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Policy learning and innovation in local regimes of home-based care for the elderly:

Germany, Scotland and Switzerland.

REPORT

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General introduction

The content of this research report focuses on the local scale dimension of the regulation of domiciliary long-term care for the aged. Long-term care has become a widely debated issue about which contradictory or at least very ambivalent discourses and even policy goals are formulated. The main aim of this research is to analyse how concrete actors networks deal at local level with these conflicting goals in spite of constraining national institutional settings. The central assumption of this project is that the policy actors present at local level are the closest to the implementation of the policy at stake or directly deal with the implementation of the policy. At this level and during this phase of implementation, concrete choices have to be made, ambivalences are to be resolved: some policy discourses turn into something real while others are put back on the shelves of offices.

This research project addresses the question whether local actors can derogate from national institutions to address the most important shortcomings perceived/formulated at either national or local level. It is centred on two main dimensions of change. The first one focuses on the capacity of local actors to trigger institutional change. The second is focused on “real” change processes, i.e. dynamics that happen without formalised, institutionalised process. In doing so, this research provides a four-step analysis of change process as they concretely happen, in real existing local contexts. The first part of the report is dedicated to an analysis of the issues of change (governance, network and diversity, quality and participation) on which we decided to focus for this report. The second step consists in an analysis of the three national cases and of their most noticeable shortcomings concerning the issues at stake. The third part of the study deals with the local case studies precisely picked for their relevance regarding the main patterns of the national cases. Finally, the last part of the research is dedicated to a comparative analysis of the mechanisms of social learning or institutional innovation in our six local cases, in their national contexts.

Background discussion: ambivalences in the domain of long-term care

The issue of long-term care has developed as an intensively debated one in the context of the escalating impact of new social risks (Taylor-Goobie, 2004) – ageing population, destandardisation of professional careers, destabilization of family structures – combined with an increase in female labour force participation¹. These structural transformations of Western societies take place in a very tense context in the domain of

¹ Here we use the OECD’s definition of *long-term care*: “Long-term care covers a series of services, delivered to dependent persons by a third person during an extended period of time, that are designed to help accomplish daily activities, such as washing, dressing, eating, sleeping, getting up, sitting in a chair and standing up again, moving and going to the bathroom.” (OECD, 2005, p. 20). In this context it is particularly important to add (nurse-related or medical) health care to this list, which, connected or not to a pathological loss of autonomy, also concerns the long term without requiring placement in a nursing home or other institution of care.

social policy, and especially in the one of long-term care policies. On the one hand, the last years have been marked by a dominant neo-liberal criticism of all social expenses and by the harsh financial crisis that has pressured public finances. On the other hand, there is a continuous raise in social expectations in the domain of long-term care. Social debates about the quality of care delivery, the risk of isolation of specific groups, scandals of frail aged people abuse, etc. have framed many discourses and have built strong social awareness on this matter. This policy domain is consequently characterized by a high level of tension, contradictions, and ambivalences not only in policy discourses and policy frames that structure the issue, but in policy goals as well.

The juxtaposition of the “objectives” formulated by the European Union – access, quality, sustainability – is a rather telling example of these ambivalences². The first two EU policy goals, access and quality, rather belong to the view of long-term care as a human right. The keywords here at stake are related to the equality of access or even to the reduction of inequalities, or tackle the issues of the rights of the citizens (informed choice for instance). On the contrary, the last objective of “sustainability” is mostly concerned with keywords or precise mechanisms implying the responsibility of the individuals to face the burden of long-term care (private insurance, prevention through health promotion or mobilisation of family carers). This ambivalence is to be found as well in the recommendations of the OECD concerning long-term care. The most recent OECD report on long-term care clearly puts the emphasis on four priorities considering the various long-term care systems (OECD 2011): the structure of the financing, the role of family carers, the stability of the professional carers and the improvement of the “value for money in long-term care”. Those issues and recommendations, which are very close to the ones formulated by the European Union, present various claims according to which long-term care is on the one hand a human activity at the heart of basic needs and, belonging *de facto* to human rights and, on the other hand, a task that can not be supported without the clear involvement of individuals via prevention, financial participation as well as mobilisation of family carers. There thus seems to be a consensus, at least among the institutions framing influential, standard discourses about long-term care, that only a negotiated policy mix, the cooperation of many actors and instruments and a splitting of responsibilities can guarantee the sustainability of long-term care regimes. But the content of this policy mix and the required innovations have to be understood in the context of each national LTC-System, which raises specific issues and institutionalizes specific ways to deal with them for the local actors in charge of the implementation of the care policy.

2. Analysing the local process of change social learning and institutional innovation

Social learning and institutional innovation

There is an abundant literature on the recent institutional transformations of the national long-term care systems (Pavolini, Ranci, 2008 ; Eydal, Rostgaard, 2011 ; SFI, 2011) but little is known about the way local actors not only implement the national regimes they have to deal with, but also adapt, and in some cases derogate, or complement the

² <http://ec.europa.eu/social/main.jsp?catId=792&langId=en>

institutional rules they are supposed to deal with. This is precisely the focus of this research. Our analytical framework is inspired by Wolfgang Steeck and Kathleen Thelen (2005), who distinguished between the “process of change” and the “results of change”. This distinction highlights the fact that real change in a regulation system or even more in the outcomes of a regulation system can happen in the absence of change in institutional rules. Reciprocally, institutional change does not automatically produce change in a domain of regulation. This concept presents an opportunity to reformulate the idea that different mechanisms of change can operate, though always defined in relation to the institution (Tallard, Théret, Uri, 2000). From this perspective, “social learning” refers to changes enacted within a stable institutional framework. It encompasses social (non institutional) actors that develop in their day to day activity new ways of dealing with the issue at stake. For instance, in the context of our research, with new forms of service delivery that may concern the quality or the participation of recipients. The term “innovation” is reserved for institutional change. The actors here at stake are institutional actors, i.e. public officers, members of official commissions, elected members of public bodies, etc. The key function of these “institutional” actors is to govern or at least steer policies. They might as well be policy actors “of the field” and provide concrete services. But there are here considered for their activity as “policy makers”. The kind of change they deal with goes through formalised procedures, to make use of specific power, financial, administrative resources, and is in many cases subject to various forms of democratic control.

Nevertheless, it must be mentioned that a series of reciprocal interactions could connect these two orders of change. The most obvious example would be the following: Institutional change forces or instigates a dynamic of change in the behaviours of those responsible of implementation. On the other hand, social learning, as a new way of using the rules, can render existing institutional methods meaningless, which, in the short-term at least, prompts their change. Alternatively, informal social learning – potentially dysfunctional – could allow institutional rules to maintain control, often because the details of a reformulation would demand political agreement that is impossible to obtain in a given historical situation. Social learning prevents, or at least very often spares the initiation of a process of change that could only lead to the complete jamming of the system.

Case selection

The selection of national models for our analysis – Germany, Switzerland, and Scotland – was based on three main criteria. Firstly, each country’s regime of long-term care for the elderly has undergone major, innovative institutional changes recently. These developments create a demand for processes of innovation of a similar magnitude in decentralized areas, or for actors’ policy learning processes in decentralized areas. Particularly interesting local cases result from these dynamics. In Germany, insurance for dependent persons, which suffered from structural shortfalls, has entered an important phase of reform in the late 2000’s (Arntz et al., 2007). This reform was characterized primarily by a revalorization of benefit increases and a reinforced focus on the specific needs of people suffering from dementia or the introduction of first elements of case management instruments (Bundesgesundheitsministerium, 2009).

These changes will have an impact on the relationship between the actors of implementation at local level that will be particularly interesting to examine. Recently (in 2002), Scotland enacted the most important reform in Europe. Although the New Labour government had turned long-term care reform for the aged into a central campaign issue in the late 1990, denouncing the system as incoherent and unjust, neither England nor Wales engaged in a substantial process of reform. Scotland was the only country to follow the Royal Commission's recommendations on long-term care and introduced *free personal care* that has had an important impact on the relations between the Scottish government and the Scottish local authorities (Bell et al., 2007; Dickenson et al., 2007). Finally, the Swiss model is particularly interesting in that it is multi-scalar, introducing a noteworthy plurality of dynamics. Indeed, federal long-term care policies in Switzerland provide a framework – which is also financial – included in the insurance for widows and survivors (*L'assurance-vieillesse et survivants* [AVS – old age and survivors' insurance], federal retirement system) and complemented with profoundly contrasting regional policies (Braun, Giraud, Lucas, 2006). Switzerland is therefore characterized by a plurality of models within which the dynamics are just as diverse. Hence, both in the regional and federal contexts, it is rich in policy learning processes and innovations.

Secondly, the three countries selected for our research on local, innovative models share traditions of particularly strong and autonomous local authorities. From this perspective, the tradition of German *Selbstverwaltung* is similar to the British *self-government*, but also to the old and strong Swiss communal autonomy. In addition, these strong local authorities adhere to political systems that permit important variations in regional authority. Swiss federalism is commonly known as the most decentralized federal system in the Western world, both if we consider the methods of distributing financial and institutional resources between the three levels of power, but also if we consider the weakness of national integration institutions and organizations (political parties and national media, for example). Linguistic pluralism, religious divisions, differentiated political traditions rooted in each region, and the influence of anti-federal and liberal tradition, underscore the ineffectual integration of this national model. German federalism is less differentiated, largely because the institutions of national integration (parties, media, unions, charities, etc.) are rooted in the federal arena³. Nevertheless, the *Länder* – but above all the cities – are important sources of finances and of specific provisions for long-term care for the elderly (Pfau-Effinger et al., 2007; Kümpers, 2008). Finally, Scotland reflects a recent trajectory of institutional decentralization, sped up by political investment strategies that were approved of by regional political figures with a re-invented Scottish identity. Regarding this tradition, the Scottish parliament has developed strategies that are particularly different from the classical British model for the last half-dozen years (Waliam, Mooney, 2008) and has preserved the autonomy of its local authorities.

Finally, the three cases we have picked are representative of the high variety of welfare state models. In line with traditions of continental Europe, the German case clearly corresponds to a subsidiary-based insurance model. Scotland corresponds to a universalist model, which is common to Northern European countries. Switzerland corresponds to a model that is based on the juxtaposition of two main layers. The federal system represents a legal framework and relies on minimal in-kind benefits

³ For a comparison between Swiss and German federalism, see Braun (2003).

rather than on cash benefits, which must be complemented with benefits that are financed, piloted and carried out in a way that contrasts *cantons* and cities. The inflection is therefore clearly liberal in certain *cantons* – central and western regions of Switzerland – or centered on state-controlled interventions that are hardly differentiated – in the catholic *cantons* of Romance-speaking Switzerland, etc. – or else largely supported by subsidiarity in traditional protestant *cantons*.

Comparative issues

The analysis of the dynamics of the national regimes of long-term care is organized around four key issues, particularly debated in the field and which are relevant for our research question. The first part of the report is dedicated to a mapping of the various debates that have in the recent years been developed about each of the issues, both in the academic field and in policy arenas. The aim of this mapping is to identify the discursive cleavages and the most important dimensions of the debate in what might be common to the various national contexts. From the comparative literature in policy analysis, we know that actors at the most various policy scales frequently use discourses or policy frames as power resources. In the logic of our research, both the communicative and the coordination dimensions of discourses might be important (Schmidt, 2002). The first dimension of discourses might trigger change in persuading actors to adopt new views or practices of care delivery for instance. The second one can enable coalitions that can maybe make more institutionalized forms of change possible.

The four debates we focus on are “governance”, “network and diversity”, “quality”, and “participation”. The first point of concern is governance. It deals with the more or less institutionalized aspects of steering of domiciliary long-term care at local level. The second point tackles the issue of the fit or tension between the diversity of needs as they locally emerge and the diversity of providers and provisions coming up from the welfare mix. The third issue is about the debates in terms of quality, that plays a very important role for the norm-setting in the domain of long-term care. Finally, the issue of participation is a defining one in the present context where freedom of choice has been a very popular slogan in the domain of care policies and the market dimension of regulation and provision has developed extensively in most systems.

3. Analytical dimensions

The initial design of our research has been developed around three main axes of analysis. Our research results are organized around those main structures that make sense in our local studies. The first axis deals with the characterising of the change process. It is centred on the mechanisms and the forms that have concretely triggered change in the local system. The second is centred on the discourses and the actors' coalitions built around those discourses. Finally, the third approach is about the scalar dimension of the change process.

A - Characterising the change processes

This analytical part deals with the issue of change in itself. One important issue tackled in our research deals with the political procedures, arenas, mechanisms that enable change in long-term care regime at local level. For the sake of this analysis, we propose to distinguish between institutional forms of change and change that happens in “real life”, in the provision of services for instance, and that does not need to be formalised, institutionalised to exist. The first part of this section will be dedicated to the display of these results. Secondly, the analytical section focuses on the characterising of the change process in itself and will provide information about the logic of the change process. Is the dynamic at stake rather top-down movement, more typical of the institutional innovation form, or is it a bottom-up dynamic, usually closer to the social learning form of change? Furthermore, the way change is spread, in the horizontal dimension, for instance from one neighbourhood or very specialized network to the whole city or the whole policy domain is as well an important way to characterize the dynamic at stake.

Lastly, it turns out to be fruitful to use the analytical grid elaborated by Wolfgang Streeck and Kathleen Thelen about the precise mechanisms of change. Are we confronted with a dynamic initiated by the adding of new instrument that ends up changing the whole equilibrium of the system (layering)? Is it rather a more radical substitution of a scheme by a new one (replacement)? Is the phenomenon at stake the transformation of the outcome of an existing institutional device by the change in the logics of use that the social actors develop around it (displacement)? Or lastly, if change happens in the end because the previous institutions do not function any more and need to be replaced by new ways of structuring and organizing social interaction on a specific matter (exhaustion)?

Those three complementary views over change will help us characterise the prevailing source and logics of the dynamic at stake. This analysis is a fundamental step to the development of further hypotheses.

B - Discourses and coalitions

Our first comparative analysis is dedicated to the role of discourses and coalitions that might trigger a process of change at local level. Actors initiating a reform process formulate their intentions and position those intentions around policy frames that structure the public debates. The literature in terms of advocacy coalition framework (ACF) has shown that in any policy system, it might be counterproductive to distinguish the role of institutionalized and non-institutionalized actors (Sabatier, 1988). Actors of both those types may initiate an important process of change and build coalitions based on discourses. The basic idea of the ACF is that actors do not need to share the same position in an institutional system or the same « interests » to be allied, in a specific policy sub-system, in favour of a specific policy goal. Recent developments of the ACF literature show how the discourse coalitions are influenced by various variables (Kübler 2002). In the first place, mobilisation structures, referring to the type of network and

form of social mobilisation, may provide solidar incentives, organisational and cognitive resources, to help the cause to prevail. Secondly, the structures of political opportunity are important as well to understand what is the openness of any political system, to identify access points for the reform (social learning or institutional innovation) at stake.

In order to run this kind of analysis, it is important to provide four types of information. First, it is important to understand the content and the rationale of the discourse formulated by the reform advocates. Secondly, it is necessary to analyse the discursive cleavages triggered by the proposal of reform: what allies have been gained to the initial proposal? And what adversaries? How has this structure evolved over time? And, what have been the consequences of the actors' coalition dynamic on the contents of policy reform? Third, the last analytical step is about the organizational and political logics of the mobilisation. Is the actors' coalition homogeneous in its organizational or political form? Are there on the contrary many complementarities in the coalition? Lastly, what is the local structure of power? This analysis should be handled via two complementary axis. The first is about the influence of the institutions organizing the local power on the forms of political mobilisations as well as on the venues of reforms. The second one is about the local structure of political and social mobilisation.

C - Policy scales as power resources

As one of its most defining strategy, our research project focuses on dynamics happening at the local scale. However, these local dynamics are embedded in higher scales context (the region, the country, the European Union, etc.), as much as they build the context of micro-level (learning process taking place at the scale of a neighbourhood, of an individual provider, or of one local office of beneficiaries counselling, etc.). In both configurations, different interactions between the various policy scales at stake are an important component of the change process. How is the national debate, for instance about “good governance” or about participation of beneficiaries in the management of long term care schemes, transformed or re-interpreted by local actors? What alliances, mutual supports or on the contrary, tensions, oppositions are developed across policy scales about the specific issues at stake? In some situations, tensions, competition for the competency leadership in the domain, for instance, hinders or slows change. In some other situations, it might on the contrary stimulate it. The organizational, social mobilization resources attached to various policy scales are also an important element that help make sense of relations between policy scales, in the context of a change process.

4. Methodology

In terms of method, our research is clearly a qualitative, empirical and comparative one. It consists of five main successive research operations.

Research's operation A: exploring long term nursing care systems at the national level.

This first operation aims at presenting the national long-term care systems on the basis of a systematical grid of analysis drawn up with regard to the current literature and to the problematic of our research.

For each country the presentation begins with a brief historical analysis of the development of long term care policy structures since the WWII. We then display the horizontal and vertical repartition of responsibilities by raising in a systematic way the following questions: who is the first responsible of a person in need of LTC at home? How is the repartition of tasks, duties, rights or obligations displayed in prevailing official discourses? What does the law say on this issue? By answering these questions we present the institutions in charge of the information and the counseling, the process of needs' assessment and the eligibility criteria. We then expose the provision of LTC, the available benefits and the system of regulation. Special attention is devoted to the training and the certification of professional care-givers and to their work conditions as well as to the role, the integration and the recognition of nonprofessional helpers. The organization of the home-based LTC, the relations between it and the health care system and the structure of governance and planning are the main other points we focus on to analyze the repartition of tasks. Finally, we describe the structure of financing and the expenditure for LTC and their evolution over the last years. To conclude we map out for each country the main issues regarding our four dimensions.

Research's operation B: selection of the local cases.

