Health games: Towards a playful responsibility

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Abstract
A current topic and goal in public health care is to make the citizens take a personal responsibility for their own health. Health games and play is one method used for this purpose. The point we like to make in the article is that may be these new forms of play deconstruct personal responsibility rather than enables it. Maybe games of health turn responsibility into too easy playing.

Introduction
Søren Kierkegaard, the Danish father of existentialism writes the following about personal responsibility in his book “either/or” from 1843: "I knew only one duty, that attending to my school, and in this respect I was left entirely to my own responsibility (...) I was exempted from all parental twaddle. He never asked me about my lessons, never heard me recite them, never looked at my exercise book, never reminded me that now it was time to read, now time to leave off, never came to aid of the pupil’s conscience, as one sees often enough when noble minded fathers chuck their children under the chin and say, “You had better be doing your work.” When I wanted to go out he asked me first whether I had time. That I was to decide for myself, not he, and his query never went into details. That nevertheless he was deeply concerned about what I was doing I am perfectly certain, but he never let me observe it, in order that my soul might be matured by responsibility" (Kierkegaard 1946: 225, Original Danish: Kierkegaard 1988: 248). The father expected personal responsibility of the son, but the farther never fully articulated this, just as he did not announce any expectation about specific action and decisions. Thereby the father avoided to turn the responsibility of Kierkegaard into duty, defined from somewhere outside Kierkegaard.

167 years later in May 2008 the Danish government invited to an open conference with participants from the ‘broad’ parts of our society about ”personal responsibility”. Seven Danish ministers published together an article with the headline: ”Community builds on personal responsibility”. In the article they write: "The single citizen has a responsibility to the community - but the community must never be an end in itself or grow so large that it take away freedom and release the single individual from personal responsibility. We must put demands on our self and each other. We must expect something, and we must have the courage to raise the question: What have you done yourself?” (Hedegaard, Jespersen, Mikkelsen, Haarder, Møller, Frederiksen & Nielsen 2008). In the following two years a number of games were created by a number of Danish ministries with the aim
of increasing personal responsibility among the citizens. The idea was that these games should be played by citizens supervised by welfare professionals.

In the quote of Søren Kierkegaard, his farther somehow played responsibility into him, never making explicit concrete expectations. More than 150 years after the Danish state takes the position of the father and invites citizens to play with personal responsibility in designed games. In the land of existentialism responsibility has become a game.

Individualization of health responsibility can be observed in most of Europe and in US during the last 10-15 years. In this article we study how authorities try to increase personal health responsibility through health games. We are following two theses. The first one is that "active and responsible citizenship" consists of both a performance role and an audience role. We shall link these two and introduce the concept "performing audience". The second thesis is that the health games designed to promote personal responsibility, deconstruct at the same time the very term of personal responsibility. The article takes its departure in Governmentality studies in health responsibility and subjectivation, but try to push the problematic in the direction of a more radical diagnostic of the present concept and promotion of responsibility. We do this with the help of a deconstructive systems theory reading Søren Kierkegaard through Niklas Luhmann and Jacques Derrida. The article consists of an introduction, a description and analysis of two Danish examples of health games and a conceptualization drawing on works of Niklas Luhmann concerning the performance role/audience role, and Jacques Derrida concerning absolute/general responsibility.

The National Council for Public Health puts the question of individual responsibility in this way: “Central to health promotion is the notion that the individual needs to be good at mastering his or her life, and, as public authorities, we need to help create the best possible framework. The ability to master one’s life is not always a private matter” (National Council for Public Health 2002: 11). This opens up a challenging steering ambition: To make the citizen able to master his life. Dimitris Michailakis and Werner Schirmer observe a similar shift from collective to individual responsibility of health in the Swedish welfare state. They observe the shift in expectations directed to the single individual with the political system as point of observation. They conclude that "attribution is a communicative steering device the political system can make use of in order to keep control over increasing claims for medical treatment” (Dimitris Michailakis and Werner Schirmer 2010: 3). We do not doubt this conclusion, but we believe that the expectation structures condensed in the expression of “responsibility” might be trickier than presumed by Michailakis and Schirmer.

