, governments have formulated political policies to promote digital, technology-based solutions to address the challenges caused by an ageing population, the finite resources available to municipalities, and staff shortages within the health and social care sectors (Nilsson et al., 2022). Through digitalization, the need to recruit new staff is expected to decrease because it may become possible to automate several health and social care activities within the coming few decades. This is considered crucial for overcoming the increasing recruitment problems in public eldercare (SOU 2020:8). The difference between policy at the national and local levels is that policy documents at the local level describe strategies and guidelines that focus more closely on practice and the provision of care.

The Swedish context
The health and social care of older adults is a policy priority and concern for both the state and local government. In Sweden, responsibility for the healthcare of older adults is shared between the regions and municipalities (NBHW, 2020b). This means that municipal eldercare provides both health and social care. At the local level in Sweden, the 290 municipalities are governed by the constitutional principle of local self-government, with extensive potential for financial manoeuvring and responsibility for the organization and provision of eldercare (Municipality Committee, 2020). Thus, the municipalities have the principal financial responsibility for eldercare provision, with freedom to organize their public eldercare. The state's responsibility is to control and monitor compliance with national laws and regulations that stipulate the distribution of equal access to care for all in need of it (Andersson et al., 2018; Szebehely & Meagher, 2018). This implies that the details of how, when and why to use WT in eldercare is for the municipalities to decide and, as a result, the use of WT differs between municipalities (NBHW, 2020a). The use of WT is voluntary; the individual care receiver needs to consent to a care effort consisting of WT (NBHW, 2019).

Typically, the health and social care services provided to older adults within formal eldercare settings are predicated upon a comprehensive needs assessment and determined through the exercise of authoritative decision-making processes by the municipal authorities. Independence, participation and safety are some of the value-laden key concepts in public eldercare in Sweden, which reflect the view of older people as active despite being dependent on care and services. Simultaneously, the threshold to receive care support has risen and the users of care have become more vulnerable (Szebehely & Trydegård, 2012). Over the last few decades, welfare retrenchment has affected the care provided to older adults, targeting those with the greatest care needs, and the care provision is more focused on personal and intimate care and less on services and domestic work (Szebehely & Trydegård, 2012).

Care ethics and care work
Care has been conceptualized in different ways by scholars, who focus variously on ethics, power relations and political aspects. Care is arguably a fundamental condition of the human state and humans are dependent on each other throughout the course of life (Kittay, 1999). However, we cannot adequately address care without also focusing on the significance of the body and embodiment (Twigg, 2000). The private nature of bodily care necessitates a special focus on ethical awareness in the relationship with the care receiver. Bodywork in care includes dealing with human waste and negotiating nakedness, and involves direct touch (Isaksen, 1994; Twigg, 2000). Relationality is a core issue for care and caring, it is described as a mutual relationship between caregiver and care receiver and is central to the
care work undertaken in eldercare. The relationship between caregiver and care receiver is
basically seen as asymmetrical and, in order to balance this asymmetry, the caregiver needs
to take moral responsibility for identifying the care recipient’s needs (cf. Noddings, 1984;
Wærness, 1984; Szebehely, 1995). Good quality care is often defined as requiring time, con-
tinuity and personal contact. Receptivity and responsiveness are perceived as central values
for caregiving. According to some ethicists, care cannot be guided by rules and regulations,
because organizations can never act morally (Noddings, 1984). The personal qualities of
the care worker and their ability to establish a personal and genuine relationship are seen
as inherent characteristics and skills that women are expected to possess (Noddings, 1984).
To avoid the individualization of caregivers’ personal characteristics, care has been context-
tualized politically. It has thus been highlighted as important to recognize the care worker’s
complex work and the need to care for these caregivers (cf. Tronto, 1994; Dahl, 2010).

