

Danish and Norwegian hospital social workers' cross-institutional work amidst inter-sectoral restructuring of health and social welfare

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Danske og norske hospitalssocialrådgiveres tvær-institutionelle arbejde i en tid med restruktureringer af sundheds- og socialsektoren

Starting in the 2000s, Denmark and Norway have undergone extensive restructuring of their health-related social benefit programmes, including how they are governed. Several reforms have sought to enhance inter-sectoral collaboration. Aiming at ensuring patients' faster return to work, policy makers have instituted economic incentives to both individuals and the health and welfare organisations who handle them. Through an institutional logics approach, this paper explores how hospital social workers in these countries are experiencing these changes. The 'social' part of post-treatment care and rehabilitation receives more attention in the Norwegian institutional set-up than in the Danish, and whilst challenges are experienced in both countries, in group interviews Danish social workers in particular express concerns about the implications of the accelerated return-to-work focus. In both countries, they report increasing difficulties in 'making their way through' the state-municipal bureaucracy. However, by drawing on the formal health knowledge derived from medical settings and the symbolic capital it bestows on them, they often manage to negotiate the work-and-welfare services, and thereby transforming the social context for the patients.

Keywords: Denmark; hospital social workers; institutional logics; institutional work; Norway; rehabilitation; return-to-work policies

Danmark og Norge har de seneste 15 år gennemgået store ændringer på sundheds- og socialområdet, både når det gælder tjenester og ydelser og styringen af området. Gennem reformer har man forsøgt at styrke koblingerne mellem sundheds- og velfærdsinstitutionerne. For at sikre en hurtigere tilbagevenden til arbejde for patienterne har man satset på økonomiske incitamenter for individer og de sundheds- og velfærdsorganisationer som håndterer dem. Denne artikel undersøger ud fra et institutionel logik-perspektiv, hvordan danske og norske

hospitalssocialrådgivere i deres daglige sagsarbejde oplever disse ændringer., i deres arbejde med at ændre deres patienters sociale kontekst. Det ”sosiale” element i rehabilitering og behandling er bedre varetaget i det norske institutionelle set-up sammenlignet med det danske, og selvom der er udfordringer i begge lande, viser gruppeinterview da også at det er blandt de danske hospitalssocialrådgivere, at man oplever de største vanskeligheder med at tilpasse sig det øgede fokus på hurtigt at returnere patienterne til arbejdslivet. De interviewede rapporterer om stadig stigende vanskeligheder med at trænge igennem i det statslige og kommunale bureaukrati. Dog viser det sig at de i interaktionen med de sociale myndigheder og andre aktører, i ganske høj grad kan trække på den formaliserede kundskab om sundhed, om den relaterede symbolske kapital, som de har adgang til qua deres udsigelsesposition i hospitalssystemet.

Nøgleord: Danmark; førtidspension; hospitalssocialrådgivere; institutionel logik; institutionelt arbejde; Norge; rehabilitering; reintegrering i arbejdslivet

Introduction

The process of rehabilitating people with disabilities and illnesses to restore their lives as active, independent citizens involves a complex co-ordination amongst institutions spanning across different sectors in the welfare state. This institutional complexity indeed characterises the situation in the comprehensive welfare states of Denmark and Norway, where health-related benefits and services play a particularly important role (Øverbye, 2005).

Nested in different parts of the welfare state's organisational hierarchy, the involved institutions operate through diverse material practices and symbolic systems concerning the relations amongst individuals, organisations and society. Consequently, cross-sectoral co-ordination problems are likely to arise, to the detriment of individual rehabilitation trajectories. Co-ordination challenges exist at the high level of

establishing policy goals, at the middle level of implementing these goals across institutions, and at the low level (street level) of delivering complex services (Øverbye et al., 2010).

On the street level hospital social workers occupy important roles as facilitators of co-ordination for individual patients at the intersection of health and work-and-welfare institutions. Thus, embedded within specialised health institutions, they function as ‘boundary spanners’ (Currie et al., 2007) who are supposed to enhance the linkages, and translate, between various forms of professional, bureaucratic and patient-related knowledge. Through extended communication, they are responsible for ensuring connections between medical services and the patient’s home municipality, work-and-welfare agencies and other actors (Nielsen et al., 2015). Hospital social workers are particularly important for ensuring access to services for the most vulnerable groups (McLeod & Sandén Eriksson, 2002).

