



Social inequality in navigating the healthcare maze: Care trajectories from hospital to home via intermediate care for older people in Norway

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ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:

Norway
Social inequality
Care trajectories
Old age
Intermediate care
Access to universal healthcare
Health literacy
Social networks

ABSTRACT

Although health inequality is a growing concern, striking differences in health and life expectancy still exist across and within OECD countries. In Oslo, the largest city in Norway, life expectancy differs by up to 7 years between districts. Equal access to healthcare can help reduce social differences in health. However, research indicates that older people at the lower level of the social gradient have more difficulty accessing health services. Older people experience early hospital discharge and several transitions between and across care levels. In this study, using Bourdieu's theory of practice as a theoretical lens, we explore social inequality in access to universal healthcare within care trajectories for older people in Oslo. Through observation of family meetings in intermediate care (N = 14) and semi-structured interviews with older patients (N = 15), informal caregivers (N = 12) and healthcare professionals (N = 18), the study identifies 15 unique care trajectories from hospital to home via intermediate care. Informed by a critical realist perspective and moving from west to east via the urban areas, there is a prominent finding of climbing down the social gradient and, subsequently, reduced access to healthcare. An overarching theme, 'Navigating the healthcare maze', was identified along with two subthemes: 'Individuality meets system' and 'Having a feel for the game'. Navigating the healthcare maze depends on where you live, your level of education and health literacy and the ability to mobilize social networks. Furthermore, it is an advantage to fit into the professional habitus of the 'active patient' discourse. The findings will be relevant for politicians, managers, healthcare professionals and other stakeholders working in the field and in the development of services adapted to the needs of various socioeconomic groups.

1. Introduction

Concerns regarding health inequality – implying that different groups within the social hierarchy possess different levels of health (Kawachi et al., 2002) – have been growing since the 1980s (Berkman et al., 2014). Despite prominent policy intended to reduce this inequality (Eldstad et al., 2022), striking differences in health and life expectancy persist across and within OECD countries (OECD, 2019; Braveman and Tarimo, 2002). In general, individuals in higher social positions tend to have better health outcomes than those in lower social positions, often referred to as the social gradient (MacGuire, 2010). Different dimensions of social status, such as income, education level, occupational status and housing affect the entire causal chain. These dimensions are also considered important determinants of lifestyle habits and of the use of health and social care services (Braveman, 2006; Norwegian Institute of Public Health, 2022). Accordingly, those with

low socioeconomic status (SES) generally have poorer general health and are more likely to be exposed to morbidity and premature mortality (Acciai, 2018).

An ageing society has led to growing awareness of health inequalities among older people. Older people with low SES have more illnesses and health problems, which implies a greater need for healthcare services. Simultaneously, research highlights that older people at the lower level of the social gradient have more difficulties accessing health services (MacGuire, 2010). This is supported by the 'World Report on Ageing and Health', which concludes that older people with low SES also have the fewest resources to take care of their health (Beard et al., 2016). Many older people need care between and across care levels, for example from hospital to home via intermediate care services, reflecting the patient journey (Kvæl et al., 2022). However, knowledge is scarce on how inequalities in access to healthcare services are expressed within these care trajectories. Accordingly, the aim of the current paper is to explore,

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<https://doi.org/10.1016/j.socscimed.2023.116142>

Received 5 May 2023; Received in revised form 28 July 2023; Accepted 3 August 2023

Available online 4 August 2023

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using Pierre Bourdieu's theory of practice as a lens, social inequality in access to national public healthcare in Oslo, Norway, within the care trajectories of older people.

1.1. Diversity in an ageing society

Worldwide, projections suggest that the number of older people will increase drastically in the coming decades (United Nations, 2020). In Norway, the number of people 80 years or older is projected to increase from 190 000 in 2000 to 350 000 in 2050 (Norwegian Ministry of Health and Care Services, 2018). This rapidly ageing population, as well as the rising numbers of older people living in suboptimal health, indicates the importance of policies and practices to support healthy ageing. There is a need for policies throughout the whole life course but also for a policy to address health inequalities in older age (Arcaya et al., 2015). Adequate health and care services can address inequalities created earlier in the life course. Consequently, equal services adapted to the needs of various socioeconomic groups may help reduce social differences in health. A key concept here is health literacy or 'the degree to which individuals have the ability to find, understand and use information and services to inform health-related decisions and actions for themselves and others' (Office of disease prevention and health promotion, 2023). Essential aspects of health literacy are understanding organizational structures and accessible care and the competence to manoeuvre efficiently within the system. The presence of a social gradient in health literacy was highlighted in a recent systemic review (Nutbeam and Lloyd, 2021). Therefore, it is important to account for different levels of health literacy when exploring access to healthcare in older years (Norwegian Institute of Public Health, 2022).