Welfare technology in eldercare

There is a range of WTs that are used in different ways by different actors within elder-
care organizations. Although welfare technologies are discussed collectively as though they
were essentially the same, there are significant differences between WTs serving different
purposes (Frennert, 2020). Even though these technologies may be discussed collectively,
the consequences of different technologies in everyday care will be dependent upon the
specific type of technology used, situated as they are in a care context with individuals who
present heterogeneous needs. It has been argued that digital technologies can change care,
or establish new forms of care (Mol et al., 2010; Pols, 2010). This can affect the relationship
between caregivers and care receivers (Groesen & Hansen, 2021; Oudshoorn, 2008) and the
distribution of responsibility and tasks (Halford et al., 2010; Langstrup, 2013). This implies
a reorganization of care work and a transformation of what care work is about, for both
the caregiver and care receiver (e.g. Järvinen, 2012; Kirkegaard & Andersen, 2018; Hansen
& Kamp, 2018). A transformation in how eldercare is performed today can be expected to
occur due to the extended use of WT in everyday care.

Despite the optimistic claims about what WT can achieve, little research has been con-
ducted to confirm the successes or failures of digital technologies in care. There are few
studies on the implications and effects of WT within eldercare, or whether these techniques
achieve the goals of increasing the independence, safety and participation of users (Authority
for Care and Care Analysis, 2020). Furthermore, it may also be difficult to demonstrate
effects of WT that are due to the users and in relation to what and how the techniques are
used. But, according to the studies that are available, WT is said to have mostly positive
effects for users, their relatives and care staff (Authority for Care and Care Analysis, 2020).
Frennert and Östlund (2018), however, state that, although WT in eldercare is promoted as
enabling efficient, safe and patient-centred care, the technology may in fact be contribut-
ing to making eldercare more fragmented, time-consuming, technology-centred and risky.
This suggests the complexity of implementing WT in eldercare. The imaginaries of digital
technology and the political context play an important role in how technologies are inter-
preted and used (Kamp et al., 2019). Thus, the political ideas expressed in local policy doc-
uments become important for how WT can transform care.

Research material and analysis

This study is based on a corpus of guiding policy documents for the development and
implementation of welfare technology in municipal social organizations, with a particular
focus on eldercare. The data was collected through an email inquiry sent to 30 Swedish
municipalities that were purposively selected based on their size. These sizes are defined in relation to the number of citizens residing in the municipality, as small (S), medium (M) and large (L), drawing from NBHW’s (2021) follow-up report on e-health and welfare technologies. The inclusion of municipalities of varying sizes was deemed essential in order to incorporate the diverse challenges that may arise during the development and implementation of welfare technologies in different contexts.

Of the 30 contacted municipalities, 24 responded to the request to send documents, while six of them did not have the requested documents. A total of 29 documents from 18 municipalities were received and carefully examined, with 19 documents ultimately retained for the final analysis after excluding general documents covering IT strategies and documents unrelated to eldercare. It is worth noting that larger municipalities tend to have more advanced digitalization strategies and formal development organizations than smaller ones, despite similarities in technology use across municipalities of different sizes (NBHW, 2022). The frequencies of answers and documents received from each municipality are presented in Table 1.

**Table 1.** Number of documents selected for analysis divided in municipality size (small <15,000, medium 15,000–70,000 and large >70,000)

<table>
<thead>
<tr>
<th>Municipality size</th>
<th>&lt;15,000</th>
<th>15,000–70,000</th>
<th>&gt;70,000</th>
<th>Total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipalities requested to send documents (n)</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Municipalities that responded to the email (n)</td>
<td>7</td>
<td>9</td>
<td>8</td>
<td>24 (80% response rate)</td>
</tr>
<tr>
<td>Municipalities stating that they did not have guiding documents available (n)</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Municipalities that sent (one or more) documents (n)</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Documents received (n)</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Documents included in the analysis (n)</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>19</td>
</tr>
</tbody>
</table>

**Material**

The corpus comprises various documents presented in different formats, including strategies, action plans and a cover letter; all of which provide guidelines for the development and use of welfare technologies in municipal eldercare (see Table 2). In essence, they are intended for use in the eldercare sector and related organizations within a given municipality. To ensure a focused analysis, documents that are too broad in scope, such as those providing guidance on IT development in the municipality, were excluded from consideration. The length of the documents analysed ranges from two to 32 pages. The names of the documents presented in Table 2 and the quotes in the results section are translated from Swedish to English by the authors.

