

Innovating eldercare

*Exploring older adults' peer-to-peer practices in the
outskirts of public care*

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*“Care, caring, carer. Burdened words, contested words.
And yet so common in everyday life, as if care was evident,
beyond particular expertise or knowledge.”
(Puig de la Bellacasa, 2017:1)*

Abstract

The focus of this thesis is everyday care between older adults and their peers who are not family. Public eldercare is also discussed. At first glance, these two issues may seem quite different. Nevertheless, trends in eldercare, including the entry of innovations, together with ageing policy and a strong belief in technology, has brought everyday care between older adults and their peers and public eldercare closer to each other. Thereby, providing new challenges for researchers and practitioners.

The aim of this thesis is to explore care between older adults and their peers and to provide both descriptive and conceptual understandings of this phenomenon. Furthermore, the aim is to reason about utilising this type of peer-based care through innovations involving public care.

The theoretical orientation of the thesis is influenced by the idea of ‘care practices’ and by practice theory, and thus a practice-oriented perspective on care is adopted. This perspective puts the routine everyday world at the centre of analysis and emphasises action rather than individuals, thereby enabling the consideration of things and materiality in care.

For the aims of this thesis, several types of empirical *data materials and methods* have been used. The data material includes 30 individual interviews with older adults, a survey study comprising the responses from 10 044 older adults and ethnographic observations of an innovation initiative aiming to utilise peer-to-peer based care. These materials have been analysed using constructivist grounded theory and mixed methods.

The findings demonstrate that care between older adults and their peers may involve a range of practices and activities. These activities could range from letting another person come knock on one’s door in the middle of the night to fetching the neighbour’s robotic lawnmower when outside its working area. This peer-based care could be characterized by reciprocity as well as being one-way-oriented. Two common forms of peer-based care activity among the participants were social activities and practical or instrumental help. The findings suggest that engagement in these two forms of care possibly links to a lower degree of social isolation among older adults. Additionally, these

activities were linked to both sex and age. The findings show that when an innovation involving public care aimed to co-produce peer-based care tensions emerged concerning the logic of this peer-based care and institutionalized logics. These tensions complicated the utilisation of peer-based. The findings also show that some older adults engaged in a variety of peer-based care during the midst of the COVID-19 pandemic in Sweden. Thereby both enabling others to maintain their daily routines and maintaining their own care routines in sometimes innovative ways. The findings from the four papers are integrated to form the concept of 'peer-to-peer care practices'. To cultivate peer-to-peer care practices through innovations involving public care, the findings suggest that there is a need to (1) take care as the starting point as opposed to the promises of technology, (2) consider who engages in peer-to-peer care practices, (3) consider the creative solutions that those who engage in peer-based care come up with, (4) refrain from assuming shared experiences among older adults, and (5) seek compromises not consensus between different logics.

Keywords

Informal care, older adults, innovation, care practice

List of papers

This thesis is based on the following studies, referred to in the text by their Roman numerals.

- I. Siira, E., Rolandsson, B., Wijk, H., Wolf, A. Beyond the definition of formal care: Informal care arrangements among older swedes who are not family. *Health and Social Care in the Community*, 2020; 28:633–641.
- II. Siira, E., Olaya-Contreras, P., Yndigegn, S., Wijk, H., Rolandsson, B., Wolf, A. Older adults' provision of informal care and support to their peers – A cornerstone of Swedish society: Demographic characteristics and experiences of social isolation. *Scandinavian Journal of Caring Sciences*, 2021; 00:1-14.
- III. Siira, E., Yndigegn, S., Rolandsson, B., Wijk, H., Wolf, A. Co-production of Peer-to-Peer Care Practices: The Case of a Social Innovation in Elderly Care. *Tecnoscienza: Italian Journal of Science & Technology Studies*, 2020; 11(2): 73-92.
- IV. Siira, E., Yndigegn, S., Wijk, H., Rolandsson, B., Larsson, L., Wolf, A. Engagement in care activities by adults 70 years and older during the COVID-19 pandemic in Sweden: Innovative maintenance and repair unnoticed? *Manuscript*.

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Göteborg, Februari 2022
Elin Sjöra

Preface

My journey with this thesis began in May 2017. At this point, I was admitted as a PhD student at the Institute of Health and Care Sciences for the research project ‘The Health Sharing Co-operative’. My role as a PhD student in this project was to study prerequisites and barriers for a peer-to-peer service where older adults (+65 years) who experienced involuntary loneliness would exchange health-promoting care services. The service was to be facilitated through a form of a digital sharing economy model, i.e. a marketplace where older adults could share and buy and/or sell services and the exchange between older adults was aimed to, among other things, decrease the experience of loneliness.

My first task as a PhD student was to write a project plan for my PhD studies and to conduct a literature review on existing research on this type of phenomenon. While I found a couple of research publications that concerned sharing economy models, older adults and care, I could not find any information on how these projects functioned after the research projects had ended (later I found out there is a term for this, ‘pilotism’). At this time, I also discovered literature that questioned the assumptions of older adults, ageing and care that guided previous research projects similar to the topic of my PhD project. This literature also questioned whether these innovation projects were developed with older adults’ best interest in mind and with consideration of existing practices.

My discoveries concerned me and caused me to question how I, at my best ability, could contribute knowledge regarding how to develop care service solutions for older adults. As a PhD student with a background in sociology, I felt that my job was to produce insights on the (social) organization of care that would promote the development of this type of service solution. I concluded that what was missing in many of the innovation projects was a lack of focus and interest in that which was to be utilised by these initiatives: older adults’ existing practices. They seemed to be neglected at the expense of developing new technology. Thus, I shifted the focus of my PhD-studies to study care between older adults and their peers in everyday life – that which was thought to be utilised in the preliminary project idea.

At the beginning of 2020, the Covid-19 pandemic hit Sweden. The pandemic has affected research all over the world including my PhD project.

It led me to study peer-based care between older adults under the circumstances of a societal crisis, which was not the initial plan. Taken together, this thesis does not stem from a straightforward journey, but when is doing a PhD really that smooth?

1. Introduction

I don't do much, but I keep an eye on my neighbour who is rather frail. I check that she takes her medicine, chat with her (from a distance these days) and contact her daughter, who lives quite far away when I think she looks too bad. It's not a big effort, but it means a lot to her that she can knock on my door in the middle of the night when her heart pounds a lot.' (Woman, 75–79 years old, living in a larger city, June 2020)

This thesis focuses on everyday care between older adults who are not family. I refer to them as 'peers'. Public eldercare is also discussed. At first glance, these two issues may seem quite different. Care between older adults and their likewise 'older' peers are part of older adults' informal everyday sphere that may have little to do with public eldercare. However, these are brought together through different forms of *innovations* that aim to develop new care services for older adults by drawing on older adults' informal networks. Swedish eldercare is not a static organisation but a 'changeable and multifaceted arena' that creates challenges for those who receive care as well as for practitioners and researchers (Harnett, 2010:18). This thesis deals with one challenge facing researchers and practitioners, namely, how to deal with the above-mentioned form of attempt to, through innovative measures, involve older adults and their peers in the provision of public care. In the subsequent sections, I will elaborate on contemporary trends in eldercare, including the entry of *innovations*, ageing policy, and finally, innovations aiming to utilise peer-based care between older adults through innovation and new technology¹.

¹ This thesis has several footnotes. I use the footnotes to make points, to give examples or to situate the text in relation to certain literature. Thus, you do not need to read the footnotes to understand the overall message of the text, but they may, for example, provide further reading.

Eldercare: a changeable arena

In short, public eldercare in Sweden is a municipal undertaking² that consists of institutionalised care and home care for adults aged 65 years or older. Since the 1950's the ideal has been to provide care in ordinary living environments, i.e. the older adult's home (Brodin, 2005; Szebehely, 1995). There is not enough room in this thesis to portray the historical development of eldercare in Sweden³, but what is important here is that its structure, and thereby also the distribution of eldercare, has changed over time:

The Swedish public elderly care grew strongly from the 1950s, and reached its highest level in the 1980s, before declining [...] (my translation of Johansson, Sundström and Malmberg, 2018:62)

Since the 1980s, there has been a shift towards a more restrictive distribution of eldercare services. This trend has been most apparent in home care, which today is one of the most common services among older adults receiving public eldercare (The National Board of Health and Welfare, 2021). While home care previously was characterised by help with chores, such as cleaning or washing, and encompassed social care, such as taking the older adult for a walk or socialising, it now encompasses care, health care and supervision of seriously ill older adults and to a large degree involves home nursing (Brodin, 2005; Wikström, 2005). Today, residential, and home-based eldercare mainly targets older adults with the greatest care needs and those who need medical attention (Szebehely & Meagher, 2018; Trydegård, 2003).

There is a great deal of research postulating that when public care, or certain contents of public care, is cut, this care is re-distributed to informal networks⁴. The 1980s can be viewed as an important time in Swedish eldercare regarding the division of responsibility for eldercare between the public and the informal spheres; since then, the care by family and non-cohabiting friends has increased (Brodin, 2005; Szebehely & Meagher, 2018; Ulmanen, 2015). Additionally, there is an increasingly strong expectation that

² Municipalities have the main responsibility for social care (SoL 2001:453) and health care regarding care for older persons (HSL 2017:30).

³ For an overview of the historical developments in eldercare see Brodin (2005), Szebehely (1995) and Johansson, Sundström, and Malmberg (2018)

⁴ See for example Szebehely (2005), Ulmanen (2015) or Sundström, Malmberg, and Johansson (2006)

older adults are to manage caring for themselves in their homes with help from relatives and friends⁵:

‘[...] the situation of changing expectations, in particular the requirement that older people maintain independence for as long as possible, is one that will resonate for many Western nations. Older people are increasingly expected to continue to live in their own homes, caring for themselves with assistance from their relatives, friends and available community services, even though their health and ability may have declined’. (Björnsdóttir, Ceci, & Purkis, 2015:71)

In the 1980s, a new perspective on older adults characterised by a belief in the older adults’ abilities to manage their life situations, was put forward in eldercare, and the focus on activating and liberating older adults’ resources emerged (Brodin, 2005; Szebehely, 1995). At this time, self-help was increasingly emphasised in eldercare. The principle of help to self-help takes older adults’ responsibility for maintaining their health as a starting point, aims to support older adults to do as much as they can for themselves and focuses on maintenance of ‘independence’ (Elmersjö, 2018; Szebehely, 1995).

In the 1990s, municipalities introduced new forms of management through objectives, sometimes referred to as New Public Management (NPM), drawing on market models that emphasised a split between those purchasing and those providing eldercare, as well as older adults’ free choice and responsibility. This development is described as a shift from viewing old age as an institutionalised period of life to the individualisation of old age – a process that increases the older adult’s responsibility concerning professional care (Vabø, 2005; Andersson & Kvist, 2015).

Taken together, today more eldercare is distributed to informal networks, including older adults’ family and friends, but also to the older adults who receive care, compared to the 1980s. Additionally, a greater responsibility is put on older adults who receive eldercare. These developments continue to guide many of the political measures forging today’s eldercare. The idea to push care onto the ordinary informal sphere in which older adults and their informal networks are active contributors to welfare production are constantly more emphasised (López-Gómez, Beneito-Montagut, & García-Santesmases, 2021; Power & Hall, 2018).

⁵ Similar ideas be found in policy reports and municipal care practices from Sweden where it is increasingly emphasized that care is to be moved to the older adults’ home and that the older adults is to take active participation in his/her care (Elmersjö, 2018, SOU 2018:39).

The entry of innovation in eldercare

A more recent trend in eldercare is the entry of *innovations* as a form of organizational development. Since the beginning of the 2000s a trend in Swedish eldercare, as well as in public care in general, has been the increased demand for innovation to develop current systems⁶. The increased focus on innovation in public care emerged from the financial crisis in the 1990s from which an increased belief in entrepreneurship spurred (Frankelius, 2014). In a governmental report from 2003, it was stated that “[...] the need for innovative processes is at least as great in the public sector as in the business sector” (my translation) (SOU 2003:90: 17). In another governmental report from the beginning of the 2000s, it was stated that the public services were to be operationalised with greater effectiveness and innovativeness and that new solutions were needed to meet societal changes in the public sector, especially in eldercare (Frankelius, 2014; SOU 2013:40).

The innovation trend in public care is coupled with an increase of time-limited projects as a form of organizational design (Åhlfledt, 2017; Jensen et al; 2013). Since the late 1990s, considerable economic resources⁷ have been dedicated to different forms of time-limited development projects in eldercare to enable development and innovation. These investments have resulted in an extensive number of projects in eldercare that are separated from regular daily operations. Such separation is often understood as a criterion for the success of innovations in public care (Åhlfledt, 2017; Andreasson et al, 2015; Wänell, 2016).

Innovation projects in public care are commonly done in collaboration between public care, universities, the business sector and citizens (Frankelius, 2014). Thus, innovation happens across organizational boundaries and involves different actors (Bekkers & Tummers, 2018). The involvement of persons receiving public care is a central issue for innovation in public care (The National Board of Health and Welfare, 2019). In recent years, the public sector in Scandinavian countries has explored how innovation projects involving older adults, the public sector and private business partners, can transform policy into meaningful change (Bekkers & Tummers, 2018; Lassen, 2019; Lassen, Bønnelycke, & Otto, 2015; Yndigegn, Malmborg, Foverskov,

⁶ For an overview of the timeline of the development of innovation in the public sector see Frankelius (2014).

⁷ i.e. 13 billion between 1996-2014 and 7,2 billion for 2015-2018. In relation to the municipals' total cost for eldercare these are not a large amounts, but in consideration to the amounts put into knowledge development and research in eldercare it is. Additionally, it is difficult to measure the effects of these investments for those receiving care (Wänell, 2016; Åhlfledt, 2017).

& Brandt, 2021). Such innovation projects involve developing new methods and new organisational structures for care as well as a shift in the boundaries between professionals' and patients' roles (Frennert, 2021; Frennert & Östlund, 2018; Sengers & Peine, 2021, Östlund, 2017).

In sum, innovation trends in eldercare together with the 'projectification' of the public sector (cf. Fred & Hall, 2017) and an emphasis on collaboration across organizational boundaries promotes a new form of delivery of eldercare. This new form of delivery of care, I argue, is not limited to involving older adults receiving care.

Ageing policy: the activation of older adults

The increased focus on innovations in the public sector is often coupled with ageing societies and portrayed as a solution to problems linked to an increased number of older adults (cf. WHO, 2020; SOU 2013:40). Ageing societies are not only an issue for the public eldercare organisation, but also for policy makers and governments that wish to prevent care needs and optimise care utilisation among older adults. In Sweden, ageing policy and eldercare are often equated in political debates (Brodin, 2005; Wilinska & Cedersund, 2011), but ageing policy does not exclusively target older adults who receive care.

Since the 1990s, the term 'active ageing' has been central to ageing policies by the European Union (EU) and the World Health Organization's (WHO). Active ageing policy focus on older adults' possibilities to actively engage in both social and physical activities. It is argued to 're-write' old age and to change the notion of how life in older age is to be lived. Based on this view, older adults' dependency is seen as a result of the institutionalisation of old age and the welfare benefits that older adults have received during the 20th century⁸. When active and independent, older adults are also believed to be able to provide social and economic benefits if participating in, for example, the "informal workforce", as put forward in WHO's action plan for healthy ageing in 2020 (WHO, 2020). Similarly, in 2021 the European Commission (2021:8) stated in a green paper on ageing that 'products and services for healthy and active ageing could improve the efficiency of health and social care systems'.

There is mixed evidence regarding whether older adults today have better health than previous generations and whether older adults live longer with

⁸ See Townsend (1981).

more ‘healthy years’ or more years with health problems, as well as how this affects care needs⁹. Fors (2013:1) suggest that ‘over time older adults today have gotten more health problems, but cope better with everyday life’ (my translation). This supposedly links to changes in living conditions during the last 50 years, which affects the need for and access to care in various ways¹⁰ (Johansson et al., 2018).

‘Active ageing’ has brought an increased emphasis on preventive measures in ageing policy¹¹. To prevent dependency following, for example, physical decline and loneliness, older adults should be physically active, adopt a healthy lifestyle and engage in social activities in their community (Lassen, 2014; Lassen & Jespersen, 2015), activities that are thought to be enabled through innovations (WHO, 2020). Consequently, through innovation ageing policy targets older adults’ everyday practices as a subject for political intervention (cf. Lassen & Jespersen, 2015). Thereby, innovations linked to eldercare delivery extends to older adults not receiving care.

Innovation projects: utilising informal care

The trend in innovations in public care mentioned above has been argued to promote a renewed interest in older adults and informal care (cf. López-Gómez et al., 2021). In Sweden, there have been previous attempts to utilise older adults’ informal care to support public eldercare. As an example, care between neighbours¹² (Jegermalm & Sundström, 2014). In this sense public and research interest in informal care is not new. What is new is the interest in utilising informal care surrounding older adults through innovations often involving new technology such as digital platforms.

One type of informal interaction that has been the focus of different innovation projects in Scandinavia is interactions between older adults and their peers – which is also the focus of this thesis. Innovation projects aiming to draw on peer-based interactions have sought to enhance supportive activities between older adults by technological means, such as digital

⁹ See (Fors, 2013; Kingston et al., 2017; Parker, Ahacic, & Thorslund, 2005; Santoni et al., 2015; Thorslund, Lennartsson, Parker, & Lundberg, 2004)

¹⁰ There are ideas that older adults today are living alone to a higher degree than before, that they live far away from their children, but this is disputed by research from Sweden (Bildtgård & Öberg, 2015; L. Johansson et al., 2018; Gerdt Sundström, 2019).

¹¹ Such trends can be seen also in a Swedish context where preventive care is central in the shift towards integrated care (‘nära vård’) (SOU 2020:19).

¹² Furthermore, there is a tradition of utilizing informal care by giving economical compensation to ‘caregivers’ to older adults of which a small number are non-family members (Sand, 2000).

platforms, to combat loneliness and promote independence among older adults¹³. Examples of such supportive activities are social activities, help with housekeeping or grocery shopping. These innovation projects involve collaboration between, for example, researchers, the business sector and older adults (see Åbo Akademi, 2020; Brandt, Mortensen, Malmborg, Binder, & Sokole, 2012; Mälardalens Högskola, 2022; Yndigegn, 2015). In such projects, older adults are both providers and receivers of care, a double role that is proposed to become more prominent following ageing populations (cf. Womack, Lilja, & Isaksson, 2017).

One challenge with many research initiatives that aim to create innovations that involve older adults' care contribution is that they disregard the ways older adults are already involved in care. Often due to a strong focus on developing new technologies or new ways of working (cf. López-Gómez et al., 2021). This challenge relates to a defining characteristic linked to ageing populations and innovations in contemporary times, namely the 'thinking and living toward the future' (Adams, Murphy, & Clarke, 2009:246). In this situation of anticipation, the future becomes a conceptual possibility and the present is disregarded and perceived as 'lacking' (López-Gómez et al., 2021; Suchman, Dányi, & Watts, 2007).