Norway is among the richest countries in the world and is by law obligated to provide universal healthcare coverage to all residents. Nevertheless, its inequalities in health are larger than in many other European countries. In Norway, inequalities are especially large between groups with different levels of education (Enroth et al., 2022). Accordingly, women and men with the highest education levels have better health and live 5–6 years longer than those with lower education levels. In Oslo, life expectancy differs by up to 7 years between poor and wealthy districts (Norwegian Institute of Public Health, 2022).

As part of the policy of 'ageing in place' in Norway, i.e., the opportunity for older people to remain in their own home with support to live independently for as long as possible (Pani-Harreman et al., 2020), older people experience early hospital discharge and often several transitions both within and across care levels (Kvæl et al., 2019a). Older people appear to be particularly at risk of adverse events related to hospital discharge and care transitions (Forster et al., 2004). Hence, intermediate care (IC) has been established to support the pathway from specialist to primary level, involving a continuum of services to enhance recovery and thus enable older people to maintain independence following a period of illness (Sezgin et al., 2020). This patient care trajectory from hospital to home via IC includes several healthcare professionals that must coordinate specific care services so that older people may experience an integrated patient journey (Kumlin et al., 2020). Since socioeconomic inequalities in health are considerable in Norway, and evidence on inequalities in healthcare use among older people is sparse (Hansen et al., 2012), studies in this field are of special interest. The current article will contribute with findings on social inequality in access to universal healthcare within the care trajectories of older people in Oslo.

1.2. Theoretical approach – Bourdieu's theory of practice

The French sociologist Pierre Bourdieu (1930–2002) has had a significant influence on understanding how social structures, culture and power relations shape individual and collective behaviours in society (Bourdieu, 1977). One of his contributions is the theory of practice, which emphasizes the interactions between structure, power and agency

in the social world by synthesizing objective and subjective approaches (Aakvaag, 2008). Bourdieu argued that social actors are not purely autonomous but are influenced by culture norms, traditions and objective structures, which create distinctions within a social class hierarchy (Rhynes, 2005). With the concepts of field, capital and habitus, Bourdieu's theory of practice may be a suitable lens to understand social inequalities in access to healthcare in the care trajectories of older people.

Bourdieu's concept of *field* embraces the various structures, institutions, authorities and activities people act within (Aakvaag, 2008). The field is comprised of the transitional care services for older people from hospital to home via IC, and the concept provides the frame of analysis. The boundaries of a specific field are considered not to be static, but constantly challenged by practices and power dynamics. In addition, Bourdieu highlights that every person acting within a field may influence the boundaries, and rivalry among people is of great relevance in shaping the future structure of the field (Rhynes, 2005). In our study, this implies that care will be influenced by the organizational structures (such as the municipal purchaser–provider split model), environmental factors (e.g., transferring via an IC unit) and personnel (a team approach). However, the wider structures of the society, such as the policy of 'ageing in place', will also influence how care trajectories are conceptualized in the services. Within the field, patients, medical staff, family members, and allied healthcare professionals interact with its structural aspects (Rhynes, 2005).

Broadly, Bourdieu defines *capital* as scarce resources for which there is competition among individuals and groups. Capital gives power by virtue of being a resource (Aakvaag, 2008). Capital can present itself in different ways. Economic capital is understood as directly convertible into money and may also be institutionalized in the forms of property rights and other valuable assets. For Bourdieu, *cultural capital* means having acquired and mastered the dominant cultural code or 'taste' in a society. Cultural capital gives power through educational qualifications, access to attractive positions in the labour market, better opportunities for participation in politics, science and art, access to exclusive environments and general status, prestige and honour (symbolic capital). Bourdieu describes *social capital* as access to social networks such as family, friends, neighbours and voluntary organizations. Social capital gives power because social networks can be mobilized if desired (Bourdieu, 1977).

Bourdieu defines *habitus* as an integrated system of enduring and embodied dispositions that regulate how we perceive, evaluate and act in the physical and social world. Habitus is determined by the past, traditions, culture and/or norms often not clearly expressed. Furthermore, habitus is influenced when learning through imitation from others in the field (Bourdieu, 1977). For example, the principle of patient involvement might influence professionals' expectations of the active rehabilitation patient, while on the other hand, the war generation of older patients might still think that 'the doctor knows best'. Thus, the professionals', patients' or relatives' habitus are considered learned behaviour, thinking and action patterns shaped by both the specific field as well as all forms of capital.

1.3. Aim of the study

This article explores how economic, cultural and social capital, as well as ways of acting and responding (i.e., habitus) can provide advantages in older peoples' struggles in accessing universal healthcare services in the field of care trajectories.

2. Material and methods

The methodology includes detailed examination of the phenomenon of interest within its context by using different measurement techniques (Yin, 2018). Underpinned by a critical realist approach where the researcher intends to reveal underlying structures causing the

observable events as experienced (Fletcher, 2017), we use observation and semi-structured interviews with different stakeholders to explore the construction of the unique cases.