**Table 2.** Type of guidance documents for WT in eldercare included in the analysis

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of document</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>Municipal strategy for digitalization</td>
<td>9</td>
</tr>
<tr>
<td>S2</td>
<td>Municipal strategy for digitalization</td>
<td>8</td>
</tr>
<tr>
<td>S3</td>
<td>Action plan for digitalization within eldercare organizations</td>
<td>12</td>
</tr>
<tr>
<td>S4</td>
<td>Strategy for digitalization within social services, especially eldercare organizations</td>
<td>11</td>
</tr>
<tr>
<td>M1</td>
<td>Description of the work with digitalization in social service organizations</td>
<td>11</td>
</tr>
</tbody>
</table>

(Continued)
Our analytical approach included three distinct but interconnected analytical steps that were all informed by our theoretical framework. The first of these was to identify the dominant ways in which care and WT were described in the municipal guidance documents. The second step involved more theoretically informed analyses, building on theories about articulation (see Laclau, 2005; Laclau & Mouffe, 2014). In practice, this meant distinguishing specific assumptions that were used to underpin the identified descriptions, but also, more specifically, conceptualizing how care and WT were linked to ideas about, for example, ‘self-care’ and organizational matters in documents. An important part of this stage of the analysis, and an analytical practice that arguably adds to the potential of a critical approach to policy analysis, was that it also included the identification of articulations about care and WT that were ‘silenced’ – matters that were not brought up in the documents and, thus, not highlighted as important issues in the context of municipal digital eldercare (Bacchi, 2009; Bacchi & Goodwin, 2016). This perspective also helped us to move on to our third and final analytical step: to theorize and discuss potential consequences of how care and WT are articulated in municipal guidance documents.

Results
In what follows, we begin by presenting the ways in which care and WT is described in the municipal documents and the specific assumptions that seem to support those descriptions. We then present two articulations that emerge from the documents: that care and WT are represented in ways that foreground organizational aspects and that care is ‘postponed’. The article concludes with a discussion about how such articulations contribute to changing the meaning of ‘care’ in everyday eldercare in ways that lead to relational and bodily aspects of care being neglected.

Descriptions of and assumptions about care and welfare technologies
A general description of care and WT in the corpus presupposes a future in which the provision of formal care for older adults in need will be problematic: “We stand before a growing older age group that demands care at the same time as the working age groups are decreasing”
It is described as though there is an upcoming shortage of care and that WT is a necessary solution to fix “the everyday ‘pains’ in social service” (S2). Correspondingly, there is a recurring description of WT as a possible solution to an expected shortage of care staff. WT is alternatively described as useful for other purposes than replacing the need for care staff; it can also strengthen the participation, activity, independence and safety for care receivers. However, the expectation that fewer care staff will have to provide care for a growing number of older adults is given the limelight in these municipal guiding documents. It is stated, for example, that:

The organizations will meet users who are involved in their own health and care to a greater extent, at the same time as care staff is lacking, or will be lacking, to care for the elderly [...]

Despite the complexities, digitalization is the clearest answer to how the challenges within health and care should be met. (S3)

Overall, care is articulated as an organizational challenge, and WT as a solution to this challenge.

There appear to be certain assumptions being made in the documents that support the above description of care and welfare technologies. Firstly, older adults in need of care are assumed to be rational, independent actors with the ability to remain active through the support of technology. Independence, for example, is central in the documents and described as something inherently good that older adults should strive for:

… they [the care receivers/users/elderly with needs] are going to be offered a wide range of welfare technological and digital services that offer opportunities to be independent as far as possible. (L3)

Another dominant assumption seems to be influenced by the ideal of ageing-in-place, that older adults want to live independently for as long as possible (Edebalk, 1990). In this case, the first ideal, being independent, seems to be seen as enabling the second. Making care receivers independent appears to be seen as a way of ‘releasing resources’ (M5).