Aims and research question

At its core, social work is about transforming ‘the individual’s context so that his or her “normal” mechanisms again can begin to function’ (Brante 2011, 17). Hospital social work is characterised by a longer ‘distance’ to the person’s everyday life context than is municipal social work. Succeeding in improving the person’s situation after discharge may entail institutional work across sectors. This paper explores how Danish and Norwegian social workers in rehabilitation institutions and hospitals negotiate the diverse institutional logics of the health and work-and-welfare sectors in order to improve the patient’s post-hospital context for recovery and social reintegration. The analysis is set against the backdrop of major governance reforms for enhancing efficiency, improving co-ordination between involved actors and institutions, and encouraging inter-professional collaboration – reforms strongly motivated by the aim

of, and intentionally geared towards, returning people with health problems to work.

The analysis draws upon four group interviews with hospital social workers in Denmark and Norway on their experiences with collaborating with different actors involved in critical decisions about the direction of individual patient trajectories. Their accounts of this interaction are valuable for understanding the consequences of the restructuring of social services in society – the processes of inclusion and exclusion in accessing health and social services under the current inter-sectoral restructuring in the Nordic welfare state.

Background

In many European countries hospital social work has come under pressure. Following accelerated productivity in treatment and turnover, patients are now discharged from hospitals before the phase in which previously most social services would set in (Märker & Turba, in press). However, whilst both Denmark and Norway have strongly reduced average lengths of hospital stays (OECD 2011), they display different patterns for prioritising hospital social work. During the past three decades, the numbers of hospital social workers have been dramatically reduced in Denmark, but have increased in Norway (Nielsen et al., 2015, Statistics Norway, 2000, 2015). Moreover, whilst parallel at the general level, recent restructuring of social services for people with disabilities and illnesses in Denmark and Norway has resulted in important differences between the two countries.

A wide-ranging 2007 reform of the governance structure in Denmark, the ‘Structural Reform’, entailed assigning local authorities more financial responsibility for the health services they provided for their residents – encouraging investments in preventive measures and post-acute treatment and care. From a block grant calculated

on the basis of estimated needs, they were now to co-finance hospital treatment of their residents (Bilde et al. 2010). Their new responsibilities concerned preventive health care for the general citizenry (primarily lifestyle issues and living conditions), the local patient population (particularly measures for the chronically ill) and general rehabilitation (outpatient treatment), leaving only specialised rehabilitation to the hospitals (Pedersen, 2007).

To ensure patients' physical rehabilitation, hospitals must issue a rehabilitation plan. However, unlike in Norway, the 'social' part of restoring the patient's life (e.g. guiding the patient's navigation across public agencies, taking special measures to support the patient's family, or providing financial counselling) is not specifically addressed (Danish Health and Medicine Authorities, 2011).

In addition, the 2007 reform co-located public employment services and municipal social assistance offices, and in 2009, the government decentralised everything into job centres run and financed solely by the municipalities (Christiansen & Klitgaard, 2009). Despite setting up one-stop shops, the reform implied further functional differentiation, with the administration of benefits under the aegis of one authority, social services under another, and active labour market policies under yet another (Bredgaard et al., 2011). Consequently, citizens with more complicated social problems needed further case co-ordination (Askim et al., 2011). To remedy this situation, in 2011 the government entitled this patient group to a coordinating caseworker. Yet stakeholder NGOs found this change insufficient for preventing patients from finding themselves in an institutional 'no-man's land' (Danish Association for the Disabled, 2014).

A 2013 reform of disability benefits continued a long-term retrenchment trend by delimitating the target group. Unless severe impairment prevented people

under the age of 40 from working even one hour a week, they were no longer eligible, but instead relegated to a new mandatory programme of various work-promoting measures (Høybye-Mortensen et al., 2013).