2.1. Context of the study

The healthcare system in Norway is largely public and divided into specialist and primary care levels. Specialist services provide hospital care organized into four national state-owned health corporations, while primary care is provided at local levels (municipalities) and embraces homecare services and nursing homes, as well as transitional care services such as institution-based IC services, rehabilitation or reablement (Ringard et al., 2013). Inspired by the New Public Management trend from the 1980s, with the overall aim of making healthcare services less bureaucratic and more effectual by introducing private sector management models, a purchaser–provider split model is still an important organizational structure underpinning care delivery in Norway (Andreassen, 2009). In practice, this means that when the hospital claims the patient is ready for discharge, the municipal case manager (the purchaser) has the administrative authority to decide upon suitable services in the community delivered by the frontline providers, i.e., healthcare professionals working in community care services. As part of this trend, the city of Oslo synchronized most municipal rehabilitation into four IC institutions in 2015 (Norwegian Ministry of Health and Care Services, 2009).

In 2022, there were 6755 IC beds in municipal institutions throughout Norway (Statistics Norway, 2015–2022). The four IC institutions in Oslo have a total of 454 beds. By the fourth quarter of 2022, Oslo had 709 037 inhabitants living in 15 geographical districts (Statistics Norway, 2023). Each of the four ICs is responsible for serving three to five of these districts representing the east, west, south and urban areas (centre) of Oslo, all locally situated. The primary tasks of the IC institutions are to deliver rehabilitation, treatment, assessment and palliative care (Sezgin et al., 2020). However, as mentioned, there are large differences in SES within and across the city districts (Norwegian Institute of Public Health, 2022).

2.2. Study participants

The specific cases in this study are the care trajectories of older people transferred from hospital via IC institutions in Oslo serving different geographical districts. Through observation of family meetings (N = 14) and semi-structured interviews with older patients (N = 15), their relatives (N = 12) and healthcare professionals working in an IC setting (N = 18), this study identifies 15 unique care trajectories from hospital to home via IC institutions. The patient participants had to be 65 years or older, transferred to IC due to chronic disease and/or frailty, dependent in activities of daily living at admission day, and having an overarching aim of ageing in place. Older people having serious mental problems, inadequate Norwegian skills or aphasia were not included. The 15 participating patients (10 women and 5 men) had a mean age of 87 years. The average stay in IC was 4.4 weeks. Only four of the patients had obtained higher education (such as college or university). The relatives included (six daughters, two sons, one husband, one sister, one daughter in law and one support person) were stated as the closest or preferred next of kin by the participating patients. The staff were chosen due to diversity in age, nationality, profession and experience representing the multidisciplinary IC team (i.e., nurse, nursing assistant, physical and occupational therapists, doctor, and municipal case manager).

2.3. Data collection

This empirical project was conducted in three of the four IC institutions serving the municipal districts in the west, urban area (centre) and east of Oslo between 2017 and 2018. Since the fourth IC institution

was the first author's previous working place, it was not included. The data collection was conducted in six IC departments (each with 24–32 beds). The purpose of spreading the data collection across departments and IC institutions was to explore various cultures and collaboration arenas to embrace the diversity these services represent.

Initially, to embrace the diversity that these services represent, we recruited a strategic sample of 15 older patients admitted to IC: five patients from six wards within the three IC institutions representing eight geographical districts as well as heterogeneity related to age, gender, education, diagnosis and family network. Suitable patients were approached by IC staff. Those agreeing to participate were provided with in-depth information. With the patient's consent, relatives were asked to participate, as well as the IC team and the municipal case manager. The researcher observed family meetings (N = 14) held within the first days of the IC stay. The main idea of these meetings is to voice patients' and relatives' needs, make a rehabilitation plan and discuss the length of stay as well as follow-up services. Observing people in a natural situation such as a family meeting may reveal more information than participants might recall, choose to report, be aware of, or decide is of relevance (Morgan et al., 2017).

To capture all the dimensions of the care trajectory, the patients were interviewed twice; the first interview was conducted in the IC ward and the second in the participant's home. Each interview lasted between 30 and 60 min. Among the 15 participating older people, 3 did not have any close relatives. Four relatives were recruited from each of the three IC institutions. The 12 relatives were interviewed 2–4 weeks after patient discharge (duration 45–75 min). These interviews were conducted in their home, at the IC institution, at their workplace or in a cafe. During the care trajectories, we also interviewed staff (N = 18), six from each IC institution. The staff interviews were conducted at their workplace, and each lasted roughly 60 min. All interviews were face-to-face and recorded as MP3 sound files. Semi-structured interview guides were used during all interviews in exploring experiences and preferences regarding admission to IC, quality of care, patient and relative involvement, access to preferable services, negotiation with gatekeepers and discharge to home. All three interview guides (patients, relatives and healthcare staff) are previously published (Kvæl and Bergland, 2021; Kvæl et al., 2019b).