Thirdly, there is an assumption that the use of WT will reduce costs and decrease the dependence on staff in future eldercare, by using technology that partially or completely replaces care staff and creates care at a distance. Examples of welfare technologies that are mentioned for this purpose are: an automatic medical dispenser that “can replace a delivery of medicines to the user” (M1); and camera surveillance as a way to “decrease the number of care staff during the night shift with the support of digital tools” (L4b).

A fourth and formal assumption is the governmental principle of digital first:1 “Digital first is the theme for the digital work with development in our municipality. It means that all changes and development of work will primarily search for digital solutions” (S1). The documents describe technology as the ‘go-to-thing’, or obvious solution, when updating or developing new forms of arranging care.

Overall, the descriptions of care and WT centre around the ability of municipal eldercare to provide care. This description is supported by assumptions that older adults will be active and more involved in their own care, ageing at home independently with the support of WT that will decrease both costs and dependence on care staff. The final assumption identified is that ‘digital first’ is an important ideal when organizing eldercare.

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This description, and the assumptions with it, are corroborated by articulations of care and WT in the documents, such as 'care as an organizational need', 'care as postponed', 'self-care' and 'prevention', which will be developed in the following sections.

Care as an organizational need

A pronounced articulation of care and WT found in the documents is that care is connected to organizational matters. This is often done by highlighting issues in eldercare that could be resolved by using WT. For example, digitalization in eldercare is articulated as necessary due to the demographic changes and as a means to meet the demands on welfare:

In order to cope with the challenges within welfare, many and various opportunities need to be taken advantage of […] In order to be able to provide care staff and funding in the welfare sector in the long term, and at the same time meet people's needs and expectations of the municipal organization, continued development in this area is necessary. (M3)

In this articulation, it seems that WT in care is beneficial for everyone and is based on a problem in the population of older adults and not within the organizations themselves. Also, WT is articulated as a way of organizing care in a new way, which satisfies an organizational need corresponding to a decrease in dependency on care staff.

A change in the demographics assumes other financial conditions that place new demands on the organizations within the municipality. This implies that we need to find new ways to organize work, use staff resources effectively and be innovative in how we accomplish new tasks. (M2)

In short, it is claimed that, without WT, organizations will not be able to meet the care needs of older adults. In this articulation, the need for organizations to provide care takes precedence over how WT might affect the care effort from the perspective of the care-receiving older adult. The output of new digital solutions in a care effort for the care receiver is even equated with that of care provided with a physical caregiver present. For example:

In cases when a traditional care effort (for example, nightly checkup) is replaced by a comparable digital solution (camera for checkup at a distance), a form of 1:1 relationship is created. The form of the care effort is changing, but the output remains the same (but is more resource efficient). (L6)

Here, the situated, interdependent and complex character of care work, as identified in previous empirical research, is silenced and WT is presented as a suitable 'technological fix' (Lindberg et al., 2022). This silence, or non-articulation of the conditions that might be changed by WT in everyday care work, further underpins the reality that organizational needs are central to these policy documents.

There seems to be an underlying incongruity between the individual and organizational needs in the documents. There are statements made that WT will provide person-centred care and that the individual comes first. However, this collides with the organizational requirement to be able to provide care and the principle of digital first. The principle of digital first filters down from national level to the municipal documents, and this helps to prioritize WT as a solution to organizational needs before the individual's preference for care. Examples of this can be seen in the policy documents. When it is suggested that WT could be problematic for older adults, discussions are often focused on how to make individuals more digitally competent, rather than suggesting alternatives to WT in care:
Depending on individual needs and preferences, digitalization can, for some and in some situations, be perceived as a decrease in quality, compared to traditional forms of care efforts […] It is important that the implementation of digital technologies is preceded and surrounded by measures to minimize these side effects. (L6)

Altogether, in these documents, the focus is on making older adults digitally competent and increasing their acceptance of WT. This strengthens the articulation of care and WT as an organizational need and as a solution that is important to enable the organizations to provide care.

