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Risky Business: How Older 'At Risk' People in Denmark Evaluated their Situated Risk During the COVID-19 Pandemic

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"I can certainly be frustrated that we have a government, particularly a prime minister, who thinks she has to be a mother to us more than she has to be a leader – that's the thing that worries me" (Jørgen, age 72; interview 5 May 2020)

Introduction

Throughout history, humans have had to assess and analyse risk in order to "cope with uncertainty, the essential unpredictability of the future, and account for past misfortunes" (Alaszewski 2015, 205). In contemporary societies, such determinations are typically made by government officials in consultation with specific experts. Thus, when the World Health Organization declared a pandemic in March 2020 (WHO 2020), governments around the world decided to 'lockdown' the usual movements of society. In Denmark, the prime minister and national health authorities immediately assumed an authoritative and protective approach to reduce potential harms to both population health and the healthcare sector; i.e., by 'flattening the curve' of infections, they hoped to prevent hospitals and healthcare workers from becoming overburdened with patients needing intensive medical care. The political response was thereby to temporarily close businesses and schools, require 'non-essential' employees to work from home, and encourage all citizens to adopt specific preventative measures such as self-isolation, increasing hand hygiene, severely restricting group activities, and remaining physically distant from others.

These recommended measures were also based on a risk analysis, which means that statistical models were used to calculate and predict future states based on cause/effect correlations and probabilities (Boholm 2003, 167). In the case of the coronavirus, the Danish government and health authorities had to calculate the chances of the population becoming infected and needing medical services as well as to predict which groups were most likely to get ill. Based on the available evidence, there was a call to protect those who were considered to be particularly susceptible to the virus and thus with a higher risk of developing serious consequences and possibly dying from infection; i.e., people with

compromised immune systems or certain chronic illnesses (e.g., cardiometabolic disease, lung disease) as well as people age 65+ and especially age 80+ (DHMA 2020).

The COVID-19 pandemic has presented us with a unique opportunity to examine how societies perceive urgent biological risk, and how they manage population groups who may be susceptible to such risks; e.g., older people. In this paper, we explore what it means to be categorised as ‘at risk’ and how people age 65+ managed uncertainty and risk during the initial months of the pandemic. To unfold this discussion, we first describe how, from a cultural-historical perspective, the Danish welfare state has developed a risk-adverse position regarding public health with an emphasis on individual responsibility. We then draw upon semi-structured telephone interviews conducted with 32 people across Denmark, including eight women and six men between the ages of 65 and 83, during the first months of the COVID-19 pandemic (Clotworthy *et al.* 2020). These qualitative interviews were conducted to gain insight into how the pandemic and the first months of the societal lockdown affected mental health, everyday behaviour, and social relationships among certain population groups.

In our analysis here, we present older people’s narratives of being labelled a ‘risk group’ and how they negotiated their continued political belonging (Thelen and Coe 2019). We describe how, in response to unclear biopolitical discourses and decisions being made for ‘their own good,’ older people reclaimed their agency by evaluating their individual circumstances to determine their own “situated risk” (Boholm 2003). In our concluding reflections, we discuss the possible consequences of public-health measures that categorise particular social groups, such as people over a defined chronological age. We also explore the potential future impact of state interventions on older people’s healthcare practices, arguing that political directives that label older people as ‘high risk’ may – paradoxically – put them at more risk. As the COVID-19 pandemic continues, we suggest that a fairer approach to public-health crises that considers older people’s agency and their ability to evaluate their own risk may ultimately benefit ‘the common good.’

Denmark’s risk-management strategy: individual responsibility to benefit ‘the common good’

The basis of public health is that government authorities identify widespread health problems and risks, and then set an agenda for appropriate action (Vallgård 2001, 388). As Mary Douglas (1966) suggested in her exploration of “purity and danger,” the meaning of ‘risk’ may be based in culturally embedded systems of logic and reason (cf. Alaszewski 2015, 214). As such, many contemporary societies have emerged with a focus on mitigating the risk posed to individuals within the collective, with ‘risk’ understood as “the statistical probability of an outcome . . . estimated in terms of money, deaths, or cases of ill health” (Boholm 2003, 160). To prevent or reduce such risks, certain societal and personal protections often emphasise ‘the common good’ (Velasquez *et al.* 2018; Anderson 2011, 247), a concept that is prominent in Scandinavian welfare states that have historically focused on the community, universal rights and responsibilities, and the shared well-being of all citizens in order to overcome collective hardship. Such an emphasis on social cohesion and egalitarianism has been instrumental in how Denmark emerged as a modern European welfare state (Lidegaard 2009, 28). Moreover, the Scandinavian model of social and economic development has traditionally included “a strong emphasis on security, safety, equality, rationality, foresight, and regulation” (Gullestad 1989, 73). This focus on security and safety also tends to be inclusive, emphasising that everyone in the collective should be protected in order to ensure survival – of both the individual citizen and the state.

