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Social care for older people – a blind spot in the Norwegian care system

Walter Schönfelder PhD ^a, Helga Eggebø PhD ^b,
and Mai Camilla Munkejord PhD ^c

^aDepartment of Child Welfare and Social Work, UiT the Arctic University of Norway, Tromsø, Norway;

^bNordland Research Institute, Universitetsallen 11, Bodø, Norway; ^cDepartment of Business Administration, Western Norway University of Applied Sciences, Bergen, Norway

ABSTRACT

A growing number of older people in Norway receive care services at home. Public policy aims at promoting social safety, preventing social problems and providing recipients of care with the means to live an active and meaningful everyday life together with others. However, health-related services have long been prioritized at the expense of other care services. Our aims are to investigate how professional caregivers in Norwegian home care for older people relate their professional mandate to social care to assess what different professional positions regarding social care imply for realizing the ideal of integrated and person-centered care. Interviews with 16 professional caregivers are analyzed within the framework of positioning theory. A variety of discursive positions relating the own professional mandate to social care are identified. Findings suggest that the absence of common standards leaves it up to the individual caregiver if social care needs are met or not. Common standards for social care delivery and a more suitable skill mix among health and social care professionals are proposed.

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Introduction

Most European countries subscribe to the European Innovation Partnership for Healthy and Active Aging (European Commission, DG Health and Consumers and DG Information Society and Media, 2011). The partnership has been established in preparation for the demographic challenges posed by the increasing number of older people and the expected increase in demand for care services. One of the proposed means for realizing the aim of healthy and active aging is the integration of health and social care services. In recent years, several European countries have reformed their legal frameworks in line with the intentions for service provision as laid out in the partnership.

In Norway, where this study takes place, health and nursing care have been the basic pillars of care to older people aging at home. End-users of care are entitled to

CONTACT Walter Schönfelder  walter.schonfelder@uit.no  Department of Child Welfare and Social Work, UiT the Arctic University of Norway, Tromsø 9037, Norway.

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comprehensive health and social care services provided by the municipalities. So far, we know very little about how the professional care providers in Norwegian home care relate to this legal framework in their daily work.

In order to address this knowledge gap, we have two aims in this article. First, we want to investigate how professional caregivers in Norwegian home care for older people relate their professional mandate to social care. Second, we want to assess what different professional positions regarding social care imply for realizing the ideal of integrated and person-centered care. To answer these questions, we first delimit our understanding of social care and discuss the social-political context of care in the Nordic countries in general in Norway. Based on qualitative interviews with 16 professional caregivers we then delimit four professional positions regarding social care. In our conclusion, we argue that social care remains a blind spot in Norwegian home-based care and propose suggestions for addressing the need for social care among older recipients of care living at home.

Social care defined

Healthcare as a field of professional service delivery is regulated by a detailed legal framework and by specific educational tracks that serve as gatekeeping mechanisms for access to the healthcare labor market. In contrast, the delivery of social care services is organized far more heterogeneously (Anttonen & Sipilä, 1996; Daly & Lewis, 2000; Leichsenring, 2004; Miller, 2016; Robertson et al., 2014; Taylor, 2012). A number of countries, including the UK, Ireland, Germany and Austria, have professionalized the field of social care apart from healthcare (British Medical Association, 2014; Österle & Bauer, 2012; Ray, 2013; Steiner, 1998; Wanless, 2006; Züchner & Cloos, 2012). In other countries, including Norway, social care is regulated rather loosely and regarded as an embedded part of healthcare.

