10 Getting Old and Keeping Going: The Motivation Technologies of Active Aging in Denmark

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Introduction

During a game of billiards at a Danish activity center for older people, Kåre raises his glass of schnapps and says jokingly: "Cheers! This is active aging." At the time of fieldwork, he was 80 years of age and one of the daily players of billiards at the activity center The Cordial Club. Placed in the suburbs of Copenhagen, The Cordial Club is a self-organized activity center housed in municipal dwellings with approximately 100 members, who use the club to play billiards, cards, darts, bingo and dice, as well as to socialize. A group of 30 to 40 core members run the club and attend three to four times a week. Many mainly play billiards, often six hours daily four days a week. To become a member one must be a retiree, and most members are over 70, with some members well into their 90s playing billiards for as long as the center is open. Both genders attend the center – with a small majority of men - but most activities are divided between the genders, so men mostly play billiards and women mostly play cards. Aske Juul Lassen conducted ethnographic fieldwork at the club as part of a broader study of how life in old age is organized and lived in Denmark.

Since the end of the 1990s, active aging has been a key agenda for policies regarding older people in Europe (Lassen and Moriera 2014, Walker 2009). Taking an active life in old age as the means to increase quality of life and postpone decline and dependency, active aging policies

facilitate different types of social, physical, mental and productive activities for older people. Although the interlocutors in this study did not use the term "active aging" until Aske told them about his research project, they all saw themselves as active individuals who wanted to keep going and engage in life. However, at the same time, interlocutors like Kåre distanced themselves from any exterior pressure to conduct life in a certain way. Kåre made sure to continuously point out that he swam 800 meters every morning, and, as such, acknowledged that he felt the need to stay physically active. In the next moment, however, Kåre would ward off any idea of a healthy old age as the ideal, as he felt that he had labored hard his entire life and had now earned the right to relax and live as he pleased. So when Aske told about active aging policies in the European Union (EU), these were seen as both an unwelcome intrusion into the members' life conduct, as well as an object of ridicule.

In many ways Kåre lives out the ideal of active aging. His daily swimming and his engagement in the local community through The Cordial Club tells a tale about an old man who has the zest to live an active life physically and socially. He has a wife twelve years younger than him, and this helps to keep him young, he says. They travel a lot, attend concerts, and go on long bicycle trips. But Kåre also lives what could be perceived as an unhealthy lifestyle in many ways. He suffers from type 2 diabetes and cardiovascular diseases, but these do not impede him from drinking a lot, and he does not wish to be bothered by any advice on diet or exercise from his GP or general practitioner. He talks about the focus on lifestyle and health as a "health regime," and says: "I don't want to be put under administration just because I have a couple of diseases. I would really wish they [the doctors] would just leave me alone." While doing gardening work some years ago, he suffered a thrombosis. He engaged in a rehabilitation program, but constantly argued with the doctors at the clinic, saying that they were intruding into his private affairs: "I have worked hard and always contributed. I wish they would just let me enjoy retirement without all the hassle."

Kåre regards his diseases as part and parcel of growing old, and does not see them as a reason to be concerned, nor as a reason to slow down in any way. He lives out the ideal of an active late life, but without prescribing to the health aspects of active aging. He feels a wish to "keep going," but sees this as his own wish that has nothing to do with active aging policies or any type of intervention into the way old age is lived. For him, "keeping going" is about taking an interest in life; it is about swimming, playing billiards, listening to jazz, traveling, socializing and drinking—it is not about health, exercise, diet or activity for the sake of activity itself. In this way, Kåre partially bends the premises of active aging and partially integrates them in his everyday life.

The Danish Welfare State and the Nordic Model

As a senior citizen in Denmark, Kåre's everyday life as well as his ongoing negotiations with the ideal of active aging are taking place in a particular societal structure. The Danish welfare state is often referred to as the Nordic Model, grouping the Scandinavian countries (Denmark, Norway, Sweden and Finland) together in a specific societal regime sharing similar characteristics such as a tax-financed public provision of a large number of social services: child care, basic and advanced education, hospital care and health services, and care for the elderly. Access to these basic social services is independent of income and employment status.