In Norway, in 2001 the government sought to strengthen the ‘social’ part of rehabilitation by providing a broader set of services. Hence one introduced ‘individual plans’ for rehabilitating patients and of ‘co-ordination units’ in the municipalities to facilitate general rehabilitation following discharge from hospital (Norwegian Directorate of Health, 2012). In order to promote a focus on work inclusion and retention, in 2004, general practitioners were required to report specifically on patients’ work ability when issuing sickness certificates (Hammer & Øverbye 2006). In 2006, the Norwegian labour and welfare reform merged state-level agencies for employment services and social security. It integrated this new state agency with parts of local social services, through the establishment of work-and-welfare offices in each municipality (Gubrium, Harsløf & Lødemel, 2014).

The 2012 ‘Coordination Reform’ for improving coordination of services across levels of government (state, region and municipality) and sectors (health and social) encouraged local authorities to take greater responsibility for health prevention and post-treatment care services (Norwegian Government, 2009). Involving a 20% municipal co-funding of their residents’ general hospital admissions, compensated by larger block grants, the initial calibration of the new incentive structure resembles a blueprint of the Danish reform (Torjesen & Vabo, 2014). Although after three years the government abolished the block grant-co-funding arrangement, another economic incentive remained: substantial fees (‘day fines’) for municipalities for each day between the time when their residents were ready for discharge and the time when they were offered general rehabilitation or long-term care if needed (Romøren, Torjesen &

Landmark, 2011).

In summary, both Denmark and Norway applied the ‘maximalist strategy’ (Øverbye et al. 2010) of mergers of agencies as a solution for co-ordination problems. Moreover, both share an impulse towards promoting ‘active’ – i.e. recovery- and work-oriented – behaviour amongst patients. Both countries have combined this active orientation in rehabilitation and employment programmes with new regulation and incentive structures that encourage health and work-and-welfare institutions to prioritise active measures.

Nonetheless, differences not only exist but have also widened. Market-inspired governance reforms and work-oriented activation for recipients of health-related benefits have established a substantially stronger foothold in Denmark than in Norway. Norway has also paid stronger attention to the social aspects of rehabilitation. Conversely, the active solutions enacted in Denmark have been stricter, and the penalty for ‘passivity’ imposed on individuals, and on the organisations who handle them, harsher. In addition, the concrete implementation of active return-to-work policies and policies aimed at curbing inflows into permanent disability benefits have been much smoother in Denmark than in Norway (Kvist & Harsløf, 2014; OECD, 2010).

Theoretical framework

To understand hospital social workers’ practice under this inter-sectoral restructuring, we draw on the institutional logics strand within new institutionalism (Friedland & Alford, 1991, Thornton & Ocasio, 2008). This approach aims at incorporating perspectives on macro-structure, culture and agency. It was developed for exploring the relation between organisations that operate through their own material practices and through symbolic systems (Friedland & Alford, 1991). These material practices and symbolic systems are not fully compatible across organisations and are sometimes even

contradictory (Blomgren & Waks, 2015).

Hospital social workers find themselves at the intersection of societal ‘key institutions’ – including different subsystems within the state (hospitals and work and welfare offices), the market (employers) and the family (patients) – from which fundamentally different logics emanate. As hospital social workers deal with patients in transition from one sectoral context to another, undertaking ‘projective’ cross-institutional work is an important part of their work. Such exercises require a strong sensitivity to different institutional logics in ‘an imaginative engagement of the future’ (Emirbayer & Mische quoted in Battilana & D’Aunno 2009, p. 47).

These differences in prevailing institutional logics can be related to different perspectives on ailment (Twaddle 1979). The *disease perspective*, with a medically grounded focus on physical malfunctioning, is predominant in the health services. The *sickness perspective*, with its socio-legal focus on social role capacity, dominates the work-and-welfare services. The *illness perspective* concerns the patients’ subjective interpretations of their own state of health. In attempting to align the contending institutional logics represented by these perspectives, hospital social workers may draw on different categories of knowledge: *formal knowledge*, which comprises authorised bodies of information and ideas organised by theories and concepts; *practical knowledge*, which is shared by all members of a profession or by those doing the same work; and *everyday knowledge*, which is shared by all members of a community (Friedson, 2001, p. 34).

Yet contradictory institutional settings can also be a source of agency at the street level. Thornton and Occasio hold that ‘contact with institutional logics in multiple and different organizational fields increases the awareness of and experiences with contradictions in logics...’ (Thornton & Occasio, 2008, p. 116). Hence, the hospital

social workers' inter-sectoral field is likely to enable certain agency to do cross-institutional work and even 'institutional entrepreneurship', i.e. the capacity for amending institutions from within (Leca & Naccache, 2006).

