research article

Unravelling the dichotomisation of care and reablement: an ethnographic exploration of contradictions between policy rhetoric and practice in Danish and Norwegian eldercare

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Reablement has been positioned as a superior care ideal distinct from home care. Drawing on cross-national ethnographic data, this article instead demonstrates how the continuity and interdependency between reablement and conventional home care is more significant than suggested by policy rhetoric. Findings highlight the continuities and overlaps between activating and compensatory care, for example, how compensatory care might take the form of psychosocial reablement, activating and enabling even the frailest clients to age in place. The article concludes by pointing to the dangers of a narrow conception of reablement and argues for the benefits of more focused attention on clients' psychosocial well-being.

Key words home care • reablement • health and social care professionals • older peoples' psychosocial well-being

Introduction

In response to the anticipated socio-economic impacts of demographic ageing, active-ageing measures have been put forward as potential solutions (WHO, 2002; European Commission, 2013). One prominent example is the introduction of reablement, comprising short-term home-based training programmes aimed at optimising functional independence to reduce the need for long-term care. Reablement has found its way into the policy agenda of an increasing number of Western countries (Rostgaard et al, 2023). In Denmark and Norway, reablement has been introduced

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not only as a short-term intervention but also as a fundamentally new approach to care, or a new understanding of what constitutes good care (Bødker et al, 2019).

On the policy level, reablement has been positioned within a narrative of required change (Clarke and Newman, 1997) that emphasises the need for a new understanding of good care by underscoring the discontinuity between reablement and traditional home-care approaches. Reablement, which aims to activate older adults through a 'doing with' approach, is portrayed as a superior alternative to the conventional 'doing for' approach, in which care workers compensate for clients' functional decline rather than enable them to retain their skills. The underlying normativity of this polarised narrative is that conventional home care is provided by compassionate but misguided care workers who unintentionally contribute to making older people passive, depriving them of their strength and vitality. In contrast, reablement figures as a professional and goal-oriented approach that enables people to regain strength and abilities, thereby increasing their independence and quality of life (Metzelthin et al, 2022).

Nordic care studies reveal that the polarised narrative is not simply a top-down policy discourse. Reablement has also gained ground as a superior care ideal among lower-skilled care workers, who experience reablement as offering them new professional identities with higher status (Hansen and Kamp, 2018; Vik, 2018; Graff and Vabø, 2023). The therapeutically informed practice of reablement is seen as more professional, whereas conventional home care is perceived as driven by care workers' 'caring genes' (Hansen and Kamp, 2018; Bødker et al, 2019; Jensen and Muhr, 2020). Hence, the discourse surrounding reablement continues a long-standing trend of dichotomising care work and competence (Wærness, 1984; Davies, 1995).

By portraying care approaches as belonging to either a stereotyped past or a desired future, the policy narrative risks contributing to a devaluation of care and distorting what happens in actual care practices. As noted by Newman (2001: 17), such 'from–to' dualisms 'often appear to involve a misremembering or over-simplification of the past and an overly tidy view of the present or future'. At the same time, the narrative structure makes change seem both inevitable and unidirectional: 'all of the "old" is to be discarded in favour of the "new"' (Clarke and Newman, 1997: 49). The main objective of this article is to uncover how the polarised narrative on home care and reablement obscures the complexity and deeper continuities between the two modes of care work.

Nordic reablement studies have shed light on the intricacies of day-to-day care practices, revealing that care professionals providing reablement frequently end up 'doing for' clients, either to fulfil their needs (Dahl et al, 2015; Bødker, 2019) or because of time constraints or lingering habits (Jokstad et al, 2019). Accordingly, compensatory care and reablement should be seen not as dichotomous but as complementary forms of care (Bødker et al, 2019). In this article, we add to these studies by arguing that they are not only complementary but also often interdependent forms of care. Building upon Clarke and Newman's (1997) critical perspective, we depart from the premise that defining good care will depend on situational conditions. The article explores the daily actions of care professionals and investigates how their practices align with the values, principles and challenges emphasised in the political narrative of change. How do care professionals balance the binary concepts presented in the policy narrative, such as the dichotomy between 'doing for' and 'doing with', or between 'compassionate' and 'goal-oriented' care? We delve into the practices of home care

and reablement through an ethnographic analysis of data gathered from a multi-site case study conducted in Denmark and Norway.