Starting in the 1930s, social and welfare programmes in Denmark were implemented to protect ‘the elderly’ and other ‘weak’ social groups (Petersen, Petersen, and Christiansen 2010, 2011), such as children and people with disabilities, who may often require support from caregivers to survive and thrive. However, an “increasingly pervasive process of individualisation” (Mik-Meyer and Villadsen 2013, 4) began to develop in the 1990s when the Danish state assumed a more neoliberal character; i.e., “political, economic, and social arrangements within society that emphasize market relations, re-tasking the role of the state, and individual responsibility” (Springer, Birch, and MacLeavy 2016, 2). As Denmark emerged as a ‘competition state’ with a focus on industrial growth and development (Pedersen 2011), the government’s approach to protecting population health began to emphasise prevention. Specifically, there was a growing interest in preventing lifestyle-related diseases in order to produce better average life-expectancy rates (Vallgård 2001) and to “improve Denmark’s ranking in the global longevity competition, [which is] necessary for the common good of society” (Anderson 2011, 247). Thus, in its ongoing need to cultivate healthy and productive workers to drive the economy, the Danish government has assumed a risk-adverse position, which has subsequently transformed all citizens into ‘pre-patients’ (Larsen and Esmark 2013, 6). This approach has also led to the development of health policies and welfare programmes that function to “create the self-caring self,” (Rostgaard 2006, 452) wherein citizens should take care of themselves in order to remain active and independent for as long as possible. In practice, both health policies and healthcare practitioners encourage citizens to make the ‘correct’ choices (Pedersen 2016, 37) – rational choices that should enable them to master their lives, take more responsibility for their own health and welfare, and continue to be self-governing and self-sufficient until they die at a ripe old age (Clotworthy 2017, 21).

However, despite this longstanding emphasis on citizens’ individual responsibility, the Danish government adopted a parental approach to managing the COVID-19 pandemic, as our interlocutor Jørgen pointed out in the opening quote. The political decisions were not open to debate; they were made without democratic consensus nor consideration for citizens’ freedom of choice and self-determination. Instead, the government consulted with experts – such as the Danish Health and Medicines Authority (*Sundhedsstyrelsen*), the Danish Patient Safety Authority (*Styrelsen for Patientsikkerhed*), and particularly virologists at Statens Serum Institut – to analyse the potential risks to population health. Drastic protective measures, such as the societal lockdown and restrictions on visits to hospital patients and residents in long-term care facilities, were thereby implemented. This governmental response strongly resembles traditional clinical health encounters wherein medical experts make unilateral and paternalistic decisions, assuming that they can transfer information in an accurate and unbiased way to individual patients who will then be “filled up (like an empty glass) with new knowledge and thereby transformed into informed and willing decision-makers” (Charles, Gafni, and Whelan 1999, 655).

The Danish government’s protective measures and restrictions also demanded specific rules for living; i.e., obedience and compliance from all citizens’ “docile bodies” (Foucault 1979), which can be understood as the ultimate outcome of state intervention in individual citizens’ healthcare practices. However, it was not merely fragile people living in long-term care facilities whom the government sought to protect from the coronavirus. The public-health guidelines specified that *all* people age 65+ were ‘at risk,’ suggesting that they should self-isolate and “cocoon” as much as possible (Schrage-Frueh and Tracy 2020), and indicating that other citizens should be extra-cautious to ensure that older people avoided infection. From a biopolitical perspective, old age is often a particular area of concern; it requires security mechanisms to optimise a particular state of life (Foucault 2003, 246) and improve existing life by eliminating accidents; i.e., “the random element” (2003, 246; 248) in the life course. However, the coronavirus was more than just a random accident to be prevented, and the Danish state’s

response was to revert back to its strategy from the 1930s: to manage and protect ‘the elderly’ and other ‘weak’ social groups in a way that would ensure their survival. As such, government officials made certain blanket decisions not simply for the ‘common good’ of the population but for certain groups’ ‘own good.’