Because social care is provided within a variety of different organizational frameworks, defining the term is rather challenging. Social care is essentially a relational task, often with gliding transitions between paid and unpaid labor and a normatively rooted distribution between public and private responsibilities. A definition encompassing these transitions is provided by Daly and Lewis (2000, p. 285), who describe social care as “the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out”. Because we focus on professionally provided social care to older people, our article has a more limited scope. In that respect, social care has been regarded as a domain of organized service delivery, aiming at supporting the autonomy of care recipients (Anttonen & Sipilä, 1996, p. 90). Although such an understanding of social care directs attention to professionally provided care services, it

obscures the crucial relevance of the relational components of care work in the support of autonomous living. These relational components are not only essential in professional home nursing but, as emphasized repeatedly, in practical assistance as well (Eggebø et al., 2019; Hafskjold et al., 2016; Ludvigsen, 2016; Pesut et al., 2017). For the purpose of our study, we locate our point of departure in a definition of social care close to that proposed by the British Commission on Funding of Care and Support (2011). We understand social care as support provided by professional care workers for people of all ages with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines, in building and maintaining social relationships and in participating fully in society.

Social care for older people in the Nordics and in Norway

The Nordic countries are usually categorized as a particular cluster of welfare states (Esping-Andersen, 1990; Vabø, 2012). However, there are considerable differences among the Nordic countries with regard to the organization of care for older people (Eikemo et al., 2008). In Sweden and Finland, for instance, care for older people is organized as part of social service delivery, with an increasing emphasis on providing integrated social and healthcare services (Bäck & Calltorp, 2015; Kröger & Leinonen, 2012).

Compared to Sweden and Finland, the Norwegian model leans heavily on health and nursing care as the basic pillars of care to older people. For several decades, health-related services have been prioritized at the expense of other home-based care services (Helgøy, 2005; Helse- og omsorgsdepartementet, 2017). This emphasis on healthcare is reflected in the OECD indicators, where Norway as one of few countries reports long-term care expenditures collectively as health expenditures instead of distinguishing between health and social components of care (OECD, 2017, p. 215).

Attempts to support integrated care service delivery include the legal right to an individual service plan for recipients of long term care (Holum, 2012). However, research has shown that only very few recipients of long term care have such a plan, coordinating service delivery across health and social services (Bjerkan et al., 2011).

In 2012, the Municipal Health and Care Act was implemented. At its core, the act described a more integrated understanding of care delivery as it emphasized the ambition to promote social safety, prevent social problems and ensure that recipients of care have the opportunity to live an active and meaningful everyday life together with others. Within this legal framework, end-users of care are entitled to comprehensive health and social care services provided by the municipalities. These have the obligation to provide care according to individual needs, including prevention, treatment and necessary assistance for those living with health problems. The workforce delivering

home-based care in Norwegian municipalities is usually organized on two levels. Home nursing is provided mainly by certified nurses and practical nurses. In addition, home nursing staff includes a large number of assistants (Statistics Norway, 2019). Although assistants are required to work under the direct supervision of certified nurses, it has been noted that assistants often work unsupervised and autonomously (Bing-Jonsson et al., 2015). The second category of care workers are home helpers, either with a certificate in cleaning or without a formal secondary education. Home helpers usually provide practical assistance for household tasks. However, organizational models and the specific tasks performed by these two groups vary among municipalities, as assistance for activities of daily living can be provided by home helpers, by nursing staff, or by both (Munkejord et al., 2018).

In addition to home-based care services, municipalities may issue contracts for semi-voluntary supportive contacts ("støttekontakt"); that is, trusted persons who are financially compensated for assisting end-users of care with participation in social activities. However, recruiting sufficient supportive contacts and finding the right match for users and their needs remains a chronic problem (Proba samfunnsanalyse, 2016).

As in most welfare states, care services in Norway have, over the course of the last four decades, been gradually deinstitutionalized. By today, most end-users receive home-based care services in their own home.

The process of deinstitutionalization is intertwined with two other processes, both with significant consequences for the provision of care. First, the distinction between health and social care has increasingly become unclear, with nursing staff focusing mainly on health-related issues and home helpers performing practical, household tasks (Vabø, 2009). Furthermore, there has been a tendency to deliver increasingly more healthcare services and less practical assistance (Mørk et al., 2016, p. 4). As a result, social care is addressed only implicitly in this distribution of care work, without being safeguarded by specific minimum or quality standards. Second, since the 1990s, public service delivery in Norway has increasingly been organized according to the principles of new public management (NPM). Regarding the particular adoption of these principles within health and social care delivery and their consequences, Vabø claimed that before the advent of NPM, "home care staff, including skilled nurses, were typical social professionals" (2012: 286). The extent to which nursing staff actually lived up to this claim before the introduction of NPM is debatable, as the need for more person-centered, holistic and flexible care service performance has been repeatedly emphasized in government white papers over the course of several decades (Helse- og omsorgsdepartementet, 2014; Sosial- og helsedepartementet, 1994, 1997, 2000). Despite various reforms, the professional basis for the provision of care services as well as the main challenges for providing high quality and person-centered care services remained unchanged.