We proceed by outlining key theoretical assumptions based on empirical care research. Of particular focus is how researchers in this field have conceptualised the provision of 'good care' within a wider social and cultural context. We then introduce our empirical study and provide an overview of the data, methods and procedures we used. This is followed by our presentation of the results of our analysis, structured around three types of work situations typical of reablement and home care. In the concluding section, we discuss the implications of our study within the framework of the prevailing policy narrative on care and reablement. Additionally, we discuss how our situated approach has the potential to expand the understanding of what constitutes 'good care' in eldercare settings, thereby contributing to future advancement in the field.

Notions of good care in empirical care research

Empirically grounded theories on care work share the common idea that practices of good care cannot be prescribed from a set of abstracted principles but will always be contingent on situational conditions. This was emphasised both by the Nordic pioneers of care research, who established a strong ethnographic research tradition in the field of paid care work almost half a century ago, and by contemporary international scholars examining care work in more professionalised and technology-driven contexts.

One of the Nordic pioneers was the Norwegian sociologist Kari Wærness, who studied the practical and social care work of lower-skilled home helpers in the 1970s–80s. Informed by these studies, Wærness (1984) argued that providing good care for people dependent on the help of others requires a committed attentiveness to individual and situational needs. Wærness (1984) coined the 'rationality of caring' concept to challenge the widespread notion of caring as an intrinsically feminine disposition by maintaining that caring represents a certain kind of rationality that requires specific skills and working conditions. She emphasised that this kind of rationality requires 'the sentient actor', that is, the actor who is both rational and feeling at the same time. In line with both care-policy principles of the time promoting help-to-self-help and the contemporary reablement ideal, she also maintained that 'Good caring should be performed in such a way that it, as far as possible, reinforces the self-sufficiency and independence of the receiver' (Wærness, 1984: 189).

While Wærness somewhat idealised care (Eliasson-Lappalainen and Motevasel, 1997), the Swedish sociologist Rosmari Eliasson (1995) elaborated on the theorising of Wærness by pointing to the significance of contextual conditions and conceptualising how these conditions made caring work a difficult balancing act, not something inherently good. Based on observations from the Swedish home-care sector, Eliasson argued that good care requires caregivers to see care recipients in a holistic perspective, that is, both as autonomous adults capable of making their own choices of lifestyle and as vulnerable dependants in need of assistance from others. She demonstrated how care workers (sometimes) balanced respecting each client's autonomy and simultaneously acting proactively to take responsibility for that person's well-being. However, she also pointed to the danger of adopting an either/or approach by viewing clients as either dependent objects or independent subjects. In this way, she theorised the possibility of distorted care: if assuming responsibility for the well-being of the care

recipient is held to be the only guiding principle, care may turn into objectifying paternalism; conversely, if respecting the autonomy and self-determination of care recipients becomes the only guiding principle, 'care' may easily become a sin of neglect (Eliasson, 1995). Accordingly, care workers are constantly balancing on a thin line, repeatedly facing situations in which they are in danger of being caught in the ethical pitfalls of either paternalism or neglect.

Eliasson saw the balancing act as highly contingent on the conditions of work and the culture of care in different institutional settings. She demonstrated that the emerging trend towards New Public Management (NPM) curtailed care workers' latitude, thereby contributing to bisecting the holistic view of individual care recipients, and that principle-based approaches had the potential to guide care workers towards ethical pitfalls (Eliasson, 1995; Eliasson-Lappalainen and Motevasel, 1997). Danish scholar Hanne Marlene Dahl (2017) warns against the analytical use of the concept of 'ethical dilemmas', claiming that it may risk drawing attention to individual decision making rather than issues of power or agency. Dahl (2017) instead suggests focusing on tensions between different logics to emphasise that these power issues indicate ongoing struggles between competing ways of understanding good care. Care is not a neutral or universal concept but rather shaped by power relations that operate at various levels, from the personal to the institutional.

While Wærness (1984) claimed in her early work that the rationality of caring would probably be suppressed by the scientific rationality of professionalism, Davies (1995) challenged her position, arguing that nurses' formal knowledge and technical skills would not crowd out caring, as attentive, compassionate care is an integral part of nurses' caregiving work, alongside their formal knowledge. Through her studies of nurses' work in the UK, Davies (1995: 22) demonstrated how they, despite adhering to textbook knowledge and technical skills, also regarded emotional commitment to patients as a crucial part of effective caregiving. In a similar vein, contemporary studies in various care settings depict professional care work as a complex interplay between routinised, technical tasks and the subtle weaving in and out of various kinds of attentive and situated care work (Mol et al, 2010; Gherardi and Rodeschini, 2016).