This is a crucial step for our project. Experiments conducted at the local level have been selected on the basis of a comprehensive exploration of the scientific literature but also of available experts reports and of other administrative documents. Interviews led with experts have been also very helpful.

The main criteria governing the choices of local cases has been their ability to illustrate the whole problematic of our research program and more precisely one or several dimensions at stake in the process of change in the present context: governance, network and diversity, quality and participation. See part 2 / section A for more details.

The *diversity* criteria applied to both the selection of innovative projects and to the choice of the six local cases. Hence, our six cases represent well the variety of municipal innovative context in our three countries. The innovative dimension of the project is defined as a relative concept: the projects selected had to be innovative regarding one or more of our four selected dimensions *in relation* to the national (or even regional) patterns; they had to be diffused at least at municipal level; they had to be well diversified regarding such dimensions (the four dimension are covered by the six cases study). Moreover, the level of recognition is also diversified: hence some of the project are recognized as "innovation" even at international level (like the Five panels) while other get a recognition at more regional or local level (like the Geneva' case). Lastly, the two localities of the same country had to represent diversified realities in their national context.

Research's operation C: six local cases studies.

This third research operation consists firstly in analyzing the national institutional framework in which the local case is embedded and secondly of understanding the specific nature of the innovation. This part of the research is based on six in depth local cases- studies, A case study is Yin (1994: 13) « *as empirical inquiry that investigates a contemporary phenomenon within its real-life context* ». Moreover, this cases are analyzed in the context of their regional and national configuration, following the method of the « *embedded cases studies* » (Ibid).

The analysis focused on the following main elements:

- historical reconstruction of the development of the local home-based long term care system
- Qualitative analysis of the local power system
- Qualitative analysis of the network of domiciliary care providers
- Analysis of the innovative project and its development

Local studies aims to characterize the local innovation learning processes. The six cases studies are based on qualitative data, mainly:

- secondary literature, local documentation, press articles
- documents provided by the care service providers
- about 100 semi-structured interviews of actors of the networks (1h-2hours each), i.e. more than 17 interviews for each local case study in average. The interviews were transcript.

Research's operation D: analysis of conditions and factors affecting the emergence of innovations.

Based on a thorough analysis of the local or regional system governing public policy in this area, this part of the research aims at understanding the factors that have locally further the process of innovation and learning.

Research's operation E: comparative analysis

This final research is devoted to the synthesis of the comparative analysis of institutional innovation and learning process caught in their national and regional contexts. In this respect, the first part of the report presents a comprehensive statistical overview on the LTC system in our three countries compared with other OECD countries. We look at the expenditures and their structures but also their type of financing, present an overview on the users of LTC schemes and their evolution during the last few years and finally offer some comparative statistics on the care givers.

After a synthesis of our approach and of our main results, we try to analyze the possibilities of institutional transfers to the French case.

It should be noticed that each of the researchers involved in the field study has been tasked with two countries in order to confront directly the comparative perspective. This

kind of approach was not only thought to grasp better the specific logic of each local system, but also to understand how these selected cases were embedded in a national and relevant context. This double focus of the analysis allows at the same time, firstly, a detailed exploration of local cases, and secondly, to keep the right distance towards the comparison.

The network analysis has been done through a diversified documentation (scientific literature, administrative report, pick-up of various data) and several qualitative interviews, which have allowed a rich record of information through direct exchanges.

Dissemination of data and first results

This research is based on the elaboration of a highly valuable in-depth cases study regarding the contemporary organization of HBLTC in Germany, Switzerland and Scotland as well as six local cases-studies that give as very detailed understand on the historical development as well as the concrete issues of domiciliary long-term at local level. Regarding the focus on the international research on national cases, the valorization of this cases-study is an important perspective for this research.

Moreover, the first comparative analysis confirm the importance of developing a mix approaches of policy change in the field of social care, that may combine discourse analysis and scales analysis as well as institutional analysis of change.

Therefore, the dissemination for this first research results will be as follows:

- an academic book (English)
- papers in political science reviews: political change analysis and rescaling welfare policies
- papers in care reviews: about long-term care systems and innovations

5. Report Outline

The *first* part of the report is dedicated to an *analytical presentation of the context* of our comparative analysis. It begins with an analysis of contextual data about the main dimensions of long-term care for the aged in our three countries (long-term care expenditures, care needs, care givers). It then moves on to a brief presentation of the long-term care regimes of Germany, Scotland and Switzerland, focusing on financing, governance, and provision aspects (comprehensive versions of the national long-term care regimes are available in the annex). The *second* part of the report deals with the *contemporary defining debates about long-term care in Europe*. We have chosen to focus on four central issues in that policy domain: governance, pluralism and network coordination, quality and participation. Firstly, the most important content, cleavages and debates are analysed for each of this central issues. Political, institutional and academic discussions are summarized in each case. Secondly, the present situation and the recent and contemporary debates about each issue are discussed for the three countries under scrutiny. Comparative synthesis of the situation of the various countries are presented for each issue. Aim of this analysis is to shed light on the concrete consequences of the often value centred political or academic discussions about long-term care. In line with the logic of our analysis, we then provide a last section in this part explaining the choice of our local case studies. **In that research, we question the capacity of local systems to address the most important shortcomings of their respective national setting.** This last section of the second part sums up the most striking pitfalls of each national system and explains the choice of our local case studies. Finally, the *third* part of the report is dedicated to the analysis of the change process analysed at local level in six European localities. In a first section, every case-study is briefly presented and the change process empirically documented is analysed through our analytical grid focusing successively on a first characterisation of the change process, on the analysis of local discourses and discourse coalitions, and finally on the scalar dimension of these local dynamics (comprehensive versions of the local case studies are available in the annex). The second section of this part is dedicated to an integrated analysis and conclusion from each theoretically grounded perspective. The conclusion part summarises the results of the research.

Part I : Context Analysis

Section A : Long-term care in Germany, Scotland and Switzerland: a statistical overview

We will first be looking at expenditures and the structures thereof as well as at their type of financing. The second part will present an overview on the users of LTC schemes and their evolution over the past few years. The third part will offer some comparative statistics on care givers.

It should be pointed out that despite OECD statistics the data is far from being always comprehensive and directly comparable. Moreover, there is the specific issue of Scotland, for which only national data is available. As far as possible, we have tried to make them comparable.

- Long-term care expenditure

What does one understand by long-term expenditure? The issue remains debatable, notably because of the overlapping between care and health expenditure: In practice, the division of LTC into its health and social components is challenging, given that many services provided to LTC recipients have both a health and social component. According to the definition provided by the *System of Health Account of the OECD*, it comprises “the sum of activities performed either by institutions or individuals pursuing through the application of medical, paramedical and nursing knowledge and technology with the goals (*inter alia*) of caring for persons affected by chronic illness, with health-related impairments, disabilities and handicaps and assisting who require nursing care and end of-life care”⁴. Therefore, the functional classification of System of Health Account (ICHA-HC) includes three categories related to care: Services of long-term nursing care as a component of total expenditure on health (HC.3), Administration and provision of social services in kind to assist people living with disease and impairment. This category is wider than help with IADL limitations; it also includes, for example, special schooling for the handicapped, vocational rehabilitation and sheltered employment (HC.R.6) Administration and provision of health related cash-benefits. This category is wider than cash benefits provided to persons with ADL or IADL limitations: it also includes, for example, sick pay (HC.R.7).

⁴ OECD, Conceptual framework and definition of long-term care expenditure, OECD, Health-Division, 31.05.2008, SHA-REV-02001.

Because of this and other issues, the long-term care *Guidelines for estimating Long-Term Care expenditure* (LTC Guidelines) applied in the Joint Health Accounts Questionnaire under the Joint OECD, Eurostat and WHO Health Accounts data collection *Guidelines* reports the following categories separately:

4. Long-term health care to be included in total health expenditure under the SHA framework (HC.3);
5. Social services of Long-term care (LTC other than HC.3) – that is, HC.R.6.1;
6. Total long-term care (LTC), including the “social” and “health” components of long-term care (HC.3 plus HC.R.6.1).

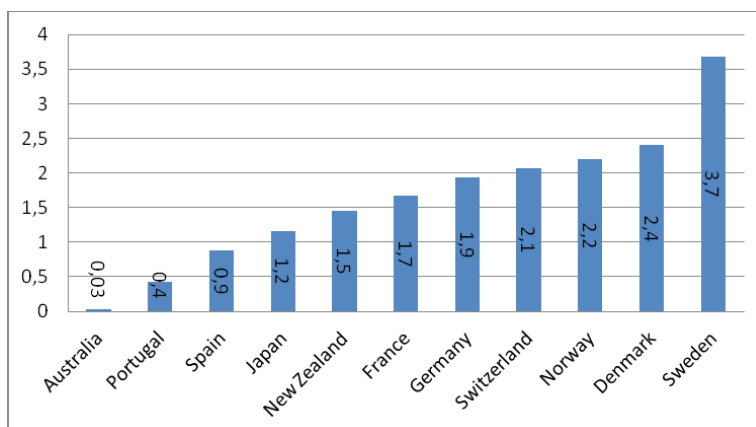
The HC.3 category is subdivided into three components: patient long-term nursing care (HC.3.1), Day case of long-term nursing care (HC3.2), Long-term nursing care: home care (HC3.3). In practice, few countries report Day cases of LTHC (HC3.2) and the category is usually combined with HC 3.1.

Total long-term care expenditure = (HC.3 + HC.R.6.1)

LTC expenditure (as a % of GDP) according to the LTC Guidelines **An illustration in the case of Germany (2009)**

	Services of long-term nursing care HC3	=			Administration and provision of social services in kind to assist living with disease and impairment (5)=(6)+(7)	=	
	(1)=(2)+(3)+(4)	In-patient long-term nursing care (2)	Day cases of long-term nursing care (3)	Long-term nursing care: home care (4)		Social services of LTC (LTC other than HC.3) (6)	All other services classified under HC.R.6 (7)
2,118(**) = (1) + (5)	1,384	0,869	0,07	0,508	0,734	0,071	0,663

Total LTC expenditure as % of GDP in 2008



Source: OECD Health Data statistics 2011, Scotland: Free personal and nursing care Scotland 09-10, Chapter 4, Table 3 and 4, own calculations
Excel: “Comp expenditure”

Table 1 compares the total expenditure for long-term care only in Germany, Switzerland and Scotland from 2003 to 2009. Total LTC expenditure covers expenditure on in-patient long-term care provided in institutions as well as on long-term nursing care provided at home (HC.3). In addition, it includes expenditure for the administration and provision of social services in kind to assist those living with disease and impairment. If one considers first the total expenditure as % of GDP, Germany and Switzerland have around 2% of GDP devoted to the LTC expenditures, which is above the OECD average but behind the leading countries from Skandinavia – no data is available for the United Kingdom and Scotland.

Long term Care Expenditure as % of Total HC Expenditure

Germany

	2001	2005	2009
In-patient LTC	6,978	7,489	7,485
Homebased LTC	4,602	4,421	4,373
Administration expenditure*		6,40	6,30
Total expenditure		18,31	18,158

Switzerland

	2001	2005	2009
In-patient LTC	16,56	17,1	17,197
Homebased LTC	2,053	2,111	2,144
Administration expenditure*			
Total expenditure	18,613	19,211	19,341

*Administration and provision of social services in kind to assist living with disease and impairment
Source: OECD Health Care Statistics 2011

It can be interesting now to have a look at the share of total LTC expenditures as a percentage of total health care expenditure. Data is not available for Scotland. Although this total share is very similar in Germany and Switzerland – slightly less than 20% – the share of home based LTC and In-patient LTC differs slightly, being more focused on home based care in Germany.

If we take a look at the sole expenditure for in-patient long-term nursing care and for home care (HC3), the situation is quite different: Total spending on LTC accounted for 1.5% of GDP on average across 25 OECD countries in 2008. There is significant cross-country variation in the resources allocated to LTC, in line with observed differences in utilization: the countries of southern Europe spend less than others, especially on care in institutions; Denmark, Norway and the Netherlands are at the top spenders because of the amount of expenditures both in home care and in care home. “This variation reflects differences in care needs, in the structure, and comprehensiveness, of formal LTC systems, as well as in family roles and caring cultures. There is also variation in the extent to which countries report both the health (so-called “nursing”) and the social-care spending components of long-term care”⁵

Germany, Scotland and Switzerland present three types of configuration regarding the amount and the structure of the long term nursing care (LTNC) expenditure. Switzerland spends more than 2% of GDP on LTNC because of the high level of expenditure in institutions (around 1.8%). The share of GDP devoted to total LTNC expenditure in Scotland is about twice as low, but the main difference to Switzerland concerns the expenditure in institutions whereas the share of GDP devoted to LTC expenditure at home is higher than in Switzerland (0.36% of GDP against 0.23% before the current crisis).

We have to keep in mind that direct expenditure covers only part of the global expenditure for LTC. As shown in France by the *Cour des comptes*⁶, we should add other expenditures, like tax breaks and other exonerations on social contribution to promote the employment of helpers, social assistance, housing benefit and so one.

⁵ OECD, *Help wanted*, 2011, p.46

⁶ Cour des comptes, *Les personnes âgées dépendantes*, Rapport au Président de la République, 2005.

**Long term nursing care expenditure in OECD countries as a % of GDP:
home care and care home.**

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009
Country	Long-term nursing care: home care								
Denmark	1,23	1,24	1,26	1,29	1,34	1,33	1,35	1,39	1,57
Finland	0,06	0,07	0,07	0,08	0,08	0,08	0,08	0,09	0,09
France	0,20	0,23	0,25	0,26	0,27	0,29	0,30	0,32	0,36
Germany	0,48	0,49	0,49	0,47	0,47	0,47	0,45	0,46	0,51
Netherlands	0,23	0,25	n. d.	n. d.	n. d.	n. d.	n. d.	n. d.	0,58
Norway	0,66	0,76	0,80	0,80	0,80	0,79	0,83	0,84	0,95
Portugal	0,03	0,04	0,04	0,04	0,04	0,04	0,04	0,04	..
Spain	n. d.	n. d.	0,11	0,11	0,13	0,13	0,15	0,16	0,18
Sweden	0,29	0,31	0,30	0,30	0,32	0,32	0,32	0,32	0,35
Switzerland	0,22	0,23	0,24	0,24	0,24	0,23	0,23	0,23	0,24
Scotland			0,28	0,30	0,33	0,33	0,34	0,36	0,39
	In-patient long-term nursing care								
Denmark	0,84	0,86	0,89	0,92	0,92	0,92	1,00	1,02	1,15
Finland	0,87	0,87	0,91	0,92	0,93	0,90	0,87	0,88	0,97
France	0,68	0,73	0,74	0,77	0,80	0,84	0,86	0,88	0,97
Germany	0,73	0,76	0,78	0,79	0,80	0,80	0,79	0,80	0,87
Netherlands	0,67	0,70	1,87
Norway	1,37	1,53	1,57	1,52	1,41	1,35	1,35	1,36	1,55
Portugal	0,06	0,06	0,06	0,06	0,06	0,05	0,05	0,06	..
Spain	0,13	0,13	0,49	0,50	0,51	0,51	0,54	0,57	0,58
Sweden	0,39	0,40	0,40	0,39	0,37	0,37	0,35	0,36	0,38
Switzerland	1,75	1,86	1,91	1,91	1,92	1,84	1,83	1,83	1,96
Scotland			0,53	0,55	0,55	0,56	0,56	0,58	0,61
	Total								
Denmark	2,08	2,10	2,15	2,21	2,26	2,25	2,35	2,41	2,72
Finland	0,93	0,95	0,98	0,99	1,01	0,98	0,95	0,96	1,07
France	0,88	0,96	0,99	1,03	1,08	1,12	1,16	1,19	1,32
Germany	1,21	1,24	1,27	1,25	1,28	1,27	1,25	1,26	1,38
Netherlands	0,90	0,94	n. d.	n. d.	n. d.	n. d.	n. d.	n. d.	2,45
Norway	2,03	2,29	2,37	2,32	2,20	2,14	2,18	2,20	2,50
Portugal	0,09	0,09	0,09	0,10	0,09	0,09	0,09	0,10	n. d.
Spain	n. d.	n. d.	0,60	0,62	0,64	0,64	0,69	0,73	0,76
Sweden	0,68	0,71	0,70	0,69	0,69	0,69	0,67	0,67	0,73
Switzerland	1,97	2,08	2,15	2,15	2,16	2,07	2,06	2,07	2,20
Scotland	n. d.	n. d.	0,82	0,85	0,87	0,89	0,89	0,94	0,99

Source: Source: OECD Health Data statistics 2011, Scotland: Free personal and nursing care Scotland 09-10, Chapter 4, Table 3 and 4, own calculations
Excel : Expenditure LTC in % of GDP

The situation of Germany ranks between those of both other countries: total LTNC expenditures amounts to around 1.3% of GDP with 0.8% for care in institutions. By definition the ratio between expenditure and GDP on the real growth depends on both variables.⁷ Adjusted to the GDP deflator⁸, the growth of LTC-NS expenditure was much stronger in Scotland than in both other countries: a real growth by a third against only 13% in Germany and 15% in Switzerland over the whole period going from 2003 to 2009, that is an annual average growth rate of 5,0% against 2,1% and 2,4% respectively. The introduction of the Free Personal & Nursing Care policy in Scotland in July 2002 has led to a strong growth in expenditure, more than a third over the whole period, especially on home care.⁹ In Germany and Switzerland real LTC-NC expenditure has grown at the same pace as the GDP – except since the beginning of the current world's and euro crisis.

Table 1 Total expenditure for LTC and net expenditure for Long Care Nurse Care (HC3) : real growth in Germany, Switzerland and Scotland (deflator: GDP price index) in Euro.