Therefore, our interest in this article is to investigate how social care appears in accounts given by professional caregivers.

Methods

Sample and data

The data used in this article have been gathered as part of an inquiry about care provided to older people in rural parts of Northern Norway. Care arrangements were studied in two rural municipalities in the provinces of Finnmark and Nordland by conducting qualitative, semi structured interviews with 16 professional caregivers during two intensive periods of fieldwork in May/June and September 2016.

The sample of respondents comprised professional caregivers. Included were specialized nurses (3), registered nurses (7), practical nurses (3) and assistants (3). With one exception, all our respondents were women. The sample reflects the reality of care as a female-dominated sector in the Norwegian labor market (Mørk et al., 2016).

In early spring 2016, the heads of care services in both municipalities distributed information about the research project in staff meetings. Home care staff who were interested in participating contacted the research team directly. Additional respondents were recruited by snowballing, that is, they were persons who had been mentioned as suitable respondents by others. Written informed consent was obtained from each respondent. To ensure confidentiality and to enhance anonymity, we have discussed our findings without reference to the municipalities.

Interviews with professional caregivers were conducted by the first author, with the second and third author participating in some interviews. The intention was to achieve a natural conversational flow. An interview guide (Appendix 1) with predefined topics was prepared to initiate and partly to structure the conversations, while giving the respondents the opportunity to elaborate and dwell on the particular aspects they chose as most relevant. Interviews lasted between 45 and 120 minutes and took place either in a meeting room at the main office of the municipal care services or at the place of residence of the authors or the respondent.

Analysis

Interviews were recorded, transcribed verbatim and imported into software for the analysis of qualitative data (<http://www.qsrinternational.com/>). The following analytical steps were performed. All authors reviewed the transcripts closely, followed by a process of initial coding during an intensive workshop. The proceedings during this workshop followed an approach labeled as

collective qualitative analysis (Eggebo, 2020). Emphasis was given to the relation between health and social care and to the positions the respondents constructed between social care and their own work performance. Several professional attitudes were delimited. The first author then coded significant passages to different professional attitudes. The results presented and discussed in this article are based on this secondary coding. All authors participated in the writing of this article.

Positioning theory as a methodological frame for analysis

For the purpose of this article, we chose a discourse analytical approach and adopted the methodological premises inherent in positioning theory as proposed by Langenhove and Harre (1999) and Harré and Langenhove (1991). Within this perspective, actors are perceived as accounting for their actions by positioning themselves and others in varying discursive frames of reference. The act of positioning is understood as “the assignment of fluid ‘parts’ or ‘roles’ to speakers in the discursive construction of personal stories that make a person’s actions intelligible and relatively determinate as social acts” (Langenhove & Harre, 1999, p. 17). As in most discourse analytical frameworks, the concept of roles in positioning theory is replaced by the concept of subject positions. The act of positioning is not regarded as fixed because actors usually use varying positions during the course of a conversation to cope with different situations. Thus, actors take up subject positions in different, sometimes competing discursive frames of reference (Davies & Hareé, 1990; Jørgensen & Phillips, 2002, p. 110).

Positioning theory has been applied to the analysis of a variety of relations on micro, meso- and macro levels (Harré et al., 2009). We will use its methodological premises to trace a variety of positions constructed by care workers about their own professional task performance and the delivery of social care.

Ethics

The study was approved by the Norwegian Center for Research Data as the responsible body for approval (reference number 48366).