3. Data analysis

Along with observational notes, all recordings from the family meetings and interviews were transcribed verbatim and analysed using reflexive thematic analysis (Braun and Clarke, 2006). First, the researcher read the transcripts and notes in an open way, searching for patterns and 'demi-regularities' across the material while taking notes. At this stage, a significant pattern of social inequality between the three IC institutions emerged across the data material. Consequently, we decided to pursue and explore this phenomenon in a more deductive way using Bourdieu's theory of practice. The researcher then coded and grouped categories into initial themes using the software Hyper Research, followed by a process of reviewing, defining and naming themes to unfold the "essence" of what each is about in order to disclose underlying mechanisms in the participants' behaviour, beliefs and experiences. Accordingly, a circular, reflexive process between the transcripts, analysis and theory is both normal and expected. Among several other topics uncovered in the material, some have been explored in previous publications. This article reports exclusively data considering social inequality in access to healthcare in the care trajectories of older people. As mentioned, Bourdieu's theory of practice provided a theoretical lens in later analysis, which resulted in the construction of one overarching theme and two main themes (Table 1).

3.1. Ethics

The project was undertaken in accordance with the Declaration of

Table 1
Identified themes.

Overarching theme	Main theme	Subthemes
Navigating the healthcare maze	'Individuality meets system' The person interacting with structural boundaries	Heterogeneity in needs Mobilizing social support Distinct attributes needed
	'Having a feel for the game' Negotiation with professionals and other gatekeepers	Most appropriate behaviour Taken for granted mindset Too generalized pathway

Helsinki and registered and pre-approved by the Norwegian Centre for Research Data (No. 53013). All participating patients, relatives and staff were provided with oral and written information about the project and the researcher's role and signed a statement indicating informed consent. In addition, all were assured of the opportunity to withdraw from the study without consequences. All sound files (MP3) were stored in

Services for Sensitive Data. This data platform is managed in accordance with Norway's Privacy and Electronic Communication Directive. This article is structured in line with Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

4. Results

In general, most of the older patients and their relatives expressed gratefulness for receiving a place in IC instead of being discharged directly to their homes. However, there were great variations in the experience of the ability to influence their own care trajectories. Moving from west to east via the urban areas, there is a prominent finding of climbing down the social gradient and, subsequently, reduced access to healthcare. This gradient is expressed through aspects such as education, personal and social resources, housing facilities, types of behaviour, health complexity, health literacy and the construction of family meetings in IC. Therefore, an overarching theme, 'Navigating the healthcare maze', was identified, supported by two main themes: 'Individuality meets system' and 'Having a feel for the game'. The whole sample's demographics and patterning of care trajectories are shown in Table 2. Although we found that declining access to health services coincides

Table 2
Characteristics of the 15 care trajectory cases.

IC	District & class profile	Older patients (N = 15)	Educ-ation	Housing	Relatives (N = 12)	IC stay	Care trajectory	Family meeting (FM)	R at FM	DC at FM
E	Lower class (1)	Male 83 Cancer with metastases, Brain surgery	Low	Flat	Daughter 61, ass. district director	7 weeks	Home-IC-home	After six days (56 min)	x	
E	Lower class (2)	Male 76 Walking problems	Low	Flat		2 weeks	Hospital-IC-home	After two days (10 min)		x
E	Lower class (2)	Female 94 Malfunction, UI, Cognitive impairment	Low	Terraced house	Daughter 64, teacher, retired	5 weeks	Hospital-IC-home	After 2 ½ week (20 min)		
E	Lower class (3)	Female 74 Hip fracture, COPD, Dia II	Low	Flat	Support contact, 73, retired	2 weeks	Hospital-IC-home	After two days (32 min)		
E	Lower class (2)	Female 68 MS, Pain syndrome	Low	Flat	Husband, 71, fitter, retired	2 weeks	Home-IC-home			
U	Lower class (4)	Male 85 Hip fracture, Arm fracture Malfunction	Low	Flat	Sister 87, nurse, retired	23 weeks	Hospital-IC-nursing home	After three days (40 min)	x	
U	Middle class (5)	Female 97 Concussion, Hypotension, Rib fracture	Low	Apartment	Daughter in law 56, dental technician	2 weeks	Hospital-IC-home	After three days (33 min)	x	x
U	Middle class (5)	Female 85 Galle chronic Cholecystitis surgery	Low	House	Daughter 50, insurance, disabled	10 days	Hospital-IC-home	After two days (27 min)	x	x
U	Neutral (6)	Female 92 Hip fracture	Low	Flat		3 weeks	Hospital-IC-home	After two weeks (47 min)		x
U	Neutral (6)	Female 90 COPM	High	House	Daughter 68, social worker, retired	2 weeks	Hospital-IC-home	After 1 week (30 min)	x	x
W	Upper class (7)	Female 88 Osteoporosis Fractures columnna, Pain	Low	Apartment	Daughter 63, lecturer, retired	1 week	Hospital-IC-home	After six days (40 min)	x	x
W	Upper class (8)	Male 88 Arm fracture, UI, Delirium	High	Apartment	Daughter 54, librarian, master	5 weeks	Hospital-IC-home	After four days (30 min)	x	
W	Upper class (8)	Female 86 Hip fracture, Osteoporosis	High	House	Son 50, real estate developer	2 weeks	Hospital-IC-home	After one week (40 min)	x	x
W	Upper class (8)	Female 91 Hip fracture, Osteoporosis	Low	House	Son 63, political scientist, retired	3 weeks	Hospital-IC-home	After 2 weeks (20 min)	x	x
W	Upper class (8)	Male 89 Dizziness, N. vestibularis inflammation	High	Penthouse		5 weeks	Hospital-IC-home	After six days (28 min)		x

