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Border Crossings:

Investigating the Comparability of
Case Management
in a Service for Older People in Berlin

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Contents

List of Figures and Tables

Table of Statutes

(United Kingdom)

National Assistance Act 1948

Chronically Sick and Disabled Persons Act 1970

NHS and Community Care Act 1990

(Federal Republic of Germany)

Sozialgesetzbuch (SGB) Erstes Buch (I) - Allgemeiner Teil (Social Law Code - Book 1 General Section)

Sozialgesetzbuch (SGB) Fünftes Buch (V) - Gesetzliche Krankenversicherung (Social Law Code – Book 5 Statutory Health Insurance

Sozialgesetzbuch (SGB) Neuntes Buch (IX) - Rehabilitation und Teilhabe behinderter Menschen (Social Law Code – Book 9 Rehabilitation and Participation of Disabled People)

Sozialgesetzbuch (SGB) - Elftes Buch (XI) - Soziale Pflegeversicherung (Social Law Code – Book 11 Social Care Insurance)

Sozialgesetzbuch (SGB) Zwölftes Buch (XII) – Sozialhilfe (Social Law Code – Book 12 Social Assistance)

Summary

Case management, a coordinating process designed to align service provision more closely to the identified needs of people requiring assistance in the context of complex care systems, is an example of those policies and practices that cross the borders of different national welfare systems, ostensibly to resolve the same or similar problems in the adopting country. Developed in the USA, case management was re-named 'care management' upon adoption in the UK as part of the community care reforms of the early 1990s, reforms which have framed my professional life in English local authority adult social care services ever since.

In 2007, a temporary research fellowship (TH Marshall Fellowship, London School of Economics) enabled me to spend four months in Berlin studying a citywide case management service for older people in the context of German long-term care policy and legislation. This experience sits at the core of this thesis which addresses the extent to which the study of a specific case management service for older people in Berlin can illuminate how case management translates across differing national welfare contexts, taking into account the particular methodological challenges of cross-national research.

Drawing on both cross-national social policy and translation studies literatures and adopting a multi-method case study approach, the central problems of determining similarity and difference, equivalence and translation form the core of the thesis. Informed by a realist understanding of the social world, the study took a naturalistic turn *in situ* that fore-grounded the more ethnographic

elements in the mix of documentary research, semi-participant observation and meetings with key informants that formed my data sources and were recorded in extensive field notes. The data were analysed to trace how case management was constructed locally in relation to both state and federal level policy and legislation, and then comparatively re-examined in the context of the key methodological problems identified above in relation to understandings of care management in England as reported in the literature, in order to further explore the question of comparability of case management across different welfare contexts.

The research clearly demonstrates how institutional context both shaped and constrained the adoption of case management in Berlin, and highlights a need in comparative research for close contextual examination of the apparently similar, with a focus on functionally equivalent mechanisms, to determine the extent to which case management can be said to be similar or different in different contexts, particularly where English words and expressions are directly absorbed into the local language. Relating the case study to findings from earlier studies of care management in England highlights the extent to which care management in England is itself a locally shaped and contextualised variant of case management as developed in the USA that matches poorly to the variant in Berlin. Indeed problems discovered in the research site constructing definitional boundaries for case management in practice mirror issues in the wider literature and raise questions about the specificity of the original concept itself. Nonetheless, the study shows that, despite the multiple asymmetries of equivalence and difficulties of translation, there are sufficient points of similarity for cautious potential lessons to be drawn from Berlin,

particularly with regards to policy changes on the horizon in England, but also in the other direction with regards to how case management in Berlin may also be re-shaped following recent reforms to German long-term care legislation.

Acknowledgements

This thesis is dedicated to the memory of my father

Norman Crossland

(26.10.1928 - 10.06.1967)

Chapter 1 - Introduction and Context

1.1 Background to the Research(er)

The following thesis is framed by a career of over two decades in local authority social care services that has been significantly shaped by the introduction and implementation of the NHS and Community Care Act 1990 (NHSCCA)[1] and the associated practice of 'care management', a coordinating process designed to promote 'needs-led' assessment and align service provision to identified need (see Section 4.4). The thesis has its roots in my long-standing professional experience of the seemingly intractable problems of integrating different components of help for older people experiencing difficulties in their daily lives, particularly the coordination of personal care services with the provision of equipment and adaptations to facilitate and promote independent living at home.

Powell asserts the relevance of the researcher's biography to the research process in social care, citing Rees (1991, in Powell, 1997) who highlights the struggle to make sense of individual circumstances in relation to the dominant constraints and opportunities presented by specific issues at specific times, in light of which I will briefly outline elements of my own biography. I joined a social services department in the year of the Griffiths report (1988), the pre-curser to the NHSCCA, and was seconded onto a specialist professional

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[1] At the time the NHSCCA came into force differences between the component parts of the United Kingdom were negligible compared to the more recent divergence that has taken place since political devolution in the late 1990s. For the purposes of this study I will focus on England and will refer to the UK only when appropriate.

training programme (rehabilitation with visually-impaired people). On

qualification my role was to assess the needs of individuals with sight loss,

providing equipment and adaptations, mobility training, emotional support, and

referring into other services, e.g. employment for those of working age, home

care where appropriate for adults, as well as schools and other children's

services. Due to demographic and epidemiological factors my case load

consisted mainly of older people.

From the implementation of the NHSVVA in 1993 I accepted, following training,

a care management role in addition to my usual specialist duties, reflecting

wider developments wherein other, non-social work professionals such as

nurses or occupational therapists were employed as care managers alongside

social work staff (Lewis *et al.*, 1997, Gorman, 2000). Routinely supervised by

professional social workers, I developed a 'hybrid' professional identity,

maintaining my specialist interests but subsequently expanding my professional

involvement across adult social care user groups.

Several features of my professional and academic biography, not least my

ability to speak German[2] (my first degree was in European Studies, and,

returning to higher education in mid-life, I explored comparative social policy as

part of my MA in Health and Social Policy), helped secure an unusual

opportunity for a temporary research fellowship aimed at academics or

practitioners active in any area of social policy who were also interested in

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[2] Throughout the thesis, German words and phrases will be indicated through the use of italics, including 'English Foreign Words' ('*englische Fremdwörter*') that have been absorbed into German

cross-national research in Germany[3] (TH Marshall Fellowship, London School
of Economics—funded by the Volkswagen Foundation). As the only Fellow
appointed with a practitioner background (having, however, completed the
second phase[4] of the professional doctorate programme at the University of
Sussex before taking up the fellowship), in 2007 I temporarily left my then post
as performance and development manager in an English local authority's adult
social care department to spend four months in Berlin investigating a citywide
case management service for older people (*Rund ums Alter*—All About Ageing),
to explore the challenges of providing and coordinating care services for older
people in the context of a different welfare system.

The Federal Republic of Germany's welfare system traces its roots to the social
insurance based reforms introduced by Bismarck during the early years of the
unified German state (see Sections 5.2 and 5.3 for more detailed discussion),
many distinguishing features of which, including patterns of organisation and
provision, have shown considerable historical continuity. Shortly after the
implementation of the NHSCCA in the UK, in 1994 the main mechanism for
providing long term care in Germany was taken out of the means-tested social
assistance system that only provided help for those unable to provide for
themselves, to be replaced by a new branch of compulsory social insurance,
under which citizens who meet the criteria for needing care receive, without
means-testing, fixed value cash or service-based benefits depending on the
level of need identified. Unlike the NHSCCA in numerous dimensions, the new

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[3] I have made extensive use of German literature for this thesis—titles referenced in German
have been read in the original.
[4] The production of a 20,000 word Critical Analytical Study (CAS) in preparation for the thesis,
see Section 1.5 below.

German legislation (SGB XI—Care Insurance) did not determine any mechanism for case management or an equivalent. The regional government in Berlin identified this as a gap and commissioned *Rund ums Alter* to provide its case management service across the city, which, in 2007, I had the opportunity to investigate in its context of the wider federal German welfare system. An additional award (Francois Duchene Travel Bursary, University of Sussex) enabled me to undertake three further short follow up visits (plus an additional self funded trip) in 2008-9. The experience of this fieldwork and the substantive and methodological issues that arose from it form the core of this thesis.

1.2 Border Crossing

> There is a … general recognition of the importance of taking a more global
>
> perspective in a world in which social, cultural and economic manifestations
>
> are imported and exported across-national borders.
>
> (Kennett & Yeates, 2001, p.40)

Kröger (2001) notes the growing interest in learning between member countries of the European Union in the area of older people's care, as each prepares for the ageing of their populations. Whilst not necessarily uniform in its effects, the impact of the demographic shift and the absolute increase in the population of people in their 80s and older, i.e. those most likely to need intensive social care (Baldock, 1997), has caused international attention to focus on the challenges associated with supporting older people in need of care, including mechanisms for identifying and coordinating sources of help in the most effective ways, including case management.

Baistow draws attention to several interconnected ways in which we can learn from cross-national research, including: *learning about others*, i.e. finding out about how life is lived and organised in another country, including both policy and professional practice; *learning from others*, i.e. by identifying examples of good practice that may be possible to borrow or transfer (with the caveat that practices are closely tied in to local contexts); *learning about ourselves*, including the process of making the familiar strange, i.e. learning to unpick our taken for granted assumptions and seeing our own ways of doing things in a

new light; and *learning with others*, the collaborative learning that can emerge from connections made through the research itself.

The thesis that follows then is a reflective and critical account of a research project that investigated a citywide case management service for older people in Berlin. It explores the degree to which the problems of that care system could be deemed similar to those experienced elsewhere, including in England, and the degree to which 'care management' in the latter and '*Case Management*[5]' in the former could be understood as constituting comparable variants of the same approach to solving those problems, asking the research questions set out below.

1.3 Research Questions

My overarching research question asks:

- What can the comparative study of a case management service for older people in Berlin tell us about how case management translates into differing national welfare contexts, taking into account the methodological challenges of cross-national research?

To help answer this question, I ask the following additional questions:

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[5] *Das Case Management*—the use of the German term will be indicated by both the use of italics and the customary use of capitals in German for nouns.

1. What are the main methodological and conceptual problems associated with cross-national comparative research?

2. What does this example of *Case Management* look like in its specific legislative and social policy context?

    a. How is help for people with social care needs organised and provided in the Federal Republic of Germany?

    b. How does *Rund ums Alter* in Berlin fit within these arrangements?

3. To what extent is this example of *Case Management* comparable?

4. What can we learn from this?

    a. Substantively

    b. Methodologically

The second question, the core descriptive question, reflects the importance of contextualising case management in terms of policy, system and organisation in order to understand it (Austin, 2002). **Figure 1.1** was developed to provide a framework to ensure my data gathering addressed all appropriate levels of context for the case study, and to frame discussion of the question of comparability. It will be referred back to at appropriate points within the thesis.
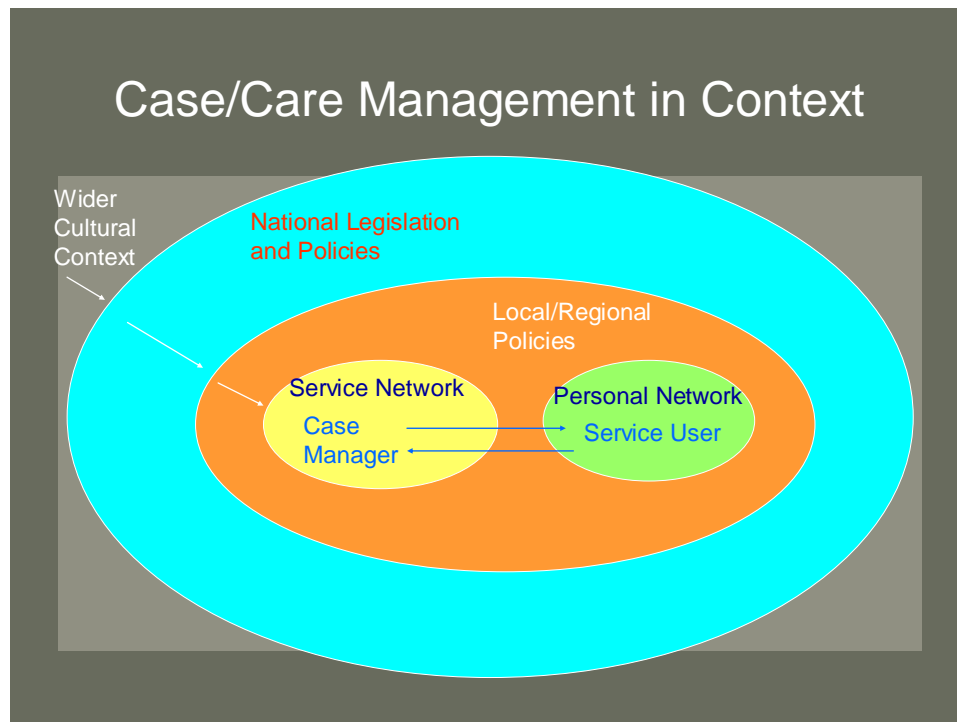
Figure 1.1: Case/Care Management in Context

1.4 Maps and Guides

Case management is a 'border crossing' practice adopted internationally as a policy-level response to specific problems in developed welfare systems (see Chapter 4). In comparative social policy research, Esping-Andersen's (1990) 'three worlds' conceptualisation of 'welfare regimes' has been of particular influence. Kennett comments that:

> His work has made a major contribution to cross-national research in that his analysis identifies the form and content of particular, developed, western regimes, as well as the pattern of processes of social relations which have emerged in particular national regimes. The use of welfare-state typologies in cross-national analysis has become extremely popular with few studies failing

to make some connection between the countries under discussion and regime

types.

(Kennett, 2001, p.7)

Esping-Andersen's (1990) use of a combination of quantitative measures such

as the accessibility, coverage and redistributive impact of benefits, including

whether rights depend upon performance, citizenship or need, alongside his

translation of more qualitative characteristics into quantitative indicators,

particularly the notion of 'de-commodification' (the extent to which different

welfare systems protect individuals from being totally dependent on their ability

to sell their labour), set a new agenda for comparative social policy. His

framework represents a shift away from earlier approaches that measured

gross welfare spending levels, and 'industrialisation' models (Wilensky 1975, in

Kennett, 2001, p.66) that suggested an inevitable link between the provision of

welfare and economic development. By contrast, Esping-Andersen focuses on

ideology as the explanatory principle, identifying three key political factors: the

degree of 'left power' in government; electoral support for Catholic

conservatism; and the extent of absolutism in the history of each state

(Ginsburg, 1993).

Esping-Andersen (1990) labels these types *liberal*, *social democratic* and

conservative, the key exemplars of which he identifies as the USA, Sweden

and, with specific relevance to this thesis, the Federal Republic of Germany

respectively. The UK is seen as a hybrid type, combining elements of social

democratic universalism (the NHS) with strong, liberal elements of means-

testing and selectivity. Social care services for older people largely belong within this latter category.

Mabbert and Bolderson (1999) note his work has shifted discussion of comparative social policy towards the multi-dimensional characterisation of welfare effort and multi-country information on the detail of social policy interventions. Critics have commented on the validity of his typology, variously suggesting additional categories to capture the distinctiveness of some southern European welfare arrangements for example, or challenging the conceptual bases of his analysis. Feminists have criticised his focus on class relations and his relative under-theorising of the family in the state/market/family nexus, a potentially serious deficit when considering the position of women as carers, service users and professionals in social care (Daly, 1994, Lewis, 1997). Ginsburg (1993) in turn focuses on issues of both citizenship and 'race' as key dimensions. Nonetheless, Esping-Andersen's framework has proved relatively robust and provides helpful compass points when locating specific services in the context of a given regime. Certainly, grasping the role of the Catholic church historically helps to understand current social policy arrangements in Germany for example (see Chapter 5).

Alber (1995) notes the increasing importance of care services to welfare state production and identifies a need to shift the research agenda away from a focus on social transfers and the attendant theoretical interest in class relations. He states that both children and older people experience social problems arising from specific life situations that cut across positions in the class structure and

asserts that such problems are becoming increasingly important in society. In his view this renders concepts such as de-commodification less salient for those outside the labour market.

Anttonen and Sippilä (1996) also contribute to the debate about the place of social services in comparative social policy research, exploring ways to incorporate social services models into the debate on welfare state regimes. The main purpose of their analysis is to describe the quantitative differences in service provision in Western Europe. They argue that a social services perspective opens up important new angles for comparative welfare state research, claiming: that it can lead to a deeper understanding of how the welfare state works; that incorporating social services into the modelling debate provides a response to feminist critiques of welfare state theory; and, citing Alber (1995), that because of its challenging nature, the variety of social services can tell us a great deal about religious, political-ideological and administrative differences between countries.

Glendinning *et al.* (2009) identify a number of authors who differentiate between geographical 'care cultures', categorising them according to a range of dimensions including: housing and living conditions; culture and expectations of family carers; expenditure on health and long-term care; religious and/or social background; average healthy number of life years; labour market and gender variations. They note an East-West divide hypothesised by some (Alber and Köhler 2005, Mette 2006, Schoenmaeckers & Vanderleyden 2006, in *ibid*) but a contrasting North-South divide by Pommer *et al.*(2007, in *ibid*), who posit a

threefold 'care regime' model that includes a 'family' type prevalent along the Mediterranean; a 'mixed' type seen in continental Europe; and a 'public' type in Scandinavia.

Lamura *et al.* (2007) use a combination of quantitative European data sources to differentiate this further, outlining a fivefold typology of 'eldercare countries'. Their first three categories reflect the above: 'Standard Care Mix', which includes both the UK and Germany in the same grouping (unlike Esping-Andersen's model); 'Public-Nordic', which includes the Netherlands; and 'Family Based', which includes Ireland alongside the Mediterranean countries. They further differentiate the 'Baltic countries' as a separate category from other 'Transition countries'. Each of these categorisations is an attempt to capture key dimensions that account for differences in the mix of public provision and private responsibility in the provision of care across countries, further developing comparative welfare typologies in relation to care services to address the critiques that emerged following Esping-Andersen's (1990) landmark work, and that frame this particular study.

1.5 Preparation

The Critical Analytical Study (CAS) is an important milestone in the Doctorate in Social Work at the University of Sussex; its completion allows progression to the formal thesis. Having been offered the Fellowship at the beginning of this phase, I decided to focus my CAS on the conceptual and methodological

problems in cross-national comparative research in preparation for the fieldwork I would undertake during the Fellowship.

In the CAS I highlighted my interest in whether policies and practices remain unchanged as they travel from one context into another, a concern that underpins my overarching research question with regards to 'case management'. I reviewed a range of academic texts on care management in England and outlined some of the key themes that have emerged in literature since the implementation of the NHSCCA, which I will revisit in Chapter 4 in the context of the wider literatures on case and care management. I then looked specifically at cross-national comparative social policy, outlining in particular 'regime theory', before considering critiques of this approach and how those critiques relate to the specific problems of comparing social care services, as noted in the previous section. Finally, I reflected on the implications of the issues explored for the research tasks I had set myself, and considered what kind of framework (see **Figure 1.1**, p.19) I might require in order to capture the most important features of the case management service I would be visiting in Berlin, that might also serve as a framework for analysing the care management service in my own local authority (a decision I subsequently re-visited as I will outline in due course). I ended the piece signalling my intention to investigate whether there is a core to the concept of 'case management' that can be both identified and said to work in very different national welfare contexts, a theme to which I will also return.

My CAS was intended, as noted, to serve as a preparatory and exploratory

investigation of the potential conceptual and methodological problems involved

in undertaking cross-national comparative research in social care. The

particular experience of those problems during the fieldwork led me to use the

CAS as the basis for a more detailed consideration of those methodological and

conceptual problems, to which I will now turn.

Chapter 2. Problems Crossing Borders

2.1 Comparisons

In this chapter I address the component of the research question that asks:
What are the main methodological and conceptual problems associated with
cross-national comparative research? Researching across national borders
raises a basic question of the extent to which it differs from social research
generally, and/or presents new or different theoretical and methodological
challenges. Kennett and Yeates (2001) summarise a range of interpretations of
comparative, cross-national research, outlining several competing perspectives
regarding the characterisation of comparative work. These range from the view
that all social investigation is by its nature 'comparative', and therefore cross-
national work is not fundamentally different, to other perspectives that aim to
distinguish what is distinctive about cross-national research. Marsh (1967, in
Kennett & Yeates, 2001) differentiates 'intra-societal' from 'inter-societal'
comparisons, claiming that the unit of study is what distinguishes comparative
work. By contrast, Hague *et al.* (1987, in *ibid.*) assert that a case study of a
single country can be termed comparative if it can be shown to be an example
of a larger phenomenon, particularly in cases that have the capacity to inform
debate beyond the country of focus. Rose (1991, in *ibid.* p.41), however,
describes this approach as "extroverted case studies with generic concepts"
and argues they are 'comparable', rather than 'comparative', in that they employ
concepts that allow for the derivation of generalisations that can be tested
elsewhere.

Turner (1987, in *ibid.*) argues for a more rigorous definition of comparative research and for more systematic methods for studying the same phenomena across different countries. Hantrais and Mangen in turn emphasise "the necessity for conceptual equivalence and the systematic analysis of phenomena. Only then can a study be classified as cross-national and comparative" (Hantrais & Mangen 1996, in ibid, p.42).

Context is a key issue and Hantrais (1999) links a shift in comparative research from universalistic, culture-free approaches to a focus on culture-boundedness to wider methodological debates within social research, thus placing the theory and practice of contextualisation at the nexus of cross-national comparative studies. She emphasises the importance of analysing socio-economic phenomena in relation to their institutional and socio-cultural settings, highlighting issues of *conceptual equivalence* and *interpretation*, as well as the potential impact of the researcher's own cultural background. She believes that:

> Cross-national comparisons afford a powerful test of objectivity not only because researchers may have a blinkered view of their own society and be convinced that theirs is the best way, but also because they may seek to analyse practices in different cultural settings through their own (inappropriate) conceptual lens. Inevitably, researchers have their own culturally and linguistically determined assumptions and their own mindsets.

> The experience of being engaged in comparative work may enable them to see the familiar from a new perspective and to become more receptive to differences.
>
> (Hantrais, 1999, p.103)

It is not immediately obvious from my practice experience that those providing social care services in England believe 'theirs is the best way'. Indeed I am often struck by the frequency of the assumption that things must be better elsewhere but Hantrais's wider point remains valid, that researchers in particular need to be conscious of how the configurations of welfare in one's home country can appear 'natural', but that they can also become 'de-familiarised' through the process of cross-national research.

2.2 Same Difference?

With regards to comparative studies in social work and social care, Baistow (2000) highlights *equivalence* as the most fundamental problem, noting that for things to be comparable at all they need to share certain features, i.e. they must have certain dimensions in common. If there are no similarities at all, there can be no points of comparison. She outlines several aspects to this problem, noting on the one hand issues that arise in establishing the equivalence of policies, structures, systems and professional roles, and on the other the related difficulties of the linguistic and conceptual equivalence of terms like *welfare state*, *social services*, and *community care*. Marsh (1967, in Kennett, 2004) suggests a useful distinction between *formal* equivalence and *functional*

equivalence, cautioning that using identical formal procedures can produce functionally non-equivalent meanings, a factor in the decision to shift the focus of the case study I discuss in Section 3.3.1.

Baistow (2000) further highlights the problems of heterogeneity *within* countries, alerting us to the dangers of generalising from the local to the national, and draws attention to the effects of occasional sudden breaks in the normally gradual processes of social and political change that can occur, such as the re-drawing of state boundaries, which indeed happened in Berlin and influenced the development of *Rund ums Alter* (see Section 5.5). She notes such concerns raise the basic question of whether policies and practices can be translated into other contexts without losing the meaning at the core of their identification as good practice, for example, or whether they can be transplanted at all outside of the system within which they develop and operate, questions of considerable relevance to this study. She highlights what she understands to be the inherent and unavoidable normativity of much comparative social policy and cautions against an implicitly evaluative bias using one's own familiar system as a yardstick, reflecting Hantrais's concerns above.

Askeland and Payne (2001) challenge the assumptions that the main purpose of cross-national work is to experience and understand *difference*, outlining several specific ideas they claim may be unfounded: that social work, social services and social policy within any one country are fairly homogenous; that ideas and ways of working are directly transferable between countries; and that experiencing different practices will illuminate understanding of our own

practices. They also challenge the belief that cross-national work enables alternative practices to have an impact and assert that much difference is erroneously ascribed to cultural or national differences, calling for a more complex analysis of both *sameness* and *difference*.

2.3 How do you say …?

The theme of *conceptual equivalence* is explored in more detail by Eyraud (2001), who foregrounds *translation* as the key question, pointing out that in order to compare or transfer social policies one must first translate. She singles out two main ideas. Firstly, she states that a language both organises and prepares the experience of its speakers and thus constitutes a specific vision of the world. This leads her to conclude that translation as an operation must utilise resources that are both linguistic *and* cultural. Secondly, she asserts that cultures not only represent different visions of the world but that they are actually different worlds in themselves, reflecting Sapir's position that:

> No two languages are ever sufficiently similar to be considered as representing the same social reality. The worlds in which different societies live are distinct worlds, not merely the same world with different labels attached.
>
> (Sapir 1956, in Bassnett, 2002)

This could be described as a 'strong' social constructionist position (see Section 3.2 below) with regards to the relationship between language and reality. Eyraud's specific claim then is that a language speaks of a particular social

reality. This means that some things which require translation from language A to language B, whether material objects or concepts describing types of social relations (or social organisations), may not necessarily exist in the society in which language B is spoken, and therefore may not have a name. The notion of *Träger* is an example in this study.

Literally translated the word *Träger* (plural also *Träger*) means 'bearer', or 'porter'. Used in relation to welfare institutions in Germany it implies 'carrying' responsibility for either funding or providing services (see Section 5.2 for further discussion). It is difficult to translate the word *Träger* precisely because its meaning derives from a markedly different "carving up" (Dunne *et al.*, 2005, p.157) of the social (care) world. The word could be deemed an example, *pace* Eyraud (2001), of entities that do not exist in the society of the translation's target language, and therefore have no name, indicating from a strong social constructionist perspective how language speaks of a specific (and separate) social reality. It is, at the very least, an example of a code unit in a language reflecting a differential partitioning of the same underlying reality (Munday, 2008).

Temple and Young (2004) focus on the role and impact of translation within social research that specifically involves working across languages (highlighting a difference between 'cross-national' and what might be termed 'inter-lingual' or 'cross-language' research, the latter of which can occur within the bounds of a nation-state and the former between states that share a common language). They describe in some detail their own relationships to the languages involved

in their respective studies, including English, Polish and British Sign Language, highlighting how even fully bilingual researchers experience shifts in how they know and speak their different languages. In particular they address the following questions: Does it matter if the translation act is identified in research? Does it matter if the identity of the researcher and translator are the same? When is a translator not a translator – that is, how far into the analysis do you involve a translator? Acknowledging that these are not the only questions this subject raises, they have chosen to highlight them because addressing them inherently highlights issues such as the hierarchies of power between languages (see '*Denglisch*', Section 6.5.1), the situated language epistemologies of researchers, and the naming and speaking for people seen as 'other'.

Temple and Young question whether and how translation within the research process might potentially introduce bias and examine different approaches to ensuring agreement on the translation of source data. They cite Edwards' (1998, in *ibid*) critical discussion of techniques such as 'back translation', which are used to ensure agreement of a 'correct' version of a text, commenting that researchers interested in translation and interpretation issues from this perspective generally discuss validity in terms of 'correct' interpretations and neutral stances, for example. They note this is the predominant model in much cross-language research, if only by default, and argue that qualitative researchers who ignore the wider contextual issues (see Eyraud's (2001) cultural resources, above) involved in translating across languages implicitly use this stance too. They point out that much research on minority ethnic

communities in the UK is written without any reference to language issues. The results are often presented as if interviewees were fluent English speakers or as if the language they used is irrelevant. As an example they cite a study of Bangladeshi women in which no information was given about the place of translation in the research process, such as clarifying the language in which the interview data were collected, at what stage (and by whom) they were transcribed and translated, and whether any issues arose from these processes.

Temple and Young (1997) also maintain that being fluent in the language of the research site offers researchers methodological opportunities that are not open to other researchers in cross-national research, including the ability to use the experience of translating to discuss points concerning meaning. Some researcher/translators regard the discussion of the translation processes as a check to the validity of interpretations but Temple and Young contend this does not imply that any final text is nearer 'the truth', commenting that the researchers themselves are often situated in many and sometimes competing ways in relation to the language of the research site, noting especially the interplay of different dimensions of insider/outsider status (see Section 3.4 below). The researcher/translator role does, however, offer the researcher significant opportunities for close attention to cross cultural meanings and interpretations and brings the researcher up close to the problems of meaning and equivalence within the research process. This was certainly my experience in the field.

Révauger and Wilson (2001) maintain that issues of *translation* and *transfer of concepts* inevitably bring comparative social policy researchers up against two problems. First is the problem of where to position themselves on the methodological continuum (see Section 3.2 Methodological Underpinnings). The second concerns how to research and present *similarities* as well as *differences*. They clearly recognise the need to record *difference* and *diversity* where they exist but state that *similarities* may be just as important. Indeed, echoing Baistow (2000), they claim it may be the strength or weakness of similarities that determine whether policy and concepts can be successfully transferred.

Révauger (2001) argues that translation in social policy is not simply an abstract linguistic topic but a very practical concern. He singles out *conceptual confusion* as the main problem encountered in comparative work, outlining the need for combined expertise in translation as well as the social policy contexts of both the document to be translated and of the target audience. He states that all translation is undertaken with a specific readership in mind and claims there is no such thing as canonical, linguistically correct, all purpose translation. Noting the considerable pressure for conceptual imports and exports, he states that social policies, like legal systems, are steeped in national cultures and both synthesise and symbolise the way a society reacts to economic or political constraints. Finally, he re-states his and Eyraud's (2001) preferred solution to the issue of translation of terms that have only a rough equivalence across languages, that *such terms should not be translated at all* but should be

explained and then used in the original language, a solution that professional translators strongly dislike.

In an overview of approaches to translation Munday (2008) notes the persistence of vocabulary rooted in early translation theory, including the words 'literal', 'free', 'loyalty', 'faithfulness', 'accuracy', 'meaning', 'style' and 'tone', and a concomitant privileging of a 'natural' target text, i.e. a translation should read as if it were originally written in the language into which it has been translated. I recognise this approach from my own studies for my first degree in modern languages, in which this was the unproblematic benchmark of 'good translation' (and quite the opposite of the solutions proposed by Révauger and Eyraud above for social policy texts).

Jakobson (1959, in Bassnett, 2002) maintains there is no full equivalence possible through translation, indicating instead the necessity for sensitivity to a range of contextual associations or connotations. Highlighting the example of the Russian word '*syr*', a food made of fermented pressed curds, which roughly approximates to 'cottage cheese' in English, Jakobson maintains that translation can only achieve an *adequate interpretation* of an alien code. In Munday's (2008) construction, the code-units will be different because they belong to two languages that *partition reality in different ways*. This does not necessarily claim, *pace* Sapir (1956, in Bassnett, 2002) above, that each language represents a *separate* reality but implies instead that entity boundaries may be drawn differently.

Bassnett also describes Nida's (Nida & Taber 1969, in Bassnett, 2002) model of

the translation process, in which the translator operates criteria beyond the

linguistic in order to first decode the source language text and then recode in

the target language, a process of analysis, transfer, and finally, restructuring,

reflecting Eyraud's (2001) concern for the use of cultural resources in

translation above. Bassnett notes this process is required even for the

translation of ostensibly simple communications such as greetings. Whilst the

notion of *greeting* is the invariant information, the translator has to consider

other criteria, such as the social context of greeting, whether over the phone or

face to face, the relative position or status of the greeter and the greeted etc.,

issues which presented challenges in this study with regards to the use of

formal and informal modes of address. She states that for translators the

emphasis must always be on the reader such that they attempt to create

something in the target language that corresponds to the source language text.

Noting that, given the same poem, a dozen translators will produce a dozen

different versions, she states there will be nonetheless what Popovič (1976, in

ibid.) refers to as an 'invariant core' to those dozen versions, representing

perhaps in critical realist terms (see Section 3.2 below) an intransitive element

of meaning captured transitively in those different translations.

A further consideration is the *purpose* of a translation, as noted by Révauger

(2001) above. *Skopos*, the Greek term for 'aim' or 'purpose', was introduced

into translation studies by Vermeer (Reiss & Vermeer 1984, in Munday, 2008).

Munday explains that Skopos theory concerns itself with translational acts,

based on a source text, that require both negotiation and performance and

which have a purpose and a result. In Skopos theory, knowing why the source text requires translation and what the function of it will be are crucial questions for the translator as they will determine what is necessary in order to produce a *functionally adequate* result, reflecting Marsh's (1967, in Kennett, 2004) notion above of *functional equivalence* in comparative research. Part of the purpose of this study it to produce a *functionally adequate* account of *Rund ums Alter* in relation to the German social policy context in which it operates, an act of *translation* in the wider sense addressed by Clarke (2005) below.

Clarke (2005) notes his increasing interest in the practices of translation as a way of thinking about the movement of keywords, discourses and policies across sites, levels and agencies. Clarke maintains that the *idea* of translation may provide a metaphorical insight to other sorts of practices that are important to the study of welfare and welfare states, including potentially illuminating processes of policy diffusion and policy transfer in transnational forms; a concern in this study regarding case management.

He highlights the Anglophone domination of policy expertise and policy networks, believing the passage of concepts into and out of what he refers to as 'Policy English' may be the site of significant articulation and variation, something I will return to with regards to the German use of *Case Management*. He contends that translation may provide a new way of thinking about the implementation of policy as it moves from policy formulation to 'front line' practice. As policy moves between levels, so it may be 'translated' into new contexts, new meaning systems and new practices. Importantly he draws

attention to the idea that each level is never an empty space simply waiting to be filled by the arrival of the new policy, but rather it is always already full of knowledges, orientations, habits and practices, a formulation that may illuminate the relationship between the local and the national in this study.

2.4 Summary

In summary, cross-national comparative social research both shares and takes part in the wider debates in social research concerning ontology and epistemology but additionally must address specific problems that include what counts as comparative between countries and how that differs from comparing within countries. The relative importance and explanation of similarity or difference is also a key theme, as are the related problems of conceptual equivalence and translation, the latter of which can be understood both literally in linguistic terms and more figuratively. Finally, the influence of context is highlighted in terms of both the object of study and the influence of the researcher's own culture and background. I will return to these themes in Chapter 6, exploring them in relation to the question of comparability. In the next chapter, I will present in some detail how I approached the specific research tasks necessary to investigate *Rund ums Alter*'s *Case Management* service for older people in the context of a very different welfare system to the one that has shaped and constrained my own professional life.

Chapter 3 - Methods and Methodology

> I am a camera with its shutter open, quite passive, recording, not thinking.
> Recording the man shaving at the window opposite and the woman in the
> kimono washing her hair. Some day, all this will have to be developed,
> carefully printed, fixed.
>
> (Christopher Isherwood, *Goodbye to Berlin*, 1939)

3.1 Introduction

When Isherwood wrote the opening lines to his most famous novel he was actively remembering and reconstructing the time he had spent in Berlin some years earlier, rendering an account of his experiences in one country and its language comprehensible for an audience in another. In their powerful simplicity, his words encapsulate core epistemological concerns in social research. To what extent is it possible to observe passively, to record without thinking? And what happens during the 'developing' and 'printing' processes, how do our experiences of the social world become 'fixed'?

Mirroring Powell's (1997) assertion of the importance of biography in social care research, Dunne *et al.* extend it to the specifics of methodology, contending that:

> To explain yourself you need to tell a good story, to construct a narrative, so
> the evolution of the methodology can receive coherence through being linked
> to narrative of the identity of the researcher.
>
> (Dunne *et al.*, 2005, p.171)

My narrative then, like Isherwood's, is that of a gay Englishman who speaks fluent German, although I am quite unlike him in many other ways, including differences of social class and generational cohort. Nonetheless, Isherwood's novel was a critical influence during my adolescence that helped sediment and shape my existing interest in and ability to speak German into a lifelong relationship with the city of Berlin and, as such, is arguably part of what Law (2004) would describe as my methodological 'hinterland' with regards to this piece of work. I first worked for several months in West-Berlin between school and university, returning whenever possible over the next few years, including during my subsequent 'year abroad' as a language undergraduate. I have remained familiar with the city for over 30 years, during which time my language fluency has waxed and waned depending on the regularity and/or duration of my trips. One of the unusual features of this study is the fact of the fieldwork being conducted in German, a factor with important methodological repercussions. My ability to speak fluent German and knowledge of Berlin undoubtedly assisted my acceptance in the research site.