Innovations, which focus on 'the lack' of the present and prompts the response by new solutions fit well into this state of anticipation; they are thought to solve future problems of ageing populations by introducing new solutions in the present (Ehn, Nilsson, & Topgaard, 2014). From this perspective, the present everyday care practices in older adults' daily lives need to be 'fixed' by intervening in them so that they can be enhanced, and thereby prevent future disasters (Isaksson, Andersson, & Börjesson, 2020; López-Gómez et al., 2021; Suchman & Bishop, 2000). Thereby, the ways older adults (already) creatively engage in responding to their own and others' care needs are overlooked along with the care that does not 'fit' the scope of ageing policy and innovation initiatives¹⁴. Thus, little is known about the micro-care relevant to the context of ageing and innovation (Beneito-Montagut & Begueria, 2021).

Neglecting the practices in which innovations aim to be integrated is said to lead to the failure of many innovation projects (Jensen & Fersch, 2016; Peine & Neven, 2018). Several scholars have critiqued such an interventionist approach and proposed focusing on already existing care arrangements

¹³ There are also examples of such projects in other countries, for example Riche & Mackay (2010) and Li, Saini, Caine, & Connelly (2018).

¹⁴ See for example Bergschöld, Neven, & Peine, (2020); López Gómez, (2015); Peine et al (2021)

(Bergschöld et al., 2020; López-Gómez et al., 2021; Peine & Neven, 2018; Shaw, Hughes, Hinder, Carolan, & Greenhalgh, 2020).

In this thesis, I focus on care between older adults and their peers rather than on technology, which has been the focus of several studies (López Gómez, 2015). My aim is not to avoid innovation or technology; however, given the above-mentioned trends in elder care, ageing policy and interventions in older adults' everyday lives through innovations, it seems pressing to answer a call posed by several scholars to focus on older adults' practices and the essentiality of developing lasting policies and innovations for older adults (Damsholt & Jespersen, 2014; López-Gómez et al., 2021; Peine, Marshall, Martin, & Neven, 2021).

Aim and research questions

The aim of this thesis is to explore everyday care between older adults and their peers (i.e. other older adults who are not family), thereby providing both descriptive and conceptual understanding of this phenomenon. Furthermore, I aim to reason about the utilisation of this type of peer-based care through innovations involving public care. Thereby, I contribute to the understanding of this type of innovating, but by taking older adults' peer-based care practices as the starting point. The thesis comprises critical reasoning, but my approach has been constructive. That is, I have aimed to contribute with knowledge that can help develop care services for older adults. Four research questions, each addressed in one of the papers in this thesis, are posed:

1. How do older adults and their peers care for each other? How is mutuality part of these practices?
2. What types of informal care and support do older people provide to their peers? How are they associated with demographic characteristics and social isolation?
3. What tensions emerge within social innovations at the intersections between formal and informal care and how do older adults and their peers navigate opportunities to co-produce care in response to these tensions?
4. How do adults 70 years or older describe the everyday care they provided their peers during the COVID-19 pandemic in Sweden in terms of care activities? How did these descriptions reflect their engagement in the repair of their own and others everyday lives?

Outline of the thesis

In the next chapter, *'Perspectives on care between older adults and their peers'* I discuss three perspectives on older adults and care from which peer-based care among older adults can be understood. This chapter also provides a brief note on my perspective on care between older adults and their peers as 'practices'. In the third chapter, *'Theoretical perspectives on care, innovations, and older adults'*, I describe the theoretical perspectives adopted in this thesis. Here, I describe my understanding of care as practices and the theory I have used to think about practices. I also problematise ideas on innovations and the idea of 'older adults'. The fourth chapter, *'Methods and materials'*, portrays the methods and data materials used in the papers included in this thesis. I begin this chapter by describing the data materials and how they were collected, including the thesis' explorative approach. Thereafter, I discuss how the data materials were analysed. Thereafter I provide a brief note on how I have integrated the findings from the four papers for the purpose of this thesis. I conclude the fourth chapter by discussing ethical and methodological considerations. The fifth chapter, *'Findings'*, summarises the findings from the four papers. Here, I also present an integration of the findings from the four papers and establish the concept of 'peer-to-peer care practices'. In the sixth and final chapter of this thesis, *'Discussion and conclusions'*, I discuss the main findings from this thesis with an emphasis on utilisations of care between older adults and their peers through innovations involving public care. I end the final chapter by proposing directions for future research. After the final chapter of this thesis, I present a summary of the thesis in Swedish: *'Sammanfattning på Svenska'*.

2. Perspectives on care between older adults and their peers

In this thesis, I study care between older adults who are also ‘older’ and who are not family (I refer to them as peers and this care as peer-based care). Despite the rich literature on older adults and care, there is little research that explicitly studies and conceptualises the workings and organisation of care between older adults who are not family¹⁵. Nevertheless, three perspectives on care between older adults and non-family members common in the literature can inform an understanding of care between older adults and their peers: ‘*Care as part of specific non-family relationships*’, ‘*Care as an organised group interaction*’ and ‘*Care as part of civic engagement*’. In this chapter, I describe these three perspectives as well as my own perspective.

There are not necessarily clear boundaries between the three presented perspectives, but to distinguish different ways of viewing care, I have separated them. To portray their dominant analytical perspective of care, I have divided these perspectives in terms of a micro-, meso- and macro-perspective. Research in these perspectives may also take on other analytical perspectives.

While care is understood differently from these three perspectives, a common differentiation is that between formal and informal care. Formal care is commonly understood as paid and undertaken in a professional context, while informal care is unregulated and seldom paid for¹⁶. Care between older adults and their peers in everyday life is not necessarily directly linked to a professional domain. Rather, it occurs in an informal setting. Nevertheless, I am concerned with how it may be utilised through innovations involving public care. Therefore, the emphasis in this section is both on informal care and on the intersection between informal and formal care.

¹⁵ There is research on care that include non-family older adults as both receivers and providers of care (Barker, 2002; Womack et al., 2017) but it does not focus on this peer relation as a base for care.

¹⁶ This is a common differentiation across research fields and disciplines (Johansson, 2017; Pfau-Effinger & Rostgaard, 2011). It is not necessarily the content of the different types of care that separates them, but the relationship through which care occurs (Sand, 2005).

Care as part of specific non-family relationships: a micro perspective

There is a great deal of research that conceptualises care in terms of specific relationships and with a *micro-perspective*, focusing on interactions, often between two individuals. As an example, Weicht (2015) describes how specific relationships between individuals are the backbone of care and its functioning. From his view, such relationships are necessarily based on a dependency-relation, where one individual is more dependent than the other. One such relationship that has historically provided care to older adults is the family¹⁷. Research on family care often focuses on care as a (care provider's) reaction to older adults' dependency and as management of 'problems', such as illness and age decline of care receivers (Ceci, Symonds Brown, & Purkis, 2019). Care relationships between older adults and non-kin, such as friends and neighbours, has often been contrasted to family care in terms of obligation and dependency-relations. It has been argued to be characterised by reciprocity to a larger degree than family care and is described as heterogenous (Barker, 2002; Lapierre & Keating, 2013; Nocon & Pearson, 2000):

In their most generic form, nonkin caring relationships are naturally occurring and ubiquitous, built out of unremarkable acts of sharing and kindness between people, especially neighbours—acts such as watering plants or caring for pets during absences, sharing homemade edible items and handmade goods, dealing with mail and packages, occasionally picking up groceries, sharing meals or jointly undertaking other leisure activities, and ex-changing information about events or acquaintances'. (Barker, 2002:158)

When *specific relationships* are understood as the frame for care a boundary is often drawn between care by family, friends and neighbours on the one hand, and professional care relationships on the other (cf. Weicht, 2015). The former is often understood in terms of its 'informal quality', such as intimacy, as opposed to professional care which is assumed to lack such qualities. As an example, relationships between friends and neighbours are suggested to enable older adults to stay healthy and independent when residential care would otherwise have been considered (Nocon & Pearson, 2000; Svensson, 2006), and there have been attempts to utilise this care in the shape of, for

¹⁷ Most older adults in Sweden rely on family members to provide informal care (Jegermalm & Sundström, 2015; Jegermalm & Sundström, 2017; Sundström et al., 2018)

example, neighbour-to-neighbour programmes (Jegermalm & Sundström, 2014; Kelley-Gillespie, Wilby, & Farley, 2012). At the same time, research has called for caution when utilising care between friends and neighbours as a means for public care, arguing that it works because it is unregulated and that it risks being damaged if attempted to be regulated or artificially extracted or created (Barker, 2002; Grime, 2018; Nocon & Pearson, 2000).

If we were to understand care between older adults and their peers in everyday life from this perspective, it could be understood as a specific type of care relationship that involves care between older individuals and their friends, neighbours and other non-kin relationships, and it is to some degree characterised by dependency and reciprocity. It would also be considered a relationship with certain ‘informal qualities’ that cannot be artificially created.

Care as an organised group interaction: a meso perspective

A type of study of care that blurs the boundaries between care as a specific informal relationship and a form of civic engagement (which I elaborate on below) is the idea of care as a form of *self-help or mutual-aid group interaction*. This perspective, which can be argued to take on a meso level perspective in analysing care, relates to studies on mutual support or mutual aid in so-called peer support groups, mutual aid groups or self-help groups (Gidugu et al., 2015; Katz & Bender, 1976a; Solomon, 2004; Waters, Fink & White, 1976). Studies on these types of ‘care groups’ often focus on older adults suffering from health problems or on care in a health care context (Kelly, 2005), but there are also studies on older adults without such health issues (Korte, 1991; Wenger, 1993).

Both peer support and mutual aid is based on a reciprocal, symmetrical and voluntary basis between individuals who share similar experiences. It is understood as different from care by family members as well as from professional care in terms of its reciprocal and symmetrical nature. Additionally, it is understood as a type of non-paternalistic or non-authorial endeavour (Dennis, 2003; Kelly, 2005; Lee & AySoAn, 2005; Wenger, 1993).

These types of care groups can both be initiated by formal care services, thus functioning as a type of intervention in older adults’ lives (Gidugu et al., 2015; Kelly, 2005), and as self-managed groups not linked to formal care (Katz & Bender, 1976a). Katz and Bender (1976a) note that self-help groups can be in- or outward oriented based on whether the focus of the

group is on caring for its members or on a social goal. They describe self-help groups as follows:

'Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about the desired social and/or personal change'. (Katz and Bender (1976b:9))

Regarding care between older adults and their peers, inward groups could be, for example, a 'we-for-us' organisation, which is characterised by volunteer work and by self-help, such as senior citizens' groups (Jegermalm et al., 2020). Outward groups could be, for example, 'we-for-them' friends-services ('väntjänster') for and by older adults or pensioner organisations. For example, such services involve older adults paying visits to elder care centres (Jegermalm & Sundström, 2014).

A study on the role of volunteer organisations in supporting older adults with mental illness shows that the 'we-for-us' groups¹⁸ experienced little support from municipal services, while the 'we-for-them' groups were well-integrated with the municipal services and linked to the municipality by contract (Jegermalm et al., 2020). Thus, depending on their orientation, inward and outward groups can be more or less formalised and have different relations to public services.

From this perspective, care between older adults and their peers could be understood as a form of organised interactions in groups or organisations, meaning interactions characterised by either a 'we-for-us' inward orientation or by a 'we-for-them' outward orientation based on shared experiences or a shared aim. This care also differs from both family care and professional care. While such a group could be more or less formalised in relation to public care, it would still be a non-authorial and reciprocal form of interaction.

Care as part of civic engagement: a macro perspective

The issue of informal care among older adults gained notable interest in the 1980s-1990s, both in research on care as a form of the Nordic welfare state research and in social sciences following the feminist critique from the 1970s

¹⁸ The conceptualization of the two groups draws on Lundström & Svedberg (2003).

(von Essen, Jegermalm, Svedberg 2015; Pfau-Effinger & Rostgaard, 2011, Johansson, 1991). Nevertheless, in Sweden, the first population survey on the living conditions of older adults (67 years and older) including patterns for informal care provision was conducted in 1954 (von Essen et al., 2015; Johansson et al., 2018). Thus, there is a long tradition of – and a lot of research – in Sweden by survey studies on older adults’ informal activity.

Research that has utilised this type of survey tradition mostly focuses on informal care as part of *civic engagement*. In contrast to the two other perspectives mentioned, research with this perspective often analyses care on an aggregated macro level to discern patterns in populations. This perspective has shown, among other things, that different types of help and care among older adults are associated with sex and age (Jegermalm & Jeppsson Grassman, 2009).

These studies do not limit civic engagement to mutual aid or relationships with a certain ‘informal quality’. Rather, they focus on care as a form of civic engagement that includes both informal care for neighbours, friends and colleagues, sometimes referred to as ‘informal help’, and volunteering (Jegermalm & Jeppsson Grassman, 2009; Overgaard, Petrovski, & Hermansen, 2018). This research tradition has argued that these two types of civic engagements (informal care and volunteering) are connected, but that the boundaries between them are not well-understood (Jegermalm & Grassman, 2013; Overgaard et al., 2018).

From this perspective, research has focused on care by civil society as part of the relation between publicly provided welfare services and informal activities (Jegermalm & Sundström, 2017). While a traditional understanding of this relationship is that the two spheres substitute for or complement each other¹⁹, this line of research argues that the relationship between care in civil society and changes in the welfare state are more complex than that. Nevertheless, this care may also be a response to extensive care needs, which is linked to cuts in formal care:

‘[...] informal help is seen as comprising a wide range of activities – from helping neighbours with practical things on a mutual basis to heavy involvement as a helper for an elderly person with extensive help and care needs’. (Jegermalm & Jeppsson Grassman, 2009:685)

¹⁹ Commonly Nordic countries with a universal care regime are thought to have less informal caregiving activities in the informal sphere as these are ‘taken over’ by the public services. As compared to countries with less public care where the informal care is assumed to be more extensive. Nevertheless, this strand of research questions this assumption (see Jegermalm & Sundström, 2015).

Researchers have also argued that informal care plays a significant role in Sweden and that its independence from the state may be an important part of peoples' informal activities (Jegermalm & Jepsson Grassman, 2009; Jegermalm & Sundström, 2015).

This research shows that it is common among older adults in Sweden to engage in informal activities and that most adults in Sweden engage in 'lighter' types of informal care, such as giving rides or keeping an eye on another person. These activities may be 'light' but may also be of great importance to persons affected by them (Jegermalm & Jepsson Grassman, 2009; Sundström et al., 2018).

From this perspective, care between older adults and their peers in everyday life could be understood as a form of civic engagement involving 'lighter care', but it could also be a response to extensive care needs. This informal care would involve mutual care between neighbours, friends and colleagues and link to volunteering. In sum, care would be considered an expression of civic engagement. This engagement could be a response to cuts in public care services, but its independence from public care would be central. Additionally, this care would be linked to the panorama of informal care that plays a significant role in Sweden.

My perspective: a focus on practices

The presented perspectives portray three different ways by which care between older adults and their peers in everyday life can be understood: (1) as a specific type of care relationship between older adults and their friends, neighbours and other non-kin relationships from a micro level perspective; (2) as a form of organised groups or organisation interactions from a meso level perspective; and (3) as a form of civic engagement concerning 'lighter' help that relates to public services from a macro level perspective. While these perspectives have contributed to the understanding of care between older adults and their friends, neighbours and other non-family members as well as of older adults' engagement in such care, they have not so much focused on care between older adults and their peers – who are also 'older' – and how this care is provided. Additionally, these perspectives have not focused on how technology and innovations may play into care between older adults and their peers.

In this thesis, to explore everyday care between older adults and their peers and to develop the understanding of how this type of peer-based care can be utilised through innovations involving public care, I adopt *a practice perspective*

on care. A practice perspective emphasises practices rather than on individuals, and thereby it enables asking how care is provided while staying open to what it is and what may be involved in this care (Mol, Moser, & Pols, 2010). This perspective puts the routine everyday world at the centre of the analysis and considers everyday activities as the place where structural consequences on a macro-level reinforce and change over time (Orlikowski, 2015).

3. Theoretical perspectives on care, innovations and older adults

Care is a concept that is difficult to define. Thus, researchers sometimes define it more narrowly. In this thesis, I have done the opposite. I have aimed to open up the concept of care and to sensitise the idea of care between older adults and their peers. In this chapter, I present the theoretical underpinnings for approaching care between older adults and their peers as *practices*. That is, I discuss the idea of '*care practices*' and the two different orientations in *practice theory* that I have adopted to study care. I also present the theoretical perspective on innovations that I have used to reason about utilising peer-based care between older adults in innovations involving public care. Additionally, I discuss the concepts of *maintenance* and *repair* that I have used to understand 'innovativeness' in this peer-based care. I end the chapter with a brief note on the idea of 'older adults'.

Understanding care

As mentioned in the previous chapter, this thesis adopts a *practice perspective* on care. This perspective links to a body of ideas called '*practice theory*' that encompass a collection of theorists and theories with different ontological and epistemological standpoints, but that share the idea of, and interest in, practices. Additionally, these theorists view social life as composed of practices (Hui, Schatzki, & Shove, 2016; Schatzki, 2018). What has been even more central to this thesis is ideas on *the logic of care* and *care practices* presented by Mol (2008) and Mol et al. (2010). I have used these ideas presented as a lens to understand care as a practices.

This thesis is carried out within the academic context of Caring Science, a Nordic human-science oriented scientific tradition that was developed as an outlet from Nursing Science and that since the 1990s has had a significant influence on nursing education and healthcare-related research in the Scandinavian countries. The main focus of Caring Science is *care*, but much of the ontological, methodological and ethical grounds for understanding care have been formulated and developed in relation to either the *patient role* or to

nurses' professional role²⁰ (Arman, Ranheim, Rydenlund, Rytterstrom, & Rehnsfeldt, 2015; Rehnsfeldt & Arman, 2016). Entering my PhD studies at an institute characterised by this tradition, and with my background in Sociology, I grasped for ways to understand and articulate care that was not about patients or nurses' professional role but about (informal) care in everyday life. As there was little written on care between older adults and their peers in everyday life, I searched for a way to be explorative and open in my studies of this care.

At this point, I found the works on *the logic of care* by Mol (2008) and the work by Mol et al. (2010) on *care practices*. Mol et al (2010) emphasise the importance of the ways that care has been studied in the nursing tradition, but instead of demarcating their interest in care to the nursing profession, they emphasise care and whoever may be involved in it. Additionally, their definition of care is not limited to what is commonly understood as 'care' but prompts exploring all the daily activities that are related to care. They encourage the researcher to be open to *what* care is. Thereby, this perspective allowed for exploring care between older adults and their peers and to let this exploration inform theory instead of letting a more narrow theoretical definition of care inform practices (cf. Mol et al, 2011).

Care practices and their logics

Mol et al. (2010) describe care as a style of working that is attentive to, and seeks to ease, suffering and pain and when it fails, it attentively tries again. In short, they define care practices as: 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (Mol, Moser & Pols, 2010:7). This definition has been critiqued for being too broad²¹. I will therefore elaborate a bit on it and present my understanding of this definition.

First, care is *attentive* to suffering and pain and in the logic of care this attentiveness is 'good' (Mol et al., 2010). From my understanding, this means that care is sensitive to suffering and pain, it recognises it and it also holds such sensibility as a virtue. Meanwhile, 'suffering' and 'pain' are not fixed beforehand but emerge in a specific situation, such as care practices. Second, care involves *tinkering*. In a practical sense, tinkering can be understood as

²⁰ Caring science *also* encompass ideas that patients, professionals or informal care providers are shifting identities rather than stable roles. From this perspective, the study of care can be concerned with, e.g. how people during a lifetime support, help and care for each other (Eriksson, 2014); however, this type of research is lacking in relation to the more traditional perspective that focuses on 'the patient'.