IC=Intermediate Care. E = East. U=Urban. W=West. The district's class profile based on the average for Oslo (Ljungren, 2017). MS = Multiple Sclerosis. COPM=Chronic obstructive pulmonary disease. UI=Urinary infection. Low education: elementary school and high school. High education: college and university. Flat = Block apartment. Apartment = Terrace apartment. R=Relatives. DC = Municipal District Coordinator.

with moving down the social gradient, there were some anomalous cases, e.g. the older person with low SES who experienced manoeuvring the system perfectly due to high health literacy, or the professor with high SES from the upper class not being treated with dignity due to cognitive decline.

Rather than breaking our data into incoherent fragments, we will use two of the care trajectory cases to demonstrate the main themes (Table 3). Although we recognize that using two contrasting cases in the further presentation will not embrace all shades of the 15 cases analysed, a comparative illustration of two very different cases may help convey more general findings in a more vivid and nuanced manner. Accordingly, the two cases were chosen to demonstrate the *range* of social differences in our data material, as well as how the two main themes interact in constructing variances when navigating the health-care maze.

4.1. Individuality meets system – access to adequate care services

The first theme, individuality meets system, embraces the complexity and different care needs in a heterogenous group and the need for particular capital to access adequate care services. Overall, we found a quite prominent pattern where well-resourced patients and/or relatives had a clear advantage in accessing the right care services.

In the first case, we meet a vulnerable woman in her mid-90s with low educational attainment from an eastern district living alone in a non-adapted terrace house. She is frail with complex health issues and has been hospitalized with successive IC several times in recent months. Due to feeling lonely and unsafe, she has applied for nursing home residence three times with subsequent rejections claiming that she is physically not sick enough. In addition, considering her cognitive impairment, she frequently changes her mind in front of healthcare staff. Her daughter, a retired teacher who lives in another city, describes the situation as hopeless and feels totally ignored by the system.

She has been in and out of institutions. [...] We've have had a lot of meetings with the district and healthcare staff, about different things ... and they come home to her house, and make agreements, still I feel nothing happens. [...] We don't feel seen [...] So to put it badly, I feel like my mother is being treated like a package, then they hope she will die in the queue, so they get rid of the problem. (Daughter, case 1)

In the second case, we meet a highly educated woman in her mid-80s living with her husband in an architect-designed house where they have accounted for being able to have a private nurse living on the second floor to take care of them in the future. They live in one of the western districts of Oslo having large economic capital. Their son, a real estate developer, lives next door and ensures that his mother gets everything she is entitled to by being her voice. After a very nice hospital stay due to femoral fracture after a fall, the family is given options regarding the further care trajectory.

So, we could make suggestions, and we just said that she must come to a place that is good for her with sufficient physiotherapy training and that ... it has a friendly environment, that was our wish. And of course, very appropriate if it's within or nearby the city area as well ... Whatever what's best for her ... (Son, case 2)

Our results indicate that proper services also depend on where you live, the economy of the district, the class profiles and thus what is offered in different situations. This is again highly associated with behaviour and expectations and what you demand as a person, i.e., habitus. In case 1, the municipal case manager emphasizes these structural differences in the field of care trajectories.

Yes, I've worked in another district of Oslo before. Slightly better economy in that district so it was easier for people to get what they wanted. There were no rejections. While here, applications are rejected all the time. It has a lot to do with finances ... I was previously at a job interview in a western district, and there it was like "How will you deal with strong relatives with lawyers?" (Case manager, case 1)

Accordingly, the same issue is illustrated by the ability to mobilize strong relatives. Relatives are considered a resource in order to voice the patient's needs, and there is a clear pattern in that this form of social capital is seen as an advantage in navigating the healthcare maze. For example, in case 2, where the relatives are highly educated and possess knowledge of rights and systems, this represents greater access to proper healthcare.