Contemporary scholars studying care work in situ consider it impossible to predefine and encapsulate 'good care' within abstract principles. Instead, they recognise that pragmatic responses to the emergence of contingencies are unavoidable (Mol, 2008; Mol et al, 2010; Pols, 2015; Gherardi and Rodeschini, 2016). Mol et al (2010) define good care as persistent tinkering in a world full of complex ambivalence and shifting tension. They emphasise that doing good reflects not only 'care' (noun) as values but also 'caring' (verb) as ways of ordering reality. Hence, good care will also be contingent on practical tinkering. Despite very attentive tinkering, good care is not always the outcome. Nonetheless, an ethos of care implies a readiness to continue tinkering if caring fails – one will then try something a bit different.

If scholars of caring practice refrain from normatively predefining what is meant by good care, how do they analyse and interpret their empirical research? Based on what she labels an 'empirical ethics of care', Pols (2015: 83) suggests an analytical approach that is 're-scriptive' rather than pre- or descriptive: 'Rather than reasoning about what is good, such a study starts by articulating participants' attempts to put something good into practice.' She argues that different and conflicting notions of doing good can be weighted and argued about reflexively using multi-site ethnographies. The researcher does not have to agree with the identified modes of doing good but will

have to take them seriously by specifying how they come into play and what they do, for example, what norms and values they tend to reinforce. According to Pols (2015), good care is often prescribed by abstract and normative arguments from outside the care context – such as the policy narratives on reablement introduced in this article. Pols (2015: 83) instead argues for empirically demonstrating 'aspects of what is good to do in particular situations' by *re-scribing* care practices and the values embedded in and around them. Our analysis and subsequent discussion in our study of everyday practices in eldercare in Denmark and Norway rely heavily on these insights.

Methodology

Study design and setting

Our empirical analysis is based on qualitative data collected within a comprehensive research project exploring how changing service ideals are put into practice in different settings. Norway and Denmark were chosen for the project due to their similar welfare models and reform trajectories. Both countries are characterised by a comprehensive, publicly funded municipal service system that aims to enable older adults to continue living at home for as long as possible (Graff and Vabø, 2023). Inspired by Linda Hantrais's (1999: 94) methodological ideas about cross-national comparisons, we regard contexts themselves as an important explanatory variable. Hence, we assumed that while policy ideas may be similar, their outcomes will vary depending on the specific societal and political context in which they are implemented.

Our case study was designed as a layered case study (Patton, 2002: 447). Each case, consisting of the municipal service system for older adults, was seen as comprising several layers of subcases. Data were derived from different levels and focal points. Our research aimed to adopt a holistic and context-sensitive approach, which involved conducting a rapid site-switching ethnography at each location (Baines and Cunningham, 2011; Armstrong and Lowndes, 2018). Data were collected in 2018–19 by a multidisciplinary team of ten Norwegian and Danish researchers with extensive prior knowledge of health and care provision in each country. The approach allowed us to gain a comprehensive understanding of the social and cultural contexts of each site, and to observe and analyse the interactions between care staff and service users in their natural environment. By switching between sites, we were able to compare and contrast the different practices and experiences across multiple locations.

Sampling strategy

Since one aim of the case study was to explore how variability in contexts may shape service provision, certain sampling criteria were applied. As well as selecting sites from different countries, we also selected one rural and one urban case in each country, varying in organisation and administrative styles. All four municipalities were selected because they had made initiatives to reshape their service organisation in line with contemporary service ideals. Interviewees were recruited prior to the fieldwork with the assistance of local organisers, using purposeful sampling (Patton, 2002) to ensure

that professionals from all relevant disciplines who could provide valuable insight for obtaining an in-depth understanding were shadowed and interviewed. During fieldwork, additional interviewees were recruited via snowball sampling to pursue emerging themes (Patton, 2002: 237).

Data collection

The research team collected the majority of ethnographic data by conducting five days of fieldwork in each site. Prior to the site visits, the team developed open-ended interview and observation guides aimed at different groups of participants and sites. We also conducted pre-interviews with local key informants and gathered policy documents, evaluation reports, administrative data and statistics in order to describe service profiles and organisations. During site visits, we collected data through a combination of individual and focus group interviews, as well as observations of care practices and organisational meetings by shadowing individual care professionals. The extensive set of ethnographic data comprise over 160 interviews with managers, key informants, health and care professionals, and care recipients. In addition, we took field notes from approximately 1,000 hours of observations. All interviews were recorded and transcribed verbatim, and the authors translated quotes into English.

Data analysis

Team-based data analysis began before the fieldwork with document studies and continued during the fieldwork through daily reflection and analysis sessions. After the data-collection period, individual sub-analyses were discussed and refined in team meetings. The team-based approach also included the initial coding procedures, in which interviews were thematically coded into 12 codes that signified the major focal points, such as reablement, user involvement and work conditions. We used NVivo software in both the initial thematic coding and the subsequent more fine-grained analysis of the data used for this article.