	2003	2004	2005	2006	2007	2008	2009	2009 / 2003	Annual Average Groth Rate
Total expenditure for LTC									
Germany	43106,8	43685,1	44087,0	45053,8	45370,0	46692,3	48871,0	113,4	2,1%
Switzerland (*)	9303,7	9678,6	9998,0	10095,5	10881,3	10761,7	10713,9	115,2	2,4%
Net expenditure for Long Term Nurse Care (HC3)									
Germany	27946,1	28008,0	28748,0	29535,4	29846,9	30520,0	31931,7	114,3	2,2%
Switzerland (*)	6562,3	6371,2	6457,4	6232,2	6191,0	7577,1	9201,1	140,2	5,7%
Scotland (**)	687,9	711,3	767,2	828,4	903,2	933,8	926,1	134,6	5,0%

(*) in billions of Swiss Francs

(**) in billions of Pounds

Sources: Germany and Switzerland OECD Health Data Statistics 2011, Scotland: Free personal and nursing care Scotland 09-10, Chapter 4, Table 3 and 4 (Net expenditure)

Excel : Fichier : dep en volume 2003-2009 et Comp/comp recipients and expenditure per capita

A look at the total LTC-expenditure *per capita* from a comparative point of view and through time confirms these observations and brings further information. In Germany, real expenditure per capita has stagnated over the first decade of the new millennium.

⁷ Adjusted for prices, the growth of GDP (basis 100 in 2000) reached 2008 111,5 in Germany, 117 in Switzerland and 121,0 in Scotland.

⁸ We have chosen the GDP price index as a deflator because it is more accurate for public expenditure – its financing or its long term sustainability – than the consumer price index, which gives information about the purchasing power of expenditure for the beneficiaries.

⁹ Since July 2002 Scottish local authorities have provided personal care to people who live at home free of charge and make flat-rate payments to care home operators who provide personal care to people who fund their care home accommodation themselves.

This can be explained by the non-indexation of benefits (see below). Conversely the main driver of the expenditure growth over this period in Switzerland has been the increase of expenditure per capita, not the cover ratio. In Scotland the 2002 reform (see below) has led to a noticeable improvement of the expenditure per capita and explains more than the whole increase of the total expenditure.

Total LTC-expenditure per recipient in real terms (deflator: GDP price index)

	2003	2004	2005	2006	2007	2008	2009	2009/ 2003
Germany	22348,1	22395,9	22005,9	22389,6	22150,2	22445,0	23226,4	103,9
Switzerland	22098,1	22886,2	23488,6	23365,5	23930,6	24593,4	25178,6	113,9
Scotland	8995,1	10088,6	10763,4	11097,5	11335,0	11985,6	12414,3	138,0

(*) in swiss francs (**) in pounds

Sources: Germany and Switzerland OECD Health Data Statistics 2011, Scotland: Free personal and nursing care Scotland 09-10, Chapter 4, Table 3 and 4 and Home Care Service Report Scotland 1998 - 2010, Table 3 for the number of recipients. (excel : “dépenses en volume 2003-2009” and “comp recipients and expenditure per capita”)

The comparison of the LTC-expenditure per recipient in Euros requires the use of real exchange rates, which seeks to measure the value of a country's goods basket against those of another country or a group of countries taking into account the purchasing power parity at the prevailing nominal exchange rate.¹⁰ We use here the “German euro”, that is the price level in Germany (not in the Euro zone as a whole) for the comparison. The following real exchange rates were used to convert Expenditures in Switzerland and Scotland in “German Euro”:

	2003	2004	2005	2006	2007	2008	2009
United Kingdom	0,76	0,75	0,76	0,77	0,79	0,82	0,85
Switzerland	2,10	2,08	2,08	2,04	1,97	1,99	2,03

Source: Eurostat, own calculation.

Excel : “OECD/taux de change euro - autres monnaies - courants et PPP - 1995 - 2010

¹⁰ The real exchange rate (RER) between two currencies is the product of the nominal exchange rate (the Swiss franc cost of a euro, for example) and the ratio of prices level between the two countries. The equation is $RER = e \cdot P^*/P$, where, in our example, e is the nominal Swiss franc-euro exchange rate, P* is the average level of price in the euro area and P is the average price of the good in Switzerland.

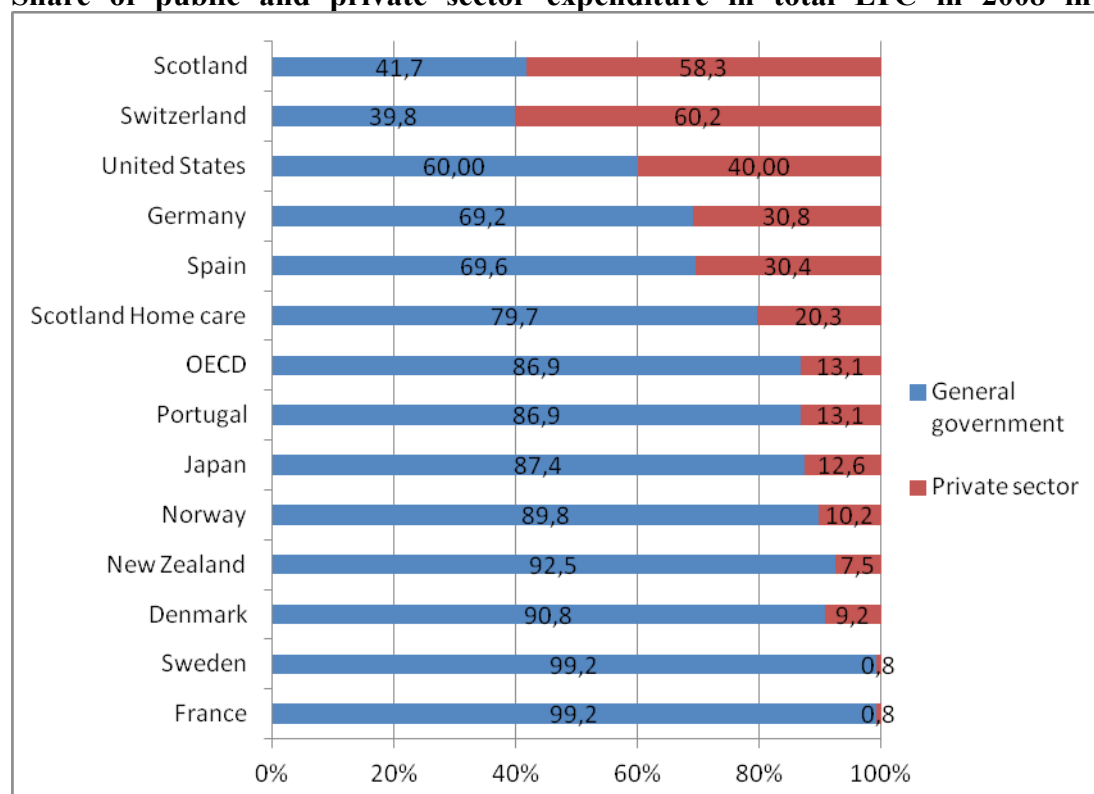
Nominal LTNC-expenditure per capita in national currency and in euro

	2003	2004	2005	2006	2007	2008	2009
In national currency							
Germany	13651.8	13591.8	13819.2	14079.0	14018.8	13964.5	13915.7
Switzerland	11979.2	12296.0	12980.0	12807.9	12585.7	13521.4	14891.1
Scotland	5872.3	6751.8	7360.0	7831.2	8185.7	8926.8	9393.8
In Euros (real exchange rate)							
(1) Germany	13651.8	13591.9	13819.2	14079.1	14018.8	13964.5	13915.7
(2) Switzerland	22360.0	22932.1	23490.1	23479.9	23597.4	25698.7	27720.6
(3) Scotland	8408.7	9570.9	10036.9	10469.9	10539.7	11135.6	11550.5
Comparison of Nominal LTC-expenditure per capita in PPA Euros							
(2) Switzerland/ (1) Germany	1.64	1.69	1.70	1.67	1.68	1.84	1.99
(3) Scotland/ (1) Germany	0.62	0.70	0.73	0.74	0.75	0.80	0.83
Comparison of Purchasing Power Standard per inhabitant (GDP PPA/Population)							
Switzerland/Germany	1.16	1.14	1.16	1.20	1.23	1.24	1.25
Scotland/Germany	0,94	0,94	0,90	0,90	0,86	0,86	0,89

Source: see previous tables, own calculation.

A look at the level of nominal expenditure on LTNC-expenditure at purchasing power parity per recipient in 2009 shows that compared to Germany it is about twice higher in Switzerland and amounts to 83% in Scotland. This data confirms that PPP-expenditure per capita has grown faster in both countries than in Germany over the last years. The difference is higher than the PPP-GDP per inhabitant in the Swiss case, yet lower in the Scottish one. The Scottish-system has provided benefits per recipient, which have grown near to the German ones. Since the 2002 Scottish reform it has been just as generous when compared to the difference between both countries regarding the PPP-GDP per head. But we cannot evaluate the generosity of each system without looking at the structure of financing.

Share of public and private sector expenditure in total LTC in 2008 in %



Source: OECD Health Data Statistics 2011, Scotland: Free personal and nursing care Scotland 09-10.

How are *total* expenditures shared between general government and the private sector? Long-term care is predominantly funded from public sources. On average, the share of total LTC spending supported by households is equivalent to about 15%, and represents a lower fraction than for health spending (25%).¹¹

The main exception is Switzerland, where the share of LTC expenditure supported by households amounts to about 60% of total spending. “In aggregate, public and private LTC spending in Switzerland reaches the level of Nordic countries, but public LTC spending represents 0.8% of GDP, a figure comparable to public LTC spending in Germany and Australia”.¹² The main explanation is that home based LTC is mainly financed by private health insurances which pay a major part of the medical services and the traditionally important contribution of private households to the financing of health care.¹³

Private spending is also relatively high in the United States (40%), Spain (31%) or Germany (31%). In Germany, the current public expenditure for the *gesetzliche Pflegeversicherung* passed in 1994 rose from 16.7 billion in 2000 to 20.3 billion in 2009, of which 4.7 billion had been spent on benefits in cash, 2.8 billion on benefits in

¹¹ As noted by the OECD: “Data on private LTC spending however may not include the high cost of board and lodging in nursing homes which account for the lion share of the cost borne by residential LTC users” (*Help wanted*, p.46).

¹² *Ibid.*, p.47

¹³ See *The Swiss System of Home Based Long-Term Care for the Aged*, in this report.

kind, 9.3 on people hosted in institutions (*vollstationär*). But the benefits hadn't been indexed to the inflation from 1997 to 2008 - the amounts of benefits have been increased with the LTC reform 2008 – and they are in general not sufficient to cover the formal costs at home or in a nursing home; co-payments are quite substantial and the public assistance (Sozialhilfe) has still to support a complementary part of the expenditures.¹⁴

In Scotland, from July 2002 personal and nursing care services became free for people aged 65 years old and over who are residents in care homes. In fact everyone who obtains personal and/or nursing care services in a care home receives £153 per week for personal care and £69 (amounts since 2009). The total amount of money spent by Local Authorities on Free Personal care and Free Nursing Care (FPNC) payments to self-funding residents in Care Homes¹⁵ has increased each year from £86 million in 2003-04 to £108 million in 2009-10. This increase “reflects the growing number of self-funders up until 2008-09 and the annual increases in the FPNC payments from April 2008. All of this is new money arising from the FPNC policy”.¹⁶ The public expenditure amounts to 17% of all expenditure.

From 1 July 2002 all personal care services provided to people in their own homes became free of charge. The amount of money spent by Local Authorities on providing personal care services has risen steadily each year from £133 million in 2003-04 to £318 million in 2009-10. “This more than doubling of spend over the last 6 years reflects the fact that an increasing proportion of older people are cared for at home, rather than in hospital or care homes; that increasingly home care workers are providing personal care services rather than domestic services; and that people living at home have increasing levels of need. It should be noted that this is not all new spend arising from the FPNC policy, but prior to the policy Local Authorities could charge people for these services”.¹⁷ Many older people already received personal care services at home without charge, prior to the introduction of the Free Personal and Nursing care, either because their income was below the means-tested threshold operated by their local authority or because the authorities already provided personal care without charge, so that public expenditure's part reached about 60% in 2002. Because of the reform almost 80% were reached in 2009. In aggregate, public LTC spending represents around 0.4% of GDP but the percentage of public expenditure in the total of Net expenditures has grown from 35% to 42%.

¹⁴ See H. Rotgang, “Social Insurance for Long-term Care: An Evaluation of the German Model”, Social Policy and Administration, Vol. 44, N°4, August 2010, p.436-460.

¹⁵ This expenditure data on free personal and nursing care relates only to self-funders who previously would have paid for all of their care. The figures allow to determine the additional costs to Local Authorities in Scotland following the implementation of this policy, in relation to care homes (see: *Free Personal And Nursing Care Scotland, 2009-10*, Scottish Government, National Statistics, 2011).

¹⁶ *Free Personal And Nursing Care Scotland, 2009-10*, p.6.

¹⁷ *Free Personal And Nursing Care Scotland, 2009-10*, p.8.

Expenditure on Care Homes and on Home care for older people in Scotland.

In millions of £	2003 -04	2004 -05	2005 -06	2006 -07	2007 -08	2008 -09	2009-10
Net Expenditure on Care Homes for Older People (Annex 8)	424,9	464,8	479,9	527,5	555,1	598,0	621,1
Total expenditure on FPNC in Care Homes (Annex 9)	86,4	93,0	97,3	99,2	104,2	106,0	107,6
Expenditure on FPNC as percentage of Net Expenditure on Care Homes for Older People	20,3	20,0	20,3	18,8	18,8	17,7	17,3
(1) Net Expenditure on Home Care Services for Older People (Annex 12)		247,9	287,4	305,0	335,5	377,8	398,5
(2) Expenditure on Personal Care at Home (Annex 13)	132,8	158,0	189,1	228,2	267,5	276,9	317,4
Expenditure on FPC as percentage of total Net Expenditure on Home Care Services (2)/(1)	59,3	63,7	65,8	74,8	79,7	73,3	79,6
TOTAL NET expenditure on care Homes and on Home care							
(3) Net Expenditure on Care Homes for Older People (Annex 8) and on Home Care Services for Older People (Annex 12)	649	713	767	832	891	976	1020
(4) Total expenditure on FPNC in Care Homes (Annex 9) and Expenditure on Personal Care at Home (Annex 13)	219,1	251,0	286,4	327,4	371,7	382,8	425,0
FPC expenditure as a percentage of total net expenditure on Home Care services (4)/(3)	33,7	35,2	37,3	39,3	41,7	39,2	41,7

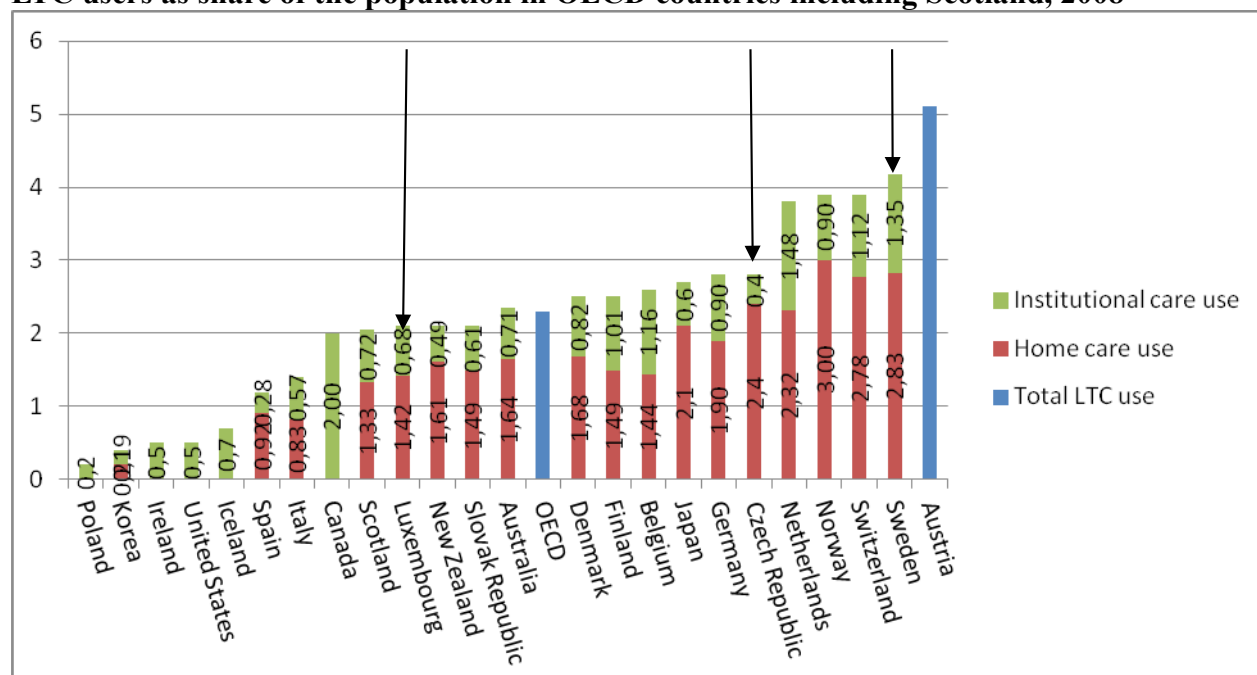
Source : Free Personal And Nursing Care Scotland, 2009-10, Scottish Government, National Statistics, 2011.

2. LTC users

Who are the LTC-users and how many are there in our three countries? The use of formal LTC services, first measured in terms of LTC recipients as a share of the total population, amounts to an average of 2.3% of the population across OECD countries. But the dispersion is quite high: from a very low level of 0.2% in Poland up to more than 5.0% in Austria. From this point of view, our three countries stand in different positions: slightly under the OECD-average concerning Scotland (2%), above this

average in Germany (2.8%) and among the countries with the highest share for Switzerland (3,9%).