At the core of this thesis sits an ethnographically-orientated case study of the complex interaction between policy, legislation, organisation and practice in another country's social care system. Austin (2002) suggests that case management cannot be fully understood separately from the particular welfare contexts within which it is set, a position mirrored more generally in approaches to comparative research. For example, Hantrais (1999) recommends situating the social phenomenon under investigation, in this study a specific example of

case management, with reference to its institutional settings, noting that the rationale for selecting the nation state as a frame of reference is precisely that it has an identifiable administrative and legal system. My first decision then was to adopt a case study approach, i.e. an in-depth investigation of a phenomenon in its real life context (Yin, 2003), the rationale for which I outline in more detail in Section 3.3. From a comparative perspective, Mangen (1999) describes a case study as an analytical focus rather than a method *per se* because it generally incorporates several distinct methods. He notes a combination of interviews and documentary research as being most typical in cross-national research, as well as a tendency to use quantitative data in largely qualitative studies to round off a multi-dimensional perspective of the situation or event under consideration.

Briefly then, I combined the following to address my research questions, utilising the framework developed for my CAS (**Figure 1.1**, p.19) to keep in focus the differing and interacting levels of the 'case in context' under investigation. I will return to how I 'recorded', 'developed' and 'fixed' this material in subsequent sections:

- Documentary research, including policy and legislation, and both publicly available and internal documents relating to *Rund ums Alter*, such as an annual evaluation report, leaflets and service descriptions, local publications and other documentation, including assessment documentation and controlled access to service user records (Appendix 1). This contributed to populating several 'levels' of the framework diagram, including the federal legislative framework within which the

service operated; local definitions of service components, including *Case Management*, specific *Case Management* practice through case records and assessment forms; and city-wide information across the different *Rund ums Alter* local centres through the annual evaluation report;

- Official statistics, both published and unpublished, specifically to locate the service in question in the context of care needs in Berlin;

- Facilitated group discussions (including the re-construction and presentation of illustrative local case management interventions, included in Appendix 2, primarily to explore local constructions of *Case Management* in practice;

- Semi-participant observation in the local office for the duration of the Fellowship-funded first phase, including participation in meetings and observing events and client interviews (see **Table 3.1** below, and Appendix 3), recorded as field notes in a methodologically reflective research diary of approximately 12,000 words. This provided a data source of the formal and informal contributions of a network of 'key informants' (**Table 3.1** and Appendix 4) that form a central component in the production of this thesis, who helped me to navigate and understand this example of case management in the context of a complex care system. It also provided a key structuring resource in terms of data gathering, methodological reflection, and early contemporaneous data analysis. A further 2000 words of field notes were taken during the follow up visits;

- Use of the wider academic literature, both in English and in German, for several purposes including supplementing (and triangulating where

possible) my data gathering, particularly with regard to the wider social policy context, as well as more directly, for example by exploring the literature on care management in England to identify specific problems in that context to see to what extent they were similar or different to those in Berlin.

The evolution of the methodology for this piece of work then, is on the one hand a story of pragmatic decisions taken in response to both changing circumstances and increased understanding of the welfare context under exploration, as I will outline below, and on the other a desire for theoretical coherence arising from a commitment to a realist view of the social world, which I discuss next in more detail.

3.2 Methodological Underpinnings

Byrne (2009) locates case study methodology generally within a realist understanding of the social world, an understanding that Pawson (2006) maintains is regarded by many as the principal post-positivist perspective amongst the many different competing paradigms in social science. Realism is based on the assumption that there is an objective reality which exists outside of the mind that can at least be approximated (Kazi, 2003). Social constructionism, by contrast, maintains that the nature of things is dependent upon the observer, i.e. it is constructed (and re-constructed) intersubjectively by its participants and therefore is not 'knowable' in the same sense (Williams, 2000).

Positivism in social science generally entails a belief that the methods and procedures of the natural sciences can be applied to the social world; that only those phenomena that can be observed can be validated as knowledge (thus excluding 'meaning'); and that scientific knowledge is both objective and value free (Bryman, 1988). Positivism also assumes the controllability of variables such that they can be isolated from their context and manipulated as if in a closed system. As Pawson (2006) notes, a ceaselessly changing complexity is the norm in social life, therefore positivist approaches and presuppositions were unlikely to help illuminate my research questions, central to which is the exploration of a phenomenon in its social, legal, organisational and political contexts, a set of nested social systems.

Several philosophical positions generally understood as 'interpretivist' influenced the challenge to positivism in social science, including *Verstehen* or understanding as the focus of social research, phenomenology, social interactionism, and naturalism, providing an intellectual framework for the development of qualitative methods in social research (Bryman, 1988). Each of these has contributed in some way to my approach. My concern is to generate *understanding* of how case management is enacted in this specific set of contexts, in order to do which I must bracket off (in phenomenological terms) my own prior experience. An early failure to fully bracket off the structures I carry in my own head led to the subsequent adoption of a more naturalist stance, i.e. that I should treat the phenomena under investigation as naturally

as possible by getting close to my research subjects and avoiding the imposition of overly technical research instruments.

My most basic realist assumption is that the social world is emergent from, but not reducible to, biophysical processes and structures, and as such should be understood as part of the natural world, a philosophically 'naturalist' position (in a different sense from 'naturalism' as an interpretive stance, above). This contrasts with a position that assumes an ontological separation of the natural and social worlds, specifically what Sayer (2000) would term 'strong' social constructionism. He states that in order to understand the specificity of the social while acknowledging the validity of a realist concept of nature, we need to recognize how the social can be both *dependent on* and *irreducible to* the material processes studied by the natural sciences, describing how:

> Biological, chemical and physical powers are necessary conditions for the existence of the social world but the latter has properties – particularly, or 'essentially', communicative interaction and discourse, which are irreducible to or emergent from these ontological strata.
>
> (Sayer, 2000, p.100)

This allows for both agency and variety at the social level. The notion of properties as *emergent from, but not reducible to* their ontological antecedents is central to Bhaskar's (2008 [1975]) 'transcendental' or 'critical' realism. In later work he stresses the way in which social order is embedded in and conditioned

by the natural order from which it is emergent, and upon which it, in turn, acts back (Bhaskar, 1998).

To illustrate the concept of emergence King (2004) notes that water has emergent properties which are irreducible to its constituent parts of hydrogen and oxygen. He extends the notions of emergence and stratified ontology to explain how the production of wider social structure through the accumulated activities and conceptions of individuals over time, whilst dependent on those individuals, is nonetheless irreducible to each individual's activities and conceptions. Social reality clearly precedes and is greater than the individual whilst simultaneously being the result of prior individual action. King describes how social structure arises out of the cumulative action of all previous individuals only to confront each subsequent individual afresh as an objective institutional reality. In this study, for example, the law as a social institution would appear to fit this description, legislation being an example of when "discourse is performative" (Sayer, 2000, p.102).

Williams and May (1996) suggest a simple experiment as a way to understand the idealism at the core of strong versions of social constructionism. This involves looking at a desk from above and noting its descriptive characteristics, before repeating the exercise looking at it from underneath, then finally from the side. There are now three separate and distinct descriptions. Williams and May suggest that, for an idealist, this shows that there may be no 'real' desk discernable amongst these competing descriptions and that each of the descriptions is as valid as the others. Transposing this idea to the social world,

they comment that, for idealists, no matter how "we 'carve up' social interactions or social structure, we can never claim to have found out what is 'real' about it" (Williams & May, 1996, p.70). Dunne *et al.* (2005, p.157) also highlight the importance of this 'carving up' of social reality, stating that it "is useful to recognize that in our research … we are intervening in the flux and flow of what are actually seamless events".

Such ontological issues raise specific problems in comparative research of *translation* and *transfer of concepts* that, as noted in Chapter 2, inevitably bring researchers up against the question of where to position themselves on this methodological continuum (Révauger & Wilson, 2001). Whilst recognising the difficulties inherent in ascribing entity-boundaries (and establishing their equivalents in another language system) I would generally argue that this 'flux and flow', whilst seamless, is neither uniform nor featureless, but is composed instead of clumps of events, properties and experiences, such that they allow for reasonably stable approximations in both description and representation. For example, the German word for 'care', '*die Pflege*', demonstrates how different languages partition reality in different ways, but also demonstrates the 'clumpiness' of reality that allows for some stability. Each word has a broad set of meanings in its own language, with conceptual boundaries that stretch in different directions, though their core meanings overlap. The English word 'care' has additional meanings of 'worry' or 'attention'. By contrast, '*die Pflege*' also means 'nursing' as well as what we refer to as 'care', i.e. in German this is not differentiated in the same way. These translational and conceptual issues

required constant attention throughout the process of conducting this case study.

3.3 Case Study Methodology

Towards the end of my CAS I sketched out a possible two country comparative case study design, for which I developed the framework (**Figure 1.1**, p. 19) to assist with comparison. This was an attempt to represent visually and generically a set of formalised, purposeful and asymmetric relationships between, on the one side, people who need assistance due to major life changes and, on the other, people employed to provide, arrange or coordinate assistance, within a context of a set of legislative and policy rules and constraints that govern these interactions. This made certain assumptions about degrees of commonality (points of comparison *pace* Baistow (2000) above) between developed Western states, such as the existence of historically embedded legislative and policy frameworks for the provision of care services or indeed of paid helpers, which may not apply if looking at emerging economies or countries with very different cultural contexts. At this stage, I believed that the degree of commonality would be sufficient to sustain a comparison of the case management service delivered within a single borough in Berlin with the care management service delivered by my home local authority, failing to grasp the distinction between 'formal' and 'functional' equivalence, consideration of which led to the decision not to proceed with this two case strategy as I outline in Section 3.3.1 below. Despite the shift away from this two case strategy, the diagram nonetheless continued to provide an

important framework for ensuring my data gathering addressed all the levels

necessary to construct the core case study of *Rund ums Alter*'s *Case*

Management service, as well as for considering its comparability in Chapter 6.

Byrne (2009) states that cases are central to proper social scientific

understanding and describes a case as a complex system. Within such complex

systems, trajectories and transformations depend not only on all of the whole,

but also on the parts, the interactions amongst the parts and the whole, and

interactions with other complex systems it may be nested within and with which

it may intersect. Working within a realist theoretical framework and taking the

notion of 'emergence' as of central importance (see Section 3.2 above), he

states that the turn to case-based methods is predicated on an explicit rejection

in social research of the utility of causal models based on variables. He does

not reject quantitative measurement or description but rejects what he describes

as *disembodied* variables. This is consistent with the realist "open systems"

critique of positivism, which Pawson (2006, p.18) summarises as the notion that

social systems are the product of literally endless components and forces. This

includes the influence of both history and culture, with patterns of behaviour

shaped and constrained by institutions, such that different organisational and

political structures exert influence on those patterns. Pawson adds the influence

of individuals' volition and choices, noting that our actions are always prone to

change the conditions that prompt them.

Byrne (2009) also draws attention to the importance of identifying a case's

parameters, citing Ragin and Becker's (1992, in *ibid.*) use of 'casing' as a verb

to describe the necessary delimiting of a case and to highlight the problem of boundaries (geographical, temporal and conceptual) in determining what constitutes a specific case, particularly where there are nested or overlapping cases. Walt *et al.*(2008) note the importance in policy studies of asking what kind of case is being addressed, outlining how this question can sometimes be clearly identifiable at the beginning of a study but in others may be constructed or re-constructed during the course of the research in a process of case clarification, as happened in this piece of work. They identify how time and resource intensive the investigation of single cases can be in a process that requires careful consideration of historical and contextual influences, noting the further challenges of working across languages and cultures that comparative case studies may introduce. They maintain, however, that cross-national comparative case study approaches are valuable in helping to disentangle general effects from those which are more country context-specific in policy adaptation, evolution and implementation.

In a linguistic twist, the *case* in this particular *case* study is an example of *case* (in a different but related sense) *management*, in the context of welfare policy and legislation. The meaning of the term '*case'* in *case management* derives from the use of the word *case* in professional helping contexts to indicate a specific 'helpee' and their circumstances. *Case* is example of a term with overlapping meanings in both research and professional social care discourse (as is *fieldwork* too). Indeed, Hammersley and Gomm cite Platt's (1981, in Hammersley & Gomm, 2000) claim that the origin of the idea of *case* study in American sociology arose directly from the use of social workers' *case* work and

case histories in the early twentieth century classical *case* studies of the

Chicago School, reflecting the theme of overlapping notions in research tasks

and tasks in social work discussed in Section 3.4 below.

3.3.1 'Casing' *Rund ums Alter*

As noted, Hantrais (1999) states it is helpful to situate the case under

consideration with reference to its legal and administrative systems and

institutional settings, within the framework of a nation state. Within such a

framework, however, Mangen (1999) identifies sampling as particularly

problematic in qualitative cross-national comparative work, especially with

regards to choosing appropriate national or sub-national units of analysis. From

my prior knowledge of the city I was aware of Berlin politically both as a *Stadt-*

Staat (city-state), i.e. a '*Land*'[6] or region in its own right within the German

federal state, and also as a city broken up administratively into smaller local

boroughs or '*Bezirke*'. Each '*Bezirk*' has approximately 250,000 residents,

roughly equivalent to the population in my local authority.

In preparation for the Fellowship application I conducted searches using the

German terms '*Koordinierung*', '*Pflege*' and '*Sozialdienste*' and '*Case*

Management' in the German language version of Google, adopting a purposive

sampling strategy (Erlandson *et al.*, 1993) in order to identify an appropriate and

relevant service or organisation through which I might be able to research older

people's 'care management' within the German system. From its online profile,

---

[6] I will use the German term throughout (*Land*, *Länder*) as 'state' is ambiguous and 'region' fails
to capture the sense of distinctiveness (*Land* also means 'country'). For discussion of
Germany's federal structure see Section 5.2.

it was clear that *Rund ums Alter* provided a regional '*Case Management*'
service for older people across Berlin and subsequently discovered that it was
both funded by the regional government and accorded official recognition under
local legislation, making it the key provider of that service.

Rund ums Alter's organisation reflected Berlin's administrative structure, with a
Coordination Centre in each borough (see Chapter 5). This appeared to offer
possibilities for comparison with an example of local authority based (but
nationally determined) care management in England between local populations
of roughly the same size, the basis for the original 'two case' strategy. This 'two
case' strategy was, however, based on a misunderstanding that emerged from
applying an organisational and commissioning model rooted in my professional
and academic knowledge of the English care system to my partial prior
knowledge of German social care legislation, specifically having misunderstood
the nature of the commissioned service in Berlin and its relationship to a more
complex overall legislative and organisational framework. The boundaries of the
case necessarily shifted from the local office to become *Rund ums Alter* itself,
with the local office serving both as an example thereof as well as my gateway
into the wider service. This maintained the micro-level focus on practice which
would not have been possible to achieve across 12 sites but raises the question
of the degree to which the specific office I accessed (see Section 3.5) was
typical of the wider service. In practice this was mitigated by engaging with staff
from other offices and also by data from documentation that explicitly addressed
the degree of variation in practices between local offices (Beratung Bildung

Innovation, 2008), including in the interpretation of specific pieces of work as '*Case Management*' (see Section 5.5.2).

So instead of a symmetrical comparison between two local authority areas using imagined conceptually equivalent points of comparison that turned out on closer inspection to be *functionally* non-equivalent, the case study became an investigation into how *Case Management* was understood and enacted in *Rund ums Alter*, in relation to its wider legislative and policy environment, through which the question of the degree to which it is comparable is explored with reference to care management policy and research studies in England. Methodologically this shift of focus also demanded a more naturalistic, less structured approach that foregrounds the researcher as research instrument (see next section) and required an intensity and breadth of engagement that would not have been practical or achievable in England alongside a full time post, hence the decision to use existing policy documents and research studies to explore the question of comparability. As noted, Hague *et al.* (1987, in Kennett & Yeates, 2001) assert that a case study from a single country can be termed comparative if it can be shown to be an example of a larger phenomenon, particularly in cases that have the capacity to inform debate beyond the country of focus, noting that a single case can offer a detailed illustration of a theme or themes of wider interest, an approach Rose (1991, in *ibid.*) reformulates as 'comparable' rather than comparative. I will return to the question of the degree to which this case study can be deemed comparative or comparable in Chapter 7.

3.4 Ethnographic Case Study

In their study of the implementation of the community care reforms in five local authorities in England, Lewis and Glennester note that:

> more can be gained by watching day to day, or at least weekly, what is happening in an organisation with frequent interviews, informal conversations and observations of life and meetings as they happen. This softer material can then be checked against council documents, policy statements, minutes of meetings and budgets and contracts
>
> (Lewis & Glennester, 1996, p.24)

They describe this as 'administrative anthropology', a description that could serve equally well as a summary of the approach to this case study. In comparative research too, Ungerson (1996) notes a revaluation of qualitative methods, including ethnography, that reflects wider trends in social research. Indeed, Rainbird (1996) highlights the similarities between conducting cross-national research as an individual researcher and the ethnographic tradition, noting that both involve immersion in another culture but pointing out that the comparative element tends to be implicit rather than explicit in social anthropology.

Borbasi *et al.*(2005) define ethnography as the exploration of social organisations or cultural conditions through firsthand experience in social

contexts, identifying participant observation as the key method, a term they understand as synonymous with 'fieldwork'. Vrasti's more colourful definition, which dovetails with Clarke's (2005) wider notion of 'translation', states that ethnography consists of the "treacherous translation of fieldwork experience" (Vrasti, 2010, p.81), and very much makes the researcher the research instrument, the limitations of which I discuss further in Section 7.4. In this context, to refocus the case study both ethnographically and naturalistically, I posed the question: what would I need to know and understand about this system to enable me to work here? I spent a total of 42 working days involved with activities relating to the research site. Although I did not engage in direct work, I attended meetings and took an active role in discussions, i.e. 'semi', rather than full, participant observation (see also 'quasi-membership' below). The role of my research diary shifted very quickly to the recording of field notes, i.e. day to day observations and reflections concerning "the field" (Atkinson, 1992, p.5) in which the research is taking place. This reflected the foregrounding of semi-participant observation in the mix of methods employed as a consequence of the change in focus of the case. Simons (2009) highlights this combination of participant observation with other methods as typical of ethnographic case studies, which focus on particular programmes or projects in their socio-cultural context.

Shaw and Gould (2001) consider the extent to which practice and research in social work can mutually benefit from considering how the perspectives and methods of one can provide a template for the other. They cite Reid's (1995, in Shaw & Gould, 2001, p.3) view that social work is similar to research, in the

sense that it is marked by "the systematic collection of data, the cautious use of

inference and the consideration of alternative explanations, the application

where possible of research-based knowledge, and the discriminating evaluation

of the outcomes of one's efforts". This overlap of professional and research

methods applies more widely than social work or social care. Borbasi *et al.*,

citing Lipson (1989, in Borbasi *et al.*, 2005), draw attention to skills considered

essential for ethnographic fieldwork that are also deemed essential for effective

nursing practice: listing good interviewing and careful listening, astute

observation and the ability to interpret several levels simultaneously, as well as

an intentional use of self, skills common to most social professions. They note

the similarities between participant observation and nursing, citing Savage's

(2000, in Borbasi *et al.*, 2005) view that both activities involve the attempt to

understand someone else's worldview through practical participation and the

generation of data. They also highlight the contribution of feminist researchers

(Tong 1995, Jackson et al. 2003, *in* Borbasi *et al.*, 2005) to the development of

newer forms of ethnography that foreground the relationships that develop

between researchers and participants as fundamental to the conduct of the

research. As noted, relationships were critical to the execution of this study.

Goina (2008) draws attention to the degree of immersion achieved within the

researched community and outlines three levels she labels as *quasi-*

membership, *membership*, and *full membership*. A quasi-member is a

researcher who is accepted as such by the hosts but does not participate in the

core activities of the group, even if they do participate in more marginal

activities. To become a 'member', according to Goina, means the researcher

adopting a more integrated position with regards to his/her hosts, becoming an accepted participant in most of the group's core activities, without implying by this that the researcher has become 'one of us'. Achieving this latter status, by contrast, is what Goina describes as full membership, citing an example of a researcher actually becoming a boxer in the course of his study of a particular boxing fraternity (Wacquant 1995, in Goina, 2008).

Quasi-membership would approximate my status within the local office. I was part of them but separate too and did not engage in direct work, although as noted above I attended meetings and took an active role in discussions. In this way I undertook semi-participant observation as I learned about the service in its policy, legislative and organisational environments. My quasi membership of the local office also opened doors to others in the wider network.

Goina argues that immersion is more important than insider/outsider status, concluding that the insider/outsider dichotomy may not be as practically or analytically useful as it appears. Depending on which of a range of dimensions and characteristics come into play, researchers can be simultaneously an insider and an outsider, which reduces the significance of the dichotomy as an analytical tool. As a former resident speaking fluent German I wasn't a complete outsider (and in Berlin terms would identify as a *Wessi*, a Westerner). Additionally, my status as an experienced social care professional made me a partial insider too, even though in many other respects I was clearly an outsider. Paradoxically, despite experiencing being an external researcher for the first time, rather than the more usual insider researcher position associated with

researching professionals and professional doctorate students that Perriton (2000) notes is especially complex because of the multiple roles and prior relationships associated with such dual identities, my specifically professional knowledge and experience played a greater role than anticipated. It influenced how I approached the research in terms of skills common to professional and research tasks, provided a lens through which I re-focused my enquiries more naturalistically, as well as gave me a degree of credibility with the staff.

In practical terms, I set up a weekly meeting with a doctoral student in social work at the Catholic University (whose work required her to read a considerable amount in English) to address matters of language, culture and etiquette, during which we spent an hour discussing our research in English and an hour in German, as a mechanism for developing our social work and research orientated vocabularies. This proved useful for discussing issues concerning appropriate forms of address, for example, specifically which form of 'you' to use in research relationships, the polite 'Sie' or the familiar 'Du'.

3.5 Gaining Access
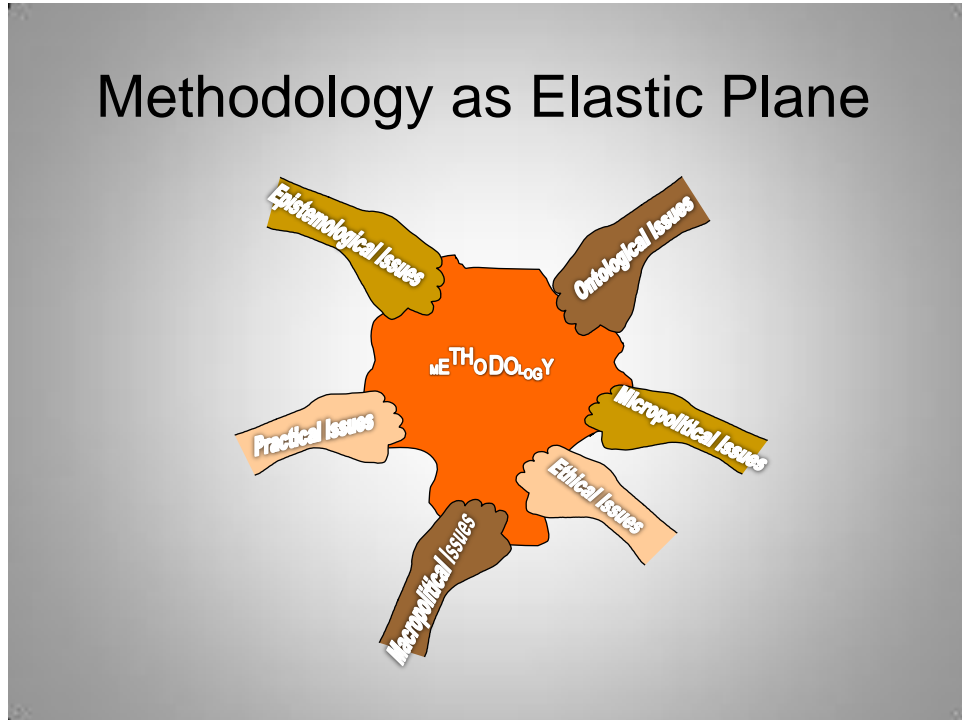
Figure 3.1: Methodology as an 'Elastic Plane'

(Source: Dunne, Pryor & Yates, 2005, p.167)

Dunne *et al.*'s diagram above is particularly helpful in its representation of how the shape of 'methodology' will change and alter due to the dynamic and mutually interactive pressures and tensions generated by the different component elements. Gaining access to a research site in Berlin provided an early example of the role of practicality and serendipity in research methodology (Dunne *et al.*, 2005, Bryman, 2004), exerting at least as much influence as questions of ontology and epistemology. The TH Marshall Fellowship required applicants to identify an academic partner organisation in Germany to support them. The maximum time I could negotiate away from my post in the local

authority was four months and so for efficiency I restricted my focus to Berlin because of my prior knowledge of the city. I relied on 'cold calling' using email addresses from higher education institutes' websites. Being unfamiliar with German higher education meant it took some time before I understood that social work was, in fact, taught only in the '*Hochschulen'*, roughly equivalent to the former polytechnics in the UK, of which there are three in Berlin that teach social work: one Catholic, one Protestant, and one secular. After some delay, I finally received an enthusiastic response from the *Katholische Hochschule für Sozialwesen Berlin*, the Catholic University of Applied Science, a formal welcome from the head of the institute and an offer to support me with access to library facilities and academic advice. I later received a response from the Protestant equivalent *Hochschule*, but decided to stay with the Catholic University because, although now atheist, having grown up within a Roman Catholic community I felt I would cope better with the unfamiliarity of a religiously-orientated university if it matched my own cultural background. The presence of the churches not just in social work education but more widely in the welfare system will be addressed further in Chapter 6.

Having discovered *Rund ums Alter* through online research I needed to negotiate access to one of its 12 local Coordination Centres. Prior to making contact with the Catholic University, I had experienced problems gaining access partly because I hadn't understood *Rund ums Alter'*s complex, multi-organisational structure (see Section 5.5.2) and had targeted a provider organisation (*Träger*) for one of the Coordination Centres, whose representative was confused by my request. 'Providers' had, in fact, little day to day

involvement with the service and in some way could be understood as organisational 'hosts'. With the credibility of the new relationship with the Catholic University I approached another centre directly, whose manager proved keen to assist, an opportunistic element to the sampling strategy that would further contribute to the study *in situ*, as I will outline below. This manager had previously contributed to the teaching of case management methods to social work students at the Catholic University and knew my main contact. So although my sample selection method began with considerations of comparability (for the original two case strategy, see Section 3.3.1 above), it ended more dependent upon human goodwill and serendipity. Once connections were made, I visited the site (and the University) twice prior to the start of the project, to introduce myself and begin to develop the relationships that would be crucial to the research project. Contacts with further key informants in the wider network were then facilitated through introductions from the local office in a snowballing effect (see Section 3.6.4 below).

3.6 Methods

3.6.1 Relationship to the Research Questions

The methods below have each contributed to answering different aspects of the research questions. Reflecting the related shifts in focus of both the boundaries of the case and from questions of comparison to comparability, the research questions have been through several formulations in the course of this study. The key themes have, however, remained constant, specifically the interest in

how policies and practices 'translate' from one welfare system to another, the degree to which problems and their solutions might be 'similar', the wider question of what can be learned from cross-national study, and the related concern with the impact of methodological and conceptual problems. The core descriptive research question, 'What does this example of *Case Management* look like in its specific legislative and social policy context?' (framed by **Diagram 1**, p.19) remained unaltered throughout and underpinned the field work for the case study.

3.6.2 Reviewing the Literatures

The wider academic literatures in this thesis both contextualise and illuminate my research, as well as providing direct evidence with which to address specific research questions such as the comparability of *Rund ums Alter*'s specific example of *Case Management.* Chapters 2 and 3 are the two main literature based components of the thesis, addressing case/care management and methodological problems in cross-national research respectively, both of which are reworked and extended from work undertaken for my CAS, in which I took as my starting point the research tasks I had ahead of me, identifying literature from different sources that would contribute to the framing of those tasks.

Grayson and Gomersall (2003, p.1) call the identification of evidence for reviews in the social sciences "a difficult business", contrasting it to the greater clarity of technical terms and definitions underpinning medicine orientated systematic reviews. They note the diversity of the literature, which is wider than simply peer reviewed academic journals and encompasses practitioner journals,

books (a key output in social science), official publications and other 'grey'

literature, as well as database variety and variability. They also note the

difficulties of negotiating the ever increasing amount of material available via the

internet and especially the problem of terminological difficulties in social

science, stating:

> Social science (especially applied social science or social policy) terminology
>
> is diffuse, imprecise and constantly changing. It is frequently 'non-technical'
>
> in nature and application, overlapping ordinary everyday language and
>
> difficult to distinguish from it. It is consequently hard to index consistently,
>
> and efficient and effective information retrieval can require considerable
>
> ingenuity (Grayson & Gomersall, 2003, p.7)

These issues were further complicated in this study by the exploration of

literature in two countries with different languages and academic practices.

Grayson and Gomersall recommend a staged approach to the retrieval of

relevant information that may be more effective in light of such difficulties that

begins with relatively simple, broad searches. These are followed by manual

sifting and reading to identify useful material, to build knowledge of relevant

terminology, and to refine inclusion and exclusion criteria. They cite Long *et al.*'s

view that "the process must not be viewed as linear, but rather as iterative,

moving down and up and back though the different layers or stages" (Long *et al.*

2002, in Grayson & Gomersall, 2003, p.8).

The roots of my literature searches pre-date both the thesis and the CAS, reflecting my interest in comparative social care since undertaking my MA in 2001-3. I have used material gathered over those years, iteratively using distinct patterns of search criteria such as differing combinations of the following: *community*, *social*, *care*, *case*, *management*, *services*, *comparative*, *older*, *elderly*, *cross-national, policy, England, Germany*, sometimes employing quotation marks to make searches more specific, e.g. "*long-term care*", "*case management*", and where appropriate employing similar German expressions such as *sozial*, *Pflege*, *Dienste*, *älter*, *Vergleich*, etc., plus research specific terms such as *methodology* or *ethnography*. I have used Google Scholar, both the English and German versions, in addition to using the electronic databases available through the University of Sussex (principally ASSIA, IBSS, SCOPUS, Social Care Online and Web of Science). I have continued such searches right through to the period of finally writing up the thesis (2010-11). During the fieldwork in 2007 I also had access to library services in Berlin, particularly the German social work database available via the library of the Catholic University of Applied Science (SOLIT), and used the libraries of both the *Deutsches Zentrum für Altersfragen* (German Centre for Questions on Ageing) and the *Wissenschaftszentrum Berlin für Sozialforschung* (WZB – Social Science Research Centre Berlin) too. At the time of the research, far less material was available electronically in Germany compared to England.

I have additionally followed leads from personal recommendations from experts and especially from reference lists from already identified sources and key authors. Identifying comparative research that addressed case/care

management in mainstream older people's services required considerable detective work. For example, trawling through German Google Scholar eventually identified the Federal Government commissioned multi-country European study (Engel & Engels, 1999), on the Health Ministry website, a critical resource that otherwise appeared nowhere else. Another comparative study (Schunk, 2001) proved similarly difficult to locate, despite being described methodologically in another text (Schunk, 1996), and was ultimately sourced by approaching the author directly. Sources were evaluated for quality as well as relevance to this study. For example, where using evidence from studies of care management in England attention was paid to the degree of clarity of method and purpose outlined in the study, although as Sharland and Taylor (2006) note, this is not always made available, particularly in older studies.

Papaioannou *et al.* (2010) show in their study of different approaches to searching in social science subjects there are no guaranteed ways of ensuring complete coverage and highlight the continued importance of contact or advice from experts. Indeed Evans (2008) in a large scale quantitative study presents the counter-intuitive finding that the increasing availability of online journals leads to a narrowing of sources cited, speculating that the increased specificity of search terms and the absence of physical browsing combine to limit what researchers will find through restricting the possibility of serendipitous discovery.

In this study, care has been taken in particular to ensure wherever possible that key authors have been included, for example Challis with regards to care

management in England, and Wendt with regards to '*Case Management*' in Germany. Case and care management literature, internationally an enormous field as Ewers (2005b) notes, has been included on the basis of the degree to which it addresses either historical accounts and generic descriptions of the approach or specific issues relating to its adoption in England or Germany, with a focus on mainstream social care services for older people (particularly with some evaluative component), rather than either more psychiatrically orientated specialist dementia services or case management in nursing. For Chapter 2, the decision to include theoretical resources from translation studies in addition to literature from the cross-national methodological literature arose directly from the fieldwork experience and in that discipline it was similarly important to include key authors such as Bassnett.

3.6.3 Documentary Research

I used a government website that provided full access to federal legislation (www.gesetze-im-internet.de), targeting those statutes that came up most often in discussions with the staff for further reading. I also gained access to publications and pamphlets produced by *Rund ums Alter* for the public as well as for internal use. I subsequently gained access to additional documents from the regional government detailing the establishment of the citywide service as well as the independent annual report for 2007 (Beratung Bildung Innovation, 2008). This latter document was crucial, as noted, for understanding both the degree of variation between the different local offices and the history of re-categorisation of the services offered, including '*Case Management*' (see Section 5.5.2). I also had access to assessment documentation; the *Rund ums*

Alter database *Hilfelotse* ('Help Navigator'); and (controlled) access to case files too. Documents were evaluated against the criteria of authenticity, credibility, representativeness and clarity of meaning (Scott 1990, in Bryman, 2004). Key documentary sources are listed in Appendix 1. Several documents were provided to me either during or following meetings with key informants, emphasising the importance of relationships to this study.

I also accessed statistical information to situate the service provided in the wider context of care needs in Berlin. Most of this data is publicly available, however, the data for Berlin from the Health Insurance Medical Service (*Medizinischer Dienst der Krankenkassen*) is internal data provided following an email request.

In addition, there were two separate one-day conferences organised by *Rund ums Alter* during my stay, one celebrating the fifteenth anniversary of the first local office in an East Berlin borough, and one organised by the citywide service, with national speakers. All the key presentation documents were made available.

3.6.4 Meetings and Interviews (Key Informants)

In naturalistic enquiry "respondents are determined on the basis of what the researcher desires to know and from whose perspective that information is desired" (Erlandson *et al.*, 1993, p.91). Having identified *Rund ums Alter* purposively and the local office opportunistically, I maintained this twin sampling strategy to identify potential contributors to the study, particularly as the study

widened to include contributions beyond the immediate local office. Indeed, such was the degree of interest and cooperation that some wider contacts had been pre-arranged on my behalf. Inevitably, this meant that I made use of pre-existing networks that tended to coalesce around the two overarching social services organisations that provided the service so I ensured, for example, that I included a manager of a Coordination Centre run by *Diakonisches Werk*, the Protestant provider, to counterbalance the tendency to meet contacts from other *Paritätisch* (secular) organisations (see Section 5.5.2 for further explanation of the structure). My presence in the service overall had been discussed and acknowledged by the ABK (*Rund ums Alter* management committee) prior to my arrival. Similarly, as the importance of local service boundaries and the impact on them of federal legislation became clearer, an introduction to a senior social worker in the local authority was facilitated. Key informants were sought out purposively in this way, whereas additional contributors were mostly acquired opportunistically.

Listed as key informants are those individuals who made significant contributions either iteratively over time or in a specific interview or meeting. Sherman Heyl (2001) identifies a number of dimensions that differentiate ethnographic interviews, including the duration and frequency of contact, quality of relationship, and the pedagogical role of the interviewee who helps the interviewer to understand their world. **Table 3.1** below sets out both the key informants and the main events, meetings and interviews from which data was derived. There is inevitably some overlap between the categories of 'meeting' and 'interview', particularly when there is more than one participant present.