Professional positions to social care

We have noted that, even if part of home care is instrumental, the core of care work is relational. Relations will necessarily develop differently, depending on the personalities of the individual care recipient and the individual caregiver. The need for social contact has been emphasized repeatedly (Marczak et al., 2019; Neumann et al., 2016; Skaar et al., 2010; Tønnessen & Nortvedt, 2012). The impact of loneliness on quality of life among older people has been

described as “living in a bubble”; that is, living in a constant state of loneliness with no hope of cure, and with the consequences most apparent when facing barriers in everyday life (Taube et al., 2016). Thus, for older people living at home alone, relational contact with care staff, short and insufficient as it may be, is particularly essential. Nevertheless, social care as we have defined it initially comprises far more than instrumentally framed contact during health-related or practical assistance.

We have identified four different positions in our material that care workers describe for themselves and their professional task performance in relation to the delivery of social care. We exemplify these positions with specific examples from our data, but we want to emphasize that we encountered these positions on various occasions. Thus, the particular quotes we have chosen represent a categorization encompassing variations in the professional attitudes we have encountered across our data and the professional positioning we discuss should be understood as ideal-typical examples in a Weberian sense (Weber, 2010).

Nothing to do with social care

The first example of professional positioning we want to discuss is the following excerpt from an interview with a practical nurse:

Researcher: When you are out, visiting your clients, what are your tasks?

Respondent: We help with all they need help with. Everything from medicine, personal hygiene, shower. And sometimes we just talk a little with them, listen to how they are.

Researcher: Is it a task for you? To talk with them?

Respondent: No, we are just checking.

In this example, care is understood rather instrumentally. The position the respondent describes for herself is that of a professional assisting in maintaining a range of functions that end-users of care are not able to perform or maintain themselves. The respondent describes the assistance she and her colleagues provide from the viewpoint of a collective “we”. According to the respondent, her tasks comprise “everything”. However, this “everything”, as accounted for here, certainly does not encompass all the care needs of older care recipients. It is limited to healthcare and to support for activities of daily living. Talking and listening to the clients is positioned outside of professional responsibility. Rather than being part of the professional mandate, it is more of an expression of common courtesy. In such a perspective, the professional positioning of home nurses takes place outside the eventual need to deliver social care.

In another part of the interview, the respondent describes her relation to other aspects of municipal care for older people:

Respondent: We have supportive contacts. We do have them, so somebody can come in to them <end-users of care> and, maybe take them to the shop, or take them for a walk.

Researcher: But you have nothing to do with the supportive contacts?

Respondent: No, usually not. They are independent from us.

Researcher: And with the home helpers you don't have anything to do, either?

Respondent: No, we have nothing to do with them. But they are mostly visiting the same people we are, too. < . . . > I think it's ok that we can be there on different days, because then they have more people visiting, during the week. < . . . >

Researcher: But how do you coordinate your visits?

Respondent: That is done by those at the office.

In this account, the relation between the respondent's task performance as a home nurse is discursively framed as self-contained and only loosely tied to other aspects of municipal care for older people. Healthcare and support for activities of daily living provided by this respondent may or may not be coordinated with the support provided by the home helpers, but it evidently has no interface with the existing supportive contact program. Coordination, as it is, is done by "those at the office", positioned outside the reach and professional responsibility of the respondent. This professional perspective fits poorly with the ideal of integrated, comprehensive and person-centered care. As far as the professional identity of the respondent in this account is concerned, social care is not part of it.

Not our task

In the second example we want to discuss, social care is positioned outside the professional mandate as well. Contrary to the first example, the respondent, a certified nurse, describes the lack of a social care component as an ethical dilemma:

Researcher: That people who are alone all week have something to look forward to, is this a task for you in home nursing?

Respondent: Actually, I would wish that somebody else could come in and take care of this, but we do not have anybody. Here, it's up to us anyway to do something about that.

Researcher: But you are not helping your patients to get out, experience something? Are you?