For the elderly population in particular, the Nordic Model is characterized by a universal pension system based on a combination of a national old age pension and occupational labor market pensions. Together with a broad scope of publicly provided and subsidized social services for the elderly—including activity centers, homecare, nursing homes and reduced prices on public transport—the pension schemes essentially ensure an acceptable income and life for the elderly population. Local authorities deliver the social services and forms of eldercare under a common legislative framework, ensuring a shared universal system while allowing for local differences.

Historically, the welfare state expanded in the twentieth century when there were "many to support few," in the sense that the working age population was increasing relative to the number of children and old. With the current demographic changes of population aging, the Nordic Model is seriously challenged and a number of reforms and initiatives have been launched, spanning from a gradual increase in the age of retirement from 65 today to 67 in 2022, to the focus on staying physically and mentally active—i.e., the ideal of active aging.

The focus on physical and mental activity challenges stereotypical categorizations of the old as passive and declining. The European welfare states reinforced these categorizations through the twentieth century, as old age was increasingly concurrent with public welfare services: "[The] association between older people and the welfare state produced both positive and negative outcomes for this group: Summarizing drastically, on the one hand, it raised their living standards substantially in most Western European countries, but on the other hand, it contributed to their social construction as dependent in economic terms and encouraged popular ageist stereotypes of old age as a period of both poverty and frailty" (Walker 2009, 77).

However, since the late 1990s, the concept of active aging has been at the heart of EU and WHO policy programs related to aging. Active aging can be regarded as a new ideal for old age, focusing on older people's possibilities for participation in socially and physically active pursuits. Active aging is based on a wide range of scientific results and aging theories, which, generally speaking, show the rejuvenating effects of various types of activity. This is a departure from the version of old age that was formed throughout the twentieth century, which equated old age with being dependent on the community and the welfare state. The new ideal for old age supports a reorganization of the social institutions associated with old age, such as old-age pensions and nursing homes. Furthermore, it requires a fundamental transformation in the expectations some parts of the population have regarding their old age. It is no longer a matter of reaping what one has

sown. Instead, continuing to "sow" and participate actively is a precondition for living a good life, throughout a person's entire lifetime.

As a supra-national institution, the European Union only indirectly organizes the way old age is lived in Denmark. As such, the national and municipal governments and administrations form the concrete old age policies in different ways. Active aging is translated differently in different European countries and in different Danish municipalities. But as an overall referential point, active aging steers the old age policies towards more participation and independency, and away from passive provision. Furthermore, in line with the ideal of participation in active aging, older people in Denmark increasingly participate in policy-building and local administration through organizations like Dane Age and Senior Citizens Councils, and through collaborations between municipalities and local organizations for the old.

In the following sections we show how active aging plays out in Denmark through concrete initiatives and current debates about rehabilitation, prevention and loneliness, exploring how policies and everyday lives are entangled, and how active aging ideals shape late life in new ways.

Fieldwork

The insights we present in this article are based on parts of Aske Juul Lassen's PhD thesis (Lassen 2014). The fieldwork consisted of participant observation at two activity centers for the elderly in the Copenhagen area—The Cordial Club and Wiedergården—as well as semi-structured interviews with a total of seventeen users at the centers. The two centers have very different user profiles. In The Cordial Club, the members mainly come from working class backgrounds, whereas those who frequent Wiedergården have more mixed backgrounds, while most have completed medium-length or longer higher education. The two centers have mixed gender profiles, with a small majority of men at The Cordial Club and a small majority of women at Wiedergården. Most

activities are predominantly used by one of the genders, although activities such as Ping Pong, darts and language clubs attract both genders equally. The interlocutors were aged between 58 and 92 with an average age of 76.