There were also other events that unexpectedly contributed data. For example, a 'round table discussion' was arranged by the local manager that included a lecturer from a different university involved with case management, a manager of a different coordination centre, and a dual qualified social worker/case manager from a third coordination centre, at which I was invited to do a presentation on care management in England. Some of that discussion inevitably turned to '*Case Management*' in Germany more widely and the particular service in Berlin. The dual qualified worker subsequently agreed to an individual interview, thus becoming a formal key informant. Another example was an extended discussion with the founder of the original volunteer initiative in West-Berlin which took place at a conference. This helped illuminate the story of the services original roots and she was happy for me to use this in the study, but the meeting was both unplanned and unstructured. It did, however, lead to the provision of a local out of print publication outlining that history, again highlighting the role of relationships, connections and serendipity. All participants were apprised of both the specific descriptive research question, my wider concern with learning from cross-national research, and that their contributions would be anonymised as far as practically possible (see Section 3.8 below for further discussion of consent). I had no refusals at any point of the research.

Key Informant	Contribution	Additional data generating meetings/events
Team Manager Centre 1	Daily informal discussions (shared office), plus more formal discussions to address specific topics, e.g. local structures, plus observation at advice session and contribution to group interviews re illustrative cases	'***Altenteam***'—bi-monthly staff meeting for all 8 *Paritätisch* run Coordination Centres x2 **Weekly team meetings** (main research site) x 10
Social Worker 1 Centre 1	Daily informal discussions, plus more formal sessions, e.g. to explain SGB XII. Observed home visits x 2, and group interview re illustrative cases	**Half day workshop** on proposed care reforms, organised by a neighbouring Coordination Centre
Social Worker 2 Centre 1	Daily informal discussions, plus more formal sessions, including discussion of selection of case records, and group interview re illustrative cases	'**Round Table Discussion**' meeting re care management in England
Team Manager Centre 2	Group discussion at Centre 2 team meeting x2, plus subsequent meetings during follow up visits regarding policy changes	**Conference 1**—celebrating 15th Anniversary of first Coordination Centre in the east of the city— Theme '*Case Management*'
Social Worker 1 Centre 2	Group discussion at Centre 2 team meeting x2	**Conference 2**—biannual event organised by the ABK management committee, with national speakers—
Social Worker 2 Centre 2	Group discussion at Centre 2 team meeting x2	theme '*Case Management*' and care reform (Also, **unplanned interview with founder of volunteer initiative**)
Social Worker Centre 3	Individual interview, plus participation in 'Round Table Discussion', see over	
Senior Social Worker (Local Authority)	Individual interview x 2, focusing on both local service arrangements and role of local authorities re SGB XII, plus provision of documents	**Meeting of ABK management committee** of *Rund ums Alter*
Policy Lead Regional Govt	Individual interview, plus subsequent informal meetings/discussions, and provision of documents	Also: methodologically relevant '**Research discussions**' at Catholic University re: language, culture and research x10
Policy Adviser Regional Parliament	Individual interview, plus subsequent informal meetings/discussions	

Table 3.1: Data Sources

Taking notes and engaging in simultaneous discussions in a second language is challenging. I took written notes either during or after meetings and interviews, depending upon the level of my own engagement, and where appropriate and acceptable recorded a number of them. However, technical difficulties with the recording equipment meant some of this material was less

useable so has since been used principally to cross check field notes, rather than as primary data. This constituted a partial loss of data but the 'belt and braces' approach of taking notes even when some meetings were recorded, as recommended by Erlandson *et al* (1993), lessened its impact, and the imperfect recordings were nonetheless useable for checking those notes.

The fieldwork phase, as noted, was guided solely by the main descriptive question (see p.63) and the framework diagram. Where specific interviews were undertaken, informants were made aware of the main descriptive question and were asked to comment from their particular individual and organisational perspectives. I used the following questions as prompts where necessary:

- What counts as 'case management' here? (Definition)

- What is it intended to do? (Aims and purpose)

- How does it work in practice? (Forms, procedures, routines)

- Who is it aimed at? (Characteristics of service users)

- How does it fit with other services?

- How does it fit with the wider policy context?

- What does the legislative and policy framework look like?

- How do older people access care and support services in Germany?

- What kinds of services are available?

- How are those services funded?

As topics or questions emerged, reflected on in my research diary, so further information or participants were purposively sought out, as outlined in the example above, to fill gaps in my knowledge and understanding of the local

interface between legislation, policy, organisation and practice, asking more specific or detailed questions as appropriate, for example, the framing questions given to the local office's social workers in preparation for the group interviews (Appendix 2.0).

I facilitated both group discussions in which the local social workers presented four 'illustrative' cases, over two sessions in the weekly team meetings (a key meeting for understanding how things worked locally). My initial suggestion was for the social workers to each present vignettes of a small number of imagined 'typical' cases, thinking this might enable them to condense their experiences into composites. However, they preferred to identify and present real cases that in some way typified their work, which I subsequently anonymised. I provided the set of questions in advance, regarding need, service provision, and relationship to policy and legislation to structure their presentations. I facilitated the group discussion, keeping notes on a flipchart, from which I drafted a summary of each case presented. I then returned the summaries to the appropriate social workers for correction and validation. Through this interactive process, I was able to identify the parameters of their local constructions of *Case Management* and link them to the wider legislative and policy environment. The cases were categorised by the social workers themselves as 'Complex', 'Unusual', 'Typical' and 'Simple' (Appendices 2.1-2.4). One possible constraint to this process was how the social workers chose to divide the task so that the content of what they presented (they chose each to present two 'types' of the four discussed, rather than each present all four) was different, and therefore not comparable with each other, which may have reflected

internal team dynamics in some way (see 'risks to participants' in Section 3.8 below).

3.7 Data Analysis and Interpretation

Simons (2009) states that *interpretation* and *analysis* are not discrete processes, but instead interact constantly throughout the research process, a position mirrored by Erlandson *et al.*(1993). They also emphasise this simultaneous and interactive collection and analysis of data in naturalistic qualitative enquiry, in which as data are obtained, tentative meaning is applied that is subsequently revised with the acquisition of new data. Keeping (theoretically and methodologically) reflective field notes meant that issues or themes that appeared important could be developed as my understanding deepened. Different metaphors assisted at various times. Early on I considered myself a kind of magpie, noticing shiny objects strewn around the landscape, picking them up to examine them more closely. This shifted to a metaphor of jigsaw puzzles, in which I was picking up pieces and trying to fit them together to make a picture of *Case Management* in Berlin, guided by the realisation that, whilst the picture I carried with me of care management in England had broad similarities, the individual puzzle pieces of each variant were cut quite differently (see Section 2.3 above on language and partitioning reality). The diary also provided a space for reflecting on and drawing together different strands and types of evidence (see 'Process Tracing' below).

Distinguishing *interpretation* as the understanding and insight derived from a holistic, intuitive grasp of the data, Simons (2009) then describes *analysis* as any procedures that enable the researcher to organise and make sense of the data in order to produce both findings and an overall understanding of the case, for example theme generation, concept mapping, and coding. Fiss (2009) argues that case study research strategies in particular must preserve the integrity of the configurational nature of the case, i.e. the understanding of it as a particular configuration of features embedded in a specific context and time. In comparative qualitative research in particular, Mangen (2001) cautions against using analytical approaches that are too highly structured because of the dangers of fragmenting, rather than highlighting, meaning.

In this piece of work then, I adopted a broad approach of process tracing (Gerring, 2007) this example of *Case Management* within its specific legislative and organisational context in order to preserve its configurational nature. Gerring states that case study research often relies heavily on contextual evidence and deductive logic to reconstruct causality within a single case, noting that the hallmark of process tracing consists in the employment of multiple types of evidence for the verification of a single inference. He makes a comparison with detective work, in which:

> the maid said this; the butler said that; and the suspect was seen at the scene of the crime on Tuesday, just prior to the murder. Each of these facts is central to the central hypothesis—that Jones killed Smith—but they are not directly

comparable to one another. And because they cannot be compared, they

cannot be analyzed in a unified sample (*ibid.*, p.173).

The most distinctive feature of process tracing lies in this non-comparability of adjacent pieces of evidence. Gerring states that, in this approach, all pieces of evidence are relevant to the central argument (i.e. they are not random), but do not comprise observations in a larger sample. Process tracing invokes a complex logic, analogous to detective work as noted, but also legal briefs, journalism, and traditional historical accounts, in which "the analyst seeks to makes sense of a congeries of disparate evidence, each of which sheds light on a single outcome or set of related outcomes" (Gerring, 2007, p.178). In this way the different elements contribute to the larger mosaic or map that is under construction.

Following the initial fieldwork phase, I analysed these multiple types of evidence (documentary, observational, and interviews/meetings) in three overlapping processes. First I transcribed my handwritten chronological field notes into an electronic format, linking the notes from specific events/meetings to other data sources, e.g. documentation, recordings, presentations etc. that either confirmed or added to the substantive content and noting which key informants were present or involved.

I next 'coded' the text in two ways. Ryan and Bernard (2003) identify themes as abstract constructs that link different expressions, differentiating between *indigenous* and *analyst-constructed* themes. 'Boundarying *Case Management*',

'Adaptations', and 'Authorisation' fit the former category, having emerged from within the research site itself. By contrast, 'Translation', 'Equivalence', and 'Similarity/Difference' are 'analyst-constructed' themes derived from the literature, and relate to the theoretical concerns of this study. As Hughes (1994) notes the analytic process involves both the reading of raw data and the application of concepts that have arisen from outside that data.

Re-reading the field notes I reviewed the degree to which emergent themes (highlighted in reflective and analytical comments in the field notes) were confirmed by noting the frequency and/or intensity with which the themes of '*Wohnungsanpassung*' or 'Adaptations'; '*Abgrenzung*' (literally, demarcation or borderline) or 'Boundarying *Case Management*'; and '*Autorisierung*' or 'Authorisation' (i.e. legitimation) were discussed or noted. During this process, a further theme of 'Organisational Complexity' emerged, due to the frequency with which it appeared in discussions or commentary in the notes. Subsequently, I read the field notes again, highlighting the *a priori* categories of 'Translation', 'Equivalence' and 'Similarity/Difference', to which I was clearly "theoretically sensitive" (Strauss & Corbin 1990, in Ryan & Bernard, 2003, p.88) as a result of my preparatory study for the CAS, and that had indeed raised issues in the field. Linking the data to these themes helped identify specific examples for consideration in Chapter 6, e.g. '*Assessment*'.

The substantive theme of 'Boundarying *Case Management*' refers to the discussion both between and within local Coordination Centres of how to distinguish between the different types of intervention offered by *Rund ums*

Alter, particularly the boundary between *Beratung* (advice/consultation) and *Case Management*. This emerged early in the project at a meeting for staff from several Coordination Centres, at which it came up in relation to different local recording practices on the common database used to generate the annual evaluation reports. It featured in a number of discussions both explicitly and implicitly (for example in the meeting with the representative of the local authority). It was also the focus of a presentation at one conference and discussed in a presentation at another. The group discussions which reconstructed and categorised specific cases also demonstrated the local office's understanding of what was '*Case Management*' and what was not. Finally, in 2009 I eventually received the 2007 annual evaluation report, the content of which both addressed issues of definition and quantified the degree of variability between individual offices.

Partially linked to the above, 'Adaptations' emerged because of its centrality to day-to-day practice in the principle research site, its role in distinguishing the service from that of the local borough, and its foregrounding more widely in *Rund ums Alter* as a particular specialism. Aside from the direct evidence from the reconstructed cases, other case records, an observed home visit, an interview with the local team manager, and local information leaflets and publications, the centrality of 'Adaptations' work to *Rund ums Alter* was also confirmed by secondary data in a German publication of a research project based in another Coordination Centre (Fichtel, 2005).

'Authorisation' arose from discussing the optional nature of the service and concerned the degree to which the social workers, when acting as case managers, experienced a lack of recognition of their role with and on behalf of service users with other agencies, especially the Insurance Funds and/or care providers, which they attributed to a lack of 'authorisation' (i.e. legitimation) for *Case Management* within the system overall, despite their formal recognition in local regulations. This emerged initially in relation to discussion of Herr C's reconstructed case (Appendix 2.3) during the second group discussion but was also a central theme in the 'round table' discussion, an interview with a case manager from another Coordination Centre as well as featuring as a major theme in one of the presentations at the biannual conference. So despite appearing less frequently, the intensity of the discussion indicated its importance to local '*Case Management*' practice at the time. As Gerring (2007) notes, the various non-comparable observations drawn upon in a given study are quite unlikely to be of equal importance, so counting them alone will give no particular indication of their overall significance or meaning.

The theme of 'Organisational Complexity' reflects the frequency of explanations or comments regarding the multiplicity of actors in both the health and social care systems, their relationships to the various elements of legislation, and their hierarchically constructed associations that mirror the federal structures of the government, including the coalition of *Träger* that provides *Rund ums Alter*'s service. This theme may be a partial artefact of my own initial unfamiliarity with the system but it is nonetheless clear that the German care landscape is characterised by multiple organisational actors with independent agendas

(Wissert, 2004). These 'indigenous' themes are referred back to throughout Chapters 5 and 6.

Finally, I used the various data sources to trace the process through which *Rund ums Alter* had come into being in its particular configuration (see **Figure 5.3**, p.155), mapping its specific relationship to the wider policy and legislative context and the care pathways determined by that context (see **Figure 5.1**, p.144), utilising the framework diagram as a guide.

These three overlapping processes identified relevant material for both the construction of the descriptive case study in Chapter 5 and the subsequent analysis of the case study's comparability in Chapter 6. Some data were unused because they reflected other issues that fell outside of the remit of this study (for example, the second '*Altenteam*' meeting generated nothing of relevance), others (mainly from the follow up visits) because they were intended to trace the policy shift ('Care Advice' and 'Care Support Centres') but the delay in implementation frustrated this. Data from these latter meetings were not analysed as such but are summarised in Section 5.6.

3.7.1 Translation, Interpretation, and Verification

I worked with my documentary and interview data in the original German but my field notes are mostly in English (interspersed with German, particularly when taken contemporaneously). This raises an important issue of translation – between listening in German and making notes in English I have had a sense of the meaning of the content that I have not consciously translated, an element of

'interpretation' that occurred instantaneously. In cases of meetings or interviews where I have a reasonable recording I have been able to cross check this instant interpretation. I began to translate some of my data (e.g. extracts from legislation, the 'illustrative case' documents) only at the point of drafting the case study, for the purpose of making it accessible to an English speaking readership. Indeed, to reframe the 'Skopos' theory of *purpose* in translation (see Munday, 2008, in Chapter 2) with regards to Clarke's (2005) wider notion of 'translation' as a way of thinking about the movement of key words, discourses and policies across sites, one purpose of this case study is to translate this German experience for an English social care audience, so in the analysis of the data it has been 'translated' and 'interpreted' in both those senses. I have, then, engaged with this data holistically and intuitively as well as cognitively and analytically in coming to an understanding of this case study (Simons, 2009), using the writing process, itself an important analytical process in naturalistic enquiry (Erlandson *et al.*, 1993), to shape and refine it.

In terms of the case study's trustworthiness and authenticity, a key criterion for naturalistic enquiry (Lincoln & Guba, 1985), spending time with my key informants allowed for my understandings to be checked iteratively in the course of the data collection, as well as more formally on two occasions when I gave presentations outlining my initial thoughts and impressions. Additionally, the 'illustrative cases' were co-constructed and verified by the social workers themselves. Finally, one of my key informants, with an overview of *Rund ums Alter* from its beginnings, was able to read English sufficiently well to offer to read through and comment on a full draft of the case study chapter. In this way,

I hope to have provided a 'functionally adequate' (Reiss & Vermeer 1984, in Munday, 2008) and trustworthy translation in the widest sense.

3.8 Ethical Considerations

Butler notes Homan's (1991, in Butler, 2002) distinction between ethics as a discipline concerned with the justification of norms and standards for personal and interpersonal behaviour and a concern with a *code* of ethics, the latter of which is largely concerned with articulating attitudes that characterise the culture of a professional group. In the context of developing codes of ethics specifically for social work and social care research in the UK, he argues that this distinction reminds us that codes of ethics and their associated prescriptiveness and normativity must always be contextualised and situated, noting they cannot be *for always* and *for everywhere*.

Peled and Leichtentritt (2002) consider how social work values relate to two schools of thought in research ethics, what they term the 'positivistic' approach adopted by Institutional Review Boards in American universities, and more relativistic approaches as exemplified by feminist communitarian thinking, both of which approaches they value. The former is described as holding four core values of autonomy, beneficence, non-maleficence and justice, upon which a number of principles are founded, such as informed consent, non-deception, absence of psychological or physical harm, privacy and confidentiality, and a commitment to collecting and presenting reliable and valid empirical materials. The latter is noted as an alternative approach rooted in principles of community,

in which communities are presumed to have common moral values which can guide research within a particular community's domain. These communitarian moral values are likely to reflect the concepts of care, governance, neighbourliness, kindness and moral good. They note, citing Denzin (1997, in *ibid.*), that research ethics in this framework are always contextual and as such the ethical responsibility of the researcher is not to any professional code of ethics but to the situated moral rules grounded in local group or community understandings. This requires of researchers that they create and modify their moral acts through a non-hierarchical dialogue with research participants within the social contexts in which the research is conducted.

In 2007 the guidance for research students at the University of Sussex[7] was different from that currently available. The Department of Social Work then formed part of the Sussex Institute, which provided a set of standards and guidelines to help researchers explore potential ethical issues. I will use that structure to outline how I addressed potential ethical dilemmas in this study. (See Appendix 5 for the Sussex Institute Standards and Guidelines in full), before reflecting on whether more recent guidance might have led me to take different decisions. Geographically, I undertook my fieldwork in another country so pragmatically also referred to the guidance available for the conduct of research at the Catholic University (KHSB, 2005). Although the support offered to me there was voluntary, the relationship with that institution was critical in establishing my credibility with my key informants and as such I chose to make that relationship central to arrangements for any concerns about my conduct as

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[7] Neither the funders (*VW-Stiftung*) nor the organising institutions (LSE, WZB) of the Fellowship requested any ethical review of the proposed study.

a researcher, as that made more sense for participants. These localised decisions mostly reflect the strictures of the more relativistic approaches outlined above that researchers must create and modify their moral acts through a non-hierarchical dialogue with research participants within the social contexts in which the research is conducted, although in doing so I also referred to a pre-existing university framework which, like the University of Sussex guidance, has clearly emerged from the more formalised approaches. Both sets of guidelines demonstrate a significant degree of congruence with the 'positivistic' principles outlined above.

Standard 1: safeguard the interests and rights of those involved or affected by the research; and *Standard 3: establish informed consent even where this is difficult* (these standards are broadly reflected in the German guidance, under the heading 'Rights of the Investigated' [*Rechte der Untersuchten*]).

Consent: My way into the research site was via the team manager, with whom I had email contact in the first instance. I gave her clear information about the research to circulate to her staff, on the basis of which they agreed as a team to participate, so the consent record I have is in email format, not a signed document. I also visited briefly on two occasions before the research took place so was able to introduce myself and describe my research interests directly to the social workers unmediated by the manager. I was explicit that they individually had the right to refuse to take part but by this stage they were clearly already committed. By the start of the research they had known for several months what the research was about and what their role would be (key

informants). On reflection, I perhaps should have insisted they signed consent documentation but at the time this would have felt intrusive, as I was already becoming part of their world ("*unser Herr Crossland*" or "our Mr Crossland"). In this respect, I depended more on the kind of contextual judgment outlined by Peled and Leichtentritt (2002), being clear that I was a researcher, that I was interested in participants' contributions to my understanding of how *Rund ums Alter*'s *Case Management* service was understood and enacted in both the local and federal legislative and policy contexts, but also that there was no problem if they did not wish to take part, a necessary tactic given the fleetingness of some of the contacts (e.g. the founder of the original self help group). I did, however, outline a procedure during a team meeting, agreed with the social work academic supporting me at the Catholic University, through which they (or other participants from the wider network, all of whom knew which office was 'responsible' for me) could raise issues of complaint or other problems deriving from my research. This felt more appropriate than directing them to the University of Sussex, instead agreeing that if issues were raised with the Catholic University then the latter would address them locally and liaise directly with contacts at Sussex. Additionally, a mid-point three way meeting took place between myself, the local team manager and the academic adviser to review the project.

Risks to participants: Much of what happens in social work and social care is unobserved, taking place either in a closed office or, more often, in a private home. My main ethical concern with regards to the small team in the main research site was to be sensitive to the fact that my presence and its purpose

may make explicit practice differences within the team that may be latent or unaddressed. Specifically, in such a small team there is the possibility that the individuals may work very differently from each other in ways that are unseen because of the nature of the work but that may be brought into focus through my questioning about what they actually did in relation to '*Case Management*'. I needed to be particularly careful during the two facilitated group sessions. On the one hand, the manager noted they rarely had chance to discuss cases together, indicating that the exercise had potential benefits for the team. On the other, however, I noted how the two social workers chose to divide the task so that the content of what they presented (they each chose to present two 'types' of the four discussed, rather than present four each) was different, and therefore not comparable with each other. During the facilitated discussion I took care only to encourage contributions that were clearly offered and didn't push if individuals chose to remain quiet for periods of the discussion. My main concern was to disrupt the relationship dynamics as little as possible, a stance that may have had some methodological implications as noted above.

Data verification: I was able to check my general understanding iteratively during my day-to-day interactions and conversations, and agreed the content of the 'illustrative cases' more formally through a process of co-production and verification with the social workers (see Section 3.6.4 above). Additionally, as noted I submitted my case study chapter to another key informant with an overview of the citywide service for review. I also gave presentations at various points outlining my initial thoughts and ideas, and have updated participants with an interim report as well as updates through email contact. On completion

it is my intention to produce a German language summary for the key

informants.

Confidentiality: I have anonymised the key informants, reducing the risk of

identification in some cases by describing their roles in more general terms. The

key concern is not to identify the particular local office. Where I accessed case

records, these were copied and anonymised before they were given to me (see

further comments below on choices with regards to service users). I also re-

assured participants that individual views would not be passed to the team

manager nor otherwise identified within the team or wider service.

Standard 2: ensure legislative requirements on human rights and data

protection have been met (data protection is only mentioned in the Catholic

University guidance in relation to the long term storage of data).

Because of the 'border crossing' nature of the research this was more

problematic as I am unfamiliar with this area of German legislation, which as

noted above did not figure prominently in the local guidance. I was reliant on the

professional judgment of my key informants who, as social work professionals,

were familiar with issues of confidentiality and data protection, and the guidance

of my academic adviser to ensure that my access to information was

appropriately safeguarded. I kept my hand written field notes journal (the main

source in which individuals are identified) in a locked cabinet and have secured

the transcribed electronic version with a password, on a computer itself only

accessible using a password.

Standard 4: develop the highest possible standards of research practices including in research design, data collection, storage, analysis, interpretation and reporting (The Catholic University guidance begins with a long section titled 'Foundations of good academic practice' [*Grundsätze guter wissenschaftlicher Praxis*]).

As detailed in previous sections of this chapter, I believe I adopted the most appropriate research design for this study, flexibly adapting the methodology in response to my increasing understanding.

Standard 5: consider the consequences of the work or its misuse for those involved in the study and other interested parties (although the notion of harm to research participants during the research is addressed in the Catholic University guidance, this element of potential consequences does not appear).

A key consideration in this regard was how to protect the staff at the main research site from any consequences arising from potential publication, particularly with regards to the central (and sensitive) question locally of the differential definition of *Case Management* between different offices (see 'Boundarying of Case Management' above and Section 5.5.4 Local *Case Management* Practice below). It was for this reason I chose to anonymise the local office. The issue would have arisen especially (but not solely) with regards to potential publication in a German language journal. However, legislative

changes (see Section 5.6) since the research was undertaken have overtaken and rendered the issue less salient.

Standard 6: ensure appropriate external professional ethical committee approval is granted where relevant

Ethical approval by an external committee was not required at the University of Sussex but in line with the former Sussex Institute's guidelines, ethical approval was granted through the supervision team following review of the ethical issues and potential dilemmas inherent in the research. There was no equivalent structure in the Catholic University.

Other considerations:

Language skills: Mangen (1999) notes a potential 'halo effect' when researchers are working in a foreign language. As a native English speaker who also speaks relatively fluent and relatively unaccented German, my language abilities literally make people, by and large, well disposed towards me. I needed to take this into consideration, for both ethical and practical reasons. I also had to consider that, whilst fluent enough, my German is not equivalent to my English and additionally that I was relatively inexperienced with both professional social work and academic research vocabularies. In the planning I was aware that my language skills would be at their best at the end of the project, an unavoidable paradox. I decided that, although I would accompany social workers on home visits where those service users allowed it, I would not attempt to interview them

independently. My day-to-day presence with the social workers allowed for an iterative process of checking what I believed I had heard that would not have been possible with service users. Additionally, it became clear from early on that my interest was in how the staff understood and enacted *Case Management* within the local legislative and policy context, as noted above.

Evaluation and judgment: As part of the introductory process, I re-assured the local staff I was not there to evaluate their case management practice. It was perhaps a naïve commitment to believe I could research without forming a judgment but, as a practitioner, I felt I would not wish for someone to come in from outside and do that to me, on reflection a symbolic interactionist stance. Nonetheless, despite the constraints this decision created, it was probably necessary to gain as much access as I did, given the sensitivities between offices outlined above that were reflected in the team manager's effective refusal to let me know the identification code for the local office in the annual evaluation report (Beratung Bildung Innovation, 2008). If I were to do this again, I would have addressed the issue of potentially uncomfortable situations and how to manage them more directly at the beginning.

Current University of Sussex guidelines: Current guidelines have a much more clearly defined pathway to (potential) ethical approval, beginning with a checklist of questions that would have identified this research project as 'low risk', the review of which is applied for through answering a further series of questions (including one concerning fieldwork abroad) constructed around confidentiality and anonymity, informed consent and recruitment, and research

context. The more recent guidelines would not necessarily have led to me making different decisions but would certainly have assisted in identifying potential decision points in advance and reduced the number of *ad hoc* decisions made. The question in particular about fieldwork abroad, although mainly focused on health and safety issues, nonetheless may have helped think through the practicalities of 'quality assurance' for research participants in another country in advance.

Before presenting the core case study in Chapter 5, I will next provide an overview of case management's development, tracing its origins in the USA and outlining its subsequent adoption in England as care management. I will then explore the German *Case Management* literature before examining a number of cross-national studies that have addressed case management in older people's services.

Chapter 4 - Case/Care Management

4.1 Introduction

Ewers (2005b) notes the growth of the case management literature both internationally and in individual countries, and acknowledges the impossibility of reviewing it in a single piece of work. In this chapter it is my intention to provide, within that constraint, an overview of case management, including the problematic issue of its definition and the related question of its unstable nomenclature. In addition to its US origins and adoption in England, I will also review German contributions to the literature before considering case management for older people in comparative studies.

4.2 Origins of Case Management in the USA

Accounts of the roots of case management frequently draw attention to the impact of *deinstitutionalisation* in the USA in the 1970s (see Moxley (1989), below). This took place firstly in mental health and subsequently in other social services, framing its emergence as a distinct approach to helping individuals with complex needs in the community (Wendt, 2001, Gursansky *et al.*, 2003, Onyett, 1992, Ewers, 2005a). Its origins, however, reach back further to early practices in the developing professions of both social work and nursing, with controversy from the earliest days of social work regarding the degree with which 'case management' overlaps with traditional 'casework' (Ewers, 2005a).

Nonetheless, case management in its modern form emerged in the 1970s, associated as noted above with a policy shift in the USA away from institutionalised care to care in the community in several branches of social services, including the care of older people. Gursansky *et al.* (2003) suggest several drivers for change in the US welfare system of the time, from the development of new drugs in psychiatry, medical technology that improved the rehabilitation of older and disabled people, to the emerging service user rights movement and the impact on welfare budgets of the 1970s oil crisis. They argue that case management provided a framework that could be endorsed by a range of stakeholders, each challenging traditional service arrangements but often from very different and perhaps contradictory perspectives.

In response to the increasing problems associated with uncontrolled development of health and social care services, the US federal government gave priority to improving coordination and integration within the system and commissioned a range of pilot case management schemes from 1972 (Kaplan 1990, in Ewers, 2005a) – the beginnings of, in Ewer's expression, case management's 'career' as an instrument for addressing the shortcomings of an ineffective and inefficient health and social care system at both the individual and organisational level. The adoption of case management into the federally funded Medicare and Medicaid programmes was critical in both establishing its legitimacy and facilitating its expansion (Ewers, 2005a).

4.3 Definitions and Key Characteristics

4.3.1 Fragmentation and Coordination

Austin (2002) argues case management can only be understood in its context of welfare systems, within which Kodner (2003) identifies a number of challenges for service providers that cross international boundaries. Regardless of country, system or setting, he notes difficulties associated with the provision of comprehensive assessments, putting together packages of care, coordinating services from multiple providers and managing these activities within budgetary constraints. Citing Leutz (1999, in *ibid*), he identifies 'coordination' as the mid-level example of three integrative strategies (between 'linkage' and 'full integration') designed to address the fragmentation that arises from different services being the responsibility of multiple jurisdictions, institutions, professions, and funding streams. Kodner identifies case management as a key example of a mid-level strategy.

Moxley (1989) identifies six key factors which underpin the development of case management. These are:

- De-institutionalisation
- The decentralised nature of community services
- Growing numbers of service users with multiple needs living at home
- Fragmentation of care services

- A growing awareness of the importance of social supports and carers

- The need for cost containment

Moxley's factors underpinning the development of case management and the difficulties for service providers outlined by Kodner (2003) above overlap with each other in a number of dimensions, as illustrated in **Figure 4.1** below.
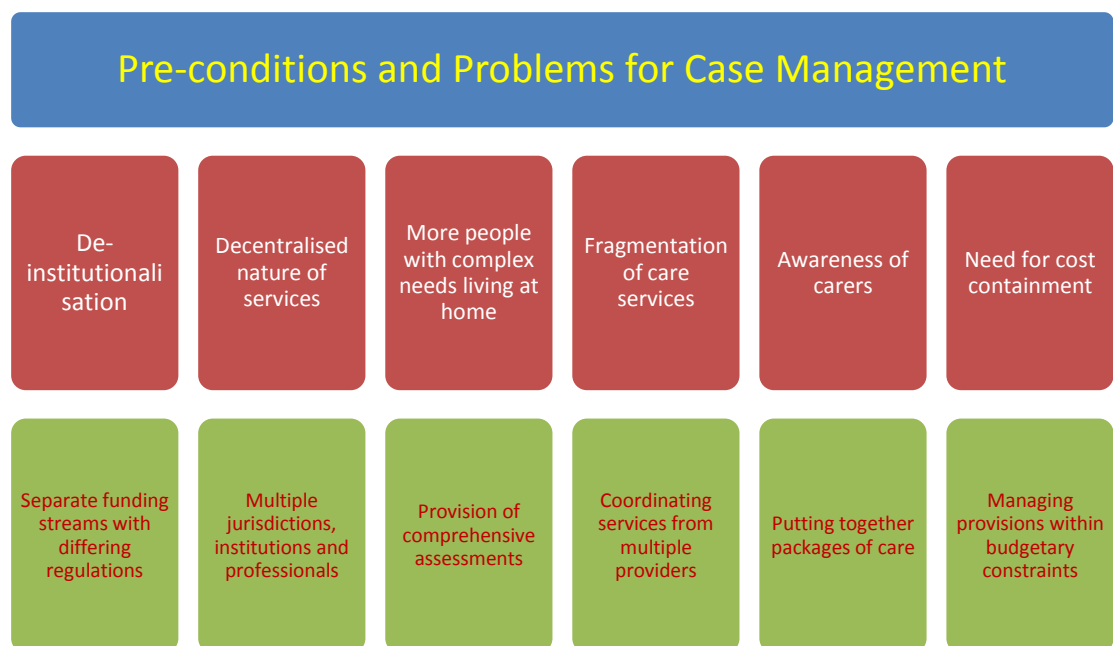
Figure 4.1: Pre-Conditions and Problems for Case Management

(Source: Adapted from Moxley, 1989, Kodner, 2003)

Moxley's (1989) formulation suggests that, providing those prior conditions prevail in any given welfare context, case management may furnish an appropriate solution to the kinds of problems engendered, for example those identified by Kodner (2003).

Challis (2003, p.139) also highlights governments' "perennial concern" to identify means of achieving coordinated and integrated long-term care and states that this can be examined at three different levels in the care system: inter-agency coordination; interprofessional coordination; and case level coordination. Noting their ultimate inseparability, he locates case management within the third of these levels. Noting Austin's (1983, in Challis, 2003) view that the origins of case management lie in the need to coordinate delivery of long-term care services to individual clients, Challis adds that it includes a broader range of objectives, specifically both the provision of client-centred care and the effective use of resources, twin elements traced by Ewers (2005a) back to the earliest forms of social work practices in mid-nineteenth century USA that included both advocacy and gatekeeper roles, a tension that prevails in case management to this day.

4.3.2 Case or Care Management?

Austin (2002, p.178) asks "What is case management?", and responds by noting that, despite more than three decades of literature, the fundamental question of case management's definition remains open. Challis (2003) also acknowledges the numerous definitions and the variable terminology surrounding case and care management. He tracks how, prior to the reforms of the early 1990s in the UK, the Griffiths Report (1988) talked of 'care management', whilst the subsequent White Paper *Caring for People* (Department of Health, 1989) referred to 'case management', only for the eventual guidance from the Department of Health (1991) to revert to 'care management'. As we will see in the discussion of *Case Management* in

Germany, this variability can be problematic, particularly in the context of cross-national research. In the UK the settled term became care management, justified by the Department of Health at the time as more accurately depicting a process in which it is the *care* that is managed, not the person, thereby avoiding any potentially demeaning effects of referring to people as 'cases' (Challis, 2003). Challis identifies a similar debate in both US and Canadian contexts, and a degree of interchangeability in the use of the terms. He maintains that the precise terms in use are less important than the clarity of meaning attached to different aspects of the process. For the purposes of this thesis, then, I will refer to 'case management' as the generic term, '*Case Management'* when referring specifically to Germany, and 'care management' when referring to England.

4.3.3 Definitions

Gursansky *et al.*(2003, p.17) identify a "remarkable agreement about the focus of practice" in the international literature, despite the diversity of forms of case management that have emerged in different settings, listing outreach, screening and intake, comprehensive assessment, care planning, service arrangement, monitoring and reassessment/review as the accepted core characteristics of the approach. This (almost) exactly matches the consensus noted by Austin (2002) that case management as a concept can be identified in terms of the following core tasks:

- Outreach
- Screening

- Assessment

- Care planning

- Plan implementation

- Monitoring

- Re-assessment

Indeed, early internet based research for my Fellowship proposal unearthed the following outline in **Table 4.1** of the core tasks from *Rund ums Alter*'s service description or *Konzept*, which I compared with the original care management guidance issued in the UK (see Section 4.4), both of which also reflect the above. I will return to the comparability of the 'core tasks' in Chapter 6.

Department of Health Guidance	*Rund ums Alter Konzept*
- Providing information - Assessing need - Care planning - Implementing the care plan - Monitoring the care plan - Reviewing the need and altering the care plan if necessary	*Beratung* (Advice) *Assessment* *Zielvereinbarung* (Agreement of Goals) *Hilfeplanung* (Care Planning) *Leistungssteuerung* (Directing Services) *Leistungsüberwachung* (Monitoring Services) *Evaluation* (Review) *Entpflichtung* (Closure)
(Department of Health, 1991)	(Rund Ums Alter, 2005)

Table 4.1: Comparing Core Task Definitions

Kodner (2003) in turn summarises case management as a comprehensive and systematic process of assessing, planning, arranging, coordinating and monitoring multiple long-term care services for the individual service user

across time, setting and discipline. Each of these definitions more or less maps across the others but with some elements either broken down into further sub-components or labelled slightly differently. Case management emerges conceptually, then, as a composite definition with fuzzy boundaries comprising relatively distinct components as below:

Figure 4.2: Case Management

Additionally Gursansky *et al.* argue the following principles underpin case management:

- Individualised and tailored service delivery that involves the client in planning the service mix, ensuring choice and contracted arrangements that maintain accountability to the respective parties

- The service arrangement for any given client is planned and established by drawing on a range of formal and informal service providers—it is not based on what can be offered from one organisation

- The principles for the service are encapsulated in notions of boundary spanning, seamless service delivery and integrated services.