Care as postponed
Care is also articulated as something that can be ‘postponed’ with the assistance of WT. According to the documents, a prominent change to which WT can contribute is that traditional care with staff physically present in a care effort will decrease, to be replaced by self-care and older adults independently managing their own needs with the support of technology. Care as ‘postponed’ is grounded in the articulations of care and WT in terms of ‘self-care’ and ‘prevention’. There is a recurring articulation in the documents that individuals will become more involved in their own care with the help of WT, and that technologies will be used to complete tasks previously undertaken by care staff, in ways that enable self-care and prevention:

Therefore, the health and care administration must move from a traditional reactive way of working, to a more prevention-oriented health and care. This means meeting the individual’s needs earlier through information, dissemination of knowledge and support for self-care. (L4a)

The articulation of prevention and self-care is given meaning through actions that can prevent older adults from becoming passive care receivers. Prevention is articulated as a means to move the need for traditional care into the future, and hence postpone it. It seems that the aim is not necessarily to prevent a care need from arising for older adults, but to prevent the provision of formal care being dependent on a physically present caregiver.

Altogether, articulations of care and WT in municipal documents focus on organizational matters and how organizations can support older adults to manage their own needs and remain independent. By neglecting the complexity of older adults’ needs, these documents bring organizational matters to the forefront. Municipalities are describing a way of postponing formal care into the future without articulating a strategy for when technologies fail to keep people independent. But what happens when WT fails to meet a need and alternatives to WT have been silenced? We believe that the powerful rhetoric of technologies as a necessity for future welfare implies that other solutions to the challenges presented might lose value or priority.

**Discussion**

Caring has long been described as a relationship between at least two people, where one (a caregiver) shows concern, consideration, affection and devotion towards the other (a care receiver) (Wærness, 1984). Our policy analysis has revealed a rearticulation of care, significantly distant from the conceptualization of care as relational. By articulating care as an organizational matter and the possible postponement of care by means of ‘self-care’ and ‘prevention’, these documents ignore the physical characteristics of care and ideas of care as relational. One of the participants in the relationship (the caregiver) is replaced
by an imagined technology, which will enable independence. WT assumes independent users, while replacing the human work of otherwise omnipresent caregivers (Cozza et al., 2019). The ambition of WT could therefore be seen to transfer the task of care to either the receiver or a technology (Hansen, 2021). The consideration of the human state as being inherently dependent on others (Kittay, 1999; Held, 2006; Tronto, 2013; Wærness, 1984) is thus silenced, and replaced by a technocentric understanding of eldercare.

Care has traditionally been characterized as ‘body work’ and ‘dirty work’ due to its proximity to the dysfunctions and discharges of ageing bodies (Dahle, 2005; Twigg, 2000). The articulations of care and WT do not take older adults’ bodies into account, with all the (dys)functions, frailties and vulnerabilities associated with dependence in old age. Because one argument is that a corporeal relationship with another human being is the foundation of making care possible (Hamington, 2004; Wærness, 1984), it is necessary to raise the question of whether care needs met through WT really constitute care at all. The small, sometimes unnoticed, gestures, smells and sounds that bypass our rational and conscious abilities are important for understanding the other (Hamington, 2004), and this is something that risks being lost when care becomes more distant.

We argue, along with other scholars, that there are differences between physical care and care performed partially or completely by a technology (e.g., Mol et al., 2010; Pols et al., 2010; Hansen & Grosen, 2019). Or, as Coeckelbergh (2013) suggests, technologies used as a response to vulnerability must always be seen as something that transforms vulnerability. Furthermore, the articulation of care as postponed is coherent with the discourse of active ageing as being a period of continuing health and activity (Katz, 2000; Minkler & Fadem, 2002). There are no articulations in the documents of dysfunctional bodies or bodily disintegration to threaten the construction of individuals as self-contained, bounded entities (Lawton, 1998). The older adults who are expected to receive care in the municipal documents seem to correspond to the idea of the third age; a period of continuing good health and vigour (Laslett, 1987). However, most people receiving formal care are part of the fourth age and are likely to experience frailty and have complex care needs (Laslett, 1987; Szebehely & Trydegård, 2018). In the documents, the construction of older adults as active, independent and able to provide ‘self-care’ excludes the frailty and dependency that a care receiver might experience. Consequently, uncertainty arises about future care for older adults who fail to match the corresponding ideas of the third age.