On one level, the Danish government’s protective approach seems to have reinforced sociocultural perceptions of older people as one homogenous category of passive, frail, dependent, and vulnerable – and thereby inherently ‘risky’ – citizens. This biopolitical logic may have also re-activated certain stereotypes and ageist assumptions about what it means to be ‘old,’ which has consequences for cultures of aging and the societal value of older people. But, on another level, our interviews indicate that people age 65+ in Denmark reclaimed their agency by determining their own “situated risk”; i.e., “risks as they are actually understood and contextualized by people in social settings” (Boholm 2003, 166). Our analysis suggests that, when certain political decisions became confusing or unclear, older people acted as ‘rational actors’ by evaluating the official discourses based on their own phenomenological lived experience. In this way, they also resisted the tacit forms of biopower (Rabinow and Rose 2006) and negotiated their continued political belonging (Thelen and Coe 2019). Furthermore, in making decisions for ‘their own good,’ they displayed a kind of relational autonomy that may ultimately benefit ‘the common good.’

Older people’s rational agency and evaluation of their situated risk

During major public-health emergencies, government directives often supersede individual rights and freedoms. This is because, in crisis situations, people can be overcome by emotions that may compromise their rationality and self-control. Thus, when the COVID-19 pandemic was declared and the societal lockdown was implemented in Denmark, it seems that government officials expected that citizens would not behave as a ‘rational actor’: an “independent, autonomous agent that, given objective data, is capable of choosing to create a self that conforms to arithmetic averages” (Powers 2003, 231; *also* Tronto 2017, 29). The power of the ‘average’ in risk management was so strong that, like many health and social policies, the Danish government’s protective measures did not consider the lived experience of those whom these security measures directly affected (Twigg 2002, 427). For example, with regards to the coronavirus, the individuals politically categorised into ‘high-risk’ groups may not actually be at increased risk for infection (compared to the general population) because they are used to taking the steps necessary to manage their health and protect themselves. Many of our interlocutors used hand sanitiser and grocery-shopped early in the morning to avoid crowds, even before the pandemic. When asked whether she was taking extra precautions due to either her age or her chronic illness, Alice (age 75) said, “I think I would’ve done it anyway. When they say that the best thing is to wash your hands, use sanitiser, and all that, then I would do it whether I was 100% healthy and well or as I am now” (24 April).

During the government’s first press briefing on March 11 to announce the lockdown, Prime Minister Mette Frederiksen appeared strong and decisive, even as she admitted, “We’re in unknown territory. We’re in a situation unlike anything that we’ve experienced before. Are we going to make mistakes? Yes. Am I going to make mistakes? Yes. I need your patience” (Regeringen 2020). The vast majority of our interlocutors were willing to be patient; they supported the lockdown and believed that the protective measures made sense based on the scientific evidence. Like others, Anders (age 76) also appreciated the prime minister’s humble approach, saying, “The [recommendations] have been well-founded and well-argued. . . . The communication has been exceptional, and I think [the officials] have been very, very open” (17 April). However, as infection rates and overall risk decreased, certain political

decisions became more unclear and confusing. Thus, similar to other interlocutors, Anders nevertheless expressed doubt about the government's plans to re-open society: "There are some political parties that say, with blank eyes and great conviction, 'Now we can just open up shopping malls and everything else,' and I think that's a little unsafe."

This uncertainty and doubt were echoed by Ingo (age 70). When asked what he thought about the government's overall strategy, he said, "There are so many wise people sitting there – and one says one thing, and the other says something else" (22 April). Alice (age 75) was slightly more critical, saying, "You couldn't really call them clever – all of [the experts] who were supposed to know a lot, they didn't really know anything. . . . You couldn't really get a clear picture" (24 April). Torben (age 72) said, "I think there's no clear line [of communication]. I can sort of understand it because times change, and things change all the time. But there's not a clear line, I think" (29 April). The uncertainty, confusion, and 'mixed messages' in the official risk analyses were especially difficult to understand for older people living with chronic illnesses. For example, Jørgen (age 72), who has diabetes and several other health issues, said,

The only information you get about being in the risk group is that you're in the risk group. . . . The fact that I've had a small stroke and could have one again, does that mean I'm in the risk group or what? I think we just pack everything together and say we're over 70, so there's not much to talk about (5 May).

Jørgen's quote points to how the official discourses regarding who is 'at risk' categorise those with chronic illnesses and older people as one homogeneous group in order to manage the risk presented both to and by them. While evaluating the available evidence is an important aspect of risk analysis, the resultant political decisions may contain certain biases and blind spots. In this case, a pragmatic and analytic generalisation failed to capture the complexity of individual citizens' lived experience, leaving them with feelings of uncertainty and arbitrariness. This caused some of our interlocutors to question the logic behind the political decisions, especially in relation to older people. For example, Edith (age 79) explained how she tries to decipher the official messages: "I listen just as much to what they DON'T say. . . . [And] I hear them say that they actually don't know what to do with the older population. Because they have to be released [from isolation] at some point or have a vaccine, right?" (17 April).