- Outcomes are specified and the and the case manager plays a critical role in monitoring and responding to changing circumstances to ensure timely, efficient and cost-effective service delivery

- Advocacy for individuals and in relation to system change

(from Gursansky *et al.*, 2003, p.201)

For Challis (2003) the definition of case management consists in the possession of the following attributes: coordination and linkage functions; the goals of integrated care and continuity of care; a focus on promoting home based care, client well being and making better use of resources; the core tasks of case management (which map against others' core task definitions above); targeting; differentiation through both intensity of involvement and breadth of services spanned; and multi-level responses, linking practice and agency levels (see Table 4.2 below).

Key Attributes of Care Management	Distinctive features
Functions	Coordination and linkage of care services; tailoring resources to needs
Goals	Providing integrated care with continuity; increasing the feasibility of care at home; promoting client well-being; making better use of resources
Core Tasks	Case-finding and screening; assessment; care planning, monitoring and review; case closure
Target population	Those with long term care needs; multiple service recipients; those at risk of losing community tenure
Differentiating features	Intensity of involvement; breadth of services spanned; duration of involvement
Multi-level response	Linking practice level activities with broader resource and agency level activities

(from Challis 2003, p. 148)

Table 4.2: Defining Care Management (Challis)

In turn, Ewers (2005b, p.54, *my translation*) in his review of the approach suggests "the core of case management consists in bridging the temporal and spatial dimensions of care processes and responding to the key challenges of highly complex and specialised health and social care systems, in line with the goal of continuous and integrated care". He further identifies three core functions that have emerged from case management's main purpose of resolving problems that derive from the various boundaries and interfaces between different sectors and providers in the care system. The first of these is *advocacy*, targeted at those unable to represent their own interests effectively and requiring support. He links this to a 'clinical case management' model involving direct helping skills and a client-centred perspective that assists with identifying and accessing appropriate services. He stresses how this emerged

in the context of US welfare norms of conditionality, in which few services are rights-based, but notes too that this advocacy function is important in the context of European welfare, specifying in particular the increasing complexity of systems and services, and noting the difficulties involved in turning abstract rights into concrete provisions.

The second function Ewers identifies is *brokerage*, the simplest form of case management and differing from the client centred advocacy function in its strongly institutional and/or organisational orientation. This emerged in response to the uncontrolled growth in the number of health and social care providers in the USA during the 1970s and 1980s and the associated fragmentation of the care landscape. In this function, a case manager serves as a neutral middle person or 'honest broker' between the service users and potential service providers. For this role to be performed successfully, Ewers argues case managers should not be located within a service providing organisation so that they may act independently of vested interests. This independence, however, comes at the cost of influence over the quality of services provided, in that brokers may draw attention to poor quality service but have no direct influence over service development.

The third core function Ewers identifies is *gate keeping*. This concerns contractual control or constraint of access to publicly financed care services. He locates its emergence as a response to the expanding duties of both Medicaid and Medicare in the USA, in the context of long term financial constraints. He notes its orientation to wider society inasmuch as this function is often

associated with overarching issues of equity of access in the context of limited

resources, as well as pursuit of specific aims such as reducing access to more

expensive institutional care. The case manager as gatekeeper occupies a

central position between the service user and the resources of the care system,

with the result of the assessment determining access to those resources.

Ewers emphasises that these three core functions are not nearly so clearly

defined in reality as he presents them in 'ideal-typical' fashion but notes the

three competing functions combine in different ways and with different

emphases in various conceptualisations of case management. It is not difficult

to conceive of these different functions as potentially mutually antagonistic.

Austin (2002) cautions too that considerable variation remains in how case

management is delivered in different settings serving different user groups. She

argues that a narrow focus on how each of the core tasks is implemented would

not sufficiently describe what case managers actually do and suggests that one

way of being more specific about case management practice is to "unbundle" it

(Austin, 2002, p.78), by identifying specific case management practices in a

particular context.

Nonetheless, there are clearly overlaps between these varying,

multidimensional approaches to defining case management as a concept, even

if the plethora of dimensions and attributes indicate a desire to make case

management more specific through the addition of additional elements above

and beyond its most basic features. Summarising the above, these can be

identified as a process of assessment and the arranging and coordination of care inputs from more than one source. This baseline description incorporates the most elemental of the 'core tasks' and would fit within both Kodner's (2003) and Ewers's (2005b) overarching definitions, reflecting in addition the latter's definition of 'brokerage' as the simplest form of case management. It also allows a degree of distinction from generic notions of 'casework' if this is narrowly understood as help provided from within a single agency or service in which the main resource is the helper her/himself. The additional attributes suggested either as definitional (e.g. Challis's (1999, 2003) longstanding argument regarding the targeting of specific user groups) or as aspects of good practice (Gursansky *et al.*, 2003), or indeed as particular functions such as gatekeeping or advocacy (Ewers, 2005b) may depend more upon the specific circumstances within which case management is implemented, but also draw attention to the potentially very wide applicability of a more basic definition.

4.4 Care Management in England

In a review of care management arrangements for older people in England, Weiner *et al.* comment that:

> Service changes in the United Kingdom reflect what might be described as broad international community care convergence, which reflects the similar goals of many governments despite significant variations in organisational structure and patterns of funding.

(Weiner *et al.*, 2002, p.419)

This convergence is also noted by the European Union's 'Observatory on Ageing and Older People', which highlights a consensus that care in the community, rather than in institutions, is the most appropriate policy for older people (Smith, 2003) – the de-institutionalisation highlighted by Moxley (1989), above.

Case management was first trialled in England as part of the Thanet Community Care Project in Kent (Challis & Davies, 1985). Case managers were specially trained social workers in the local authority, to whom budgets were decentralised to facilitate the coordination of a range of more flexible services around a group of service users targeted because of an identified risk of entering institutional care. Case managers holding devolved budgets effectively acted as micro-level purchasers, using their budgets to fund mixed packages of care from multiple sources in order to maximise allocative efficiency. This project was influential on the development of community care policy in the UK (Onyett, 1992), in which case management, re-named 'care management', was incorporated into policy during the implementation of the NHSCCA in the early 1990s, although key elements of the original pilots were in fact not retained, with care management instead developing as a mechanism for delivering care to all users rather than specific groups (Challis *et al.*, 2001). Budgets were not devolved directly to care managers either, most authorities instead instituting a separation of purchaser and provider functions.l

The wider context for the development of community care legislation was clearly the demographic shift in the UK population which, in common with most

'developed' countries, is showing a marked increase in the numbers of people surviving to older ages, with consequences for the organisation and funding of both health and social care. Wiener *et al.* (2002) also identify budgetary pressures as a driver of community care policies, but note too previous funding anomalies that led to perverse incentives to enter residential care, thus working against long standing policy objectives to provide more care at home. Previous arrangements for the provision of residential care for older people had led to a situation where government financial support (through means-tested social security payments) for private sector residential and nursing home care ballooned from £10 million in 1979 to over £1 billion ten years later (Evans, 1994). Evans describes how the NHSCCA closely followed the recommendations of the 1988 Griffiths report, with the consequence that the Department of Health and Social Security budget for residential care was re-directed to local authority social services departments. These budgets came with a series of conditions designed to promote the provision of the provision of support in the home or in residential care following an *assessment of need* as well as of means, with the aim of reducing the use of the latter form of care.

In addition, local authorities were expected to take on a new role as planners and purchasers of services rather than direct providers, the transfer of the funding for services coming with the requirement that 85% of it must be spent on provision by outside agencies, a condition highlighted as critical in securing the agreement of then Prime Minister Thatcher, who was extremely reluctant to grant local authorities greater powers (Lewis & Glennester, 1996). Local

authorities became responsible for developing the local market, particularly the

private sector provision of care in the home (Glendinning, 1998).

Key objectives included (Evans, 1994):

- the promotion of services designed to help people to continue to live in their own homes;

- highlighting the needs of carers;

- the establishment of needs-based assessment and care management as the key mechanisms to achieve high quality care;

- the development of a 'mixed economy' of care, i.e. independent sector provision alongside public services;

- the clarification of different agencies' responsibilities to facilitate accountability; and

- the achievement of better value for money in tax-funded services.

These objectives were to be achieved through the process of 'care

management', which comprised: the identification of people in need; the

assessment of care needs; the planning and delivery of care; monitoring the

quality of that care; and subsequently reviewing the service user's needs – the

'core tasks' of case management. It was intended that care managers should

act as purchasers of care, in the context of services contracted by local

authorities from local private providers, placing the exercise of choice not with

the service user but those acting on their behalf (LeGrand & Barlett 1993, in

Lewis *et al.*, 1997).

The NHSCCA established the framework for all subsequent developments in adult social care provision, implementing 'needs led assessment' and 'care management' in accompanying detailed policy, management and practice guidance (Department of Health, 1991, Challis, 1999). Glendinning (1998) notes how these processes were emphasised as the main methods for improving the targeting and coordination of services for older people, the former intended to promote a needs-led rather than service-led approach, the latter to maximise the appropriate tailoring of individualised packages of services to the assessed needs and choices of the older person, but highlights the subsequent use of assessment as a mechanism for prioritising needs and gatekeeping. Indeed Payne (2000) argues that the need for cost constraints was so influential that the assessment aspect of care management came to dominate practice. He cites as evidence the title of the guidance, 'Care Management and Assessment', noting that *assessment* is, in fact, inherent in all models of case management. He points to 22 pages of guidance on *assessment* compared with 28 pages for all the other core tasks combined, and maintains assessment was treated as a way of rationing services, rather than as a basis for creating new and more flexible types of provision. He sees this as the key to understanding how care management became bureaucratised. In this way, the re-naming of 'case management' as 'care management', ostensibly focusing attention back on the personal nature of the service (Gursansky *et al.*, 2003), or emphasising the management of the care process rather than the individual (Onyett, 1992, Wendt, 2001), came to be seen as contentious by many from the beginning (Onyett, 1992, Huxley, 1993, Payne, 1997). Core critiques concerned the

privileging of managerial concerns over those of professional social work (Payne, 2000, Lymbery, 1998) and, for Huxley (1993), the removal of key reference points for comparative evaluation introduced by the change in terminology. Indeed Weiner *et al.* (2002) suggest the general lack of specificity in the early definitions of care management was in fact intentional to allow for a degree of latitude in its interpretation.

Means and Smith (1998) describe how, under systems prevalent before the NHSCCA, service users were expected to fit into existing service requirements, and that the service they ultimately received was often dependent on what kind of professional undertook the assessment. As Challis (2003) notes, when care management was introduced in the UK, community services were nearly all provided by two public sector sources, the NHS and local authority social services, suggesting in principle little need for coordination. However he identifies the *internal* divisions of service providers into various professional and service hierarchies as causing service users' experiences of fragmentation and lack of coordination. It was perfectly feasible for two people with similar needs to receive different services from a local authority, for example, either home care or equipment services, simply depending on which service received the initial request for help. The community care reforms were intended to challenge this type of service led approach, particularly through the 'purchaser/provider split'.

Lewis *et al.* (1997) note the impact of simultaneously implementing the purchaser/provider split, a dimension unknown to the PSSRU pilots, that was

not understood to be necessary to the successful implementation of care management. However, they also note a long history in social services departments of simply assessing for available (in-house) services and the argument that if the pattern of response was to respond to need, assessment had to be separated from service provision. Such approaches have, however, proved difficult to shift. Some evidence suggests that the conceptual difficulty of separating 'need' from 'need for a particular service' combines with the influence of ever-tightening eligibility criteria to form the main constraint (Parry Jones & Soulsby, 2001), conclusions reflected in a small scale study in my own authority undertaken in the first phase of this doctoral programme, in which I identified highly 'silo-ed' responses to referrals for older people needing help that led to multiple (and unnecessary) assessments.

Despite the extensive national guidance, Challis *et al.* trace how local authorities implemented community care policy and interpreted care management practice in quite different ways, concluding that "consistent systems of care management arrangements did not emerge from our analysis" (Challis *et al.*, 2001, p.680), a view that concurs with earlier research. Lewis and Glennester (1996) in their detailed study of the implementation of the community care reforms in five different local authorities reveal confusion about how to implement case management. They note the authorities' efforts concentrated on the establishment of assessment systems in response to the Government's deadline, leading to them devoting little thought to developing the care management process as a whole. Even in authorities that took the larger view, certain aspects remained problematic, particularly review. Drawing on

data from the same study, Lewis *et al.* (1997) comment that there was no common understanding as to what care management should mean or who should be care managed, identifying some 13 different models in the official guidance. In the five local authorities they investigated they found particular confusion regarding whether care management is a role or a process, as well as who care management is intended for, noting that even in a small sample of five, each of the authorities exhibited very different models of care management.

Reviewing post-1993 studies for a Royal Commission on Long Term Care, Challis (1999) highlights the following areas for development in care management arrangements from his analysis of a range of official inspection reports: lack of clarity around eligibility and targeting; poor quality and variable assessment; little evidence of devolution of budgets to enable micro-purchasing; little attention paid to monitoring and review due to the management focus on assessment; contrast between service users' positive valuing of continuity of care manager involvement and the rarity of this in practice, with most care managers no longer involved after the assessment stage; confusion about the nature of the role of care manager and the content of activities they were meant to undertake; and few properly formulated links with health care services.

In a national survey of local authorities in England Weiner *et al.* (2002) examined a range of key indicators of variation in care management arrangements and found considerable variation concerning whether care

management was constituted as a role undertaken by an individual or a process undertaken by an agency, as well as wide variation in the extent to which a social work style is deemed necessary for care management with older people. They conclude it is likely that service users with similar needs in different local authorities will have very different experiences of the care management process.

In summary then the shift in nomenclature from 'case management' to 'care management' caused some, as highlighted above, to be concerned that it signalled a move to a more administrative and bureaucratic form of practice, and away from more 'clinical' approaches making explicit use of traditional social work skills. Questions about the nature of care management also remain unclear, particularly whether it is a process or a role, and about the related issues of continuity of care manager involvement and patterns of review. As outlined in the previous section, there is by contrast broad agreement around key elements that define the practice (the 'core tasks'). The question of who should receive a care management service appears unresolved, with little evidence of local authorities differentiating intensive care management, targeted at older people at risk of institutionalisation, from more general processes of giving information and advice or coordinating high volume but relatively straightforward services, as envisaged by subsequent policy guidance (Challis, 2003). At the same time, there is evidence of a wholesale shift across the UK away from institutionalised care to support in the home (de-institutionalisation, as discussed above) since the implementation of the NHSCCA (Knapp *et al.*, 2001), with care management, despite the ongoing absence of clarity,

understood as having been central to that outcome. Most of these concerns are mirrored in my professional experience across different local authorities, in particular the variation in practices, the absence of targeting and issues with regard to continuity of care manager involvement.

4.5 *Case Management* in Germany

As noted briefly in Section 1.1 (and explored in more detail in the next Chapter), the policy framework for long term care in Germany has been quite different. The main legislation (SGB XI Care Insurance), although implemented at approximately the same time as the NHSCCA, addressed a different set of problems that nonetheless emerged from a set of financial pressures on key institutions within the more decentralised Federal German system, in the context of similar demographic changes. Specifically, both the health insurance funds and the *Land*-level governments were under pressure because of the former's responsibilities for provision of care under certain circumstances under the health insurance arrangements that led, for example, to 'revolving door' hospital admissions because each admission triggered eligibility for four weeks post-discharge care, and the latter's responsibility to pay for care when individuals or their families could no longer afford to do so (Morel, 2007). These pressures contributed to the decision to establish a new branch of social insurance to cover the risks of long term care in 1994. As previously noted, however, this new legislation made no provision for any kind of case management (Glendinning & Igl, 2009, Evans Cuellar & Wiener, 2000), leaving

its adoption and development to pilot projects and/or regional developments, such as those in Berlin.

From the beginning case management's roots in the Anglophone world were controversial. Ewers and Schaeffer (2005), locating the emergence of case management specifically in German social work literature from the late 1980s, describe an early attempt to introduce the term *Unterstützungsmanagement* ('support management') led by Wendt (1991, in *ibid.*), under which various components taken from both US and British models were combined and incorporated into German health and social care services. They note this development was less influenced by the earlier, older history of case management in American social work, drawing instead on the versions of the 1970s and 1980s that emerged from neo-conservative health and social policies, with their concomitant emphasis on cost containment, and system rather than client orientation. Whilst recognising the opportunities this offered for the modernisation of social work in Germany at the time, they argue nonetheless that it was little more than an uncritical adoption of British and American models that took too little account of the differing welfare contexts of the USA, UK and Germany. Wendt (2001) refutes this, however. Having abandoned the use of *Unterstützungsmanagement* in favour of *Case Management*, he states unequivocally that whilst case management fits flexibly to changing circumstances and conditions in human services, its core concept remains independent of the specifics of the service areas within which it is implemented, i.e. the different shapes case management adopts in practice do not imply a fundamentally different conceptual underpinning. He notes the

criticism levelled that the method was simply imported into German circumstances from the USA but counters that it was case management as a *systematic concept* that was incorporated into various German pilots, not American case management *practices*.

Ewers and Schaeffer (2005) identify three broad models of *Case Management* adopted in Germany. The first is the provision of *Case Management* by neutral institutions, the model adopted in *Rund ums Alter*, in which there is a characteristic strict separation of the management and coordination of services from their provision, a model they claim derives from the 'sovereign consumer orientated' British health system (not something I recognise but possibly a reference to the 'purchaser/provider' split in both health and social care in the UK – although this German model is independent from both purchasers [*Kostenträger*[8]] *and* providers). This model emerged in response to the trend in older people's care away from institutional settings (*stationär*) and into community settings (*ambulant*), the ubiquitous core condition of de-institutionalisation noted in Section 4.3.1 that creates the need for the basic coordinating function of case management. They question, however, whether developing local care structures using this model actually leads to the consolidation and continuity of care envisaged, or whether it simply adds a further element to an already confusing health and social care system without significantly affecting its efficiency or effectiveness. The second model they outline is the provision of *Case Management* by providers of services, both institutional and community based, noting in particular pilot projects in hospital

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[8] 'Bearers of costs', see Section 2.3 for discussion of the term '*Träger*'

social service offices that addressed improved transitions between the two

sectors, as well as initiatives to develop a stronger general practice model in

medicine, in which 'patient escorts' (*Patientenbegleiter*) or case managers work

alongside GPs to coordinate medical and non-medical therapeutic interventions.

The third model consists of *Case Management* within purchaser organisations,

particularly the Health Insurance Funds, in which alternatives to hospital

services are sought out or in which case managers control and coordinate

specific intensive, expensive services such as rehabilitation. They note this

model draws inspiration more from US 'managed care' than either British

influences or German social work orientated *Case Management*.

In a two-part schema Wissert (2004, p.29-30) collapses these latter two models

into one category of "institutionally-embedded *Case Management*", in which it is

closely aligned to the economic interests of purchasers or providers. He notes

that examples of *Case Management* projects in older people's services have

largely been configured as his second category of "independent *Case

Management*", mirroring Ewers and Schaeffer's first category above. He

presents two main reasons for this, noting firstly the problematic presence of

multiple actors in the system and their sometimes conflicting interests, which an

independent agency is more able to question or challenge. Secondly, the 'gate

keeping' function of case management requires case managers to sometimes

reduce or otherwise make recommendations about service level or provision.

Formal independence from the economic interests of purchasers or providers

reassures *Case Management* clients that such care planning is based on their

best interests and not on the financial requirements of care organisations.

In older people's services formal *Case Management* has largely been confined to pilot schemes (see, for example, Klaes *et al.*, 2004), in contrast to both the longevity and comprehensive regional coverage achieved by *Rund ums Alter* (see Section 5.5) after its early pilot phase. In terms of what might be termed 'care in the community' *Case Management* has not had, at federal level (at least before the reforms outlined in Section 5.6), the same policy drive behind it compared to England. Nonetheless, variations of case management, differentially named, have emerged in other areas of social policy, such as *Fallmanagement* (*Fall* is German for 'case') with regards to case management reforms in employment services, and *Versorgungsmanagement*, or 'treatment management', introduced in a health care reform intended to encourage integrated treatment and recovery, adding a specifically German dimension to the problems of nomenclature and definition outlined in Section 4.3.2. I discuss the specific use of the term *Case Management* in *Rund ums Alter* in more detail in Sections 5.5.4 and 6.5.2.

Of particular note is the differentiation commonly made in German between the terms *Case Management* and *Care Management*, the former referring to the micro-level constructed around the needs of the individual service user and the latter referring to the system level coordination required to enable case management at the micro-level (Frommelt *et al.*, 2008), a factor of particular importance in the multi-actor German welfare system, which effectively codifies Challis's (2003) additional definitional dimension of a multi-level response, linking practice and agency levels. Whilst this has emerged from the indistinct

terminology in English (case management, care management, and also 'managed care' in US health policy), usage in German has solidified into a clear conceptual distinction between client-orientated and system-orientated elements of the approach, particularly in social work discussions of case management (e.g. in Remmel-Faßbender, 2005), an example of how the meaning of words adopted from another language continues to shift and refine in relation to their new social and linguistic contexts (see Sections 2.3 and 6.5.1). This distinction is built into the service concept of *Rund ums Alter* and differentiates the roles of the team leader and the social workers (see Section 5.5.3).

4.6 Case Management in 'Border-Crossing' Studies

To date, I have identified only one comparative study with a specific focus on case management in older people's services, which was commissioned for a German federal government department (Engel & Engels, 1999), to which I will return below. Case and care management for older people, however, features in a number of other studies with wider policy and/or substantive concerns.

Tester's (1996) work is a comprehensive comparative overview of community care policy for older people in six countries, the UK, USA, France, Italy, the Netherlands and Germany, within which she addresses case and care management in a chapter devoted to coordination of community care services. In Germany she identifies little coordination between hospital and community based services, or more generally between different health and welfare

services, noting that whilst the need for coordination of services for older people was often recognised in overall plans and strategies at various levels of government, these strategies mostly did not provide for long term funding of piloted coordination projects, identifying this as a general weakness shared with other countries. She concludes that German policy did not prioritise the promotion of coordination. More broadly, she concludes that the (at that time) relatively new system of care management in the UK offered the most potential for providing coordinated care but noted even then the local variations arising from the effects of conflicting aims embedded in the policy, particularly the influence of cost reduction. Despite the policy initiatives and processes implemented to promote coordination across the six countries, she finds little evidence to suggest coordinated community care had been achieved.

In a "micro-level comparison" Schunk (2001, p.223) focuses on care services for older people in two cities, Manchester and Nürnberg, looking at the degree to which the respective pathways through care systems empower older service users. She also highlights the absence of case management in the German system, noting the strict focus on determining care needs employed by the Health Insurance Medical Service, whose responsibility this is within the German system (see Section 5.3.3). In the Nürnberg case study she notes that people with care needs were likely to become dependent upon their informal carer's decision-making and/or the interests of service providers. By contrast the care planning and brokerage roles of the care managers in Manchester allowed for a degree of variability and flexibility in care arrangements, depending on the care manager's local knowledge and contacts, although she

notes this advocacy could be constrained by managerial control of resource allocation. The process for people needing care in Manchester becomes a matter of negotiation through the care manager rather than a matter of individual choice, in a system characterised by multiple assessments and waiting lists, with the care manager as the ultimate decision maker, not the service user. In Germany, by contrast, once eligibility has been agreed, the selection of services is entirely up to the individual. This apparent freedom, however, could be constrained as noted for those with little control over their pathway through care when decision making may be taken over by family members or service providers.

PROCARE is an EU funded multi-country study that investigated the integration of health and social care services for older people in nine European countries, including Germany and the UK. In the German case study (Roth & Reichert, 2004) they note the marked fragmentation of health and social care services and long standing complaints about a lack of coordination, describing the legal and structural frameworks for provision of health and social care services to older people as very complex. They also note the emergence in the German literature of the distinction between *Case Management* and *Care Management*, and highlight a constant lament in the literature at the lack of coordination. Yet they also identify a pattern of funding pilot schemes with varying degrees of success that nonetheless fail to make the transition to permanent funding, concluding that there is a need to integrate financing systems and overcome institutional barriers in the German health and social care system. Oddly, in the UK case study (Coxon *et al.*, 2004) there is no specific mention at all of care

management, although there is discussion of the NHSCCA. Mostly they focus on policy initiatives intended to straddle the so-called 'Berlin Wall' between the NHS and social care services. In an overview of all nine countries (Leichsenring, 2004) case management is identified as a key instrument in integrating health and social care for older people, but, contributing to the definitional confusion, 'case management' and 'care management' are differentiated differently by identifying the former with social care and the latter with health care, although the German distinction is also acknowledged. Leichsenring notes the use of 'case management' in most countries but with different interpretations, highlighting in particular a distinction between countries where case management is seen as a mainstream service (UK, Netherlands and the Nordic countries) and those where it features predominantly in model projects or pilot schemes (Germany, Austria, Italy and France). Key issues identified are: who the case/care manager is, their professional background, training and the degree to which they are given the means to steer care processes and act as an advocate for the client. In a separate contribution from the same study, Nesti *et al.*(2005) note in particular the variation between countries in the degree of formal or informal recognition accorded the case manager role and in the concluding section of the same volume, Billings *et al.* (2005, p.250) identify case management as one of a number of "elements for successful integration processes" which emerged from the study overall. While noting alternative definitions in different countries, they highlight a common model within which a single professional takes responsibility for managing the entire care process.

Finally, for the comparative review of case management commissioned by the German federal government, Engel and Engels (1999) identified both a partner organisation and a named expert in three German *Länder* and eight other (national) states: Belgium, Spain, Israel, Italy, Luxemburg, the Netherlands, Austria, and the UK. The aim of the work was to place national variants of case management in the care of older people into an international comparison. The individual country reports were also published separately in an English language volume (Engel & Engels, 2000).

Engel & Engels (1999) state that the prevailing circumstances in each of these countries is what renders them comparable (see Section 2.1 above), inasmuch as each of their systems is facing new challenges because of the increasing number of older, and, in particular, very old people who need services and support in the community. They also note that many countries experience a system-level division between health and social care, leading to endemic communicaon problems between medical and social care professionals. They comment, however, that the different organisational forms that health and social care services take in the individual countries shape the way the basic notion of case management is adapted in each instance. The overall aim of the research was to produce an informative analysis of the various ways in which case management is experienced and implemented in older people's services, from which models for successful problem resolution as well as good practice can be disseminated internationally. The authors note similar definitions of case management across the different country reports but significant variation in the forms in which it is implemented. Differences also emerge in the degree to

which case management is embedded in the care system. Reflecting the findings of PROCARE, Engels and Engels differentiate between variants of case management that are formally integrated into their respective care systems (highlighting the UK as the forerunner in this respect) and countries where no entitlement to case management support exists and it mainly appears in model projects. They note that the greater the integration of case management within a particular system, the more it is accepted by different stakeholders, something I will return to in relation to *Rund ums Alter*. They identify the same definitional components of case management across most of the projects (i.e. case finding, assessment, planning, linking, monitoring, evaluation, documentation) that (more or less) reflect the 'core tasks' identified in the wider literature (see Section 4.3.3 above). They state case management is most efficient when it is separated from the functions of service providers and/or funding agencies, to avoid possible conflicts of interest.

4.7 Postscript on Policy Changes

As Nutley *et al.*(2007) outline, research and policy operate to different and often conflicting timescales, with the former often reporting over much longer time periods than the typically shorter timescales adhered to by policy makers. They note it is not unusual for policy agendas to change before research projects have had chance to report. In this study, the policy environment in Germany changed shortly after my arrival, with the publication of draft reforms to SGB XI, the care insurance legislation, two elements of which were of direct relevance to the research site. I will explore the potential impact of both the new entitlement

to specific *Pflegeberatung* ('care advice' – a form of case management) and the potential establishment of *Pflegestützpunkte* (Care Support Centres) for *Rund ums Alter* and the project's practice of *Case Management* in Section 5.6.

In addition, the policy landscape for adult social care in England underwent a dramatic shift in the four months I spent in Germany, symbolised by the publication of Putting People First (Department of Health, 2007), the impact of which on care management practice in relation to personalised services is yet to be fully felt, particularly with regards to specific ways older people may need support in this newly configured landscape. This is an issue highlighted in the first formal evaluation of the piloting of individual (personal) budgets (Glendinning *et al.*, 2008), to which I will return in Chapter 7. 'Similar' pilots (*persönliches Budget*) were also underway in Germany (Klie & Blinkert, 2008), a different example of a border-crossing policy that also raises questions of translatability, but which had not yet been implemented across Germany at the time of this research. Finally, *Fair Access to Care Services* guidance (Department of Health, 2003) was superseded by *Prioritising Need in the Context of Putting People First* (Department of Health, 2010), but the core criteria (see Appendix 6) are retained.

4.8 Summary

In this chapter I have outlined the problems for the organisation and delivery of welfare services associated with the shift from institutional to community-based

services and the emergence of case management in the USA as a core response to those problems, an approach which subsequently departed its welfare system of origin, crossing international borders into very different welfare contexts. Noting the variability in both nomenclature and definition of case/care management I have identified a core differentiating function of coordination of service inputs from different sources that nonetheless remains open to broad interpretation, and remains subject to attempts to make it more specific. I have also provided an overview of issues identified in the English care management literature that have arisen since its implementation as a key component of the community care reforms of the early 1990s, to which I will refer in Chapter 6 when considering the question of comparability. In contrast, I have outlined the debate concerning the adoption of case management in Germany, where the federal-level reforms to the care system in the 1990s explicitly did not provide for a case management function, leaving its development to either pilot projects or regional initiatives. This contrast between those care systems with an embedded case/care management function and those without is highlighted in the review of comparative studies that follows, an issue which I show the German care system has responded to in recent reforms in the overview of current policy changes in both England and Germany that closes the chapter. In the next chapter then, I will outline one example of a regional development in Germany, a long-standing *Case Management* service for older people in Berlin, in relation to its wider policy and legislative context.

Chapter 5 - Case Study: A *Case Management* Service in Berlin

5.1 Introduction

Figure 1.1 (p.19) provides a framework for the case study below and (imperfectly, as I will discuss) for the discussion of comparability that follows in the next chapter, indicating the influence of each level upon the next, from the wider cultural context through to the interaction between the case manager and her/his client. In order to answer the core descriptive research question "What does this example of *Case Management* look like in its specific legislative and social policy context?" I need to answer two related questions:

- How is help for people with social care needs organised and provided in the Federal Republic of Germany?
- How does *Rund ums Alter* in Berlin fit with these arrangements?

In the following chapter then I will first of all describe the wider historical, social policy and legislative contexts before locating *Rund ums Alter* in relation to that legislative and policy framework.

5.2 Wider Historical and Political Context

Esping-Andersen's (1990) typology describes Germany as the classic corporatist-conservative welfare regime, influenced by the Church, and emphasising tradition, family, and status differentials that are strongly linked via

social insurance structures to a person's occupational status (Walker &
Naegele, 2009). These characteristics are rooted in Germany's history. To
counter the influence of the nascent labour movement (Pfaff, 2009) Bismarck
introduced social insurance in the 1880s to protect industrial workers against
the risks of sickness, industrial injury and old age (unemployment insurance
was added later), establishing the foundations of the German social insurance
state, with its distinctive distribution of responsibilities between state and non-
state actors within a framework strongly influenced by the principle of
'subsidiarity'. This requires that higher and larger levels of social collectivity
should only intervene when the family's capacity for mutual protection is
rendered impossible (Esping-Andersen, 1990), and has its roots in Catholic
social thought. Subsidiarity is a legacy of the political influence of the Centre
Party, set up to represent Catholics in the newly unified and potentially
Protestant dominated German state (Hoecklin, 1998). The main features of this
Bismarckian pattern of social provision have endured to the present day,
despite the disruptions of two world wars, the interwar period of Nazi rule, and
the 40 year history of the German Democratic Republic (Leisering, 2001).

Evers and Sachße (2003, p.55) highlight a different and older history of welfare
benefits and services that grew out of local poor laws, noting the "twin
foundations of different size and age" of the German welfare state made up of
the relatively more modern nationwide systems of social insurance plus tax
funded services such as education, and more discretionary and often locally
based services and benefits that emerged from this older inheritance of poor

law relief, a pattern also seen in other (post) industrial countries. Provision of long-term care has shifted between these 'twin foundations' (see Section 5.3.3).

The Federal Republic was founded in 1949, and its eastern bloc post-war counterpart the German Democratic Republic absorbed in 1990 (Lorenz, 1994). Ginsburg (1993) notes the centrality of the Basic Law (*Grundgesetz*), the Federal Republic's strong written constitution, that puts a firm emphasis on the rule of administrative law and regulation for the governance of social policy, and devolves considerable power within the welfare state to the regional states (*Länder*) and local government. Freeman and Clasen (1994) outline how the interests of the *Länder* are embedded into the federal system. The federal government is responsible to the *Bundestag*, the primary chamber in the German parliament. The *Länder* themselves are directly represented in the second chamber, the *Bundesrat*, which approves the federal budget and also has the power of veto over legislation which directly affects their interests. Having primary responsibility for policy areas such as education and health, as well as controlling social policy planning functions and directly funding means-tested social assistance, the *Länder* both individually and collectively enjoy considerable power, with the federal government often dependent on them for policy implementation.

This in-built, de-centred power structure is further complicated by the presence of what Freeman and Clasen (1994) call 'parapublic institutions'. They note that "large areas of public life are governed independently of the state by a heterogeneous set of parapublic institutions which merge public and private

bureaucracies" (*ibid.*, p. 2), highlighting among these the social insurance funds and the independent social services organisations, or '*freie Träger*', which grew out of the numerous local charities and relief organisations that emerged in the nineteenth century (Bönker, 2007). The interplay between these organisations and the various levels of government is underpinned by the principle of subsidiarity. Freeman and Clasen cite Mangen's (1989, in Freeman & Clasen, 1994, p. 11) description of the federal state as "not itself a universal provider, but, rather, the guarantor and overseer of certain social rights mostly fulfilled by other agencies".

Bönker (2007) highlights the degree to which the *freie Träger* (the independent social services organisations noted above) dominated service provision until the 1990s, providing around two thirds of all personal social services and playing a major role in the formulation and implementation of social policy through their formal incorporation into policy making at local and state level. They are organised into six umbrella welfare associations:

- *Deutscher Caritas Verband* (Roman Catholic)
- *Diakonisches Werk der Evangelischen Kirche* (Protestant)
- *Arbeiterwohlfahrt* (labour movement)
- *Deutscher Paritätischer Wohlfahrtsverband* (a federation of smaller secular agencies)
- *Deutsches Rotes Kreuz* (German Red Cross)
- *Zentralwohlfahrtsstelle der Juden in Deutschland* (Jewish welfare organisation)

Regulatory changes in the 1990s, motivated by concerns the traditional

organisations had become bureaucratic and unresponsive, led to the

encouragement of other independent providers, including voluntary self-help

groups and commercial providers, to compete with the traditional *freie Träger* in

a more contractually orientated welfare environment. The introduction of long-

term care insurance legislation in 1994 formally recognised commercial

providers as contract partners with equal rights (Bönker, 2007). This multi-actor

organisational complexity then provides the context for *Rund ums Alter* in

Berlin. Before considering this organisational context further, however, it is

necessary to consider the federal legal framework governing long-term care and

related services.

5.3 Key Federal Legislation and Policy

In this section, I will outline the main components of German federal law

governing long-term care and related services that form the legislative

environment within which the project *Rund ums Alter* operated.

