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Keeping the older population and their informal carers healthy and independent using digital technology: a discourse analysis of local policy

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Abstract

The general discourse in health and social care policy purports digital technology as necessary to meet growing demands for long-term care and health care as a result of an ageing population. This needs critical investigation since public policy influences people's health and wellbeing. This study aims to interrogate critically what we call the 'digital technology solution' discourse in local Swedish health and social care policies. The main concern of our analysis is the discursive constructions of older people and their informal carers and how the concept of health is constructed. A discourse analysis was conducted of 61 local policy documents using the 'What's the Problem Represented to Be' method. Our analysis revealed that so-called 'e-health strategies' were rarely concerned with health. Health was often referred to as an activity and seen as a means to achieve independence among older people. The norm advocated independence, with the responsibility placed upon the older person, supported by digital technology. Informal carers were constructed as a resource within an older person's environment and largely taken for granted. We argue that the digital solution discourse ignores older people's agency and capacities as contributors to society, not least with regards to being providers of informal care.

Keywords: ageing; informal care; digital technology; policy; discourse; health and social care; welfare state

Introduction

In Nordic countries and most European countries, governments have formed policies promoting digital technology-based solutions to address challenges due to an ageing population, finite resources in municipalities, and staff shortages within health and social care sectors. The central discourse in policy and public debate in Sweden purports digital technology as a necessary part of older people's health

and social care. This discourse with underlying presuppositions arguably needs critical investigation since the way ‘problems’ are constituted carries implications for how issues are thought about and how people involved are treated (Bacchi, 2009). The governing programme concerning health and social care for older people has relevance for society, as has become clear with the ongoing COVID-19 pandemic, placing how we care about older people at the centre of media attention and political debate. In this study, Swedish policy documents for health and social care of older people and their informal carers, the analytical subjects of this paper, serve as examples of the current discourse.

Digital technology and policy

In the *Transformation of Health and Care in the Digital Single Market* policy document, the European Commission (2020) writes that using digital tools is a top priority for empowering people to look after their health and for achieving more integrated health and social care. Swedish policy has adopted the term *welfare technology*, defined by the National Board of Health and Welfare Sweden (NBHWS) as

digital technology that aims to maintain or increase the safety, activity level, participation or autonomy of a person who has or is at risk of functional impairment. Examples of welfare technology are digital safety alarms, peer supervision, sensors with reminders or robots that can perform tasks such as feeding or showering a person. (NBHWS, 2021a)

For this study, we use the general term ‘digital technology’ when referring to the technology in the policy texts. As a point of context, it is important to note that in Sweden the relationship between the technology companies on the open market and the public providers are carefully regulated through legislation, namely the Public Procurement Act (2016:1145) which endeavours to ensure a more efficient use of tax funds, yet at the same time leads to a more time-consuming and governed procurement procedure (National Agency for Public Procurement, 2021).

The most recent policy at the Swedish national level describes the need to create conditions for older people or people with disabilities, supported by digital technology, to live independently and safely in their own homes. This is further exemplified by the possibility for people with chronic conditions to perform self-checks of vital signs and receive support to stay healthy via digital technology (Swedish Ministry of Health and Social Affairs and Swedish Association of Local Authorities and Regions (SALAR), 2020). The transfer of responsibilities to the patient, who is represented as an empowered and motivated consumer, equipped with financial and cultural capital to engage in self-care and wants to become digitally engaged, is an approach that is highly evident in Swedish policy documents at a national level (*see e.g.* Swedish Ministry of Health and Social Affairs and SALAR, 2016).

Through digitalisation, the need to recruit new staff is expected to decrease. Several health and social care activities may be possible to automate within the coming decades, and this is considered crucial due to an expected worsening in labour shortages in all public activities (Municipality Committee, 2020). The possibilities for more efficient use of resources in health and social care are also

highlighted by the Committee of Inquiry Concerning Welfare Technology in the Care of Older People (2020). Finally, the need for changes and amendments in legislation to facilitate welfare technology is suggested by the Committee of Inquiry for a National Plan for Quality in the Care of Older People (2017).

It is, thus, a predominantly optimistic view of digital technology that is presented in Swedish policy. However, viewing technologies as solutions or interventions and evaluating them solely in terms of efficiency and/or effectiveness can be considered problematic because such a narrow perspective runs the risk of overlooking fundamental changes in people's home environments resulting from these technologies and the intricate work needed to incorporate them in a meaningful way (Neves and Vetere, 2019). Furthermore, transferring tasks from the staff to the patient supported by digital technology and treating it as a gain in independence for the patient could be argued to lack a problematisation of the meaning of the word independence (Lynch *et al.*, 2018).

For example, Lupton (2018) argued that such a policy approach can be interpreted as part of the neoliberal discourse attempting to shift the state's burden and responsibility to the individual. The term neoliberalism refers to a set of assumptions and subsequent reforms geared to reducing state power, such as privatisation, deregulation, tax reduction and globalisation (for a more in-depth analysis of the concept, see Ng, 2018). Previous studies have highlighted that the way policy positions older people can negatively affect those in need of support (Nedlund and Nordh, 2015; Lindberg and Lundgren, 2021).

It is routinely acknowledged that public policy is a determinant of health, but there is no mainstream debate about how the ideas underpinning policy influence people's health. Major determinants of health or ill-health are inextricably linked to the social and economic context, and many lie outside the health sector (Bambra *et al.*, 2005). One example of policy determinants of health is the World Health Organization's (WHO) framework of healthy ageing, outlining strategies for supporting older people to develop and maintain functional ability that enables wellbeing in old age (further elaborated in WHO, 2015; see also Beard *et al.*, 2016; Nilsson *et al.*, 2020). The WHO (2019) views healthy ageing as being closely linked to social and economic equity. In this way, disadvantages in health, education, employment and earnings throughout the lifecourse are important moderators of inequity and result in widely different ageing trajectories (WHO, 2019). However, concerns have been raised about several obstacles that can be assumed to hinder a successful implementation of the framework (Rudnicka *et al.*, 2020). We argue that it is of interest to examine how local policy documents relate to health and health inequalities and how they position older people and their informal carers. The reason being that it is plausible to assume that these ideas and assumptions form essential elements of the 'digital technology solution' discourse, thereby affecting how health and social care services for older people are shaped.