Following Patton (2002: 448), our data allowed for several possible analyses to be made, both horizontally, that is, across cases, and vertically, that is, across the layers within each of the specific cases. For this analysis, we conducted both horizontal and vertical comparisons of policy narratives and care practices. While we drew on the compiled knowledge gained from the complete study in the analysis, we concentrated on policy documents and data from field notes and interviews with professionals directly involved in reablement and home-care provision. These included registered nurses, occupational therapists, physiotherapists and trained care workers.

We analysed the interviews and field notes by drawing particular attention to elements related to the 'from–to' dimensions in the policy narrative on care and reablement. To make sense of care staffs' strivings to provide 'good care', we drew on the theoretical insights on ethical balancing acts and attentive and situated care practices described earlier, while Pol's (2015) concept of re-scriptive analysis was applied to inform our discussion of our findings theoretically.

Research ethics

Ethical approval was obtained from the Norwegian Centre for Research Data (Ref No. 128713). All interviewees gave written informed consent to participate in the study and to have their data used. In all data materials, synonyms were used for names and locations. Audio files and interview transcripts were encrypted, password protected and accessible only to research team members.

Results

During fieldwork, we encountered the polarised policy narrative within each of the four local sites. For instance, visualised reminders of the reablement mindset in care workers' offices, such as humoristic cartoons illustrating the dangers of falling into the 'helping trap' – mindlessly 'doing for' instead of 'doing with' – in the Norwegian sites. Likewise, managers and therapists would regularly mention that home-care workers would easily slide into 'old habits' of 'doing for' due to being soft-hearted. Shadowing therapists, nurses and care workers in their daily work, however, we discovered that care provision of any kind in real-life settings was rarely easily classified as a polarised practice. On the contrary, we found considerable nuances and overlaps. To bring this complexity to the surface, we frame our analysis by referring to three different, regularly occurring situations in Nordic eldercare: assessing reablement potential, training situations and morning care for the most dependent. These situations were chosen due to being where we met the most obvious examples of how the linearity and oppositions of the policy narrative in practice appeared neither polarised nor dichotomised.

Before we proceed, it is important to note that although the contrasts between policy narratives and everyday practices were evident across all sites, the actual practices we observed in each site were influenced by unique national and local conditions. To illustrate this, let us consider the notion of user involvement and the concept of 'doing with' within reablement rhetoric. While this aspect was emphasised in all sites, Danish legislation links reablement to home care, which created an incentive for needs assessors and care professionals in the Danish sites to align reablement interventions with predefined standards for home-care provision. However, these may not always align with the user's own goals, needs or preferences. In contrast, the Norwegian sites, which were less regulated, allowed care professionals to personalise the interventions based on the client's goals and preferences to a much greater extent (Graff and Vabø, 2023).

Assessing the reablement potential

In policy narratives, reablement has been introduced as a truly person–centred approach contingent on active user involvement (Jokstad et al, 2019) and co-production (Ebrahimi and Chapman, 2018) by 'doing with'. Hence, it is often implicitly assumed that the purpose and logic of reablement is part of the self-image of care recipients. Shadowing needs assessors and occupational or physical therapists during the assessment processes, however, we observed how they regularly struggled to make potential reablement clients comply with the role of an active and goal-oriented

participant. In the Norwegian sites, where therapists used a formalised assessment tool designed to assess client-identified problem areas, therapists often found it necessary to take proactive measures to ensure the client was ready to play an active role in the process. Knowing that many clients felt exhausted after a hospital stay, the therapists often made visits prior to the formal assessment meeting to obtain information about the purpose of reablement and to offer the clients some time to think about their everyday life within the framework of the assessment tool. During formal assessment meetings, we observed how therapists assisted clients with grasping the logic of reablement to help them with rating and prioritising what could be their own reablement goals. For instance, we witnessed how a therapist during an assessment meeting reduced the number of rating-scale questions in the tool, changed the order of questions and added probing questions to make a 94-year-old woman feel confident enough to express her own wishes and preferences for a reablement programme.