Both of the activity centers are housed in municipal dwellings but organized by the elderly attendees themselves. Thus, the elderly people themselves take the initiative to organize the various activities and manage the daily running of the centers. The municipality calls the people who lead the activities volunteers, but the volunteers distance themselves from this label, since the line between organizers and users at the centers is blurred. Some people are responsible for activities, others prepare lunch, others fetch newspapers, others organize parties, and the frailest are allowed to simply participate in the activities. Wiedergården has a manager and canteen staff employed by the municipality, but otherwise the elderly people themselves are responsible for running the centers. Although they represent a broad socio-economic spectrum, the members of both centers are all elderly people for whom an activity center is a central part of their social life, and who all, to a certain extent, engage in their communities through these centers, and who believe that it is important to remain active in later life. In spite of their different approaches to active aging, it seems that part of the ideal of the new European good old age—the imperative to stay active—has gained a foothold across the board.

The Motivation Technologies of Active Aging

Active aging policy suggests activity as the solution to problems associated with old age such as dependence and decline. At the same time, this solution implies that the problems of old age stem from the inactive lifestyles and everyday life behaviors of old people. If older people would only become more active, the problems of old age could be solved for both the individual and society. This leads to different types of interventions in the lifestyle of old people. We focus on

Danish rehabilitation (regaining ability after decline or disease) and prevention (proactive action to postpone decline or disease) programs and legislation, and show how these intervene in the everyday lives of our interlocutors. Both rehabilitation and prevention predates active aging as health promotion methods, but in recent years these programs have been incorporated in the transformation of old age occurring with active aging. The ways rehabilitation and prevention aims at promoting health through activity and individual responsibility for the aging process seems a perfect fit for active aging. We suggest that this is due to the way active aging, rehabilitation and prevention all emphasize the importance of individual motivation for the aging process and healthy life conduct.

Rehabilitation and prevention can be seen as motivation technologies (Otto 2013). They attempt to change everyday life behavior by stimulating inner motivation, with focal points such as continuance of functional capacity and recommencement of activities of daily living after periods of functional decline. This stimulation is for example created through the nationwide evidence based 'motivational conversations', which "aim to help a person to become clarified regarding his/her values and lifestyle, in order to create an inner motivation to change a specific behavior or lifestyle" (The National Board of Social Services 2013, 20-21, author's translation). Moreover, the Danish health authorities attempt to support and engender this motivation through health promotion, home healthcare visits, and patient schools, which place the responsibility of health on the individual, and position the inner motivation to stay healthy and active as key for behavioral change. As we will describe in the following sections, this motivation is not always easily found, nor is it necessarily inner. When interventions in the lifestyles of old people attempt to transform their behavior in order to integrate activity into their everyday lives, the elderly people both adapt to and resist the expectations associated with active aging; They both buy in on their individual responsibility for their aging process as well as resist any pressure towards behavioral change; they express the

individual and societal importance of leading a healthy life as well as refuse any interference with their well-earned golden years. As such, they relate in paradoxical ways to active aging and the inner motivation it both engenders and relies on.

Rehabilitation programs and dependence

One of the ideals of active aging is elderly people's independence, understood within Danish policy as being both independent of welfare institutions and of assistance from others. Thus, dependency might mean receiving home care, being completely immobile, or being dependent on the help of one's spouse to get out of bed or clean the house. As such, active aging departs from the concept of dependency, which has been closely associated with old age in Europe throughout the twentieth century. British gerontologist Peter Townsend describes how elderly people's dependency is in important part structural and socially constructed and depends on the changes to the ways in which work and the life course are organized, in particular the proliferation of a compulsory retirement age (1981). This theory of structured dependency was eventually used to put active aging on the agenda in the European Union (European Commission 1999). The hypothesis behind the active aging agenda seems to be that if the structural framework is changed, the dependency that accompanies old age can also be fundamentally changed.