Respondent: No, we have some who we help go to the store and such. If they can't manage on their own. But unfortunately, we don't have time to go for a walk or such. If it's somebody who can't get out otherwise, or if we know that we have some spare time, we can take them to the shop.

In this sequence, the need for social care is clearly emphasized. At the same time, this need is positioned outside the respondent's own professional mandate, as it is "somebody else" who should take care of social care tasks. For the respondent's understanding of her professional task performance, this unfulfilled need presents an ethical dilemma. Social care is described as a task to be done by others. However, because the available workforce does not include staff dedicated to social care, it is partly provided by the respondent and her colleagues, who stretch their professional mandate beyond the limits "if we have some spare time". The respondent positions herself and her core tasks related to nursing and healthcare. Social care is rhetorically positioned outside the professional mandate. The surplus of time that eventually occurs is used to provide for an end-user's basic needs, that is, mainly necessary shopping. Nevertheless, as accounted for in the interview excerpt, this is a personal courtesy, not part of the professional mandate.

This professional understanding is not exclusive to Norwegian home nursing. A recent qualitative study addressing perspectives on functional ability by nurses and end-users of care in Finland emphasized that only some respondents in the former group regarded participation in social activities as a component of active care work (Lehto et al., 2017). The study further emphasized how end-users of care included in daily activities not only chores such as eating and moving but also explicitly – activities such as reading, drawing or watching TV. In contrast, nurses did not include the latter set in their accounts of daily activities.

In our example, it is interesting that respondents do not mention the possibilities of applying for social care (to be provided by supportive contacts) or for practical assistance (to be provided by home helpers). Similar to the first example, home care as accounted for in this example does not reflect the ideal of comprehensive and person-centered care as stated in the legal framework for care provision.

A task for therapists and social workers

The above respondent described social care as outside her own professional responsibility, but she provided it to the extent that a surplus of time allowed. She refrained, however, from ascribing this responsibility to a particular part

of the care-workforce. This was also the case in the account of another respondent:

Respondent: I really miss having more time! Or, maybe other professionals who could take care of the things we don't have time for. Therapists, social workers.

Researcher: What kind of things are these?

Respondent: Well, that we see them. Take them for a walk, go to the store or help them with their clothes. Instead of taking care of it in a hurry, we could help them to do it themselves. Because it is easy to do it FOR them.

The call for “more time” in care work is hardly surprising. However, the argumentation presented reveals several turns in her own professional positioning.

First, “more time” in this case is not tied to the position of the respondent herself. Her account documents a reflective rhetorical development. While “more time” initially might be posed almost as a reflex, the link between social care and her own task performance is quickly modified, with social care positioned as a task outside the respondent's responsibility.

Second, the respondent constructs a hierarchy within a system of care by placing social aspects as “*the things we don't have time for*” below health and nursing care as her own professional domain. In this way, social care appears tied to healthcare but at the same time remains a supplementary task.

Third, she constructs a collective identity for all involved in the provision of care, described by “*us*” who “*see them*” and who “*could facilitate for them*”, and with herself positioned within this system of care.

Finally, the respondent delimits a particular aim for social care provision, tied to a principle of help for self-help. Social care, as the respondent experiences it in her daily work, is not satisfactory. Instead, she describes social care tasks as taken “*care of ... in a hurry*”. Contrary to how the respondent experiences the reality of social care provision, she describes her aim to facilitate a process that would support the independence of end-users as much as possible. With this aim, it is indeed evident that other professions are better equipped than nurses are. Help for self-help, or empowerment, are elements far more central in the methodical tool kit of social work than of nursing professions. However, professional social workers are rarely represented in Norwegian home care for older people because Norwegian home care is mainly organized with a focus on health-related needs and nursing competencies (Statistics Norway, 2019). Consequently, social work competencies are not reflected in the work force. As in the first two perspectives we discussed, within this third perspective on professional positioning, social care needs remain addressed at best in part, at worst not at all.

If only we had the time

The last of our examples reflects a professional understanding where social care is described as an integral part of comprehensive and person-centered care provided by the home-nursing staff.

Researcher: What has to be in place to ensure a safe everyday life for those who live at home? As an elderly person?