Yes, relatives are very involved. We have four districts on the western edge. There are a lot of lawyers and doctors and so on, so they are very engaged. And you know, treating relatives is almost an art form of its own ... because I often feel that we treat relatives more than we treat the patient. (Nursing assistant, case 2)

Individuality meets system is also expressed through differences in the collaboration between the IC institutions and the various districts in different models of care (e.g., institution-based versus home-based rehabilitation), as well as the overall policy of 'ageing in place' and, thus, deinstitutionalization with a subsequent lack of nursing homes.

'Patient storage', that they get an IC place even if they're not suitable for rehab. So yes, we do get patients without rehabilitation potential. Yes. And it happens, regardless of district. (Nursing assistant, case 1)

In a field with scarce resources, there exists competition for services among individuals and groups. However, access to the right care level depends both on where you live, i.e., the economy of the district and what it may offer as services (economic capital), as well as on possessing distinct attributes, such as education and health literacy (cultural capital) and the ability to mobilize social capital to negotiate care needs.

Table 3
Case characteristics.

	Case 1	Case 2
Patient characteristics	Female, 94 years, low education level, living alone in a non-adapted terrace house, duration of IC stay: 5 weeks	Female, 86 years, high education level, living with husband in an architect-adapted house, duration of IC stay: 2 weeks
City district	Lower class/low SES – east Oslo	Upper class/high SES – west Oslo
Patient diagnoses	Rib fracture, urinary infection, pneumonia, heart failure, mild cognitive impairment	Femoral fracture, operated with osteosynthesis, hypothyroidism, osteoporosis
Family meeting	Duration 20 min, held in the patient room, present at the meeting: the patient, a nursing assistant, the physical therapist and the occupational therapist, held after 2.5 weeks	Duration 40 min, held in a conference room, present at the meeting: the patient, her son and daughter, the municipal case manager, a nurse and the physical therapist, held after one week
Care trajectory	Hospital to home via IC	Hospital to home via IC
Relative interviewed	Daughter, 64 years, retired, teacher, lives in another municipality	Son, 50 years, in work, real estate industry, lives next door to the patient
IC team interviewed	Municipal case manager, nurse, nursing assistant, physical therapist, doctor and occupational therapist	Municipal case manager, nurse, nursing assistant, physical therapist, doctor and occupational therapist

4.2. Having a feel for the game – access to quality of care within services

The second theme, having a feel for the game, embraces the patients' and relatives' negotiation with professionals and other gatekeepers to access quality care. The findings suggest that the ability in navigating the healthcare maze influences the prioritization of who receives attention and subsequent individualized, high-quality healthcare.

In the first case, the vulnerable woman seemingly does not fit into the professional habitus of the active patient with a clear objective to live independently in her home. On the contrary, lacking cultural capital, she finds it hard to ask for help, she does not want to be a burden, and, in line with the habitus of the war generation, she has faith in professional expertise. Accordingly, she feels lonely; she does not want to be "fixed" but to be seen as a person.

Yes, they had ... I don't think I can boast that they had a lot of time for me, for the patients ... for small talk. Because I thought ... when I passed that staff room, where they had ... a common chat and so on, then I thought that some of them might as well chat with us ... It's particularly important in places like this [IC institution] that you have the feeling that someone is listening to you. I think that's very important. (Patient, case 1)

In the opposite case, the patient is regarded as a pleasant one that fit into the system, i.e., the rehabilitation context and the professional habitus of the idea of the active patient who takes responsibility for her own rehabilitation process. You are not supposed to be too demanding or slow, but active enough to participate in activities and preferably have uncomplicated health issues. In case 2, the physical therapist during the family meeting praised the patient in front of her relatives for her good behaviour (habitus), i.e., her engagement with healthcare professionals, her compliance to exercise, her motivation for going home and willingness to be active and independent, be it the recipe for a successful and suitable patient:

Yes, you are now at a rehabilitation unit, and we feel that you are making good use of our services. You participate in groups ... Yes, and now you handle the walker and ... So, here we will prepare you as much as possible for the discharge to home and for your independence. (Physiotherapist, case 2)

In IC services, the routine is to conduct an early family meeting to voice the patients' and relatives' needs, make a rehabilitation plan and discuss the length of stay as well as follow-up services. These meetings are supposed to take place early in the process with the older person, informal caregivers, the IC team and the municipal case manager attending.