While some clients were enthusiastic about regaining functional capacity, other examples revealed that not all were capable or willing to see themselves as candidates for reablement (see Bødker, 2019). This was particularly evident in the Danish sites, where reablement was largely regarded as a means to reduce the need for home care (Graff and Vabø, 2023). Within these settings, the very idea of supporting people's self-identified goals was toned down and replaced by a reductive conception of reablement as a way for home-care staff to work in a more goal-oriented way in order to help people manage typical home-care tasks. Being self-sufficient in performing tasks like vacuuming or washing dishes did not always correspond to the client's needs or wishes, however. Some Danish therapists referred in interviews to the moral distress they experienced when a care applicant, who they had assessed as 'able to regain functional abilities', was unwilling to accept the offer of reablement because this would push them to use their energy on tasks they hoped to be relieved of. If clients were assessed to have the potential 'to regain functional abilities', declining the reablement offer could potentially result in the denial of regular home-care services. The focus on reducing the number of home-care hours meant that much emphasis was put on convincing people to agree to reablement. Home-care applicants were often expected to use their remaining strength on housework even if it meant that they would be too drained to do much else. Shadowing a care worker visiting an older client who had recently declined an offer of reablement, the researcher overheard his frustration about the way he felt humiliated and overruled in the assessment meeting:

> There was no help to get from them. We gave up. The needs assessor and the therapist – they told me to demonstrate whether I was able to vacuum the floor. I managed to do four metres. Then, they told me that it was not required for them to help me more than every third week. They told me to split up the task in several steps and do the whole job over three weeks. (Observation notes, DanCity)

Seen through Eliasson's (1995) analytical lens, these examples from the Danish sites indicate how the turn towards reablement, when combined with restraining regulations, could push needs assessors to abandon a holistic view of the client. Thereby, they risked drifting into the ethical pitfall of paternalism, in which decisions are made for the client without fully taking their needs and desires into account.

In summary, our findings suggest that the 'doing with' approach promoted in policy narratives of reablement was frequently downplayed during assessment procedures. Professionals assessing the potential for reablement had to override the assessment process and 'do for', in some cases, because a client was tired or confused and, in other cases, because user involvement conflicted with legal and economic preconditions.

Training to regain functional capacity

In both countries, the training programmes used in reablement interventions were mainly focused on boosting the bodily strength, physical functioning and practical skills of clients. Enhancing psychosocial well-being was rarely, if ever, a goal in itself. The individual programmes varied, but typical goals would be 'to manage morning care independently', 'to manage certain practical household chores' or 'to walk safely to the grocery shop'. The training programmes initially appeared to follow a straightforward means–end logic. In practice, however, the programmes took a less instrumental approach, aligning more with what Wærness (1984) refers to as 'the rationality of caring'. Therapists often found it necessary to adjust or lower the goals originally set and would identify new subgoals as needed. Both therapists and care staff were consistently attentive to the immediate condition of everyone receiving care, adapting the training to such contingencies as the weather or recent incidents. These situated care practices were observed repeatedly across all sites. Observing a training session in the home of an older man with walking difficulties, he complained about feeling exhausted and dizzy since yesterday. The reablement nurse listened attentively and discussed with him whether it could be related to his blood–pressure medicines. She remarked that he was short of breath and felt anxious, so she kept checking whether he managed to do the exercises: "Are you doing OK?"; "Can you manage to do another repetition?"; "Perhaps you should see your GP?" The episode exemplifies how reablement, like nursing work in a hospital (Davies, 1995), appears as weaving in and out of different elements of situated work. Reablement staff did the coaching of physical exercises in line with the goal-oriented reablement plan. Simultaneously, they acted as sentient actors (Wærness, 1984), using their emotional skills and adapting to the client's situated needs.

Episodes like these highlighted the simplification of the policy narratives' either/or dichotomies, prompting us to contemplate the policy narratives' tendency to lump together different dimensions and sets of dichotomies, for instance, that activation will make the older person more self-reliant, whereas compensatory care renders them passive. In practice, however, the dichotomies appeared to collapse and entangle. First, we noticed that compensatory practices were not merely characteristic of conventional home care. In fact, reablement therapists widely used assistive technologies and arrangements to compensate for the clients' lack of muscular strength or mobility. These forms of compensatory devices did not create passivity, though. On the contrary, they assisted in activating clients, as they made various activities less demanding and life easier and safer. Second, we noticed how some reablement interventions that – according to the policy narrative – would result in a general activation of clients had seemingly lacked any long-term gains. Throughout the various sites, we encountered former reablement clients who faced difficulties sustaining activities that they were previously capable of performing during the intervention. Care workers in the Danish

sites shared accounts of former reablement clients who had regained the ability to take care of simple household chores like doing the dishes but lacked the motivation or ability to continue doing so once the intensive reablement programme had ended. The presence of dirty dishes and untidy living spaces indicated a decline into passivity and neglect following reablement rather than a renewed sense of maintaining a tidy home.