This focus on independence problematizes the everyday lives of individuals who are dependent on other people's help. This can be illustrated by the amendment regarding rehabilitation in the Danish law on social services, § 83 piece 3, from January 2015, which states that "prior to the assessment of the need for help [homecare and/or assistive technology] (...) the local council must assess whether a tender regarding § 83a would improve the person's functional capacity and thus reduce the need for help" (Folketinget 2014, 1, author's translation). This requires the citizen with rehabilitation potential to complete a rehabilitation program before a visitation to homecare can be

given. Rehabilitation is usually used as a term for a program that a person undergoes after an accident or a drop in functional capacity. Rehabilitation programs focus not only on physical activity, but more holistically on the citizen's everyday life, social relations and mental state, encouraging the citizen to participate in establishing goals for rehabilitation. The aim is usually to regain the skills to handle activities of daily living, and sometimes this can be obtained through the use of aids—such as devices that enable the older person to put on support stockings in the morning and take them off at night by him or herself—thereby freeing the citizen from waiting for homecare personnel to arrive and saving public resources.

When the national parliament debated the amendment in 2014, one of the central points was whether it should be permitted for an elderly individual to refuse rehabilitation and still retain the right to homecare. Eventually it was added to the law that the older person cannot be refused help by the municipality solely with reference to the recipients inability to complete the rehabilitation process, but the biggest national organization for older people, DaneAge, has questioned whether this addition is sufficiently clear. Through rehabilitation, elderly individuals are expected to find their own internal motivation to be rehabilitated. Professionals should aim to "elicit the citizen's motivation" (The National Board of Social Services 2014, 7), but it is a difficult space to navigate when they encounter those who are unable to find the motivation, and in whom it cannot be elicited. As such, the legitimacy of the dependence of old people is problematized and turned in to a question of motivation. In this regard, rehabilitation is a motivation technology that aims to internalize the need for activity and healthy behavior, thereby postponing or avoiding dependence.

In general, participants in the activity centers were afraid of being dependent on someone else's help, and in this way, the ideal of independence and autonomy permeated their everyday lives. Several of the interlocutors had noticed how they were expected to fight for their independence as part of the rehabilitation process. They described how much their independence

means to them, but also that they do not want to be "disempowered" or "placed under administration" just because they suffer from a few illnesses. When their everyday lives are problematized, and their motivation to fight for their mobility is brought into question, they react with defiance and a resistance against what several call the "health regime."

Kåre displayed this kind of resistance when he, following a blood clot, was referred to a rehabilitation program. He felt that the staff interfered too much, and he refused to take his blood-thinning medication, because he believed that it gave him too many bruises, and because he felt just fine. When the doctor tried to get him to take his medicine, he became angry. As we described in the introduction, he did not want to be put "under administration" because of some diseases.

During his rehabilitation program, Kåre often argued with his nurses, because they wanted him to drink cordial instead of beer, and would not let him ride his stationary bike with as much resistance as he himself would like:

> If they had just asked, they would have discovered that I was quickly up and swimming 1000 meters again after the operation. Although I was two minutes slower than before the operation. But they only focused on the cycling. When a doctor finally asked me, it turned out to be bloody unnecessary for me to go all the way over to Bispebjerg [the hospital]. The way they treat an old man is completely hopeless, of course. I have always worked hard and contributed. I wish they could just let me enjoy my retirement years without all the hassle.

Kåre felt that the doctors questioned his motivation to regain his heart function, and that his beer drinking was problematized. More than just a potential dependency was problematized—at that stage, Kåre had not yet received home care—his beer drinking and even his preferred exercise habits were also questioned. The goal was a particular form of independence: Independence from care, but not an independent or autonomous approach to the rehabilitation process.

This ambivalent goal of independence is also evident in Daisy's story. She cared for her ill husband for a period of five years until his death twenty-five years ago. The constant heavy lifting of her husband and her work as a cleaning lady meant that Daisy suffers from joint pain, and she cites hard work as the cause of her osteoarthritis. Furthermore, she has type 2 diabetes and high blood pressure, and she was given an artificial wrist after a fall two years ago (see also Lassen 2015). Of her many diseases, her wrist and her arthritis worry her the most, because she fears that they may jeopardize her independence. She considers her elevated blood pressure and blood glucose levels to be primarily her doctor's problem. They are too difficult for her to deal with and do not seem to have any obvious impact on her independence, although the doctor often points out that it is dangerous to ignore these diseases. She evaluates the severity of her various diseases based on the immediate threat they represent with regards to her independence. Her fear of being dependent on home help leads to a unilateral concern about, and motivation to take care of, individual diseases, while she neglects other diseases, which have less noticeable (yet potentially lethal) consequences.