Family meetings should take place between three days to a week after admission. Quite early. But not too soon either, because then you haven't got to know each other. Early in the sense that patients and relatives can adjust to what is happening. After all, they always hold certain expectations. (Case manager, case 2)

However, we found enormous differences in how these family meetings were held, both regarding time, composition and content (see Table 2). Again, we saw a clear advantage of various forms of capital. In the first case, the family meeting was held after two weeks and, due to short notice, neither the patient's daughter nor the municipal case manager could participate. Accordingly, the 94-year-old woman with cognitive impairment was alone, having no clue of the purpose of the meeting. No relative was present to voice her needs. In addition, nothing was decided at this meeting, as nobody with administrative authority was present. Rather, when the patient mentioned she had not been given any physical exercise, the physiotherapist cut her off by saying:

However, everything you do is training. You know, morning care, walking to the dining room, or in the corridor, that is also training, right? (Physiotherapist, case 1)

In the opposite case, the family meeting was held at one week, and the patient was present with her son and daughter along with the IC team and the municipal case manager. Here, they planned the care trajectory in detail including a home visit to adapt any physical barriers in and around the house as well as where to receive vegetarian dishes after discharge. In addition, the patient from the western district had access to training with the physiotherapist daily during her IC stay. She received true rehabilitation and felt she was treated with dignity.

I had a great time there, and a physiotherapist trained me daily and helped me back on my feet. She was very sweet and motivating, so I felt I got a lot better when I was a patient there. Yes, it was a very nice place to be. (Patient, case 2)

Accordingly, within a field where healthcare professionals' habitus is strongly associated with efficient patient flow and active patients, one must be physically sick enough to qualify for certain services, but simultaneously possess distinct attributes or capital to obtain access, i.e., exhibiting the right behaviour and being a patient that fits the system. The latter also implies willingness to live independently at home. However, not all patients have these resources of various types of capital, which also depend on where you live, thus reinforcing social inequality through access to universal services when navigating the healthcare maze.

5. Discussion

The present study provides nuances in understanding social inequalities in access to universal healthcare coverage in the care trajectories of older people. One prominent finding is the ability to navigate the healthcare maze, which relies on where you live, the ability to mobilize social networks and having distinct competencies related to interaction with structures, i.e., to fit into the field or system, as well as having a feel for the game, i.e., to negotiate with staff members' habitus and gatekeepers in a competent way. In our material, moving from west to east via the urban areas, there was a prominent finding of climbing down the social gradient, expressed in aspects such as education, personal and social capital, housing facilities, types of behaviour, health complexity, health literacy and the construction of family meetings.

In this study, the care trajectories of older people from hospital to home via IC was the field of analysis. Seen from a critical realist perspective (Fletcher, 2017), important underlying mechanisms affecting these care trajectories are a rapidly ageing population (United Nations, 2020) and a policy of 'ageing in place' (Pani-Harreman et al., 2020), resulting in older people experiencing early hospital discharge (Kvæl et al., 2019a). Consequently, within this field there is great emphasis on efficient patient flow, inspired by NPM models, and an increasing lack of qualified staff (NOU: Official Norwegian Reports, 2023:4, 2023). As our data material expresses, in a field of scarce resources older people must be sick enough to qualify for certain services or at least know how to express complex health issues to be heard.

As illustrated by the two selected cases, our material revealed a pattern where people from lower strata and with complex health issues had greater problems with orienting themselves in the system and accessing the right services at the right time. These inequalities are also highlighted in the World Report on Aging and Health by the WHO (2015), which claimed that disadvantaged older people, e.g., those having complex health issues such as dementia, often confront more challenges in accessing health-related services (World Health Organization, 2015). A study of 12 European countries reported inequalities by education level among older people in visits to medical specialists and dentists (Terraneo, 2015). In the recent International Health Literacy Population Survey 2019–2021, more than half the Norwegian sample answered that they found it difficult to navigate the healthcare system. Furthermore, one in three had inadequate health literacy. This form of cultural capital decreases with age (Le et al., 2021). Similarly, in our material only four of the patients had received higher education, mostly

from upper-class districts.

Considering social capital as power, research highlights that informal caregiving provides a substantial contribution in providing long-term care for older people in European countries (European Commission, 2018). This is also the case in Norway, where roughly half of all help and care to older people is provided by family caregivers (Hjemsås et al., 2019), bridging a care gap because the welfare state does not always deliver adequate care (Gautun and Bratt, 2023). Access to health and care services for older people is significantly affected by assistance from resourceful family caregivers, who can help them with tasks such as obtaining information and communicating with service providers (Gautun and Bratt, 2023). Similarly, our data demonstrated that strong relatives, through family meetings and follow-up services, translated their resources into direct healthcare access for the older patients in the study, while in lower class districts the relatives and district coordinator were seldom present.

Although research literature often portrays the caregiving role as stressful and burdensome (Schulz and Beach, 1999), other population-based studies highlight little or no caregiving-related strain when caregivers possess necessary inner (communicative skills, health literacy, coping behaviours) and outer (economy, informal and formal care) resources to adapt to different situations (Roth et al., 2015). In the first case, the daughter experienced the situation of her mother receiving insufficient care as stressful. Tønnessen et al. (2009) showed how nurses in home care must prioritize and how relatives often have a key function when rationing services (Tønnessen et al., 2009). Rationing can mean not offering certain services, postponing or cancelling services, encouraging the use of other types of services or reducing the quality of services (Harrison and Hunter, 1994). In the second case, the son had an advantage in accessing the healthcare system, suggesting that informal caregivers might promote contact with healthcare staff and ensure better follow-up care when needed (Smith et al., 2009).