LTC users as share of the population in OECD countries including Scotland, 2008

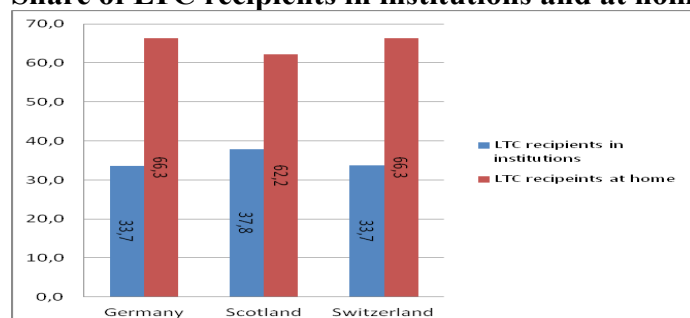


Source: OECD Health Data Statistics 2011: Home Care Service Report Scotland 1998 - 2010, Table 3; Scottish Care Home Census 2000-2011, Table 2; Free personal and nursing care Scotland, Annex 1; Population Scotland 1911-2010.

Excel: comparisons; More LTC users receive care at home than in institutions.

Not the structure of the recipients' population but the total share of LTC users differs between the three countries. On the 23 countries for which data are available from OECD, about 70% of all LTC users receive services at home, ranging from 55% in Belgium to over 80% in the Czech Republic.¹⁸ In 2008 all three countries were next to the average with a share of Home care users close to two thirds of all recipients – slightly more in Switzerland and slightly less in Scotland. But despite different structures providing LTC the proportions are astonishingly close - as they are also by sex.

Share of LTC recipients in institutions and at home in 2009

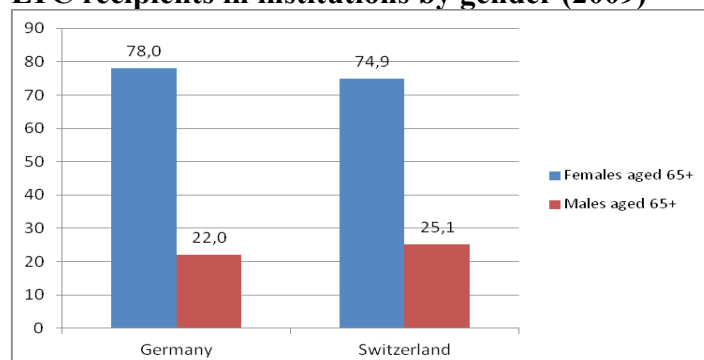


¹⁸ See *Help wanted*, op. cit., p.40

Source: see previous graph. Exel : “graphs”

As is well known, demand for LTC in institutions is highly gender-related: in both of these two countries women represent about three fourths of the LTC patients in institutions.

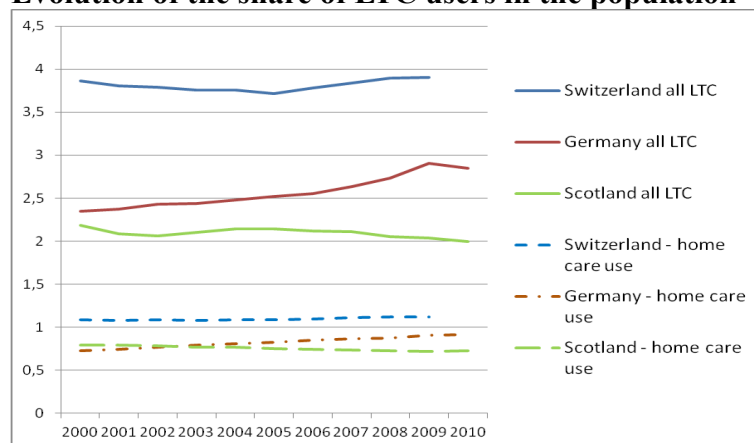
LTC recipients in institutions by gender (2009)



Source: Germany and Switzerland OECD Health Statistics 2011, Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2

How has the share of recipients as a percentage of total population changed during the last ten years and what are the underlying factors? The share has been stable in Switzerland over the whole period with two phases before and after 2006; it has fallen slightly in Scotland and grown on a small scale in Germany. Are these changes due to diverging growth rates of the global population or to the evolution of the numbers of users and in how much the structure of the LTC-users' population differs by sex and by age in Germany, Scotland and Switzerland?

Evolution of the share of LTC users in the population



Source : see pervious graphic.

As is well-known the use of long-term care increases with age. On average about 12% of the population across OECD countries aged 65 and over were receiving some long-term care services at home or in institutions in 2009 and approximately half of all LTC users are aged over 80 years. From this point of view Scotland and Switzerland are close regarding the share of the 65 or 80 and over and slightly under the EU-average

whereas Germany belongs with Japan and Italy to those countries which have the highest level of old-aged population in the world, although differences remain minimal.

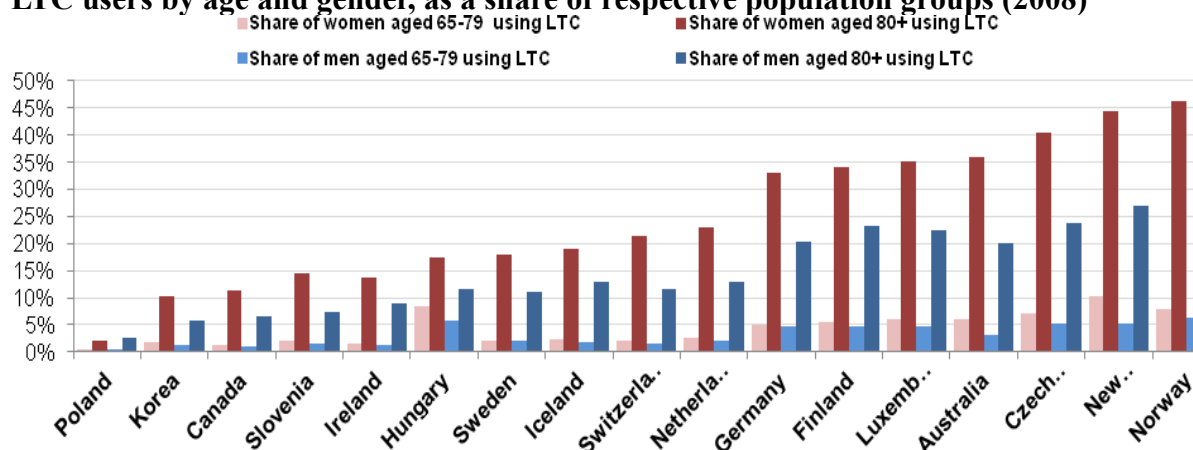
The share of the people aged of 65 and over and of 80 and over in the total population

Country	2010	
	% 65+ 2010	% 80+ 2010
United States	13,0%	3,7%
Norway	15,0%	4,5%
Sweden	18,3%	5,3%
OECD	14,7%	3,0%
UK	16,5%	4,6%
France	16,7%	5,3%
Denmark	16,6%	4,1%
Scotland	16,8%	4,4%
Portugal	18,0%	4,5%
Greece	18,9%	4,8%
Spain	16,7%	4,9%
Switzerland	17,1%	4,9%
Italy	20,3%	5,9%
Germany	20,6%	5,1%
Japan	23,1%	6,5%
EU27	17,4%	3,4%
World	7,6%	1,1%

Source: OECD Labour Force and Demographic Database, 2010, Scottish office of statistics.

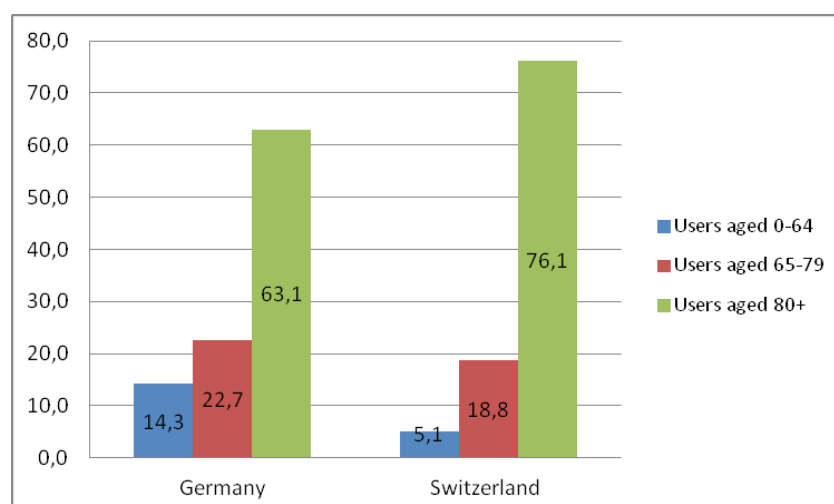
What exactly is the share of LTC users by age compared to the share of respective population groups? Depending on several variables, there is an important dispersion between OCDE countries; a dispersion, which grows with the age pattern. Between 2% (Poland) and 46% (Norway) of the women aged 80 years old or over use LTC services, while the correspondent male proportion ranges from 2.6% in Poland to 32% in Norway. Switzerland and Germany belongs to the average.

LTC users by age and gender, as a share of respective population groups (2008)



Source: OCDE, Help wanted

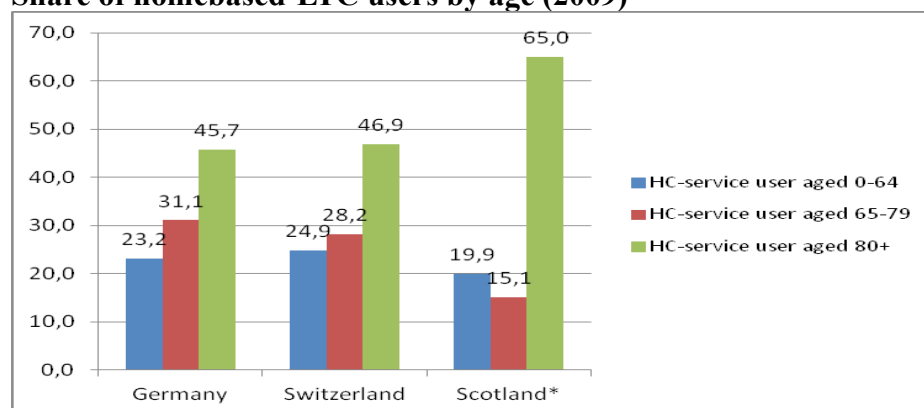
Share of LTC users in institutions by age (2009)



Source: Germany and Switzerland OECD Health Statistics 2011, Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2; For Scotland different age's groups: 0-64, 65-75, 75+

In all countries, the great majority of the persons being cared for in institutions belongs to the age group of 80 years and older: In Germany they account for 63% of the LTC recipients and in Switzerland even for 76%. The share of the age group between 65 and 79 is similar in both countries (23% in Germany and 19% in Switzerland), but the share of in-patient LTC receivers being younger than 65 years is substantially smaller in Switzerland than in Germany (14% in Germany against 5% in Switzerland).

Share of homebased-LTC users by age (2009)



Source: Germany and Switzerland OECD Health Statistics 2011, Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2. *For Scotland different age's groups: 0-64, 65-75, 75+*

More interesting for our research is the fact that in the case of home-based long-term care, the age-related differences between users are less pronounced than those observed in the case of in-patient care and almost the same in Germany and Switzerland. Scottish data is not directly comparable except for the 20 years old and younger, which is very close to those of the other countries.

To sum up, in spite of differences in the organization of care supply, the striking fact is, firstly, that the repartition of LTC-users between care homes and home care is very close in the three countries and, secondly, that the population of home care users is also very similar by sex and age.

Does that mean that the proportion of care users under old people is the same in these countries? The demand for LTC is highly age-related everywhere and reflects higher female life expectancy and survival rates. But there are some gaps between Switzerland and Germany concerning the share of LTC users, above all among the oldest people. A higher share can mirror cohorts' effects but also institutional or well-being variables. The feeling of well-being is more widespread among aged people in Switzerland than in Germany.¹⁹ Moreover the existence of a LTC social insurance in Germany may lead to more frequent cases requiring LTC.

¹⁹ François Höpflinger, Lucy Bayer-Oglesby, Andrea Zumbrunn, *La dépendance des personnes âgées et les soins de longue durée Scénarios actualisés pour la Suisse*, Cahiers de l'Observatoire suisse de la santé, 2010.

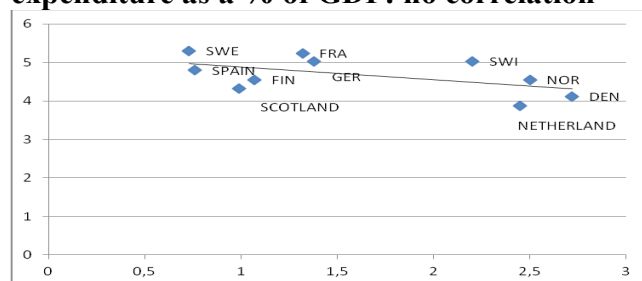
Share of LTC-users in several population age-groups

	65-69	70-74	75-79	80-84	85+	85-89	90
Switzerland							
Males	1.1	3.4	7.2	9.0	23.3	16.0	41.5
Females	1.7	3.6	5.7	15.9	38.2	31.0	59.2
Total	1.4	3.5	6.3	13.3	33.9	26.3	54.6
Germany							
Males	2.8	4.8	8.9	15.6	30.8	27.5	38.9
Females	2.5	4.9	10.7	22.2	49.5	40.7	68.8
Total	2.6	4.8	10.0	20.0	44.7	37.2	61.6
France							
Males	2.5	4.2	7.5	11.0		18.6	41.5
Females	2.5	4.2	6.0	14.5		27.0	59.2

Source: Germany: Pflegestatistik, Statistisches Bundesamt, 2009, Switzerland and France: Höpflinger et al. 2010.

A confirmation of the complex relationship between age and the use of LTC is given by the correlation coefficient between the shares of the 80 years old and over in regard to the population and LTC expenditure as a percentage of GDP for ten OECD countries. Should all countries financial resources be provided to the same extent and the probability to be a care user be the same, then LTC expenditure would correlate closely with the age structure. If this relationship is limited, this would point to the differences in the LTC providing systems. This coefficient tends in fact to be weak and rather negative; an indicator that public policies and innovative practices are key factors.

Share of the 80 old years and over in the population and LTC expenditure as a % of GDP: no correlation

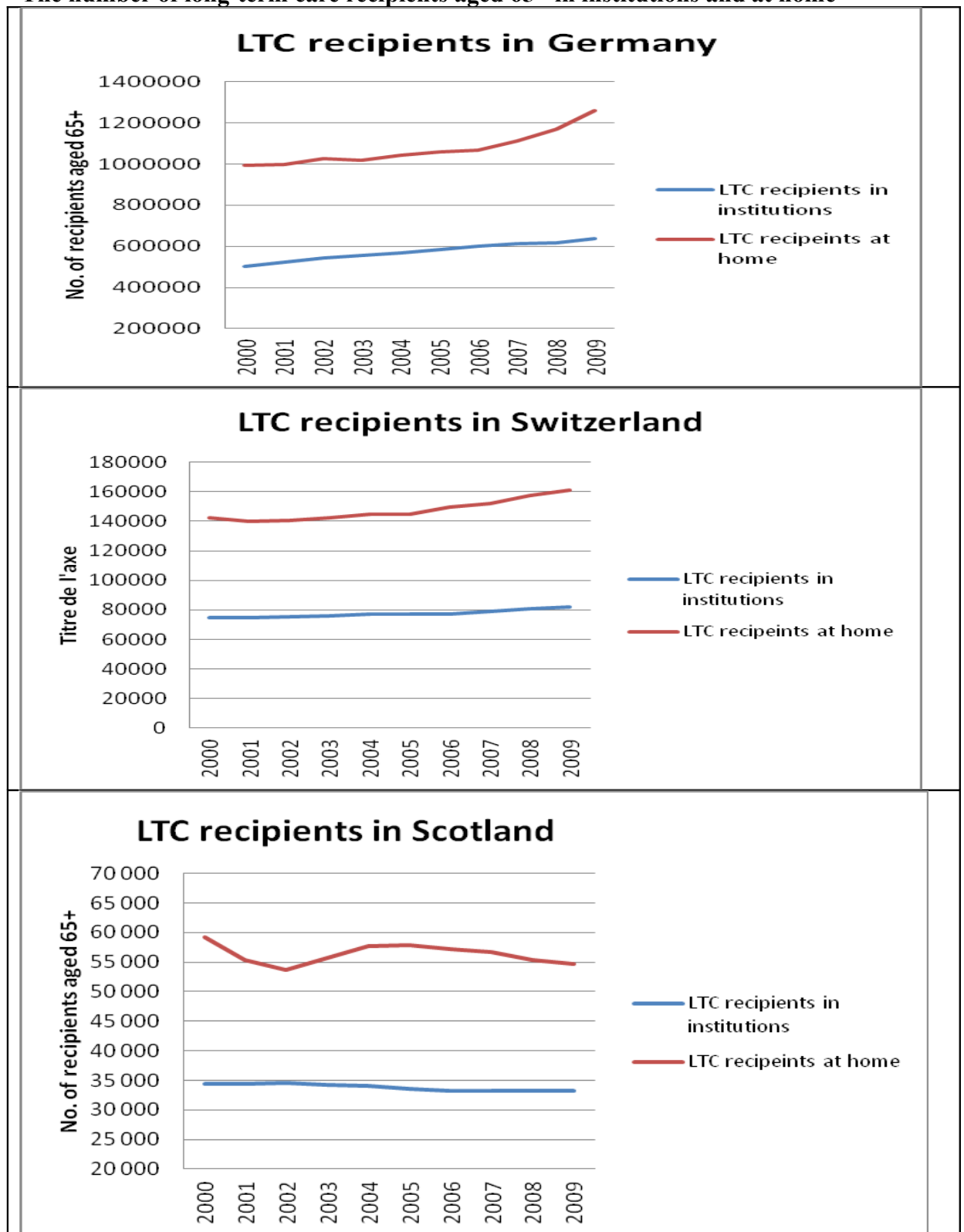


Source: own presentation with data from OECD.