In this perspective, with Bourdieu (1998), one may consider how material practices and symbolic systems prevailing in one organisation take precedence, endowing affiliated agents a certain 'symbolic capital' of importance in their cross-institutional work. Hence, the 'structural overlaps' characterising the field in which hospital social workers operate may allow them to mobilise symbolic capital – for example by articulating the sickness perspective (the logic of the labour market) within the health setting or the disease perspective (the logic of the health system) when confronting the work and welfare bureaucracy. Yet, such structural overlaps – that in Denmark and Norway have proliferated due to the large-scale organisational mergers – may also accentuate antagonisms between contending institutional orders, constraining the room for social work.

Arguably, structural overlaps result not only from material changes (organisational mergers) but also from more subtle cultural shifts that link symbolic systems that had been previously considered separate. In this respect, we point to the trend, particularly strong in the Nordic countries, of linking the previously autonomous domains of health and work. A focus on working life has come to dominate the health system with an increasingly explicit focus on medical return-to-work measures (Johansen & Solbjør 2012), an increasing prioritisation of those health conditions associated with high rates of absenteeism (Vallgård & Lehto 2009), and – supplanting previous emphases on rest and recreation – the growing notion that employment in itself is beneficial to people's health (Larsen, Cutchin & Harsløf, 2013).

Study design and method

To explore hospital social workers' institutional work we analyse data deriving from the Danish-Norwegian project, *Professions, legitimacy and evidence in transforming health and welfare organisations* (PHLEGETHON), which examines a number of professional groups involved in medical and vocational rehabilitation. From this larger material, this paper reports data collected from four group interviews (December 2012-January 2015) with 14 hospital social workers in Denmark (two interviews, each with three participants) and in Norway (two interviews, each with four participants). The research participants, 13 women and one man, were all trained social workers, several with supplementary training (e.g. in cognitive theory or mental health subjects). Almost all of them had long work experience. The Danish participants worked at different hospitals belonging to the Copenhagen Metropolitan Region. The Norwegian interviews involved social workers at hospitals located in the capital, Oslo, serving the municipalities in the Southern and Eastern Norway Regional Health Authority.

Two researchers participated in each interview. The interviews were recorded and transcribed verbatim. Informed consent from all research participants was collected. In the data analysis that follows, all-female pseudonyms are used in place of the research participants' names, to ensure anonymity.

Our analysis aims at assessing how inter-sectoral restructuring is experienced by street-level professionals in Denmark and Norway. That observed differences may also originate in differences in local operational culture between the hospitals and wards constitutes a methodological concern. Yet from an organisational perspective the hospitals involved are very similar. In both countries, the hospital social workers are affiliated with the health system: in Denmark, employed by the regional authorities, in Norway, employed by regional health enterprises. The hospitals are all located in

metropolitan regions. Moreover, social work education is similar in the two countries. From a European perspective, both stand out by emphasising a critical, reflexive approach, encouraging a strong degree of independent practice in the organisations in which candidates are later employed (Campanini 2010).

Analysis of group interviews

Return-to-work policies as orientation for social work in hospitals

The interviews made clear that the work orientation that policy makers accelerated in the 2000s is heavily experienced on the ground. In the Norwegian rehabilitation hospital, the return-to-work agenda is uppermost in the minds of the staff from the very moment that patients enter the hospital:

We receive patients with different types of injuries, but common for them all is that we start out by trying to map if they have been in a job, and if they are able to keep it. We start this thought process at the stage when they have just arrived. (Silje, Norwegian social worker)

Attitudes towards this change in policy, and in its implementation through the local processing of patients, differed somewhat amongst the research participants. Mette, describing her tasks related to work assessments of people in rehabilitation – an assessment that included determining whether and to what extent they can work, given their injuries – was generally positive:

There is much focus on jobs [i.e., the patient's possibilities for returning to work], on collaboration with the work-and-welfare agency, and on collaboration with the employer. This is also highly exciting. (Mette, Norwegian social worker)

Bente's attitude was more critical. She found that the work-and-welfare agency's intensified work orientation hampered services for the group with no or limited work

ability:

If you mention work, all the doors are open, but as soon as you are outside of the labour market, then the local work-and-welfare office doesn't have the same measures. (Bente, Norwegian social worker)

In Denmark, the orientation towards return-to-work also featured prominently in the hospital social workers' accounts. They found that often this focus was exhausting their patients:

...and I can see that the patient is about to collapse, but the caseworker from the job centre shows no understanding, because they have to run their active measures and 'such a young and healthy guy with only a little bit of dementia ... he still has work ability'. (Lone, Danish social worker)

The Danish hospital social workers apparently found it necessary to protect very sick patients from what they regarded as unreasonably harsh job centre requirements:

This person needs a disability benefit as quickly as possible ... because then he can avoid going through work assessment tests and resource profiling. ... In such cases, you sometimes have discussions with the job centres about how much case processing the person really needs to be subjected to when he is very sick ... (Sofie, Danish social worker)

In the Danish interviews, the complicated organisational make-up was a recurring theme. Since the 2007 governance reform and the 2009 creation of all-municipal job centres, the hospital social workers found that the social part of rehabilitation had disappeared:

... the hospitals are supposed to treat the patients as quickly as possible. Then the municipality takes over, providing [general] rehabilitation and also retraining, but the social part is completely gone. It's as if the problem doesn't exist. *We* see it, because we meet the patients, but in reality, our own system is not in favour of our

doing a whole lot. They just say: ‘You shouldn’t do the work of the social service department’. (Lene, Danish social worker)

Whilst hospital social workers in both countries reported feeling the intensified orientation towards return-to-work policies, we detected the most unequivocal stance against its implications in the Danish interviews. This finding may be explained by Danish policy makers' having gone further than their Norwegian counterparts in implementing these measures, whilst at the same time neglecting the social part of post-treatment care and rehabilitation.

Traditional social casework as the basic script for hospitals’ attention

Situated outside the work-and-welfare services, hospital social workers have no formal power to decide on the types of needs-tested benefits and services the patients are to receive. Nevertheless, exerting influence on these decisions, through projective agency, is amongst their most important tasks. To restore the patients’ own mechanisms to function, it is this post-hospital context they must address.

Bente described a patient with congenital osteoporosis who had applied for a part-time disability benefit. The work-and-welfare agency refused to accept the documentation, because the testing and assessments had not been conducted under their auspices. She continues:

My task is then to make his needs visible and to argue that the types of tests and assessments we did were actually appropriate... My challenge is that we are regarded as the patient’s advocate – we’re not regarded as sufficiently objective.
(Bente, Norwegian social worker)

However, despite hospital social workers finding themselves assigned the somewhat partial role of patient advocate, our material suggests that they also actively assume this

role. For example Silje explained that to influence the outcomes of her patients' cases, she sometimes finds herself writing formal letters advocating on their behalf to actors involved at all levels.

Nevertheless, in one of the Norwegian interview groups, some disagreement emerged over their relation with the formal work-and-welfare bureaucracy. Mette argued that her affiliation with the hospital strengthened her position:

My experience with the work-and-welfare agency is the opposite of what you said. They are often very interested in getting to know our assessment of the case... I find that when you contact people and tell them that you are from this hospital, they are most obliging and eager to know what we, together with the patient, ended up finding out. (Mette, Norwegian social worker)

According to the hospital social workers, their job is to consider and act on individual cases in their entirety, at a time when others are becoming more and more specialised:

There is no one out there with the responsibility for the whole human being, is there? It's so specialised, and of course, I understand the need for specialised skills, but this often means that each of them is only seeing a tiny part of the user. (Bente, Norwegian social worker)

Whilst this statement received approving interjections from several others, another participant suggested that, 'out there', some institutions are indeed meant to co-ordinate in full. She mentioned both the 'individual co-ordinator', the person designated to take such overall responsibility after discharge from the specialised hospital, and the 'individual plan', the planning tool for facilitating cross-sector co-ordination. However, yet another participant quickly brushed aside this suggestion, complaining about the 'giant problem' created by these arrangements. What often results is a 'plaything' game about who should co-ordinate, and she often finds herself acting as informal 'long-distance' co-ordinator for the patient in his or her home municipality.