²¹ See in Mauro Turrini's comment on their work in Mol et al (2011).

relating to ‘people willing to adapt their tools to a specific situation while adapting the situation to the tools, on and on’ (Mol et al., 2010: 15). In a more abstract sense, it relates to ‘being attentive, inventive, persistent and forgiving’ (Mol, 2008: 64). Third, care involves *tenacity*. It involves not giving up and calls for a combination of adaptability and perseverance (Mol, 2008:91). From my understanding, this is linked to the idea that while it is important to ‘do good’, we do not always know how ‘doing good’ will work out in practice; however, it is crucial to persist.

According to Mol (2008) and Mol et al. (2010), care has specificities and a logic. The logic of care has its own version of ‘the good’ as well as how to do it; the moral act is to engage in practical activities, not to make value judgements. Good care depends on specifications; there is no ‘one size fits all’ (Mol, 2008). The idea of care practices and the logic of care move us away from the idea of rationalist humans and universal principles for care and suggest another type of rationality and logic that points to that what is appropriate to do depends on the specific situation²².

Following the above-mentioned logic of care and its specificities, care practices need to be improved on their terms (Mol, 2008:84):

‘[...] if care practices are not carefully attended to, there is a risk that they will be eroded. If they are only talked about in terms that are not appropriate to their specificities, they will be submitted to rules and regulations that are alien to them. This threatens to take the heart out of care – and along with it not just its kindness but also its effectiveness, its tenacity and its strength’. (Mol et al, 2010:7).

Therefore, one must pay attention to the specificities of care and its logic if one wants to utilise care between older adults and their peers through innovations involving public care. This resonates in studies on initiatives aiming to organise care by the means of new technology, which show that neglecting certain dimensions of care risks overlooking the care potentially offered by the same technological solutions (Roberts & Mort, 2009; Shaw et al., 2020).

All four papers of this thesis are guided by the presented ideas on care practices and their logic – explicitly or implicitly. In Paper I, these ideas were coupled with *social practice theory* (Schatzki, 2012) to guide the analysis and conceptualisation of how older adults care for their peers. In paper III, the idea of care as practices, and more prominently the idea of the logic of care, were used together with a *posthuman practice theory* and a *sociomaterial framework*

²² The rationality and ethics of care has previously been studied and discussed by theorists such as Waerness (1984), Gilligan (1982) and Tronto (1993).

(Gherardi, 2017; Orlikowski & Scott, 2008) to analyse the constitution of peer-to-peer care in an innovation involving public care. Paper II does not explicitly involve these ideas, but the focus on activities, i.e. care as a form of actions, was influenced by this perspective. Finally, in Paper IV, I used these ideas together with theory on *maintenance* and *repair* (Gherardi, 2004; Henke, 1999) to analyse care among adults 70 years or older during the COVID-19 pandemic in Sweden.

Social practice theory and posthuman practice theory

I have used the above-mentioned ideas on the logic of care (Mol, 2008) and care practices (Mol et al, 2010) to understand care as practices but to understand the idea of practices I have also adopted two different perspectives on practices: *social practice theory* and *posthuman practice theory*. Together I use this theory to understand care between older adults and their peers as a *phenomenon* (centring what happens in practice as opposed to what is derived from theory), as a *perspective* to view care between older adults and their peers (articulating certain aspects of this phenomenon) and as a *philosophy* for understanding how the world is shaped (an ontological assumption that practices are constitutive of reality)(Orlikowski, 2015).

Practice theory, or theories of practice, which treat social life as being composed of practices, emerged in the social sciences from the 1970s-1980s by a first generation of practice theorists, such as sociologists Giddens (1984) and Bourdieu (1977). Since then, practice theory has come to denote a stream of thought in which practices are central. The study of practices is adopted across disciplines and addresses diverse issues, but a commonality is that they understand life as composed of ‘practices’ (Schatzki, 2018). A practice perspective focuses on activities and actions rather than on human individuals. In this sense, practice theory opposes individualism, that is, ideas that human action is rooted in human individuals and human individual properties²³. Additionally, it also counters the mind-body dualism that has dominated much philosophical thought in the modern era (Schatzki, 2018).

According to Hui et al. (2016), the second generation of practice theorists includes Schatzki (2002) and Gherardi (2006) whose writings I have used in this thesis. They respectively belong to the above-mentioned *social practice*

²³ It should be noted here that this idea also opposes social system and structuralist theories in which abstract systems or structures are central to social conduct (Schatzki, 2018).

theory and *posthuman practice theory*, which differ concerning the understanding of humans and materiality in practices and their separation or entanglement²⁴. What separates them is the issue of ‘whether materiality merely mediates human activities – as in human-centred theories – or is constitutive of practice, as in posthuman practice theories’ (cf. Gherardi, 2017).

This thesis finds itself at the crossroad of these two orientations. To analyse the organization and constitutions of care, I have drawn on them both. In Paper I, I used ideas on social practices by Schatzki (2012) to conceptualise the organisation of older adults’ care practices. In paper III, I adopted a posthuman perspective on care in line with Gherardi (2017), Gherardi and Rodeschini (2016) and Orlikowski and Scott (2008) to understand the sociomaterial constitution of care practices as part of a co-production initiative. Finally, Paper IV also adopts a practice theory perspective but focuses on *maintenance* and *repair* (Gherardi, 2004; Henke, 1999).

Nevertheless, while I consider the role of things in care practices, the emphasis is at large on humans, or more specifically older adults, rather than things or materiality. Also, because my focus is on older adults and their care practices, for the most part, I do not equate human and material agency.

Social practice theory

Social practice theory, as described by Schatzki (2012), can be considered an ‘element-based practice theory’ that understands practices as a set of elements, namely, *practical understanding*, *rules*, *teleoaffective structure* and *general understandings*. *Practical understanding*, put simply, involves knowing how to carry out desired actions. *Rules* are explicit directives or instructions. *Teleoaffective structures* imply the combinations of actions, emotions and moods a person carries out for a particular end. Finally, *general understandings* are abstract senses of, e.g. worth and value.

To understand particular practices, as in this case care between older adults and their peers, one needs to identify the actions and activities that compose such practices as well as the organisation of these actions (Schatzki, 2018). Practices are organised constellations (or ‘nexus’) of people’s *activities*, or doings and sayings. An activity belongs to a practice if it expresses one of the

²⁴ From my understanding, Mol et al. (2010) lean towards a posthumanist approach to understanding care practices. In their perspective, care is not solely a human-to-human activity that can be separated from things or technology. As an example, in their view, a coffee machine may give care too. Additionally, they, together with many of the contributors to the anthology ‘*Care in practice: On tinkering in clinics, homes and farms*’ in which the idea of ‘care practices’ is presented to come from science and technology studies (STS) – a field in the social sciences concerned with technology and materiality.

elements of a specific practice, but there is no exact number of activities to a practice. Instead, practices are open-ended.

Activities, according to Schatzki (2012), are indeterminate *events* that happen to people – they are not fixed prior to a person acting but are determined when they happen. In other words, people do not carry out activities, but activities come to be by peoples' actions (among other things). Activities are bound with material entities that 'hang together' and form an order or, *arrangement*. Finally, activities are distinct from 'mere occurrences', such as a thunderstorm, which is not organised.

From this perspective, *agency* emerges as decentred from the mind of subjects or individuals and instead from activities (Schatzki 2002: 240); however, humans do understand what they wish to do and do so intentionally (Schatzki, 2018). The act for the sake of things and because of things. Such 'things' may be in the past, present and future. While Schatzki (2002) emphasises the role of materiality in practices, he nevertheless privileges the role of humans and does not equate human and material agency²⁵.

Posthumanist practice theory

The posthuman practice theory presented by Gherardi (2017) is influenced by relational materialism. In this epistemology, the idea of performance and becoming are central. In focus are modes of ordering rather than ordered products, or as Gherardi (2017:39) puts it, 'an epistemology rather than an empirical phenomenon'. Instead of viewing practices as activities, Gherardi (2017) proposes a view of practices as a mode of ordering heterogenous elements as a form of performative accomplishment (Gherardi & Rodeschini, 2016:266)

From a posthuman practice perspective, practices are inherently *sociomaterial*. The term sociomateriality was introduced in organisation studies by, among others, Orlikowski and Scott (2008). From this perspective, there are no clear boundaries or separation between the social and the technological or between human and material. Rather, relations and boundaries are enacted in practice (Orlikowski & Scott, 2008). They are 'constituted as relation effects performed in a texture of situated practices' (Gherardi, 2017:40). Thus, a posthuman perspective foregrounds the *constitution of practices*.

In Paper III, a posthuman practice perspective was adopted together with the idea of *affordances* (Gibson, 1977) to analyse the sociomaterial constitution

²⁵ For a thorough discussion on this see Lammi (2018).

of care practices. I viewed affordances as outcomes of sociomaterial assemblage shaped by and shaping complex interactions between humans and things (Orlikowski & Scott, 2008). From this perspective, performativity was ascribed to *sociomaterial assemblage* rather than to humans or technology.

Problematising innovations and shifting perspective

When I use the term ‘innovation’, I refer to initiatives involving technologies and older adults that aim to, in some ‘innovative’ way, draw on informal care. For example, this has been done by trying to organise and strengthen informal care or by enhancing social connections between older adults²⁶. I do not discern between innovations focusing on social connection and innovations focusing on informal care, partly because social connectedness and informal care are difficult to separate in practice and partly because innovations are seldom limited to strictly concern one or the other.

Several studies have pointed to dominant views on innovation and care overlooking care (López-Gómez et al., 2021; Roberts & Mort, 2009; Shaw et al., 2020). Therefore, to reflect on how care between older adults and their peers can be utilised, I draw on literature that problematizes dominant approaches to innovations²⁷. As mentioned, one problem with the dominant view on innovations is that it neglects the present on behalf of developing new solutions. Another is that it ascribes transformative change to singular moments of innovation and by so-called ‘individual geniuses’, for example, entrepreneurs in the public or private sector, which are posited over or against an environment including a field of actions in which innovations are to occur. Furthermore, such innovating necessitates a certain type of response or ‘use’ (Suchman & Bishop, 2000). As an example, such ‘response’ can entail specific ways that care should be done²⁸ (cf. Shaw et al., 2020).

Suchman (2002) has argued for understanding innovations as collective achievements and shifting focus onto the everyday practices through which innovations come to be: to ‘decentre sites of innovation from singular persons, places and things to multiple acts of everyday activity’ (Suchman, 2009:2). In this view, innovations are new ways of working that grow ‘out of an ongoing interaction between understandings based in prior experience on

²⁶ For examples of studies that explore and discuss such technologies see (Beneito-Montagut & Begueria, 2021; López-Gómez et al., 2021; Shaw et al., 2020).

²⁷ Mainly these authors belong to the fields of feminist studies, science and technology studies (STS) and socio-gerontechnology.

²⁸ For another illustrative example see also Lassen et al. (2015) on making older adults practices ‘doable’.

the one hand, and leaps of faith inspired by imagination on the other' (Suchman, 2002:100). Transformative change, which is the goal of innovation, in this sense is not entitled to individual professional designers or entrepreneurs but is a collective aspect of everyday practice²⁹.

The nature of innovations is often framed as a 'thing' rather than a quality, as noted by Pink, Salazar and Duque (2019:461):

'[...] the ontological status of a technological innovation is that of something determined by a narrative of innovation; it is a categorization of a thing, rather than a definition of the qualities of the thing in itself.'

This way, a distinction is often made between creative improvisation in everyday life and 'innovations'³⁰. Such distinction according to Pink et al. (2019) does not mean that innovations (as 'things') break established conventions and improvisation does not. Rather, improvisation characterises creativity through its *process*, while innovation does this through its *products*.

Understanding innovation to be a process or a quality rather than a thing enables exploring it in relation to improvisatory creativity of everyday life as well as considering informal care between older adults beyond the impression that they stem from technological innovation and can only be changed when an innovation intervenes (cf. Pink et al., 2019) This is needed as older adults are seldom framed as 'innovative' in discussions on innovations (Peine, van Cooten, & Neven, 2017, Peine et al, 2021), although they are capable of 'creatively finding solutions to the challenges that they encounter as they age [...] by using things that surround them as resources' (Giaccardi, Kuijer, & Neven, 2016:4) In Paper IV, I explore such 'innovativeness' using the concept of *maintenance* and *repair*.

Maintenance and repair

Innovation and *maintenance* and *repair* may seem quite different. In common ideas, innovation comes first, and then later comes repair. Nevertheless, if we agree with authors such as Jackson (2014) in that the world is always breaking and that such breaking is both generative and productive, then maintenance and repair may be entangled with innovation. As Grant (2020) put it,

²⁹ This argument is echoed by others (Damsholt & Jespersen, 2014; López Gómez, 2015; Peine et al, 2021).

³⁰ Pink et al (2019) draw on ideas by Hallam and Ingold (2007). For an illustrative example of this separation see Bergschöld et al. (2020).

maintenance and repair are ongoing processes of “differentiation” rather than a “return” to a previous state. From this perspective, new solutions may be invented through the maintenance of ‘keeping things going’ and ‘putting things back in order’. As Graham and Thrift (2007) argue, maintenance and repair involve ingenuity, learning, adaptation, and improvisation and may lead to new inventions.

To analyse maintenance and repair concerning care activities between peers during the COVID-19 pandemic in Sweden in Paper IV, I drew on conceptualisations by Henke (1999) and Gherardi (2004). Both use a practice theory perspective in their study of maintenance and repair and focus on a form of social order. I drew on Henke (1999) for his focus on people and their activities and I used Gherardi (2004) as she offers tools to reflect on repair in relation to care (Cozza et al., 2020). Gherardi (2004) describes repair as a form of ‘engineering heterogeneous elements’, such as ideas, relations or technology. This ‘engineering heterogeneous elements’ occurs in micro-interactions in everyday life. What is repaired is the texture³¹ of organising a specific order of ‘normalcy’ (cf. Cozza et al., 2020), that is by no means univocal or singular but is linked to, for example, different norms (Denis, Mongili, & Pontille, 2016). From this view, I considered older adults’ everyday care activities as a way by which ‘normalcy’ could be repaired.

A note on ‘older adults’

Based on the above-mentioned focus on older adults’ practices and activities rather than older adults as individuals, I would like to make a note on the idea of ‘older adults’. This thesis does not focus on ageing, older age or older individuals. Nevertheless, older adults are not a blank space.

‘The phrase “older people” is a linguistic generalisation that serves a range of functions ; it is at once a descriptive category, a basis for “expert” interpretation and cataloguing of needs and resources, and a linguistic device to subject position’. (Fealy, McNamara, Treacy, & Lyons, 2012:100)

As the quote portrays, the term ‘older people’ (or ‘older adults’) serves many purposes. One of them is being a *descriptive category*. In this thesis, the term is used this way – to describe an age group, i.e., adults aged 65 years or older,

³¹ Texture refers to the so-called connectedness in action. As Gherardi (2017:51) puts it “This term brings out the definitive feature of texture, its endless series of relationships which continually move into each other’.

who are targeted by ageing policy and innovations for ageing and/or receive some form of eldercare. A distinction is often made between older adults as ‘active’ and who can contribute to society and older adults who are ‘passive’ and need others’ (care) contributions (Gilleard & Higgs, 2011; Weicht, 2013). My understanding of individuals 65 years or older is that they can be both ‘active’ and ‘passive’ and either-or and that their relation to being ‘active’ and ‘passive’ is temporary and thus shifts over time as well as with context and relationships.

Viewing care ‘a mode, a style, a way of working’ that is realized in practice (Mol et al, 2010:7) does not presume older adults to be independent contributors or dependent receivers. It does not limit care to an action undertaken by a specific type of human with a specific set of abilities or other characteristics. Thus, one can supposedly be active, independent, and ‘contributing’ while also being passive, dependent and ‘receiving’ altogether when engaging in care. Exactly *what* care is in a specific situation we cannot confidently know before it happens (Mol et al., 2010). As stated by (Mol et al., 2010: 10):

‘[...] care may move in complex ways [...]; it may involve putting a hand on an arm at just the right moment or jointly drinking hot chocolate while chatting about nothing in particular’.

Nevertheless, age categorisations are inevitably homogenising as they assume that those within the category are ‘the same’ and different from those outside the category (Harnett, 2020; Harnett, 2021). Thus, categorising people by age is linked to assumptions that all individuals in the same group demand the same particular kind of care arrangement (Weicht, 2013) and that this care is different from the care demanded by those outside the category. In this thesis, I do not look for sameness or differences; rather, I try to describe and conceptualise care between older adults in its varieties.

4. Methods and materials

In this chapter, I present the methods and data materials used in this thesis. First, I describe the data collection and the materials, including the overarching approach of the thesis and how I have asked the participants about peer-based care. Then I turn to discuss how the data materials have been analysed. I also present how I have integrated the findings from the four papers for the purpose of this thesis. I end this chapter by discussing ethical and methodological considerations related to collecting and handling the data materials.

Data collection and data materials

To gain in-depth knowledge into care between older adults and their peers in everyday life, including how this care can be utilised through innovations involving public care I have adopted multiple methods (cf. Denzin, 2012). To understand *how* peer-based care is done I have conducted individual interviews, ethnographic fieldwork and analysed free-text answers, and to understand *what* older adults commonly do as part of this peer-based care I have collected and analysed numerical survey data. The overall methodological approach of this thesis can be considered ‘exploratory’ because it emphasises conceptual development from empirical data. An exploratory approach enables both flexibility and open-mindedness and is useful when a phenomenon has received little empirical study (Stebbins, 2001). For an overview of the Papers I-IV see table 1.

One aspect of using the idea of care practices (Mol et al., 2010) is that it encourages you to stay open to *what* care is while exploring *how* it is done. Throughout the data collection for the papers in this thesis, I have used the Swedish term ‘stöd’ (Paper I, II and IV) and the Danish term ‘støtte’ (Paper III) when asking the participants about care (in the survey, I also asked respondents if they ‘in other ways helped’ another person)³². The terms can be translated to the English term ‘support’.

³² In Swedish, the term ‘stöd’ can semantically be defined as moral and more abstract help that may involve sympathy (The Swedish Academy, 2021). The Danish term ‘støtte’ can be defined as concrete

Table 1. Overview of the research questions, method/ data materials, and participants in the four papers included in this thesis.