We will now be focusing on the number of persons aged 65 and older receiving LTC in institutions or at home in Germany, Switzerland and Scotland. Among these three countries, the number of both LTC recipients at home and in institutions has increased most distinctively in Germany, with 27% in both areas between 2000 and 2009. Germany is followed by Switzerland with an augmentation of LTC users in institutions by 10% and at home by 13%. In Scotland, by contrast, the number of persons aged 65 years and older receiving LTC has slightly decreased between 2000 and 2009, by 3% in the case of LTC recipients in institutions and by 8 percent in the case of LTC recipients at home. After the introduction of free personal care the number of older people receiving home care service increased to 57,900 in 2004/05 before falling down to around 51,700 in 2010/11. Over this time we have seen a shift towards more intensive home care provision and an increasing proportion of people in need to receiving

personal care services.

The number of long-term care recipients aged 65+ in institutions and at home



Source: OECD Health Data Statistics 2011, Scottish Care Home Census 2000-2011, Table 2, Free personal and nursing care Scotland, Annex 1. (Excel “LTC users”).

Long-term care recipients aged 65+ in institutions and at home in Germany, Switzerland and Scotland (2000-2009)

Germany	2000	2003	2006	2009	Change 00-09 and 03-09
LTC recipients in institutions	504631	557078	601657	638872	27%/14,7%
LTC recipients at home	994406	1018173	1066331	1259081	27%/23,7%
Total LTC recipients	1499037	1575251	1667988	1897953	27%/20,5%
Switzerland	2000	2003	2006	2009	Change 00-09 and 03-09
LTC recipients in institutions	74562	75900	77105	82008	10%/8,0%
LTC recipients at home	142573	142093	149449	161047	13%/13,3%
Total LTC recipients	217135	217993	226554	243055	12%/11,5%
Scotland	2000	2003	2006	2009	Change 00-09 and 03-09
LTC recipients in institutions	34.433	34.302	33.313	33.255	-3%/-3%
LTC recipients at home	59217	55746	57187	54718	-8%/-2%
Total LTC recipients	93.650	90.048	90.500	87.973	-6%/-2,3%

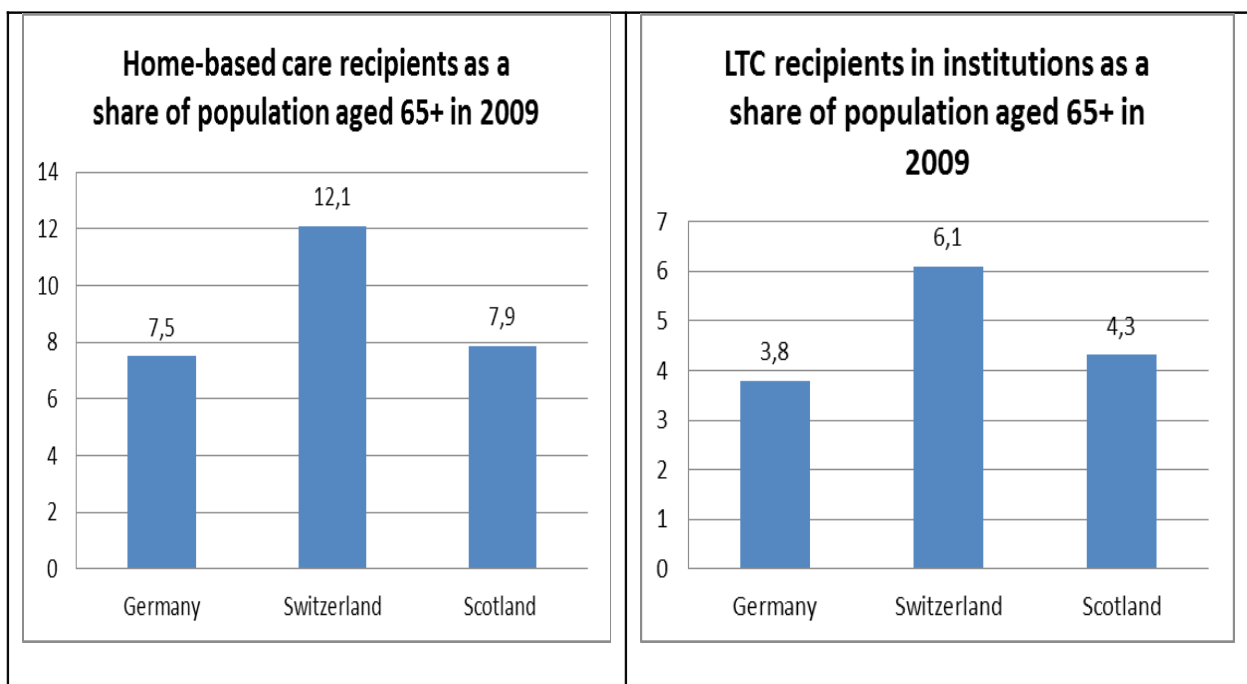
Source: Germany and Switzerland: OECD Health Statistics 2011, Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2 (Excel : Comp/graph/tab LTCB recipients).

Since 2003, there has been an increase in the number of people receiving free personal care (FPC) services at home. The latest figures for 2010/11 shows that over 46,700 people are now receiving personal care services provided without charge at home. In 2003, 57% of home-care recipients received personal care services. This percentage has steadily increased each year to reach 90% in 2010/11.

Data on the number of LTC recipients as a share of the population aged 65 years and above in 2009 offers supplementary information. With 12% of the population aged 65 and above, the number of LTC recipients at home is by far the highest in Switzerland, compared to 7.9% in Scotland and 7.5% in Germany. Care homes are much more developed in Switzerland and focus on the 80 years old and over and the percentage of persons who die in institutions is higher in Switzerland than in most other European countries.²⁰

²⁰ Höpflinger and al., *La dépendance des personnes âgées...*, op. cit. p. 104.

LTC users as a share of population aged 65 and older



Source: Germany and Switzerland OECD Health Statistics 2011, Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2. (excel Graph).

This also applies to the number of persons being cared for in institutions, which ranges from 6.1% in Switzerland through 4.3% in Scotland and to 3.8% in Germany. The Swiss LTC-System is not only more expensive regarding the level of expenditure per recipient (see above), it has also a much higher “cover ratio”, compared to Germany and Scotland, which are again close from this point of view.

Life expectancy at age 65 in 2009			
	Males	Females	Difference
Switzerland	19,0	22,2	3,2
United Kingdom	18,1	20,8	2,7
Germany	17,6	20,8	3,2
France	18,2	22,5	4,3
Population aged 65 years and over reporting to be in good health, 2009			
	Total	Females	Males
Switzerland	71,8	69,2	75,2
France	43,2	41,5	45,4
OECD	45,2	42,4	49,0
Germany	36,8	35,5	38,5
Healthy life years at age 65, European countries, 2009			
United Kingdom	11,8	10,7	
France	9,2	8,8	
OECD	9,0	8,8	
Germany	6,5	6,4	

OECD: Health indicators.

As we can see from the previous table, these differences in shares of LTC-users cannot be explained by divergences regarding life expectancy or the state of health of people aged 65 and over, which are higher in Switzerland than in the United Kingdom but above all than in Germany.

The number of home-based care recipients as a share of population aged 65 and older as well as the share of recipients in institutions has grown slightly in Germany but dropped in Switzerland and above all in Scotland.

Home-based care recipients as a share of population aged 65 years and older				
	1997	2000	2003	2009
Germany	7,3	7,4	7	7,5
Switzerland	13,4	13	12,4	12,1
Scotland		7,4	7,6	7,9
LTC recipients in institutions as a share of population aged 65 years and older				
	1997	2000	2003	2009
Germany	3,2	3,7	3,8	3,8
Switzerland	..	6,8	6,6	6,1
Scotland		4,3	4,2	4,3
Total LTC recipients as a share of population aged 65 years and older				
		2000	2003	2009
Germany		10,6	10,3	11,1
Switzerland		19,7	19,0	18,8
Scotland		11,7	11,0	10,1

Source: OECD, Health Indicators, , Scotland: Home Care Service Report Scotland 1998 - 2010, Table 3 and Scottish Care Home Census 2000-2011, Table 2, own calculations.

Excel : comparison/ comp LTC users

In Germany the rise of the *number* of LTC-users (+27%) has been led mainly by the evolution of the population's structure but also pushed by a small increase in the share of recipients in the population aged 65 and over. In Switzerland, the ageing of the population has been the main engine of the rise in the number of recipients.

The evolution of LTC-recipients from 2000 to 2009: a resolution

	Number of recipients	Recipients as a share of 65 +	Population aged 65 years and older
	6. = (2)*(3)	(2)	(3)
Germany	126,6	105,3	120,0
Switzerland	111,9	95,4	117,3
Scotland	93,9	86,5	108,6

Source: own calculation

In Scotland, the drop of the number of recipients has been due to the fact that the share of recipients has fallen whereas the evolution of the population has had a contrary effect.

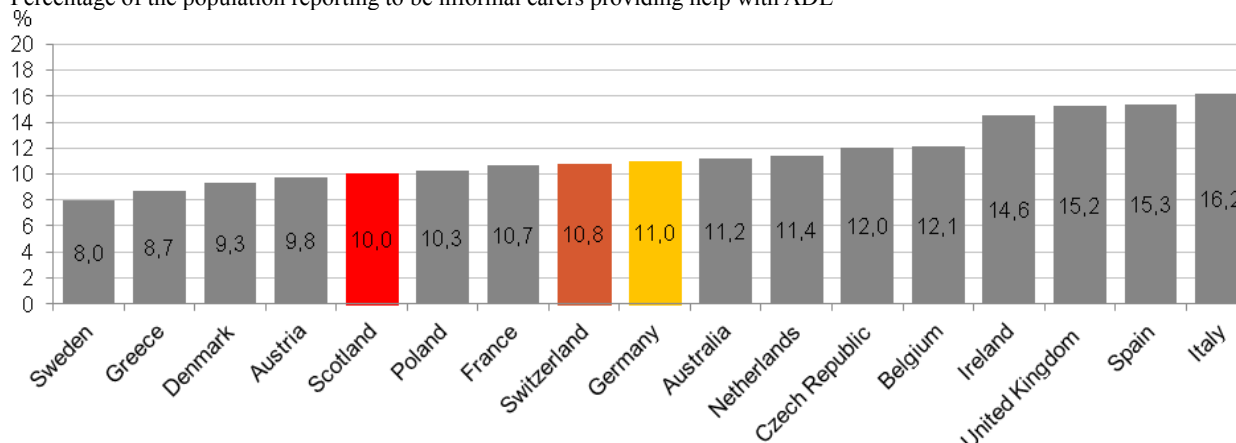
3) Informal and formal carers.

We will first present data on informal carers before focusing on formal LTC workers. As

pointed out by the OECD: “There is a lack of comprehensive or comparable international evidence on carers. The definition and measurement of unpaid care presents significant challenges, especially in a study which attempts to make international comparisons. Many carers do not see themselves as such and, even if questioned, would not declare that they were carers. Society’s attitudes towards family responsibilities and the availability of services to support both carers and people with health limitations vary widely across countries, influencing the pattern and declaration of informal caring”.²¹

Percentage of the population reporting to be informal carers providing help with ADL

Percentage of the population reporting to be informal carers providing help with ADL



Note: Samples include persons aged 50 and above. The United States includes care provided to parents only. The following years are considered for each country: 2005-07 for Australia; 1991-2007 for the United Kingdom; 2004-06 for other European countries; and 1996-2006 for the United States, 2001 for Scotland. ADL: Activities of daily living; IADL: Instrumental activities of daily living.

Source: OECD estimates based on HILDA for Australia, BHPS for the United Kingdom, SHARE for other European countries, and HRS for the United States.

On average across OECD countries, one out of nine people aged 50 and over reported providing care and ADL assistance for a dependent relative around 2007. The percentage ranges from 8% in Sweden, where formal care provision is more developed, to a rate about twice higher in Italy and Spain, whereas Switzerland and Germany are very close to 11%.²² For Scotland the last data was published in July 2010 on the basis of the 2001 Census and the Scottish Household Survey (SHS) 2007/2008: While around 7% of households in the SHS sample have a carer providing help or care within the home, around 10% of the adults provide additional help or care to someone not living with them.²³

As shown by the SHARE panel, in Europe a quarter of the relationships between parents and children (aged 50 and over) have to do with help. This help focuses primarily on household chores, repairs and gardening. It is also related to activities within the household and dealing with public administration. The frequency of helping

²¹ OECD, *Help wanted*, op. cit., p. 86.

²² *Help wanted*, op. cit.

²³ See *The Future of Unpaid Care in Scotland Scottish Executive*, 2006.

relationships in child-parent dyads varies from 13% in Spain to 37% in Denmark. Switzerland and Germany are situated halfway.²⁴ Considering the intensity of care (number of hours provided), the situation is reversed: intergenerational LTC represents the largest number of hours in the Mediterranean countries. Its intensity is much lower in Scandinavian countries.

Weekly hours of care provided by informal carers, around 2007

In %	0-9 hours	10-19 hours	20+ hours
Denmark	76,1	8,6	15,3
Switzerland	71,7	9,5	18,5
Sweden	71,5	15,4	13,2
Ireland	63,4	14,0	22,6
Netherlands	61,5	13,8	24,7
France	59,6	13,2	27,1
Germany	55,5	14,2	30,3
Australia	55,1	17,5	27,3
United Kingdom	55,0	18,3	26,7
Austria	52,6	17,6	29,9
OECD	52,1	15,6	32,3
Belgium	51,2	16,4	32,4
Scotland	63		37,0
Czech Republic	48,0	14,2	37,8
Italy	45,6	15,4	38,9
Poland	43,4	8,9	47,9
Greece	39,9	15,2	44,9
United States	35,4	34,2	30,5
Spain	31,7	16,1	52,2
Korea	20,4	17,6	62,0
OECD (18)	52,1	15,6	32,3

Source: OECD.

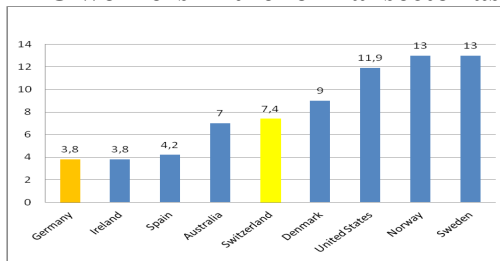
Switzerland is a special case in this regard: while being located between the North and the South, the children help their elderly parents relatively often, but spend less time on it (an average 2 hours per week against, for example, 8.7 hours in Italy). Germany is not far from the OECD average, with half of the carers spending less than 9 hours and three quarters less than 20 hours. In Scotland, according to the 2001 Census, 63% of carers were undertaking less than 20 hours of care per week and 23% were undertaking more than 50 or more hours. 79% of carers providing care to people not living with them, provide less than 20 hours per week.

Several researches have shown that formal and informal carers are rather complementary above all when the Activity of Daily Life (ADL) of recipients is very limited. The following data on formal LTC workers according to the OECD definition refers to “nurses as well as personal carers who are paid to provide care and/or assistance with activities of daily life to people requiring long-term care at home or in institutions other than hospitals”. Unfortunately there is no available data for Scotland

²⁴ Brandt, M., *Hilfe zwischen Generationen. Ein europäischer Vergleich*, Wiesbaden, VS Verlag für Sozialwissenschaften, 2009.

or for the United Kingdom (outside statistics on providers and hours of care, see above).

LTC workers in the formal sector as % of total population aged 65+ in 2009

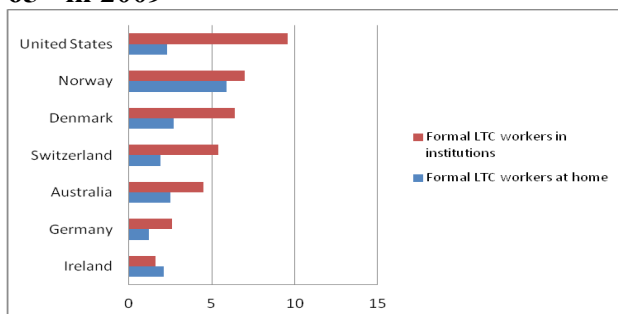


Source: OECD Health Data Statistics

Excel: Comp. LTC workers

In percentage of the population aged 65 and over, among countries for which data is available, the number of formal LTC workers is again the highest in North-European countries and the lowest in Germany. In Germany 69% of the *Pflegebedürftige*, that is 1.62 billion, receive some long-term care services at home. Among them 1 billion are helped by informal carers and 0.5 billion receive care from 12.000 professional care home services, for which 270.000 employees (30% of the professional care givers) work.²⁵ In Germany LTC remains for the time being more in charge of families than in other developed countries. The fact that a huge majority of LTC-receivers prefer to get the benefit in cash rather than the benefit in kind although the former is twice lower may be a part of the explanation. LTC workers in the formal sector as a percentage of the total population aged 65 and over are almost twice higher in Switzerland, due to the share of recipients in institutions.

Formal LTC workers at home and in institutions as % for total population aged 65+ in 2009



Source: OECD Health Data Statistics

Excel: Comp. LTC workers

However, the gap between both countries seems to be less important for workers in care homes. According to the Spitex statistic, 28.744 professional care givers corresponding to 12,480 full time jobs provided services at home to 210,840 clients in Switzerland in 2008. That makes respectively 0.7% of total employment in Germany and 0.9% in Switzerland.

²⁵ Pflegestatistik, Statistisches Bundesamt, 2009.