A lot of different international studies observ how health responsibility is addressed to the single individual. Some claims that the individualization of health responsibility represent an “intrude upon people’s private lives (Gatelaars 1992: 411pp). Other studies on the theme question whether individualization and promotion of personal responsibility leads to empowerment of the individual or to new forms of discipline and blame (McCLean 2005). Roy investigates the construction of responsibility for health in popular women’s magazines, pointing to the discourse in which “Women must ensure their own health to embody the subject position of the responsible citizen which also includes feminine care-giving duties to ensure the health of their families.” (Roy 2008: 473). Women should not be passive patients but takes control over their health being a kind of proactive patient. Roy talks here about healthism as a discourse producing the subject position of an entrepreneurial self directed toward good health (Roy 2008:473). The invitation to the individual to take responsibility can be regarded both as a possibility for the patient/individual, at least if the
health professionals let them, although “often professionals cling to power in their engagements with patients, controlling information and dismissing efforts by patients to theorise or explain their condition” and as powerful way to “construct patient-hood and notions of normality and pathology.” (Fox et al. 2005: 1300). Other studies discuss the theme as a matter of “tension between the management of collective and individual risk that informs neo-liberal health care governance.” (Joyce 2001: 599), and a number of studies aim at investigating the question of health and responsibility as a matter of identity “understanding the relationship between self, body and society.” (Fox and Ward 2008: 1007). Building upon these governmentality inspired studies on the relation between health responsibility and subjectivation, we like to twist the problematic a little bit. We will not focus so much on the consequences on identity and subjectivation, but on the condition for producing personal responsibility. The new ways of addressing responsibility through health games influence the very form and category of responsibility. The category of personal responsibility is deconstructed in the health discourse. This will be our argument. And further we like to peek a little bit to the thesis of individualization. Maybe the new form of addressing responsibility to individuals not simply leads to individualization, but represent a double movement; individualization and massification simultaneously.

The form of personal responsibility

We will begin theorizing about personal responsibility reading Kierkegaard in a rather sociological poststructuralist way through Niklas Luhmann and Jacques Derrida. We take our departure in Luhmanns description of modern society as a functionally differentiated society.

In a Luhmanian systems theory perspective, functional systems such as economy, politics, law and health always operate with a distinction between so called performance roles and audience roles, and the distinction mark very different ways of addressing expectations to individuals. It is distinctions like doctor/patient, lawyer/client and teacher/student. Rudolf Stichweh writes about this relationship: “The concept of inclusion means that all those members of society who are not involved in the operations of a function system via performance roles are nonetheless important as a public of this function system. That is there are specific roles for members of the respective public: roles for voters, consumers, sports spectators, and religious lay persons” (Stichweh 1997: 97).

Niklas Luhmann considers the audience role as a particular parasite upon the function system. The word parasite is not a value laden word. It simply means that the audience cannot exist outside the system. The patient is only a patient in connection to the health system. Audience is to Luhmann “the excluded third” (next to the binary code) (Luhmann 1990: 178-179). Audience is first of all an internal fantasy within the function system, a fantasy which only offers a very limited role script (Stäheli 2003). It is a parasitic role in the sense, that it is not a position from where one is able to perform anything according to the operations of the function system. One is primarily offered the position of an observer. So a distinction is drawn between performance roles and audience roles, and an individual addressed by a performance role will be recognized as a person when the individual accept the packages of expectations condensed in the role. The individual who is addressed by the audience role will on the other hand never be recognized as a person, but just as an element in a passively observing audience belonging to the mass. As patient you are traditionally addressed as audience, and therefore not observed as a performing person, but merely a mass category. We have formalized it like this:
Every single function system produces both its own performance roles and its own audience roles, and each audience role frames different expectations addressed to the individual. The health system observes a patient, the educational system a student, the social care system a client etc.

Both in the case of performance role and audience role personal responsibility is presumed by the function systems as an “constitutive outside”, necessary for the function of roles but unmarked and incommunicable in the systems. Through the distinction role/person the system is able to distinguish between system motivation and personal motivation observing that last one as irrelevant for the system. You might have personal motivations becoming a doctor. What matter for the health system is that you are binding yourself to the generalized motivation defined in the role. On the other hand personal responsibility is presumed as a condition for binding yourself to the roles of the system and translating role obligations to personal commitments. So personal responsibility exist as an unarticulated presumption regarding performance role to a large extent and regarding audience role in a very limited sense.

But what is then the presumed form of personal responsibility? What is the structure of expectation in personally responsibility? or more precisely: What do an individual expect of himself observing himself as wanting to act personal responsible? Looking for a structure of expectation we are looking for a unity of difference. We ask: “Through which distinction is personal responsibility emerging as an expectation?”