Paper	Research question	Method/data material	Participants
I	How do older adults and their peers care for each other? How is mutuality part of these practices?	Grounded theory approach to gather material and analyse data Individual semi-structured interviews collected December 2017- May 2018	30 older persons between 65-93 years All were retired and living in their own home. All were living in Sweden
II	What types of informal care and support do older people provide to their peers? How are they associated with demographic characteristics and social isolation?	Mixed method study including thematic analysis and statistical analyses Free-text answers and quantitative data from a web survey via the Swedish Citizen Panel fielded in June 2020	10 044 respondents 65 years or older Most of the participants were men, had a university degree, were married, and lived in a larger city. A majority managed daily activities on their own. All were living in Sweden
III	What tensions emerge within social innovations at the intersections between formal and informal care and how do older adults and their peers navigate opportunities to co-produce care in response to these tensions?	Ethnographic study of an innovation project guided by a grounded theory approach to gather and analyse data Fieldwork from May to December 2019 of the Give&Take project's living-labs in Copenhagen	Most older adults participating in the living-lab in Copenhagen were women. All were retired and living in Copenhagen, Denmark.
IV	How do adults 70 years or older describe the everyday care they provided their peers during the COVID-19 pandemic in Sweden in terms of care activities? How did these descriptions reflect their engagement in the repair of their own and others everyday lives?	Inductive analysis of free-text answers using grounded theory techniques 1327 free-text answers from a web survey via the Swedish Citizen Panel fielded in June 2020	1372 respondents 70 years or older Most of the participants were men, had a university degree, were married, and lived in a larger city. A majority managed daily activities on their own. All were living in Sweden

help or moral support that is provided to a person that you wish to strengthen (The Danish dictionary, 2021).

The choice of words was made to stay open to care that emerged in the participants' narratives. When asking older adults about care (in Swedish: 'vård' and/or 'omsorg') before the data collection (pilot interviews) for Paper I, encountered difficulties in discussing everyday care between older adults and their peers. The participants associated these terms with professional care and did not recognise that they had any experience with it. When I used the term support³³:

the participants opened up about how they engaged in peer-based care:

Me: If we go back to support, do you give support to say, elderly friends? Could you give an example?

Interview person: [cries] Many have passed away, so that is something I have experienced. Especially one person who passed away a couple of years ago, she felt very lonely, so I tried to be with her as much as I could, but I understood that she suffered from that loneliness. She had many friends, but they weren't there when she got sick. They were somewhere else, and she complained that they didn't call. I think that is awful.

Me: What did you do when you were there?

Interview person: No more than sitting there and letting her express what she felt like, but I made sure I called her and asked her what I should bring with me and what was important, and she didn't want to bother me, but I could recognise myself in what it feels like to crave something and not be able to go outside and how nice it would be if someone delivered it for me. And when she visited the doctor for treatment, I accompanied her of course, because she wanted company. I can see it did her good.

This excerpt is from an interview with a 73-year-old woman living in a larger city in Sweden. It portrays how she associated the term support with caring for a lonely friend, including going to the store for her friend and accompanying this friend to medical treatment. In daily life, words are not tightly linked to specific conceptualisations or processes. Instead, they 'slide and shift' and as a researcher one, therefore, should be flexible with the ways words are used in the practices that one studies (Mol et al, 2011:85).

³³ Note that I did not define support but asked the participants for what it meant for them.

Individual interviews: Paper I

From December 2017 to May 2018, I conducted 30 individual interviews with men and women who were retired and aged between 67-93 years to explore how they cared for themselves and other older adults with whom they were not family.

Through interviews, researchers can identify activities that compose practices (Schatzki, 2012). In Paper I, interviews allowed me to gain knowledge on care in spaces that I did not have access to. To give an example, the interviewees told me about coincidental instances that had them engaged in care or about intimate conversations with friends.

The data collection and the design of Paper I was inspired by constructivist grounded theory (Charmaz, 2014). While I was not able to carry out theoretical sampling and most of the analysis was conducted as all data was gathered, I adopted

grounded theory techniques, for example, to let the participants define terms (i.e. support) and memos. I later analysed the data using grounded theory.

The participants were recruited via two of the largest pensioner associations in Sweden, PRO and SPF Seniorerna, in three municipalities in Sweden: a larger city (Gothenburg) and two smaller cities (Falkenberg and Kiruna). I recruited participants by visiting the local pensioner organisations during meetings and events in the three different municipalities. Most of those who wished to participate were younger than 80 years and female. To recruit participants who were male and older than 80 years, I was provided with a list of names of potential participants by my contact person at the organisations. On a few occasions, the contact person also helped initiate the contact by introducing me to members of the organisation who were male and older than 80 years.

The participants chose where the interview was to take place: in the participants' homes, at the pensioner organisations' facilities, at meeting facilities ('träffpunkter') or at the university (my institute). On most occasions, the interviews and the recruitment process entailed having a coffee (in Swedish: 'fika') with participants or members of the pensioner organizations. Thus, there were many occasions during the data collection when I got to sit down and chat with members of the pensioner organizations. While not included as empirical material in Paper I, these occasions enriched my understanding of care between older adults and their peers as well as provided insights into environments where peer-based care took place.

The individual interviews had a mean length of 60 minutes. To steer the interviews, I used an interview guide with a set of themes (e.g. support) with open-ended questions (e.g. 'do you provide any kind of support to others?')

that I followed up with prompts (e.g. ‘could you tell me more about that?’). An interview technique is often referred to as ‘semi-structured interviews’ (Bryman, Nilsson, & Linderholm, 2018).

I also asked the participants to draw their social network as it appeared to them on a blank paper by freehand (210 mm x 297 mm). As the respondents drew a map of their social network, I followed up with questions on care concerning, for example, different relationships or persons in their drawings. I used this freestyle mapping technique to create a structure for the participants’ narration, for example, to keep track of relationships discussed in the interview, and to generate narrative from their visualisation to help depict the participant’s social network (cf. Altissimo, 2016; McCarty, Molina, Aguilar, & Rota, 2007). See figure 1-2 for examples of the participants’ drawings of their social network. I later transcribed the interviews with a few edits due to breaks, such as if a family member of the participant joined the conversation (this happened on a few occasions when the interviews took place in the participant’s home), or if a participant received a phone call.

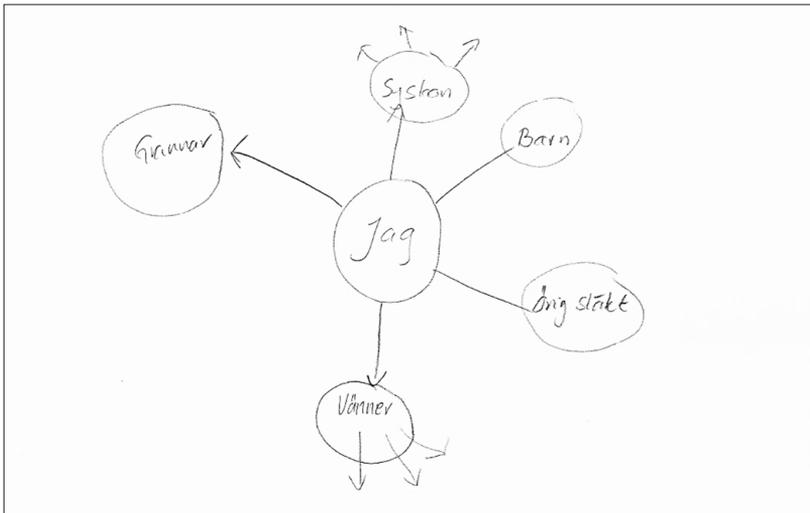


Figure 1. Drawing by a participant during the individual interviews.

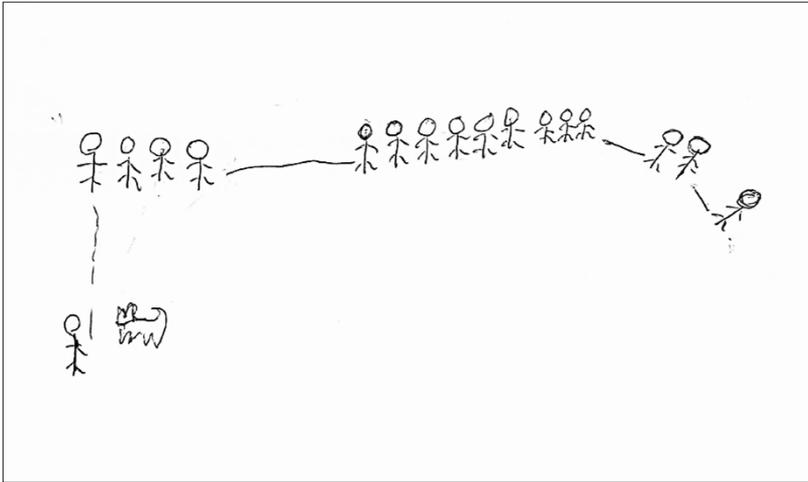


Figure 2. Drawing by a participant during the individual interviews.

Web panel survey data: Papers II and IV

To gain an overview of care activities between older adults and their friends, neighbours and acquaintances and to explore their relation to social isolation (paper II), I conducted a web survey that was distributed via the Swedish Citizen Panel. The survey, which was distributed in June 2020, was also used to explore how adults 70 years or older engaged in providing care to their peers during the COVID-19 pandemic (Paper IV). During this time, the COVID-19 pandemic affected all sorts of everyday life activities for the Swedish population, especially for adults aged 70 years or older (Fristedt, Carlsson, Kylén, Jonsson, & Granbom, 2021; Nilsson, Ekstam, Axmon, & Andersson, 2021).

Through two questions on the respondents' care provision to peers (one open-ended question), 10 short questions on their experience of social isolation and demographic data, the web survey provided the opportunity to obtain an overview on (Paper I) as well as a broad description (Paper IV) of older adults' care provision to their peers. I will now briefly describe the Swedish Citizen Panel.

The Swedish Citizen Panel

The Swedish Citizen Panel (SCP) is an infrastructure for collecting panel data via online questionnaires that can be utilised by academic researchers and Swedish authorities. The SCP is run by the Laboratory of Opinion Research (LORE) at the SOM institute at Gothenburg University (The SOM Institute, 2022). In 2020, at the time of our data collection, the panel consisted of 75 000 respondents 16 years or older. Most of the respondents opted in to answer questions posed by researchers or authorities. That is, they enrolled in the panel on their initiative via the SCP website. These respondents have typically received information about the SCP via, for example, advertisements in two of the largest newspapers in Sweden and through so-called ‘piggybacking’, i.e. they received information on the SCP when participating in other academically run surveys. A smaller group of the respondents were recruited via a sample frame provided by the Swedish Tax Authority to represent the Swedish population. These respondents received a postcard with an invitation to join the SCP and accepted. In June 2020, when the survey was distributed, the SCP’s panel consisted of 78% opt-in respondents and 22% probability-recruited respondents. (Siira & Wolf, 2022). LORE conducts all the recruitment for the panel. The respondents were not provided with any economic incentives.

The web survey ‘Involuntary loneliness among senior citizens’

I utilised the infrastructure of SCP to send out a survey to adults 65 years or older in June 2020. The web survey ‘Involuntary loneliness among senior citizens’ focuses on care between older people and their peers and contained questions on the experience of loneliness. The survey was distributed to 13 327 respondents aged 65 years or older in the SCP (after e-mail bounce backs and failed deliveries). The 13 327 respondents were mostly respondents who had opted in to answer questions. A smaller group of respondents had been recruited to represent the Swedish population. The survey was designed to take 10-12 minutes and contained 14 questions (three questions with free-text options), two instruments and one scale. A participation rate of 75% yielded a sample of 10 044 respondents. LORE collected and provided demographic data on the respondents.

Data from the web survey utilised in Paper II and IV in this thesis includes two questions on the respondents’ care provision to peers, 10 questions on social isolation, and demographic data provided by LORE. The two questions on care provision to peers included a screening question in the first section

of the survey: *'Do you provide support or in other ways help someone who is 65 years or older and who is not a family member or a relative?'*, which was followed by a question on what kind of support the respondent provided: *'What type of support or help do you provide?'*. The response option of the first question was 'yes' or 'no' and the second question was answered by free text. Only respondents who answered 'yes' to the first question were provided with the second question on what type of support they provided.

To measure social isolation we created a score based on 10 items (item 2, 3, 7, 8, 11, 12, 13, 14, 17 and 18) from a Swedish translation of the 20-item UCLA-Loneliness scale (Engelberg & Sjöberg, 2005; Larsson et al, 2016; Russell, 1996). The ten items were formulated as the following questions (Swedish translation presented in brackets):

2. 'How often do you feel that you lack companionship?' (Hur ofta känner du att du saknar sällskap?)
3. 'How often do you feel that there is no one you can turn to?' (Hur ofta känner du att du inte har någon att tala med om dina problem?)
7. 'How often do you feel that you are no longer close to anyone?' ('Hur ofta känner du att du inte har någon nära vän?')
8. 'How often do you feel that your interests and ideas are not shared by those around you?' ('Hur ofta känner du att dina intressen och idéer inte delas av andra människor i din omgivning?')
11. 'How often do you feel left out?' ('Hur ofta känner du dig lämnad utanför?')
12. 'How often do you feel that your relationships with others are not meaningful?' ('Hur ofta känner du att dina relationer med andra inte är meningsfulla?')
13. 'How often do you feel that no one really knows you well?' ('Hur ofta känner du att ingen egentligen känner dig speciellt väl?').
14. 'How often do you feel isolated from others?' (Hur ofta känner du dig isolerad från andra?)
17. 'How often do you feel shy?' ('Hur ofta känner du dig blyg?')
18. 'How often do you feel that people are around you but not with you?' ('Hur ofta känner du att människor i din närhet ignorerar dig?')

The response alternatives to each item/question were: 'never', 'rarely', 'sometimes' and 'always (in Swedish: 'aldrig', 'sällan', 'ibland' and 'alltid').

Data from the survey utilised in Paper II

For Paper II, all respondents answering the first screening question and the second open-ended question were included. We also used the 10 questions on loneliness (to create a social isolation score) and demographic data provided by LORE on the respondents' sex, age, marital status, personal income, education and geographical location (countryside/sub-urban area/urban area), employment status and place of birth.

A total of 10 044 respondents answered the first screening question and the second open-ended question. 88% of these respondents had opted-in to join the SCP and 12% had been recruited by LORE to represent the Swedish population. In total, 2169 of the 10 044 respondents answered the second question with a free-text option. 14 respondents answered the free text option by stating that they engaged in caring for a family member. Their responses were therefore deemed not applicable and excluded from the analysis. 12 respondents who answered the open-ended question stating that they engaged in professional care were included in the analysis after checking that the results from the statistical analyses did not change when the respondents were removed. The inclusion of the 12 respondents was judged appropriate as they pointed to the intersection between formal and informal care.

Data from the survey utilised for Paper IV

For Paper IV, only the respondents 70 years or older and their answers to the follow-up question on type of care were used. A total of 1,372 respondents aged 70 years or older answered this question. Their answers ranged between 1-134 words. In total, the answers comprised 10 172 words. Shorter answers typically entailed a list of activities, 'visits, transport, shopping', and the lengthier answers were more detailed, such as this answer provided by a woman between 75-79 years, living alone in a larger city:

I live in cohousing. When someone gets ill, we make sure that the person gets food, and we check that they manage the situation. As a doctor, I have called those who are ill to check on them, and when necessary, to give advice. We shop for each other and run errands. We have coffee [Swedish: fikar] together to avoid getting bored. The joint dinners are cancelled'.

Although the data material was small in terms of the total number of words and the length of the answers, it was 'dense' in the sense that the shortest

answers also contained words linked to images of activities. Additionally, the answers contained little to almost no fill-in-words and the like.

Finally, the data material allowed for analysing care activities among older adults during the COVID-19 pandemic in Sweden when both recruiting and interviewing were difficult and often demand making contact with people and meeting in person (although other ways exist). Thus, the free-text answers provided a way to gain insight into older adults' activities that I could not observe or ask about in person.

Fieldwork: Paper III

To gain insight into how care between older adults and their peers may be utilised and supported by innovations involving new technology, I studied an innovation project involving public care that aimed to utilise older adults' resources to connect with and care for each other. From May 2019 to December 2019, I conducted fieldwork at one of the empirical sites, or 'living-labs', of the Give&Take project (2019). I also considered in retrospect how the innovation had developed since it launched in 2014.

The Give&Take was a three year (2014-2017) interdisciplinary co-designed project that was funded by the EU Ambient Assisted Living Programme (AAL). The project involved collaboration between three research institutions in Denmark and Austria, as well as a Danish municipality and two private companies in Denmark and Portugal. The collaboration aimed to create a digital peer-to-peer platform that was to be used by older adults. The platform called Give&Take was meant to support as well as organise the sharing of favours, things and services between older adults. The project idea was to innovate eldercare services for older adults by drawing on older adults' resources. Thus, the project involved both social and technical innovation.

As an empirical site, I explored one of the living labs, where the project developed the innovation together with older adults. The living lab was a walking group for older adults that started as a public initiative following municipal policy aims to develop new and complementary welfare solutions through co-production with older citizens. The Give&Take innovation was meant to support the walking group in self-organising their activities under supervision from the municipality.

To gather data and to analyse the Give&Take project, I adopted ethnographic tools and techniques provided by Emerson, Fretz & Shaw (2011). When studying practices, ethnography is the advocated method. The reason is that observations can provide detailed descriptions of practices (Mol

et al., 2010; Schatzki, 2012). Regarding care, which is not necessarily verbal, articulated or reflected upon, this holds especially true (Mol et al., 2010; Thygesen, 2009).

In a general sense, ethnography involves observations of phenomena in a specific context (Emerson et al., 2011). However, in contrast to many ethnographic studies, the ethnographic emphasis in Paper III rested on the studied phenomenon rather than on the description of a setting or structure. To guide the ethnographic exploration, I used the principles of Charmaz' (2014) grounded theory to help structure and guide the focus of the ethnographic conduct. Ethnographic methods, such as observations, interviewing and the analysis of written documents, are all tools for gathering data to include in a grounded theory analysis. Meanwhile, grounded theory can assist in travelling more easily towards abstract and conceptual interpretations while moving between data and analysis and avoiding potential problems in ethnographic studies such as 'seeing data everywhere and nowhere, gathering everything and nothing' (Charmaz, 2014:23).

Field notes and memos were used to assemble the experiences during ethnographic observations and to note emerging conceptual ideas. Consequently, I could let codes and ideas stemming from the observations guide further empirical and theoretical exploration of the data material. I also used memos during the collection of individual interviews to note conceptual ideas and concepts and let them direct further exploration, which is called 'theoretical sampling' (Charmaz, 2014).

The data material collected during the fieldwork included participatory observations of the walking group's events (five instances), informal conversations with the participants, observing the digital Give&Take platform (approximately 60 hours), three interviews (two with older adults and one with municipal staff), transcriptions of five interviews with members of the walking group that had previously been conducted as part of the project, and written and visual material (pictures and videos) about the Give&Take project and/or the municipal services.

The three interviews conducted during the fieldwork lasted up to 60 minutes, were guided by an interview guide (one for the members of the walking group and one for the municipal staff) with sets of questions following emerging conceptual ideas and were later audio-recorded and transcribed. The participants were anonymized through pseudonyms.

One of the co-authors, SY, had participated in the Give&Take project from 2014–2017 and had conducted participatory observations in the walking group at the time. We drew on her experience from the project, which was discussed among all co-authors.

Analysis of the data materials

I analysed the data materials using constructivist grounded (Charmaz, 2014), ethnographic tools and techniques (Emerson et al, 2011) and mixed methods (Morse and Niehaus, 2009), including thematic analysis (Braun and Clarke, 2006) and a set of statistical analyses. Here I describe how these methods have been used in each of the papers.