Respondent: You know, if it was up to me, I would hire more people. More nurses. Then you would have more time. So maybe, you would have spent five more minutes with the patient.

Researcher: But what would you do with these five minutes?

Respondent: Well, just being there. That you show that you are there. For example, many times in home nursing, they just knock at the door, go in, give the medicine and drive on. Usually there is a need for more, but there's no time. If you had five more minutes, maybe you could fix it for the patient. It is very important that you listen to the patient!

Before we look more closely at this professional positioning, it is worth noting that the respondent in this example was not asked about her daily work routines but about an ideal. As such, she described a holistic form of care delivery where both nursing and social care would be delivered by the existing home-nursing staff. Both problem and solution are described. Ideally, home nursing staff should be responsible for social care as well as for nursing care. The problem is insufficient time resources. The solution is “*more people*”, “*more nurses*”. In this respondent's account, “*there is a need for more*” than nursing care. However, social care in this perspective is limited to the encounter between home nursing staff and end-users by “*just being there*”. This is a rather limited understanding of social care, which only partly includes support for building and maintaining social relationships and includes no support for participation in society. Both are elements of the definition of social care, which we have introduced in the introduction to our article.

The understanding of social care is aimed at sincere engagement in the patients' needs and at taking the time to “*listen to the patient*”. What distinguishes this respondent's account from the first example we discussed is that in this case, listening is part of the professional mandate. What distinguishes this respondent's account from the previous example further is that the care provided is not aimed at fostering the end-users' empowerment and self-determinacy.

Discussion

The highly developed and sophisticated system of welfare institutions makes the Norwegian model of delivering care to older people particularly interesting

for investigating the often-unclear demarcation between health and social care and the demand for comprehensive and person-centered care delivery.

In the Norwegian model, social care has become an increasingly marginalized component of professional care for older people; it is left in an unclear position between nursing care and practical assistance.

Without a doubt, many care workers try very hard to accommodate the social needs communicated by their end-users. Nevertheless, as we have documented, healthcare workers take quite different subject positions in relation to social care. Only in one of the four perspectives on professional positioning that we have discussed is social care understood as an integral part of the system of care within the current legal framework for care delivery. On a system level, the variation in professional positions leaves social care in a precarious blind spot of care service provision. On an individual level, end-users of care are at risk that their social care needs may or may not be addressed adequately, depending on the professional position of the caregiver they encounter.

It is hardly surprising that public care services for older people are incomplete and that there are gaps between the ideal of integrated, comprehensive and person-centered care and actual service provision. It is more interesting to identify the reasons for these gaps and to develop suggestions for improving existing care systems. Based on our analysis, we want to delineate several suggestions for addressing the need for social care, which is a blind spot in the Norwegian home care system for older people.

A first suggestion is a normative one. The variation in subject positions we have documented illustrates that the ambition of comprehensive and person-centered care is not yet realized sufficiently. Therefore, the need for social care must be clarified unequivocally as a crucial part of care delivery among care providers working within the current legal framework for care.

A second suggestion regards the policy level for care delivery. As we have shown, the legal framework entitles end-users of care to services that enable them to live an independent, active and meaningful life in the community. On a policy level, national standards for the delivery of social care are absent. Therefore, national care policies and specific guidelines adequate to the ideal of comprehensive and person-centered care are needed. Such policies will have to include compulsory minimum standards for assessing and delivering both social- and healthcare.

A third suggestion regards the skill mix in the home-care workforce and the particular social care needs for people of advanced age who are living in their own homes. Among these people, loneliness particularly is a problem that care services with a primarily health-oriented focus are not necessarily equipped to address. While the legal framework for care delivery acknowledges the need

for social care to avoid loneliness and social isolation, this need is not reflected in the skill mix of the workforce delivering home care. As illustrated in our analysis, home care staff were aware of the needs for social contact and activity among end-users but did not have the resources, tools or even the will to meet these needs. The same observation has been made in other national contexts. Among others, it has been pointed out that nursing-based care services have proven fallible with regard to ensuring that social care needs are accommodated according to the needs and expectations of end-users (Lehto et al., 2017). It has further been documented that primary health care teams comprised solely by physicians and nurses reported challenges in meeting the social service needs of older recipients of care (Berrett-Abebe et al., 2020). In addition, it has been pointed out that an emphasis on nursing based care services accelerate a tendency to downsize social care services (Leichsenring, 2012).