Thus, both Daisy and Kåre are motivated to stay independent, but they adapt this expectation to their everyday practices and desires. Kåre drinks beer, swims, and would like to be left alone by his doctors; Daisy takes care of her arthritis but not her diabetes. Both express motivation towards maintaining independence, but their stories show how motivation and independence are formed differently in everyday lives. It is not something inner, nor is it something determined by the authorities. Rather, it is formed through their life stories, habits and social relations.

Prevention programs and decline

One of the problems with old age addressed by active aging is the physical decline experienced by elderly people and the passive lifestyles that many seem to initiate once they have retired. In this regard, decline and passivity are problems that can be solved through the correct activities and the proper lifestyle choices. Central to this solution are prevention programs, which intervene in the lifestyle of healthy people, i.e., before they suffer from eventual conditions. This is rooted in the believe that risk factors such as smoking, alcohol consumption, unhealthy diet, and lack of exercise lead to poor health and quality of life. Instead of spending huge amounts on health care for people suffering from lifestyle diseases, prevention sets in beforehand, and is trusted to benefit both national expenditure and quality of life. This has led to municipal initiatives, which has inner motivation as a key emphasis. Changing health behavior prior to onset of diseases requires motivated citizens who are able to understand the long-term consequences of their behavior and act accordingly. Initiatives include patient schools, motivational conversations with public employees, health campaigns focused on lifestyle and preventive home visits.

The Danish preventive home visits (PHVs) have previously been analysed by Lene Otto as an implementation of the active aging scheme (2013). Since 1998 it has been mandatory by law for Danish municipalities to offer a PHV yearly to all citizens aged 75 or older. The PHVs take place in the home of the citizen, as a dialogue between the citizen and a health professional, aiming to improve self-care and detect physical, functional and mental problems in the early stages. As Otto states, the PHV's main objective when they were introduced in the 1990s was to prevent functional decline, but today they seem to have taken on a broader perspective, placing physical activity, diet, and social participation as focal points of discussion. The goal is to empower the citizen to look for the potential to self-care. The PHV provides the citizen with a language and an understanding of their aging bodies, enabling a space where their functional capacity can be negotiated. While this

might help to improve quality of life, it also increases the individual responsibility for self-care (Otto 2013). Where rehabilitation programs set in after decline and dependence, prevention programs intervene prior to decline and dependence and do not accept these as a consequence of old age.

However, many center members subscribe to a different understanding of the correlation between old age and decline, and point out that decline inevitably accompanies old age. For example, 73-year-old Kisser says, "Of course, it is part of getting old." Several of the interlocutors have a number of chronic diseases, which require treatment, as is the norm for their age group. Thus, there seems to be a significant discrepancy between elderly people's perception of decline as something inevitable, and the way it is articulated in active aging policies. In Danish active aging policy, decline becomes a problem rooted in an unhealthy lifestyle and the individuals' lack of motivation. Yet in the interlocutors' everyday lives, decline is ever present, as they notice that they are capable of doing fewer and fewer activities with age despite their often very active lives. The interlocutors Valter and Kisser had stopped cycling together, and Kisser had been forced to give up her part-time job selling sandwiches and sodas to the local choir, because she experienced breathing difficulties. She explained that "I almost couldn't drag myself home anymore, and I needed to just stop right away, but what will be next?" She feared her decline would become a self-perpetuating problem, as she could participate in less and less activities.