The organisation of health and social care for older people in Sweden

The Social Services Act¹ obliges local authorities to provide home-based and residential care for older people (Szebehely and Meagher, 2018). Health and social care services for older people are organised and provided mainly at the local or regional

level under the constitutional principle of local self-government, with extensive room for financial manoeuvring and responsibility for tasks and functions of central importance (Municipality Committee, 2020). Based on government provision, services are framed within a tax revenue system (mainly municipal income tax) and provided by Sweden's 21 county councils (regional level), which are responsible for providing advanced medical and geriatric care, and 290 municipalities (local level) are responsible for providing long-term care (home help, home care, residential and nursing care) of older people (Andersson *et al.*, 2018; Szebehely and Meagher, 2018). Region population density varies from 59,749 to 2,383,269 inhabitants. The municipalities have an even greater variation from 2,450 to 962,154 inhabitants. The median Swedish municipality has barely 16,000 inhabitants. In many cases, population-wise, small municipalities have the largest geographical areas. The co-ordination between regional and local level is subject to change due to the recent reform *Good Quality, Local Health Care: A Reform for a Sustainable Health Care System* (Committee of Inquiry for Coordinated Development for Good Quality, Local Health Care, 2020) which forces the authorities to increase co-operation between regional and local levels. Local authorities determine eligibility (needs assessment) and how those needs can be best met according to the available resources. Even though the legislation granting the right to care remains unchanged, eligibility criteria for access have been tightened due to austerity measures (Szebehely and Meagher, 2018). A care manager decides the person's need for care in the form of home care services or residential care on application from the older adult and after a needs assessment has been conducted (Andersson *et al.*, 2018). There are stark differences between municipalities regarding eligibility, service coverage and spending (Szebehely and Meagher, 2018); thus, due to local self-government, local policy may vary considerably, which is of interest in this study.

The Swedish welfare state was and is still to some extent characterised by universalism, generous social transfers and a strongly interventionist state. In the 1990s, there were cutbacks, privatisation and marketisation of welfare services and an increased emphasis on an active rather than a passive welfare system (Eikemo and Bambra, 2008). The notion of choice became central in the care of older people in Sweden as an argument for increased marketisation. It is articulated as a key to the increased quality of life and empowerment of older people. However, it is questioned to what extent older people with care needs actually have the opportunity to be active citizens and make well-informed choices (Andersson and Kvist, 2015). Another element of the choice reform was that private providers could supply additional services to their users, paid for privately but with a tax rebate. Older people with economic resources can thus complement their needs-assessed care with top-up services (Moberg, 2017), suggesting increased inequalities in the care of older people despite opposite goals of the welfare state.

Older people and their carers

Older people are a heterogeneous group, regardless of what chronological age inclusion is set into the category (Nilsson, 2008). Likewise, the ageing process is not uniform; socio-economic factors such as age and education affect morbidity and

longevity (Barnett *et al.*, 2012; Rouzet *et al.*, 2019). Older people suffering from declining health are highly likely to rely on the help and support of their informal carers. Informal carers are individuals (most commonly family members, but potentially friends or neighbours) who provide usually unpaid help, support and/or care on a regular basis to someone with a chronic illness, disability or other long-lasting health or care needs outside a professional or formal framework (Eurocarers, 2020). Informal carers are estimated to provide at least 70 per cent of all care for older people in Sweden (Katzin, 2014). Older people are also informal carers, often providing care for a spouse or a child (Jegermalm and Torgé, 2021). However, there is ambivalence regarding Swedish older people's preferences for care, with some preferring to avoid dependence on family members (Sand, 2016), whilst others have a desire to receive help from their families, yet not always receiving help from their families to the extent they would wish (Berggren and Trägårdh, 2015). Sweden has a long history of emphasising the individual and the importance of independence from the family, volunteer organisations and the church. In Sweden, the State is expected to provide resources to support or secure the individual's independence (Berggren and Trägårdh, 2015). That said, increased reliance on help from the family has been rising in Sweden since the 1980s, and similar trends are observed in the other Nordic countries. Informal care is more common among older people with less formal education, and there are signs of increased class and gender inequalities (Szebehely and Meagher, 2018).

Local policy in Sweden forms government programmes that affect the older person and informal carers. For example, the declining coverage of residential care has increased older people's reliance on their family and affected the opportunities for informal carers (sons or daughters) to maintain paid work (Ulmanen and Szebehely, 2015), with subsequent impacts on health and wellbeing for both parties. We are interested, therefore, in how older people and their informal carers are discursively constructed within the digital technology solution discourse.

Older people's digital preconditions

Even though it is promoted in national policies, digital technology is not widely available, nor is it offered as part of the formal home care services in all Swedish municipalities. As an example, in 2021, 26 per cent of municipalities provided digital medical dispensers. Furthermore, 10 per cent offered digital health monitoring and 34 per cent provided digital technology supporting physical exercise. Nighttime cameras for supervision, replacing personal check-up visits at night, were offered in 76 per cent of municipalities, an increase compared to 2020, while GPS alarms connected to an alarm centre are used in little more than half of the municipalities, presenting a slight decrease compared to 2020 (NBHWS, 2021b). According to the report from NBHWS (2021b), implementation projects with digital technology had to be postponed due to the COVID-19 pandemic, as resources were redirected to manage the acute situation. On the other hand, digital surveillance at night and co-ordinated individual planning supported by video have increased following the need for social distancing. Nevertheless, it is important to pose the following question: if technology is a vital part of the future of health and social care, as digital technology discourse proclaims, why has it not been taken up and implemented to a larger extent in the municipalities?

Rationale and aim

The general discourse in national policy states that welfare technology and digitalisation are a vital part of the solution to challenges in the health and social care sector. According to statutory local self-government in Sweden, the 290 municipalities are responsible for the health and social care of older people and support for their carers. Informal care constitutes at least 70 per cent of all care provided, and an analysis of local policy in health and social care should arguably consider informal carers as well. Those policies emphasising the need for welfare technology within health and social care services of older people require critical attention. However, while we do not argue against the challenges of the demographic shift, we see a need to increase the knowledge concerning how older people and their carers are produced as subjects and how health and care are discussed. In this way, it can be argued that local health and social care policies, as part of the current discourse, can be seen as a determinant of health for older people and their carers.

Thus, this study aims to interrogate critically the digital technology solution discourse evident within local Swedish health and social care policy. The main concern of our analysis is the discursive constructions of older people and their informal carers and how the concept of health is constructed within this discourse.

Methods and material

Study design

This study is a discourse analysis based on the poststructuralist tradition.

Poststructuralism proposes that the realities we live in are contingent and open to challenge and change (Bacchi, 2016). Social policy is a highly normative discipline that constructs ideal models of society (Bacchi and Goodwin, 2016). Discourse analysis is a useful method to increase or even create awareness of assumptions and perceptions taken for granted and underpinning the governing of health and social care (Bacchi, 2009), with consequences for older people and their informal carers. Discourse means 'practices that systematically form the objects of which we speak' (Foucault, in Bergström and Ekström, 2018). This study focuses on what we call 'the digital technology solution' discourse.

Data collection

Policy documents are seen as cultural products and political actors that define, organise, and transform health and social care (Timmermans and Berg, 2010). Our data consisted of policy documents from Swedish municipalities, randomly chosen based on the often employed classification scheme of municipalities developed by SALAR (2016) (see e.g. Malmberg and Andersson, 2021). SALAR's classification defines three main categories (A, B and C) and nine subcategories of municipalities (see Table 1), distinguishing larger cities and towns from smaller and more rural municipalities.