Thus, in response to the government's apparent lack of logical decision-making, many of our interlocutors drew upon decades of experience of being told to take responsibility for their own health: they actively assessed the official discourses in relation to their personal circumstances, and decided for themselves how they would manage the existential threat of the virus based on their subjective perceptions of 'risk.' For example, Ingo (age 70) said, "I've had three small strokes, so I know very well what it's like to be close to death. But I don't [take precautions] because I'm afraid of dying of coronavirus. I just protect myself as best I can" (22 April). Edith (age 79) was emphatic that older people should take responsibility for themselves: "I know full well that no one can give us an answer, so people will have to decide for themselves whether we continue to be in isolation or whatever. . . . What will [the government] do to protect us? We can only protect ourselves" (17 April).

In order to cope with uncertainty regarding the duration of the lockdown, many of our interlocutors chose to accept the situation and remain positive. For example, Alice (age 75) said, "It's just the way it has to be – it's sad and boring, but I've accepted that" (24 April). Lars (age 73) echoed this point with regards to people who were worried or complained about the societal restrictions: "It must be because they have a more negative attitude than I have – like, 'Oh, it's such a pity that I have to sit here and can't

get around as I usually do.' But you just have to try to take some initiative for yourself" (5 May). When asked about the possibility that he could become infected, Lars insisted on remaining positive, saying, "Of course [the virus] could hit me, but I'm not going to be negative, I'm certainly not." Katrine (age 65) was simply pragmatic about the risk of infection: "I don't think it would be fun [to get infected]. . . . But if you do, then you just have to take it as it comes" (28 April).

These quotes suggest that our interlocutors were able to rationally evaluate the government's risk prediction and put it into context for themselves. This was especially clear when they were asked whether they thought about dying from the coronavirus. Toini (age 73) said, "I imagine you can die in so many ways – you can be run over or you can fall off a cliff, you can die of cancer. . . . One's just as uncomfortable as the other, isn't it?" (22 April). Mathias (age 83) also said, "I can't help but think that COVID-19 does this and that, but many people also die from cardiovascular disease or diabetes . . . or old age. . . . So, if they have to go anyway, then it's not corona's fault" (17 April). Anders (age 76) did not consider the virus to be extraordinary, saying,

I don't have a strong opinion about [dying from] corona or something else. . . . In other contexts, I think we do what we can to make sure death isn't a daily companion. We take pills to keep diseases in check, and we get surgery and do things to repair ourselves. And now, of course, we also take some precautions for this coronavirus. I think it's just a given (17 April).

Many of our interlocutors were similarly realistic about the actual threat of the virus. Thus, rather than fearing the *perceived* or *predicted* risks and allowing emotions to compromise their rational agency, they considered COVID-19 to be just another way one could die – which, as Hanne (age 76) said, is "something we all have to do at some point" (21 April). Moreover, as we have described, our interlocutors actively evaluated their situated risk based on their lived experience, and subsequently chose to manage the existential uncertainty on their own terms. They did not allow biopolitical discourses and authoritative, protective measures to determine their rules for living. Instead, they decided how to best manage their own personal risk. In this way, they acted with autonomous agency, marking out the parameters within which they were "immune from paternalistic intervention" (Christman 2004, 157).

However, these autonomous decisions – i.e., whether or not to self-isolate or adhere to extreme hygiene practices, etc. – were not simply made for 'their own good' as individuals. In times of both stability and precarity, there are exchanges and negotiations between the individual citizen and the state, and a person's "perception of fairness may generate feelings of either belonging or exclusion" (Thelen and Coe 2019, 292). As our interlocutor Anders said, the government's plans to re-open society were perhaps "unsafe." Jørgen, on the other hand, suggested that there is a tendency to pack people over a certain age together, which meant "there's not much to talk about." Thus, they both judged these political decisions to be unfair.

Yet, our interlocutors did not allow such unfairness to exclude them from the political collective. By questioning the government's 'unclear' decisions and deciding for themselves which protective measures to follow, they acted with *relational* autonomy; i.e., as a "free, self-governing agent who . . . defines her basic value commitments in terms of interpersonal relations and mutual dependencies" (Christman 2004, 143). As such, our interlocutors' evaluations of their own risk and the protective practices in which they engaged were not purely individualistic; rather, these 'at risk' people chose to govern themselves and comply with certain precautions in order to protect their co-citizens' health and

thereby contribute to ‘the common good.’ As Signe (age 83) said, “All of society should be protected” (16 April). This rational, relational autonomy is something that governments should consider when faced with future public-health crises, as we elaborate on in our final reflections.