The imperative to stay active in order to avoid an intensification of their physical decline seems to be an integral part of the interlocutors' perception of the aging process. However, at the same time, they experience decline as an inevitable aspect of growing older, and passivity as a consequence of decline. Like dependence and decline, active aging discourse envisions passivity as a problem of lack of inner motivation, whereas the example with Kisser shows how she dreads the

way decline and passivity enhance each other, and that this enhancement is inscribed into the ageing process.

The activity centers in Denmark must be seen in the light of this entanglement between passivity, decline and dependence. Activity centers are often a part of nursing homes in Denmark, where older people – usually with mild impairments - from the municipality can attend a range of activities during the day for free, in order to keep going despite beginning dependence. In the last decades more and more private initiatives – usually supported by the local municipality –attracts older persons with other activity requirements who do not wish to frequent the premises of nursing homes. The Cordial Club and Wiedergården are examples of such initiatives that run almost solely on volunteer work. Most center members are active in their communities outside of the centers, and engage in e.g. volunteer work, crafts and sports, and since Aske met the interlocutors at an activity center they were all active to some extent. But the activities that the interlocutors engaged in—such as billiards, bingo, and darts—often differed from the ones promoted through active aging programs, which tend to emphasize physical exercise and social work and volunteering for the community. All of the interlocutors stressed the importance of getting on with their day, and generally disapproved of their inactive acquaintances, but they also stressed that rest and relaxation are important parts of their everyday lives. They both adhere to the ideal of an active old age, as well as resist the idea that activities like running or doing volunteer work fit better with a good old age than billiards or forging. In fact, many interlocutors stressed billiards as an ideal old age activity, due to the way it allows for activity and passivity to intertwine when waiting between turns and chit-chatting between games (Lassen 2014b). The smooth rhythm of the game enables them to play for many hours daily, and thus, even though it is perceived as a primarily social activity, they are physically active during the entire day. But it is a kind of physical activity that is constituted by the passivity they are also emerged in during the game.

So, What about Loneliness?

As we have shown throughout the chapter, the Danish welfare state intervenes heavily in the lifestyle of aging citizens under the rubric of active aging. But in recent years, the focus on the lifestyle of citizens has broadened from the parameters of diet, physical activity, smoking, and drinking, to also include the mental health of its aging citizens. This is evident in the campaigns against loneliness launched by DaneAge, the Senior Citizens Councils, and many Danish municipalities, all in 2015, wherein initiatives such as volunteering, visiting friends, cafés for the "lonely old" at community centers, and discussion groups for newly retired males (regarded as especially at risk for becoming lonely) all aim at reducing loneliness in what has been labeled The People's Movement Against Loneliness. This coincides with numerous epidemiological studies that point to poor social relations as an important risk factor for the onset of disability (e.g. Lund et al. 2010).

In the realm of the Danish welfare state, loneliness in old age has been reinforced, one might argue, by the institutionalization and professionalization of care, which has removed care for the old from the family and community. Although loneliness is a significant problem for the elderly people who experience it, loneliness is not an automatic consequence of growing old. A recent study shows that in the older group, seven percent of men and ten percent of women are lonely (Danish Health and Medicine Authority 2014, 110-11). The loss of one's spouse or friends, one's children living in a different city, or limited mobility may bring about loneliness, but it is important that aloneness (voluntary) is not mistaking for loneliness (involuntary).

Many of the interlocutors in this study experienced some degree of loneliness. Many had lost contact with their old friends, and only a few lived close to their family. For example, Daisy felt that the weekends were a difficult time, because the activity center was closed and most of her social contact took place there. During the weekends, she sometimes went for walks alone in an

amusement park, but she no longer went to the cinema or the theater in the evening due to changed bus routes and her fear of being out after dark. Her friend's husband had fallen ill, and her friend spent all of her time looking after him, so they no longer saw each other during the weekends. She had a brother who lived close by, and he was her only sporadic weekend social contact. Other interlocutors had no friends left outside of the activity center, and the activity centers were often used to find a partner or a date. As such, the activity centers were a large part of many people's social life and, due to sick or deceased spouses and limited contact with friends and ex-colleagues, the centers were often the elderly people's opportunity to spend time with others.