We created notes for all 290 municipalities and sorted them into each group. One note from each group was randomly drawn, constituting our selection. We wanted to ensure a high level of variation in terms of population in the

Table 1. Classification of municipalities

Group	Characteristics of municipalities	Examples
A	A1: Large cities, at least 200,000 inhabitants	Stockholm (population 975,500, area 214.9 km ²)
	A2: Commuting municipalities near large cities, more than 40% commuting	Vallentuna (population 34,119, area 358 km ²)
B	B3: Medium-sized towns, at least 50,000 inhabitants	Lund (population 125,941, area 439 km ²)
	B4: Commuting municipalities near medium-sized towns, more than 40% commuting	Aneby (population 6,905, area 553.9 km ²)
	B5: Commuting municipalities, less than 40% commuting to near medium-sized town	Lysekil (population 14,331, area 695.5 km ²)
C	C6: Small towns, at least 15,000 inhabitants	Värnamo (population 34,601, area 1,382.4 km ²)
	C7: Commuting municipalities with more than 30% commuting to small town	Vingåker (population 9,074, area 439.5 km ²)
	C8: Rural municipality, less than 15,000 inhabitants	Hagfors (population 11,558, area 2,000.1 km ²)
	C9: Rural municipality with visitor industry	Tanum (population 12,999, area 2350.4 km ²)

municipalities since the population base affects how much the municipality spends on care for older people. A comparison of how much each municipality in the final sample spent on health and social care of older people revealed that the municipalities in group A spent around 10,000 SEK per inhabitant whilst the municipalities in group C spent around 17,500 SEK per inhabitant (Council for the Promotion of Municipal Analyses, 2021). The nine municipalities approached were helpful and accommodating, sending all available documents. However, the municipality from group C6 did not send any documents despite repeated promises, nor was it possible to identify any published material on their website. The ongoing situation with the COVID-19 pandemic might have contributed to this, and apart from repeated friendly reminders, it seemed unethical to persist under the circumstances.

Via contacts with local officials (email and telephone) and based on the principle of public access to official documents,² excluding documents containing any form of personal data, the following documents were retrieved:

- Operational plan for the local committee responsible for the health and social care of older people.
- Local vision and strategy documents.
- Digitalisation plan/plan for e-health.
- Budget for the local committee responsible for the health and social care of older people.
- Local project plans including digital technology.
- Operational plan/strategic plan for the support of informal carers.

The collected documents were annual reports from 2018 to 2020 and other documents on the list that were valid during this specified timeframe to capture an image of the current state starting from the latest Swedish election. A total of 61 policy documents made up the ‘practical texts’ and the entry-points for analysis (see Table 2).

Data analysis

The discourse analysis was conducted using the ‘What’s the Problem Represented to Be’ (WPR) method as the analytical tool (Bacchi, 2009). The method with its framework of questions is considered apt at interrogating the problem representation in policy and can therefore be deemed well suited as an analytical tool for use in the often highly normative and complex social care domain (Daly and Westwood, 2018).

It is important to note that every policy constitutes a problematisation by nature. In this way, no concept or category can be accepted as value-free and uncontested. The term ‘problem’ is used in everyday speech to describe something that is difficult to deal with or to refer to a challenge that needs to be solved. In the post-structural approach, the word ‘problem’ is used in a different way. It refers to *the kind of change implied* in a particular policy proposal. ‘The problem’ – what is seen as in need of fixing – can be determined according to the actions proposed, *i.e.* the problem representation (Bacchi, 2009).

The analysis started with repeated close readings of the policy documents, looking for the topic of interest and contextual paragraphs connected to the topic. After the initial readings, all policy documents were uploaded to the NVivo software program (QSR International, 2021) for further organisation and analysis of text excerpts. We employed the following main questions from Bacchi’s (2009) framework:

- (1) What is the problem in local policy concerning health and social care for older people and informal carers represented to be?
- (2) What deep-seated presuppositions or assumptions underlie this representation of the problem? The task includes reflecting on the meaning of the categories, which are considered to be socially constructed.
- (3) What is left unproblematic in this problem representation? Where are the silences? The task is to question and challenge the ideas proposed in the policy text to open up alternative representations of the problem.
- (4) What discursive, subjectification and lived effects are produced by this representation of the ‘problem’? However, this is not a question of measuring ‘outcomes’.

The analysis continued with identifying text/s in the policies that described the problem, goals and solutions related to the care of older people. These statements were extracted and analysed regarding the underlying assumptions upon which these problematisations rested. The analysis then went on to identify text that described older people and informal carers. These categories based on age or social role have subjectification effects producing the policy subjects ‘older people’ and ‘informal carer’. In the same way, text describing health and welfare technology

Table 2. Local policy documents

Group	Operational plans/budgets	E-health strategy	Policy for supporting carers	Other policies and strategies	Total number
A1	<ul style="list-style-type: none"> • Budget for the local government committee responsible for the provision of health and social welfare services 2020 • Budget for the local government committee responsible for the provision of health and social welfare services 2019 • Budget for the local government committee responsible for the provision of health and social welfare services 2018 (N = 3) 	<ul style="list-style-type: none"> • Strategy for digitalisation, e-health 2018, committee responsible for the provision of health and social welfare services 	<ul style="list-style-type: none"> • Strategy for an informal carer perspective in the activities by the committee responsible for the provision of health and social care services 2018 	<ul style="list-style-type: none"> • Strategy for dementia care 2019 • Plan for the work with human rights 2019–2022 • Procedure for quality enhancement 2020 • Strategy for prevention of violence against older people in close relationships 2019 (N = 4) 	9
A2	<ul style="list-style-type: none"> • Operational plan with the budget for the local government committee responsible for care and labour market 2018–2021 • Operational plan with the budget for the local government committee responsible for care and labour market 2019 	<ul style="list-style-type: none"> • E-health strategy • Policy for digitalisation (N = 2) 		<ul style="list-style-type: none"> • Policy programme for older people plan 2019–2026 	7

	<ul style="list-style-type: none">Operational plan with the budget for the local government committee responsible for care and labour market 2020Operational plan with the budget, local government council 2020–2023 (N = 4)			
B3	<ul style="list-style-type: none">Operational plan with the budget for the local government committee responsible for the care of older people 2020–2022Annual accounts for the local government committee responsible for the care of older people 2019Targets and budget 2020 with an operational plan for 2021–2022 from the local government councilOperational plan with the budget for the local government committee responsible for the care of older people 2019–2021	<ul style="list-style-type: none">Policy for information technology development and digitalisation	<ul style="list-style-type: none">Updated work process for health promotion and information for older people 2019Annual report from the older people commissioner 2019Action plan for an older people-friendly municipality 2019 (N = 3)	9

(Continued)

Table 2. (Continued.)