A post-corona risk-management strategy: rational agency to benefit ‘the common good’

The COVID-19 pandemic has presented us with a unique opportunity to examine how societies manage urgent biological risk as well as how people phenomenologically experience risk-adverse public-health measures. And, with some degree of hindsight, we can say that Prime Minister Frederiksen was correct: We are in unknown territory, and everyone has made mistakes. In Denmark, one mistake was that the political response to a potential threat was risk-adverse and authoritative to such an extent that it infantilised citizens, assuming that they would be unable to behave rationally under duress. Another, related mistake was that the recommended precautions were overly protective towards certain social groups (i.e., older people and people with chronic illnesses), categorically labelling them as ‘vulnerable’ to infection. The official discourses also contained certain representations of aging, which can shape older people’s political belonging as well as the care and protections they are believed to require (Thelen and Coe 2019, 281). Thus, marking *all* ageing bodies as ‘frail,’ ‘vulnerable,’ or ‘at risk’ is a form of ageism, implying that they needed to be managed, guided, and protected by governmental agencies (*see e.g.*, Kaufman 1994; Weicht 2013). Paradoxically, political directives that label all older people as ‘high risk’ and expect them to self-isolate during a pandemic may put them at more risk for age discrimination and social exclusion.

Everyone makes mistakes – even politicians. But our empirical material suggests that, when an urgent public-health crisis develops, it is essential that government officials and health authorities themselves behave as ‘rational actors.’ This means that they should analyse the available evidence and consult with experts in order to predict potential risk, and subsequently implement preventive measures to ensure that the highest proportion of the population is protected from harm. However, they should keep in mind that, although people age 65+ are indeed more susceptible to infection from COVID-19, not all people over this defined chronological age are ‘at risk’ *to the same degree*. Thus, being part of a risk group should not necessarily mean that the non-risks determine the rules for the entire group. Furthermore, regardless of their increased susceptibility to biological infection, older adults have a right to self-determination – even during a pandemic. As such, the individuals who *are* ‘at risk’ should be able to claim that designation for themselves (after consultation with their primary healthcare provider).

We suggest that, instead of going to extremes – such as Denmark’s strictly paternalistic approach or the United States’ unstructured, ‘every man for himself’ non-strategy – decisionmakers should implement protective measures that are *in proportion* to the threat. An example of a more rational, balanced approach was tested in the Netherlands; here, government officials started allowing older people in long-term care facilities (who have the absolute greatest risk of infection from COVID-19) to receive personal visits again. A national study of 26 care facilities found that all participants recognised the added value of “real and personal contact” (Verbeek *et al.* 2020, 904) between residents and their loved ones to improve well-being, which can positively impact overall health and longevity. Importantly, the first results of this study indicate that compliance with local public-health guidelines was “sufficient to good” with no major incidents (2020, 904).

Such an outcome suggests that government officials and health authorities should endeavour to recognise the rational, relational agency of older people. Not only does this mean replacing the word

‘vulnerable’ with ‘valuable’ in official discourses – it also means considering older people’s lived experience and their competence to make rational decisions during a public-health crisis. As we have described here, older people willingly complied with the advised precautions when such directives were well-reasoned, open, and clearly communicated. Our interlocutors did not expect limitless freedom of choice or to be consulted regarding the urgent public-health decisions that needed to be made for ‘the common good.’ However, they did want political decisions to be based on sound scientific evidence rather than made for economic interests.

To avoid future mistakes, we suggest that the known facts (i.e., the calculated potential benefits and risks to the collective) should be openly and regularly discussed to establish trust and confidence in the decisions being made. Reciprocally, people who identify as being in a risk group should be trusted to evaluate and manage their own risk, and to adopt *appropriately* responsible behaviour. Going forward, we believe it is important that risk analyses of public-health crises consider older people’s lived experience, their capabilities and essential value to society, and the potential effects of specific restrictions on their mental health, quality of life, and well-being. When faced with future public-health crises, such considerations will ensure that the measures implemented to reduce harm and protect population health are more balanced, inclusive, and equitable for each individual.

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Data access

For access to the data collected in the interdisciplinary project ‘Standing together – at a distance: how Danes are living with the corona crisis,’ please contact principal investigators Naja Hulvej Rod (nahuro@sund.ku.dk) or Klaus Hoeyer (klho@sund.ku.dk). We welcome collaborations with both Danish and international research groups. We hope our data collection will become part of a comprehensive and wide-ranging database that contributes to a greater understanding of the societal, cultural, and social consequences of the COVID-19 pandemic.

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