5.3.1 Overview

The Federal Republic of Germany is formally defined as a 'social state'

(*Sozialstaat*) in its constitution, within which 'human dignity' (*Menschenwürde*) is

codified as a basic right or *Grundrecht* (Freckmann & Wegerich, 1999). The

Sozialstaat can be summarised as a distinctive form of welfare mix that has

emerged from the expansion of traditional Bismarckian compulsory social insurance comprising multiple private, voluntary and government agencies into a system governed by a constitutional framework, particularly the Social Law Code, with its key principles of solidarity, subsidiarity, self-responsibility, and self-administration. The framework represents the consensual outcome of decades of negotiation between the various political parties, different levels of government and the non-governmental stakeholders in the system, all of which is overseen by independent and interventionist constitutional courts. As Freeman and Clasen note, the idea of the 'social state'

> gives coherence to legislative action, as expressed in the Social Code (the *Sozialgesetzbuch*), … the strong legal codification of conditions for and entitlements to social insurance rights in particular [that] has to be acknowledged as an important feature which distinguishes Germany from other welfare states.
>
> (Freeman & Clasen, 1994, p.10).

5.3.2 The Social Law Code (*das Sozialgesetzbuch*)

In 1971 the decision was taken to codify various separate individual laws and social rights together into one legislative framework, a process that began in 1975 and continues to this day. SGB XII, the twelfth and most recent book, was revised and incorporated in 2005, having previously been a separate statute, the *Bundessozialhilfegesetz*, or Federal Social Assistance Law (Kievel *et al.*, 2009, Foster & Sule, 2010). The *Sozialgesetzbuch* constitutes a special and autonomous branch of administrative law, with its own courts organised at three

levels, the highest of which is the Federal Social Court (*Bundessozialgericht*) based in Kassel. The courts deal primarily with decisions regarding entitlement to the various benefits outlined in the different books of the Social Law Code, its decisions binding on all parties, including government (Freckmann & Wegerich, 1999). The first book of the 12 interlocking volumes of the code, SGB I, outlines the general rights and duties in the various areas of welfare, including which organisations are responsible for providing appropriate advice and guidance in those specific areas (*Beratungspflicht* – Duty to Advise, see §14, §15 SGB I). The following books are particularly relevant to this study, the first of which is the most important:

- *Sozialgesetzbuch (SGB) XI – Soziale Pflegeversicherung* (Eleventh Book--Social Care Insurance[9])

- *SGB XII – Sozialhilfe* (Twelfth Book--Social Assistance)—in particular Chapter 7 – *Hilfe zur Pflege* (Help with Care)

- *SGB V – Gesetzliche Krankenversicherung* (Fifth Book – Statutory Health Insurance)

- *SGB IX—Rehabilitation und Teilhabe behinderter Menschen* (Ninth Book – Rehabilitation and Inclusion of Disabled People)

From this point, to retain the sense of coherence between the different books I will follow the German practice of referring to them as SGB XI, etc. To avoid confusion between SGB XI and SGB XII, however, I will refer to them as SGB XI (Care Insurance) and SGB XII (Help with Care) where necessary for clarity.

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[9] 'Social nursing', see Section 3.2—not 'social care' in the wider English sense

5.3.3 Social Law Code – Eleventh Book: Social Care Insurance (SGB XI)

The introduction in 1994 of SGB XI (Care Insurance) added long-term care risks to the Bismarckian insurance system and (to a degree) took them out of tax-funded social assistance. As Walker and Naegele (2009) remark, the strong Bismarckian family-orientated tradition and federal governmental structure in Germany meant that previously care was largely a family and/or local responsibility, with the independent social services organisations playing important roles as providers.

Morel (2007) highlights the impact of the rapid increase in the number of dependent older people in the 1970s and 1980s in Germany and the concomitant increase in social assistance spending, for which the *Länder* and the municipalities were financially responsible. Morel locates the drive for reform as originating in institutional crisis (of regional and local government, plus the Health Insurance Funds), rather than pressure from voters or a response to changes in society. She notes one cannot assume any causal link between social problems and policy, highlighting instead the public statements of the *Länder* at the time to be rid of the financial burden of providing for the needs of frail older people. They were in a strong enough political position to push for a shift in financial responsibility, given their constitutional veto power within the two chamber federal system (Götting *et al.*, 1994). As noted earlier, these demographic and financial pressures were also felt by the Health Insurance Funds. Before the passage of SGB XI (Care Insurance) the funding for long-term care was partial and fragmented. For example, statutory health insurance

(SGB V) could cover care costs for four weeks to facilitate hospital discharge if prescribed by a doctor, which led to 'revolving door' re-admissions to qualify for further four-week periods.

Increasing numbers of older people had to rely on means-tested provision under the pre-SGB XII (Help with Care) social assistance legislation, under which private assets were regularly exhausted within one or two years (Götting *et al.*, 1994, Glendinning *et al.*, 1997). The restricted availability of funding for long-term care combined with the influence of subsidiarity that placed legal responsibilities on families for the care and support of older members meant that community based services in particular were poorly developed. Family carers not in employment were also not covered for their own social insurance contributions, falling outside of the work orientated insurance system. Among key weaknesses identified by Glendinning and Igl (2009) were the scarcity of home care services (care services were mainly provided in institutions, mostly run by the independent social services organisations) as well as weak mechanisms for planning and coordinating local services. The *Länder* had no control over either the eligibility criteria or the level of benefit under social assistance legislation, for which they nonetheless bore financial responsibility. The fact that the system was generating severe pressures on both the Health Insurance Funds and the *Länder*, two powerful interest groups, focused the debate on how universal coverage could be achieved (Glendinning & Igl, 2009, Morel, 2007).

The passing of SGB XI (Care Insurance) had the effect of changing the status of care, moving it between the 'twin pillars' (Evers & Sachße, 2003), from being a residual personal social service under social assistance to being a social risk covered universally (but only partially) by the social insurance system – an important caveat being that, as *teilkasko* (i.e. not comprehensive) insurance it was never intended to cover the *whole* risk, but to contribute to an amelioration of the personal and financial burdens associated with care (Bundesministerium für Gesundheit, 2008), unlike the comprehensive (*vollkasko*) cover of other branches of social insurance.

The need for care is defined in SGB XI as follows:

> People in need of care are persons who need over the long term (likely to be at least six months) a substantial (or greater) degree of help with normal, regularly recurring activities during the course of daily life, because of a physical, mental or psychological illness or disability (SGB XI §14, my translations here and below)

The legislation further defines 'illness or disability', outlining conditions affecting the musculoskeletal system, the internal organs, the sensory system, and the central nervous system, including psychoses and learning disabilities. 'Help' is defined either as consisting of support, through which activities of daily living are partially or completely taken over, or as supervision or instruction that enables activities to be undertaken independently. Finally, the 'normal, regularly recurring activities' are further defined as follows:

1. The domain of physical (i.e. personal) care includes washing, showering, bathing, teeth cleaning, hair brushing, shaving, and emptying the bowels and the bladder.

2. The domain of feeding includes the preparation (e.g. cutting up) or the ingestion of food.

3. The domain of mobility includes getting up and going to bed independently, getting dressed and undressed, walking, standing up (e.g. transfers from chairs), climbing stairs or getting out from and returning to the home.

4. The domain of domestic care includes shopping, cooking, cleaning the home, washing dishes, changing and washing the laundry and clothing, or activities necessary to heat the home.

Both Klie *et al.*(2003) and Zippel (2003) draw attention to the narrowness and medical orientation of the definition of need for care in SGB XI.

Under SGB XI, the journey through care begins with an application to the specific Care Insurance Fund (*Pflegekasse*) the individual belongs to. The application can be made by the individual directly, a carer or a professional on their behalf. The determination of the need for care and the assigning of a given 'care level' (*Pflegestufe*) is the responsibility of the Health Insurance Medical Service (*Medizinische Dienst der Krankenversicherung*), an organisation funded by the federal level confederation of Health Insurance Funds, which employs doctors, nurses and other medical staff to undertake the *Pflegebedürftigkeitsfeststellung*, or the 'determination of the need for care', a

functional assessment under §18 SGB XI. This process is laid down in detailed

guidance produced by the federal Health Insurance Medical Service, which

includes a standardised form to be used in every case[10] (MDS, 2006).

Each domain of care, as defined in SGB XI, is separately addressed and

evaluated. The person in need of care is deemed either able to undertake an

activity independently, able to undertake it with help or supervision, or unable to

undertake the activity at all without help. Since an amendment to the legislation

in 2001 special consideration must be given to individuals with dementia-type

illnesses, in recognition that the definition underestimates the level of care

needed in these circumstances. If help is needed, the amount is recorded in

numbers of minutes. The potential availability or absence of informal carers is

not taken into account. At the end of the process a final score is produced, with

added weighting for activities of 'basic care' (*Grundpflege*), i.e. all care activities

other than domestic help, from which the decision regarding 'care level' will be

reached. The process generally takes place in the person's home and the

Health Insurance Medical Service should provide their recommendations via the

Care Insurance Fund within five weeks of the application being made, with

shorter timeframes for people in hospital or hospice care. Around 75% of

applicants meet the eligibility criteria (Glendinning & Igl, 2009).

In keeping with §5 SGB XI (Priority of Prevention and Medical Rehabilitation),

the assessor, referred to as a '*Begutachter*' (translating approximately as

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[10] One of my social worker informants had previously worked as a nurse, including undertaking such assessments under SGB XI. She was sceptical with regards to the degree of uniformity achieved amongst assessors and in her social work practice built up knowledge of which local assessors were 'stricter', information which contributed to how she assisted clients wishing formally to challenge their ascribed care level.

'expert' or 'expert evaluator'), must in principle make appropriate recommendations for medical rehabilitation before the provision of benefits (either cash or services) can be considered, although cost shifting problems have prevented the development of rehabilitative services. As Glendinning and Igl (2009) point out, costs are borne by the Health Insurance Funds, but any savings accrue to the Care Insurance Funds, a problem foreseen from the very beginning (Götting *et al.*, 1994). Klie *et al.*(2003) assert that this ostensibly compulsory principle, enshrined in both care insurance and health insurance legislation, has little more than symbolic and rhetorical meaning. However, the recent (post-2008) reforms include in-built financial incentives and are expected to encourage further developments in this area (Kraus, 2009, Ulrich, 2009).

The 'care levels' (*Pflegestufen*) are defined as follows in SGB XI:

- **Care Level 1** (considerable need for care). To qualify for Care Level 1 there has to be a need for help daily in at least two activities in the realms of personal care, eating or mobility, as well as for support with household tasks several times a week. The average amount of time needed for help every day must be at least 90 minutes, of which more than half must be spent on basic care.
- **Care Level 2** (severe need for care). To qualify for Care Level 2 there has to be a need for help with personal care, eating or mobility at least three times a day at different times of the day, with additional needs for domestic help several times a week. The daily requirement for care and

support must reach at least three hours, two of which must be solely for 'basic care'.

- **Care Level 3** (severest need for care). Those who qualify for Care Level 3 need care daily at any time of the day, including at night, as well as needing domestic help several times a week. The necessary help must add up to at least five hours, of which four hours must be for basic care.

- **Special rule for hardship cases** (*Härtefallregelung*). In residential care settings individuals with Care Level 3 who have an unusually high need for care can access additional benefits worth up to an extra €1688 monthly (as at 2007), for example in cases of severe dementia or in the end stages of cancer.

(With acknowledgement to Zippel, 2003, p. 212, English text my own)

As indicated above, benefits can be taken as a cash payment (*Pflegegeld*) to support informal carers (Bönker, 2007), in keeping with what Morel (2007) identifies as the (Bismarckian) conservative aims of the legislation to encourage and maintain family carers in their roles. Alternatively, the benefit can be taken as services (*Sachleistungen*), or a combination of both.

The value per month (pre-2008 reform, see Section 5.6) of the benefits in Euros are set out in **Table 5.1** below.

Care Level	Cash/Services (in the community)	Institutional Care
1	€205/€382	€1023
2	€410/€921	€1279
3	€665/€1432	€1432
Hardship Case	€1918	

Table 5.1: Care Insurance Benefits

(Source: Zippel, 2003)

Benefit levels were set in 1994 and were not inflation linked (Götting *et al.*, 1994). In 2006 around 48% of all recipients chose cash-only benefits to support informal carers, compared to over 30% choosing institutional care of one type or another, 10% a combination cash and services package, and 9% (community based) services-only (Bundesministerium für Gesundheit, 2008). The cash option also provides access to training courses in care practices for carers, social insurance payments on behalf of full-time carers, and additional benefits to pay for substitute care when the family carer is away or ill. Not treated as taxable income it is of considerable indirect value, and often treated as a supplement to the beneficiary's (or their household's) income (Glendinning & Igl, 2009). How the cash is used is not restricted (Evans Cuellar & Wiener, 2000).

Reichert and Philips (2009) cite several sources to argue that from the perspective of potential users, professional care services represent a 'second choice' (after family provided care) and that, especially for older service users, there is an aversion to the idea of using professional care, meaning these are

used only as a last resort (Giese & Wiegel 2000, Scheekloth & Müller 2000, in Reichert & Phillips, 2009). This may account for the relatively small 9% noted above opting for the services-only benefit in the community.

The value of benefits in kind (i.e. services) depends upon whether care is provided in the community (*ambulant*) or in an institution (*stationär*). §3 SGB XI (Priority for Care in the Home) sets out a clear preference for care to be delivered in the home environment, ranking different care models in order, with institutional provision ostensibly as a last resort. Benefits paid for institutional care do not cover 'board and lodging' costs (Glendinning & Igl, 2009), however, which have to be met through the person's own means or income or, if this is not possible, through social assistance (see SGB XII below).

Land-level associations of Care Insurance Funds (and municipalities as payers of social assistance) negotiate prices and contracts annually with the equivalent *Land*-level associations of organisations that provide professional home care and institutional care services (Glendinning & Igl, 2009). The supply contract regulates the type, content and extent of care an organisation must provide, strictly defining what Arntz *et al*. (2007) misleadingly translate as 'care packages' (*Leistungskomplexe*) as this does not directly equate to the concept of 'care package' as understood within the UK system, which refers to the sum of different services and inputs provided. For example, Berlin has an agreed list of 18 'care packages' (generally referred to as '*Modulen*' or modules), each of which is a precisely described set of care tasks priced according to a weighting

system, for example 'Module 3—Extended Major Physical Care (with bathing)' priced at €25.20 in 2007 (Bundesministerium für Gesundheit, 2008).

Evans Cuellar and Wiener (2000) suggest the service benefit can be thought of as a 'voucher' for use with approved services, to the value determined by their 'care level'. Approved service providers are those whose representative organisations are included in the annual negotiations with the *Länder* and the Care Insurance Funds. Individuals can choose any local provider approved by the Care Insurance Funds and an individual contract is agreed between the user and the provider, based on the fixed 'care packages' and prices specified at the *Land* level. Service users can terminate this at any time and switch to another approved provider, although one of my respondents noted that older service users are less likely to engage in this type of consumer behaviour. At the time of the research there were over 30 providers active in the locality of the main research site. There is evidence to suggest that some individuals use the cash option (*Pflegegeld*) to buy non-approved care provided illegally by Eastern Europeans crossing the border to work (Tießler-Marenda 2002, in Hillmann, 2005), a possibility noted from the beginning (Ungerson 1994, in Glendinning *et al.*, 1997), although *Pflegegeld* was never intended to be any kind of 'direct payment' in the UK sense.

Walker and Naegele (2009) acknowledge broad agreement in both the UK and Germany that older people wish to and should be able to continue living in their own homes but that current housing stock often doesn't support this ambition. They note the importance of adjusting living space, including the re-fashioning

of sanitary areas to meet the needs of older people. To this end, SGB XI also provides for the funding of technical aids or equipment to facilitate care or independent functioning (there is some overlap here with the provisions of statutory health insurance), as well as allowing for a single payment of €2557 as a contribution to the costs of necessary adaptation to the home (§40 SGB XI), an element of considerable relevance to the service provided in Berlin.

As previously noted, there is (prior to the 2008 reform, see Section 5.6) no federal funding of care management or advocacy services in SGB XI (Glendinning & Igl, 2009, Evans Cuellar & Wiener, 2000). Where such services have existed they have tended to be regional and/or project based (Frommelt *et al.*, 2008). As we shall see below the *Land* Berlin used its own powers under SGB XI to address what it perceived as this gap in provision. Before that, however, I will briefly outline other important elements of the Social Code.

5.3.4 Social Law Code – Twelfth Book: Social Assistance (SGB XII)

As noted earlier, SGB XI was never set up as a comprehensive insurance scheme but was intended to provide a contribution to the personal and financial burden of care for those in need and their carers (Bundesministerium für Gesundheit, 2008, Morel, 2007, Zippel, 2003). Given the absence of index linking (Götting *et al.*, 1994), this has led over the years to increasing numbers of beneficiaries having to either provide their own co-payments or, if they do not have the resources, having to turn to social assistance (*Sozialhilfe)*. This legislation has been known since the most recent reform in 2003-5 as the twelfth book of the Social Code, or SGB XII (Social Assistance).

Reichert and Philips (2009) note that although both the UK and Germany are similar with regards to traditions of the 'nuclear' family, there is a difference with regard to family legislation. In the UK there is no legal obligation to care between adult generations. In contrast, Germany belongs to a more familistic tradition, whereby there are formal family obligations to provide support to parents and children. Glendinning and Igl (2009) note an increasing number of claims by social assistance boards for refunds from children of older claimants forced into SGB XII for additional help, despite the fact that a number of recent decisions of the Social Courts have decreased the financial responsibilities of families in relation to social assistance claims.

In Germany, tax funded social assistance provides the safety net that covers the gaps between the five 'pillars' of social insurance and has its roots in the older system of poor relief, as noted earlier. The first sentence of the legislation states that it is the duty of social assistance "to enable the beneficiary to lead a life appropriate to the dignity of a human being" (Bundesministerium für Arbeit und Soziales, 2006, p. 113, *my translation*), reflecting the constitutional basic right to 'human dignity'. Social assistance is formally 'subordinate' (*nachrangig*) legislation, i.e. it should only provide benefits when all other possibilities have been exhausted, including other legislative provision, the income and means of the beneficiary, as well as those (family members) with a legal duty to support them, in accordance with the principle of subsidiarity. The legislation covers a range of life circumstances defined in separate chapters which specify benefits available and any principles governing these. The most important chapter for

the purposes of this study is Chapter 7 – Help with Care (*Siebtes Kapitel – Hilfe zur Pflege*). This chapter is formally 'subordinate' to the long-term care provisions of SGB XI, i.e. like all provisions under SGB XII (Social Assistance) it only comes into play when all other possibilities have been exhausted, as outlined above (Bundesministerium für Arbeit und Soziales, 2006). Prior to the passing of the eleventh book in 1994, the social assistance leglislation, in its pre-2005 version the *Bundessozialhilfegesetz*, was the only mechanism through which individuals without the means or income to buy care privately or relatives to provide it could access help with care.

In the post-2005 version, §61 of Chapter 7 defines the need for care, illness and disability, and the usual activities of daily living exactly as outlined in SGB XI (Care Insurance). §62 specifies that any decision of the Health Insurance Medical Service with regards to the extent of an individual's need for care under SGB XI will also apply under SGB XII (Help with Care). The three levels of care outlined in SGB XI also apply to SGB XII, governed by exactly the same criteria, but there is no monthly upper limit to the value of service benefits at each care level (Sallmon, 2007), although 'cash for care' benefits are the same. As noted above, social assistance is provided only when individuals (and responsible relatives) cannot or can no longer afford to top up their benefits from SGB XI (Care Insurance), which as Thomas (2003, in Glendinning & Igl, 2009) notes, needs to cover an average monthly gap of €130 between the value of benefits for services under SGB XI and the actual costs of the home care services required.

Social assistance can also provide for what professionals refer to as '*sogenannte Pflegestufe 0*', i.e. 'so-called Care Level 0'. This semi official concept describes people who have a need for care that does not meet the minimum level of help to trigger the award of 'Care Level 1', i.e. 90 minutes per day. The expectation under SGB XI, as only partial insurance, is that the individual will use their own means or income to pay for this level of care. Those without the means can, however, apply for social assistance through SGB XII, hence the notion of 'Care Level 0'. Additionally, social assistance can also help with the additional costs of residential care. Relatively few people now fall entirely outside of the social insurance provisions but those who do can apply directly for social assistance. **Figure 5.1** broadly outlines the care pathways of the Eleventh and Twelfth Books of the Social Code.

SGB XI (Care Insurance)

SGB XII (Social Assistance—Help with Care)

Person perceived to be in need of care

Care Insurance Fund (application under SGB XI)

No care insurance, **self fund** or apply directly to Social Assistance

Medical Service MDK (functional assessment)

Local Authority (functional and financial assessments)

All services, including cash benefits, can also be provided by local authorities under SGB XII (Social Assistance)

Care Level Outcome: Refusal ('Care Level 0')

Care Level Outcome: Care Levels 1; 2; or 3

Self fund or apply to SGB XII (Social Assistance)

Cash benefits (supporting informal care)

Benefits as professional care services

Residential Care

Self fund 'board and lodgings', or apply for Social Assistance

Domiciliary Care Services: Approach providers directly

Self fund additional costs or apply to SGB XII (Soc. Ass.)

Figure 5.1: Care Pathways: SGB XI and SGB XII

5.3.5 Other legislation: Social Law Code Fifth and Ninth Books (SGB V, SGB IX)

Two other components of the Social Code merit a brief overview with regards to this study. First of all, statutory health insurance (*SGB V – Gesetzliche Krankenversicherung*), the fifth book of the social code and one of the early 'pillars' of the social insurance system, is important for both its relationship to long-term care insurance and for understanding how differently it operates compared with the NHS in the UK.

Pfaff (2009) notes that the German health care system is characterised in particular by a separation of purchaser and provider. The Health Insurance Funds purchase health care, which is provided by a range of public, private and third sector organisations in a highly regulated, 'corporatist' market that maintains a strong separation between institutional and community-based provision (Moran, 1994). Some provider organisations (e.g. the *freie Träger*) may operate across both health and social care, running both hospitals and care homes and potentially creating vested interests (during hospital discharge, for example). Patients present their *Krankenschein* (health insurance certificate) whenever they seek treatment and have the right to consult any registered doctor of their choice, including community based specialists. In addition to the monthly insurance contributions, patients must also pay a range of co-payments. Examples include prescription charges of between €5 and €10, 10% of the cost of assistive equipment, €10 per day for hospital stays (to a maximum of 28 days), and quarterly practice charges of €10. Under certain circumstances

(see for example 'Typical Case', Appendix 2.3), these charges can be reduced or waived if they cause financial difficulties (Bundesministerium für Arbeit und Soziales, 2006).

Although the ninth book of the social code, SGB IX - Rehabilitation and Inclusion of Disabled People, is arguably geared towards younger disabled people because of its considerable focus on work and support with employment, there are some benefits that older people with age related impairments can access, including applying for a 'severely disabled' identity card (*Schwerbehindertenausweis*) (§69 SGB IX). This can trigger access to other services or benefits, particularly local transport services (see 'Complex Case' Appendix 2.1).

5.4 Care Needs in Berlin (SGB XI, SGB XII)

This federal level legislative and policy environment frames the *Land* level provision of care in Berlin. Across the city the total number of people in receipt of long-term care services or benefits under SGB XI at the end of 2007 was almost 96,000 (in a total population of under 3.5 million), of which approximately 85% are aged over 60. The table in Appendix 7 sets out in detail the age profile, level of care and choice of care service of this population. Almost 23,000 have chosen to receive care services in the home, in preference to either residential care or cash benefits to support informal care. According to internal documents from the regional office of the Health Insurance Medical Service for Berlin and Brandenburg (M.D.K. Berlin-Brandenburg, 2008) there were almost 26,000 first

time applications for care level assessment in Berlin in 2007, of which 24% were refused (so can reasonably be assumed to be mostly 'so called Care Level 0'); around 47% Care Level 1; 22% Care Level 2; and almost 7% Care Level 3. A further 19,000 applications were made that were either repeat applications, requests to be re-graded to a higher care level, or (a relatively small number of) formal appeals against decisions (around 1100).

A report for the *Land*-level government (Sallmon, 2007) indicates that at the end of 2006 there were 23,515 people in receipt of benefits or services under SGB XII (Social Assistance—Help with Care), about a quarter of whom are 'Care Level 0', mostly receiving care at home. However, half of the total receiving help with care under social assistance live in care homes. Of every 1000 individuals in receipt of care benefits under SGB XI (Care Insurance), i.e. Care Levels 1, 2, and 3, there are 173 in receipt of additional benefits under SGB XII (Help with Care), roughly one in five. This illustrates the context within which the case management service for older people at the heart of this study, *Rund ums Alter*, operates.

5.5 Local Policy and Practice in Berlin: The emergence of *Rund ums Alter*

'All about Age'—Berlin's Coordination Centres

Figure 5.2: '*Rund ums Alter*' Logo

As noted, from the passing of SGB XI (Care Insurance) through to the reforms of 2008 (see Section 5.6) there was no provision of case management (Glendinning & Igl, 2009, Evans Cuellar & Wiener, 2000). This was not the case, however, in the *Land* Berlin. The focus of this section is the emergence of a dedicated *Case Management* service for older people, commissioned by the *Land* Berlin using its power to develop infrastructure under SGB XI, and provided by a coalition of independent social services organisations. It is perhaps useful to conceive of *Rund ums Alter*, the service at the heart of this study, as a virtual organisation, an example of a horizontally integrated service provided by different organisations but bound together through the use of common symbols, such as logo (as pictured above), website, stationery etc. (Hatch, 1997). The service traces its origins to a local self-help group for older people in a West-Berlin borough established in the early 1970s that, under the

motto 'older people helping other older people', had developed a visiting service
for older people living in care homes. Over the years they identified clear
evidence that many individuals were living in care homes both unhappily and
unnecessarily (Tresenreuther, 2001).

The establishment of the Coordination Centres for older people was explicitly
linked to demographic developments in the city. Out of an overall population of
3.4 million people in 2007, 30% are aged over 55 and 17.9% over 65 (Rund
ums Alter, 2007a). In response to the difficulties presented to older people by a
highly differentiated and fragmented care system that offered few options other
than going into a home for those in need of care, the first 'Coordination Centre
for Community-based Rehabilitation of Older People' (*Koordinierungsstelle für
ambulante Rehabilitation älterer Menschen*) was opened in the borough of
Wilmersdorf in April 1988. Funded through a three-year pilot project
commissioned by the *Land* (West) Berlin[11], it formed part of a local strategy for
reform of older people's services. From the very beginning, *Case Management*
was envisioned as a core component, designed to coordinate access to
available services and, through its focus on the service user's individual needs
and circumstances, to assist older people to remain in their own homes (Fichtel,
2005). In 1992, following a positive evaluation of the Wilmersdorf pilot, the first
Coordination Centre in the eastern part of the city was opened in the borough of
Pankow, using funds for developing employment opportunities in the former
eastern districts. From 1993 onwards further Coordination Centres were opened
across the boroughs of Berlin, achieving citywide coverage by 1999, by which

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[11] Berlin is one of three *Länder* known as 'city-states', or *Stadt-Staaten*. Prior to re-unification
West-Berlin had a special status due to it being 'occupied territory', but was *de facto* a West
German *Land*. The *Land*-level parliament is called the *Senat*.

time they had been renamed as *Koordinierungsstellen – Rund ums Alter* (Coordination Centres – All about Age), capturing in their very name the most basic dimension of case management.

In February 1997 Berlin's elected members in the *Senat* formally accepted a report recommending the retention and continuing development of borough-based Coordination Centres across the city, commissioning it as part of the *Land*-level responsibility for developing the care infrastructure under §9 SGB XI (Care Insurance). The report noted the increasing and potentially confusing complexity of the new, more competitive care market since the implementation of SGB XI and the emergence of new private and voluntary providers, as well as the degree to which many older people in need of care felt overwhelmed by the expectation that they would act as 'sovereign consumers' within the newly reformed system. Within this 'new paradigm', the report highlighted an increasing need for services that support older citizens as consumers to empower them as they engage with and direct their own care services. To this end it was determined that the Coordination Centres should offer no rehabilitation services themselves but should focus on assisting service users to negotiate their way through the various options available within the health and social care system. Additional restrictions applied to organisations interested in becoming a *Träger* of a local Coordination Centre to ensure the independence of any advice or recommendations offered to those looking to meet their care needs (i.e. they should not favour care services provided by their own or related organisations). Two key principles in the new legislation, '*ambulant vor stationär*' (community based before institutional care) and '*Rehabilitation vor*

Pflege' (rehabilitation before care) were embedded into the operational

guidance for the Coordination Centres, which were specifically set up as

'*Einrichtungen der Sozialarbeit*', i.e. social work institutions (Senatsverwaltung

für Gesundheit und Soziales, 1997, Rund ums Alter, 2007a, Klenk *et al.*, 1996).

Other important milestones in the development of the Coordination Centres

were the establishment in 1995 of the *Arbeitsgemeinschaft Berliner*

Koordinierungsstellen or ABK, the management committee made up of the

team leaders of the different Coordination Centres, and the development in

1998 of a common database of care services and related information, known as

Hilfelotse (a guide to help, literally a 'help pilot' or 'help navigator', see

www.hilfelotse-berlin.de). In 2003, a common telephone number across the city

was established to facilitate access to appropriate information and help. Finally,

in 2005, a common website was developed (www.koordinierungsstellen-

rundumsalter.de).

Figure 5.3: Process Tracing—the Emergence of *Rund ums Alter*

1970s Self help initiative
- Identified older people living in care homes unnecessarily
- **Sources**: Published literature, local documentary sources, discussion with founder

1988 First Coordination Centre (West-Berlin Pilot Project)
- Self help group funded through regional pilot scheme
- **Sources**: Published literature, local documentary sources

1992 First Coordination Centre in eastern part of Berlin
- Post-unification, funded through employment initiative for eastern districts
- **Sources**: Interview with policy lead, *Land* government documentation

1992 onwards-- *Land* policy to encourage expansion across City
- Employment initiative funding in East, pilot projects in West
- **Sources**: Interview with policy lead, published literature

1994--SGB XI (Care Insurance) passed
- Paragraph 9-- outlines the duties and powers of the *Länder* with regards to developing the care infrastructure.
- **Sources**: Federal legislation

1997 *Berliner Senat* decision to commission city-wide service under SGB XI §9
- Core principles from SGB XI embedded (§3,5)
- **Sources**: Land government documentation, interview with policy lead

1999--City Wide coverage achieved
- Subsequent developments included common telephone number and website
- **Sources**: Local documentation, discussions with key informants

5.5.1 Purpose and Aims of *Rund ums Alter*

The main purpose of the Coordination Centres is to enable older people to remain in or return to their own homes, through supporting them to achieve as far as possible a self-determined and independent life in the event of illness, disability or need for care. To achieve this, each Coordination Centre is required to provide the following services, as outlined in the main service description leaflet or *Konzeption* (Rund ums Alter, 2007a): Information; Advice/Consultation (*Beratung*); *Case Management*; and Networking (see Appendix 8). The Coordination Centres are evaluated annually against these core tasks (Beratung Bildung Innovation, 2008), the boundaries between which are in practice variably interpreted between different offices, an issue I will return to (see Section 5.5.4).

The steps of case management are described in the document using the following typical combination of adopted English and German terms (my explanatory translations in square brackets):

- *Intake (Aufnahme)*

- *Assessment (Bedarfsanalyse)* [Analysis of Need]

- *Hilfeplanung* [Care Planning]

- *Implementierung (Organisation und Koordination)*

- *Monitoring (Leistungssteuerung und –überwachung)*

- *Evaluation der Ergebnisse* [Evaluation of Outcomes, i.e. Review]

- *Entpflichtung* [Closure]

The *Rund ums Alter* project was deliberately set up as a '*niedrigschwellig*'
service, i.e. with a low threshold for access. Any older person can approach for
help or advice, and they are in turn free to accept or reject that help or advice. A
key attribute of the service is its independence and neutrality with regards to
funding organisations and providers of care, thus ensuring impartiality in their
advice and support to those in need of care, reflecting the 'independent *Case
Management*' model (Wissert, 2004, Ewers & Schaeffer, 2005)

Rund ums Alter has enjoyed a high profile both Berlin-wide and in the localities
for many years, reflected in the support of Berlin's senator for health and social
services (Dr. Heidi Knake-Werner, retired 2009) who wrote the foreword for
each edition of the service plan (Rund ums Alter, 2007a) during her period of
office and opened both conferences I attended, the (smaller) fifteenth
anniversary of the first Coordination Centre to open in the eastern part of the
city and the larger scale biennial conference organised by the ABK
management committee that attracted high profile professional and academic
speakers and participants from across Germany.

5.5.2 Organisation and Resources

Rund ums Alter in Berlin is provided by a coalition of small welfare
organisations belonging to two of the large traditional welfare associations
('*freie Träger*'), the *Paritätischer Wohlfahrtsverband* and *Diakonisches Werk*
(the secular and Protestant umbrella organisations respectively), under the
auspices of the *Liga der Spitzenverbände der Freien Wohlfahrtspflege Berlin*
(the League of Umbrella Organisations of the Independent Social Services,

Berlin). As suggested above, it is useful to conceive of *Rund ums Alter* as a 'virtual' organisation, a horizontally integrated service hosted by a number of different responsible agencies. **Figure 5.3** illustrates the organisational complexity of *Rund ums Alter*.

ABK
(citywide management board)
Made up of 12 local office managers,
plus 1 for Jewish community

8 local offices run by *Paritätisch* affiliated organisations

Citywide centre run by Jewish welfare organisation

4 local offices run by *Diakonisches Werk* affiliated groups

Rund ums Alter commissioned by the *Land* (Regional Govt) under its duties to develop and support an appropriate infrastructure for long-term care under §9 SGB XI

Figure 5.4: Organisation of *Rund ums Alter*

Each local centre is also (vertically) located within the organisational structure of its *Träger* (provider), so for example each team leader in a Coordination Centre will have a line management relationship within that provider organisation. During the four months I spent in Berlin, I had a clearer sense of belonging to a local branch of *Rund ums Alter* than I had of being a part of that local office's

provider organisation, even though links with that provider organisation were significant.

Rund ums Alter is evaluated annually on the basis of data inputted into a dedicated common database and collected from each local office. The 2007 annual report, produced by an independent consultancy on behalf of the major stakeholders and funding organisations (Beratung Bildung Innovation, 2008), maps service provision, measuring various inputs including working time spent on different activities, and client profiles. They produce a range of quantitative data intended to satisfy the external funding bodies that money (€1,581,996 for the year 2007) is being spent appropriately, and for internal quality management purposes. Individual Coordination Centres are anonymised in the report. Despite requests, I did not gain access to the code for the local centre I was based in, a noticeable exception to the high degree of cooperation and assistance I otherwise experienced. The reasons for this reluctance (I simply got no answer each time) were perhaps associated with the contested nature of the figures, which took considerable negotiation to finalise with the team leaders of the individual centres, and almost certainly derived in part from sensitivities around the issue of establishing conceptual boundaries between the various activities, the amount of time they spent on each of which the staff had to record daily (see 'Boundarying of *Case Management*', Section 3.7 above).

In 2007 there were 32 full time equivalent posts across the whole service (each local office has between 2 and 4 staff). Quantitative data have been gathered systematically since 2002. However, changes to categories and improvements

to data quality mean that chronologically comparable data have been collected only since 2005. Over time a number of different types of provision were re-categorised, with previously finely differentiated categories amalgamated into five core service components:

- *Information*;

- *Advice/Consultation*[12];

- *Case Management*;

- *Structure Optimisation* (setting up and maintaining collaborative structures, or *Care Management*); and

- *Other Services* (e.g. assisting with pursuing complaints).

Two definitional changes took place in 2004 of particular relevance to this study. First of all, advocacy work on behalf of service users or their carers, previously categorised under *Advice/Consultation*, was re-designated as *Case Management*. Secondly, 'home adaptation' work, previously in its own category, was also subsumed into *Case Management*. The report concludes from the decrease in variation between Coordination Centres over time that they are defining a '*Case Management*' service more uniformly, although the variation remains significant between offices. This variation reflects the discussions I witnessed that focused particularly on the 'boundarying' (*Abgrenzung*) of *Case Management*, especially in relation to Advice/Consultation (*Beratung*), suggesting those offices using broader definitions are recording higher numbers of case management cases than those operating stricter or more defined

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[12] 'Advice' only weakly translates '*Beratung*', which carries weightier connotations of a thorough 'consultation' and is a central concept in German social work.

criteria, such as intensity of involvement, breadth of services spanned or indeed targeted groups of service users such as those at risk of entering institutional care (Challis, 2003).