Let’s return to Kierkegaard’s observations on this point: “Duty is the universal which is required of me; so if I am not the universal, I am unable to perform duty. On the other hand, my duty is particular, something for me alone, and yet it is duty and hence the universal. (...) for I can do duty and yet not do my duty, and I can do my duty and yet not do duty” (Kirkegaard 1946: 221, Original Danish: Kierkegaard 1988: 243). Kierkegaard is aware that it is not possible to fulfill the expectations condensed in the form personal responsibility by living up to the general expectations in one’s surroundings regarding responsibility. Personal responsibility is your own responsibility. It cannot be derived from norms, rules and ethics. Your responsibility is only yours and should not respond to others. Kierkegaard makes us also aware, that if we expect responsibility of others we have to hold it back not making expectations too explicit.

Derrida’s postructuralist and deconstructivist reading push Kierkegaard’s analysis further saying that the possibility of responsibility begins in the impossibility of responsibility (Derrida 1992: 24). Personal responsibility is split in two incommensurable forms that yet have to be connected: The absolute responsibility where you respond to no one and do not follow the common rules or norms and the general responsibility with its ethics, norms, rules obliging everybody in any situation. In
the absolute responsibility you stand all by yourself. It is a singular responsibility nobody can replace. One cannot take or carry the responsibility of another. "But what is also implied (in the absolute responsibility) is that, by not speaking to others, I don’t account for my actions, that I answer for nothing [que je ne réponde de rien] and to no one, that I make no response to others or before others. It is both a scandal and a paradox.” (Derrida 1992: 60). Your responsibility is not a response to any explicit demand. “Secrecy is essential to the exercise of this absolute responsibility as sacrificial responsibility.” (ibid: 67). You cannot explain your choice through a reference to general rules; it is your decision and cannot be explained. The general responsibility, on the other hand, is where one has to make account for his or her action in relation to expectations in one’s environment. The general responsibility consists of ethics, rules, norms. The two forms are incommensurable, because you can only carry the absolute responsibility by rejecting your general responsibility. Yet you have to – if you should take your personal responsibility – to take both the absolute responsibility and the general responsibility. You have to take both forms of responsibility and at the same time they exclude each other. The personal responsibility is constituted as a paradox, where one is only absolute responsible, if one is at the same time general irresponsible. “As soon as I enter into a relation with the other, I know that I can respond only by sacrificing ethics, that is, by sacrificing whatever obliges me to also respond, in the same way, in the same instant, to all others.” (ibid: 68).

The result is a reentry of the two concepts of responsibility on the absolute side of the distinction: You are only personal responsible if you are both absolute and general responsible in an absolute and singular manner. We have formalized the expectations structure like this:

<table>
<thead>
<tr>
<th>The absolute responsibility</th>
<th>The general responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only that responsibility is absolute, that answers its general responsibility in an absolute and singular manner</td>
<td></td>
</tr>
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</table>

**The form of personal responsibility**

*Figure 2: The form of personal responsibility*

Every concrete responsibility, every concrete decision, striving to become responsible has to fold out this paradox, not by solving it, but through deparadoxification making the impossible look possible, that is referring to the general in a personal way hiding the reference. Ethics (general responsibility) say Derrida is a temptation, the absolute responsibility has to resist:”The ethical therefore end up making us irresponsible. It is a temptation, a tendency, or a facility that would sometimes have to be refused in the name of responsibility that doesn’t keep account or give account, neither to man, to humans, to society, to one’s fellows, or to one’s own. Such a responsibility keeps it secret, it cannot and need not present itself” Derrida 1992: 62).

This is what is presumed but not prescribed by the function systems. They can and do prescribe roles, performance role presuming a large amount of personal responsibility and audience role presuming almost no personal responsibility observing the single individual just a mere category.
But the function system cannot prescribe personal responsibility. That would be to cancel the
distinction between role and person and tempt the responsible subject with rules and ethics falling
to pure general responsibilities.

**Health games**

What we like to do in the following is to take a closer look at a number of health games precisely
designed to increase personal health responsibilities. And we like to show how the paradox of
inviting the patient (client/student/parent) to not only be passive but active in taking responsibility
for creating him/herself in the gaze of health has some weird effect in deconstructing the very
concept of "personal responsibility".

Our cases are Danish, but health games are a broader international phenomenon. England and the
USA have similar campaigns. In the USA, there is even a website for the discussion of different
serious health games, “Public health games – Serious games and Simulations for Public Health and
related Fields” ([www.publichealthgames.com](http://www.publichealthgames.com)). Other sites combine film, information, and games
for children, e.g. the side “Kidshealth” ([www.kidshealth.org/kid/closet/games/candy_game.html](http://www.kidshealth.org/kid/closet/games/candy_game.html)).
Another site is “Health Finder” which is located on the US Department of Health and Human Services website ([www.healthfinder.gov/kids](http://www.healthfinder.gov/kids)).