Constructivist grounded theory: Papers I, III and IV

Constructivist grounded theory (Charmaz, 2014) was used to analyse data material in three of the four papers in this thesis (Paper I, III and IV). Grounded theory was chosen because it allows for exploring practices without pre-defining them. Additionally, it encourages the researcher to see beyond the obvious and prompts analytical thinking throughout data collection and analysis. *Constructivist* grounded theory by Charmaz (2014) was chosen for the method's ontological assumptions, focus and flexibility. Constructivist grounded theory assumes that reality is multiple and that the 'research reality' is influenced by both what the participants and the researchers bring to it. Thus, theory is 'constructed' rather than 'revealed'. Furthermore, like practice theory, grounded theory focuses on actions. For example, in grounded theory, the researcher codes for 'gerunds' or verbs rather than nouns (Charmaz, 2014), which is also how care practices are described (cf. Mol et al., 2010, Mol et al 2011).

In Papers I, III and IV, I used three types of coding typically included in grounded theory analyses: *initial coding*, *focused coding* and *theoretical coding*. For Paper I and IV, coding was done after the data material had been collected, while for Paper III, coding was carried out during the data collection. Throughout the coding process, the constant comparative method was used. This method is used to compare, e.g. codes-codes, categories-categories, or categories-codes, and to make analytical distinctions between codes, categories and texts (Charmaz, 2014).

In all three papers (I, III, IV) I generally first read through the material to get 'a sense of what was going on'. Then, I conducted initial coding. *Initial coding* involves a type of inductive coding process where the researcher moves quickly through the data and remains close to the data and open to different theoretical possibilities. The initial coding laid the foundation for the next two phases of coding. For Papers I and III, this was done through line-by-line coding, and for Paper IV, I also carried out word-by-word coding because

parts of the data material were more 'list-like'. For Paper IV, I used 'in-vivo' codes (Charmaz, 2014) on a few occasions. 'In-vivo' codes helped me stay close to the words of the respondents and to use their words for actions to define the data material. It also helped me to explore leads in these codes and to develop my understanding of what they meant.

Focused coding entails structuring the data material by the codes from the initial coding. Here, the most re-occurring or significant codes are used to create categories (Charmaz, 2014). In paper I, I used mutuality as a 'sensitising concept' (Blumer, 1986) during the focused coding to create categories. Sensitising concepts prompts you to ask questions to the data and to draw attention to certain features of the data material in grounded theory analysis (Bowen, 2006).

For Paper III, I carried out both the initial coding and parts of the focused coding during the data collection. Thus, the initial coding was used to initiate further data collection and to pinpoint areas for further empirical and theoretical exploration. During the focused coding, data collection was prompted when e.g. the data material did not seem to mirror all the properties of a category.

Theoretical coding involves stipulating relations between categories and moving codes in a more analytical direction (Charmaz, 2014). For Paper I, I drew on elements of practices, as described by Schatzki (2012), in the focused coding to structure the analysis and in the theoretical coding to analyse the relationship between practices and arrangements. For Paper IV, I drew on ideas regarding maintenance and repair (Gherardi, 2004; Henke, 1999) during theoretical coding to analyse aspects of these phenomena in the categories stemming from the focused coding.

For all three Papers (I, III and IV), I used the theoretical perspectives presented in the previous chapter: *Theoretical perspectives on care, innovations and older adults*, as 'interpretive theories'. That is, I used these perspectives as a guide for conceptualising care in abstract terms and as a starting point to approach care (rather than an end) (Charmaz, 2014). Laying out these perspectives is part of a reflexive process where one can consider one's own, and common, presuppositions about the world, such as that the world is inherently made from human-human interactions, ignoring socio-material aspects of social life. Finally, my analyses for all three papers (I, II and IV) were scrutinised through group discussions with the co-authors of each paper.

Mixed methods: Paper II

When measuring informal care in surveys, there is a risk of underestimating the extent of the care that is studied. Classifying activities of care in respondents' statements is suggested as one solution to this problem (Rutherford & Bu, 2018). For this reason, in Paper II, I utilised the written responses to the free-text question to create categories of care that could be used in statistical analyses. To analyse the data used in Paper II, I adopted mixed method by Morse and Niehaus (2009). This method was used because it provided a practical structure to handle both the written answers to the free-text question and the numerical data from the web survey, including demographic characteristics.

In line with the method by Morse and Niehaus (2009), I adopted a deductive theoretical approach with a quantitative component (the core component) and a qualitative component. The quantitative component consisted of statistical analyses of providing care, demographic characteristics and social isolation. The qualitative component included a deductive analysis of the free-text answers using thematic analysis (Braun & Clarke, 2006). In short, a thematic is about 'identifying, analysing, and reporting patterns (themes) within data' (Braun & Clarke, 2006:79). The thematic analysis by Braun and Clarke (2006) was chosen as it provides a structure for how to systematically sort data into themes while also being a flexible method, e.g., it can be used with all sorts of theoretical frameworks and in deductive analyses (Braun & Clarke, 2006).

To be able to analyse and compare different types of activities, I coded each of the answers into *one* of the themes, 'social activities', 'practical/instrumental activities', 'caregiving activities' and 'volunteering activities/other organised activities', found in previous research. Answers that involved more than one of these activities were either coded by the activity that was most prominent in the answer or the activity that was first mentioned in the answer. Thus, I assumed that the first or most prominent activity in the answer was also the most primary activity that the respondent engaged in. As an example, this response, provided by a 70-74-year-old and living in a medium-sized city, was coded as 'social activities':

Keep in touch with a widow of a co-worker. I call, and I have also helped with shopping and errands to the bank'.

While the respondent had engaged in shopping and errands, social activities, such as keeping in touch and calling, were mentioned first and seemed to be the primary activity he engaged in. Answers that could not be sorted into one

activity or that described care in more general terms were sorted into a theme constructed from the empirical material ‘a little of all/varied’.

During the thematic analysis, I first read through the answers to familiarise myself with the text, then I coded the answers according to the themes. While the themes were chosen beforehand, the process of coding answers and creating themes involved moving back and forth between the codes, the themes and the answers and refining the codes and defining each theme. Through this process, the theme ‘a little of all/varied’ was developed. Finally, I analysed the answers by their apparent, or ‘semantic’ meaning (cf. Braun & Clarke, 2006). Thus, I did not look for ‘underlying meanings’ in the respondents’ answers.

The ‘mixing’ of the two components occurred as part of the data analysis. The themes yielded from the thematic analysis were used to create a variable for types of care and support activities together, which was later used in the statistical analyses. The answers in each theme were organised into categories and then into numbers to analyse the different care activities in relation to the demographic variables and loneliness. By developing a quantitative variable from the elicited text, we could analyse both the type of care and the frequency of this care (cf. Symonds & Gorard, 2010).

Paper II was co-authored with Patricia Olaya-Contreras (second main author) who conducted most of the statistical analyses. In the descriptive statistical analyses, the variable for the type of care was handled as a categorical variable. In the multivariate analyses providing care to a peer was handled as a dichotomous variable (yes/no). The social isolation score was considered ordinal data with a cut-off value (≤ 24 : low social isolation and > 24 : high social isolation). Missing values on the items for the social isolation score were imputed by using the respondents’ mean values on other of the ten items (less than 10% was missing). The Chi-square test (two-tailed test) and Fisher’s exact test were used to compare groups. The Kruskal-Wallis test, independent-samples median test and Pairwise comparisons tests were performed to compare multiple groups. The odds ratios (OR) and confidence intervals (95% CI) were calculated to test the association between the dichotomous outcome variable for providing care and support (yes/no) and demographic variables, including social isolation. Logistic regression was used to test the association between the dichotomous outcome variable and the other variables. The model was adjusted for sex, education and type of recruitment.

A nonrespondent analysis was carried out showing that response the question “*Do you provide support or in other ways help someone who is 65 years or older and who is not a family member or a relative?*” associated with being female, younger age

and high income. Finally, SPSS Statistics software was used to conduct the statistical analysis.

A note on integrating the findings

In chapter 5 (*Findings*) in this thesis, I have drawn together the findings from the four papers to develop a conceptual understanding of care between older adults and their peers. In contrast to more traditional forms of data integration or ‘triangulation’, the point of drawing together the findings was not to increase the validity of the results (cf. Denzin, 2012; Moran-Ellis et al., 2006). Instead, the integration aimed at generating an overarching, although multifaceted, account of care between older adults and their peers as a *phenomenon* with an emphasis on *how* this peer-based care is done (Orlikowski, 2015). Thus, rather than stating facts, the integration was meant to shift ideas and learn new things about care (cf. Mol, 2008). This approach can be referred to as ‘interpretative integration’ (Moran-Ellis et al., 2006).

The emphasis on *how* peer-based care was done stemmed from the fact that the papers provide many examples of *what* the participants did when engaging in peer-based care, but less on the mechanisms that constituted this care. Because the focus was on *how* care between older adults was done the emphasis of the integration was on Paper I, III and IV. The findings from the papers stem from different groups of older adults and relate to different contexts. The integration draws together themes on peer-based care that seem to cut across such variation. In practice, this involved looking for themes that were in play in care between older adults their peers and which re-occurred in the findings from the four papers. More specifically, I searched for such themes in the findings and the discussion section in each of the four papers. The integration was inspired by the theoretical framework for this thesis.

Ethical considerations

All four papers followed the principles for biomedical research in the Helsinki Declaration. The declaration, which contains ethical principles for medical research, are useful guiding principles also for research related to social and human science. For example, its basic principles such as to have the individual’s best interest in mind, to obtain informed consent from individuals before participating in research, to take sufficient measures of

precautions to secure the privacy and confidentiality of their personal information, and to minimize harm, are all important general ethical considerations (Vetenskapsrådet, 2017).

Regarding the individual interviews in Paper I, the participants gave their informed consent before the interviews. I also informed them that the study had no association with their participation in the pensioner organisations, except for recruitment. Participants were informed that if an interview caused uncomfortable feelings, they could withdraw their participation without any consequences and/or follow-up on the interview with one of the authors, a registered nurse. No participants wished to do so.

The respondents who participated in the web survey via the Swedish Citizens Panel (SCP), which was used for Papers III and IV, were informed about the general terms and conditions and the privacy policy of the SCP before participating. Before participating they also needed to approve these terms and conditions. LORE assures that all personal data of the participants obtained by the SCP is handled per the General Data Protection Regulation (GDPR). The respondents could contact the primary investigator to make complaints, leave feedback, etc. At the end of the web survey, the respondents were also asked to give their comments on the survey. Many respondents voiced their opinion on, and their experience of, the survey questions.

Data collection for Paper III was conducted within the frame of a larger research project, the Give&Take project in Denmark. Before my first interaction with the walking group, Signe Yndigeegn (co-author and supervisor), who had participated in the Give&Take research project and had contact with a few attendants of the group, visited the group to ask if they agreed on me participating as a researcher and informed them about the study. Before conducting participatory observations in the walking group, I again informed the attendants about my role as a researcher, the intentions of the study and that interaction with me could potentially imply gathering data for Paper III. All participants gave their consent to be part of the participatory observations. Before the individual interviews with attendants and one of the municipal staff, I collected informed consent. The participants were also informed that I would observe their activity on the digital Give&Take platform as researchers during the participatory observations. The older adults who had access to the Give&Take platform agreed to their activities on the platform being observed. For the material that was gathered on previous occasions within the Give&Take research project, the participating researchers had gathered informed consent.

Ethical approval for collecting and handling individual interviews used in Paper I (ref. 719-17) and survey data via the Swedish Citizens Panel used in Paper II and IV (ref. 798-17), was provided by The Regional Ethical Review Board, Sweden. Data collection for Paper III followed the Danish ethical legislation according to the need for informed consent to participate in a research study; however, according to Danish law, ethical approval was not needed as the data collection did not include sensitive data.

Any identifiable information of the respondents has been removed during data collection or analysis to safeguard the participants' integrity; e.g. personal information linked to interviews (names) have been replaced with code keys stored separately to the data material. Empirical data and personal information have been stored according to the General Data Protection Regulation (GDPR) and routines at the Gothenburg University.

Methodological considerations

The discussion regarding methodological considerations of this thesis is divided into two areas *trustworthiness* and *transferability and generalisability*. To assess the trustworthiness of the findings from the papers in this thesis, I have used Charmaz (2014) criteria for evaluating grounded theory studies. Each criterion: *credibility, originality, resonance and usefulness*, poses a set of questions to researchers to reflect on their study, for example, 'Has your research achieved intimate familiarity with the setting or topic?' (Charmaz, 2014:182). While the criteria and the questions are dedicated to grounded theory studies, I believe they are useful for reflecting on general issues related to trustworthiness. The transferability and generalisability are discussed in more broad terms.

Trustworthiness

Concerning the first of Charmaz's (2014) criteria, *credibility*, I gained a familiarity with the topic of care between older adults and their peers both in-depth and width by collecting and analysing the large amount and diverse sets of data included in this thesis. It should be noted that I, as a researcher (in my 30s), have been an 'outsider' (cf. Charmaz, 2014) to these practices, and therefore my 'intimate familiarity' with these practices can be questioned. At the same time, our view of the world is always a view from 'somewhere', and the crucial question might not always be how intimate or correct this vision is, but how we handle the limitations of our vision in a responsible way

(Suchman, 2002). To avoid pitfalls, such as homogenising older adults, I have recurrently reflected on my assumptions on care, older adults, old age and ageing. I have tried to stay open to the narratives of the participants, thereby attempting to forestall my preconceptions and their impact on the analysis and findings. Thus, I have tried to take responsibility for my limited vision.

Another issue regarding the *credibility* of the findings is the issue of de-contextualising practices. Approaches such as statistics and survey methodology that present general patterns among larger groups of people de-contextualise practices. That is, they erase differences and situational specificities by focusing on general patterns. Both social practice theorists and posthuman practice theorists agree that practices happen ‘somewhere’ (Gherardi, 2017; Schatzki, 2012). For practice theory, this ‘somewhere’ is important as practices happen through interactions that are influenced in one way or another by the situation in which they happen (or are performed). Nevertheless, when combined with oral history overviews of quantifiable features of practices can enrich the understanding of practices (Schatzki, 2012). In this thesis, I have not solely carried out a survey study and used statistical methods but have also conducted interviews and ethnographic fieldwork. Furthermore, the findings of this thesis that are based on the survey study are based on written, i.e. older adults accounts, on how they provided care to their peers.

The second criteria, *originality*, is achieved through the descriptive and conceptual insights that the analyses of the four papers deliver regarding peer-based care between older adults, which has sparsely been studied. The aim of this thesis was to stay open to how care occurred in practice and to provide sensitising research on these practices. Through adopting a practice-based perspective on care and an explorative approach this thesis extends previous research on older adults and their informal care relationships. Here it should be noted that I, to handle the data material utilised in Paper II, used a deductive approach that entailed sorting the data material into ‘fixed’ and pre-defined groups. Thus, the findings of Paper II do not have the same novelty as the other papers in terms of building an understanding from practice. Nevertheless, the findings provide insights on care activities between peers in a larger group. Thereby deepening the understanding of the occurrence of different forms of peer-based care among older adults.

Third, *resonance* between the conceptual understanding and the empirical observations is achieved through the variation of data material in this thesis. One source of data material alone could not have provided the equivalent comprehensive understanding of peer-based care. To consider the resonance

of the findings among older adults I have presented the findings and discussed them

with older adults in different constellations (as an example with a network for retired white-collar workers and by recurring conversations with Lena Larsson in her role as a ‘target group representative’ in my research group). This said, the findings from this thesis do not solely reflect the experiences of the participants but my interpretation of them as ‘practices’. As Schatzki (2012) notes, practices must be conceived by means other than direct experience.

Finally, I intend for the findings in this thesis to be *useful* in reflecting on how care between older adults and their peers can be utilised through innovations involving public care. Nevertheless, the usefulness of the findings from this thesis needs to be evaluated in relation to future research, including innovation projects, involving peer-based care.

Transferability and generalisability

In broad terms, *transferability* concerns the degree to which findings can be transferred or generalized to other settings or groups than the one being studied. *Generalisability* can also be understood as drawing conclusions on broader contexts or populations based on smaller samples from the same context or population (Polit & Beck, 2021). There is especially one issue that affects the *transferability* of the findings from the papers based on qualitative methods (Paper I, III and IV) and the *generalisability* of the findings from Paper II, in which I adopted quantitative methods. That is, the data materials in this thesis mostly entail older adults who to a large degree manage their daily life on their own and who are either already engaged in peer activities (Paper I and III) or engaged and interested in societal issues (respondents in the SCP in Paper II and IV). This relates to participants being recruited through (1) pensioner organizations, (2) a peer-to-peer innovation, and (3) a web panel (participants in web panels are often already engaged in societal issues and interested in sharing their opinions, see Siira & Wolf, 2022). Taken together, this implies that the participants in the papers had some sort of social capital, i.e. a majority of the participants are not older adults with excessive health problems who are isolated from others and who do not engage in social activities. Also, most of the participants in the four papers were younger than 90 years. Therefore, the *generalization* and the *transferability* of the findings to groups of older adults with little social capital or the ‘oldest old’ should be made with caution.

The *transferability* and the *generalizability* of findings based on data material collected via the SCP to women, the oldest old, or older adults with little education or born outside Sweden needs also need to be done with caution. Of the older adults who responded to the web panel survey, the majority were men with a university education. Most participants were also between 65-84 years and only a small group was born outside of Sweden. Besides affecting the *transferability* and the *generalizability* of the findings, it possibly also influence how care is portrayed in Paper II and Paper IV.

The *generalizability* of the findings from Paper II relates to the *validity* and *reliability* of the estimates that were used. Therefore, I will briefly discuss the estimates used to measure social isolation and care. First, the 10-item version of the UCLA-loneliness scale is to be considered reliable and valid for use among different populations (Elphinstone, 2017). The isolation score we built from ten items of the UCLA scale has previously been used in research to measure social isolation (Ausín et al, 2019; Borges et al 2008; Dussault et al, 2009; Penning et al 2014). The Swedish translation of the UCLA scale has been used in previous research (Engelberg & Sjöberg, 2005; Larsson et al, 2016), but to my knowledge, the translation has not been validated. To validate the Swedish translation of the UCLA scale was out of the scope of my PhD project. However, this should be considered.

Second, as stated, there is a risk of underestimating the extent of care when measuring informal care in a survey. This relates to the *validity* of measurements (Rutherford & Bu, 2018). To handle this issue, we classified the respondents free-text answers using thematic analysis and thereby constructed a categorical variable on types of care that we used in statical analyses. Nevertheless, classifying free-text answers using qualitative methods can be said to lessen the *reliability* of the measurements.

To measure *if* the respondents provided care (yes/no) we used a broadly defined question. Broadly defined questions set in the context of care is suggested to generate the most reliable estimates of the scale informal care provision (Rutherford & Bu, 2018). Finally, the *generalisability* of the findings in paper II also links to the data material from the web survey being collected during a time (in June 2020) when the daily lives of older adults (those aged 70 years or older) were heavily influenced by age-specific restrictions issued by The Public Health Agency of Sweden. This should be considered if these findings are generalized to the older population in Sweden post the Covid-19 pandemic.

Finally, the fieldwork from the Give&Take project was conducted in Copenhagen, Denmark. This possibly affects the *transferability* of the findings to a Swedish context. While Denmark does not equal Sweden or the other

way around, Denmark was an excellent case to explore innovation in eldercare. In Denmark, as in Sweden, eldercare is mainly a welfare state responsibility (Rostgaard & Szebehely, 2012), nevertheless, the Danish state has moved to a stronger user orientation in the provision of care compared to Sweden. The Danish state encourages older adults to participate in developing new health concepts, and thus there has been an increased number of innovations involving technology that through collaborations with citizens aims to strengthen older people's capabilities (Jensen & Fersch, 2016; Lassen, 2015). Sweden will probably see similar trends in the future, making learning from our Scandinavian neighbours important.