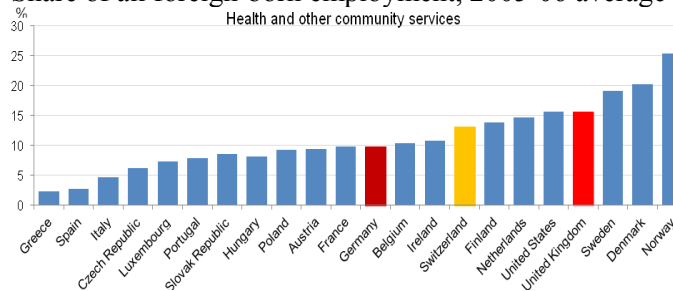
Workers in care home services

	Number of employees	Number of equivalent full time job
Germany (2009)	270.000 (0.7% of total employment)	About 177.000
Switzerland (2010)	36.409 (0.9% of total employment)	15.683
Scotland	No data available	

Source: Splitex, Statistisches Bundesamt, Pflegestatistik 2009, Deutschlandergebnisse

Employment of foreign-born in health and other community services and households

Share of all foreign-born employment, 2005-06 average



Source: OECD.

As pointed out by the OECD, LTC carers are more often foreigners than in other industries: the share of foreign-born employees in the sector is larger than the share of foreign-born employees in general in all countries. Next to North-European countries, this share is the highest in the United Kingdom with 15% followed by Switzerland and Germany (10%). Migration channels may also differ between the countries.

Synthesis

In comparison with the OECD countries Switzerland has one of the highest level of expenditure for the long term nursing care (LTNC) as a percentage of GDP as well as for expenditure per capita – twice higher than in Germany – because of a high level of expenditure in institutions, mainly financed by private households. The LTNC at home is regulated at *canton* level but organized by an association of private providers (SPITEX). The main driver of the expenditure's real growth (with an annual average growth rate of 5,7%) over the last years has been the increase in expenditure per capita, not in cover ratio.

Total LTNC expenditure in Scotland is still under the OECD-average because of the low level of expenditure in institutions, which are mainly financed by the households. But the introduction of the Free Personal & Nursing Care in 2002, managed and financed by the local authorities, has led to a strong growth of home care expenditure per head, which has become almost comparable to the German one.

The German case is characterized by the introduction of a new social insurance during the 90s, which was aimed at improving the social protection of the LTNC-users and at alleviating the costs for the social assistance. Over the last years public expenditure has risen very slowly in spite of a growing number of LTNC recipients –in Germany this is mainly due to the ageing population more than to the rise of cover rate, which has remained stable –, whereas the expenditure supported by households remains comparatively high.

To sum up, on the macro level, Germany, Scotland and Switzerland present three different configurations regarding the amount, the financing and the structure of the LTNC expenditure. In spite of these differences in the organization of care supply and care financing, the distribution of care users between institutions and home based care is very close in the three countries and the population of home care users is also very similar by sex and age. Moreover the proportion of informal carers in the population is very similar in the three countries but not those of formal LTC-workers in the labour force. Against this background it is all the more interesting to compare and to analyze the public policies and their change at the micro level.

Section B: National long-term care regimes

The Long-Term Care Regime in Germany

The German long-term care regime is based on four pillars: the long-term care insurance, health insurance, social assistance allowance for long-term care, and contributions of the private households.

The *statutory social long-term care insurance* was implemented in 1995 as the fifth pillar of the German system of social insurance. Its introduction was the result of a discourse that had been lasting for about twenty years: the psycho-social and financial situation of home dwelling elderly persons in need of care slowly gained public attention; notwithstanding, the dominant debates focused on the financial situation of the municipalities – whose expenses for social assistance assurance in the context of care needs were continuously rising – as well as on the applicable mode of financing (funded vs. pay-as-you-go). The latter was decided in favour of the pay-as-you-go system (*“umlagefinanziertes System”*) that is financed by contributions by employers and employees. Insurance is obligatory; beyond a certain income threshold it is possible to contract with a private insurer. Thus, population coverage is high. But in contrast to the prevailing principle of needs coverage in the German social insurance system, long-term care insurance provides only *partial coverage* regarding the patients’ needs: Beneficiaries have to prove an at least “considerable” need of care which will probably last for more than six months to qualify for benefits. Ideologically, the insurance was meant to support home care before institutional care and should encourage the readiness to care of relatives and neighbours. The applied concept of “need of care” is centred on the body and the amount of benefits is capped. There are some *elements of consumer’s choice*: Beneficiaries may select between cash benefits and – higher – in-kind benefits that comprise social care (personal and domiciliary care and recently in case of considerable need of general supervision also social attendance). Benefits in kind have to be delivered by professional, accredited providers; the beneficiaries are free to choose the provider. Long-term care insurance also provides part-time care and respite care, and it contributes to support by volunteers under certain conditions.

Outpatient acute nursing care is in the responsibility of the *statutory social health insurance*, it is not paid for by the long-term care insurance. To compensate the partial coverage of long-term care insurance, *social assistance allowance* has to be granted by the local authorities after appliance in cases of financial indigence where the care need is not completely covered by the long-term care insurance. Expenditures are again rising in this pillar. The fourth pillar of long-term care is *private contributions*, be it financial subsidies or concrete help among family members or other related persons as well as volunteers; the aim of introducing long-term care insurance was to support and complement family care, not to replace it.

Fragmentation of care in Germany is high, and interfaces between long-term care insurance, health insurance and rehabilitation still seem to be underdeveloped as financing and regulation of services are distributed among different actors and levels which in practice leads to problems of access to and coordination of services.

Furthermore, the regime is characterised by strong *competition between providers*: All providers who fulfil certain minimal standards have to be admitted to the care market which is dominated by a huge number of not-for-profit and for-profit providers who compete in providing services in the same catchment areas.

Current discourses about the long-term care for elderly persons on the one hand still focus on the applicable mode of financing as well as on the quality and amount of services that should be provided; the situation of persons with dementia and their needs which are not adequately addressed by the body-centred concept of need of care as well as the revision of this very concept are central to this discourse. On the other hand, there is a strong discourse of the future development of the ratio of the number of potential care givers to those in need of care. One element in this discourse is the call to support care by informal care givers, such as relatives, neighbours or acquaintances as well as the question of social and financial appreciation of formal care work. Last but not least, the transparency and publication of measures and results of quality controls is an issue which has gained some public attention in the context of debates on the future development of quality assurance. Related to this discourse is the question of knowing how and to what extent care recipients are addressed as patients, users, consumers, or citizens.

Governance of the regime of long-term care in Germany happens under the framework of joint decision making of the federal and the State level, in case of long-term care connected with a strong corporatist component. A general regulative framework is set at the federal level. Main issues, e. g. quality assurance, are framed at this level, and measures for cost containment are guaranteed. Decisions about implementation are left to the bargaining of providers, insurers and local authorities' associations at the federal and State level; implementation itself takes place at the local level. Against this background, governance-induced innovations at the federal or State level with obligatory status throughout the country would need broad coalitions and are hardly expectable. General regulations which leave room for variations in local implementation are more likely in this context. Municipalities only rule over soft instruments, as coordination and communication or voluntary public spending to set financial incentives, to shape the local system of home based long-term care. However, this limited spectrum of opportunities still leaves local actors some possibilities for varying implementation and, thus, innovation at the local level.

The Long-Term Care Regime in Scotland

The Scottish long-term care regime has been radically transformed by the introduction of the Free Nursing and Personal Care (FNPC) scheme in the early 2000's. According to this system, all persons over 65 years are eligible to this care allowance financed by the Scottish government. The benefits are determined according to the estimated needs. Maximal personal care payments are set at £159 a week and nursing care at £72. The FNPC is complemented by the United Kingdom wide Attendance Allowance (AA) paid by the Department for Work and Pension (London) at a maximal rate of £73,60. None of those instruments are means tested.

The *fragmentation* of the Scottish system of long-term care is acute. The problems of coordination between the National Health Service (NHS) and the personal care framework are heavy as well in terms of financing as in terms of practical coordination. The issue of patients' discharge from the hospital is considered as being severe. The usual lack of home care service capacity causes important delays in discharges (bed blocking).

The *governance* of the Scottish long-term care regime lies in the hands of the Scottish central government and of the local authorities. Representing the core of the Scottish specific policy for long-term care for the aged population, the FNPC is concretely paid and organized by the Scottish local authorities. The local authorities, mostly via their representative body at Scottish national level (COSLA), negotiate with the central government in Edinburgh, the financial transfer they get from the government on the basis of their FNPC expenses and of the local demographics. However, the local authorities may want or need to complement the central government financing and need to make use of their own budgets. The Scottish local authorities are in charge of the organisation and provision of the care delivery. Many city councils have social work departments that tackle this job directly. Others organise a private market. Most of the local authorities have mixed systems of delivery. The central government decides about the content of the provision and is in charge of the quality control. It also tries to steer or at least to influence the implementation by the local authorities via specific agencies such as the Joint Improvement Team that assists city council administration to improve their methods and instruments of implementation. The government can also propose agreements and package deals to the local authorities – in 2008, the government raised the budget granted to the local authorities for FNPC but tightened the definition of services to be provided and restricted the tolerance towards the waiting lists imposed by some local authorities.

The *patterns of delivery* of the care system are very diversified and vary across local authorities according to the policies of each city council. The councils set the prices, organize the commissioning and can also set priorities in the local structuring of the long-term policies such as the integration of long-term care policies in the other policies for the aged. The delivery of care is concretely triggered after a needs assessment that is run by the local authorities.

The Long-Term Care Regime in Switzerland

Over the last 20 years, the Swiss health care system has undergone several major reforms that have resulted in a shift of competencies from the federal to the cantonal level, and in an increase of the financial burden borne by patients and local authorities. The controversial debates that have accompanied these reforms have been dominated by a *cost containment* frame, with the financial repartition key and the status of dependency as central stakes. The debates have not led to the elaboration of a global old age strategy, nor have they given much attention to gender equality issues and to the question of how to define "care".

Governance of the HBLTC regime is characterised by a high degree of vertical, horizontal and operational fragmentation, due to federalism, subsidiarity and the prevalence of the liberal principle of individual responsibility. Health is a cantonal

competence, therefore each of the 26 cantons has its own health care regime. The federal state's role is limited to the domain of insurance legislations (health insurance law LaMal, retirement insurance law LAVS). Implementation lies with the cantons that, in addition, have their own cantonal health legislations and cantonal health ministers. When it comes to service provision, private actors and local authorities are key: private provider organisations deliver the bulk of HBLTC services, and private health insurances pay the largest share of the costs for medical services (60%); local authorities supervise and are the main partners of the private service providers and contribute the largest part (about 60%) of the public subsidies that finance HBLTC.

In 2010, the expenditure for long-term home based care was of 2.6% of the overall health expenditure of Switzerland and 0.2% of GDP (OFS 2011b:4, OECD 2011). It is met by a complex mixture of health insurances, social insurances, public support and private households. HBLTC funding is governed by a variety of rules. The only homogeneous funding rules that apply across all cantons are those concerning *medical* care services and transitional acute care after a hospitalisation (national health insurance law): they are financed by a large extent through health insurance contributions and public subsidies. Non medical care services are financed according to cantonal funding regimes that vary greatly. The commonality across cantons is that non medical costs are not reimbursed by the mandatory health insurance, meaning that all costs that are not covered by subsidies are on the patient herself. Thus the patients bear considerable share of the costs themselves (monthly health insurance premium, various incompressible out-of-pocket contributions, in many cantons also a supplementary contribution for home-based care services). These costs may be as high as 4.5x the basic old-age pension (AVS). Under specific conditions, elder people can claim (means-tested) supplementary benefits and special (non means-tested) invalidity allowances from the old age insurance (AVS). These can be used to contribute to meeting the cost for HBLTC care. Some costs may be on complementary (voluntary) health insurances for which the patient then pays an additional premium. In 2010, the total income generated by HBC service providers stemmed mostly from billed care services and from public subsidies.

HBLTC service provision is grounded on a tight cooperation of doctors, private and public actors, non profit and for profit actors. The initial needs assessment is done either by local authorities or by private HBLTC providers upon mandate of the local authorities. 90% of all HBLTC (medical, non medical care and domestic economy services) are delivered by private non profit organisations, namely Spitex/Swiss Association for Home-Base Care. Only medical services are subject to a unified quality assurance standards. Service delivery is triggered by a needs assessment by a health care professional, by the local authorities or by a provider organisation mandated by local authorities. The needs assessment does not follow a unified procedure. Service delivery is mostly assured by private non profit organisations that provide medical as well as non medical care and domestic economy services. The large variety of actors involved in service provision and the complexity of the funding system leads to major coordination problems and high transaction costs. Coordination costs for medical HBC services are now partly covered by the health insurance.

Syntesis of Part I

Germany, Scotland and Switzerland are representative of three models of LTC provision. Germany has opted in the nineties for a social insurance completed by the remaining social assistance. The 2002 reform in Scotland has introduced a universalist model implemented by the local authorities. Switzerland is characterized by the predominance of the private sector and within the public one by a dual architecture with cash benefits paid at the federal level by health and Old-Age social insurances but completed at the local level by the cantons, which are responsible for the care delivery. As a consequence, the three countries present contrasted configuration regarding the amount, the financing and the structure of long-term care expenditure but strong similarities concerning the population of home care users and the percentage of informal carers in the population.

Concerning the financing of the LTC, private spending is particularly high in Switzerland (60% of total spending), where home based LTC is mainly financed by private health insurances and in Germany (30%) where long-term care social insurance provides only partial coverage. The Scottish 2002 Free Nursing and Personal Care reform has led to a rise in the HBLTC public expenditure's part from 60% to 80% in 2009.

All three HBLTC systems are embedded in federal structures, which make some issues of governance similar. Regarding the horizontal distribution of tasks in all three cases, a general regulative framework is set at the national level with the central government deciding about the content of provision and in charge of the quality definition of care. In Germany the implementation of the care policy lies in the hand of the statutory social care funds – implemented within the social health insurance –, which negotiate the care provision with the providers and the local authorities. In Switzerland the HBLTC provision is implemented at the canton or at the municipalities level, a decentralization of the system reinforced by the 2008 reform -like in Scotland- where the local authorities are in charge of the organization and provision of care with often mix systems of delivery. On the horizontal dimension, all three countries are characterized by a strong organizational fragmentation between health and care systems, and by a strong competition between private (and non-profit) providers, despite the Spitex organization in Switzerland. Finally, in all three systems the beneficiary participation has remained underdeveloped so far.

Part II : Contemporary Defining Debates on Long-Term Care

The first section of this part is dedicated to a mapping of the defining debates about the 4 issues we have picked (A). From those mapping we analyse the positions of the German, Scottish and Swiss institutions and debates and we identify the most striking shortcomings of those regimes (B). The case selection presented in the last section (C) is based on the previous analysis.

Section A : Defining debates – Competing interpretations

In this section we provide an overview of international (European), institutional and academic debates on our four analytical issues governance, coordination and complementarity, participation and quality in home-based long-term care by presenting the official as well as challenging discourses and jarring interpretations.

1. Mapping governance issues

Defining “governance issues” and “network pluralism and coordination mechanisms”

The difference between *governance issues* and *pluralism and network coordination* is an analytical one. It primarily rests on the basic differentiation between top-down regulation and bottom-up self-regulation, or more precisely between steering a policy domain and the service provision that comes from within this policy domain (Mayntz & Scharpf 1995).

Governance issues deal with the organisation of institutionalized power resources in the policy domain at stake. Institutions, policy measures, policy recommendations, and all forms of direct or indirect steering of the caring activities are

to be classified into this category. Governance issues are about formalized procedures organizing the power relations within the care regime. *Pluralism and network coordination* is concerned with the nature of the welfare mix dealing with service provision. This welfare mix refers to a network of inter-organizational service delivery. It emerges both from public and private provision. The latter should be further differentiated between for profit and not-for-profit organizations. Public and private actors might initiate coordination mechanisms, most probably at local or regional level. This dimension of concrete delivery concerns itself with another aspect of the power relation at stake in the domain of care. It is not the issue of the power to control, organize, set goals and constraints, which is here at stake, but much more the power that comes in the context of concrete needs addressing via one form or another that of the coordination of the concrete actors of the provision.

In the detailed analysis and discussion of the discourses and rationales grounding lots of concrete debates but also lots of concrete power mechanisms, institutions, instruments, managing tools, etc., there is some overlapping between both main questions.

Academic and sociopolitical discourses about governance in the domain of long term care.

The discussion about *governance* dates back from the late 90's. It refers to an important and structural transformation of power relations in advanced industrial societies. The ambivalence and the multiple significations of this term have been commented upon in several classical works (Pierre 2000; Hirst 2000). Most of the various meanings of this term refer to a more or less explicit critique in terms of inadequacy, inefficiency, etc. of state regulation or more generally of hierarchical forms of regulation. This critical appraisal of the state is clearly related to general interrogations about governability, accountability and legitimacy. Important debates had started in Western societies about the keywords of (un)-governability or about their incapacity to learn and improve in the 60's, but this trend has developed and has become important at a political and societal level in the 1970's (Crozier, 1970; Scharpf 1974).

As a criticism of the hierarchical traditional Western state, governance can be understood as an answer to both the anti-authoritarian movement typical of the "new left" of the 60's and the 70's (libertarian, post-industrial movements in the aftermath of the 68 events in Europe and North-America) on the one hand and to the massive liberal attacks on "big government" and all forms of statism as state intervention in the economy or in the society that have developed in the public and political debates from the 70's onwards and have never really weakened since.