The relationship between play and the building of personal responsibility within the welfare state
has not been object of a lot of studies. Actually we have only found studies of the relationship
between steering and play within organization studies primarily addressing the private sector
Monthoux & Statler 2008, Fleming 2005). Most close to a serious discussion of what play do to
responsibility is the study of Bogdan Costea et.al. in their conceptual-historical studies of the
relationship between play and work. They state the entrance of: “a kind of ‘Dionysian’ mode, a
spirit of playful transgression and destruction of boundaries, a new bond between economic
grammars of production and consumption, and cultural grammars of the modern self” (Costea et.al.
2005: 141, Costea et.al. 2006). Play changes the self-relation. What are left out are reflections of
how play is incorporated into the state and the public administration as a steering tool and how it
affects the ascription of responsibility to citizens (see Andersen 2009 for deeper study of the history
of the relation organization/play). It is in this realm that the present article seeks to make its
contribution.

The two cases we like to present is “Health at play” and “Yum-Yum”, especially the “agreement
pages”.

**Case one: “Health at play”**

In 2007, together with the organization School and Society, The National Board of Health and the
Danish Veterinary and Food Administration published the game *Health at play – dialogue and
cooperation about health in the school*. The purpose of the game is to initiate dialogue about health
in schools and to formulate and agree on issues of food and meals, movement, drugs, wellbeing,
knowledge, and attitudes.

The game is based on a rather ambitious health ideal that intervenes in almost all aspects of life.
The game refers to this ideal as a "positive concept of health" defined in opposition to other
conceptions, which merely concern the prevention of sickness. Health is said to concern *lifestyle, living conditions, quality of life, physical wellbeing, psychological wellbeing,* and *social wellbeing.* This definition of health leaves no aspect of life to be defined outside the domain of health policy. Life in all its facets becomes a health concern. The introduction to the game says: "All these areas represent important elements of a healthy life and are of equal importance in the dialogue”.

The game comes with a short presentation video, which can also be found on the National Board of Health’s webpage. The video includes interviews with different stakeholders about the game. In the video, a health consultant for Gladsaxe Municipality says: "As a municipality, we could simply and single-handedly define the framework for defining health, but it is important that both parents and students are able to recognize themselves so that it is not only something they engage in while in school but something they carry over into their lives at home." Making citizens expressing what they mean by the concept of health is seen as a way to produce personal responsibility. Parents and students should through this campaign learn to recognize themselves as more or less healthy and work for their own health both at school and at home. So health responsibility is not presumed among the citizens. Public definitions of health are not expected to work because a responsible receiver is not expected in the starting point - but is to be "created".

The video then goes directly to Karsten Jensen, a consultant, who says: "The question is not whether we should all live the same way; whether we should all have the same preferences. In a diverse society, it is important that there is room for differences". This is the regulation problem in a nutshell, which is what *Health at Play* is supposed to provide a response to. There is a wish to regulate what takes place in the home so that home activities can be perceived as healthy. At the same time, however, it is not possible to articulate this regulatory ambition without generalizing health, cancelling differences of singular lives and violating the idea of personal responsibility. Play becomes a mode of inviting the citizens as audience to take personal responsibility regarding health and thereby becoming individuals in the health system.

*Health at Play* is intended for use in the context of parent events, pedagogical days, or events for older students. It takes approximately two hours to play. The game is instructed by a teacher and is set up by dividing parents into groups of four to six seated at different tables. On each table is placed a game board with three spaces entitled "agree", "partially agree", and "disagree". Clearly, the agenda is about regulating consensus. Each of the groups is given a stack of statements. Some of these are:

- It is not okay for students to try alcohol at home.
- Movement and play need to be incorporated into more classes than just physical education.
- Students need knowledge, experience, and positive role models in order to choose healthy alternatives to soft drinks, candy, and chips.
- Parents are the children’s most important role models.
- Parents are responsible for establishing a strong parent network in the class.
- Children and young people need to be motivated to live a healthy lifestyle.
- Children and young people must learn to take responsibility for their own health.
The game instructions outline a structure for the course of the dialogue where the parents are invited to discuss and categorize the statements under the headline play. A doublet suspension problematic is working here. First: the statements are public statements, which does not want to look public but desire to become private statements ‘coming from within’ the single parent. Second: The dialogue is one that does not want to look like one building up public binding norms. That is why it is called a play –not binding, just for fun. Never the less the statements are inviting the parents to investigate their health attitudes in public and observe how other parents are observing them. The parents are not expected to have a capacity of health responsibility. But it is expected that through bringing private thoughts into public dialogue, personal responsibility is fostered. Obligations or rules are not explicit. Instead playful dialogue becomes a kind of withdrawn normativity, a norm about a normative and playful public dialogue.