Group	Operational plans/budgets	E-health strategy	Policy for supporting carers	Other policies and strategies	Total number
	<ul style="list-style-type: none"> Operational plan with the budget for the local government committee responsible for the care of older people 2018–2020 (N = 5) 				
B4	<ul style="list-style-type: none"> Operational plan for the local government committee responsible for health and social care 2020 Budget with an operational plan for the local government committee responsible for health and social care 2021–2022 (N = 2) 	<ul style="list-style-type: none"> E-health strategy 2020–2030 	<ul style="list-style-type: none"> Policy for supporting informal carers 2018 	<ul style="list-style-type: none"> Vision 2040 	5
B5	<ul style="list-style-type: none"> Budget and operational plan for the local government committee responsible for health and social care 2020 Annual account and quality report from the local government committee responsible for health and social care 2019 Annual account 2018 (N = 3) 	<ul style="list-style-type: none"> Digital agenda 2018 	<ul style="list-style-type: none"> Action plan for support of informal carers 	<ul style="list-style-type: none"> Patient safety report from the local government committee responsible for health and social care 2019 Vision 2040 Strategic plan for sustainable development priorities 2020–2023 (N = 3) 	8

C7	<ul style="list-style-type: none"> Operational plan for the local government committee responsible for health and social care 2016–2019 Strategic plan and budget 2020–2023 Activity report including informal carer support 2019 (N = 3) 	<ul style="list-style-type: none"> Policy for digitalisation 2019 	<ul style="list-style-type: none"> Public health plan 2020–2022 Sectorial programme including public health sector 2016–2019 (N = 2) 	6
C8	<ul style="list-style-type: none"> Budget 2019 with a view on 2020–2022 Budget and operational plan 2018 Budget and operational plan 2020 (N = 3) 	<ul style="list-style-type: none"> Policy document support for carers 2015 	<ul style="list-style-type: none"> Public health programme 2015 Policy for living together guarantee – the right to grow old together 2013 Action plan for care of older people 2019–2024 Policy for activity centre for people with dementia living at home 2017 (N = 4) 	8

(Continued)

Table 2. (Continued.)

Group	Operational plans/budgets	E-health strategy	Policy for supporting carers	Other policies and strategies	Total number
C9	<ul style="list-style-type: none"> • Budget 2018 and operational plan 2019–2022 • Budget 2019 and operational plan 2020–2021 • Operational plan with the budget for the local government committee responsible for health and social care 2020 • Operational plan appendix for the local government committee responsible for health and social care 2020 • Meeting minutes of health and social care board 2020 (N = 5) 	<ul style="list-style-type: none"> • E-health strategy (draft) 		<ul style="list-style-type: none"> • Final report from an e-health project • Vision and strategy document 2020 • Policy programme for health and social care 2017–2025 (N = 3) 	9
N	28	8	4	21	61

was extracted and examined to see how these concepts formed policy objects (Bacchi, 2009, Bacchi and Goodwin, 2016).

By challenging the ideas and proposals in the policies, it was possible to identify silences, meaning factors that were not mentioned in the text but that could nevertheless be argued to play a role for the issue in focus. Finally, through reflecting on the problematisations, proposals, and policy subjects and objects, it was possible to elaborate on effects that these policies might produce as part of the discourse (Bacchi, 2009, 2016). This process was not linear. Instead, the analytical questions were posed several times to the text and discussed in the research group. The policy documents were all written in Swedish. Quotes were translated into English.

Methodological considerations

Discourse analysis relies on interpretation, but using a framework, in this study the WPR method, allows for a systematic and rigorous manner of analysis constituent with epistemological and theoretical assumptions (Greckhamer and Cilesiz, 2014). Transparency is in this study obtained through describing the chosen method and process of analysis, providing a list of all included policies and providing supporting quotes throughout the Results section that allows the reader to assess the rigour of the knowledge claims.

We selected the policy documents through discussion with local government officers with extensive experience of working with local policy development. It is important to reflect on alternative samples; the study could have focused on policy documents from municipalities with different socio-economic profiles or municipalities from various regions mirroring geographical and cultural differences between northern and southern Sweden. Several municipalities are involved in regional collaborations for e-health and welfare technology (NBHWS, 2021b), and the inclusion of strategic documents at the regional level might have provided additional perspectives. However, we made our choice based on an attempt to provide an overview of local Swedish policy concerning health and social care for older people, where municipalities that differ concerning structural parameters, such as population (SALAR, 2016), were represented.

The context of the study is the Swedish secular individual culture. We do not argue that the findings are transferrable to health and social care in other countries or regions. Such a generalisation would ignore the cultural differences between different regions and societies. Instead, we believe that the findings can inspire comparisons and discussions about how the digital technology solution discourse is treated in local policy in other regions.

Findings and discussion

In this section, we present how the digital technology discourse was expressed in local policy, and how different representations of health, older people and informal carers were discursively constructed into political subjects and objects. We present the findings together with a discussion summarised under each representation respectively. However, the representations are interconnected in the way that in policy text/s describing the need for digital technology or describing health,

assumptions and presuppositions could be found about older people and *vice versa*. The analysis focusing on informal carers is somewhat more distinct, since informal carers were not really part of the digital solution discourse as expressed in policy, nor were they linked to the health of older people in any clear way.

The digital technology solution discourse in local policy

The well-known discourse that we refer to as the digital technology solution discourse, describing the necessary development of digital equipment and services to facilitate and support older people, was evident in the local policy. Several of the policies stated the necessity of digital technology to manage future needs, as exemplified in the following quotes:

For a good experience of the health and social care board's service, the development of digital services and welfare technology is central. (Budget 2020, A1, Hälsa- vård och omsorgsnämnden, Nämndsbudget för 2020)³
Using new technology is a must if we are to meet the future with the demographics we have in the municipality. (Operational Plan with Budget 2020, C9, Nämndsplan med budget 2020, Vård och omsorgsnämnden)

The assumption concerning the potential of technology in terms of the ability to promote independence, wellbeing, social inclusion and meaning seemed to be generally incorporated. The discussion in the policy documents was mainly about how to organise implementation so that neither staff nor users lagged behind in this implementation process. A critical analysis of the consequences of such implementation was not found. Instead, the policies repeatedly described the values that would be achieved using digital technology, and the words 'independence' and 'efficiency' re-occurred:

Using welfare technology such as mobile alarms, mobile applications and tablets, alarm mats, cameras and more, older people can be more involved, more independent and maintain a high quality of life. Technological development and digitalisation also provide opportunities for efficiency and the opportunity to manage resources. (Action Plan 2019, B3, Handlingsplan för äldrevänlig kommun 2019, 1 August 2019)

The digital technology solution discourse as expressed in local policy could be seen to correspond with what international research refers to as the 'the ageing and innovation discourse', positioning ageing as a problem and technology as a possible solution (Neven and Peine, 2017). This discourse uses a powerful rhetorical combination, stating that new technology will provide a triple-win for (a) older people, (b) society and (c) private investors and companies (Oudshoorn *et al.*, 2016). The digital solution discourse, on the other hand, as seen in the selected policy documents for this study, differed slightly from the ageing and innovation discourse. The producers of the technology (the tech companies) were not mentioned, and the third winner (as described in the ageing and innovation discourse) remained invisible throughout the policy documents. The focus in local policy was on identifying the 'best technology' and what outcomes could be

expected from its implementation. The winners in the local policy documents were stated to be older people, professional health-care workers and society via increased efficiency in terms of economic resources, thus leaving the role of private investors and companies a silence.