5. Findings

In this chapter, I first, to answer the research questions, present a summary of the findings of each of the four papers in this thesis. I then present an integration of the findings from the four papers. The integration generates an overarching account of care between older adults and their peers as a *phenomenon* with an emphasis on *how* this care is done. The findings, and their implications for the understanding of how this peer-based care can be utilised through innovations involving public care, are discussed in the following chapter (*Discussion and conclusions*).

Summary of the findings of the papers

Paper I: How do older adults and their peers care for each other? How is mutuality part of these practices?

Paper I investigated how older swedes (who were not family) cared for each other and how mutuality was part of these practices. The paper showed that care between older adults and their peers could be about ‘anything’, ranging from asking about one’s health to providing advice on how to go about handling technology, such as computers or phones. Rather than being task-like or limited to specific activities, this care was heterogenic and multifaceted.

The participants engaged in different types of care according to their abilities, understandings and motives as well as their everyday circumstances. Care practice among the participants was, for example, to keep an eye on each other as friends or neighbours or to talk to friends about illness, death or problems in one’s family.

I looked for how these practices related to *mutuality* and found three care practice arrangements in which different forms of mutuality could be traced: *‘caring as part of a friend- or neighbour relationship’*, *‘caring for people in need’* and *‘care for “us”*’.

The participants could be involved in one of these, two of them or all three, and the arrangement seemed to provide older adults with different types of value. The arrangements were linked to handling issues related to

risks of themselves or others, for example, becoming ill or lonely or simply getting older.

The first arrangement, *caring as part of being friends or neighbours*, was linked to reciprocity and reliability between the older adults and was described as self-evident; however, such symmetry was flexibly adapted to current circumstances. This care was often more intimate and tightly linked to norms regarding how to be a good friend or neighbour. Care between the participants and their friends took place in different settings, while care between neighbours was related to the participants' homes.

Caring for someone because of their need for help was to a higher degree one-way oriented, less flexible and task-like compared to care between friends and neighbours. It was often guided by ideas of how to be a good person and to do something righteous while constructing the other person as the dependent 'older person'. This form of care demanded recognising others' needs and knowledge or resources to help them (e.g. a car or living in the same area).

Regarding *caring for 'us'*, the 'us' was often an activity or a club and mutuality was upheld by formalised structures rather than relationships between older adults. The participants less often described these practices in terms of care. Rather, care 'happened' as they attended to their own needs, for example, while they exercised in a group or participated in a course on, i.e. phones and computers. Nevertheless, the participants cared for the activities and made sure the activities functioned. This care was guided by values and obligations to different networks, clubs and associations.

The three care arrangements not only involved the participants and other older adults but involved 'things', such as phones or cars. We concluded that to cultivate this type of informal care, it needs to be understood from the perspective of older adults' everyday care practices rather than a utility focus stemming from formal care.

Paper II: What types of informal care and support do older people provide to their peers? How are they associated with demographic characteristics and social isolation?

In the second paper, we investigate the types of informal care and support older people provide to their peers and how these types of care and support were associated with demographic characteristics and social isolation. Of 10 044 respondents, 2155 (21.5%) provided care and support to their peers (e.g. friends, neighbours and acquaintances). The respondents were more likely to

provide care and support to their peers if they were older than 80 years, male, married/in a relationship and living in an urban area.

Among respondents engaged in care and support to their peers, the most common activities were practical/instrumental help (50.6%) and social activities (25.1%). About 8% engaged in volunteering/other forms of organised activities, 10.5% engaged in 'a little of all/varied activities' and only 5.7% engaged in caregiving activities. More men and respondents younger than 75 years compared to women and older respondents older than 75 years were more often engaged in practical/instrumental activities and volunteering/other forms of organised activities. Older respondents (>80 years) were more often engaged in social activities compared to younger respondents. We found no statistically significant differences between being involved in different types of care and support activities regarding income, employment, municipal size or country of birth.

Comparing respondents who provided any type of care and support to respondents not providing care and support, there was no statistically significant association with the experience of social isolation. Nevertheless, the respondents with the highest score of social isolation were more likely to be engaged in caregiving compared to other activities or to be older than 85 years. Respondents who were older than 85 years and engaged in caregiving activities experienced a higher degree of social isolation compared to those engaged in practical/instrumental or social activities in the same age group. The same pattern was found among the younger respondents. Overall, the female respondents, the older (>85 years) respondents, those with lower income or education and widowed respondents experienced a higher degree of social isolation compared to men, younger respondents (<85 years), respondents with higher income and education and those married/living with a partner.

Thus, the findings suggest that engaging in peer-based care in the forms of social activities and practical/instrumental help can possibly contribute to wellbeing (i.e. lower degree of social isolation) for older adults, while caregiving activities may contribute to experiencing social isolation. We concluded, in line with previous research, that informal care and support is a common phenomenon among older swedes and that it may be significant to older adults during a societal crisis, such as the COVID-19 pandemic.

Paper III: What tensions emerge within social innovations at the intersections between formal and informal care? How do older

adults and their peers navigate opportunities to co-produce care in response to these tensions?

In Paper III, I attended to one specific innovation to explore how a social innovation at the intersection between formal and informal care co-produce opportunities for older people to care for each other. I also investigated what tensions emerged within such co-production and how the actors navigated them. The site of our empirical studies was a 'living lab', i.e. a walking group where the social innovation was developed. I focused on the digital platform (the Give&Take platform), members of a walking group and municipal services. The platform, which was designed to support exchanges between older adults, was intended to support older adults in self-organising the walking group and in linking the walking group members with the municipal services.

I focused on opportunities for care formed by the digital platform and the older adults. Nevertheless, I found that the sociomaterial assemblage that formed care practices between the older adults involved not only the digital platform and the older adults but also the groups' routines, objects, such as the care centre, where the group met and had coffee after their walk, the local walking routes and the walking group members' relationships with each other (among other things). For the older adults attending the walking group, this involved more than simply walking. and one participant described it as 'therapy'.

Regarding the digital platform, it formed several opportunities for care. It allowed for intensifying relationships between the older adults in the walking group, thereby enabling care between them, tracing the activities of the participants, thereby enabling the municipal services to supervise the walking group, formalising the older adults' attendance in the walking group and distributing responsibilities for the walking group.

The opportunities for care that the platform provided were met with some resistance from the members of the walking group: they resisted the formalisation of their attendance in the group, emphasised control over 'their' walking group, safeguarded their own boundaries, and although they cared for other walking group members, they resisted taking on personal responsibilities for care.

Tension arose as the municipality, through the platform, tried to supervise the walking group for it to align with the municipality's principles, and the walking group members to a large degree resisted such supervision. The municipality needed the older adults to take on responsibility for the walking group in a certain way to ensure its appropriateness. While the group was self-organised as was intended, their ways of doing so, such as by withdrawing

from more formal responsibilities, impeded the opportunities formed by the platform and created problems for the municipality. Thus, the municipality's issue of how to manage the co-production in ways that would produce a legitimate care service that was built on self-management and peer-to-peer interactions was not resolved.

Finally, by focusing (too much) on the municipality's expertise and interests, the co-production became more about administrating care resources than actual care. At the same time, by loosely tying the walking group members and the municipality to each other through obligations, the platform functioned, as a 'boundary object', that supported a form of partnership that possibly also benefited the older adults. We concluded that considering the logic and specificities of care together with the logic of effectiveness, efficiency and appropriateness (and their possible clash) in public care can expand our understanding of the co-production of care involving older adults.

Paper IV: How do adults 70 years or older describe the everyday care they provided their peers during the COVID-19 pandemic in Sweden in terms of care activities? How did these descriptions reflect their engagement in the repair of their own and others everyday lives?

In the final and fourth paper of this thesis, I investigated how adults 70 years or older provided care to their peers during the COVID-19 pandemic in Sweden and how this care reflected maintenance and repair. The respondents engaged in a variety of care activities that were linked to *helping in the home* and *helping outside the home* and to a *social space* that intersected various physical spaces, e.g. they could take place via phone, outside or in one's car.

The type of care activities involved, for example, doing household chores, shopping and meeting with or visiting others. The care activities involved things. As an example, care that involved *helping in the home* could revolve around caring for a peer's things. These activities could also be part of the respondents' volunteer engagement or of being a trustee.

The repair reflected in the care activities was linked to two forms of maintenance, which sometimes overlapped: *maintenance of others' daily routines* and *maintaining one's own care routines*. The responses also mirrored that not all care activities could be maintained during the COVID-19 pandemic but were put on pause for the time being. Some respondents maintained a form of

volunteering by sponsoring volunteer associations or organisations, which can be considered a form of repair.

The *maintenance of others' daily routines* often mirrored the breakdown of daily routines following the COVID-19 pandemic, such as the inability to be physically close to others, to go shopping or the need to avoid public transport. The respondents helped others maintain their routines while complying with age restrictions and by violating them. Often, age was described as an organising principle for how to engage in care. The *maintenance of others' daily routines* also involved enabling the maintenance of social contact.

As the physical space for caring was broken due to the COVID-19 pandemic, the respondents had to engage in repair to *maintain their care routines*. The respondents did so by working with different elements of physical distance. This was done, for example, by keeping two meters distance indoors, by meeting outside or by spending time together via the phone.

I concluded that adults were not solely passive receivers of care and help during the COVID-19 pandemic in Sweden, but they also helped their peers manage their circumstances, thereby contributing to the 'common good'. I also concluded that the concepts of maintenance and repair can be used to highlight the innovative and inventive quality of some older adults' care activities, thereby informing both policy and innovations concerning ageing and older adults.

Integration of the findings in the papers

I will now draw together the findings from the four papers in this thesis to illustrate care between older adults and their peers as a *phenomenon*. In contrast to more traditional forms of integrating data ('triangulation'), the point of drawing together the findings is not to increase the validity of the results. It is aimed at generating an overarching, although multifaceted, account of care between older adults and their peers as a *phenomenon* with an emphasis on *how* this care is done. For this purpose, I use the concept of 'peer-to-peer care practices'.

As a *phenomenon*, peer-to-peer care practices are constituted by various practices and activities of care that may occur between older adults and their peers. This care can be highly visible but can also be – as part of an everyday context – mundane and vague. It may involve knocking on another person's door in the middle of the night, having coffee together ('fika'), driving someone to the grocery store or taking out the trash. It may also involve a form of repair and maintenance; a 'putting things back in order' when one's

own and others' daily routines are disrupted. Such repair and maintenance may involve creativity, innovativeness, and inventiveness (e.g. Paper IV). Besides such generative qualities, peer-to-peer care may also involve resistance. In other words, peer-to-peer care practices have a 'sovereignty' to them that may make them difficult to manage (Paper III).

Peer-to-peer care practices are entangled with public care. They may be done when public care is insufficient, in addition to formal care or be evoked by public care. For example, by carrying out tasks not included in the home care services or accompanying another person to doctors' appointments (e.g. Paper I). Also, the peer-to-peer care practices may be supported by public care initiatives (paper III) or partly formalized, as when participants were 'trustees' (contracted by public care to safeguard a few peers' needs) (e.g. Paper II).

Peer-to-peer care practices are constituted by the conditions and circumstances in which they are done while they also influence these conditions. The findings of the papers in this thesis portray a few elements that were at play in the conditions and circumstances that constituted peer-to-peer care practices: *knowledge*, *norms*, *affects*, *things* and *places*. *Knowledge* related to experiences or expertise in a certain area or knowing how to go about things that enabled providing help with a specific matter. For example, knowledge on health and/or care was used to provide advice on health issues (e.g., Paper IV). *Norms* influenced what care that was deemed appropriate in a specific situation as well as how one should behave in relation to caring for others and others' caring care for oneself. This could involve, for example, how to be a good person or what was expected and appropriate in, for example, friendship relations (i.e., Paper I). *Affects*, while not explicitly mentioned in the papers, were found in the shape of feelings of intimacy in different relationships or attachment to others, such as bonds between long-time friends. *Affects* guided, for example, the flexibility of care (i.e., Paper I). *Places* influenced the ways in which care was and could be done. For example, different kinds of care activities were linked to different places. Such places include the older adult's home or an eldercare residence. Care could involve accompanying someone to places such as the hospital or the grocery store (e.g., paper IV). Finally, *things* are part of the conditions and circumstances that influence peer-to-peer care practices and were involved in care in a variety of ways in the papers in this thesis. Things influenced the ways care was done, as well as enabled and evoked care. For example, a coffee machine enabled for having coffee together and could be crucial for making space for care (e.g. Paper III). The different elements at play in peer-to-peer care practices also relate to each other. For example, in a situation where a

participant was helping a peer with technology both *knowledge* and *things*, among other elements, were involved (e.g. Paper I). How peer-to-peer care practices are *done* is also linked to *gender* and *age*, but the findings of this thesis do not provide examples of the mechanisms by which such a link may function (see Paper II).

6. Discussion and conclusions

This thesis aimed to explore everyday care between older adults and their peers, thereby providing both descriptive and conceptual understandings of this form of peer-based care. Furthermore, I have aimed to reason about how this type of care can be utilised through innovations involving public care. In the previous chapter, I answered the research questions linked to the aim of this thesis and established the concept of ‘peer-to-peer care practices’. In this chapter, I juxtapose³⁴ the concept of peer-to-peer care practices to the three perspectives on care portrayed in Chapter 2 (*Perspectives on care between older adults and their peers*³). Thereafter, I discuss the issue of utilising peer-to-peer care practices through innovations involving public care. Finally, I end this chapter by addressing what I believe are meaningful orientations for future research on care between older adults and their peers.

Juxtaposing the findings in the papers to other perspectives

There is little previous research that explicitly addresses care between older adults and their peers, as I have previously mentioned. To portray how care between peers could be understood, in chapter 2 in this thesis I, therefore, used research on older adults and care, which did not explicitly focus on care between older adults and their peers. To frame the concept of peer-to-peer care practices I now return to these perspectives and juxtapose peer-to-peer care practices against them. Thereby, I show how the idea of peer-to-peer care practices is both consistent with these perspectives and deviates from them and thereby extends the understanding of care between older adults and their non-family members.

Following the above-mentioned perspectives, care between older adults and their peers could be understood in terms of (1) a varied form of informal

³⁴ According to Grant, (2020:18) ‘juxtaposing’ or ‘juxtaposition’ “places a slice of a story, in all its density, proximate to other stories to propel an argument [...] It is a way to hold differences together conceptually, without requiring one story be read in terms of the other.”

care that occurs between older adults and their friends, neighbours, and other non-kin relationships (2) a form of care that occurs between people in groups or organizations centred around self-help or mutual-aid groups which are either ‘in-ward’ or ‘out-ward’ oriented, or (3) as a form of civic engagement that mostly concerns ‘lighter’ help provided to friends, neighbours and colleagues and that is linked to volunteering.

In line with the idea of the *first perspective* (1), peer-to-peer care practices can occur in a specific type of relationship such as between friends or neighbours. Peer-to-peer care practices can be characterised by some sort of dependency relation as well as reciprocity and have what could be termed ‘informal qualities’ as in the first perspective. For example, peer-based care can occur between friends for whom the relationship’s reciprocal characteristics are central, or it can involve more task-like care between an older adult and someone they consider to need care or as ‘the older person’ (e.g. Paper I). However, what is relevant in peer-to-peer care practices is not necessarily dependency or reciprocity, it might as well be self-care, inclusiveness or other matters (e.g. Paper III). Furthermore, peer-to-peer care practices do not exclusively occur in specific relationships such as those between friends and neighbours – they can occur between, for example, acquaintances or strangers. Also, peer-to-peer care practices do not solely happen in dyadic relationships but can occur as a form of group interaction, for example, between (more than two) older adults engaging in an activity. Peer-to-peer care practices may also be directed at such activity rather than other individuals, for example, towards a shared aim. This was the case for the peer-based care observed among the older adults in the walking group in paper III, i.e. to keep their weekly peer-based activity operating.

Understanding care as a form of group interaction is in line with the *second perspective* (2). From this perspective we may discern between a ‘we-for-us’ inward and a ‘we-for-them’ outward orientation in such groups. While care as part of a ‘we-for-us’ orientation was found in the papers included in this thesis, a ‘we-for-them’ orientation was not explicitly portrayed in any of the papers. Nevertheless, some of the participants mentioned being engaged in groups or activities to care for other older adults (who were not members of the same group). For example, through friends-services’ (‘väntjänster’). Thus, peer-to-peer care practices may occur in groups with this orientation – but this is an area for future research. In line with the second perspective, peer-to-peer care practices can involve some form of non-authorial quality. This could be observed in paper III where the participants made sure that all members in the walking group agreed on the decisions being made. Finally,

peer-to-peer care practices may occur in groups or activities that are formalised to some degree as was the case in the walking group in paper III.

One aspect of the *second perspective* (2) that in some ways contradicts the idea of peer-to-peer care practices is the idea of a shared understanding or shared experience as the base for care. Some of the participants expressed that care is linked to a shared understanding, such as arranging daily phone calls with a friend because both were lonely during the COVID-19 pandemic (not described in any paper). Nevertheless, for the most part, the findings of this thesis do not portray that a ‘shared experience’ would constitute peer-to-peer care practices. Instead, participants could have different experiences that played into why they engaged in the same care practices (see Paper III). This is noteworthy as many mainstream innovations that target older adults rely on ideas of older adults as sharing similar experiences because they are “old” (cf. Bischof & Jarke, 2021).

As mentioned in Chapter 3 in this thesis (*Theoretical perspectives on care, innovations and older adults*) age categorisations are inevitably homogenizing; they assume that those within the category are ‘the same’. Similar to categorizations by sex or ethnicity, they are not neutral, but link to ideas on ‘old age’. While chronological age is a central organizing principle in Swedish society and is used as a ‘proxy’ for, for example, the need for care due to old age (Harnett, 2020; Harnett, 2021) it is problematic when used in innovation projects to approach older adults as ‘the same’. For example, when innovations target ‘all older adults’ instead of smaller groups of older adults that do share the same experience of something. This type of approach has been critiqued by, among others, Peine et al (2021) who argue that mainstream approaches to ageing and technology rely on disturbing stereotypes of older adults.

In line with the *third perspective* (3), peer-to-peer care practices mostly involve the provision of ‘lighter help’ to peers. That is, although they can be responsive to extensive care needs, peer-to-peer care practices seldom involved medical care such as wound dressing or medicine distribution – care that could be understood as ‘heavier’ (cf. Jegermalm et al., 2014). Peer-to-peer care practices can be considered a form of civic engagement – that is, if civic engagement is understood as ‘volunteering’ (e.g., paper II). Thus, the concept of peer-to-peer care practices, in line with the above-mentioned third perspective, points to the entanglement of care and volunteering. However, thinking of peer-based care as *practices* (Mol et al., 2010) enable us to think about care beyond specific relationships between individuals (in dyads or groups) or a specific form of engagement or activity, such as civic engagement. Instead, we may look for actions of care that occur between

older adults in different situations. This way, the phenomenon of peer-to-peer care practices cut across the three above-mentioned perspectives, both resembling and differing from them.