From the perspective of regular home-care staff, the imperative of refraining from 'doing for' clients in such cases could lead to undignified living situations and the ethical pitfall of neglect (Eliasson, 1995). However, the care workers' perspective was overridden by the dominant policy narrative, which advocated against assuming tasks that clients were capable of handling themselves, considering it disrespectful and paternalistic. This viewpoint was underpinned by an overriding political and managerial focus on cost containment in all sites (Graff and Vabø, 2023).

Providing morning care for the most dependent

In policy narratives on reablement, conventional home-care work is frequently depicted as misguided, with compassionate care workers not taking into consideration that they may unintentionally hinder the self-reliance of clients. The underlying assumption is that care workers may lack the necessary knowledge and detached attitude to effectively motivate clients in regaining or maintaining their daily living skills. However, based on our observations and interviews within regular home-care provision, we will argue that narratives about soft-hearted care workers should be nuanced and expanded upon. First, in line with previous research (see, for example, Hansen and Kamp, 2018; Bødker et al, 2019; Graff and Vabø, 2023), we found that care workers had, in fact, embraced the principles of reablement and demonstrated several examples of how the reablement approach had become a regular part of home-care practices. However, enabling clients in this way was often seen as time-consuming, especially during busy morning hours, when care workers provided bathing and dressing assistance to home-care clients. In such situations, care workers were sometimes tempted to do tasks for the clients instead of waiting patiently for them to manage independently. This was driven not by being 'soft-hearted' but rather by the understanding that the demanding nature of their work necessitated making decisions on how to allocate their time. They often had to prioritise efficiently moving on to the next client on their schedule due to the fast-paced nature of their job.

Second, we found that the care workers not only embraced the mindset of reablement but also often exhibited a more comprehensive understanding of enablement that involved a more implicit form of social activation achieved through 'doing for' in specific situations. An illustrative example is how, after a morning care visit, a care worker explained to the shadowing researcher that she had just broken an established routine of involving this client in preparing breakfast. In the presence of a visiting researcher in the kitchen, the client preferred to sit and engage in conversation while the care worker took charge of preparing breakfast. Reflecting on the situation later, the care worker revealed that she had experienced a moral dilemma in the situation, unsure of whether it was best to gently encourage the woman to participate in breakfast preparation for a more activating experience. Ultimately, she decided that it was right to make an exception in this case because the visiting researcher made the setting appear as a socially activating and life-giving tea party.

During our observations, we also noticed how care workers were able to improve the mood of clients by proactively providing what the prevailing policy narrative perceives to be compensatory and passivating care. For these care workers, reablement was just one component within a broader array of care approaches aimed at enabling and motivating older people to maintain their independence and continue living in their own home. At one of the Danish sites, the home-care services had systematically worked with a specific approach called 'joyful moments' to identify the individual keys to thriving in everyday life. When asked about the relationship between this approach and reablement, a care worker hinted that there could be tensions between the two due to the personalised nature of the former:

> 'We had a user with dementia who was to receive reablement. However, she was used to getting her morning coffee in her bed. Then, all of a sudden, she was expected to go to the kitchen and prepare and drink her coffee there. This caused a lot of tensions. She wailed and cried every morning. So, we actually returned to the routine of serving her coffee in bed; it [the reablement programme] ruined her day to a degree that she stopped thriving.' (Care worker, DanVillage)

By comparing the practices of conventional home care with reablement, we discovered that the process of motivating clients to sustain their usual way of life is more complex and varied than is commonly portrayed in the dominant policy narrative. While it is true that some people are certainly motivated by the process of improving their physical capacity through training and an interactive 'doing with' approach, our observations also reveal that certain care recipients were motivated and enabled by receiving assistance with tasks that they found unpleasant or difficult to perform. Being relieved of energy-consuming tasks allowed them to use that energy for something else that was important to them, for instance, to participate in social activities. In line with the basic tenet of care theorists (Wærness, 1984; Mol et al, 2010), the factors that motivate older people to continue living at home are contingent on their unique health and life circumstances.

Discussion

We introduced the article by referring to contemporary transnational discourses advocating for active-ageing measures, such as reablement. On the discursive level, the shift towards reablement is positioned as a paradigmatic shift, representing not only a new approach but also a redefined conception of what constitutes good care. Inspired by Clarke and Newman's (1997) research on welfare state transformations, we have characterised the dominant policy narratives on reablement as being based on a series of binary oppositions: from a compassionate to a goal-oriented approach; from 'doing for' to 'doing with'; from compensatory care to enablement; and from passivation to activation. This kind of dualised narrative of change may be successful in the sense that it may become taken for granted as 'common sense' (Newman, 2001: 7) and hence set clear directions for change. However, claiming a stark contrast and discontinuity between the past and the future poses a risk of concealing the tensions, uncertainties and ambiguities that individuals encounter when attempting to make sense of suggested changes (Clarke and Newman, 1997).