Like their Norwegian counterparts, the Danish social workers also stressed their holistic perspective on patients:

We unpack the whole patient, not just the specific illness. It's the consequences of the illness that we're looking at, where we uncover matters work-wise, economic-wise and family-wise and what lies in the patient and the family, you know ... what roles they have and so on. (Therese, Danish social worker)

However, the Danish social workers find themselves in a marginalised role in the hospital's professional hierarchy. They described their role in the hospital system as the person who provides an 'extra service', a service regarded by the higher echelons of the organisation as a kind of luxury. Importantly, they indicated that this role was particularly pronounced when attending to patients who are not targets for return-to-work action because of old age or special problems such as substance abuse. They said that the hospital management views providing social services to such individuals as a form of charity that adds no real value to the health care services.

Formal health knowledge as a critical tool in hospital social work

Bente finds herself deploying everyday, practical knowledge, combined with or as an alternative to formal knowledge, in terms of evidence ('facts'). She combines these types of knowledge to persuade the relevant actors (the caseworkers at the work-and-welfare agency, the previous employer and others) to co-operate:

My strategy is to make them understand that the client is struggling with issues common to all humanity, even if there is a special and rare diagnosis – so my strategy is to normalise, without making light of the issue... Depending upon the people I'm dealing with, it's largely my experience and communication skills that I deploy. ... Some people, you have to humour, others you can confront with facts.... (Bente, Norwegian social worker)

To foster understanding and favourable collaboration, she has to carefully consider how to present the health problems. In this process of ‘stigma management’ on behalf of her patient, she also draws on formal knowledge:

... issues with increased tiredness and fatigue are much more difficult to ‘sell’ ... both when it comes to the employers and others. So actually describing that he has to be able to sit down for half an hour at noon, and that it doesn’t mean that he won’t work, but [only] that he needs some adjustment of the work situation... Then it becomes important to refer to the experience with the whole diagnosis-related group, the research and experience. (Bente, Norwegian social worker)

The formal knowledge derives mainly from the field of medicine, concerning the effects of different treatments and services for groups with special diagnoses (e.g. chronic fatigue syndrome). In evoking this disease perspective, the hospital social workers rely on collaboration with the doctors, nurses, psychologists, occupational therapists and physiotherapists. Importantly, their communication of formal knowledge appears particularly important when there is a lack of ‘hard evidence’:

It has improved recently, but in the beginning, following the work-and-welfare reform, I often had to go down to the work-and-welfare agency to clarify why this or that patient had not returned to full-time work – given ‘such a small’ head injury. You know, for many of the patients there is no visible proof of their injury on the MRI [magnetic resonance imaging] pictures. (Charlotte, Norwegian social worker)

The Danish social workers described themselves as mediators between the health care and the work-and-welfare sectors. They use formal knowledge (e.g. about the social service legislation) and everyday and practical knowledge to explain to the medical personnel the possibilities, or the lack thereof, in the work-and-welfare sector. They find that nurses and doctors often have unrealistic expectations of the types of social services that are available to patients:

You know, I also bring knowledge to the health care personnel concerning social issues and the social service legislation and how X municipality works and perhaps I'm contributing to dispelling certain myths. Because the myth that everybody can just call their municipality and then they have a personal caseworker who ... is obligated to manage everything for you, that myth still exists ... it died with the Structural Reform, because it doesn't work like that anymore. (Birgitte, Danish social worker)

The hospital social workers use formal knowledge from the medical professions when they negotiate with social workers in the municipality. One of the interviewees works with young people suffering from a slowly progressing fatal disease. From many years of experience with this patient group, she knows how the different stages of the disease is related to different needs for extensive social services, including child protection services. However, getting home municipalities to realize how they can best cater to these needs has often proved difficult. Therefore, on her own initiative, she has prepared general guidelines for the municipalities, to apprise municipal caseworkers about the social services needed as the disease progresses:

My experience is that when I do this, it becomes so much easier to make my way through with assistance ... I hope to make the local municipality have this assistance on hand when the needs occur, and I can only achieve that by somewhat pre-empting the matter. (Lone, Danish social worker)

In this way, arguably, the hospital social worker is attempting to transform the future context of the patient (and the patient's family) – the context materialising when, returned to the home municipality, the disease will gradually exert its physical and social consequences.