One way in which the idea of peer-to-peer care practices differs, which I have not yet discussed, is that in all three above-mentioned perspectives formal and informal care are taken to be two distinct spheres for care that have different qualities and that are different to each other³⁵. This is a common and important theoretical separation in research and theories on care (Pfau-Effinger & Rostgaard, 2011), but one that needs to be scrutinized if we wish to reason about the utilisation of this peer-based care through innovations involving public care.

Utilising peer-to-peer care practices?

In this section, I discuss utilising peer-to-peer care practices through innovations involving public care. First, I discuss the issue of *informal vs. formal care*, and how the participants' care practices were often related to formal care. Second, I discuss the idea of *managing self-management* and how the logic of care can guide us in thinking about this. Third, I discuss the *technology and innovativeness already there in older adults' care practices* and, finally, I (cautiously), based on the findings of this, thesis provide some action-oriented advice on *how to cultivate 'peer-to-peer care practices'* through innovations involving public care.

Informal vs. formal care?

The idea of utilising peer-to-peer care practices through innovations involving public care implies – at least to some degree – weaving it together with public care. Several innovation initiatives aim to draw on the informal care that older adults are somehow engaged in (Brandt et al., 2012; López-Gómez et al., 2021; Shaw et al., 2020). At the same time, there is a range of

³⁵ For example, studies such as Barker (2002), Grime (2018) and Lapierre and Keating (2013) argue that care between older adults and their friends and neighbours is different from professional care and should not be formalized, for example, Jegermalm and Jeppsson Grassman (2009) and Jegermalm and Sundström (2014) postulate that the independence from public welfare is an important aspect of older adults civic engagement. Similar ideas are found also in other fields (Brandsen, Trommel, & Verschuere, 2017).

research that warns against turning the informal into something formal³⁶. As an example, Nocon and Pearson (2000) state that care and support between older adults and their friends and neighbours cannot be artificially created or heavily regulated by statutory agencies. Instead, it needs to be supported in 'its own right'. This perspective resembles the ideas of Mol et al. (2010), but Nocon and Pearson (2000) argue that this is because of the 'informality' of this care and its difference from public care. Mol et al. (2010) argue that care needs to be supported in its own right because of its specificities. For Mol et al. (2010) these specificities of care are not linked to either an informal or a formal sphere but may occur in both. Thereby, the idea of care practices by Mol et al. (2010) allows for thinking about care between older adults and their peers as something that is not strictly 'informal', but that can have 'informal qualities' while also being influenced by formal care. From this perspective, we may refrain from making a distinct division between formal and informal care.

The idea that informal care between older adults is alien to professional or 'artificial' care, i.e. that is it 'natural' and that work precisely thereof (cf. Barker, 2002), enables the idea of peer-based care as 'untapped' (cf. Peine et al, 2021). Untapped, that is, concerning its potential of contributing to public care through, for example, older adults' self-management of their own and others care needs. The peer-based care that the participants in this thesis engaged in was not distinctly separated from public care. Rather it was entwined with public care. The participants supplemented and organized public home care services; they drove peers to, for example, the grocery store so that they would not have to pay for public travel services ('färdtjänst'), they acted as a trustee ('god man') for peers, and they provided help when home care services did not. In sum, older adults were already self-managing themselves and their peers in ways that supposedly promoted public care. Thus, care between older adults and their peers was not as 'unregulated' and 'un-intervened' as an idea of untapped informal resources would suggest.

Instead of overlooking these and other types of care among older adults and their peers due to their lack of newness (cf. López-Gómez et al., 2021), those aiming to utilise this care as a means for public care should build on the care that is already there in many older adult's lives. It is in these practices that new solutions need to be integrated (Damsholt & Jespersen, 2014). Finally, if one wishes to utilise this peer-based care through innovations involving public care, this is perhaps not a question about formalizing the

³⁶ This should be considered in light of a long tradition in, for example feminist research, of dividing care as either a work of love in the private/informal sphere or as a form of maintenance/professional work (Pfau-Effinger & Rostgaard, 2011).

informal but of *cultivating* care practices, which on many occasions are already entwined with public care.

Managing self-management?

The public sector can be said to have a specific ‘identity’ shaped in and by politics through a binding allocation of values that must be balanced in specific situations. Therefore, innovations that attempt to meet social needs must be assessed in terms of efficiency and effectiveness, as well as acceptance of specific groups or by society needs to be considered (Bekkers et al, 2011). The peer-to-peer care practices that participants engaged in, although they were entwined with public care, differed from public care in terms of the norms that conditioned them. The logic of peer-to-peer care practices, while being attentive to others suffering, care was not necessarily efficient, effective, legitimate, or appropriate from a public care perspective. This created clashes when attempting to utilise peer-based care through innovations involving public care, as shown by Paper III.

In paper III, clashes occurred between the municipal services’ need for an appropriate and effective care service and the older adults’ unwillingness to take on the responsibility to ensure this type of service. The older adults were asked to self-manage and self-organize and thereby co-produce a form of public service, but at the same time, the municipal staff had to manage the group for it to align with the above-mentioned public principles. The older adults did not comply with such management and thereby the co-production generated more work for the municipal staff (instead of less) and put the co-produced service, which had great importance for many of the participants, at risk.

Additionally, Paper IV showed that the respondents, 70 years and older, were by no means passively accepting different forms of attempts to regulate their care through age-specific restrictions during the COVID-19 pandemic. Rather, they violated rules, such as age restrictions, and stretched them to fit their circumstances. This points to the complexities when attempting to manage self-management, which need to be taken into consideration when attempting to utilise peer-to-peer care practices in innovation involving public care. Perhaps if we consider this type of complexity, we may thereby also abstain from nostalgic images of informal care as structures that can simply be activated? (cf. Wærness, 1984; Wærness, 1980).

The findings from Paper III propose one way of handling clashes and tensions between different logics when utilising peer-based care between

older adults: the digital platform developed as part of the Give&Take innovation functioned as a 'boundary object', which enabled the co-production of care between the municipality and older people, although their logics clashed. This was enabled by the loose character of the co-production that the digital platform contributed to. Boundary objects, as described by Leigh Star (2010) and Star and Griesemer (1989), are shared spaces that allow different groups to work together without consensus. According to Star and Griesemer (1989), consensus is not needed for cooperation or successful work. Similarly, Suchman (2002) argue that resistance to change or premises of a particular agenda could be seen as a requirement for sustainable innovation. Previous research has shown how competing values of, as an example, standardisation and 'looseness' are formed into working solutions in healthcare through both technology and persistent tinkering (Lydahl, 2019). As shown in paper III, there was no consensus between the older adults and the municipality care services; still, the work was 'successful' in creating opportunities for older adults to socialise and care for each other, which they did. Adding to this, this form of partnership also supposedly benefited the older adults.

A boundary object is not pre-made but emerges through actions (Leigh Star, 2010). Hence, from this perspective, the task would not be to implement 'new' technology into the lives of older adults. Instead, it would be to explore that which 'can be brought together and that which must be kept apart' between this type of peer-based care and public care services in terms of co-producing public care (Allen, 2020:360). Thus, the aim with innovations involving older adults peer-to-peer care practices would be to 'seek compromises between different 'goods' [...] as a matter of practical tinkering, of attentive experimentation' (Mol, Moser and Pols, 2010:13). As opposed to intervening in older adults' everyday care. *Cultivating* peer-to-peer care practices through innovations involving public care would thus not be done at one point in time, but it would be about continuous collective efforts in everyday practices (Suchman, 2002).

Technology and innovativeness already there in peer-to-peer care practices?

Previous research has almost exclusively focused on older adults use of new technological devices, as opposed to technologies that are already there in older adults' lives (Bergschöld et al., 2020). The findings in this thesis point to how technology is part of the participants' care to their peers. As an

example, many of the participants in the four papers used phones when caring for their peers. On many occasions care also involved computers and different forms of online communication (mail, social media etc.). Thus, technology was already there in older adults' peer-to-peer care practices. Furthermore, some of the participants used this technology to adapt their care practices when they, for example, could not meet up in person (see paper IV). There is a need to consider the many ways that groups of older adults already engage with technology, as well as how they improvise in relation to technology, when developing innovations (López-Gómez et al., 2021).

In this thesis, when reflecting on the utilisation of peer-to-peer care practices through innovations involving public care I have focused on innovation in a traditional sense. That is, as a 'thing'. I have also explored older adults' care practices using the concept of maintenance and repair to point to their innovative qualities. This way we may pause the distinction between creative improvisation in everyday life as a process and innovations as a product or a 'thing' (cf. Pink et al., 2019). As shown in paper IV, this way we may discover how care between older adults and their peers change without the intervention of an innovation. Recognizing the generative nature of older adults improvisation when engaging in care in relation to their circumstances may provide clues on how to *cultivate* peer-to-peer care practices as well as how to develop other innovations involving older adults. Peine et al (2021:4) have asked what will happen if we put focus 'on the many creative and resourceful solutions, technical and non-technical, that many older adults themselves have come up with?'. They argue that this would enable apprehending alternative worlds and ageing futures, and I would like to add that it would enable more 'innovative' solutions³⁷.

Action-oriented advice on how to *cultivate* peer-to-peer care practices

As mentioned in the preface of this thesis, my PhD studies started with the aim to contribute to the knowledge on how to develop a platform for the exchange of services and knowledge among older adults and their peers. This thesis came to revolve around care between older adults and their peers and the idea of utilising this peer-based care in innovations, instead of contributing with knowledge on how to develop a specific platform. Nevertheless, it does provide some action-oriented guidance for researchers

³⁷ As noted by Suchman et al. (2007) most discussions on innovations are surprisingly repetitive.

and practitioners³⁸ on how to approach *cultivating* peer-to-peer care practices through innovation projects. For the advice to be as direct and accessible as possible, it takes the shape of five bullet points:

1) *Take care as the starting point – as opposed to the promises of technology*

First, taking care practices between older adults and their peers as the starting point when reflecting on how this care can be cultivated prompts thinking about how this care is best supported – instead of reflecting on how a certain technology can support this care. As noted by Mol et al (2010) to develop care there is a need to build on what is already there. Thus, if one aims to *cultivate* peer-to-peer care practices it is important to recognize the care that is already there in participants' lives. It is also in these practices that new innovations are to be integrated.

2) *Consider who engages in peer-to-peer care practices*

The findings from this thesis show that peer-to-peer care practices are diverse and can include a range of different activities. Thus, many different individuals may be involved in this form of care. Nevertheless, as shown in paper II, activities of peer-based care are associated with sex and age. It was more common for 'older' older adults to engage in social activities and the gendered patterns for care resembled those previously found in a family context (Ekwall et al., 2004). Therefore, it is important to consider who may engage in peer-based care and who does not. Finally, it may also be important to reflect on what such patterns of involvement imply.

3) *Do not assume a shared experience among older adults*

Many technological innovations aim to address older adults shared experiences among older adults. One such experience which is commonly targeted is loneliness. Concerning loneliness, the findings from this thesis suggest that social activities between peers may indeed affect the experience

³⁸ The advice are for researchers and practitioners, not policy makers. Thus, I do not discuss the fact that a comprehensive elderly care system may be the best guarantee for upholding and promoting informal activities such as peer-based care (cf. Jegermalm & Sundström, 2014).

of social isolation, but this needs to be further studied. The findings from this thesis point to older adults' having different experiences while being involved in, sometimes the same, care practices. Rather than aiming to address a shared experience among older, innovation initiatives that aim to cultivate peer-based care among older adults should acknowledge the variety of these experiences.

4) *Consider the creative solutions that those engaged in peer-to-peer care practices come up with*

The findings of this thesis suggest that there is a need to recognize the 'innovativeness' in peer-based care among older adults. Additionally, there is a need to explore how technology links to such creativity and inventiveness. Give the questions *what will happen if we put focus 'on the many creative and resourceful solutions, technical and non-technical, that many older adults themselves have come up with?' some serious consideration (Peine et al 2021:4). Perhaps it will generate more innovative thinking?*

5) *Seek compromises not consensus between different logics*

Cooperation and successful work does not necessarily involve consensus (Star & Griesemer, 1989). It may not be possible to align certain norms and values when trying to *cultivate* older adults peer-to-peer care practices. Instead, innovation might be about seeking compromises and exploring what could be brought together and not between peer-to-peer care practices and public care, while allowing for tensions to arise and fade. The idea of 'boundary objects' (see discussion above) may guide such attempts.

Directions for future research

This thesis contributes to a practice-based understanding of care between older adults and their peers. This perspective has allowed me to stay open to what care might be (and become) rather than restricting my exploration to a certain set of features of peer-based care. By trying to follow care in older adults' everyday lives while not making difference between essential and accidental characteristics (cf. Mol et al 2010), I have constructed the concept of peer-to-peer practices. Thereby I have contributed to generating

conceptual understanding from practice about care between older adults and their peers as both a *phenomenon* and as a *perspective* (cf. Orlikowski, 2015). As a *perspective*, the concept of peer-to-peer practices is meant to evoke the theorisation of actions, patterns, and connections in care between older adults and their peers. It calls for attending to this care between older adults as a complex phenomenon with a specific mode of working. Such calls are needed as care is treated as something easy to handle, uniform and un-complex (Roberts & Morts, 2009) and, when it comes to innovations for older adults and care, still figures as a somewhat ‘practical necessity, rather than an intellectually interesting topic’ (Mol et al, 2010:7).

The phenomenon of care between older adults and their peers can be considered an interdisciplinary matter where there is knowledge and understandings in many different disciplines, which could enrich each other. I propose future research aiming at utilising informal care among older adults to take interdisciplinarity seriously to avoid inventing the wheel all over again.

More specifically, peer-to-peer care practices should be analysed in relation to specific situations and groups to discern how these are practices linked to different situations – one intriguing area is that of so called ‘senior housing’, meaning co-housing for older adults, often those aged 55 years or older. Research suggests that extensive informal care between older adults in co-housing implies less of a need for public care (Sundström, 2002). Such studies would possibly benefit from an ethnographic approach that can provide detailed descriptions of care practices.

There is also a need for more research on how older adults make use of seemingly mundane things and technologies in providing care to their peers, as mentioned above. This exploration has not been within the scope of this thesis but would further inform the understanding of peer-to-peer care practices.

Finally, practices are not attached to people, but people engage in them. This thesis has explored peer-to-peer care practices among older adults. The idea of peer-to-peer care practices can possibly also be used to understand peer-based care in other groups.

Sammanfattning på Svenska

”Jag gör inte så mycket - men jag håller ett öga på min granne som är rätt skräpelig, jag kollar att hon tar sin medicin, jag pratar lite med henne (på avstånd i dessa dagar) och tar lite kontakt med hennes dotter som bort rätt långt borta, när jag tycker att hon ser för dålig ut. Ingen stor insats, men det betyder en del för henne att hon kan ringa på min dörr även mitt i natten, för att hennes hjärta bankar så väldigt. Eftersom jag själv är 77 så blir det inte någon hjälp med inhandling av varor, det sköter något av hennes barnbarn.” (Kvinna, 75–79 år, boende i en större stad, juni 2020)

Den här avhandlingen handlar om vardaglig omsorg mellan äldre personer och andra äldre personer som inte är deras familjemedlemmar (såsom vänner och bekanta). På engelska kallar jag dessa ”peers”. En term som bland annat kan förstås som att personer är ”jämnåriga” eller tillhör samma åldersgrupp. Avhandlingen handlar samtidigt om äldreomsorg. Vid första anblicken kan dessa två områden; vardaglig omsorg mellan äldre personer som inte är familjemedlemmar och äldreomsorg, tyckas vara långt ifrån varandra. Samtidigt har trender inom äldreomsorg, inklusive intåget av *innovationer* i äldreomsorgen, äldrepolitiken och en stark tilltro till teknik fört dem närmare varandra. På så sätt har det också skapats nya utmaningar för forskare och personal inom äldreomsorg. En av dessa utmaningar är att samtidigt som innovationer ämnar tillvarata omsorg mellan äldre personer så förbises ofta själva omsorgen då fokus läggs på potentialen hos tekniska lösningar.

I den här svenska sammanfattningen av avhandlingen beskriver jag kortfattat avhandlingens syfte, frågeställningar, teoretiska ramverk och det empiriska materialet. Jag sammanfattar även resultatet från de fyra artiklarna som ingår i avhandlingen (den fjärde är inte publicerad). Till sist så beskriver jag kort de slutsatser jag dragit utifrån fynden i de fyra artiklarna.

Syfte, frågeställningar, teori och material

Syftet med avhandlingen är att utforska vardaglig omsorg mellan äldre personer som inte är familjemedlemmar (såsom vänner och bekanta) och skapa kunskap om detta fenomen. Vidare är syftet att resonera kring idén om att nyttja den här typen av omsorg genom innovation som involverar offentlig

vård- och omsorg. På så sätt ämnar jag att bidra med kunskap som kan stödja utvecklingen av omsorgstjänster för äldre personer. Avhandlingen har fyra frågeställningar som besvaras i fyra olika artiklar:

1. Hur ger äldre personer som inte är familjemedlemmar omsorg till varandra? Hur är ömsesidighet en del av dessa praktiker?
2. Vilken typ av informell omsorg och stöd ger äldre personer till andra äldre som inte är deras familjemedlemmar? Hur är de förknippade med demografiska karaktäristika och social isolering?
3. Vilka spänningar uppstår inom sociala innovationer i skärningspunkten mellan formell och informell vård och hur navigerar äldre personer möjligheter till att samproducera omsorg i relation till dessa spänningar?
4. Hur beskriver personer 70 år eller äldre den omsorg de gav till andra äldre som inte var familjemedlemmar under Covid-19-pandemin i Sverige? Hur speglade dessa beskrivningar olika former för upprätthållande av ordning av ett ”normalt” vardagsliv?

I avhandlingen använder jag mig av ett praktikorienterat perspektiv på omsorg. Ett praktikorienterat perspektiv sätter handling i fokus i stället för individer. Det sätter också det vardagliga och rutinemässiga som centralt i den vetenskapliga analysen. Det innebär att jag sett på omsorg som en form av sociala handlingar som människor engagerar sig i samt att jag har fokuserat på just den vardagliga omsorgen. I detta synsätt är det inte enbart människor som kan vara involverade i omsorg utan även ting såsom en mobil eller en dator. Vidare så påverkas omsorgspraktiker av den situation i vilken de sker. Med andra ord så skapas omsorgspraktiker inte enbart av människor utan även av den kontext i vilken de sker samt de ting som är inblandade i den. Slutligen så möjliggör ett praktikorienterat perspektiv att man som forskare kan förhålla sig öppen för det som sker i praktiken snarare än förstå det inom ramen för ett snävt teoretiskt ramverk.

De fyra artiklar som ingår i avhandlingen baseras på tre olika datamaterial. Den första artikeln bygger på 30 individuella intervjuer med äldre personer. Den andra och den fjärde artikeln baseras på en webb-enkät besvarad av 10 044 personer 65 år eller äldre. Den tredje artikeln bygger på etnografiska observationer av ett innovationsprojekt som syftade till att nyttja omsorg mellan äldre personer (som inte var familjemedlemmar) och inbegrep offentlig vård- och omsorg. Det etnografiska materialet baseras på observationer av innovationsprojektet samt individuella intervjuer med deltagare i projektet.