Indeed the trend has been towards an increase in *Case Management* and a decrease in both *Information* and *Advice/Consultation*, in the context of an overall increase in the amount of time spent on direct client related activity. The average number of individual clients seen per worker in 2007 was 257, within a range of 122 (lowest) and 464 (highest). The total number of clients, carers or professionals seen or advised across the service in 2007 was 8,260. Interestingly, the average cost per client in relation to the overall funding (approximately €192 per client in 2007) is not calculated in the report. Finally, although the figures are constructed differently, comparing the total number of clients for *Rund ums Alter* in 2007 (8,260) to the numbers making either new (26,000) or repeat (approximately 20,000) applications for care benefits under SGB XI (Care Insurance) in Berlin in the same year (M.D.K. Berlin-Brandenburg, 2008) gives some indication of the level of *potential* demand, should more of those latter individuals decide they needed help navigating the care system (as may happen as a consequence of the 2008 reforms).

5.5.3 A Local Coordination Centre

For the duration of my Fellowship I spent three days of each week based in one of the 12 local offices. This particular office is community based within a block of flats in a neighbourhood at the centre of the borough that it serves. There are a team leader, two social workers and an administrative worker, most of whom

work on contracts that are not quite full time. The total population of the local

borough is around 250,000, of whom over 20% are aged over 65, 13% being

between 65 and 74, and 7.5% over 75 (www.berlin.de).

The team leader's role is focused on coordination at the system level (*Care*

Management in the German sense), including taking the lead on the

development and running of a local coordination committee that brings together

different agencies and stakeholders working with people with dementia. She

also leads on promoting the services offered by the Coordination Centre, and is

responsible for the day-to-day management and supervision of the team. The

administration worker provides support to the team and offers an information

service to callers to the office, accessing the *Hilfelotse* database. The office is of

a sufficient size to enable one-to-one consultations to take place in private if

necessary. The core services of '*Beratung*' (advice) and '*Case Management*'

are provided by the two social workers either working from the office or in

service users' homes. There is a team meeting every Wednesday morning,

within which work is planned and coordinated. Every two months there is also a

general staff meeting for the Coordination Centres run by *Paritätische*

organisations, and the team leader attends monthly meetings of the ABK, the

citywide management group for *Rund ums Alter*.

Local relationships and service boundaries are established on a borough by

borough basis, depending upon the level and type of service offered by the local

borough's social service office (*Sozialamt*). Although the broad strategy for

service provision is set at the *Land* level, local boroughs do have some

discretion as well as specific strategic responsibilities for the locality. Each has

its own administration reflecting its particular political complexion. In this

borough, the local authority continues to offer a specialist advisory service for

older people, alongside its specific duties under SGB XII (Social Assistance,

including Help with Care). In its 2007-08 update of its borough strategy for older

people, the local authority lists the team leader of the local Coordination Centre

as a key partner, reflecting the general tone of cooperation locally. The local

authority is also a partner in the local dementia network in which the

Coordination Centre plays a leading role.

In practical terms, all cases requiring access to care through the means-tested

provisions of SGB XII were automatically referred by the Coordination Centre to

the local authority's *Sozialamt*, for which this was a statutory duty. In turn,

individuals enquiring about home adaptations with the local authority's older

people's advisory service were routinely referred to *Rund ums Alter*, because of

their specific expertise in this regard. There was, however, a degree of overlap

between the agencies in the domains of information and advisory services for

older people, with differing interpretations of its effects. For example, a

representative of the local authority indicated that responsibilities were

effectively divided along geographical lines, with *Rund ums Alter* and the

borough servicing different specific neighbourhoods, an interpretation not

shared by the local *Rund ums Alter* team leader, who preferred to emphasise

the difference in their services, possibly because of the general view of the

Land that duplication of services should be avoided. Without spending more

time in the local authority it was not possible to determine which interpretation

was most accurate. Interestingly, although the local authority's social workers

brokered and arranged care under SGB XII (Help with Care) they did not

describe this as *Case Management*, despite considerable similarities in the

assessment documentation used by both offices. For the purposes of this study,

such differences were noted as examples of difficulties in establishing

definitional and/or service boundaries.

5.5.4 Local Case Management Practice

Each local Coordination Centre adhered in principle to the definition of case

management outlined above in the *Rund ums Alter* service plan. Beyond the

formal definition, however, it became clear there was some disagreement

between the different local offices in terms of how the definition was

operationalised and defined in relation to the other services offered by the

project, namely '*Beratung*', i.e. providing advice/consultation, and

'*Wohnungsanpassung*', the organisation of adaptations to make the home

environment easier to manage. This '*Abgrenzung*' or boundary issue was

debated at some length and with a little tension at one particular general staff

meeting for a group of Coordination Centres I attended, and was subsequently

discussed in a presentation at a local conference celebrating the fifteenth

anniversary of the first Coordination Centre in the eastern part of the city.

The working definition in the local office where I was based was a simple

heuristic (referred to as a '*Faustregel*', usually translated as 'rule of thumb' but

without the English expression's contested etymology) that, if a request for

service concerned more than one distinct area of need and required some level

of coordinating input, then it would be recorded as *Case Management*, reflecting the most basic dimension of case management noted above. To explore this definition in more practical terms, I asked the two social workers to present to me, as outlined in Section 3.6.4, a sample of cases of differing levels of complexity, and of these which they would define as '*Case Management*', i.e. to explore how they construct case management within this local context.

5.5.5 Illustrative Examples of Local *Case Management*

The texts set out in Appendix 2 emerged from the facilitated group discussions of the cases summarised in **Table 5.2**. Through this process, I was able to identify the parameters of their local constructions of *Case Management* and link them to the wider legislative and policy environment. Each of these examples, although each a real case, also represents an ideal type, designed to demonstrate the different levels of case complexity dealt with in the office, as well the relationship, actual or potential, between the cases and the policy and legislative context, including the interface with the local authorities social service office that deals with means-tested support under SGB XII (Help with Care).

	Frau A *Complex*	Frau B *Unusual*	Herr C *Typical*	Frau D *Simple*
Client lives…	Alone	Alone	With wife	Alone
in a…	Care home	2 room flat	2 room flat	2 room flat*
Established Care Level?	2	1	2	'0'
Needs help organising:	*(if pursued)*			
Care Services?	Yes	No	Yes	No
Adaptations?	Potentially	Yes	Yes	Yes
Needs General Advice?	Yes	Yes	Yes	Yes
Needs Funding Advice?	Potentially	Yes	Yes	Yes
SGB XI applies?	Yes	Yes	Yes	No
SGB XII?	Potentially	No	No	No
SGB V?	*(If pursued)* Yes	No	Yes	No
SGB IX?	Yes	No	No	No
Counts as Case Management?	*(If pursued)* Yes	Yes	Yes	No

*equivalent of one-bedroom flat in British English

Table 5.2: Overview of Illustrative Cases

One of the clearest indicators from the above cases, which confirmed my
impressions from other data sources, e.g. sitting in on team meetings, routine
conversations, the focus of particular leaflets and brochures (for example, Rund
ums Alter, 2007b), is the centrality of '*Wohnungsanpassung*', or arranging
adaptations in the home, to the work of '*Rund ums Alter*', both in this locality
and more widely across the city (see also Fichtel, 2005, whose work with
service users in different centre noted this too). This was presented as a
particular area of expertise and the production of the specific brochure referred
to was deemed especially important in the local office. Interestingly although it
is theoretically possible to finance the additional costs of adaptations through

SGB XII (Social Assistance), this is both unusual and dependent on quite variable practices between local authorities.

A second theme arises from consideration of where these individuals are in terms of their care journeys. Frau A, deemed a complex case because of the perceived contradiction between her stated desire to move out of the residential care home and her lack of action even when supported to take the necessary steps, was already receiving care at Care Level 2 in an institutional setting. In terms of the aims of *Rund ums Alter*, Frau A's case was very much about the complications of attempting to undo a previously clearly unnecessary move into residential care. Frau B by contrast was already receiving a domiciliary care service at Care Level 1 and was proactively engaging with the onset of age-related physical impairments that were impacting on her established strategies for coping with her lifelong impairment that arose from her illness in young adulthood. Both her relative youth (early 60s) and her pre-existing impairments made her case unusual but nonetheless it can be understood as broadly fitting the principles of 'rehabilitation before care', i.e. the provision of home adaptations to prevent or postpone the need for a higher care level. In terms of the local 'rule of thumb' her case required coordination of the application for funding under §40 of SGB XI with applications to grant making charitable bodies for the remaining amount as well as the adaptations work itself. Herr C's case, by contrast, demonstrates intervention *at a point of crisis* that prevented an unwanted move into a care home and as such represented, according to the social workers, a 'typical' *Case Management* case (and indeed would be 'targeted' in narrower definitions of case management). Without this intervention

by social worker 2, triggered by Herr C's wife, the default option for them both would have been to move out of their shared home. Through assisting the couple to bring together a range of inputs *Rund ums Alter* clearly enabled them to remain in their own home as they wished, achieving the central purpose of the service. Prior to this crisis, Herr C had not been in need of care at all. Frau D, in turn, was a self funder at 'so-called' Care Level 0. Her need for help was confined to one area of daily living, getting in and out of the bathtub safely. The advice and guidance offered to her again fitted with the broad theme of prevention of future care input through the provision of advice regarding home adaptation.

Finally, the provision of appropriate advice and help with funding options and arrangements is also a key theme that comes through from these cases. Each of the individuals described needed informed advice and support to assist them with financial elements of their care. If Frau A were to go ahead with a move out of residential care, she (and her son, given his potential responsibilities) would need extensive advice and help with the financial elements of restructuring her care and support, including potentially a referral to the local social service office under SGB XII for help with care under social assistance, and, depending on the property, help to raise additional money towards potential adaptations. Frau B would have been unable to pay the additional costs (above the amount she was eligible for under SGB XI) for her technically complex installation of a level access shower without Social Worker 1's applications to charitable bodies on her behalf. Herr C and his wife also needed considerable help making the best use of their own resources alongside the provisions of SGB XI (Care Insurance)

and SGB V (Health insurance), including help with applying for a co-payment waiver under the latter legislation. Frau D too, as a self funder, needed assistance in working out the most convenient way to fund her adaptation, Social Worker 2's advocacy on her behalf leading to her landlord offering to absorb 20% of the costs, to arrange the work through the property company, and for Frau D's contributions to be paid for through her rent account over time. Even in the context of an ostensibly more equitable care system, there is a need for competent and informed support with regards to funding options for different components of care.

These four cases do not present a comprehensive picture of all the work undertaken in the local Coordination Centre. They do, however, illustrate the range and types of work undertaken, demonstrating how *Case Management* is constructed in this office within the context of local and regional care infrastructures and federal legislation. In terms of their 'care journeys' the first three have already had their care needs established by the Health Insurance Medical Service, the fourth is aware she would not be eligible for Care Level 1 and her financial circumstances would exclude her from consideration under SGB XII under 'so called care level 0'. The *Case Management* role consists primarily of brokerage (identifying and coordinating resources for both care services and adaptations), advocacy (representation in disputes over billing, applications for waivers, grants etc.), and what might be termed 'care navigation' (assisting the service users through the complex care environment). The focus of the next section, the potential changes implied in the draft reform law, may change this mix.

5.6 Policy Changes: *Pflegeberatung* and Care Support Centres (*Pflegestützpunkte*)

A formal draft reform of Germany's long-term care legislation was published in September 2007 (Bundesministerium für Gesundheit, 2007) within days of my arrival, central to which were two developments of particular relevance to *Rund ums Alter*: firstly, introduction of a right to *Pflegeberatung*[13] or 'care advice'[14], a process ostensibly based on case management, and secondly, the improvement of local care provision and coordination through the development of single points of access, or *Pflegestützpunkte*, (Care Support Centres). Other measures included an updating of the value of benefits. Discussion of the reform and the implications of these two core components were to frame the entire fieldwork phase, including the follow up visits. The implementation of the changes in Berlin, which I hoped to trace, took much longer than anticipated so in this section I will outline what the proposed changes were and what impact they were having during the period of my research up until my final visit in December 2009. It remains my intention, however, to pursue the implementation in Berlin further in a future piece of work.

The two components became law from 1st July 2008 (§7a *Pflegeberatung* and §92c *Pflegestützpunkte*, SGB XI), with the entitlement to *Pflegeberatung*

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[13] In the original draft the phrase *Pflegebegleitung* (literally *escorting* or supporting someone through the care process) was used, *Pflegeberatung* appearing later in 2008 (Krahmer & Schiffer-Werneburg, 2010)

[14] The two components of this word, *Pflege* and *Beratung*, are both problematic with regards to translation, as already noted. It also raises issues with regards to 're-naming'. For these reasons, I will continue to refer to *Pflegeberatung* in the original, following the convention that in cases of terms that have only a rough equivalence across languages, that they should not be translated at all, but explained and then used in the original language (Revauger 2001, Eyraud 2001).

planned to come into force from January 2009. Care Support Centres, however, will only be set up in those *Länder* which agree to their development, i.e. this element of the reform will not be uniformly implemented across the federal republic, a compromise reached because of a lack of consensus at *Länder* level.

Krahmer and Schiffer-Werneburg (2010) describe how the new provision of §7a SGB XI introduces a legally enforceable individual right to a comprehensive advice and support service (*Pflegeberatung*) for all those in receipt of or awaiting benefits under SGB XI. *Pflegeberatung* is expected to play a key role in the overall management of an individual's care and was introduced in response to the recommendations of the federal government's 'Round Table on Care'. Those eligible are not, however, required to take up the offer of *Pflegeberatung*; it is voluntary, not compulsory, i.e. it is not a pre-condition for the receipt of services.

They note that *Pflegeberatung* as set out in §7a SGB XI is structured as individual case management (although using the term *Fallmanagement*, not *Case Management*), a process that extends beyond the Care Insurance Funds' pre-existing general duty to explain or advise (*Beratungspflicht*) as set out in §7. It is targeted directly at the eligible individual, not their spouse, partner or other relatives or carers, although these can be included on request. The duties of *Pflegeberatung* comprise then not only the recording and analysis of the need for assistance (which must be undertaken in light of the outcome of the 'determination of the need for care' by the Health Insurance Medical Service's

assessors, see Section 5.3.3), but also: the production of an individual care plan; support during the implementation of the care plan; the oversight and adaptation of the care plan; and, in cases of complex need, the evaluation and documentation of the whole process. With *Pflegeberatung* those eligible should be offered individual guidance to assist them through the process of taking up and coordinating those services required from the various service systems. These could include health promotion, curative, rehabilitative and other medical services, alongside care, social assistance (i.e. SGB XII) and other social support services. The legislation states that the independence of *Pflegeberatung* (i.e. from the interests of funders and providers) must be assured, and that it should be offered through Care Support Centres (*Pflegestützpunkte*) in *Länder* where they have decided to establish them under §92c. By law *Pflegeberater/Pflegeberaterinnen* (care advisors) should hold a qualification in care/nursing, insurance advice, or social work, supplemented by further qualification in case management (this requirement to be fully implemented by June 2011).

5.6.1 Care Support Centres in Berlin

(*Care Support Centres Berlin: Informing, Advising, Supporting*)

Figure 5.5: 'Pflegestützpunkte in Berlin' Logo

Sixteen new Care Support Centres were piloted across Germany from 2008, commissioned by the Federal Ministry of Health (Michell-Auli *et al*., 2008), two of which involved Coordination Centres in Berlin. By the end of 2009, the Coordination Centres as previously organised had ceased to exist as independent bodies, although part of their former logo (see **Figure 5.2**) features prominently in the new logo for the Care Support Centres in Berlin pictured above. As noted the shift from 'Coordination Centre' to 'Care Support Centre' will form the basis of a different piece of work and falls outside of the timeframe of this study. Nonetheless, it is important to note the effects of the proposed policy changes on the Coordination Centres during the fieldwork. They were experienced both as an opportunity, i.e. the Coordination Centres immediately saw themselves as potential Care Support Centres and central to future developments across Berlin, producing formal position papers to make their case; and as a threat, in terms of the at the time unknown potential effects of

key elements of the changes, particularly which organisations would be the

Träger for the new centres and what the implications of that changed structure

might be for *Rund ums Alter*. The proposed changes were very much 'in the air'

and the focus of much informal and formal discussion, including at both

conferences I attended in November 2007. A key early concern was whether

the *Land* Berlin would choose to take part or opt to leave *Pflegeberatung*

entirely to the Care insurance Funds (a positive decision was reached in

December 2008). Other concerns included the potential loss of independence

from funding organisations (the plan was for the Care Insurance Funds to hold

main responsibility for the provision of and to partially finance the Care Support

Centres, seen as potentially damaging to independence, due to their vested

interests as the funding body for care services); a related concern regarding

who would undertake *Pflegeberatung* within the new structures (social workers,

nurses or insurance advisers); the impact of having to provide a service across

all care groups, not just older people; and how to manage potential demand

once individuals had a clear entitlement to *Pflegeberatung.*

In May 2009 the regional representatives of the Care Insurance Funds and the

Land Berlin finally concluded their negotiations over the framework agreement

for the joint commissioning of Care Support Centres in Berlin (press release 13th

May 2009, see www.berlin.de/landespressestelle/archiv/2009/05/13/127765/),

an extended process that demonstrated something of the power and influence

of the Care Insurance Funds and perhaps explained some of the anxieties in

Rund ums Alter with regards to their prospective new *Träger*. The agreement

provided for a total of 24 Care Support Centres to be set up from existing

institutions (the 12 Coordination Centres, plus Care Insurance Fund advisory services) by summer 2009, to be extended to 36 by the end of 2011. The Federal Government's intention is for this to be achieved using available resources within pre-existing structures and budgets.

During the course of the sequence of short visits (April and October 2008, March and December 2009) I continued to meet with my network of key informants, including visiting the original Coordination Centre research site. Over this period the prevailing mood became more anxious as the arena for considering how the increasingly clear reforms would impact either positively or problematically shifted from the front line of service provision to the political level, principally between the representatives of the *Land* level government, the local boroughs, and the Care Insurance Funds. Through 2008 there was concern whether the *Land* Berlin would choose to develop Care Support Centres at all, despite the presence of two Coordination Centres in the Federal pilot project. By April 2009 the decision of the *Land* to go ahead was clear but the influence of the Care Insurance Funds was now felt as the negotiations ran over their supposed deadline. Even amongst those involved in the pilot there were distinct worries regarding the impact of the Care Insurance Funds not only as *Träger* but also with regards to staff trained as insurance advisers potentially practising *Case Management*, and a related concern regarding how the different duties would be shared between the new partners. This latter concern was shared by my key informants in the main research site when I undertook my last visit in December 2009, by which time they had been a designated Care Support Centre for only four weeks, many months later than anticipated, and

had experienced little change, apart from the dissolution of the old management structures, including the ABK (*Rund ums Alter* citywide management board – see **Figure 5.3**). Local managers, feeling some degree of loss of control, were by this point involved in setting up new structures with the insurance funds but it was still not clear who would offer *Pflegeberatung* at what level within those new structures, nor exactly how this might relate to their local practice of *Case Management*. In combination with the retirement of two key influential long standing supporters of *Rund ums Alter*, the Senator at the political level and the policy lead in the administration, there was clearly uncertainty about how the changes would work out in practice, although the commitment to the policy's aims remained intact. At a practice level, the staff in the local office intended to continue to function just as they had done as a Coordination Centre until such time as they were expected to do something different. This then was the situation at the end of my research project.

5.7 Summary

In this chapter my intention was to sketch out, in answer to my principal research question, the cultural-historical, legislative and policy context of German social care provision, and how that framed the emergence of and local policy rationale for *Rund ums Alter*, in order to present a close up view of how *Case Management* has been constructed, understood and indeed contested within this context. Its emergence and support from the *Land*-level government (see Figure 3.2) demonstrate the capacity for variation in policy within the less-centralised German system, in which the Berlin regional government used a

range of mechanisms to support its establishment, from the early West-Berlin

pilot through the use of employment support grants in the East to finally the use

of specific powers in SGB XI (Care Insurance) to establish a city-wide service

following the implementation of that legislation in the mid-90s. The absence of

any mandate for case management within that federal legislation, however, has

contributed to the perceived lack of legitimation (*Autorisierung*), particularly with

regards to the Insurance Funds, powerful independent agents within the system

whose role with regards to *Case Management* will now change as they become

responsible for *Pflegeberatung* under the recent reforms. Additionally, the

different responsibilities of the boroughs under SGB XII (Help with Care)

effectively prevent coordination of all care inputs because of the necessity to

refer all those requiring help through social assistance into a different system,

limiting *Rund ums Alter*'s *Case Management* to coordinating SGB XI and

privately funded services only. I have closed this chapter at a point where

Berlin's local and particular response to the problems of coordination within the

German system is presented with both opportunities and threats as policy and

legislative changes at federal level, which finally recognise and respond to the

coordination gap in the system, shift the balance of stakeholder influence in

ways that have yet to play out, but which have already signalled the end of

Rund ums Alter as it has been constituted for much of the last two decades,

with as yet unknown potential consequences for local *Case Management*

practice, the development of which up until this point taken place in a clearly

social work orientated professional context.

Chapter 6 - A Suitable Case for Comparison?

6.1 Introduction

In this chapter, I will consider the question of to what extent and in what ways this example of *Case Management* can be considered comparable in light of the border-crossing problems identified in Chapter 2. To explore this in relation to care management in England I will refer back to the key issues and themes identified from the research literature in Section 4.4, and to care management policy. I will structure the chapter around the framework illustrated in **Diagram 1** (p.19), taking into account the three central and overlapping dimensions of *similarity/difference*, *equivalence*, and *translation*.

6.2 Wider Cultural Context

The UK and Germany are not dissimilar, being relatively large, economically developed liberal democracies in northern Europe speaking languages that are relatively closely related. Linguistically, modern English has hybrid roots deriving from the merging of its Anglo-Saxon and Norman French antecedents; with simple everyday words often deriving from a shared Germanic past and more abstract, formal or complex vocabulary often deriving from French/Latin roots (Levin & Novak, 1991). English has since become the dominant *lingua franca* internationally as a result of British colonialism, more recent US hegemony and the influence of Anglophone popular culture. One consequence of this has been the absorption of '*englische Fremdwörter*', or English foreign

words, into the German language, a theme I will return to below with regards to key specific terms central to this study. Broadly, then, it is not unreasonable to describe the UK and Germany as northern European cultural cousins.

A detailed investigation of how their histories and cultures compare and contrast is beyond the scope of this piece of work but it is worth highlighting some important similarities as they provide a common framework, within and through which clear differences emerge. As noted in Chapter 2, historically embedded legislative and policy frameworks for the provision of welfare services provide clear points of comparison, with common themes such as the interface between targeted services rooted in older 'poor law' style approaches to welfare and historically more recent developments such as universal pensions and health care. One key difference is the continuing central presence of religious organisations in Germany amongst the independent social services providers (*freie Träger*), including in *Rund ums Alter* (some branches of which are run by *Diakonie*, the Protestant provider) and, of course, the Catholic University. These phenomena derive directly from the political influence of the Catholic Church during both the Wilhelmine and Weimar periods. More striking, given the role played both historically and in the present by the Jewish Welfare Association alongside the Catholic and Protestant churches, was the absence of a formally recognised Islamic welfare association, in a city and country with significant Turkish populations. Small Islamic welfare organisations appeared, ironically, to belong to the *Paritätischer*, the umbrella group that mostly represents smaller secular groups. It was almost as if the religious struggles of the past were embedded in the very structures of welfare, leaving no room for the religious

and cultural questions of the present. Although faith groups have a role in service delivery to some degree in England, their institutional presence is not equivalent to the situation in Germany, where they are powerful actors within the system. Indeed, members of both Catholic and Protestant churches must pay '*Kirchensteuer*' (church tax) from their salaries unless they have formally renounced their membership. Those who do may then be excluded from employment in church-run *Träger*. For example, although it was not necessary to be a Catholic to work at the Catholic University, it was nonetheless a requirement that employees remained formal members of a Christian church.

6.3 National Policy and Legislation

The overarching legislative structure of the *Sozialgesetzbuch* or Social (Law) Code emerges as a major difference between the UK and the Federal Republic. Social care legislation in the UK is fragmented (even more so since devolution), "a confusing patchwork of conflicting statutes enacted over a period of 60 years" according to the current consultation underway in England with regards to a proposed rationalisation of adult social care law (Law Commission, 2010, p.1). In Germany by contrast, although the process remains incomplete, from 1975 onwards the main components of '*Sozialrecht*' or 'social law' have been reviewed and incorporated into an overarching legislative code, the *Sozialgesetzbuch* (Kievel *et al.*, 2009), as noted above. From my own perspective, despite my fluent second language level German not being equivalent to my native English, German legislation is easier to make sense of

than UK legislative texts, which are indeed as incomprehensible as the Law Commission report describes.

Partly as a consequence of the legacies of different systems of law (Civil Law in Germany, Case Law in England) primary legislation in Germany also contains detail that in England often appears as secondary legislation in regulations or statutory guidance issued by the government. An example of this would be §15 of SGB XI (Social Care Insurance) which sets out the criteria for each of the three 'care levels' (*Pflegestufen*), the 'functionally adequate' equivalent of which are arguably the Fair Access to Care Services criteria (Department of Health, 2003, Department of Health, 2010), issued as statutory guidance in England, to which I will return below.

The policy drivers are clearly equivalent. Despite some differences of detail, the key driver of policy in both countries has been how to provide care and support to an ageing population in conditions of constrained budgets, with core institutions in each country experiencing financial strain prior to important legislative changes that took place more or less contemporaneously. The question is the degree to which the legislation (NHSCCA, SGB XI) that emerged from these policy drivers is itself equivalent.

As noted in previous chapters, I quickly understood in the field that SGB XI could not be considered in isolation from SGB XII (Social Assistance) Chapter 7 (Help with Care), particularly as, in the context of *Rund ums Alter*, this formed the basis of a local division of responsibilities between agencies. The key

difference between SGB XI and the NHSCCA derives from the former's nature as a form of social insurance, a mechanism for funding care that universally provides those insured (and meeting the criteria) with (partial) coverage of the costs of care without any kind of means test. The partial nature of the coverage means, however, that significant numbers of recipients must apply for help under the social assistance legislation, SGB XII (Help with Care). This latter piece of legislation, subject to means testing, in turn then looks more similar, in terms of its *mechanisms*, to the NHSCCA. However, it is formally subordinate to the overriding statute of SGB XI (Care Insurance), including for the criteria against which the level of need for care is assessed, an example of the coherence of the wider legislative framework of the Social Law Code.

Access to care services in England is via the local authority (either town or county council, depending upon which level locally has 'adult social services responsibilities'). In Germany access is through the individual's specific care insurance fund. In England local authorities are the sole gatekeeping agencies with financial responsibility for social care budgets. In the Federal Republic the Care Insurance Funds hold one component of social care funding, the other main agencies being the *Länder* holding budgetary responsibility for care under SGB XII (Help with Care), and the local authorities responsible for its implementation, an example of the organisationally more complex care landscape in Germany that makes equivalence difficult to establish.

SGB XI (Care Insurance) provides a clear definition of 'need for care', stating that "people in need of care are persons who need over the long term (likely to

be at least six months) a substantial (or greater) degree of help with normal,

regularly recurring activities during the course of daily life, because of a

physical, mental or psychological illness or disability". The closest equivalent in

UK legislation is Section 29 of the National Assistance Act 1948 which, in the

language of its time, defines people whose welfare local authorities shall make

arrangements for as "persons aged eighteen or over who are blind, deaf or

dumb, or who suffer from a mental disorder of any description, and other

persons aged eighteen or over who are substantially and permanently

handicapped by illness, injury or congenital deformity". This definition, in

tandem with the provisions for assessment under the NHSCCA and associated

statutory guidance, in turn triggers the potential provision of services under both

NHSCCA and the Chronically Sick and Disabled Persons Act 1970,

demonstrating the confusing patchwork of statutes governing provision of care

in England referred to above. Whilst there is clearly some thematic resonance

between these definitions, particularly with regards to physical and mental

impairment or illness and a concern with the degree and duration of any

condition, the German focus on the "normal regularly recurring activities of daily

life" (SGB XI §14) finds its functional equivalent in England's FACS guidance

(see Appendix 6), which comes into play at the point of assessment.

The FACS guidance (Department of Health, 2003, 2010) outlines a number of

distinct areas in which needs arising from the impact of a physical or mental

impairment or other condition must be assessed alongside the potential risk to

the individual's independence should help not be provided. In addition to the

focus on health status, the ability to maintain choice and control over the

immediate environment, and the ability to carry out personal care and domestic routines, there is (in principle, if not always in practice) a concomitant focus on work, education and learning, as well as the maintenance of social support systems, relationships, social roles and responsibilities. This gives the formal assessment guidance a wider, more socially orientated flavour than the purely functional, medically orientated process undertaken under SGB XI, with its four key domains of personal (physical) care, feeding, mobility, and domestic help.

The next stage in Germany is a tightly defined *Begutachtung* ('expert evaluation' of level of care), undertaken by a doctor, nurse or related professional, according to the (98 pages of) national guidelines issued by the Medical Service of the Umbrella Associations of the Health Insurance Funds (MDS, 2006), during which each element of each domain will be evaluated in terms of number of minutes of assistance required, as described in the previous chapter. The functional equivalent of this in England is an assessment under Section 47 of the NHSCCA, discussed further in Section 6.5.1. This is the central mechanism that lies at the heart of care management in England.

A key difference lies in the fact that, in Germany, individuals who meet the eligibility thresholds have entitlement to funds, whereas no such entitlement exists in England. In addition, in England the provision of informal care is taken into account, unlike in Germany, as noted in Section 5.3.3. A similarity between the two models derives from the grading of care needs (which in and of themselves are not limitless) into four separate levels, Care Levels 1, 2 and 3 in the German system (plus the semi official 'so called care level 0'), and into Low,

Moderate, Substantial and Critical in England. The descriptors for the levels do not easily map onto each other, a direct comparison of the definitions of Care Level 2 (SGB XI) and 'Substantial' (FACS) **Table 6.1** demonstrating how differently the need for care can be constructed.

SGB XI §15	FACS
Care Level 2 (severe need for care)	**Substantial – when**
To qualify for Care Level 2 there must be a need for help with personal care, eating or mobility at least three times a day at different times of the day, with additional needs for domestic help several times a week. The daily requirement for care and support must reach at least three hours, two of which must be solely for 'basic care'.	There is, or will be, only partial choice and control over the immediate environment; and/or Abuse or neglect has occurred or will occur; and/or There is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or The majority of social support systems and relationships cannot or will not be sustained; and/or The majority of family and other social roles and responsibilities cannot or will not be undertaken.

Table 6.1: Access Criteria - Care Level 2 vs. 'Substantial'

The interpretation of FACS criteria is highly variable (Hudson & Henwood, 2008), something I have also experienced amongst practitioners professionally. However, as noted in Section 5.3.3, one of my social work respondents in Berlin had prior experience as a nurse providing assessments under SGB XI and remained professionally sceptical of their uniformity.

A further critical difference lies in the power of councils with social services responsibilities in England to set their own threshold for eligibility under FACS, the infamous 'postcode lottery' whereby neighbouring local authorities may well set their thresholds at different levels, meaning that on one side of a municipal boundary someone could be eligible for (means tested) help with 'moderate' needs and on the other side only when their needs are assessed as 'critical'. Many local authorities in England have set their eligibility threshold at 'substantial' but significant variation remains, which is all the more striking, given the context of an otherwise highly centralised structure of government. In the Federal Republic by contrast, noted for its fragmented and de-centred government structures (Leisering, 2001), the criteria set out in SGB XI (Care Insurance) apply nationally and are not subject to local political variation. As noted above, the criteria apply equally to SGB XII (Help with Care) too, formally 'nachrangig' or subordinate legislation. This latter, means-tested safety net is used to provide care even at 'so-called Care Level 0', i.e. to those whose care requires less than 90 minutes help per day, the criterion for Care Level 1. Whilst the amount of income and savings individuals are allowed to keep is relatively low (the most common phrase used by respondents was 'enough to pay for a funeral'), the safety net is there for those without the resources (or relatives) to pay for or provide their care. In England, if a person with 'moderate' care needs lives in a locality where the council has set the threshold at 'substantial' there is no option but to cope without help for those with neither the personal means to fund the help privately nor family nor other networks willing or able to provide care.

The contrast is illustrated in **Table 6.2** below:

Germany	England
1. SGB XI (Care Insurance) 2. SGB XII (Help with Care)	NHS and Community Care Act
1. Social Insurance 2. Tax funded	Tax funded
1. Not means tested 2. Means tested	Means tested
Eligibility criteria from SGB XI apply to both statutes with no local variation	FACS criteria apply nationally with local variation regarding threshold for provision

Table 6.2: Legislative Similarities and Differences

The above comparison illustrates the difficulties inherent in establishing equivalence. The respective legal frameworks, each of which is shaped by, even embodies, specific historical and cultural influences (Révauger, 2001), in turn establish ('cause') the structures and mechanisms for care provision at subordinate levels, creating a differential partitioning of care processes that requires micro level (cf. Schunk, 2001) investigation to determine comparability.

6.4 Local and Regional

Indeed, a brief consideration of the respective political structures in England and Germany will illustrate further differences that also reveal a specific

weakness in **Figure 1.1** as a tool for comparison, specifically the collapsing of 'local' and 'regional' into one level. Below I have set out diagrammatically the differing levels of government with social care responsibilities in German and in England. The principle difference is the number of layers, with the *Länder* exerting considerable political influence in their own right, as well as possessing specific powers and responsibilities, as illustrated in the case study with regards to Berlin.

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                    ┌─────────────────┐
                    │     Federal     │
                    │   Government    │
                    │    (Germany)    │
                    └─────────────────┘
                  ┌──────────┴──────────┐
        ┌──────────────────┐   ┌──────────────────┐
        │  Das Land Berlin │   │ 15 other Länder,  │
        │ (state level govt)│   │   each with own   │
        │                  │   │     premier       │
        └──────────────────┘   └──────────────────┘
                 │                      │
        ┌──────────────────┐   ┌──────────────────┐
        │   12 Bezirke     │   │  Each with own    │
        │ (local boroughs) │   │ local substructure│
        └──────────────────┘   └──────────────────┘
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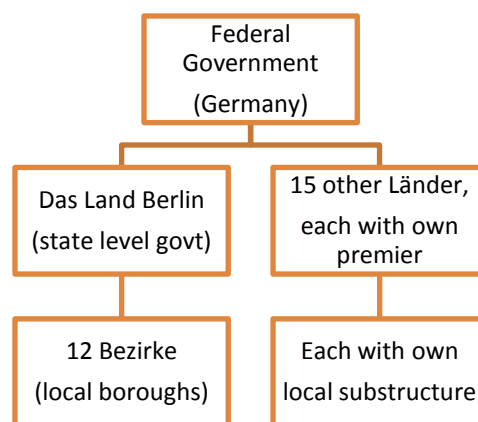
Figure 6.1: Federal and Local Government Structures (Germany)

By contrast, in England, despite the existence of several 'types' of local authorities, there are only two levels of government with regards to social service responsibilities, the national (i.e. the UK government, there is no government for 'England', unlike the other nations of the UK) and 'councils with adult social services responsibilities' (CASSRs), as depicted below. As noted above, power is significantly more centralised, with the former exercising considerable constraint on the latter's autonomy.
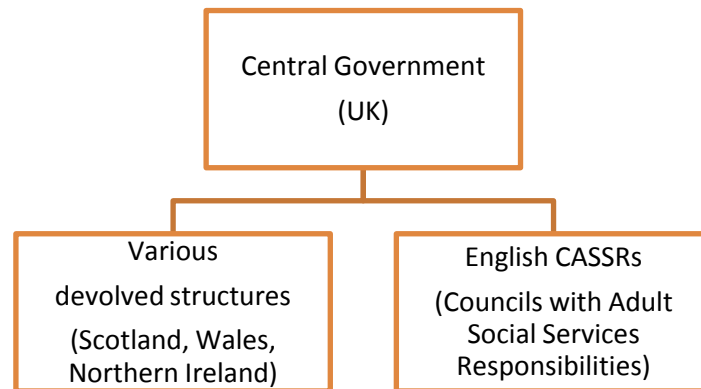
Figure 6.2: National and Local Government Structures (UK)

In addition to governmental structures in the Federal Republic, there is also the presence and influence of "parapublic institutions" (Freeman & Clasen, 1994, p.2), those bodies that merge public and private bureaucracies, such as the social insurance funds and the independent social services organisations or '*freie Träger*'.