As our findings reveal, and in line with Bourdieu's economic capital, the geographical districts possess varying class profiles, affecting the availability of healthcare. This is also highlighted in an EU report stating that when services are not available, those with economic resources may find other ways to access them (Baeten et al., 2018). Patients who can afford it may seek healthcare (e.g., long-term care facilities or healthcare staff with enough time to serve individualized food) in a parallel private sector and pay for it either through voluntary health insurance or out of their own pocket (Baeten et al., 2018). In case one, the vulnerable patient was denied access to long-term care facilities, while in case two the son organized private delivery of vegetarian food on top of other public services to ensure quality of care for his mother. Furthermore, the architect-designed house in case two, with the son living next door, was arranged to have a nurse living on the second floor in the future. These findings are in accordance with those of Syse et al. (2022), who illustrated through Norwegian registry data that older people with a partner and children with different forms of resources or capital are also the least likely to move into a nursing home (Syse et al., 2022).

Finally, our findings revealed the advantage of fitting into the system, reflecting the professional habitus of the active patient and the user involvement discourse as an underlying mechanism in care trajectories. As illustrated in case two, suitable patients are supposed to be active, taking responsibility for their own rehabilitation process. Preferably, they have uncomplicated health issues, are not too demanding, engage with staff in an active way, are motivated, and express an overall willingness to go home after the IC stay. However, as shown in case one, not all patients have the specific capital and/or willingness to take on this responsibility, which gives them different conditions to negotiate their care needs. Johannessen and Steihaug (2019) underline the same issue of what they call the 'ideology of activity', namely that patients can hardly choose not to become independent and self-reliant, thus warning against linking dignity with independence and self-reliance (Johannessen and Steihaug, 2019).

5.1. Strengths and limitations

The researcher conducting the observations and interviews had a background as a physical therapist and broad clinical as well as research experience in IC services. This "inside" perspective was an advantage in obtaining trust and in understanding the care trajectories. Simultaneously, the second author has background as a sociologist and broad experience from social research on healthcare and could challenge 'taken-for-granted truths' in the data. Combining this inside and outside perspectives we believe has been an advantage in keeping an analytic distance to the field and data material. The researcher collecting the data material was aware of her preconceptions (i.e., access to quality healthcare is sometimes random and unfair) and thus maintained a diary throughout the process to ensure a reflective distance from the data material. During observations, all parties were aware of the researcher's role and that she was familiar with family meetings. However, she consciously positioned herself in the background in order to show respect and attempted to be as neutral as possible. Furthermore, inspired by a responsive interviewing style (Rubin and Rubin, 2012), an open posture and listening while maintaining eye contact as well as echoing or repeating what the interviewee said were used intentionally to encourage and progress the conversations (Ryan et al., 2009).

The credibility of the study is established through a triangulation of methods, i.e., interviewing the patients twice to capture the entire care trajectory, interviewing their relatives and healthcare staff in IC and observing family meetings, with prolonged engagement in the field (Nowell et al., 2017). The number of participants was informed by Malterud's 'information power' determined by objective, participant specificity, theoretical framework, interview quality and analytical approach (Malterud et al., 2015). The final analysis has been discussed in a stakeholder group consisting of user representatives, staff, researchers and key informants. Although Pierre Bourdieu's theory of practice provided an interesting lens for understanding access to universal healthcare in unique care trajectories among different social strata, the framework may have limited our understanding of the individual's free will, ability to reflect, social mobility and communicative skills (van de Werfhorst, 2010). Another limitation might be the transferability of the study to different contexts, care levels or participants. We believe, however, that the transparency of the method and the rich context descriptions allow the reader to make inferences about contextual similarities, enhancing the transferability of the study (Nowell et al., 2017).

6. Conclusions

The present study reveals social inequality in access to universal healthcare within the care trajectories of older people in Oslo, Norway. Navigating the healthcare maze depends on where you live, your levels of education and health literacy and your ability to mobilize social networks. Furthermore, it is an advantage to fit into the professional habitus of the active patient. The findings will be relevant for politicians, managers, healthcare professionals and other stakeholders working in the health and social care services. Furthermore, they may be valuable in the development of services adapted to the needs of differing socio-economic groups, supporting the UN goal of securing healthy lives and contributing to well-being in older years (Baeten et al., 2018).

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

CRedit authorship contribution statement

Linda Aimée Hartford Kvæl: Conceptualization, Methodology, Investigation, Formal analysis, Project administration, Writing - original

draft. **Heidi Gautun:** Writing - review & editing.

Data availability

The data that has been used is confidential.

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