Simultaneously, social workers' potential and their contributions to improved care throughout the life course has been emphasized (Saxe Zerden et al., 2019). The positive effect of social work interventions for older people, both on quality of life and cost effectiveness of care, are well documented and, among others, summarized in a recent systematic review (Rizzo & Rowe, 2016). We therefore suggest aiming to develop care for older people through more integrated care services with professionally trained staff who reflect the need for expertise in health and social care. This requires a workforce comprising both health and social professions.

Conclusions

The aim of our analysis was to investigate how professional caregivers in Norwegian home care for older people relate their professional mandate to social care, and to assess what different professional positions regarding social care imply for realizing the ideal of integrated and person-centered care. To answer these questions, we have applied the premises inherent in positioning theory as a methodological perspective (Harre & Langenhove, 1999; Harré & Langenhove, 1991; Harré et al., 2009). The main strength of such a qualitative approach is that the examples are analyzed in depth. Each example is an expression of professional positioning that we have encountered on various occasions across our data material. The variations in professional positions we have documented demonstrate that social care is largely positioned in a precarious blind spot in Norwegian home care, leaving the social care needs of end-users at the discretion of the individual care worker. Since our study has been conducted in two rural municipalities in Northern Norway, care arrangements are organized according to local challenges, not the least in terms of distance and climate. However, providing high quality and

comprehensive care services is a mandatory task for all municipalities in Norway, regardless their size or geographical challenges.

As a qualitative investigation, our study does not allow for drawing conclusions about the extent to which these professional positions are prevalent among professional caregivers. Nevertheless, we believe that the insight in the Norwegian reality of professional care for older people is valuable for further investigations into how social care needs are accommodated in various care settings. This includes systems of care for other groups of end-users as well as different national settings with other legal frameworks and with a different skill mix among the care workforce.

For Norwegian home-based care to older people we want to emphasize that the absence of common standards for the delivery of social care leaves the end-users of care in a precarious blind spot. A more suitable skill mix in the care workforce that includes social work professionals is needed.

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ORCID

Walter Schönfelder PhD  <http://orcid.org/0000-0003-0199-154X>

Helga Eggebø PhD  <http://orcid.org/0000-0001-8502-6645>

Mai Camilla Munkejord PhD  <http://orcid.org/0000-0002-5700-7639>

Declaration of interests

The authors declare that they have no conflict of interest.

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Appendix 1. Interview Guide (translated from Norwegian)

Which care services are available to older people living at home in your municipality?

- Home nursing/practical assistance
- Activities for older people available?
- Organized as part of home care services?

What would you highlight as good and bad in how care services work here?

- Physical distance?
- Available staff?
- All necessary professions represented?

Do you see a need for improvements?

In your daily work: Do you experience care needs among older people that are not covered by public care services?

What are the challenges for organizing homecare services to older people living far from the center of the municipality?

- Geographical distance
- Coordination
- Staff recruitment and retainment

What is the professional background of you and your colleagues?

Do you work as a team?

Do you have a distribution of work, according to the professional background?

From your understanding: Is home care the same as home nursing?

In Sweden, home care is part of social services. In Finland, health and social care is organized together.

Is social care something you discuss in <municipality>?

- Do you see a need for interdisciplinary health and social care?

Are you in your daily work in contact with relatives of the older people you serve?

- Do you have examples for a distribution of care work between yourself and the relatives?

When you hear the term – what does “integrated care” mean to you?

- Have you and your colleagues discussed what
 - integrated care is
 - what it means for you in your work?

If you could choose freely, what would you need to provide good care services for older people living at home?

- What do you already have in place?
- What would have to be improved?