These structural differences in Germany, at both federal and regional level, arise from the distribution of responsibilities for care embedded in the legislation and the financial and organisational consequences of those responsibilities. It is tempting to equate 'social insurance' with hypothecated taxation (like 'national insurance') but this does not capture the 'differentness' for someone from a UK perspective of grasping the fact that money goes directly and compulsorily from pay packets to organisations constitutionally independent of the government that act as powerful agents in their own right within the welfare system. It is important to acknowledge this lack of equivalence at an organisational level. My original 'two case' strategy was based on the apparent organisational

equivalence of two local authorities that proved mistaken, at that preliminary

stage not having fully understood the relationships between the complex matrix

of organisational actors and the legislative framework. The *Bezirk* in Berlin and

the local authority in England were not *functionally equivalent* (Marsh, 1967 in

Kennett, 2004), and neither was *Rund ums Alter* equivalent to a third sector

organisation commissioned to provide a specific service on behalf of an English

council.

This organisational complexity is added to by the range of private providers

active in the care sector since the implementation of SGB XI (a consequence of

the legislation that bears *similarity* to the NHSCCA) and illustrates why, in this

multi-actor system, there is such an emphasis in *Rund ums Alter* on *Care*

Management in the German sense, i.e. the need for the development and

management of network arrangements at the organisational or system level, a

core task of the local team leader in *Rund ums Alter* that took up a considerable

amount of her time (and raises questions regarding the inefficiencies generated

by the organisational complexity). Arguably, *Care Management* could be

described as functionally equivalent to 'partnership working', although the range

of potential partners is significantly greater in the German context. This

organisational complexity is mirrored in the insurance model healthcare sector

too, in stark contrast to the monolithic NHS, with some providers active, as

noted, in both the health and social care arenas.

6.5 Local *Case Management* Practice

Within this complex legislative and organisational context *Rund ums Alter*, as outlined in Chapter 5, offers three levels of service: information; advice/consultation (*Beratung*); and *Case Management*. As we have seen, different offices differentiated between these concepts, especially the latter two, differently, leading to the tensions around the issue of *Abgrenzung* or 'boundarying' of the concept of *Case Management*, reflected in the annual evaluation figures. In the local office, it was generally a simple algorithm based on whether there was a need for more than one service and some degree of coordination, the most basic components of case management identified in Section 4.3.2. There was no sense of targeting based on level of service user need or risk of entry to institutional care, despite the incorporation of 'community based before institutional care' from SGB XI into the service concept, although such latter cases would inevitably meet the 'rule of thumb' for *Case Management*, as did Herr C. (Appendix 2.3). The variation in operational definitions between offices in Berlin is, however, reflected in English local authorities' variable implementations of care management (Weiner *et al.*, 2002, Challis *et al.*, 2001), a similarity that may emerge from the wider and long standing definitional variance of case management, noted in Section 4.3. A key difference derives from relationship of the case managers to the financing of care as a consequence of the automatic access to funding for service users who meet the criteria of SGB XI. In England funding is directed to services either provided or commissioned by local authorities, not to individual service users, altering the role of the care manager as broker.

6.5.1 Assessment vs. '*Assessment*'

There is a notion in translation of 'false friends' (Munday, 2008), that is words which can confuse people learning a second language because of their close resemblance to a word in their own language, an example being '*sensibel*', meaning 'sensitive', not 'sensible'. Encountering English words adopted into another language can be even more challenging, as meanings accrue in relation to the word's new linguistic context. The German word '*Assessment*' proved extremely problematic in this respect, particularly in combination with the tendency to use one's own familiar framework as a template for understanding (Baistow, 2000). Writing the original proposal for the Fellowship, I made the assumption, based on internet research, that *Rund ums Alter* had been 'commissioned' to provide 'assessment services' (my conception of which was clearly structured through my English experience of care management) within the German care system in Berlin. Having downloaded an earlier edition of *Rund ums Alter*'s *Konzept* leaflet, I contrasted the Department of Health's 1991 guidance on care management with the process of *Case Management* outlined in the German leaflet (see **Table 4.1**).

I was aware at this stage of neither the interface of SGB XI (Care Insurance) with SGB XII (Help with Care), nor their influence on local service arrangements, nor the extent of the role of the Care Insurance Funds and specifically the role of the Health Insurance Medical Service in determining the need for care. I was lulled into a false sense of 'similarity', amplified by the use of the German word *das Assessment*, an example of '*Denglisch*', a phrase

describing a range of linguistic phenomena which includes the increasing

borrowing of English foreign words in German professional vocabularies,

perhaps an example of Anglophone domination through 'Policy English', *pace*

Clarke (2005).

It took some while to unpick the different mechanisms signified by different

phrases, to figure out that what is described as 'assessment' in community care

in England is (to some degree) functionally equivalent on the one hand to the

Begutachtung (see below) undertaken by the Health Insurance Medical Service

and on the other the determination of eligibility for financial assistance under

SGB XII (Social Assistance – Help with Care), i.e. 'assessment' in community

care refers to two distinct mechanisms, determining the need for care and

means testing. '*Das Assessment*' was truly a 'false friend', its meaning in this

case being highly context specific. Although in the broad sense its usage is the

same as in English, the German word '*Assessment*' was not applied to the

process undertaken by the Health Insurance Medical Service to determine the

level of need for care. This was instead described routinely as a '*Begutachtung*',

which, in turn, can also be translated as 'assessment' in English, although

carrying the specific sense of 'expert opinion'. Payne (2000) argues that the

assessment element came to dominate care management practice in England

because of its role in rationing services, at the expense of other aspects of case

management and my professional experience would certainly confirm the

primacy of assessment in adult social care practice. What had seemed 'similar'

from a distance, based on the descriptions of the 'core tasks' of case

management in **Table 4.1**, turned out to be very different when examined close

up, confirming the need for a more complex analysis of similarity and difference (Askeland & Payne, 2001).

The assessments undertaken in *Rund ums Alter* are not equivalent to the assessment process in English care management, instead they were separate from and additional to the determination of need for care under SGB XI. The new provisions of §7a *Pflegeberatung* now require a formal recording and analysis of the need for help and support that builds on the outcome of an individual's 'determination of the need for care' undertaken by the Health Insurance Medical Service (see Section 5.6 and discussion below). How that will incorporate pre-existing *Rund ums Alter* practice is yet to be determined.

6.5.2 What's in a Name? '*Case Management*'

Of particular interest in Berlin, given that the seeds of my interest in coordination lay in the bringing together of care services with equipment and adaptations (see Introduction), was the involvement of *Rund ums Alter* in '*Wohnungsanpassung*' or 'home adaptation' services. The social workers developed expertise in a practice area largely controlled by occupational therapy services in England (a non-equivalence of role) and routinely assisted service users with arranging adaptations to their homes, including, as in the 'illustrative cases', level access showers ('*bodengleiche Duschen*'), raising a question with regards to the maintenance of professional boundaries and the degree to which they should be crossed in the interests of service users. By developing this expertise as social workers, they effectively integrated the provision and coordination of adaptations and care services.

The merging of '*Wohnungsanpassung*' conceptually into '*Case Management*'
for the purposes of the annual evaluation of *Rund ums Alter* is also interesting
in relation to my professional experience of a lack of clarity as to whether
equipment and adaptation services are positively included within the broader
notion of care management in England, a concept often narrowly understood in
practice as the brokering and arrangement of personal care services. Although
care managers within local authorities routinely refer to occupational therapy
services within the same organisations I would question the degree to which
care and equipment inputs are routinely *coordinated*, the services instead often
being managed and financed as separate units with separate assessments and
timescales, reflecting the internal divisions originally identified by Challis (2003).
This aspect further highlights the difficulties in establishing the nature of case
management but separately suggests that, having identified a gap in the
German social care system and claimed it for themselves (illustrated locally by
the representative of the *Bezirk* confirming they always refer such work to the
organisation) *Rund ums Alter* may have then consolidated and protected the
practice by identifying it as *Case Management*.

Another key difference that considerably constrained comparison between this
Case Management service and care management in England lies in the
relationship of the practices to their respective legislative frameworks. One of
the themes that emerged during the fieldwork was the lack of '*Autorisierung*' or
formal legitimation the social workers experienced when working as case
managers within the care system, a factor also highlighted in the discussions of

the 'typical' case management undertaken on behalf of Herr C. (see Appendix 6.3), and noted by Nesti *et al.*(2005) as a variable between countries in the PROCARE comparative study. *Rund ums Alter*'s relationship to the legislative framework is indirect, having been commissioned by the *Land* using its powers under §9 SGB XI (Social Care Insurance) for maintaining an overarching care infrastructure, in order to fill a perceived gap in the federal system, the absence of a case management function. Although commissioned explicitly to pursue the aims embedded in §3 and §5 of the legislation, 'rehabilitation before care', and 'community based care before institutional care', there is nothing either in or arising from the legislation (prior to the 2008 reforms, an issue I will return to below) that describes or defines case management, unlike the statutory care management guidance issued following the NHSCCA in England, which clearly 'authorises' care managers in their professional roles. Additionally, the service is '*freiwillig*', or 'optional', i.e. the service is additional to the usual provisions within the care system so has to find its own clients through publicity and outreach work. *Rund ums Alter* is not in itself a gateway to care services but was specifically set up as '*niedrigschwellig*' or 'low threshold' for access in order to assist individuals with their journeys through a complex care environment. As a consequence the social workers have no responsibility for the amount of resource made available to the service users through the determination of their care level (indeed, the social workers sometimes helped service users to challenge the decisions of the Health Insurance Medical Service), and no responsibility to consider cost, quite unlike care managers in England.

Indeed, the rights based elements of SGB XI (Care Insurance) guarantee that, if the criteria determining the need for care are met, then benefits will be provided, either as cash or a fixed payment towards services, according to care level. This contrasts sharply with the current circumstances in England, under which many local authorities are shifting their FACS thresholds to 'Substantial' and beyond, effectively removing potential service users from the system. Given the preponderance of *Rund ums Alter* service users with Care Levels 1 and 2, arguably roughly equivalent to 'Moderate' and 'Substantial', it begs the question of comparability of user groups and the degree to which this affects what is provided in the name of case management. Challis (2003) in particular emphasises the dimension of targeting those with complex or severe needs to *define* case management and differentiate it from how services are organised for other less dependent older people requiring social care services, contrasting 'care management' with 'intensive care management'. The parameters of *Case Management* in the local office of *Rund ums Alter*, at least as shown in the illustrative cases, three of which were designated as such, tend toward a broader interpretation. The new §7a SGB XI stipulates that the helping process of 'especially complex' cases must be evaluated and documented separately, a differentiation in the new provision that may lead to the development of two versions of *Pflegeberatung*, depending on the complexity of the case.

It will indeed be interesting to see the impact over time of both *Pflegeberatung* and the new care support centres (*Pflegestützpunkte)* under §92c in this respect, given the expectation is that, in principle, they are expected to act as a single point of access and that *Pflegeberatung* is intended to incorporate and

coordinate all forms of help and support, no matter what their source, including those provided under SGB XII (Help with Care). Given the potential for role conflict amongst the different agencies now required to cooperate within the framework of the Care Support Centres, this will require significant local negotiation. Significantly, with the introduction and definition of *Pflegeberatung* in the reformed legislation, the problem of lack of '*Autorisierung*' or 'legitimation' for *Case Management* should no longer apply, as the concept is no longer simply an approach or a method but a legally defined intervention. As at my last visit, however, who was authorised to provide *Pflegeberatung* (and perhaps at what level, given the notion of 'complex cases' in the legislation) within the new structures remained an open question, as noted in Section 5.6.1.

Organisationally, the creation of Care Support Centres in Berlin represents a merger of two services, the former advisory services of the Care Insurance Funds and *Rund ums Alter* (and in time will need to link with the local authority's *Sozialamt*). As Clarke (2005) notes, there is never an empty space simply waiting to be filled by the arrival of new policy, it is always already full of knowledges, orientations, habits and practices. In this case, there are two sets of each of these dimensions that will need to be amalgamated into a single coherent service. Bringing their experience as a 'virtual' organisation with multiple *Träger*, the former staff of *Rund ums Alter* may yet set the template for the further development of Care Support Centres in Berlin, bringing their specific variant of *Case Management* practice into this new organisational arrangement.

More speculatively, the process of re-naming can lead over time to redefinition, as has been argued in the English context. Given the lack of definitional consensus regarding the concept of case management beyond those basic components outlined in this study, re-naming could alternatively be understood as a mechanism for identifying specific locally implemented variants. In the recent reforms, none of the potential German terms for case management (*Case Management*, *Unterstützungsmanagement*, *Fallmanagement*) appear in the text of §7a, only *Pflegeberatung* is referred to. Many practitioners in England remain unaware of care management's antecedents in US case management, understanding care management as a thing in itself. Indeed, I have come to understand the familiar, i.e. care management in England, from a new perspective through the experience of cross-national research, as Hantrais (1999) indicates can happen, seeing 'care management' now as an already locally shaped variant of 'case management' that may be becoming increasingly detached from its origins in case management that many deemed tenuous from the beginning. Certainly my most recent professional experience has been of the increasing separation of the different steps of care management, e.g. assessment, arranging services, reviewing etc., each of which may be undertaken by a different person or even a different team, departing from at least one of Gursansky *et al*'s (2003) principles, the notion of the case manager monitoring and responding to changed circumstances, which requires continuity of case manager involvement. As *Case Management* in care services is re-named *Pflegeberatung* in Berlin (and across Germany) it is also being brought into a new *Träger* relationship with the Care Insurance Funds, who, like local authorities in England, hold budgetary responsibility for care provision and will

have to respond to the increase in demand the newly established right to

Pflegeberatung will inevitably bring, perhaps altering the model in German

terms from 'independent *Case Management*' to 'institutionally-embedded *Case*

Management' (Wissert, 2004). In this respect, developments may yet become

more similar in ways that might not be welcome, i.e. managing increasing

demand within current budget constraints, a key reason suggested for the

emergence of a more bureaucratic form of care management practice in

England (Payne, 2000), with the potential for similar conflict over the role of

social work skills in a new practice arena that will be shared with both nurses

and insurance advisers. It will indeed be remarkable if *Pflegeberatung* achieves

the Holy Grail of having a single professional responsible for managing and

coordinating the entire care process, regardless of the source or funding of

each component service.

6.6 Summary

In this chapter I noted how key differences can co-exist alongside base-level

points of similarity, outlining on the one hand the wider cultural similarities

between England and Germany and more specific dimensions such as the

commonality of historically embedded legislative frameworks that enable the

organisation and provision of welfare services, and on the other how specific

elements such as the historical influence of churches can lead to quite different

organisational arrangements within that wider commonality. I highlighted key

differences in how the overarching legislative framework for the provision of

care is constructed but used the notion of functionally equivalent mechanisms to

identify points of similarity. More broadly I caution that apparent similarity can be a function of perspective or distance that necessitates micro-level study to fully determine. I also demonstrate how formal equivalence can be potentially misleading, particularly at the organisational level, again necessitating a focus on functional equivalence instead. Finally, I show how translation remains problematic even when English words are absorbed into another language with their core meaning relatively unchanged, e.g. assessment, highlighting the need for 'unbundling' (*pace* Austin, 2002) case management in its specific welfare contexts. In the final chapter, I will outline what can be learned from this study overall.

Chapter 7 - Conclusions

7.1 Learning

My overarching research question asks, as noted above:

- What can the study of a case management service for older people in Berlin tell us about how case management translates into differing national welfare contexts, taking into account the methodological challenges of cross-national research?

and my final questions refine this by asking what we can learn both substantively and methodologically from this case study.

Baistow (2000) cautions that the most important condition for learning from cross-national research is awareness of the kinds of problem that arise both in its execution and in drawing conclusions from it, the issues highlighted in Chapter 4 to which I return in Section 7.2. As noted in Section 1.3 however, she draws attention to specific ways we can learn from cross-national research, including: *learning about others*; *learning from others*; *learning about ourselves*; and *learning with others*. I will next address a number of ways in which this case study may contribute to learning before turning to the limitations of this study.

7.2 Substantive Learning

It is clear that the preconditions for the development of case management identified by Moxley (1989) pertain to the German context of care, namely:

- De-institutionalisation

- The decentralised nature of community services

- Growing numbers of service users with multiple needs living at home

- Fragmentation of care services

- A growing awareness of the importance of social supports and carers

- The need for cost containment

Many of the problems that Kodner (2003) identifies for case management to address are present too, particularly the need for the coordination of services from multiple providers and the fragmentation that arises from different services being the responsibility of multiple jurisdictions, institutions, professions and funding streams that leads to the most basic definitions of case management. What is not clear is the degree to which this example of *Case Management* resolved those problems or indeed was able to because of the influence of the wider context.

In this study I have traced how *Case Management* was established in Berlin in relation to a wider German legislative and policy context that had itself explicitly eschewed the approach (Evans Cuellar & Wiener, 2000), through the independent agency of the *Land* Berlin using its powers for developing the

overall care infrastructure under that same federal legislation (§9 SGB XI).

Locating *Rund ums Alter*'s *Case Management* service in its specific context of

care processes, mechanisms and structures effectively 'unbundled' it, *pace*

Austin (2002). Instead of focusing on the implementation of the 'core tasks' of

case management, the superficially similar definitions of which, as I have

demonstrated, represent a poor framework for comparison, I have identified a

specific set of practices with specific groups of service users, the constraints on

which are a direct consequence of that policy and legislative environment, *viz*:

the separation of the 'determination of the need for care' from the *Case*

Management assessment process; the co-existence with the system for

providing help with care through social assistance (which, despite some

similarities of practice did not, as noted, refer to its activities as '*Case*

Management'); and the lack of '*Autorisierung*' that resulted from the absence of

any formal recognition of *Case Management* in that wider policy and legislation.

The introduction of *Pflegeberatung* at the federal level is intended to address

each of these areas but at the time of the research, this local version of *Case*

Management, already in existence for most of two decades, was clearly both

shaped and constrained by that wider context. Reiberg (2007) describes the

Coordination Centres as one of the few practice examples in Germany where

Case Management is implemented fully, both in terms of all the phases of *Case*

Management in individual case work (not a reliable guide, as noted), as well as

at the system level of coordination undertaken in their respective local boroughs

(*Care Management*). Yet I think this view fails to conceptualise the role of the

Health Insurance Medical Service as part of the case management assessment

process, mainly because it is so 'taken for granted' within the German system, although this was the focus of a post-presentation discussion with a German national expert at the second conference I attended.

Comparing this to care management in England further demonstrates the need to examine the specific content and context of local practices, even when they are ostensibly the same, as with the 'core tasks' (see **Table 7.1** below). In order to 'unbundle' processes comparatively, an active engagement with the key problems of similarity/difference, equivalence, and translation is necessary. The *Case Management* provided in Berlin was in the main a brokerage, advocacy and care navigation service, with a strong focus on the arrangement of adaptations in the home, an activity not always conceptualised as care management in England but always regarded as the professional domain of occupational therapists. Although there was an assessment process in *Rund ums Alter*, the core determination of care needs had, as noted, already taken place, the mechanism that is functionally equivalent to the community care assessment that lies at the heart of care management practice in England. As shown in Chapter 6, there are multiple points of non-equivalence. Even if components of the service are recognisable, this may lie in either the wider similarities of case work, or the flexibility of interpretations of case management and wider notions of case work. Despite the fact that neither example targets specific groups of older people for (intensive) case management, the optional nature of the service in Berlin contrasts sharply with the compulsory nature of the pathway through care management for those wishing to be considered for help with care in England. Indeed, Challis *et al.*(2000) comment that in some

'Core Tasks' (Austin, 2002)	Comments	*Case Management* in Berlin	Care Management in England
Outreach	*Different relationship to wider context (compulsory/optional) determines different practices*	Must seek out clients ('optional' service)	Single compulsory gateway to community care via local authority
Screening	*Different pathways (see diagram 5, Section 5.3.4) arising from legislation determines 'client group' in Berlin. Single pathway in England*	Client group defined by the division of the legislation – those requiring 'social assistance' referred on to local *Sozialamt*. Practice based 'rule of thumb' to determine whether Information, Consultation, or *Case Management*	All entrants to system go through care management process
Assessment	*Assessment processes not functionally equivalent, raise core issues of 'translation,' and highlight lack of organisational equivalence (role of 'parapublic' institutions, etc.)*	*Rund ums Alter Assessment* additional to 'determination of level of care', undertaken by Health Insurance Medical Service under SGB XI Means testing for SGB XII clients undertaken by *Sozialamt*	Assessment process dominates care management practice under NHSCCA
Care Planning/ Implementation	*Highlights the incorporation of 'adaptations' work into 'Case Management' definition, illustrating non-equivalence of role and malleability of definitions of case management* *Contracts with service user in Berlin, with local authority in England*	Significant amount of 'care planning' devoted to 'adaptations', plus assistance with identification and contracting with local providers approved by the Insurance Funds	Production of 'statement of needs' and 'care plan', generally drawing from private providers holding large scale contracts with local authority Differential degree to which OT services (internal to local authorities) are incorporated or kept as separate process
Monitoring	*Generally practice in England more formalised because of its statutory nature*	Case held open until all elements in place, then formal evaluation	Review after 6 weeks common practice
Re-assessment	*As above*	Clients encouraged to contact for further assistance if required (continuity of involvement)	Requirement under FACS for review every 12 months, often not prioritised (and little continuity of care manager involvement)

Table 7.1: Comparability of '*Case Management*' and 'care management'

locations this leads to care management being little more than a process through which individuals receiving social care will pass, rather than something more specific.

In terms of my overarching research question, then, I believe I have demonstrated the degree to which this version of *Case Management* in Berlin has been both constructed and constrained by its wider context, giving it a highly localised flavour. I have also shown that two variants of case management, *Case Management* in Berlin and care management in England differ considerably along a number of fundamental dimensions, although it is possible to identify functionally equivalent mechanisms between the systems within which the practices take place. Paradoxically, one of the similarities lies in the *internal* local definitional variations in each example, in Berlin between local offices' differing interpretations of *Case Management*, and in England between local authorities' differing implementations of care management. This indicates that not only does case management become significantly shaped by the local environment, as in both these examples, but that (again in both examples) it continues to generate differing interpretations of what it is or should be. If this were to be replicated in further micro-level studies of specific examples of case management, it would strongly suggest that the roots of this variability perhaps lie not in inadequate local interpretation of the approach but in an original concept that may be relatively poorly boundaried in and of itself, as indicated by the absence of a settled definition despite more than three decades of literature (Austin, 2002).

The question therefore remains whether there is an identifiable "invariant core" (Popovic, 1976 in Bassnett, 2002, p.33) to the concept of case management. As outlined in Section 3.3, there are a range of overlapping (and competing) definitions that range from the more abstract core definition provided by Ewers (2005b) invoking the temporal and spatial dimensions of care processes to the principles-based approach of Gursansky *et al.*(2003), to the possession of an extensive range of key attributes that Challis (2003) argues defines the approach, including targeting and the core tasks. There are clearly overlaps between these aspirational definitions, from which the most basic definition of case management can be constructed, but what is missing is any sense of the degree to which any or all of these aspirations are achievable in concrete circumstances of specific care contexts and the extent to which any constraints may be structural. Case management is predicated on the notion of coordination, an assumption of agency by case managers in circumstances where that agency may be constrained by existing welfare structures. In this particular example, social workers coordinated a range of care inputs for older people but that range was limited by the structural consequences of the specific legislative context. The multitude of aspirational definitions beyond the most basic, however, detracts from, rather than contributes to conceptual clarity in practice. Indeed, the distinction made in Germany between *Case Management* and *Care Management*, i.e. between coordination at the individual case and at the organisational level, is a rare example of a contribution to clarity that perhaps warrants wider acceptance.

At a policy level Glendinning (2007) suggests much can be learned from the German system, without necessarily adopting social insurance. She highlights the single set of criteria outlined in SGB XI (Care Insurance) and the relative uniformity with which it is applied and administered across Germany by the Health Insurance Medical Service, comparing this with the variable mechanisms for access to currently fragmented and separately administered long-term care and related resources in England, suggesting that Attendance Allowance (itself arguably functionally equivalent to the cash benefit under SGB XI), NHS Continuing Care, and local authority adult social care could be amalgamated and access made more equitable and transparent through the adoption of a similar mechanism. Whilst agreeing in principle, I would be cautious of a potential medicalisation of care if, as in Germany, the assessment process was given over entirely to health care personnel. As noted, FACS criteria in England address a number of domains that go beyond the narrow German focus on physical care and emphasise the service user's social context, some element of which should be retained, although the argument for bringing together those disparate elements of long-term care is persuasive. As shown in this study, however, the operation of means tested co-payments in tandem with a universally available but limited provision can itself create organisational boundaries and coordination problems of its own.

Nonetheless, *Rund ums Alter*'s optional advocacy, brokerage and care navigation model could indeed in my view potentially provide a template for different ways to support older service users in England in the changing structures brought in under the *Personalisation* agenda (Department of Health,

2007) in England, particularly if wider changes to the system result in less emphasis on the assessment process. The social workers' role in Berlin was often to support service users in 'spending' their allocated level of benefit, likened to a voucher system by Evans Cuellar and Wiener (2000), that has similarities to the notion of a 'care managed' personal budget (Glendinning *et al.*, 2008). Additionally, many of the users of *Rund ums Alter*'s services were individuals who had to fund the gap between what they received under SGB XI (Care Insurance) and what they actually needed, i.e. they had no recourse to SGB XII (Help with Care). In this sense they are partially equivalent to 'self funders' within the English system, for whom local authorities ought to provide information and guidance (Dalley & Mandelstam, 2008). A small commissioned care navigation service, perhaps provided by a local third sector organisation, could provide such support to those who must fund their own care, helping them to make cost effective decisions and avoid premature entry to institutional care.

A further point of 'learning from others' that involves 'border crossing' of a different sort arises from the fact of the social workers in Berlin developing knowledge and expertise in the commissioning and specification of adaptations to the home, an activity that was formally re-defined within their service as '*Case Management*', but which, even if recognised as sitting within the overall care management process in England, would not be undertaken by social work trained professionals. As noted earlier, this raises important questions about crossing professional borders to meet the needs of service users. The experience of their practice in Berlin confirms for me that professional flexibility, supported by appropriate training, is something that should be welcomed.

7.3 Methodological Learning

This study has demonstrated the need, at least in studies that cross linguistic barriers, for close methodological attention to the overlapping problems of establishing similarity and difference, equivalence, and translation. For direct comparison there is a critical need to distinguish formal from functional equivalence (Marsh, 1967, in Kennett, 2004) to guard against drawing inappropriate inferences. Given the influence of structure demonstrated in this study it is particularly important to acknowledge that establishing equivalence at the organisational level may not be achievable (or appropriate). The very notion of regional government with genuine power to shape and influence local services autonomously is entirely missing within the English context. This lack of organisational equivalence was one of a number of 'asymmetrical' dimensions that presented themselves in this study. The notion of 'functional equivalence' in such circumstances becomes key.

Methodologically, this study has demonstrated a need for caution, particularly if researching from afar. What can appear similar from a distance may turn out to be very different close up, as with the case of 'assessment' vs. '*Assessment*' above or, indeed, the 'core tasks' of case management, the definitions of which in both examples indicated a greater degree of similarity than was actually the case once 'unbundled'. Issues of translation are difficult and must be addressed directly, specifically because of the way that social reality is differentially partitioned in different languages, but this does not mean a 'functionally

adequate' (Reiss & Vermeer 1984, in Munday, 2008) translation cannot be identified, depending on the degree of points of similarity at the wider cultural level. Indeed one of the more intriguing factors during the fieldwork was trying to identify, even at the moment of becoming aware of the differences of structure, role and process, what it was that contributed to an overall sense of professional familiarity with the tasks at hand. There was clearly some kind of "invariant core" (Popovic, 1976 in Bassnett, 2002, p.33) underlying the differently partitioned reality I was experiencing which may have been rooted in wider conceptualisations of professional helping relationships (Rogers, 1989 [1958]), that enabled a degree of comparability at the most basic level, against which the differences stood out.

Finally, this study has shown how English words adopted into other languages, reflecting the power of 'Policy English' (Clarke, 2005), continue to accrue nuance in response to their new cultural and linguistic contexts, sometimes acquiring a precision they don't possess in their original contexts (*Case Management*, *Care Management*) and sometimes retaining their general meaning but being utilised (or not) in specific contexts, e.g. *Assessment*. This is a particular danger for English mother tongue researchers who do not speak the language of the research site and may assume these terms are identical. It is for this reason I have emphasised specific *englische Fremdwörter* ('English foreign words') as *German* words.

7.4 Limitations of this Study

One of the core concerns in social research is the influence of the researcher on the research process, particularly in ethnographically orientated qualitative research where the researcher is effectively the research instrument and the data are essentially generated from the social interactions and experiences of the individual researcher. Reflecting back on Isherwood's (1939, p.9) "I am a camera ..." quotation at the start of Chapter 2, it is clear that I have not "passively recorded" without thinking as Isherwood claimed for himself. Instead I have drawn on my academic and professional knowledge of care management in England as an imperfect map (that at times had to be bracketed off) to actively negotiate new terrain, the experience of which I have critically analysed and interpreted in light of the specific constraints of cross-national social research, "fixing" this experience through the process of writing, both the immediate writing of field notes, their subsequent analysis and transformation into a narrative of the case.

Hammersley (2001) notes the dichotomy based on the assumption that research is systematic and rigorous, whereas evidence from professional experience is portrayed as unsystematic and as lacking in rigour, i.e. it is not built up in an explicit, methodical way but rather through an at least partially unreflective process of sedimentation. In Section 3.4, however, I drew attention to work that indicates certain approaches to qualitative research are more closely aligned to the skills and activities engaged in by professional helpers,

specifically ethnographic approaches (Goina, 2008, Shaw & Gould, 2001), and suggest this dichotomy is less clear in practice. In this piece of work, as previously noted, the more ethnographic elements took centre stage as I re-orientated my position, making my field notes a core (but not sole) source of data, a method I had no prior research experience of using (apart from keeping *case notes* in practice). Had I foreseen this development I may have sought specific training in this method, particularly to train myself to distinguish at the point of writing between the observational, the interpretative, and the reflective more clearly. What this raises is the degree to which the evidence has been filtered through the person of the researcher and the extent to which that has been addressed successfully. In Chapter 3 I have outlined the multiple methods that have been employed to generate this case study specifically to ensure it is not solely reliant on ethnographically generated data and specifically in Section 3.7.1 outline the measures taken, which I believe underpin its authenticity.

In their review of social care research Sharland and Taylor critically evaluate Boaz and Ashby's (2003, in Sharland & Taylor, 2006, p.514) radical argument that we should distinguish between the "signal" of research and the "noise". In this formulation, demands for high quality methodological technicality are understood as noise that can threaten to drown out the message of the research, i.e. its signal, which represents its true value and authenticity. Whilst not accepting Boaz and Ashby's depiction of all technicality as solely noise, the metaphor is helpful in considering the degree of 'interference' affecting the signal due to methodological issues. The field notes data, because of its 'reception' through my own simultaneous interpretation, is influenced by both

what I was attending to (and by extension, what I was not attending to), the degree to which I fully understood what was happening or being said, as well as the degree to which I technically recorded this. For these reasons, it was important that this was not my sole data source, that I engaged in iterative checking with research participants and also sent the draft case study to a key informant for review, to ensure a clear enough and trustworthy "signal".

Many accounts of ethnography also make reference to the danger of 'going native', a process of identifying with the research subjects that endangers the researcher's ability to stand back from the context, and by extension their researcher role. During a later follow up visit, I realised I had assimilated the belief of some of my key informants that the Care Insurance Funds represented a threat. This may have resulted from my increasing understanding that the strongly social work orientated approach of *Rund ums Alter* could indeed be challenged by the inclusion of other professionals in the Care Support Centres and reflected a desire for that social work orientation to survive. This realisation, however, reflected on in my research diary, helped me to re-orientate my position. Nonetheless, it brought to the surface the fact that, despite the constraints on the service outlined in this study, I positively rated what they actually delivered to their service users. I have tried to bracket off this general positive attitude as I have addressed the specific questions of the study.

Finally, this is an N = 1 case study, which incorporates a question that explores its potential comparability with other examples of case management by drawing on published accounts of care management and care management policy in

England. The case study is comparative (or rather *comparable* in Rose's (1991, in Kennett & Yeates) reformulation) in Hague *et al's* (1987, in ibid., 2001) sense that it is an example of a larger phenomenon (the adoption of case management in different welfare contexts) that has the capacity to inform debate beyond the country of focus, and offers a detailed illustration of a theme or themes of wider interest, specifically the importance of identifying how translation takes place in cross-national studies and especially the problematic adoption of English foreign words into other languages' professional and technical vocabularies. However, findings from a single case study cannot be generalised and without further micro-level studies to 'unbundle' additional examples of case management in specific contexts this study's conclusions with regards to other elements, including variations in the local definition and implementation of case management and what that might mean in relation to the core concept, must not be inappropriately generalised either.

7.5 Original Contribution to Knowledge

Nonetheless, within the constraints set out above, this thesis clearly demonstrates, through the process of unbundling one example of *Case Management* at the micro-level, i.e. tracing the relationship of specific practices to their wider policy, legislative and organisational contexts, the determining impact of those contexts on how it has been enacted, shaped and constrained in Berlin. Furthermore, through examining its comparability in relation to care management in England the study shows how broadly similar definitions of the 'core tasks' of case management used in Berlin and in England (see **Table 4.1**)

are in practice so different (as summarised in **Table 7.1**) when analysed in relation to the functional equivalence of their component mechanisms as to question the utility of the core tasks for either defining case management or providing a framework for comparison. It also illustrates that problems of variability of definition in multi-site examples are not necessarily solely due to local influences but may also derive from the relatively unspecific and/or variable definitions of case management more generally. Additionally, the study has shown in particular how the adoption of English words and expressions into non-English language welfare contexts does not resolve or alleviate the central problems of establishing similarity/difference and equivalence in cross-national social research. Indeed, it may simply make translation more complex.

7.6 Reflections

Before setting out on this journey, both literally and more figuratively, I generally thought of comparative cross-national social research as unambiguously useful for the development of policy and practice in England. I have shifted to a much more nuanced position that recognises the inseparability of practice from context and therefore demands a more critical stance in relation to the notion of transferability, i.e. the degree to which policies and practices 'translate' from one welfare context to another. If we are not careful, we end up with the policy equivalent of an online 'Babelfish'-style translation, where the wider context that shapes the meaning is absent. This also highlights more generally the problematic nature of establishing entity boundaries in social research. The social world is inherently 'fuzzy', a problem for both quantitative and qualitative

approaches to research. In this study, I have had to consider in some detail how

wider historical issues impact and influence welfare policy and legislation, which

in turn both enables and constrains practice at the front line of service delivery,

particularly the classic problem of the relationship between structure and

agency. As a practitioner and manager I often ascribed problems to 'agency',

and yet in the course of this research (and another project in the first phase of

this doctoral programme) the evidence for the determining effects of 'structure'

has been persuasive. Case management as an approach is predicated on the

notion that case managers can act across and against organisational barriers

but the differential carving up of responsibilities within welfare systems that is

embedded within legislation often seems to create structures which at times

appear unassailable. I very much hope I get the opportunity to see if the

implementation of *Pflegeberatung* in the German welfare system helps to

overcome the structural divisions created by the wider legislative framework and

to see to what extent the social work orientated practices of *Rund ums Alter*

survive in the Care Support Centres in Berlin.

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Appendices:

Appendix 1: Documentary and Electronic Sources

Senatsverwaltung Für Gesundheit Und Soziales (1997). Erhalt der Koordinierungsstellen für ambulante Rehabilitation. Berlin: Abgeordnetenhaus von Berlin.