The narrative of a reduced need for formal care due to WT is ubiquitous in the municipal documents, but reflections about its implications for everyday care practice is not apparent. The non-articulation of alternatives to WT neglects the complexity of individual needs in formal eldercare. From our theoretical point of view, the articulation of care and WT embody a discourse about ageing and technologies that help to rearrange care in everyday care practices in the municipalities. Consequently, the failure to articulate any alternatives to WT could exclude other care alternatives for the future (Bacchi, 2009; Bacchi & Goodwin, 2016). What matters and what is excluded from mattering (Barad, 2007) in the discourse presented in the documents becomes important. When alternatives to technologies are not explicitly articulated, do they matter? A critical discussion about what is being excluded from mattering is relevant for policy, because the way in which care and WT is problematized has consequences for the actual practice of eldercare.

Conclusions
Our focus of this article has been on the local policy documents that serve as guidance for municipalities to develop and implement welfare technology in eldercare. The analysis
has revealed a unidirectional approach towards implementing WT that reflects national policy goals. Ageing, in the context of caregiving, is presented in government policy discussions as a significant issue tied to the shifting demographic landscape characterized by an increasingly ageing population (Neven, 2010), and WT constitute the solution to such challenges (Peine & Neven, 2019). WT is thus conceptualized as a necessary one-size-fits-all solution which represent technological solutionism, underpinned by the belief that WT has the potential to reduce care-related costs (Mannheim et al., 2022), primarily through its capacity to enhance efficiency and reduce the labour intensity that characterizes care work.

Care scholars have commented on the solutionist tendencies in government policy regarding health and social care: that WT are being presented as a single solution to what are really a series of multifaceted and interconnected issues (Lindberg et al., 2022; Frennert, 2020). To meet challenges in demography through the implementation of WT goes in line with neoliberal logics emphasizing economic efficiency and cost reduction, which tend to favour organizational understanding (Meagher & Szebehely, 2013; Andersson et al., 2015; Lloyd & Sullivan, 2018). Furthermore, using self-care and preventive care, users are not only required to be active and independent but also to take responsibility for their own needs and consequences of actions, or lack of actions and competences (cf. Brown, 2005). Consequently, the rearticulation of care as an organizational matter and possible to postpone is addressing other problems than care in itself, similar to what has been labelled ‘care fixes’ (see Dowling, 2022). WT is becoming yet another strategy to endure austerity measures and cutbacks that have persisted for decades within the care sector (cf. Meagher & Szebehely, 2013; Lloyd & Sullivan, 2018).

Overall, the descriptions, articulations and non-articulations in the analysed documents indicate an everyday eldercare in which care is becoming disembodied. Firstly, transforming care between a caregiver and care receiver in a physical setting into care-at-a-distance and reliance on support for ‘self-care’ is a form of disembodied care. Secondly, a description of care in which body work and dirty work remain unarticulated ignores the foundation of care and represents disembodied care. Thirdly, active ageing and the emphasis on ‘functioning bodies’ neglects bodies that cannot manage care and, again, where a caregiver is partially or completely replaced by WT, this is a form of disembodied care. In addition, the way WT has been conceptualized in the municipal policy documents as a necessary digital one-size-fits-all solution, has left alternatives to WT non-articulated and silenced. This further strengthens the notion of priority being given to digital solutions in eldercare. Given the centrality of municipal policy in eldercare practice, we worry that this could lead to a systematic devaluation of physical, relational care where bodies meet and matter. To portray welfare technologies as a solution to care, without recognizing care work, is to simultaneously neglect the vulnerability and dependency that many people experience in old age. The physical, and sometimes dirty, details of what really constitutes care and caregiving must be acknowledged, we argue, also when using WT in eldercare.

References