The game is devided in phases. First, the groups discuss the statements and classify them into the statements they agree with, disagree with, or partially agree with. Second the group focuses on the statement cards that the group agrees with. The three statements are given a priority and the dialogue shift towards suggestions for action for parents, students, and the school respectively in response to the individual statements. These are written into a prioritization table (shown below). Suddenly the whole dialogue shifts from game to decision. The groups now present their suggestions to each other and the game instructor sums up the selected statements in a prioritization table, calling it a collective agreement which is subsequently emailed to all participants “so that we all know which agreements have been reached.” The instructor suggests that the collective agreements should be evaluated at subsequent parent meetings.
Figure 3: Prioritization table

One might question whether this qualifies as play. It is called a game, but it ends up as agreements. These agreements are snuck in through the back door, and the game never encourages dialogue about whether agreements should be made in the first place. One could argue that it is a game in the sense that the reached agreements have been created in a way so that the communicative afterlife of the agreements obtains an oscillating quality, constantly oscillating between observations of the agreements as agreements and observations of the agreements as an agreement game.

On the level of play, parents and the school are parts in the agreement facing each other as independent legal actors with the possibility of binding their own freedom. The game refers to “collective agreements”, which can be reached together with parents as if they were one body or at least one collective legal actor rather than separate individuals. But the parents are not a collective body. That is a fiction within the game, a fiction that nonetheless is used as a power technology in relation to the individual parent who appears to be disloyal if he refuses to play the game. The whole game is based on the expectation that no individual parent is going to refuse to be part of the game. And why would any parent do so as long as it is simply a game? So everyone plays only to discover that the game is not a game but a negotiation and decision process. However, one is still unable to refuse to play because as soon as one says no, the negotiation process is going to return to
simply being a game, and as part of a game there is no possibility for the parents’ opinions to play a binding role. The game therefore produces the peculiar situation that it is impossible to enter out of the game even though one has voluntarily entered into it. Moreover, articulating the negotiation and decision process as a game or as play is a way of getting around the difficulty that the agreement cannot be sanctioned. Parent meetings are not an organization where parents are authorized to makes binding decisions. Therefore, the school pretends to makes collective decisions and emphasizes throughout the game the impression of consensus among parents, which it will subsequently be difficult for individual parents to deviate from.

What we like to point out in particularly here is the question of responsibility. As we mentioned, a personal responsibility has to be personal; it presupposes the individuals’ free will. There are a number of characteristics about the “Health at play” that do not call for the individuals’ free will: 1) It is an invitation to participate in a play in the starting point voluntary but impossible to enter out of. 2) It is an invitation to take part in a dialogue that seems to be a public dialogue on norms, turning out to be private statements ‘coming from within’. 3) It is a decision process articulated as a game.

Another interesting aspect of the agreements is that they do not only define specific obligations. In fact, the collective agreements outline obligations with respect to the self-creation of the families. The families commit to creating themselves in the image of a healthy family. Thus, the collective agreements mean not only a commitment of one’s individual freedom. It is also a commitment to a specific way of creating oneself as a free family. Therefore, one is not free until one has created oneself and one’s family in a way so that one’s lifestyle, living conditions, quality of life, physical well-being, and social well-being can be considered healthy (for the contractualization of the citizen: Andersen 2004, 2007, 2008).

*Case two: Yum-Yum agreement pages*

The next case comes from the campaign “Healthy through play”, organized by the Danish Ministry of Food, Agriculture, and Fisheries. “Healthy through play” is minded particularly at vulnerable families and their willingness, knowledge, and capacity to live a healthy lifestyle with respect to both food and exercise.

The campaign in question is from 2008 and is the result of collaboration between the Ministry of Food, Agriculture, and Fisheries and the National Board of Health. The campaign is designed to motivate Danish families with young children aged 1-6 to live a healthier lifestyle. As the website says: “‘Health through play’ is a health-pedagogical tool for the health professional (health visitor, consultation nurse, health consultant, dietician, etc.) working with families and the improvement of food and movement habits” ([http://www.legdigsund.dk/Services/forfagfolk/forfagfolk.htm](http://www.legdigsund.dk/Services/forfagfolk/forfagfolk.htm)). Play is articulated as the ground attitude to health promotion. The campaign motto is “to make it easy, fun, and manageable to live a healthy lifestyle.” Health responsibility presumed to be looking too heavy for the citizens to carry.