In this article, we have aimed at opening this black box by exploring how care professionals involved in home care and reablement manoeuvre to provide good care in their day-to-day work. We based our analysis on a situated approach inspired by scholars of care who argue that 'good care' is always contingent on individual and situational circumstances (e.g. Wærness, 1984; Eliasson, 1995; Mol et al, 2010), and who warn against bifurcating between care as the emotional warmth of humaneness and professional medical treatment (Davies, 1995) or rationalising technologies (Mol, 2008). Our research has revealed that in real-life situations, notions and actions of 'good care' are far more complex than suggested by the simplified policy narrative. Rather than unfolding in line with the extreme dichotomies of the polarised narrative, we find that efforts to provide good care tend to appear as 'something in between', with the different dimensions of the narrative entangling and collapsing in multiple and shifting ways, depending on situation and context:

- *Between compassionate and goal-oriented care*: both therapists and care workers based their caring on a mix of compassion and goal orientation, whether providing home care or reablement. They all visited older people with the aim of performing specific tasks, such as conducting a formal assessment procedure, assisting a person in a training programme or helping people with preparing breakfast. Performing these tasks, they aimed at acting with compassion, in the sense that they were emotionally attentive to the condition of the client and continuously adjusted content, approach and pace of work to the situation. Hence, in line with Davies (1995), Mol et al (2010) and Gherardi and Rodeschini (2016), we found that the care work appeared as a complex interplay between routinised technical tasks and the subtle weaving in and out of various kinds of attentive and situated care work.

- *Between 'doing for' or 'doing with'*: although the 'doing with' approach was recognised by all categories of professional, time restricted their ability to enact this ideal. Since home-care staff were generally allocated less time per visit than reablement staff, they were more apt to regret that 'doing with' was restricted by strict timetables and more inclined to be 'doing for'. However, therapists also had to make short cuts sometimes to keep within time schedules, for example, by completing assessment forms for the clients or skipping complex questions to avoid a client feeling mistreated. Hence, their underlying notion of performing good care corresponded with Eliasson's (1995) concept of good care as a balance between taking responsibility for the other and respecting their self-reliance and integrity. Consistent with this concept, failing to provide good care is not only about paternalism, such as 'doing for' the clients what they could manage independently. Rather, failing to provide good care also encompasses neglect, that is, not taking into consideration clients' expressions of needs or goals, as well as the recognition that vulnerable old people may be overwhelmed by the role as active participants in shaping their own care service.

- *Between compensatory care and enablement*: although reablement services certainly involved a focus on training functional ability, these services also relied largely on compensatory techniques. In line with the reablement literature (see, for example, Ebrahimi and Chapman, 2018), the therapists we observed regularly suggested assistive devices and equipment to compensate for impairment in desired daily activities. Hence, compensatory strategies were highly entangled

with the training of functional ability, as individuals often regained daily living skills through a combination of physical training support and the use of assistive technologies and devices.

- *Between passivating and activating clients*: the notion that conventional home care leads to passivity while reablement promotes an active lifestyle, as well as in the long term, was not consistently evident in real-life situations. While training may help some clients to regain their previous level of functioning, not all will experience the same outcome. Some may regain the physical ability to perform housework but lose the motivation to maintain their engagement once the social connection with reablement staff ends (Glendinning et al, 2010; Bødker, 2019). This was particularly evident when clients had little or no social network, which diminished the perceived importance of keeping the house presentable. Contrary to the reablement narrative, we also observed how conventional 'doing for' care, such as serving coffee in bed to cheer up a client or preparing lunch to allow the client a social moment with the researcher, played a significant role in revitalising and enabling them to continue their daily lives at home.

The structure of the reablement narrative makes it difficult to think outside the box. For instance, as the dichotomy between compassionate and goal-oriented care is highly entangled with the dichotomy between passivating and activating approaches, it appears unreasonable to assume that compassionate approaches could contribute to activation or that goal-oriented approaches could contribute to passivation. Additionally, we argue that the simplified and normative conception of reablement, combined with the inclination to lump together all 'undesirable' aspects of care as failures of the past, may mask the conditions and complexities of the service contexts in which the reablement approach is introduced. By drawing attention to the way in which conventional care work and reablement unfold on a day-to-day basis, we have made visible how notions of what is 'good' or 'bad' care are situated and contextual. Our empirical descriptions are much in accordance with Mol et al (2010: 12–13), who argue that:

> Good and bad may be intertwined; good intentions may have bad effects; if one looks hard enough any particular 'good' practice may hold something 'bad' inside it (and vice versa); while sometimes it is simply unclear whether (for whom, to what extent, in which way) some form of care deserves to be praised or to be criticised.