At the same time, the active, social and engaged communities that active aging engenders do not seem to be the good old age for all. The good old age can also be experienced alone, or momentarily alone.. Some interlocutors explained how they sometimes need to take a break from all the togetherness they experience at the center and in their community. Kåre feels just fine spending his day listening to jazz records and staring out the window from his library in solitude. Sometimes. Valter needs his solitude at nights after a long day of chores in the center, where he is daily manager. He loves to see family and his ex-wife during weekends, but finds nights during the week to be "his own", where he cooks, reads, plays computer and watches television. In the same way, Iris would not do without her nights alone where she surfs the net and finally get some time alone after a day of working in her company and taking care of her demented husband. And Lisbeth constantly tries to keep her schedule as open as possible so she will not be overwhelmed by social company and have time to do impulsive activities.

As such, many interlocutors buy into the ideals of active aging, but life is not only social activity, exercise and engagement. The interlocutors also want to be left alone, and perceive time alone as quality time. Togetherness and activity are not constants. Activity and passivity constitute each other and so does loneliness and togetherness. Aloneness can be momentary, and aloneness

can be wanted. Constant engagements in other people may be an ideal for many younger people continually online engaging with peers and sharing narratives. But for many older persons, the constant engagement in active aging is experienced as youth-centric and as a disruption from their life stories. They want to participate and be active, but not necessarily in the ways expected by the local authorities.

This is not opposite to active aging, but something that policies of active aging must not forget in their eagerness to create the active and long old age. Loneliness complicates the message from active aging. By focusing on the active community, active aging risks creating a feeling of loneliness in people who were previously fine in their own company and it risks giving all passive or solitary situations a negative spin. Moreover, the focus on independence, which we have shown is central in active aging, also risks creating loneliness. Where old people in Denmark previously to a larger degree were dependent on homecare and healthcare, rehabilitation and prevention programs risk engendering motivated, lonely citizens who are able to take care of themselves in their own homes. Loneliness nuances the debate of active aging and questions how much the good old age can be designed by the Danish welfare state.

Conclusion: Active Aging in the Welfare State

The shifts in the discourse on old age and population composition challenge how old age was previously organized in Denmark. Through the twentieth century a range of public institutions, such as home-care, nursing homes, and public pensions, formed old age into a period of provision and care. At the turn of the millennium this was increasingly seen as a strategy that pacified older people, which was bad for both quality of life and public funds. Under the international policy framework of active aging, the Danish aging policies began to focus on independence and active participation in one's own health and community. This has fostered a very specific form of growing

old, wherein the institutions of old age have gradually been reformed. In the realm of the Danish welfare state, active aging policies target every aspect of the lifestyle of old people and are not just about physical activity or diet, but also about social activity and mental health.

In addition to fostering independence, active aging aims at eliminating passivity and loneliness. While this is a remarkable ambition, in its eagerness to stimulate constant engagements, relations and participation, active aging risks changing the perception of aloneness into something inherently negative. While some interlocutors experience loneliness, aloneness is often seen as valuable. They both buy into many of the ideas behind active aging, but also bend it and change it as they go.

This ambivalent attitude towards active aging is recurrent in our data. The old people it targets see many benefits from aging in active ways, but find Danish active aging policies to be too meticulous and far-reaching as they aim to intervene in every aspect of their daily lives. In current Danish politics it is very evident that the schism between care and independence is urgent. Older people form a crucial group of voters, and care and provision reforms challenge the way many Danes perceive old age in the welfare state. When the national budget for 2014 was negotiated, the central-left coalition fell apart due to one of the parties' insistence on elderly people's right to two weekly baths. This insistence coins the active aging dilemma in Denmark: What are the basic rights to care and provision in a welfare state, and how much self-care and self-provision can be expected from the increasingly larger group of people approaching retirement? While active aging provides the answer that independence and activity is good for all, it does not answer what happens to those who cannot live up to the expectations of an active and healthy old age, and who might envision other ways of aging well.

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