The discussion in terms of governance is consequently both a very ambitious and ambiguous one. It is very typical of the political synthesis that has flourished from the mid-nineties onwards in international or "modern" social-democrat discourses such as in the British Third Way. Governance, as a critique of hierarchical government is neither clearly and directly related to the libertarian criticism of the New left, nor is it clearly and directly related to the liberal attack on "big government". It should however "somehow" be a consensual answer to both lines. This original ambivalence is very probably the most important reason for the very frequently underlined vagueness and

lack of analytical accuracy of this term and of the related discussion, both in the North-American as in the European academic debate (see literature.... mais aussi Gaudin). It is also worth mentioning that, in spite of the tremendous success of the term both in academia and in "institutional" or "official" discourses, this notion has had absolutely no relevance or whatsoever for the "public". The discourses, writings, communications, debates in which the notion of "governance" has flourished have been strictly limited to "institutionalized", specialized, policy circles. Some professional politicians have tried to introduce this notion in real public or in communicative discourses to use the terminology by Vivian Schmidt (2002), but this has turned out to be a very weak, inefficient and very frequently misunderstood notion by the bright audience²⁶.

In the domain of social policy "the history of Western welfare states (...) is based on the interactions between politics, administration, associations, professionals of social intervention and private households. Those interactions make sense in the more general context of differentiated national settings" (Bode, 2007: 403). This plurality of actors goes along with a high level of plurality in modes of social coordination, in social or political traditions, legitimacies, organizations, etc. typical of the various actors involved in this kind of activities. Precisely because of this diversity and lack of homogeneity, even within each and every national context, the term of governance, and its rather fuzzy but encompassing character, has been really successful in this policy domain.

The activity of domiciliary long-term care is very typical of this kind of situation. The functioning of those systems implies in most cases, at least in Europe, a full range of actors and governance traditions corresponding to various basic functions of a long-term care regime:

²⁶ In the mid of the 2000's, the French Premier J-P Raffarin made several times use of this notion, with very poor results.

Basic functions	Actors / organization and governance tradition
Financing	<ul style="list-style-type: none"> * insurance-funds, that can be private market actors, or governed by neo-corporatist arrangements (in many countries, there are various mix forms between those poles – for instance French mutualisme) * public financing funds managing tax money
Steering and organization	<ul style="list-style-type: none"> * traditional democratic decision making process framed according to the various national traditions for matters of centralization / decentralization, majoritarian / consensus based, representative / direct democracy, etc. * regional and local steering arrangements of various forms (centred on public actors, network like in a rather open form or on the contrary in the context of closed commissions – for instance centred on the power of insurance funds)
Control and supervision	<ul style="list-style-type: none"> * quality control agencies, that can be independent authorities, public agencies, private firms (benefiting from a public delegation) and that can be centred on health, financing, legal, professional, etc. issues
Implementation and service provision	<ul style="list-style-type: none"> * variety of service providers (market, public, associative actors), organized at a more or less centralized / decentralized level * types of local / regional coordination (competitive market, allocation of tasks, open networks) * issues concerned by the coordination (mutual information, planning / structuring, deliberative definition of policy goals, financial matters, professional issues, etc.)

In this context of high plurality both of actors involved and issues, procedures, functions, elements making up the concrete care delivery for aged persons, it seems clearer to organize the map out of debates, ideas, frames of analysis, etc. from a cross-sectional perspective. The “governance” notion is related to several meanings that have been theorized in the academic context. It should however be reminded that in most cases, the models analysed in the academia were in most cases directly inspired by concrete developments, policy schemes, arrangements, or sometimes, by discourses, observed in the real world. To grasp those meanings and forms associated with the idea of governance in a systematic way, we took up the typology of categories provided in a reasonably recent review article written by two prominent specialists of the governance approaches (Kersbergen & Waarden 2004). We might say that the discussion about governance in the social care domain has a noticeable relevance in at least five out of the nine meanings listed by van Kersbergen and van Waarden²⁷.

a. “governance without government / self organization”: community care

²⁷ The exhaustive list is the following : « Good governance », « Governing without government I: International relations », « Governance without government II: Self organization », « Economic governance (with and without the state): Markets and their institutions », « ‘Good governance’ in the private sector : Corporate governance », « ‘Good governance’ in the public sector: New public management », « Governance in and by networks I », « Network governance II: Multilevel governance », « Network governance III: Private – from hierarchies to networks ».

This first conception of governance is a normative and prescriptive idea according to which care is best designed, organized and provided for in a context that should be autonomous from state regulation and intervention. It is also believed to be more efficient when primarily organized by professionals or in the context of a community, directly by community members or actors. This version of governance is prominently related to the leftist libertarian critical appraisal of "classical" forms of care or more generally of welfare provision. The (central) state should not impose on all communities similar, more or less bureaucratic and standard forms of care delivery. Care should be organized within, by and for the community, or at least, at the local scale. This critique of centralized, big, rigid, institutional forms of care has developed from the late 70's and has been focused on care-homes. At least in the contexts of continental Europe, this criticism addressed to care-homes and all forms of institutionalisation was related to the anti-psychiatric movement initiated and theorized in Italy. In this country as well as in Switzerland, France, or Germany, the debates triggered by this criticism have had a strong influence on the orientation of the policies in the domain of long-term care away from care-homes and towards domiciliary care.

In the British debate, the necessity to enable older, dependent people to live independent lives at their private homes and, consequently to decrease the proportion of institutionalized people had been recognized already in the early 50's, at first mostly for economic reasons (Victor 1997). However, the real implementation of community care in the United-Kingdom as well as in most European countries has not taken off before the 70's. During this decade, social work services have been set up or at least developed, mostly at the level of Local Authorities (White, Harris, 2001).

By then, the motivation for the transfer of responsibility from big homes to the relatives or, rather to local welfare agencies, was prominently political. Favouring decentralized, small scale, non-hierarchical forms of long-term care provision, community care has been the first version of governance as a form of long-term community care. However, in the 80's and even more so in the 90's, economic rationales have been again very important motivations for policies aiming at de-institutionalize or at leaving as many people in need of care as possible in their private homes.

b. "economic governance (with and without the state): markets and their institutions"

This version of the term governance is a normative and prescriptive position according to which private provision should/would be more efficient than the public one. It is clearly related to the criticism of "big government" mentioned earlier on and corresponds to the neo-liberal version of the governance discussion. This positive appraisal of market regulation has become close to becoming a taken for granted interpretation in many official discourses and benchmarks advocated for by international organizations especially in the 80's and 90's. In this kind of framework, the inefficient public provision should be replaced by market provision. The market is here conceived as an efficient way to allocate resources in the domain of social care. In the United Kingdom from the late 80's onwards, further development of community

care was fuelled by the development of private providers supported by the policies of the Conservative government (Victor 1997). A few years later, in Germany, the introduction of the long-term care insurance was linked with a far-reaching movement of liberalization of the market of provision.

Today, the domination of the market mode of organizing care delivery has declined. For instance, it does not belong to the last recommendations made by the OECD in the domain of long-term care (OECD, 2011). In the contemporary context of care service delivery, which is very much influenced by the market norm, it seems to be necessary to think of instruments that may combine the outcome of care-management with the one of market regulation or to better organize the intersection between market regulation and political steering of the domain. Mur-Veeman, Steenbergen, Hardy and Wistow (Mur-Veeman et al. 2003) mention two classical instruments: commissioning and contracting, as well as registration.

c. “good governance in the public sector: New Public Management”

In this third version of governance, the normative and prescriptive idea is that organisational and management modes developed in private businesses, in a market environment, should be introduced in all kinds of public administrations. This idea has had a huge influence on all domains of social policy delivery. More important and specific to the domain of care service is maybe the idea that good governance in the public sector should introduce a shift from steering (policy decision) to rowing (service delivery). The shift from *patients* to *clients* in most care delivery units is even more frequent in public organizations than in private ones. It demonstrates not only the crucial character of the market in that domain, but also refers to the self-persuasion process by public administration that they are able to behave and perform like private companies. The latest reports and policy recommendations by the OECD (2011) are still very clear on this issue. There must be a “pressure on governments to improve value for money in long-term care” (OECD, 2011:32).

Specific governance instruments have been developed in the area of long-term care. They address problems identified in that domain. The issue of care continuum, both at a certain point of time – coordination of services – in a more dynamic and related to the trajectories of the beneficiaries, is very intensively discussed as a key problem in most countries (OECD 2005).

The OECD report (Ibid) mentions two basic families of instruments that might improve the coordination of care providers in relation to both these dimensions. In the first place, various countries have recently defined more clearly their goals and priorities concerning long-term care. They also provide information about demographics, make previsions based on an epidemiological studies, estimate costs of long-term care in the years or decades to come, etc. National level administrations could develop this kind of cognitive instrument that are then spread at the local or regional levels. As national administrations have in most countries no direct control over the implementation strategies of local levels, they can at best try to structure their choice by

mean of influence.

The other instruments listed are more compelling and concern the concrete organization of service delivery. The various forms of care management encompass one of the more promoted and analysed instruments (Pavolini & Ranci 2008; Mur-Veeman et al. 2003), crucial for an optimization of the “care continuum”. The beneficiaries of long-term care as well as their relatives or informal care-givers face in most cases huge difficulties to co-ordinate and maintain an efficient system of care. The instrument of *single entry point* (OECD, 2005) is supposed to be efficient from the perspective of the care-receivers and of their families, as it is in charge of the organization and of the sustainability of care arrangements. In many countries, it seems difficult to impose on competing care organizations a regulation by one administrative or co-ordinating body. In various settings, joint or coordinated assessment organizations represent a more flexible alternative. They are intermediate forms open to a greater variety of stakeholders and combining the process of need assessment with the process of service delivery organization.

d. “governance in and by networks”

In this dimension of the governance discussion, the network provision is seen as a further alternative to public, “big government” provision. Besides the promotion of market actors, and the transformation of public providers thanks to the rules of the New Public Management, the integration of third-sector providers into inter-organizational provision networks is seen as a useful way to escape the public approach to home care delivery.

The discussion about governance and networks is key to the domain of social care. It represents a clear intersection with the domain of network coordination. It namely includes the idea of a mix in service providers, as well as an explicit negative assessment of hierarchical regulation and on the contrary the promotion of pluricentric form of governance. In the academic discussion in political science, there are two main ways of conceiving policy networks. In the first place and in the dominant tradition, policy networks are a much valued policy tool inasmuch as it is able to overcome the often artificial distinction between decision-making process and provision. In the domain of social care provision, the idea of an exchange of resources, of negotiation (Benz, 2007) and of “game-like interactions rooted in trust and regulated by rules of the games” matches nicely the situation of autonomous care providers that have to co-operate and to compel to similar strict (quality) rules in the interest of the beneficiaries.

Besides this first view on policy networks that values consensus and the pragmatism of the functioning of low scale arrangements dealing with depoliticized issues (such as the concrete organisation of long-term care delivery), there is another conception that integrates the dimension of conflict. For David Knoke and Franz-Urban Pappi (1996) for instance, policy networks are precisely interesting as they allow to understand that in spite of a potentially high level of diversity in opinions, worldviews, interest positions, etc., various actors can co-operate and deal with conflict and diversity

in the flow of their activity of regulation and provision.

At local or regional level, there are in many national settings various forms of governance networks. They are in some cases rather consensual networks, limited to functions of coordination in implementation. These networks can have to deal with more conflictual matters such as the organisation of a care market or the policy of financing. They might consequently be more conflictual. In the domain of long-term care, the progressive disqualification of public provision leads to the diversification of the relevant actors of the domain. The keywords associated with network governance are in that domain more or less explicitly congruent with this transformation of the domain.

e. “network governance: multilevel governance”

This fifth and last view of governance is inspired from the domain of international relations and more specifically from the literature on Europeanization. This discussion is about the autonomy and the strength of networks relating various levels of government. Some specific sector or issue such as care, involving various governmental levels or policy scales, triggers such a dynamic multilevel dynamic.

2. Mapping network pluralism and coordination mechanisms

Even if this first mapping of the discussion about governance briefly evokes the notion of network it has not covered the richness of this concept in the domain of care. The aspect of the network discussion that has been already mentioned earlier on is the one relating it to governance. The aspects of “coordination” are there the most salient.

The second aspect that should be tackled now relates to the plurality of needs and of organised provision. This dimension is also linked to the critique of undifferentiated provision by the state or public actors.

The concept of welfare mix has contributed to frame and influence the discussion about the shortcomings of the comparative analysis of the forms of social service delivery (Evers 1990; Evers 1996). The analytical framework of welfare mix has demonstrated the existing plurality in social services delivery at local level in most European contexts. On the one hand, it has shown that the statuses of the actors were diversified and that public organizations were supplemented in most contexts by private for profit actors, but by then most importantly, by not-for-profit private actors. Beyond those differences in terms of status, the literature on welfare mix highlighted the varieties of concrete goals but also of values and discourses that were related to the

various actors involved in the concrete implementation of social service delivery.

The welfare mix framework has developed an approach emphasizing the plurality in the modes of action, but also of the values and discourses advocated by the various actors. According to Evers, third sector actors specifically participate to the public sphere at local level. Plurality of actions and more importantly of discourses contributes to the local democratic sphere. Welfare pluralism is conceived by Evers as an important channel for local traditional or new forms of social mobilization in the social policy domain. It is also a key space for individual participation to collective tasks, which corresponds to an important dimension of citizenship. Finally, the interactions and sometimes the tensions between these various forms of social action between private actors but also between public and private actors triggers important learning processes or processes of mutual influence (Evers 1995).

It is possible to differentiate three periods in the evolution of welfare mix dealing with the concrete implementation of social policies. According to Evers (Evers 2005), the most important patterns of the classical welfare policies in Europe are as follows. Firstly, the state plays a key role in the decision-making as well as in the steering of most social policy programs. Secondly, there is a clear division between the public and the private domains of action. Lastly, there is an important and often neglected role of the civil society via the third and voluntary sector. This last element plays an important political role both in nourishing the local, but also the national public sphere in the social policy domain, and in providing a frame for individual commitment to collective and altruistic tasks.

After WWII and until the late 70's, there has been an important trend of institutionalisation of third sector social action. In most countries, the most important associations or other forms of not-for-profit sector organization of the social policy domain had been involved in formalized relations with the state, be it at central, regional or local level. The process of mutual influence of public administration and third sector organization has reached a high degree during the 80's and had for consequence to weaken the space open to individual, voluntary participation (Ibid). The institutional and organizational closeness between third sector and public organizations resulted as well in the intrusion of public procedures, organizational frames, mentality into associative structures.

Since the 80's there has been a very important shift in the relations between the state and other providers of social policy. This shift rests on two main transformations. Firstly, most states have decentralized their social policy programs. Central states aimed at giving away certain tasks on the one hand, but on the other at making the implementation more efficient in responsabilizing local actors, in relating implementation to local specific needs and finally in looking for a new balance between universal standards and diversity of service providers. This transformation, from the late 80's, early 90's onwards, ended up in a clear weakening of the strict separation of the different steering mechanisms and in an increasing mix of market and state-based organizational features and steering mechanisms. More precisely, new roles and a new division of labour was introduced: *"Welfare states increasingly define themselves as purchasers and regulators of services provided by private and non-profit business"* (Ibid). The market as a regulation tool was discovered and imposed on the social policy

sector (Bode 2006). The already mentioned introduction of New Public Management in public organizations is an indication of this spreading of the private managerial norms in this field. The last step of this transformation concerns the consequences at the level of the organizations themselves. According to Adalbert Evers (2005), most organizations active in the welfare sector are becoming hybrid. Procedures, resources, goals and values, etc. are not any more specific to a certain status (public, private for profit and private voluntary or associative) but there is a mix in every kind of organization of various logics. However, private, market and managerial logics tend to prevail in all kind of organizations and tend to become the *lingua franca* of the social services domain. All organizations of the domain of social policy are developing according to the hybrid form of *social enterprise* that has the following patterns:

- (5) autonomy
- (6) entrepreneurial style of action
- (7) balances goals and steering inputs from public and local civil society ground against market relations
- (8) preserves positive social effects not only for its individual users, but as well for the whole community

Thus, the new form taken up by plurality does not only concern the network of providers but is integrated, internalised by the various organizations themselves. However, those organizations may keep specific value orientation or further target specific groups or problems.

These issues of plurality have proved specifically important in our domain of home-based care services delivery for the elderly. In bigger cities or even in dense areas, religious or ethnic specific services have developed to a large extent. This development seems to be under-investigated for the time being.

The precise agenda of long-term home-base care throughout Europe implies a specific apprehension of co-ordination and co-operation. The challenges of matching needs qualitatively and quantitatively, of cost containment in the face of raising needs, and of concrete service delivery at patient level are key issues in the various European care regimes. Provision networks are directly addressed by these challenges, as well as governance structures. There is a great concern in most countries to optimise these two dimensions in the face of the mentioned challenges.

The issue of integrated care has been advocated both from the rationale of cost containment and from the logic of patient well-being or quality in the service delivery. This issue has already been mentioned as a governance instrument. However, the literature concludes very often on the importance of a “common culture”, a “willingness to cooperate”, a “common understanding”, etc. that can trigger bottom-up dynamics.

3. Mapping Quality

Quality of long-term care in general – its definition, assurance, development and governance – has become an increasingly addressed issue during the last years in international discourses and also in the countries under investigation in our study. In the OECD report on Long-Term Care for Older People of 2005, the issue of (poor) quality is perceived as one of “the drivers of reform to improve access to long-term care services and increase spending in several countries” (OECD, 2005, p. 66), even though quality had „only recently emerged as a focus for public policy“ (ibid., pp., 71). Regarding the link between quality and participation, there is a clear tendency to address those who depend on long-term care with more emphasis as *consumers* who should be empowered and obviously are supposed to act in a care market (OECD, 2005, p. 74). The report also brings up the costs of adapting existing caring infrastructures to the expected demographic development (ibid., p. 76) – an issue which is elaborated into greater detail in the 2011 report (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). The 2008 report of the European Commission GD Employment, Social affairs & Inclusion on “Long-Term Care in the European Union” identifies a high-level quality in long-term care services as one of three main aims in long-term care in the Member States – among access for all to adequate long-term care and long-term sustainability of the member states’ regimes of long-term care (European Commission, 2008).