Following Pols (2015), we do not assume that the intra-normativity existing in a particular field is inherently good in the sense that it should be prescribed. However, intra-normativities 'may be *questioned* for example by *comparing* them' (Pols, 2015: 83, emphases in original). By juxtaposing the normativity embedded in the dominant policy narrative on reablement with the normativity observed in practical fieldwork, we have demonstrated how the latter is being framed by local discourses emphasising the necessity of cost-efficiency in response to demographic ageing. This has resulted in both regular home-care workers and reablement therapists being compelled to make compromises regarding principles and values associated with providing 'good care'. Hence, the time pressure and managerial constraints inherent in conventional home-care provision (Szebehely, 2005) have, to some extent, affected reablement provision as well (Graff and Vabø, 2023).

Comparing the values in the policy narrative on reablement with the values embedded in the day-to-day work of home-care staff, we also question the way in which conventional home care is currently being associated with passivating care. While the dominating policy narrative tends to present task-oriented approaches and physical training as the key to an active independent life at home, our observations of the micro-practices of home care reveal that practical home care may sometimes be provided as a kind of psychosocial enablement. We have shown how even minor 'doing for' tasks can contribute to reviving and motivating the frailest, most dependent older clients to carry on their lives at home. Thus, we suggest that policymakers and practitioners should be made aware of how even small acts of compensatory care may contribute to a process of enablement by boosting the well-being and motivation of older people to carry on life at home. Instead of solely emphasising the value of promoting functional independence and maintaining a hands-off approach, we believe that the subtle art of enhancing the psychosocial well-being of clients should be equally valued in policy discourses and care provision. The question should be raised as to whether more focused attention on the psychosocial well-being of clients will contribute to obtaining greater benefit from the current investment in reablement. Compensatory care, assistive technologies or help with heavy housework may enhance the psychosocial well-being and functioning of the client, and may motivate them to maintain or regain their functional capacity. Therefore, as mentioned by Bødker et al (2019), reablement and compensatory care should be perceived as complementary forms of care. In our analysis, we have expanded on this perspective by making visible the interdependence between compensatory care and reablement, illustrating that they are not only complementary but also frequently reliant on each other. Hence, it is essential to investigate the intricate interactions between diverse care approaches and comprehend how these interactions are influenced by contextual factors. By conducting such an examination, researchers can gain a deeper understanding of the complexities involved in providing effective and tailored care. Considering the increasing emphasis on enabling older people to age in place rather than in long-term care institutions, this broader perspective of 'good care' presents an opportunity to enhance our understandings of how to effectively support care recipients in maximising their psychosocial well-being and motivation to remain in their own homes as long as possible. Additionally, the broader perspective of what constitutes good care, as opposed to the current policy narrative, contributes to placing value in care workers' competencies.

Conclusion

In conclusion, our article has presented a critical perspective on the prevailing narrative surrounding reablement, challenging the notion of a unidirectional shift from conventional home-care practices towards reablement as a superior mode of care. Through ethnographic data gathered from day-to-day work in Danish and Norwegian eldercare, we have disclosed the existence of significant continuities and overlaps between established and new care approaches, which are often overlooked in dichotomised policy narratives. We have observed that therapists, nurses and care workers in both reablement and regular home-care services constantly navigate multiple and sometimes-conflicting ideals, limited resources and managerial constraints while adapting their care strategies to the evolving needs of frail elderly individuals.

Our findings indicate that a reablement approach often necessitates the use of both compensatory and enabling approaches. Likewise, in practice, compensating and 'doing for' approaches, which are commonly viewed negatively in policy narratives for fostering passivity, can contribute to activating even the most dependent individuals. Small arrangements made to compensate for older people's lack of self-reliance can have a positive impact on their psychosocial well-being and rejuvenate their desire to live at home. Based on these insights, we suggest that there is untapped potential to increase the benefits of investments in reablement while also recognising the value of traditional care approaches. By embracing a more inclusive and comprehensive perspective, we can enhance the overall quality of care provided to older adults.

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[1] Main and corresponding author.

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Conflict of interest
The authors declare that there is no conflict of interest.

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