The discursive construction of health

In this section, we turned the focus to the concept of health and how it was constructed in policies concerning digital technology and health and social care for older people and their carers. In the municipalities, the strategic plans for digital technology are called e-health strategies, which signals that these plans are concerned with the concept of health. However, health proved to be rather hard to locate in these strategies. The following quote is derived from the e-health strategy of the municipality from group A2, motivating the need for an e-health strategy:

Meeting challenges linked to demographic development

An ageing population with increased needs. Fewer will help more people. To meet the ever-increasing demands of the new generation of pensioners. (e-Health Strategy, A2, Strategi för EHälsa)

In this policy, it is stated that ageing populations have increasing needs and demands. The pursuit of healthy lives and wellbeing for all at all ages, as stated in the third Sustainable Development Goal (United Nations, 2021) and the Swedish Health and Medical Services Act,⁴ does not seem to be a focus. Instead, this policy appears to be a strategy to manage future health and social care staff shortages. The policy explains the direction and principles for the work as follows:

Facilitate and provide safety and security for users

Our projects, activities and initiatives are ultimately aimed at facilitating the everyday lives of our care recipients, users and clients in various ways with regard to the individual's needs, integrity and will. (e-Health Strategy, A2, Strategi för EHälsa)

Even though the strategy is called a 'strategy for e-health', health is not in any way part of the intended outcome. Instead, it can be argued that the concept and role of health is a silence in this municipality. In municipality A1's strategy for digitalisation and e-health, there is a brief definition of health, but the strategy returns to the more traditional values of independence and safety and a needs-based approach. Health promotion is limited to fall prevention, surveillance, video calls and gaming. The e-health strategy from municipality B4 includes health, although not as a major heading. The technology is promoted to support activity, thereby increasing health and decreasing the need for care. The perspective is focused on the individual taking up activities, such as exercise and entertainment via technology, and thereby reducing the need for care. Health is thus treated as a means to an end rather than a goal *per se*:

Activity involves the performance of a task or action by an individual. These are the tasks that an individual can do (capacity) and actually does (implementation).

Many scientific studies show that physical, social and mental activity is important in terms of increased health and reduced need for care. Technical equipment such as tablets with apps for exercise, entertainment and cognitive aids and communication can support physical, social and mental activity and should be part of the preventive way of working. (e-Health Strategy 2020–2030, B4, Strategi för E-hälsa 2020–2030, 17 September 2019)

The activities in the example above seem to have a rather narrow focus, referring to physical activity, entertainment or social gatherings. Other activities, such as active participation in current debates, education, social responsibility or environmental issues, are not a focus for this group. In the introductory statement to the Social Services Act, public social services are stated to promote people's active participation in the life of the community. Nilsson *et al.* (2020) showed a gap in research and a lack of technology-mediated interventions for older people supporting their ability to contribute to society, such as volunteering, mentoring, or providing care or support.

The e-health policies talk about the need to protect older people from danger and explain how technology can provide safety and security, thus placing high expectations on these technologies:

Technical solutions can provide safety and security with regards to protecting users from danger, but looking at individual needs, technical solutions such as therapy robots or remote supervision and distance communication can also increase wellbeing and reduce anxiety. (e-Health Strategy 2020–2030, B4, Strategi för E-hälsa 2020–2030, 17 September 2019)

The examples provided as the policy text continues are sensors for detecting falls or safety alarms; however, provided that the hazard in many cases is a traumatic fall, none of these technologies actually prevent the fall from happening in the first place. Nevertheless, the technology is stated to protect the users from danger. No potential limitations in these technologies' ability to be an integral part of the care and promote health and wellbeing are highlighted.

In the documents' named strategies for digitalisation, there is no focus on health or digital technology to support care for older people; however, one document emphasises the goal to increase quality in health and social care. In the more general policy documents concerning health and social care, in this case, the budget, it is stated that to face the increase in the number of older people, which implicitly increases care needs and thereby constitutes a cost, it is of strategic importance to influence and optimise all factors enabling a healthy and independent life:

To meet the increased number of older people, it is of great strategic importance to try to influence and optimise all the factors that affect the opportunities to live a healthy, independent life in later life in the municipality. (Annual Accounts 2019, B3, Årsbokslut 2019, Tjänsteskrivelse till äldrenämnden med 4 bilagor, 7 February 2020)

We argue that health is thought of as a tool to avoid a significant increase in the demand for care, rather than a value in its own right. Operational plans highlight the importance of health promotion. Health-promoting activities focus on the individual participating in social activities, engaging in physical activity and taking up a healthy diet. These are thought to increase people's quality of life, reduce suffering and prevent them from becoming an additional economic burden for society. It is unclear how this preventive work is to be executed; the policy only points to specific areas of focus for preventative measures. The policy explains good health using a statement from Antonovsky's (1987) sense of coherence model; however, this is not operationalised or developed, but instead, the text returns to the individual responsibility of adopting a healthy lifestyle, pointing especially to the lifestyle among the oldest old:

The experience of good health is not necessarily explained by the absence of illness but rather by the experience of a sense of coherence and meaning. However, it is clear, even in the near future, that a healthy lifestyle, such as diet, alcohol and physical activity, among the very oldest contributes to improved health and a longer life. (Action Plan for Care of Older People 2019–2024, C8, Äldreomsorgsplan för X kommun 2019–2024, 12 June 2019)

This individual focus in the local policy documents on lifestyle can give cause for concern. Bennett *et al.* (2021) stated that primary prevention strategies focusing on proximal factors, such as diet, have appeared to benefit only the most advantaged. Further, as an explanation, Bennett *et al.* (2021) suggested that the least advantaged may be less likely to adopt behaviours if they perceive their life expectancy as being limited.

The following example is from the same action plan highlighting gender equality and social equality. However, it relates only to how preconditions and expectations might differ according to one's socio-economic position:

Older people have different preconditions and expectations depending, among other things, on gender, ethnicity and socio-economic status, which means that the future's continued mission for safe and secure ageing is the opportunities for gender equality and equal opportunities. (Action Plan for Care of Older People 2019–2024, C8, Äldreomsorgsplan för X kommun 2019–2024, 12 June 2019)

Graham (2007) points to how the process of ageing in low socio-economic groups begins approximately 10 years earlier than that in high socio-economic groups, with men and women in disadvantaged circumstances ageing more quickly than their financially advantaged contemporaries. Chronic illnesses, such as heart disease and respiratory illness, increase in line with declining social class (Graham, 2007). Head *et al.* (2019) reported that men and women in Sweden with high social positions can expect 80–83 per cent of their life between the ages of 50–75 to be in good health, compared to 72–75 per cent for those in lower social positions. According to the Public Health Agency of Sweden (2020), people with no or little secondary education have higher mortality rates for coronary heart disease, cancer and suicide than people with a tertiary education level. In the overall sample, these

inequalities in health affecting older people and their carers are only briefly discussed in the policies of municipalities in group A, that is the most urban municipalities in the sample. The responsibility for health in old age appears to be placed on the older person him- or herself, something that becomes clear in the following quote:

An important task is to facilitate the individual's own planning and responsibility for their ageing and/or based on their social environment and/or disability. (Policy Programme 2017–2025, C9, Översyn och revidering, Vård och omsorgsprogram 2017–2025)

The policy programme emphasises individual responsibility, which can be interpreted as an ideological stance. The policy continues:

Communicates information related to ageing, own disability, the importance of taking into account one's own health and life situation, safety and security. (Policy Programme 2017–2025, C9, Översyn och revidering, Vård och omsorgsprogram 2017–2025)

Litva and Eyles (1994) earlier described how being healthy becomes a moral code. Petersen and Lupton (1996) argued that in contemporary Western society, the pursuit of good health is both a right and an obligation. Being ill tends to be equated with not being a good citizen, and one may become an economic burden. Now, suppose that remaining healthy or, as stated in the policy text above, 'taking account of one's health' becomes an obligation. What consequences would that entail for an older person? For example, recent research shows that if a person with three chronic conditions hoped to follow all clinical guidelines, from self-care and prescribed medication to appointments, that person would need to spend up to 70 hours per month in health-related activities. The potential workload increases significantly with the increasing number of conditions (Buffel du Vaure *et al.*, 2016). This raises questions regarding from what or whose perspective these policies are written. In the following quote, preventive measures are seen as a way to control costs rather than decrease human suffering:

The possibility of postponing the disability of the older people will be of great importance in limiting the costs of tomorrow's care for older people. (Policy Programme for Older People Plan 2019–2026, A2, Program för äldreplan 2019–2026, 1 January 2019)

In a telecare service study, Lynch *et al.* (2018) discussed how the aspirations of service users are initially at the forefront of consideration but how thinking quickly turns to organisational issues, particularly cost savings. This tension between perspectives was also evident in the local policy texts we analysed. The intended outcomes for older people were consistently accompanied by intended outcomes for the public sector.

The discursive construction of older people

In the previous section looking at how health was constructed, it was possible to discern how the policy documents positioned older people as in need of care and protection but still responsible for their own health. In this section, we look closer into how older people are constructed and what subject positions are ascribed to them in the policy documents. Throughout all the policies, the demographic challenge forms a background for the digital technology solution discourse; see, for instance, this quote from an e-health strategy:

The background is that operations are facing a number of challenges, such as an ageing population, an increased proportion of users with chronic diseases who are in need of care for a longer period of time, increased costs and difficulties in finding employees with the right skills. (e-Health Strategy 2020–2030, B4, Strategi för E-hälsa 2020–2030, 17 September 2019)

Tornstam (2018) stated that the argument about the ageing population as a demographic bomb that will shortly explode continues to live, as it can support necessary reinforcements in health and social care. Alternatively, Tornstam (2018) stated that it was a reflection of society's views on the older population as a large and costly group.

In the policy documents, older people are written about as one homogenous group with ever-increasing needs for support, for example:

The following overall challenges have been identified in the work on the strategy: Meeting challenges related to demographic development. An ageing population with increased needs. Fewer will help more people. Meeting the ever-increasing demands of the new generation of pensioners. (e-Health Strategy, A2, Strategi för EHälsa)

Pulkki and Tynkkynen (2016) showed how the political debate placed all older people as potential care recipients. It is not a question of if, but when care is needed. This is also evident in the local policy where the text explicitly states which group poses a threat to the budget and who is also quite demanding, as shown in the following quote:

The municipality will have a big challenge balancing the budget because there are fewer who will support more people. X municipality has a demographic composition with many older people and they have increasing demands. (Operational Plan C9, Nämndsplan med budget, Vård- och omsorgsnämnden)

Tronto (2015: 39) wrote that 'The purpose of economic life is to support care, not the other way around.' In this vein, it appears from the above quote that it is the budget itself that appears to be in need of more care, rather than the older people.

In policy documents regarding the economy, preventive measures and health promotion for older people are stated to prevent the overuse of scarce resources. However, prevention is also presented as an unproblematic win-win for all:

Prevention and health promotion initiatives will continue to be central to, where possible, postponing care needs for the future and providing older people with opportunities for increased quality of life. (Annual Account 2019, B3, Årsbokslut 2019, Tjänsteskrivelse till äldrenämnden med 4 bilagor, 7 February 2020)

The quote brings to mind the concept of biopower. Biopower, Cruikshank (1999) explained, turns human needs, welfare and desires into governance. It seeks to unite the interest of the individual with the interest of society.

There seems to be a need for more independent citizens in the following statements, suggesting a current problem regarding 'dependent' and 'passive' older people. The policy text defines the needs and wishes of older people:

Digital development should be based on the needs of the inhabitants and contribute to increased independence, safety and security, accessibility and service. (Targets and Budget 2020, B3, Mål och budget 2020 med plan för 2021, 2022 S+L+MP, Kommunfullmäktige)

At the same time, users' quality of life is strengthened by supporting them, based on their individual ability, in the use of technical solutions aimed at independent and involved citizens of society. (e-Health Strategy 2020–2030, B4, Strategi för E-hälsa 2020–2030, 17 September 2019)

In general, older people are recognised not for who they are but for what they presumably lack. Weicht (2013) wrote about how a collective of younger people defines the situation for a collective of older people. In the above case, it seems that older people's quality of life needs to be and will be increased if they receive support to live up to an independent and involved citizen ideal. This could potentially reinforce stereotypes of older people as passive and dependent. The concept of independence is commonly an objective and a goal for introducing and using digital technology. Tornstam (in Odén *et al.*, 1993) wrote about a fundamental value theme in society that guides our way of perceiving both ourselves and the people surrounding us. Productivity, efficiency and independence are salutary words in a performance-oriented society. The ideal citizen is active and successful, with physical and mental strength. These ideals and norms risk causing contempt for weakness and unproductivity (Odén *et al.*, 1993). Hillcoat-Nallétamby (2014) earlier wrote that from the perspectives of policy makers, practitioners and older people, remaining independent becomes synonymous with remaining in one's own home. Critique of this approach points to a tendency to overromanticise the home, ignoring its potential as a place that creates social isolation, alienation and disempowerment (Hillcoat-Nallétamby, 2014). The risk that digital technology could contribute to social isolation or alienation is not highlighted within the analysed policy documents.

The concept of safety and security is another frequently used concept in the digital technology solution discourse:

People's safety in everyday life is one of the most important tasks for our municipality. Safety issues must be taken into account by everyone in the municipality

and characterise all services. (Budget and Operational Plan 2018, C8, Budget och verksamhetsplan för år 2018 [2019–2021])

In particular, digital technology artefacts, such as GPS alarms and webcams, are attributed names such as security camera or safety alarm, with the implicit intention to lead the associations to safety and security-creating properties for older people instead of surveillance. Safety and security conceptualised in these policies seem to be attributed several meanings, such as protection from harm and even danger and crime, a sense of trust and an absence of anxiety. They also appear as an historical rewriting of trust. Ideologically, social work has highlighted solidarity, equality and safety as a substitute for Christian ideals of mercy while aspiring to set boundaries and exercise control to enhance people's ability to fend for themselves (increasing independence) (Carlström, 2005).