The campaign refers to a report entitled “The health of socially at-risk citizens – barriers, motivation, and possibilities”. It was initiated by the National Board of Health and carried out by SFI (The Danish National Center for Social Research). The report is an interview study of a number of citizens from different at-risk groups and a number of employees, who are in frequent contact
with the target groups. And the report indeed encourages that health steering and health promotion has to be funny and organized as play. The report says:

According to citizens whom we have talked with, in order to different health-promoting offers to be successful, it is important that people do not feel pressured into participating but can decide on a voluntary basis whether or not they want to participate. Moreover, it is important to incorporate fun and enjoyment into health-promoting projects so it does not become an unwanted responsibility or yet another requirement that they cannot honor (National Board of Health 2007: 8).

Health promotion should not be an unwanted responsibility for citizens and it should also not be difficult and heavy. The challenge articulated by the National Board of Health seems to be how to promote private health responsibility without public requirement. Health promotion and responsibility should equal enjoyment and fun. These words are repeated in the following quotes which extends the chain of equivalence: “collective fun” ≈ “snowball fight” ≈ “wiffle ball” ≈ “cooking” ≈ “laughter” ≈ “humor” ≈ “street performance”:

Finally, several employees point out that fun and enjoyment ought to be an important element of health-promoting efforts. By stressing that it should be fun to exercise and live a healthy lifestyle they hope to be able to break down some of the barriers that citizens and employees might experience. Some employees provide examples of activities that have caused collective enjoyment such as snow ball fights, wiffle ball, and cooking (National Board of Health 2007: 31)

Health promotion is supposed to be fun, playful, and voluntary and above all should not look like health promoting work characterized by seriousness, requirements, heavy responsibility, and duty. This should even count for the self-relation of the professional when they meet the weak citizens as role models:

Moreover, employees in one of the re-training centers report using humor and self-irony during physical activities with citizens. By making fun of their own lacking fitness, employees can help create an informal atmosphere that leaves room for everybody (National Board of Health 2007: 40)

The employee is to simulate the citizen. The concomitant difference is ‘strong system’ versus ‘weak citizen’. Citizens are observed as a weak mass lacking capability of individual responsibility. The quotes do not suggest that the system needs to show weakness. The system and its employees have to play that they are weak like the citizens.

There are many games and elements in the campaign. We are focusing on the so-called agreement pages. There are eight agreement pages, one for each nutritional advice in the campaign. The basic idea of the agreements is that parents and children in individual families should make agreements with one another about food and movement. The role of the health professionals is to sell the idea and supervise the agreement conversation. The agreements cannot be about just anything. The eight agreement pages contain each their theme, which needs to be discussed. These have been taken from the eight nutritional advice points in the campaign. Another element is that the agreements
have a limited duration so that the family makes an agreement about a new piece of advice when the first agreement expires, etc.

The campaign addresses itself to health professionals: “As a health professional, the agreement pages allow you, through dialogue with the family, to find out which nutritional advice would be particularly pertinent for the family to focus on. The family then writes down the agreement as a concrete goal, e.g. ’take a thirty minute walk twice a week’” (http://www.legdigsund.dk/Services/forfagfolk/forfagfolk.htm). This form of agreement is interesting. It is not only a question of health professionals interfering in the individual family’s eating or walking habits. It is a question of intervening in the family members’ mutual social relations by providing a special form within which sociality can exist – the form of contract – without opening up a dialogue about the fact that the contract is also a particularly value-laden form. It affects the social space. Having shared norms in a family, e.g. about not putting sugar on the breakfast table, means something entirely different than making an agreement about the very same thing. Agreements indicate that someone is seeking to contractualize internal family relations (see also Andersen 2007, 2008). This contributes to creating the family as a negotiating family. But why does the campaign do this? It is done in order to make unambiguous regulatory ambitions look like voluntariness. It is meant to look as if it is the family’s own initiative to take on particular health prescriptions. The campaign does not like coercion and wagging fingers. It has to appear as if the family has formulated the contract on their own, that it has emerged from below and denote a horizontal relation of mutuality among the family members.