Sammanfattning av resultatet från artikel I

Den första artikeln undersökte hur äldre personer som inte var familjemedlemmar (såsom vänner eller bekanta) gav omsorg till varandra och hur ömsesidighet var del av denna omsorg. Materialet som låg till grund för den första artikeln innefattade som sagt 30 individuella intervjuer med personer 65 år eller äldre som bodde i Göteborg, Falkenberg eller Kiruna. Intervjuerna tog omkring 60 minuter och gjordes med hjälp av en intervjuguide med på förhand bestämda frågor. Samtliga intervjuer genomfördes mellan december 2017 och maj 2018. Deltagarna rekryterades via pensionärsorganisationerna PRO samt SPF Seniorerna.

Resultatet från artikeln visade att den här omsorgen kunna handa om ”allt”. Den innefattade allt från att fråga om ens hälsa till att ge råd om hur man skulle gå tillväga för att hantera en viss teknisk pryl. Snarare än att vara i form av avgränsade uppgifter så var omsorgen alltså heterogen och mångfacetterad. Omsorgspraktikerna bland deltagarna i studien innefattade till exempel att hålla ett öga på sina vänner eller grannar för att se till att de mår bra eller att prata med en vän om sjukdom eller problem.

Jag undersökte hur omsorgen relaterade till ömsesidighet och fann tre olika grupper av omsorgspraktiker där tre olika typer av ömsesidighet speglades. Dessa var *”omsorg som en del i att vara en vän eller granne”*, *”omsorg till någon som behöver den”* samt *”omsorg för oss”*. Deltagarna kunde vara involverade i en av dessa grupper av omsorgspraktikerna eller i alla tre. De olika typerna av omsorgspraktiker tycktes ge deltagarna olika form av värde samt var kopplad till att hantera risker för dem själva och andra, av vilka några handlade om att bli sjuk, ensam eller att åldras.

Den första formen av omsorgshandlingar *”omsorg som en del i att vara en vän eller granne”* kopplade till en typ av balans av att ge-och-ta samt en typ av pålitlighet och beskrevs ofta som en självklar del av att vara till exempel vänner. Den här omsorgen var tätt kopplad till normer om hur man bör vara som en god vän eller granne. Omsorgen skedde på olika platser, men omsorgen mellan grannar var ofta förknippad med den äldre persons hem.

Den andra gruppen av omsorgspraktiker *”omsorg till någon som behöver den”* handlade i högre grad (än ovan nämnda omsorgspraktiker) om att ge omsorg till någon eftersom de var i behov av det. Den här omsorgen var också oftare mer enkelriktad och mindre flexibel samt mer uppgiftlik än omsorgen mellan vänner och grannar. Den styrdes ofta av idéer om hur man kan vara en god människa och göra något rättfärdigt, samtidigt som deltagarna också konstruerar den personen som de gav omsorg som *”den beroende gamla personen”*. För att engagera sig i den här typen av omsorg krävdes bland annat att deltagarna hade kunskap eller resurser för att hjälpa den andra eller

de andra personerna. Sådana resurser kunde vara en bil eller att personen bodde i samma område.

Den tredje formen av omsorg ”omsorg för oss” handlade om omsorg som en del av en aktivitet eller en klubb. Deltagarna beskrev sällan den här formen av omsorg i termer av just omsorg. Snarare skedde omsorgen när de deltog i de här aktiviteterna. Deras deltagande kunde handla att ta hand om sig själva och tillgodose sina egna behov. Mer specifikt kunde den här typen av aktivitet involvera att träna i grupp med andra äldre eller att delta i en kurs om telefoner och datorer. Omsorgen skedde som en del i att deltagarna tog hand om aktiviteterna och såg till att de fungerade. Ömsesidighet i omsorgen upprätthölls av formaliserade strukturer snarare än relationer mellan två äldre personer. På liknande sätt styrdes omsorgspraktikerna av värderingar och skyldigheter gentemot det aktuella nätverket, klubben eller föreningar.

De tre olika typerna av omsorgshandlingar involverade inte bara äldre personer utan även ”ting”, som telefoner eller bilar. Slutligen bör de som önskar att främja den här typen av omsorg försöka förstå den utifrån hur den sker i äldre personens vardag och inte utifrån ett nyttofokus baserat utifrån offentlig vård- och omsorg.

Sammanfattning av resultatet från artikel II

I den andra artikeln så undersökte vi vilken typ av informell omsorg och stöd äldre personer ger till andra äldre som inte är deras familjemedlemmar samt hur denna omsorg är förknippad med demografiska karaktäristika och social isolering. Artikeln baseras på ett antal frågor i en web-enkät som distribuerades till äldre personer via Medborgarpanelen vid SOM-institutet vid Göteborgs universitet. Enkäten skickades ut och besvarades i juni 2020 under en tid då Covid-19 hade en stor påverkan på det svenska samhället. För att analysera frågorna som inbegrep en fråga med fritextsvar så använde jag mig av s.k. mixad metod.

Totalt svarade 10 044 personer 65 år eller äldre på enkäten. Av dessa var det 2155 respondenter (21,5%) som gav stöd eller omsorg till andra äldre som inte var deras familjemedlemmar. Det var mer troligt att respondenterna gav omsorg om de var äldre än 80 år, man, gifta eller i ett förhållande och bodde i en större stad. Den vanligaste typen av omsorg eller stöd till andra äldre var praktisk/instrumentell hjälp (50,6%) samt sociala aktiviteter (25,1%). Omkring 8% angav att de var engagerade i volontärverksamhet som en del i att ge omsorg och stöd till andra äldre. 10,5% angav att de var involverade i ”lite av varje”. Enbart 5,7% var involverade i mer vårdorienterad omsorg.

Fler män och respondenter som var yngre än 75 år, jämfört med kvinnor och respondenter som var äldre än 75 år, var engagerade i praktisk/instrumentell hjälp eller volontärverksamhet. Respondenter som var äldre än 80 år var oftare engagerade i socialt stöd och omsorg jämfört med yngre respondenter. Jag fann ingen statistiskt säkerställd skillnad mellan att vara involverad i olika typer av omsorg och demografiska faktorer såsom inkomst, anställningsform (de flesta var pensionerade), storlek på den stad respondenterna bodde i eller födelseland.

När det gäller social isolering så fann vi inte någon statistiskt säkerställd skillnad i upplevelse av social isolering mellan personer som gav någon form av stöd eller omsorg och de som inte gjorde det. Däremot så var respondenterna med det högsta upplevelse av social isolering oftare engagerade i mer vårdorienterat omsorg. De var också ofta äldre än 85 år. Respondenter som var 85 år eller äldre *och* engagerade i mer vårdorienterade stöd och omsorgsaktiviteter upplevde en högre grad av social isolering jämfört med de som var engagerad i praktisk/instrumentell hjälp eller sociala aktiviteter i samma åldersgrupp. Samma mönster fanns bland yngre respondenter. Generellt så upplevde kvinnliga respondenter, respondenter som var äldre än 85 år, respondenter med lägre inkomst och utbildning och respondenter som var änkor/änklingar en högre grad av social isolering jämfört med motsatta grupper.

Resultaten antyder att stöd och omsorg mellan äldre personer i form av engagemang i praktisk/instrumentell hjälp eller sociala aktiviteter möjligen kan bidra till välmående och minskad upplevelse av social isolering bland äldre personer. Slutligen så visar resultaten, i linje med tidigare studier att olika typer av informella aktiviteter är ett vanligt förekommande fenomenen bland äldre personer i Sverige.

Sammanfattning av resultatet från artikel III

För att få insikt i hur omsorgen mellan äldre kan nyttjas och stödjas av innovationer som involverar ny teknik studerade jag under maj 2019 till december 2019 ett specifikt innovationsprojekt: Give&Take. Projektet var ett treårigt (2014–2017) danskt forskningsprojekt som fokuserade på att tillsammans med äldre personer, kommunal personal samt privata företag skapa en ny tjänst för utbyte mellan äldre personer. Den nya tjänsten var en digital peer-to-peer-plattform tänkt att stödja och organisera utbyte av tjänster och social kontakt mellan äldre personer (som inte var familj).

Projektet byggde på idén om möjlighet till förnyelse av äldreomsorgens tjänster genom nyttjandet av äldres egna resurser.

Inom ramen för artikel III så undersökte jag en av de kontexter där innovationen (den digitala plattformen) introducerats. Denna kontext var en promenadgrupp för äldre personer som initierats av kommunen. Promenadgruppen var ett försök att skapa nya former av omsorgstjänster genom äldre medborgares engagemang. Gruppen byggde på att de äldre själva organiserade de veckovisa promenaderna och att kommunen höll översikt över dem. Give&Take-projektet och den digitala plattform som projektet skapat var tänkt att stärka den sociala interaktionen och utbytet av tjänster mellan de äldre personerna i promenadgruppen. Tanken var samtidigt att den digitala plattformen skulle hjälpa de äldre i att organisera promenadgruppens aktiviteter. Utöver detta skulle plattformen fungera som en länk mellan promenadgruppen och den kommunala personalen.

Min undersökning av Give&Take projektet fokuserade på vilka spänningar som uppstod när omsorg skulle samproduceras inom ramen för innovationsprojektet och hur de äldre personerna navigerade möjligheter till omsorg i relation till dessa spänningar. För att undersöka detta använde jag mig av etnografiska metoder. Det innefattade bland annat observationer och individuella intervjuer. Jag studerade Give&Take projektet både retrospektivt samt i dess dåvarande tillstånd.

Fokus för studien låg på den socio-materiella förutsättningarna som skapade möjligheter till omsorg. Detta innefattade inte bara människor utan även ting. Jag fokuserade särskilt på de äldre personerna i promenadgruppen och den digitala plattformen som Give&Take projektet skapat. Detta till trots så framgick det att även andra materiella ting såsom den lokal där gruppen möttes upp inför samt efter deras promenad hade betydelse för omsorgen i gruppen.

Jag fann att den digitala plattformen skapade möjligheter till omsorgspraktiker bland de äldre deltagarna. Plattformen möjliggjorde att relationerna mellan personerna i promenadgruppen fördjupades (och därmed skapade möjligheter till omsorg mellan dem), den 'spårade' också promenadgruppens aktiviteter så att den kommunala personalen kunde ha en överblick över hur det gick för gruppen (om de var ute och gick eller hur långt de gått) och därmed stötta dem vid behov. Plattformen bidrog samtidigt också till att formalisera de äldres deltagande i gruppen och fördela ansvar för promenadgruppen mellan dem.

Samtidigt så möttes de möjligheter till omsorg som plattformen öppnade upp för av motstånd från de äldre deltagarna. De motsatte sig formaliseringen av deras närvaro i gruppen, betonade kontroll över "deras" promenadgrupp,

värnade sina egna gränser och, även om de brydde sig om andra deltagare, så motsatte de sig att ta på sig personligt ansvar för promenadgruppen och omsorgen om andra.

Spänningar uppstod således när kommunen genom plattformen försökte övervaka samt styra promenadgruppen för att den skulle överensstämma med kommunens principer. Gruppens deltagare motsatte sig i hög grad sådan övervakning och styrning. För den kommunala personalens del så behövdes att de äldre skulle ta ansvar för promenadgruppen på ett särskilt sätt för att säkerställa gruppens ändamålsenlighet utifrån kommunens perspektiv. Samtidigt som deltagarna självorganiserade aktiviteten, så som det var tänkt, innefattade det att de också drog sig ur mer formellt ansvar för gruppen. Detta skapade problem för kommunen samt förhindrade de möjligheter till omsorg som den digitala plattformen bidrog med. Därmed så kunde kommunen inte skapa en samproduktion som skulle leda till en legitim och samtidigt självorganiserad omsorgstjänst utifrån deras egna principer. Slutligen, genom att fokusera för mycket på kommunens kompetens och intressen kom samproduktionen att handla mer om att administrera omsorg än faktisk omsorg.

Samtidigt fungerade plattformen, genom att löst knyta promenadgruppsdeltagarna och kommunen till varandra genom skyldigheter, som ett 'gränsobjekt'. Detta 'gränsobjekt' underbyggde en form av partnerskap som möjligen också gynnade de äldre deltagarna. Avslutningsvis så är det viktigt att beakta inte bara logiker och normer från offentlig verksamhet utan även omsorgens logiker och normer vid försök till samproduktion av omsorgstjänster som involverar offentlig verksamhet och äldre personer.

Sammanfattning av resultatet från artikel IV

I den sista och fjärde artikeln i avhandlingen (som är i s.k. manusform) undersöker jag hur personer 70 år och äldre gav omsorg till andra äldre (som inte var familjemedlemmar) under Covid-19 pandemin i Sverige. Datamaterialet som låg till grund för denna undersökning var detsamma som i artikel II. Alltså en web-enkät vid Medborgarpanelen insamlad i juni 2020. Däremot så analyserade jag enbart fritextsvar av äldre personer angående vilken typ av stöd de gav till andra äldre. Sammanlagt utgjordes analysen av 1327 korta fritextsvar.

Under denna period rådde omfattande åldersspecifika restriktioner i Sverige som påverkade vardagen för personer 70 år och äldre. Trots detta ägnade sig respondenterna åt en mängd olika omsorgsaktiviteter. Dessa var

kopplade till andras eller det egna hemmet och till stöd och hjälp utanför hemmet. Omsorgen skedde också via telefon.

Omsorgen handlade bland annat om att göra hushållssysslor, handla åt andra äldre personer eller att mötas upp för att socialisera. De omsorgsaktiviteter som respondenterna beskrev innefattade även ting. Till exempel när omsorgen handlade om att hjälpa till med hushållssysslor eller praktisk hjälp i en annan persons hem.

Omsorgen kunde också vara del av ett volontäringagemang eller ett delvis formaliserat uppdrag som att vara god man för en annan äldre person.

Jag analyserade även hur den här omsorgen speglade olika former för upprätthållande av ordning av ett ”normalt” vardagsliv. Upprätthållandet av en ”normal” vardag som en del av omsorgsaktiviteterna kopplade till att *stödja andra äldre personer i att klara av deras vardagliga rutiner* trots de omständigheterna som följde av Covid-19. Exempel på sådana omständigheter var behovet av att hålla fysisk distans till andra, att inte kunna åka och handla i affären eller att behöva undvika kollektivtrafik. Respondenternas omsorg handlade bland annat om att hjälpa till att möjliggöra att andra äldre kunde ha social kontakt med andra trots behov av fysisk distans, att se till att de kunde handla mat eller att de kunde ta sig till läkarbesök utan att behöva ta kollektivtrafik. När respondenterna hjälpte andra äldre personer att behålla sina rutiner gjorde en del det samtidigt som de själva följde de åldersspecifika restriktionerna. Andra gjorde det och bröt mot restriktionerna. Ofta beskrev respondenterna ålder som en princip som avgjorde hur man skulle engagera sig i omsorg för andra.

En annan form av upprätthållande av ordning av ett ”normalt” vardagsliv som respondenternas omsorgsaktiviteter omfattade var att *upprätthålla de egna omsorgsrutinerna*. Alltså att fortsätta ge omsorg till andra trots omständigheterna.

Eftersom det fysiska rummet för omsorg krackelerade under Covid-19-pandemin då man bland annat var tvungen att hålla fysisk distans till andra, var respondenterna tvungna att improvisera för att upprätthålla sina egna omsorgsrutiner. Improvisation handlade i de här fallen om att hantera det fysiska rummet och fysiska avstånd på olika sätt. Till exempel så möjliggjorde respondenterna sin omsorg till andra genom att mötas upp och samtidigt hålla två meters avstånd inomhus, genom att träffas ute eller genom att umgås tillsammans via telefonen. Samtidigt kunde inte all omsorg mellan äldre personer upprätthållas under den aktuella tidsperioden. I stället sattes till exempel volontärverksamhet såsom ”fixartjänster” på paus.

Avslutningsvis konstaterades i artikel IV att äldre personer inte enbart var passiva mottagare av omsorg, stöd och hjälp under Covid-19-pandemin i Sverige. Istället så hjälpte respondenterna andra äldre personer att hantera

vardagen under de rådande omständigheterna och bidrog på så sätt till det allmännas bästa. Resultatet visar också på att respondenternas omsorg innehöll inslag av uppfinningsrikedom och innovation i att skapa nya lösningar för sina omsorgsaktiviteter.

Slutsatser

Sammantaget så visar resultatet från de fyra artiklarna att omsorg mellan äldre personer (som inte är familj) kan innefatta en rad olika praktiker och aktiviteter. Detta innefattar allt från att låta en annan äldre person komma och knacka på ens dörr mitt i natten för att hens hjärta bankar så väldigt till att hämta grannens robotgräsklippare som hamnat utanför sitt arbetsområde. Den här typen av omsorg karaktäriseras av ömsesidighet, men kan likväl vara en-vägs-orienterad. Två vanliga former av omsorg mellan äldre personer är praktisk/instrumentell hjälp samt sociala aktiviteter. De olika formerna av aktiviteter kopplar till både kön och ålder och möjligtvis bidrar de också till minskad upplevelse av social isolering. När det gäller att nyttja den här formen av omsorg i samproduktionsprojekt som innefattar offentlig verksamhet kan logiker om till exempel formalitet och effektivitet skapa spänningar. Sådana spänningar kan hindra att denna form av omsorg nyttjas för att utveckla nya omsorgstjänster inom offentlig verksamhet. Resultaten från avhandlingen visar också att personer 70 år och äldre ägnade sig åt en mängd olika former av omsorg under Covid-19-pandemin i Sverige vilket möjliggjorde för andra äldre att behålla sina vardagliga rutiner. Genom uppfinningsrikedom upprätthöll personer 70 år och äldre även sina egna omsorgsrutiner.

Slutligen integrerar jag resultatet från de fyra artiklarna för att skapa konceptet ”äldre-till-äldre-omsorgspraktiker” och konstaterar att för att främja den här typen av omsorg genom innovation som innefattar offentlig verksamhet finns det behov av att (1) ha omsorgen som utgångspunkt – i motsats till teknikens löften, (2) överväga vem som engagerar sig i den här formen av omsorg, (3) ta hänsyn till de kreativa lösningar som äldre personer själva kommer på, (4) avstå från att anta att äldre personer har en delad erfarenhet och att ha detta som utgångspunkt, och (5) söka kompromisser och inte konsensus mellan olika logiker och normer i samproduktionen av denna form av omsorg.

Den praktiska nyttan av resultaten från denna avhandlings resultat behöver avgöras i framtida innovationsprojekt som syftar till att nyttja äldre personers omsorg till varandra för att utveckla omsorgstjänster för äldre personer. Den teoretiska nyttan i denna avhandlings resultat ligger i det

praktikorienterade perspektivet på omsorg som avhandlingen utgått från. Detta perspektiv har möjliggjort för mig att vara öppen för vad omsorg mellan äldre personer kan innebära och hur den görs. På så sätt har jag skapat begreppet ”äldre-till-äldre-omsorgspraktiker” som baseras på empiriska studier av den här formen av omsorg i praktiken. Begreppet åberopar att komplexiteten i omsorgen mellan äldre personer tas hänsyn och övervägs. Något som tycks viktigt då denna omsorg ofta förbises när fokus i innovationer sätts på potentialen hos ny teknologi.

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