Discussion

The limited material reported here provides insight into changes that have occurred in the inter-sectoral field of health and social welfare, as they are experienced on the ground. Some changes have seemingly taken place over night – as exemplified by how the Structural reform in Denmark meant that citizens no longer have a designated caseworker in their home municipality, something that hampers inter-sectoral communication and coordination. Other macro-level changes are less experienced on the ground. In the Norwegian data we observe how hospital social workers found that the institutional arrangements meant to facilitate cross-sectoral coordination have not really materialised in the manner anticipated by the government. However, most of the restructuring appear as emerging only gradually, reflecting that institutional change is not only a matter of legislated re-organisation, but involves a more gradually occurring transformation of cultural schemas and symbolic systems (Thornton, Jones & Kury 2005).

The hospital social workers' experiences of not always being trusted by the work-and-welfare authorities may represent a more gradual change induced by the inter-sectoral governance reforms. In Norway, in the wake of the 'structural overlap' created by the work and welfare administration merger, arguably, the role of social workers has become marginalised. Røysum (2013) argues that social workers in the new system have seen their traditional social casework methods and professional ethics devalued and are struggling to have their competence recognised. Likewise, in Denmark social workers find their profession becoming marginalised in the job centres, which no longer require that new caseworkers have a background in social work (Baadsgaard et al., 2014). In this sense, arguably the macro-level restructuring of social services has

somewhat limited hospital social workers' capacity for improving their patients' social context.

Yet the interviews suggest that the hospital setting, imbued by the disease-oriented logic, provides a strong position of enunciation for social workers. In the Nordic countries, hospitals are particular strong institutions, and there is a tradition of strong medical professional power (Haave, 2006). This relative power basis of hospitals and the medical profession likely lends itself to hospital social workers when interacting with the work and welfare authorities, employers and other actors. Both the Danish and Norwegian hospital social workers share examples of having performed projective cross-institutional work. Indeed, they seem to have adopted 'a practical knowledge of the institutional logic – i.e. knowledge of the causal powers they expect to use in the specific context in which they operate' (Leca & Naccache 2006, p. 633). By articulating formal health knowledge to the work and welfare authorities, they often seem able to succeed in 'making their way through' into the patients' social context, as it is constituted by their home municipality or (future) workplace.

Conclusion

For understanding professional service work, 'researchers should pay attention to the larger institutional environment where calls for reform are made' (Leicht et al. 2009, 600). In this study, we focused on hospital social workers' strategies for improving the patients' context for functioning (restoration and rehabilitation), in the face of larger institutional reforms that affect both the patients' situations and conditions for hospital social work.

In group interviews, the hospital social workers indicated that inter-sectoral restructuring in the field has greatly impacted on their daily work with patients. Whilst

some view the intensified return-to-work orientation as exciting, others find that the new organisation and programming impedes the traditional holistic approach of social work. The differences that we observed at the macro-level, in terms of the direction and pace of return-to-work-oriented reforms in the two countries, were largely reflected on the ground in the differences in the testimonies from the Danish and Norwegian research participants. The Danish hospital social workers in particular felt squeezed in a system that increasingly prioritises quick return-to-work measures over longer-term treatment and social rehabilitation.

To affect the context of the individuals they are assisting, hospital social workers need to perform and transpose institutional logics pertaining to health services, work-and-welfare institutions, and the patients' life-worlds. Both the Danish and Norwegian social workers reported that they tend to assume the role of patient advocates and counsellors in their dealings with the work-and-welfare services. However, the interviews indicated that the advocate role was also partly imposed on them, even in situations when they were relaying factual information concerning the patients' health conditions.

To negotiate different institutional logics constituted by the disease, sickness and illness perspectives, in determining the types, volume and quality of health and social services for the patients, hospital social workers consciously employ various forms of knowledge. Working in a setting with strong medical expertise, they acquire vital formal knowledge that often proves to be 'valid' when they are negotiating with other parts of the system, and beyond, to improve the contexts in which the patients are to function. Carefully choosing their approaches, and registers of knowledge for the particular context, whether a sceptical employer or a reluctant caseworker from the work-and-welfare agency, they often manage to transforming the context for the patient, for this person to better functioning after discharge.

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