Below are one example of agreement, where focus is on fruit and vegetables. On the right-hand side of the page is the campaign’s nutritional advice combined with other nutritional information. The right-hand side is where the health professional begins his or her “dialogue” with the family by introducing a piece of advice and providing information about health. It is basically one-sided communication about what is healthy and unhealthy. A clear line marks the distinction between the right and left-hand side of the page. The right-hand side represents one-sided communication, framing the creation of reciprocity, which is later supposed to be found on the left-hand side of the page. It is on the left-hand side that the agreement is to be written, in the field at the bottom of the page entitled “Our agreement”. At the top middle of the page it says “tear here”. The idea is that once the agreement has been made, the family tears off the right-hand side of the page whereas the left-hand side can be posted on the refrigerator. Why not post the entire page? It is precisely because the agreement has to appear as if it has emerged from within the family itself. The unambiguously defined framework for the agreement, which appears on the right-hand side of the page, has fulfilled its function and can be disposed of, in part so that we may forget the one-sided regulatory origins of the agreement.
The campaign expresses a certain embarrassment in relation to the form of the agreements. The agreement pages have been designed to not look like actual agreements, and colors and drawings create a fun, childish, and inviting appearance. Despite the fact that these agreements are about the promotion of health in at-risk families, whose health is often threatened by poor nutrition and lack of physical exercise, this seriousness is lacking from the agreement pages. What is important is “promoting”, not “health risks”. They support the positive energy and motivation, not the obligation inherent in any contract. Addressing the family, the material says:

Make agreements with your child. Your child sees you and uses your habits as a mirror – also in relation to food and movement (…) It is a good idea to create little rituals in your daily routines, e.g. to tick off the agreement table every day after you pick up the children. Many children take agreements very seriously, which makes it fun and a game to keep the agreements” (www.legdigsun.dk/Lav_aftaler_med_dit_barn/aftaler.htm).

Here, the embarrassment associated with contracts is transformed into the notion that contracts are in fact fun. They are a game. And keeping a promise is like playing a game. This creates a strange form of double communication according to which the contract is on one hand a contract with mutual responsibilities and on the other hand a contractual game, where it is fun to fill out the table. It is put as if there is no difference between breaking a promise made as part of an agreement and loosing a game by not scoring a certain number of vegetables for the week.

The agreement pages withhold its choice of communication form. The campaign is constructed so that the health professionals can always respond to opposition from families by saying that something else is going on than what the families are saying. A health professional can suggest regulation by using the agreement pages, and if the family then opposes regulation, he or she is able to argue that they merely represent a voluntary agreement, which the family is invited to make with itself. The communication implies that the agreements constitute voluntary surrender of freedom.
And if the family feels that the agreements are too unpleasant, the agreements are really just a play-agreement where it is important to remember that children often find such games fun. The agreement pages make up a machine of displacement in relation to communicative expectations of responsibility. Every time the form the communication shifts the appealing to private responsibility is also shifted. With the help of the agreement sheets the health professionals can always deny what they are doing, retreating to play (Andersen 2010). The campaign makers have created particular opportunities to get around emerging resistance by the citizens. It becomes a game of public articulation and disarticulation of claims to private health responsibility. The professionals appeal to personal responsibility but when they see that the citizens see the appeals as an unwanted claim, the appeal is withdrawn and substituted by a new appeal in a new form, ending up with an appeal to responsibility play.

**Turning audience into persons deconstructing responsibility**

In the previous cases we have seen how the public authorities haven’t found it easy to appeal to personal responsibility. The campaigns themselves describe it as difficult because 1) they did not find a personal responsibility to appeal to, especially in the campaign addressing ‘weak’ citizens, 2) they expected resistant’s, 3) they found health responsibility too heavy for the citizens to carry. We have also seen how citizens as audience through health games are invited to observe themselves in a health system perspective, taking a personal responsibility.

In the next part of the paper we shall describe the steering ambitions in the analyzed health games through the concepts "performing audience" and "deconstructed responsibility". This admits us to more precisely address the impossibilities embedded in the steering ambitions.

The shift to what we have marked as “personal responsibility” result in a strange doubling of the earlier introduces distinction between performance role and audience roles made by function systems. With the concept of “active citizenship” new expectations are addressed to the audience. The audience is expected to recognize itself as a multitude of free individuals, each taking personal responsibility as if what is personal responsible is in favor of the collective community. The self-in-community of course looks different depending on which function system anchor the perspective. Self-responsibility is something different observed in the care system, the educational system etc. The common structure of these new expectations is that the single individual addressed as audience has to observe herself in the code and language of the system. It is now expected of the audience that it create itself as a multitude of individuals creating themselves in the image of the function system. We will talk about audience role of second order when it is expected of the citizen to perform self-observation in the gaze and code of the function system (Andersen & Born 2005). What happens is a kind of reentry of the distinction between performance role and audience role, creating the expectation of the ‘performing audience’:
Figure 5: Audience role of second order