Submission to the Berlin regional parliament that established Rund ums Alter as a citywide service, organised on a borough by borough basis.

Rund ums Alter (2004) Leistungsbeschreibung für Berliner Koordinierungsstellen Rund ums Alter.

Formal document specifying in details the services and other activities each Coordination Centre will provide in accordance with both federal and regional legislative requirements.

Rund ums Alter (2005 and 2007 versions). *Konzept: Rund ums Alter, Berlin, Arbeitsgemeinschaft der Berliner Koordinierungsstellen.*

Information pamphlet introducing *Rund ums Alter*, outlining its development, describing its aims and who it is intended to serve, outlining the case management method and describing the services available.

Rund ums Alter (2007b). Wohnen im Alter: Wohnberatung, Wohnungsanpassung. Albatros e.V. und Volkssolidarität Landesband Berlin e.V.

Local publication produced by *Paritätisch*-affiliated Coordination Centres, outlining how older people can be helped to remain in their own homes through the provision of aids and adaptations and the advice and help available through *Rund ums Alter*.

Gesellschaft Für Beratung Bildung Innovation Mbh (2008). Leistungsbilanz 2007. Berlin: Liga der Spitzenverbände der Freien Wohlfahrtspflege.

Evaluation report for 2007, covering a range of services commissioned by the regional government in Berlin including *Rund ums Alter*, produced by an independent research company on behalf of the Berlin Federation of Independent Social Services Organisations.

Medizinische Dienst der Krankenkassen Berlin-Brandenburg (2008).

Unpublished internal statistical monitoring data from the regional Medical Service of the Health Insurance Funds, sourced through personal communication 30.03.10.

Medizinischer Dienst Der Spitzenverbände Der Krankenkassen E.V. (2006). Richtlinien der Spitzenverbände der Pflegekassen zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches. Essen, MDS.

Official guidelines governing the process for determining the level of care according to SGB XI published by the Medical Service of the Federal Coalition of Health Insurance Funds, including the assessment schedule

Rund um Alter assessment documentation

Local Borough assessment documentation

Selected case records (*Rund ums Alter* local office research site)

Various publicly available information leaflets covering different aspects of care

www.hilfelotse-berlin.de, database of health and social care related services in Berlin, maintained and updated by *Rund ums Alter*.

www.gesetze-im-internet.de, online service of the Federal Ministry of Justice providing access to the entire range of current federal legislation in Germany

www.statistik-berlin-brandenburg.de, regional statistical data service

Appendix 2: Illustrative Cases (Local Coordination Centre)

2.0 Framing Questions for the Construction of Illustrative Cases

1. What are the person's current circumstances?
2. What needs does s/he have?
3. How could these needs be met?
4. What services might contribute to meeting these needs?
5. Who might be able to offer such services?
6. Under what conditions, or according to which criteria can one access such services?
7. How would such services be paid for or financed?
8. Under which legal or policy procedures are such services determined or regulated?
9. What role, if any, does *Case Management* play in this case?

2.1 Frau A: A Complex Case.

Frau A (early 80s) is in need of care and lives in a residential care home. She would like to move out but no longer has her own flat. She needs help with bathing, dressing, and toileting, as well as needing support with her mobility outside of the home. She would benefit from physiotherapy too. According to Social Worker 1 she would need an intensive geriatric orthopedic rehabilitation service to help her overcome her problems, in particular with using the toilet. This would be funded via her health insurance (SGB V). Frau A will only consider this once she has been able to move into her own flat, which she has yet to find. She has numerous options to find a flat (in Berlin there is no shortage of accommodation). Frau A could easily find a flat for herself or with the help of her son.

An element of her mobility needs could have been addressed through the provision of an electric wheelchair (financed through the health insurance funds) but her health insurance organisation refused this. She does have the Magnet Card [local transport scheme], however, through which she receives subsidised taxi journeys, as well as Telebus (for which she is registered disabled under §69 SGB IX, Participation and Inclusion of Disabled People).

Her care needs were assessed at 'care level 2' and her personal care needs are met currently within the care home. However, she must also pay her own 'hotel costs' there. If she were to move out of the home, she would receive care either through §36 (services) or §37 (cash for care) of SGB XI at care level 2.

In her own flat she would need personal care, domestic help, help with mobility and welfare advice too. If her income and means were too little for her to afford her co-payments, then first of all her son would be financially assessed to see if he would be required to take on the costs. If that were not possible, then she would need to go to the local authority social services office to apply for social assistance (SGB XII).

It was decided at the first visit with the client that this case would be appropriate for a case management approach because there were at least three different themes to address together [i.e. arranging for a geriatric rehabilitation service through SGB V (Health Insurance); re-configuring her 'Care Level 2' provision to services in the community; and help and advice regarding meeting additional costs, including potential referral for help under SGB XII (Social Assistance—Help with Care)]

[This case was deemed 'complex' because Frau A's responses and behaviour demonstrated ambivalence about moving, despite her expressed wish to move back into the community].

2.2 Frau B: An Unusual Case.

Frau B (in her early 60s) has been physically impaired for 40 years due to the effects of polio. She can hardly move her arms. She lives alone in her flat, and has been designated in need of care under SGB XI at care level 1. She has received a domiciliary care service three times a week for some time now. Frau B. has a small pension.

In addition to the care needs that have already been met, Frau B has recently been experiencing increasing problems when bathing. She also needs help opening and closing the windows in the living room. On referral she enquired about the possibility of a bath with a door built in the side. She needs advice and help to have her bath adapted, as well as help with financing this.

Frau B received advice from social worker 1, after which she decided to have a level access shower installed, as well as an electronic system for opening and closing the windows. She was recommended a specialist company that was able to undertake this kind of adaptation in a tower block, as there are technical difficulties that need to be properly addressed. Social worker 1 also negotiated with the landlord on her behalf.

To part finance these measures, Frau B has a right to a single payment of €2557 according to §40, section 3 of SGB XI (long-term care insurance). The total costs of the adaptations were €7496. Social worker 1 had to apply to several charities for the remaining amount.

This case was recorded as 'case management' because it involved coordination of different inputs as well as advocacy during the negotiations.

2.3 Herr C: A Typical Case.

Herr C (77) was in a rehabilitation unit after a stroke. He remained dependent on other people for his basic needs despite the rehabilitative input. The team at the rehab unit recommended a move into a care home, specifically one where his wife (82) could also move into supported accommodation. Neither of them

wanted this. Both of them wanted for him to be enabled to move back into their flat with appropriate help and support.

Herr C needs help in all aspects of daily living. The couple needed advice on how to re-arrange their 2 room flat in such a way so that Herr C could be cared for at home.

Firstly they needed a hospital bed installing in the bedroom. The old beds were disposed of by a removal company. Frau C will sleep in the living room in future. The large cupboard in the hallway past which Herr C could not manoeuvre in his wheelchair was moved into the living room by the same removal company. The wheelchair and other assistive equipment (bath lift, raised toilet seat, transfer board, support pillow, wheelchair stair climber) were applied for through Herr C's health insurance fund (SGB V) by the social services office attached to the rehab unit before his return, who arranged a prescription from the doctor treating him there. This social services office likewise applied to his long-term care insurance fund for his care level to be determined.

In the flat, the (door) thresholds needed to be removed. This happened only after his return home. Social worker 2 helped the couple to find a carpenter who could do this job. Permission for the building work was sought from their landlord and, following negotiations, the landlord accepted the costs.

Herr C requires four care calls per day. Frau C needed advice and support with arranging the care services with the care provider, as well as with working out the different ways the care would be paid for.

Herr C also needed a community based physiotherapy service. In order to get out of the flat at all he would require a specialist mobility service that is licensed to use a wheelchair stair climber (specialist piece of equipment). The flat is on the raised ground floor. Herr C will be wheeled by a carer to the ground floor in the wheelchair with the help of the wheelchair stair climber.

He received the equipment via a doctor's prescription under SGB V and had to contribute up to €10 maximum per piece of equipment. He also received the physiotherapy service under SGB V, again with a co-payment.

Herr C is in receipt of benefit in the form of services (rather than cash) at care level 2 under SGB XI. Herr C pays the remaining costs to the care provider out of his own means. He also pays for the mobility service.

Because Herr C has to pay out so much himself, social worker 2 applied for a co-payment waiver at the health insurance fund under SGB V. She also made a similar application for his wife with her (separate) health insurance fund.

This case was a typical 'case management' because it had the aim of avoiding Herr C's unwished for admission into a care home. After six weeks this was reviewed with the client. Secondly, there was the need for a strong coordinating role in this case because there were so many different agencies. Thirdly, there was a need for social worker 2 to act as a mediator, particularly on behalf of

Frau C, who was overwhelmed by the whole situation. For example, she needed help to appeal against a bill for the care service that had been incorrectly made out.

2.4 Frau D: A Simple Case.

Frau D. (79) is physically and mentally fit. She has problems getting in and out of the bath. She lives alone in a 2 room flat. She was given the address of the Coordination Centre by her landlord (HOWOGE—a housing cooperative), so she could be advised by the Coordination Centre with regards to potential solutions to her problem.

She needs advice on adapting her home/converting her bathroom, including the different options for financing this. Frau D. expressed the wish that the Coordination Centre would support her when needed and guide her through the whole building process. It is Frau D's wish to replace the bath tub with a shower that has the lowest possible step into it. No further need for advice or information is expected. Frau D. is not in receipt of any benefits or provision under SGB XI. She has a relatively good pension and has savings available.

Her needs will easily be met through appropriate advice and guidance from the Coordination Centre until her desired goal is achieved. This will include advice about adaptation possibilities and their financing as well as information on requesting different cost estimates from building companies. Frau D has requested that social worker 2 is present during initial appointments with these companies. There will be, together with Frau D, a comparison made of the estimates.

The advice and guidance will be provided by social worker 2. The building companies will be identified from the landlord's approved list. It is also possible following consultation with the landlord to appoint other firms to do the building work.

Since Frau D receives no benefits from SGB XI she will have to pay for adapting the bathroom from her own means. The Coordination Centre negotiated with the landlord with regards to sharing the costs. The landlord is prepared to take on 20% of the costs. The remaining costs will be added to Frau D's monthly rent. Frau D also has the option to pay the whole bill via the landlord, minus the landlord's agreed contribution.

This case doesn't count as 'case management', but as 'advice' [*Beratung*].

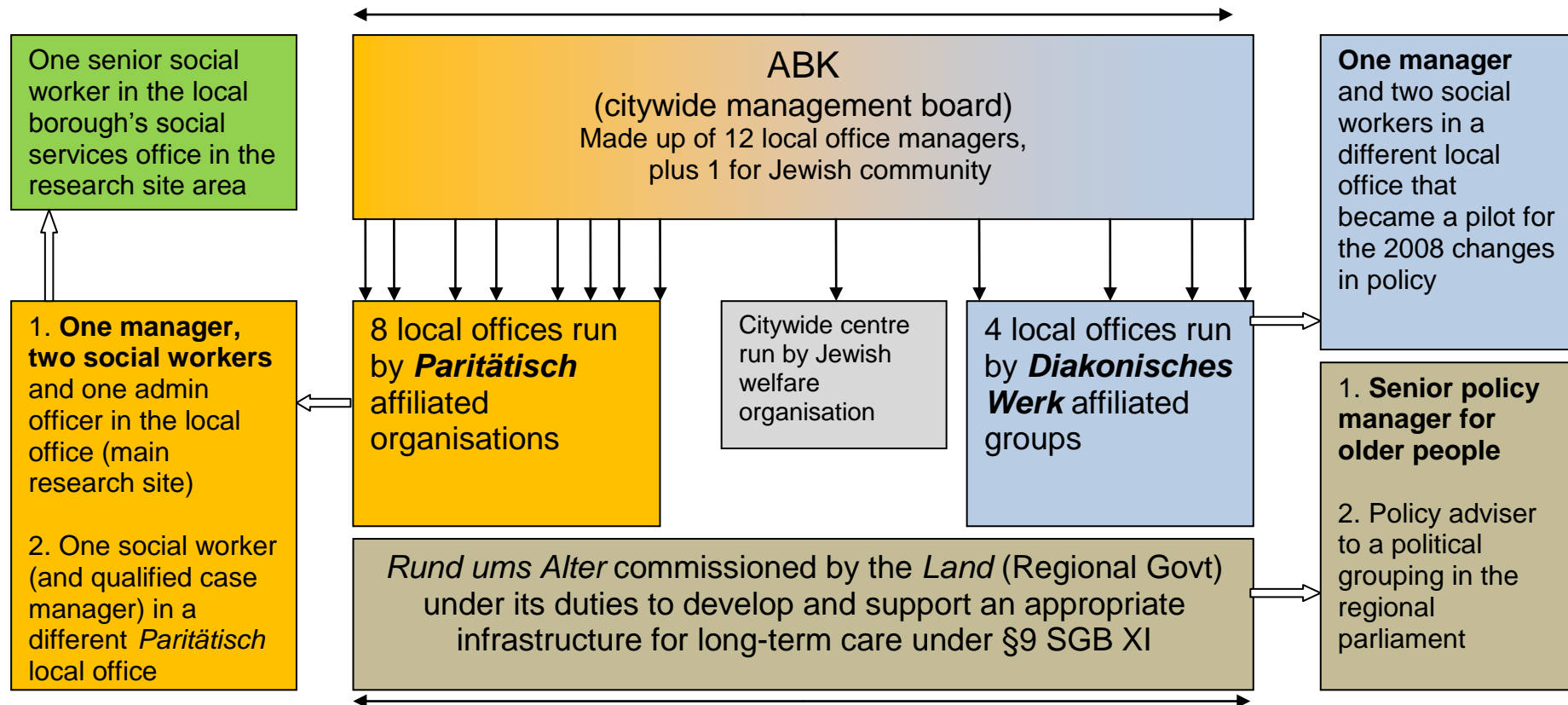## Appendix 3: Chronology of key meetings, interviews, and events attended

Main Period in Coordination Centre 10 September to 16 December 2007, three days per week (Total 42 days)				
Month	**Conferences/Events**	**Meetings**	**Interviews**	**Other**
September	Pflegeforum des MDS: Pflegequalität und Pflegereform, 11.09.07 (Medical Service of the Insurance Funds conference on care quality and care reform)	Support meetings with social work academic at Catholic University of Applied Science x 2 Bi-monthly network meeting ("Altenteam") of Coordination Centres run by organisations belonging to the Paritätische Wohlfahrtsverband Promotionskolleg at the Catholic University, (quarterly meeting of doctoral students) Weekly Team Meeting in local Coordination Centre x 2	Team manager, at the local Coordination Centre, re local structures	Weekly library visits at Catholic University, Centre for Social Research, and/or German Centre for Questions on Ageing Observed home visit (closing case following adaptation of bathroom for older disabled person) Observed advice sessions at local supported housing scheme open day
October	Half day workshop re proposed care reform organised by another Coordination Centre, 23.10.07	Observed meeting-demonstration re "Case Management" support software package Initial meeting with manager of a different Coordination Centre involved in both training and publishing re case management, prior to round table discussion below Support meetings with social work		"Illustrative case" exercise with local social workers (2 sessions, 4 cases) Weekly research discussion meeting with Catholic University doctoral student (English/German mutual language assistance) x 4 Weekly library visits as above

		academic x 2		
November	Conference, 15th Anniversary of a neighbouring Coordination Centre 01.11.07 Theme: Case Management Major Bi-Annual Conference of the ABK (Berlin wide management committee of *Rund ums Alter*) 08.11.07. Theme: Case Management and proposed care reform	Round table discussion with academic involved in teaching case management, with representatives from three Coordination Centres, re Care systems in England and Germany Bi-monthly network meeting ("Altenteam"), as above Meeting with manager of Coordination Centre run by Diakonie, the protestant welfare organisation Weekly Team Meeting in local office x 4 Support meetings with social work academic x 2	Interview with older person and activist, involved in Coordination Centres from the very beginning—theme history of the Coordination Centres Interview with dual qualified case manager and social worker at neighbouring Coordination Centre, theme case management in current system Interview with senior social worker from the local Bezirk, theme local interfaces between the services	Observed home visit, appeal against 'care level' decision of the MDK Review of selected case files, followed by discussion with social worker Meeting with part time doctoral student undertaking comparative study of volunteering with older people in Germany and England, working as adviser in health and social care to members of Berlin senate—theme difficulties of comparison Weekly research discussion meeting with doctoral student as above x 4 Weekly library visits as above
December		ABK, Berlin wide management committee meeting of "*Rund ums Alter*", presentation on themes and issues so far Weekly Team Meeting x 3 Support meetings with social work academic x 2	Interview with the policy lead for older people's services in the Berlin regional government, significant individual in the development of Coordination Centres	Weekly research discussion meeting with doctoral student as above, x 3 Weekly library visits as above

Supplementary Visits 2008-09				
	Visit 1 **21-23 April 08**	**Visit 2** **15-18 Oct 08**	**Visit 3** **24-27 Mar 09**	**Visit 4** **6-9 Dec 09**
Meetings	Local Coordination Centre—update on local developments Local borough—given documentation relating to 'care modules'	Meeting with manager of Diakonie Coordination Centre, update on decisions and negotiations between regional govt and insurance fund organisation.	Meeting with manager of original Coordination Centre site—update on uncertainty generated by proposed changes Meeting with social work academic, update and recommended reading	Meeting with manager of Diakonie Coordination Centre, discussion around the relationship between case management and *Pflegeberatung*
Interviews			Facilitated group discussion with Diakonie Coordination Centre staff, identified as pilot 'Care Support Centre'	Facilitated group discussion with staff of original Coordination Centre, operating now as 'Care Support Centre' but for just one month after delayed implementation
Other	Meeting with doctoral student: research update	2 day conference on personal budgets, partly focused on case management, with special seminar on international comparison of policy	Day spent in German Centre for Questions of Ageing Library	Meeting with part time doctoral student and policy adviser , topic political support for 'Care Support Centres'
Note1 : *in June 2008 the manager referred to in Visit 2also came to England on a private visit to attend an English language course in my home town—during her visit I arranged for her to meet key individuals involved in my own local authority's re-structuring in response to the Personalisation agenda, of particular comparative interest for her was the development of an access point in adult social care. Although strictly speaking this was not part of my data collection, it represents nonetheless an example of the ongoing dialogue that developed over this period which has clearly informed my work. She managed a Coordination Centre that became a pilot 'Care Support Centre' (see Section 5.6.1)*				
Note 2: *in August 2008, I provided an update report on my thesis in German which I distributed to all my key informants*				

Appendix 4: Key Informants

Eleven Key Informants, mapped against the *Rund ums Alter* organisational diagram. The five in bold were of particular importance

One senior social worker in the local borough's social services office in the research site area	**ABK** (citywide management board) Made up of 12 local office managers, plus 1 for Jewish community

1. **One manager, two social workers** and one admin officer in the local office (main research site)

2. One social worker (and qualified case manager) in a different *Paritätisch* local office

8 local offices run by *Paritätisch* affiliated organisations

Citywide centre run by Jewish welfare organisation

4 local offices run by *Diakonisches Werk* affiliated groups

One manager and two social workers in a different local office that became a pilot for the 2008 changes in policy

1. **Senior policy manager for older people**

2. Policy adviser to a political grouping in the regional parliament

Rund ums Alter commissioned by the *Land* (Regional Govt) under its duties to develop and support an appropriate infrastructure for long-term care under §9 SGB XI

Appendix 5: Sussex Research Ethics Guidelines (2007)

University of Sussex
Sussex Institute

Standards and Guidelines on Research Ethics

Background

The university has set up a Research Governance Committee to oversee research governance arising from research and experiments, projects and demonstrations. It has produced a Code of Conduct for research governance (www.sussex.ac.uk/Units/research/policies/resgovncecode.pdf) and for ensuring that Schools within the university have proper procedures in place. These have been informed by national legal requirements (e.g. Data Protection Act) and the guidelines produced by many of the professional associations (e.g. Social Research Association, 2002). The university committee describes research governance as including ethical review, research integrity, quality assurance and risk assessment. It has set out the responsibilities for itself and for the Schools' research governance committees. In requiring Schools to set up research governance committees, the university is acknowledging the need to protect the rights and interests of others who might be involved in the funding, conduct and implications of research.

The Sussex Institute works in four broad areas of applied social research - law, social work and social care, adult learning and child learning - in which high standards of research ethics are essential and challenging. The requirement to set up a research governance committee provides the opportunity to stimulate debate and provide leadership on research governance that will contribute to improvements in the quality of research. The SI governance committee has produced these standards and guidelines so that staff and research students can take responsibility for checking their own research activities and considering further implications of their work. They also apply to people involved in research under the auspices of the university including collaborators and volunteers.

The responsibility is with staff and students carrying out research to check that they have met the guidelines (through the use of the checklist in the Annex) and to raise with the committee any concerns or issues. Any research where there may be a problem should not start until the committee have been consulted. Research being undertaken within Masters or Doctoral Programmes should address the issue of ethics against each of the standards below in their research proposals. When a study is highly sensitive in ethical terms or when unanticipated problems emerge once it has begun, the individual member of staff or student's supervisor would be expected to draw it to the attention of the committee in order to check the detailed proposal for compliance. However, the ethical implications of all research should be considered not just to secure initial approval but throughout the lifetime of a project.

Why are research ethics needed?

The University needs to protect itself, staff, students and those involved in any research carried out under its auspices by staff and students. Should research in which the university is involved come into ethical question, the university would need to be able to demonstrate that reasonable measures had been taken. This would include:
  - ➢ an established set of ethical standards and guidelines
  - ➢ staff and student development and support for ensuring they are used and understood

There is no system for registering social researchers that provides a guarantee for research funders, those participating in research or the users of research of professionalism. Hence, it is possible for poor research well presented or that which may have been influenced by vested interests, to have a considerable impact on public perceptions, policy or practice (e.g. recent MMR study). Participants involved in research, particularly if vulnerable, less articulate or children need to have their interests protected through minimum standards.

The Social Research Association provides a comprehensive and practical set of guidelines. It stresses the need for transparency and professionalism defining research governance as *ways of discovering and sharing information that are open to public scrutiny and can be seen to be subject to the highest ethical standards* (Social Research Association, 2003, p.7). The standards and guidelines which follow draw heavily on them and on the Barnardos Statement of Ethical Research Practice (www.barnardos.org.uk/resources). A set of standards and related guidelines for implementing them should provide staff and students with a system for checking planned research.

Standards

The key standards identified are as follows:

> ➢ safeguard the interests and rights of those involved or affected by the research;
> ➢ ensure legislative requirements on human rights and data protection have been met;
> ➢ establish informed consent even where this is difficult;
> ➢ develop the highest possible standards of research practices including in research design, data collection, storage, analysis, interpretation and reporting;
> ➢ consider the consequences of the work or its misuse for those involved in the study and other interested parties;
> ➢ ensure appropriate external professional ethical committee approval is granted where relevant.

These standards are applicable wherever the research is undertaken. However, the differing cultures and contexts in other countries may have implications for the ways in which they are interpreted and implemented. This will be explored and addressed through the staff and student development associated with these standards and guidelines.

Standards and Guidelines

Many organisations have produced standards and guidelines and noted that ethical issues should be subject to ongoing discussion and not treated as static rules. Legislative requirements are not referred to in detail but need to be taken into account. Named individual contacts within the university, who can provide further guidance on these matters, are listed at the end.

Standard 1: Safeguard the interests and rights of those involved or affected by the research
Note that links to guidelines relating to Standard 2 are provided at the end.
Standard 3: Establish informed consent even where this is difficult

Guidelines (for Standards 1 and 3)

> ➢ Consider the physical, social and psychological well-being of those involved or affected by the research;
> ➢ Obtain consent in writing and signed (which is not in itself evidence of 'informed consent') to the involvement in the research and for the use of data collected;

- ➢ Obtain informed consent without coercion (i.e. participants should not feel they have no choice or are pressured by disparities of power). The option should be provided to refuse to participate, to participate without being recorded, or to withdraw at any time with no further consequences. This means transparency about the purpose and processes of the research, what time commitment is expected of them, how it is funded, what influence it is expected to have and how it will be disseminated;
- ➢ Where covert research is proposed, the case for doing so should be brought to the attention of the research governance committee and where required, approval sought from the relevant external professional ethics committee.
- ➢ Verify data collected through interviews with respondents where appropriate and possible. Feedback on findings should be offered;
- ➢ Invite those who are to be involved in the research to participate as far as possible in the design, data collection and reporting of the research. This should be seen as an opportunity to develop a relationship based on active participation, open communication, partnership and trust between researcher and researched;
- ➢ Offer conditional anonymity and confidentiality and if preferred by participants and feasible, guarantee and honour this. Disclosure which is justified (by danger to the participant or others - see section below on involving vulnerable people in research) must be made to the appropriate person (see checklist in Annex). Depending on the scale and depth of the study, steps taken to anonymise participants might need to extended, for example, in small scale in-depth case studies in which one participant might be the only one with a particular combination of characteristics and therefore easily identifiable. Similarly, managers may be easily identified as the only individuals to which the description in a research report could apply.
- ➢ Any possible exceptions to this agreement should be explained at the time it is made.

Standard 4: develop the highest possible standards of research practices including in research design, data collection, storage, analysis, interpretation and reporting

Guidelines

- ➢ Ensure existing relevant literature and ongoing research (listed for education on www.nfer.ac.uk/ceruk) have been identified and built on;
- ➢ Select research approaches, methods and procedures that are fit for purpose and not designed to confirm the researcher's hypotheses or preconceptions or because more acceptable to a research sponsor;
- ➢ Collect only data that will be used to address the question since any data collection places a potential burden on the respondent. The exception may be in approaches derived from grounded theory in which the research questions emerge as the analysis develops or where data are archived for future use to address research questions not yet identified;
- ➢ Report research findings with integrity. Avoid the temptation to distort findings in order to make them more positive and thereby, more publishable;
- ➢ Report findings accurately, acknowledging that some research is open to a variety of interpretations. Verify findings and interpretations through use of procedures such as audit trails, triangulation and checking back with respondents where appropriate;
- ➢ Establish ground rules on intellectual property rights and reporting restrictions with external funders from the outset;
- ➢ Donate data to the appropriate data archive and provide sufficient contextual information to ensure that it can be understood, reanalysed and interpreted by others. Specific guidelines for research involving secondary analysis is available from the UK Data Archive, (University of Essex and Royal Statistical Society, 2002).

Standard 5: Consider the consequences of your work or its misuse for those you study and other interested parties

Guidelines

> ➢ Consider the short and long term consequences of any research from the outset. The benefits of research which assists a funder in policy decisions or developing a service in the short term, may not be immediately apparent to individual respondents;
> ➢ Recognise and compensate (not necessarily financially) where possible, the costs of research to the participants minimising the coercive nature of this;
> ➢ Predict what support might be needed following the research. Questions raised in the research may have an unsettling effect on the individual, relationship or organisation;
> ➢ Take some responsibility for changing the dynamics in the situation (e.g. classroom, home, institution or service) through intensive case studies or participant observation. Be willing to spend time discussing issues that might arise, have information about relevant support services and document the effects of your presence.

Standard 6: Ensure appropriate external professional ethical committee approval is granted where relevant

Guidelines

> ➢ Use the checklist in the Annex to scrutinise your research plans;
> ➢ Invite comments from colleagues on your research plans and in particular, on any potential consequences for those who you are involving in your research;
> ➢ Seek comments from the School Committee where there are any sensitive or potentially ethically challenging issues;
> ➢ Seek approval from the appropriate external professional ethical committee where appropriate (e.g. research involving health and social care issues), to ensure requirements have been met.

Research involving vulnerable people

> ➢ Consent procedures should be explored with vulnerable people (in care, at risk or involved in illegal activities). Informed consent should be sought directly from participants (not depending on relatives or carers) using alternative forms of communication with those with learning difficulties or sensory disabilities to maximise access such as signing, symbols or Braille;
> ➢ Consent should be monitored, for example, through non-verbal cues that might indicate that it was misunderstood;
> ➢ Anonymity and confidentiality are likely to be particularly important and sensitive. Researchers need to make clear that disclosures suggesting serious danger to the respondent or others cannot be treated confidentially;
> ➢ Where information given in a research context suggests that there is a threat of serious harm to the participant or others, researchers should disclose this to the relevant authorities (see checklist in Annex) but inform the participants and their guardians/responsible others of their intentions and reasons for doing so. Notes should be kept in case a complaint arises;
> ➢ Researchers should make themselves aware of relevant services (e.g. counselling), in case support needs emerge during the research.

Research involving children

- ➢ Children (defined as those aged under 18) will need particularly careful consideration with respect to establishing and monitoring consent, the role of gatekeepers, the use and communication of findings and the potential disruption (emotionally or practically) caused by the research itself;
- ➢ Informed consent from young people should be actively and directly sought using communication methods that maximise their understanding of the research;
- ➢ Disclosure of information suggesting serious harm to the child or others should be addressed as indicated in the guidelines above on vulnerable people;
- ➢ Participation in the research should be made as rewarding and enjoyable as possible;
- ➢ Interviewing children should either be undertaken by two researchers or in areas where the researcher and child are not entirely alone to protect the researcher as well as the child;
- ➢ Consider the gender of interviewers where appropriate, for example in research involving children who have been sexually abused;
- ➢ Feedback on the findings should be given in ways that are meaningful to the participants.

Specific issues relating to students undertaking research and their supervisors

- ➢ A Student Project Ethics Committee is being established nationally to review research proposals that are currently supposed to be cleared by the NHS Research Ethics Committee but which are undertaken by students primarily for educational purposes.
- ➢ The Sussex Institute (and wider university) will need to establish procedures for providing reassurance that students undertaking research have had sufficient training and support and their research plans scrutinised and approved.
- ➢ All trainee teachers and those who are qualified and working in schools have to have completed police checks as do social workers, probation officers and others working with children.

Reviewing the use of the standards and guidelines

The standards and guidelines are being supported through staff development activities. The School committee intends to conduct a project audit on a small number of projects from across the SI. The projects would be reviewed to see how far the plans proceeded as intended, whether ethical issues arose which had not be foreseen and how these were addressed. Researchers and students can volunteer their projects for this process. In the long term, a robust system of monitoring and evaluating the implementation of the standards and guidelines will help identify good practice and any revisions needed.

Promoting greater responsibility amongst staff and research students through support in implementation of the guidelines

Some aspects of the guidelines are general across all research in SI e.g. establishing informed consent, other aspects are relevant to some research across all parts of SI e.g. involving children in research, and others may only apply to one study e.g. interviewing vulnerable people. A range of staff development activities will be encouraged from small workshops to co-researching/coaching (for example by researchers from two projects accompanying one another on group interviews). Through the 'Students as Researchers / Student Voice' research projects and previous projects in social care with vulnerable young people, we have well developed expertise at the Sussex Institute in methods of consulting children which we can build upon.

Further guidance and contacts on legislative requirements

Data Protection Act information at www.susx.ac.uk/Units/dpo named person: Paul Roberts.
Summary on www.dataprotection.gov.uk
The Data Protection Act stipulates that people are entitled to know how and why their personal data are being stored. It applies to all types of data (not just electronically held). It enables data to be used for secondary analysis not just for the purposes for which they were originally collected with consequent implications for informed consent.

Disability Discrimination Act (DDA) summary on www.disability.gov.uk
The DDA makes it unlawful to discriminate against disabled people. Adjustments should be made to ensure access. Within the research context the DDA is relevant to issues of sampling, access to data collection methods and feedback (through for example, amplification, signing, Braille, etc.) and presentation of research.

Human Rights Act summary on www.homeoffice.gov.uk/hract/
The Human Rights Act 1998 which came into force in October 2000 applies to public authorities. Research carried out on behalf of a government department would be included in this definition. However, the Social Research Association suggests that it is as yet unclear what the implications are for social science research.

Convention on the Rights of the Child (UNCRC) www.unicef.org/crc/
Children's rights are protected through the United Nations Convention on the Rights of the Child (UNCRC) in 1989. The UK Government ratified the UNCRC in 1991, and has to report regularly to the UN on progress in implementing the UNCRC. A key right is article 12 which provides for children's rights to express their views on all matters that affect them including being facilitated to give informed consent. Many of the UNCRC 54 articles are about respecting and including children. Research ethics guidelines produced by other organisations suggest that the spirit of this Act should apply to research contexts involving young people and vulnerable adults involved in research.

Appendix 6: Fair Access to Care Services Criteria

FACS: The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

Critical – when
- o life is, or will be, threatened; and/or
- o significant health problems have developed or will develop; and/or
- o there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- o serious abuse or neglect has occurred or will occur; and/or there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- o vital involvement in work, education or learning cannot or will not be sustained; and/or
- o vital social support systems and relationships cannot or will not be sustained; and/or
- o vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial – when
- o there is, or will be, only partial choice and control over the immediate environment; and/or
- o abuse or neglect has occurred or will occur; and/or
- o there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- o involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- o the majority of social support systems and relationships cannot or will not be sustained; and/or
- o the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when
- o there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- o involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- o several social support systems and relationships cannot or will not be sustained; and/or
- o several family and other social roles and responsibilities cannot or will not be undertaken.

Low – when
- o there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- o involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- o one or two social support systems and relationships cannot or will not be sustained; and/or
- o one or two family and other social roles and responsibilities cannot or will not be undertaken.

(Department of Health, 2003)

Appendix 7: Figures for recipients of care benefits—Berlin (2007)

Numbers of recipients of benefits of Long-term care Insurance in Berlin as at 15.12.2007 (source: Amt für Statistik Berlin-Brandenburg www.statistik-berlin-brandenburg.de)	
Total	95,870
Male	29,200
Female	66,670
Domiciliary Care Services	22,863
Care Level I	11,828
Care Level II	8,305
Care Level III	2,730

Residential Care	27,069
Care Level I	9,205
Care Level II	11,250
Care Level III	6,451
Still awaiting a decision regarding care level	163

Cash for Care Benefit	45,938
Care Level I	29,325
Care Level II	13,333
Care Level III	3,280

Age distribution of recipients (all services/benefits)	
under 15	1,927
15 - 59	11,931
60 - 64	4,223

Numbers of recipients of benefits of Long-term care Insurance in Berlin as at 15.12.2007 (source: Amt für Statistik Berlin-Brandenburg www.statistik-berlin-brandenburg.de)	
65 - 69	7,581
70 - 74	9,750
75 - 79	11,696
80 - 84	15,652
85 - 89	17,232
90 - 94	10,253
95 and above	5,625

Appendix 8: Core Services provided by *Rund ums Alter* (Excerpt)

- A comprehensive, locally based **information service** covering care services of different types (domiciliary care, short term and day care opportunities), leisure opportunities, visiting services, equipment and adaptations, respite for carers, alternative forms of accommodation for older and disabled people, amongst other things, with the aim of enabling the individual needing the information to take the next steps independently.

- **Advice and Consultation** (*Beratung*) in all questions with regards to age and ageing, disability and the need for care, advice on social and legal rights, explanation of different sources of funding (including support with making applications), help with pursuing claims, arranging and coordinating any necessary assistance, and with planning and organising measures for adapting the home. The aim of any consultation is to enable independent implementation of the necessary steps, to facilitate access to the welfare system as well as raise awareness of legal rights. Direct support is given when the client expressly requests it and when there is no other individual or organisation available. Consultation is also available from the Coordination Centre as professional support as and when necessary to other services for older people in pursuit of a particular case. This serves to improve planning processes and procedures in the care of older people.

- **Case management** includes the planning, organisation, monitoring and review of individual case orientated support processes where there is complex need. *Case management will be implemented when, because of a health related or social crisis the provision of care at home is significantly threatened and/or admission to a care home is threatened, but the individual wishes to return/remain at home.* The aim of this service is to overcome the crisis, to link the person into the care and welfare system and to ensure legal entitlements are met.

Networking includes the initiation, the construction and care of cooperation and coordination structures in the local health and social care economy with the aim of producing an efficient and structured network. A considerable component is the review of planning processes and procedures in the care of older people. Other aims of this provision include the identification of weaknesses and deficits, the establishment of frameworks, the improvement of care infrastructure and quality, the securing of access to provisions in the welfare system and the development of consumer competence.