In the policy documents, older people are semantically treated as their own group:

The activities are aimed at three target groups: 1. older people, 2. adults with physical disabilities, and 3. adults with somatic disease. (Budget 2020, A1, Hälsa- vård- och omsorgsnämnden, Nämndsbudget för 2020)

This quote distinguishes older people as something other than adults. While the text specifies adult individuals with some kind of need due to illness or loss of function, older people make up a group based solely on the fact that they are older. The implicit assumption is that they have needs and are separated from the category of adults. The term 'Project culture for older people', in one of the documents, also supports the statement that they are seen as 'the others', separated from the middle-age norm. Palmore (2000) argued that normal ageing is seen as a loss of functioning and abilities, thus not needing any further explanation. The word 'older' carries negative connotations. This corresponds with Nuessel (1982), who stated that language shapes reality and constructs the meaning of old age. Further, through the prescription of various tools to measure risks and ill-health, the image of the group of older people is created and maintained:

Senior alert is a national quality register for preventive care where every person in the national home healthcare quality register, 65 years or older, is registered with a risk assessment, underlying causes and measures in the areas of falls, malnutrition, pressure ulcers and oral health. (Procedure for Quality Enhancement 2020, A1, Ledningssystem för systematiskt kvalitetsarbete, Hälsa- vård- och omsorgsförvaltningen, 1 May 2020)

All users of home health care from the age of 65 are apparently considered as being at risk. This is seen not least in the name of the tool, Senior Alert. It appears to alert professional staff that they are dealing with an older person, and special attention is needed. Accounting practices constitute the very realities they supposedly count (Cruikshank, 1999); in this case, when all home health-care users of a certain age are registered with a risk assessment, the image of older people as vulnerable and at risk of becoming dependent might be reinforced. Lupton (1995) argued that the experience of being labelled 'at-risk' may be detrimental to people's health status, causing stigma associated with being a member of an at-risk group.

In these last quotes, digital technology was not part of the target for policy. However, we argue that the construction of older people, as shown in these quotes, provides further insights into the ideas underpinning the ‘digital technology solution’ discourse.

The discursive construction of informal carers

In the final section, we focus on the discursive construction of informal carers. We found that four municipalities had strategies for informal care support, and informal carers were included in other documents as well. Throughout the analysis of policy documents concerned with support for informal carers, digital technology was absent. Despite promoting digital technology as a necessary part of care, it was apparently not considered to carry the same potential in the policy documents concerning support for informal carers. The policies for supporting carers did not highlight any option for digital technology. The telephone is the most advanced technology referred to in these documents. A possible explanation is that even though there are digital technologies supporting carers, in a Swedish context, this can be perceived as problematic. The digital technology solution discourse is promoted to support older people’s independence, in accordance with the Social Services Act and the state-individualism treaty of the welfare state. Supporting the informal carer to provide care, as many of the information communication technologies for carer support aim to do, could be argued to create another form of dependence for the older person, namely dependence on informal care. The basic ideas underpinning the Swedish welfare state consider dependence on family to be undesirable (Berggren and Trägårdh, 2015).

The stated objectives of the support for informal carers, according to the policies, are to reduce their burden, reduce the risk of ill-health and support them in achieving a higher quality of life:

An important aspect of prevention is also via support of carers to prevent ill-health in today’s informal carers as they themselves get older. (Policy Programme for Older People Plan 2019–2026, A2, Program för äldreplan 2019–2026, 1 January 2019)

One way of interpreting the objectives is that informal carers, like older people, are seen as a homogenous risk group in need of interventions to avoid constituting a social or economic burden on society through ill-health. This corresponds to Twigg and Atkin’s (1994) models of carers, one of them being ‘carers as co-clients’; also:

Research shows that relatives providing extensive care to a person in need of help are a high-risk group for ill-health, such as cardiovascular diseases, mental ill-health and stress disorders. (Strategy for an Informal Carer Perspective, 2018, A1, Strategi för ett anhörigperspektiv i hälsa-, vård- och omsorgsnämndens verksamheter, 27 September 2018)

The category of informal carers is constructed on the basis of the assumption that they need support to continue providing support for their kin. The group is generalised to have a lower quality of life and worse health:

Informal carers carry out a large part of the care, after which they need to be supported to reduce the physical and psychological burden that being a carer can entail. (Action Plan for Care of Older People 2019–2024, C8, Åldreomsorgsplan för X kommun 2019–2024, 12 June 2019)

In a recent study concerning informal care, declines in quality of life were not observable since the carers provided few hours of care or reported caring as not burdensome. However, for carers who provided care ≥ 50 hours weekly or who reported that care was often burdensome, quality of life was decreased (Sacco *et al.*, 2020). Despite these differences in informal caring experiences, the assumption is that informal care, by nature, entails strain and risks. This assumption and construction of carers as vulnerable hinders any problematisation of how structural factors might contribute to the burden. Furthermore, carer burden is a complex concept, and in fact, some carers gain much satisfaction from caring and have a relatively high subjective quality of life, particularly when they are able to ask for help from other family members/friends and are able to talk about their situation with others (Erlingsson *et al.*, 2012). When care in itself is considered a problematic factor causing ill-health, we would argue rather that it is a sign of care being undervalued in society.

The municipality from group B5 divides informal carers into groups based on the recipient of care. For example, whether individuals care for an older person or for a person with a mental illness. The problematisation surrounds the recipient of care, missing all other social structures, such as economic position or labour market position, that might affect the informal carer and potentially facilitate their life situation, as is the stated purpose of the policies. Already in the political debate preceding the legislation for supporting carers in 2009, individual explanatory models were dominant, emphasising how every situation is unique, to the detriment of models pointing to how the surrounding structures, such as gender-, class- or ethnicity-bound injustices, might produce unfair outcomes (Katzin, 2014).

The quote ‘They shall take part in the care of their next-of-kin’ presents informal care as natural and self-evident, not requiring further problematisation. The paradox that informal care is voluntary while at the same time needed due to reduced public finances remains invisible in this statement. It is often assumed that all family members automatically want to care for their aged relative, but this is a highly individual situation. For example, in conflict-filled, strained or distant relationships, it is not at all automatic that a family member will wish to take on a caring role. Indeed, taking on a caring role in this situation, where no or little satisfaction is experienced, can lead to a situation of potential or actual abuse of the older person, and poor mental health and wellbeing for the carer (Nolan *et al.*, 1996). The focus is to a large extent still on the care recipient, and the informal carer is seen as one of many resources surrounding the care recipient. This is in line with Twigg and Atkin’s (1994) typology of ‘carers as resources’:

Within the framework of preventive health, working actively with the development of support for carers. Informal carers are an important resource and partner. (Policy Programme 2017–2025, C9, Översyn och revidering Vård och

omsorgsprogram 2017–2025)

As a carer, I feel safe and secure and well treated, and I feel that I am seen as a resource. (Policy Programme for Older People Plan 2019–2026, A2, Program för äldreplan 2019–2026, 1 January 2019)

In a recent scoping review by Nilsson *et al.* (2020), this was the role of carers in many of the intervention studies mediated by technology. Seeing carers as resources could potentially impede a more person-centred approach towards carers, allowing carers to formulate their own priorities and preferences both with regards to their caring situation and in their lives in general.