The excluded audience only offered recognition as a category is now included as performing, and have to be individualized to become so. The student should contribute to each own learning process. The patient must take part in the diagnosing and in the treatment of himself or herself. The client has to help herself etc. An individualization is happening, and the client, the student, the patient is ascribed a certain status of person in the function system. But the audience as a parasite does not disappear! The addressed quality of categorized audience follows as the shadow of the individualized audience. As a self-treating patient one is addressed a person in a limited and fragile way. One is expected to observe oneself in the eye of the system, but nothing else. One should not interfere in the operations of the system. To comment the work and judgments of the doctor or teacher will be observed as an aggression, and is not welcomed. On the one side the audience is offered a possibility getting status as person. On the other side you are in constant risk falling back into the passive category again, if the function system cannot recognize its own operations in the self-reflections of the individual. The patient is now addressed both as person and as mass category. The active citizen is like Alice in Wonderland both inside and outside. The individualized audience ascribed personal responsibility becomes a monster symbolically linking what cannot be linked; system and environment (Felt). The active citizen is invited within the function system under the condition that she stays outside (Knudsen 2010, Knudsen 2011). The performing audience is expected to observe itself through the gaze of the function system and take responsibility for acting according to the logics of health, education etc. But the performing audience is not expected to question the function system or to insist on having something relevant to say from somewhere outside the system. And thereby not having the possibility for taking a personal responsibility.

The games allow the function system to oscillate between offering a performance role to the citizens and to turn them into pure observers without a will of their own. One moment they are invited to take personal responsibility in connection to their own behavior concerning their own wellbeing, the next moment – especially if they do not respond according to the ‘right’ way of regarding and acting healthy – what they say can be dismissed because what we do is just for fun.

We shall finally will argue that this is also influencing on the very form of personal responsibility. It puts at stake the production of responsibility and its constitution. We believe we can look at it in two ways. One is how the health games actually violate the form of personal responsibility. The other is how a new form emerge displacing personal responsibility with a kind of playful hyper-responsibility equivalent to the new permanent tension between individualization of the audience still being an audience.

Observed in the first look, it is striking how the health games constantly produce ethical temptations for the citizens. They offer the citizens an easy way out of their personal responsibility substituting personal responsibility with advises, dialogues and recipes. The health games only appeal to the general responsibility and risk the absolute and singular responsibility. Often they do not articulate expectations about specific responsible action. Instead the citizens are tempted to break that secrecy which protects their absolute responsibility. When the absolute responsibility is announcing itself in playful dialogues, it is no longer absolute; the personal responsibility is no longer yours alone but ours, the common respond to norms. They invite the audience to become individuals with responsibility, but do not really trust them the capacity of singularity. They do not as Kierkegaard’s
father give the personal responsibility time to mature or alternatively trust that the personal responsibility is already present. They substitute it with public play. And when the citizens reject the temptations of ethic, they are not observed by the health professionals as responsible, but as an audience (or mass) enacting blind resistance. The health professional then tries to tempt the citizens in new ways, making responsibility easier to carry or just fun and playful. But the result is simultaneously a devaluation of expectations to absolute responsibility. The citizens are no longer expected to have capacity of elevating themselves out of the mass. Like children they are only in, as long as it is funny and easy.

But there is another possible reading marking that what is happening is a displacement of the form. On the external side of the distinction general responsibility is doubled. General responsibility becomes itself a unity of a distinction. This distinction is drawn between an emergent and singular general responsibility on the inner side and a polyphonic surplus of responsibility on the other. What the health games mark is that it is no longer possible to articulate stable general expectations about responsibility framing the singular and absolute responsibility. It has of course always been so that there is a surplus of general responsibilities. But now general responsibility is produced in such a way that it reflects this surplus. The health professionals reflect that they can not take responsibility for what health responsibility is. Health responsibility is too much to be articulated as stable rules or norm. The health games mark that general responsibility has become singular and bounded to temporary processes. So the health professional do not with the health games take responsibility for defining general responsibilities. They take instead responsibility for facilitating a process in which participators can investigate possible general responsibilities, and marking this process “play”, the temporary and singular of the general is underlined. What is the expected of the absolute responsibility? Well, it is not simply expected to be a responsible decision and act. What is foremost expected is self-investigation of the possible relations between the absolute and the general, and when the general has become emergent and singular (on the temporal dimension), the only possibility to act absolutely is to be playful and take part in the responsibility games.

The result is a kind of playful hyper-responsibility where you are only a subject of responsibility when you are assessing responsibility in temporary collective games. We have no normative conclusion about this development. If we should give an answer it would be in the direction of propelling the hyper-responsibility even more claiming a discussion about the side effect of health games on the relationship between person and responsibility.

References