Overall, the policies tended to focus either on the older person or on the informal carer. A dyadic perspective, where services and interventions were created to maintain and preserve the relationship between the informal carer and care recipient and where the needs and preferences of both parties were considered, could not be found. Persson *et al.* (2020) stated that dyads living with illness may face the impending threat of the relationship transforming from a reciprocal to an asymmetrical relation if the relationship is reduced to a mere description of one's function for the other.

In other policies, informal carers are viewed not as resources but rather as a kind of counterpart or even a threat to the work environment for the staff:

Informal carers also have demands on how the customer should be taken care of, and the nurse assistant is often left alone in the situation with the carers. (Annual Account, 2019, B5, Socialnämndens årsredovisning och kvalitetsberättelse för 2019 med bilagor)

Jönson (2011) described a fight theme in the social care of older people, where older people and their carers are positioned in opposition to professionals/care systems. According to Twigg and Atkin (1994), this is the case of the 'superseded carer', where the staff come in and take over all the care of the older person without considering the needs and preferences of the carer, who (contrary to the above quote) is the one often left feeling helpless, because she or he may still want to contribute to the care of their older relative.

The construction of informal carers can further be seen in how the policy text assumes that informal carers fail to recognise and understand their own needs, which would implicitly underpin the need for further support:

Most informal carers prioritise the needs of the care recipient and may find it difficult to identify their own needs. Therefore, long-term support for carers and help for carers to identify their own needs are needed. (Strategy for an Informal Carer Perspective, 2018, A1, Strategi för ett anhörigperspektiv i hälsa-, vård- och omsorgsnämndens verksamheter, 27 September 2018)

'The assumption that people do not know their own best interests is politically suspect' (Cruikshank, 1999: p. 86). The construction of carers as being unaware of their own needs might contradict a person-centred approach (for an explanation of the person-centred care concept, see e.g. Gyllensten *et al.*, 2020) if the point of

departure is that professionals know more about the carer than the carers know about themselves and their personal caring situation.

Except in municipality A1, informal care is not discussed in relation to socio-economic position in any way. This is worth noting since chronic illness and disability affect people in lower socio-economic positions at an earlier age than they affect people in higher positions (Graham, 2007; Head *et al.*, 2019), implying that there are more informal carers taking on care-giving responsibilities from a younger age in socio-economically disadvantaged groups. Using the concept of differential vulnerability, meaning that the effects of a given risk factor are likely to be stronger in groups with lower socio-economic positions (Diderichsen *et al.*, 2012), it is possible to assume that being an informal carer might have a more detrimental effect with subsequent worse health outcomes for people from disadvantaged groups. However, any form of inequality affecting informal carers remains a silence in the policy documents.

Concluding discussion

We set out to interrogate critically the digital technology solution discourse in local Swedish health and social care policy. We primarily focused on the discursive constructions of older people and their informal carers and how the concept of health was constructed within this discourse, as expressed in these policies. The analysis revealed that health is not a leading concept in the discourse. Health is in some policies connected to an idea of activity, but the activity supported by technology is mainly limited to recreation. There is a focus on the need for a healthy lifestyle, and in some parts, it can be interpreted that older people have an obligation to remain as healthy as possible. Informal carers are constructed as being at risk and are seen as one of many resources in the older person's environment. Previous research shows that health inequalities persist (or even increase) when digital technologies are employed (*see e.g.* Davies *et al.*, 2021). Even though in this study, policies from more urban municipalities highlight the situation, they in no way develop arguments about whether and how care mediated by digital technology might affect these inequalities. Instead, the responsibility for health tends to rest solely with the older individuals themselves.

Based on these findings we argue that the digital technology solution discourse has the effect of changing how we conceptualise care of older people, turning the focus to assistance for the individual. Maibaum *et al.* (2021) stated that the expectation to fix demographic change by focusing on technology, in their case, care robots, creates an economic-instrumental interpretation of care.

In the same way, the conceptualisation of health changes when it is reduced to activities or behaviours following a healthy lifestyle. Katz (2000) wrote about how activity has become a panacea for the political woes of the declining welfare state in the management of so-called 'risky populations'. The political demand for solutions might be in the way of critical reflection and the failure to see weaknesses may lead to policy strategies that have unrealistic beliefs in the impact of the technology.

The digital solution discourse, as expressed in the local policies, does not emphasise an increased reliance on family, even though this has been the trend since the 1990s (Ulmanen and Szebehely, 2015; Swedish Family Care Competence Centre, *forthcoming*). Based on our analysis, we suggest that while policy is aware of the

retrenchment of the welfare state, preventive measures (by the older persons themselves) and technology are the answer to the question of who will provide care in this discourse. Traditionally, when discussing caring responsibilities, one speaks of the state, the market or the family, but neither the market nor the family is visible in the discourse. Arguably, the role of the market (not least in terms of producers of technology) and the role of informal care largely remain a silence. This is problematic because while informal care increases, the gap between policy and reality faced by older people and their carers widens.

Future policy would do well to consider older people as contributors to society, not least in terms of providers of care and support to family members/significant others. Policy should usefully recognise, empower and support those informal carers who wish to care for their relative/significant other and provide them with real choices, acknowledging the reality that informal care forms a key part of care for older people; yet, at the same time acknowledging that taking on a caring role is neither desirable nor appropriate for everyone (Nolan *et al.*, 1996; Eurocarers, 2017). In Sweden, with a devolved government, there is a possibility for the wider public, including older people, informal carers and their organisations, to be involved and influence policy at local level. Indeed, several municipalities in Sweden have a senior citizens' council with representatives from pensioners' organisations as a consultative assembly to the local government. While the digital solution discourse will most likely prevail, future research should usefully engage in how the use of welfare technology can be developed to help reduce health inequalities in old age and counteract ageism as part of the work towards more age-friendly societies.

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Ethical standards. All data were retrieved according to the principle of public access to official documents (Freedom of Press Act (1949:105), Chapter 2, Article 1 (see <https://www.riksdagen.se/globalassets/07.-dokument--lagar/tryckfrihetsforordning-2021.pdf>)).

Notes

1 Social Services Act (SFS 2001:453) (see https://ec.europa.eu/anti-trafficking/sites/antitrafficking/files/social_services_act_sweden_en_1.pdf).

- 2 Freedom of Press Act (1949:105), Chapter 2, Article 1 (see <https://www.riksdagen.se/globalassets/07.-dokument--lagar/tryckfrihetsforordning-eng-2021.pdf>).
- 3 A1 refers to the classification of municipalities (Table 1). A1 is the label for the subgroup 'Large cities, at least 200,000 inhabitants'. All quotes were translated by the authors. For a list of all quotes in the original language and the included policy documents, contact the corresponding author.
- 4 Swedish Health and Medical Services Act (SFS 2017:30) (see https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-201730_sfs-2017-30).

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