The international and national discourses on quality are often linked to questions of effectiveness and efficiency of the systems of long-term care and thus to issues of financing and of the societal distribution of resources. For long, there has been a concentration on structural and procedural aspects of quality of long-term care. Recently, there is a shift in focus towards quality in terms of outcomes, e. g. in the recommendations of 2005 OECD-report, and towards the perspectives of users or recipients²⁸ of long-term care. Additionally, after a prevailing and strong focus on institutional care settings, gradually also quality in home based long-term care settings is receiving more attention, but “the regulation and regular quality assessment of the home-care market is a relatively new development” (OECD, 2005). Both discursive tendencies may be linked to the rising concern of the relation between care provision, outcomes and costs which is e. g. documented in the title of the recent OECD-report “Providing and Paying for Long-Term Care” (Colombo, et al., 2011).

Discourses on quality, its assurance, development and governance, show a variety in concepts, measures, indicators and instruments in and between countries and their systems of long-term care. In the following, we will give a very short overview of some analytical dimensions of quality, quality assurance, quality development, and governance to provide a framework for the analysis of international and national discourses which are further explained in the ANNEX.

²⁸ The expressions “care recipient” or “care receiving person” withhold the aspect of mutuality and the interactive character of long-term care as well as the directive role care recipients perform or shall be allowed (and empowered) to perform departing from the idea of personal dignity and autonomy. Even though we are talking of care recipients, we estimate the latter mentioned aspects of care relations as crucial, especially with regard to the issue of quality and its assurance (compare the chapter on Participation).

In a broad approach, quality may be understood

"as a multidimensional concept, entailing objective but also subjective aspects, that might be partially evaluated using well established and recognized standards, models and methodologies, but is also connected to each user's needs, expectations, motivations, perception, experience and capacity to learn and to the effort and resources required to provide a suitable level of service from the perspective of all the stakeholders involved" (Santana, 2010, pp., 513, 513).

The assurance of quality and its development are strongly interconnected. The prevailing perspective of *quality assurance* is that of a *minimum standard of quality* that has to be fulfilled. *Quality development* in contrast generally aims at rising and optimizing quality and thus applies a perspective of gradually coming closer to a possible maximum of quality or of *continuously optimizing*. Both perspectives, quality assurance and development, may be investigated with regard to their scope, dimensions, level and direction of application, measurement and indicators, instruments as well as prerequisites. Even though concepts of integrated care are gaining importance in international discourses for several years now (Leichsenring, 2004), quality-related activities in practice and theory often are limited to just one sector. Quality-related analysis should go beyond this by identifying *which sectors and segments are involved in regimes of quality assurance (scope)* and development and by reflecting the implications of these limitations. Regarding home care, it is only recently that the question of *quality of family care* has gained advergence.

Discourse and practice of quality assurance and development generally rely on the *three dimensions* of quality established by Donabedian (1966): *structural, procedural and outcome quality*. The OECD and the European Commission also follow this approach in their reports of 2005 and 2008 (European Commission, 2008; OECD, 2005). In their beginnings quality discourses and measures concentrated on the structural dimension of quality such as room situation or staff ratio. This was gradually complemented by including processes, e. g. discharge management, or the continuity of carers, which the OECD reports to be "one of the most frequent complaints of recipients of home care across countries" (2005, p. 76). Over the past years there has been a shift towards increasingly considering *outcomes*. Yet, this is varying between countries (ibid., p. 76). Regarding outcome criteria two main discourses have been developed: On the one hand respective debates join those of health care and evidence-based medicine calling for the need of *objective, reliable and valid outcome criteria* to evaluate long-term. On the other hand debates and activities increasingly take into account the *perspective of care recipients* and try to establish concepts and instruments of quality assurance which also do justice to the subjective experience of care receiving individuals. In this context the concept of "quality of life" is discussed a lot. Recently, in some countries complex and comprehensive approaches have gained attention deriving from the issue of human dignity and basic human rights (compare European Commission, 2008, p. 24) and try to develop – at least complementary – *normative quality concepts* on this basis. An example for this is the German Charter of Rights for People in Need of Long-term Care

and Assistance” (Ministry for Family Affairs Senior Citizens Women and Youths, 2007). In its implementation, a manual for the self-evaluation of long-term care home care services has been developed which is publicly accessible (Konkret Consult Ruhr, 2011). Lots of debates on quality assurance concern the adequate measurement of quality of long-term care. As mentioned above, there is a tendency in many countries to by and by also include outcome indicators and the client's perspective beneath the still prevailing dominance of objective, structural (referring to staff ratio, qualification, technical equipment and other) and procedural indicators (referring to the implementation of standards and professional guidelines for care practice, training, complaints management). Even though there are some outcome-oriented instruments like OASIS or RAI-HC, a widely acknowledged problem is the absence of consented, objective, reliable and valid indicators to measure quality in long-term care. Furthermore, the problem of risk adjustment seems not to be solved yet.²⁹ Measurement of quality may be used to assure and develop quality in two ways: by counselling on the bases of results or by making results publicly transparent to enhance competition between providers. Here again it is crucial to know which perspective leads the measurement of quality. This decides if published quality measurement results will meet the interest of potential ‘users’ or ‘consumers’. The implementation of such mechanisms, which are performed in different countries, may be attributed to overarching strategies of driving forward the *market character* of provision of long-term care (compare also OECD, 2005, pp. 74-75).

Regarding the instruments of quality assurance and development, a common differentiation is the one between top-down versus bottom-up oriented strategies that is often related with controlling versus discursive measures: Top-down strategies often encompass the top-down setting and implementation of structural or procedural standards or outcomes. According to the OECD, in many countries the fulfilment of externally set minimal standards is a precondition to be accredited as a service (OECD, 2005, p. 73). Self-regulatory approaches often work similarly but also may include measures like the self-binding of service providers, e. g. to established norms, values and rights of care requiring persons. Bottom-up-strategies follow a more reflexive and experience- and performance-related approach. Such strategies include the qualification, training, and/or education of staff and/or informal carers. An often contested but more and more applied practice is the publication of measures and results. The Internet provides new opportunities and allows “consumer groups to gather information on unacceptable quality deficits and to increase the pressure on policy makers to implement strategies to prevent these” (Colombo, et al., 2011, pp. 159-187; OECD, 2005, p. 75). This raises the question of the limitations of the assumed consumer's status of care recipients. The OECD touches upon this aspect when admitting that “the interpretation of assessment reports is a complex task for most consumers” (2005, p. 75).

The governance of quality issues may be characterized by *repartition of competencies* (horizontal and vertical), by the *degree of (de-)centralization* (Wiener, et al., 2007, p. vi), by the *prescription or stimulation of quality measures*, by the *binding nature of*

²⁹ Risk adjustment shall address the problem that care receiving persons may bring with them different risks e. g. for pressure sore or a bad nutrition state. If quality is measured on an organizational level, care providers who care for clients with lower risks are more probable to perform better.

regulations, and by the *structure of incentives or disincentives* for quality assurance and development. Government regulation may be differentiated from self-regulatory approaches and the establishment of market competition (OECD, 2005, pp., 72ff).

4. Mapping Participation

Participation is a crucial issue of the reform of health and social care services. In the case of care for the aged, two restrictions to a full development of participation can be noticed. First, in the field of older people services, there is a tendency to think in terms of people participation as consumers of health/social services (Bartlett/O'Connor 2010). Second, compared with other categories of marginalized people (disabled, children, ethnic minority) dependent elderly are the least likely to have influence on decision making and are seldom seen as partner in planning (Braye 2000). Indeed, more than « participation », the so-called “personalization” of elderly care is a new tendency in European countries. It refers to better involvement and larger choice in domiciliary long-term care services. As we shall see, the most discussed instrument in this context is the *personal budget*. Against this background, this analysis shortly frames the main dimensions of participation (1) and summarized the European context regarding long-term care for elderly (2).

Main dimensions of participation

« Participation » is still a contested concept, with strong ideological content (Braye 2000). It is embedded in different ideology, and implemented in vary different ways. Freely drawing on Bray's framing of the participation issue, we will shortly discuss five dimensions of participation : the approaches to participation, the different types of participation, the driving forces behind participation, the problems in participation implementation and the quality issue of participation.

Approaches to participation

The participation dimension is an important part of the litterature of democracy (Young 1990) In the field of helath care, participation is a concept that was largely diffused with the “new public health” and the promotion if “community care” in the 1980'. Nevertheless, as critical litterature emphasies (Petersen/Lupton 1996, Wearness 1987), those models are politically ambivalent.

Shortly said, there are two main approaches to participation of elderly in both social services and research (Beresford and Croft 1993, see also Bray 2000, Ray 2007, Glasby 2007). The first is the **consumerist approach**, which is based on market principles and focus on the individual « consumer » and its choice. In theory, this consumer choose between services, influenced by prices and quality. In this approach, the aim of participation is to enhance market competitiveness, influencing the consumer's choices (principles are : accessibility, information, choice, redress, representations see Bray 2000). Hence, the concrete form of involvement is mainly determined by the managerial (and at the field level, the professional) agenda.

The second approach is the **democratic approach**, which aims to enforce citizenship and collective action and give participants both the access to the agenda and the means to secure changes regarding their own life (serie of rights to involvement and high quality services). Hence, the purpose here is to achieve greater influence and control. As Bray (2000) writes « the focus is upon participatory rights », rather than welfare needs. Collective action and State intervention to reduce inequalities are important in this approach. This author identified a third model of participation in social services, she called the **therapeutic model**. In this approach, the participation is, in itself, good for people. The two approaches have been summarised by a table by Glasby (2007 : 136).

Consumerism (and bureaucratic approaches to involvement)	Empowerment (and citizenship approaches)
Service/provider orientated	User oriented
Inflexible	Responsive
Provider-led	Needs-led
Power concentrated	Power sharing
Defensive	Open to review
Conservative	Open to change
Input Orientated	Outcome orientated

Empowerment is a very loose concept. It may considered as «an aspiration for participation across both consumerist and democratic orientations of participations » (Ray 2005 : 75). Indeed, empowerment is both a passive and active process (from the user's point of view). In the context of the consumerist approach, individual will be empowered *through* a panel of new resources, like access to information, choices between opportunities or right to complain. In that sense, it appears as a passive process. The limits of such approach have been pointed out. As Lupton and al (1998) argue, this form of participation hardly challenges established power relations. Moreover, by limiting the participation to a pre-set agenda, it can contribute to occult more conflictual issues and be used as a mean of social control³⁰. Users groups criticized this approach beeing « at best, enabling and, at worst, an other form of professional paternalism » (Ray 2005 : 76, referring to Jack 1995). By contrast, in a democratic perspective, empowerment has got a radical meaning. It focus on the building of personal capacity and skills development and aims to enforcing collective action and political participation. It has a more active dimension. For Thomson (1997) « emancipatory practices has tow components –life politics, where empowerment lies is identifying and addressing barriers to self actualisation, and emancipatory politics, where it adresses barriers to equality and social justice ». (Bray 2000: 11).

Glasby (2007 : 138-139)) refers to Means and Schmidt (1998) who distinguish different form of empowerment, drawing on Hirschman : • Empowerment through « exit » (services users as consumers) ; • Empowerment through « voice » (service users have something to say about the service); • Empowerment though « rights » (service

³⁰ As Beresford express (1993: 18, cited by Bray 2000). "Participation is reduced from people's right to participate fully in society...to being involved in the running of welfare services they might prefer not to recieve".

users as citizens); •Empowerment through « struggle » (service users movements campaigning and developing alternative services).

Different types of participation

Participation programmes differ regarding the degree of involvement and the social arena in which it takes place. Different types of instruments may be used in order to enhance participation.

Degrees or levels of participation. This dimension of participation refers to the degrees of power-sharing or equality between the parties. At a first level, participation may be **full or partial**. In full participation, the power to determine the outcomes is equally shared. In partial participation, the parties influence each other but the final power rests with one (Bray 2000, drawing on Pateman 1970). The participation level is sometimes presented as a scale. The most famous is Arnstein's (1963) « ladder of citizen participation » (citizen control, delegated power, partnership, placation, consultation, informing, therapy, manipulation) (Glasby 2007 : 138). The participation may also be **individual or collective**.

Participation concerns **service planning or service delivery**. Bray (2000) distinguishes 6 social arenas of participation. First is the involvement of the individual in its **own use of service**. This can be done in the three steps : assessment of need, care planning, periodic review. Second is **strategic planning for service provision and development** : users may be involved in planning meetings, advisory or management groups, monitoring, inspection or review mechanism. A third arena is the development **of user-led services** (organization that are independent from local authorities). The offer more flexibility, choice, involvement and accountability to users than voluntary sector agencies. Fourth, **research** into social care is an emerging participation area. At a first level, it's about understanding the user's point of view ; at a second and more radical level, service users may participate as researchers –contributing to define research design a.s.o. Five is promoting the **involvement of service users in their broader social context** (service as a mean to a broader goal of social participation)³¹. The sixth arena goes beyond service users and is about democratic **reforms**. It targets the community and enhances the participation of people as citizens.

Moreover, participation refers to individuals, but also to *community*. This understanding of participation through community empowerment has been diffused in the context of the crisis of the Welfare state and the economy program; it has been reactualised with the demographic issue of ageing and the policy shift towards ambulatory and home-based care; it was supported by the idea that community participation may facilitate the implementation of health policy; lastly, the reference to community care accompanied the shift toward a more preventive approach of care. Hence, as it refers to community care, participation concept has got a strong *territorial* (going local) and *social dimension* (the idea of active society), and refers to the concept of *welfare pluralism* (Renschler and al. 2005). Regarding the governance of elderly care field, it may refer to the activation of local or sub-local community and actors. Indeed, participation

³¹ See our Geneva's project "Voter en Ems!". Resop, Political Science department. (Sgier and al. 2009, Lucas, Illoren 2009)

Lastly, we can look at the diversity of *participatory instruments*. In England, the government distinguish between user consultation and user-driven services. Three examples of user-driven public services are cited in the PASC report in 2008 :

- « *The expert patients programme* enables patients with long-term chronic conditions to gain the skills needed to manage their conditions better on a day-to-day basis. Expert patients are also able to provide peer support, advice and information to others with the same condition.
- *Individual or personal budget and direct payments* entail giving patients financial control over the health and social care services they receive, so that they can direct the support or service they get. These sorts of financial mechanisms recognize that patients are often best placed to understand what they need and to make decisions about their own care accordingly.
- *Community care navigator (CCNs)* are health service staff who have been specifically trained to engage with patients in community settings, in order to offer help and advice with their (usually long term) conditions. We visited a CCNs project in Newham, east London, which worked with people locally to identify chronic illness at an early stage, increase knowledge of long-term health conditions and support self-management of conditions. » (PASC 2008 : 10)

The driving forces behind participation programs

The participation concept has to be understood in the reframing of the health policy from a biomedical paradigm towards a more preventive approach. It is linked to the welfare state crisis and reframing that occurs from the 1980s. It is grounded on the financial crisis (less public budget), but also governance crisis (how to govern with strong actors), trust crisis (how to implement policies once confronted to the mistrust of groups of populations?) and to a devolution movement towards more local policies. More recently, participation concept may be linked to the diffusion of the active state paradigm. Regarding elderly, in 2012, European year of active ageing, participation is strongly related to the idea of inclusion. Social participation is supposed to prevent the loss of autonomy of elderly.

Following Braye (op cit) the driving forces behind participatory approaches may be : first **legal and policy mandates** for social services (for ex. organising consultation); second, **professional mandates** : professional mandate may be driven by principles (respect and participation) or by pragmatism (participation as a mean to reach the goal). Third, **user mandates**. At one level, users may want to improve self-definition of needs, representation and self-advocacy, choice a.s.o. At a second level, they may want to challenge the dominant paradigm of care and the model used for understanding needs and entitlement. A good example is the concept of « personal budget » and « self-directed support » and that have been developed bottom-up in England by a social innovation network called *in Control* (see www.in-control.org.uk).

Problems in participation's diffusion and implementation

Despite increasing rhetoric around participation, its diffusion is slow. Moreover, in

implementing participation, there is a danger of tokenism or manipulation. What are the main areas of difficulties for participation to develop in practice ? Following Bray (op cit.) the two main areas are the politics of organisations and the politics of professions.

Organisation's politic is characterized by a conflict between managerial and professional aims and values. The politics of organizations' problem for participation refers to the marketisation of the care sector and the « espousal by public sector agencies of the ethos and practices of private sector management ». This includes a centralised control to set missions and strategy, with a delegated autonomy for operational manager, but with strict performance target. This do not allows for a real shared power with users. Moreover, resources shortage may also play an key role in limiting the alternatives and choice for users (for example regarding elderly home-care vs residential placement).

The **politics of professionalism** is an other barriers to the development of participation. Indeed, « professionals may be defensive and resistant to challenges, through uncertainty and fear of what lies beyond attempt to share power. They may find justification in stereotypical views of user's competence to participate » (Bray 2000 :12). Another difficulties is the conflictual imperative of social work : balancing between autonomy and protection, or between risk management and empowerment. As a result of both organisation's politics and politics of professionalism, unsatisfactory initiative have been taken regarding participation.

Participation in elderly care – European level

At the European level, the **European Social Charter (1988)** of the Council of Europe emphasizes the enabling of elderly to remains full member of the society (through resources and information about services) and already mention « participation in decision » the context of long-term care institutions (see annexe). After the Amsterdam Treaty in 1997, the revised Charter became an part of the structure of the EU. It contributes to the development of « hard laws », in particular the scope of anti-discrimination laws (Townsend 2007).

Progress about user's involvement in health and social care have also been boosted both by the focus on *Human rights* (**Charter of Fundamental Rights of the European Union, 1993**) and by the concept of *Health promotion* and the diffusion of the community care model. Hence, the **Ottawa Charter on Health Promotion** (WHO, 1996) insists on the mediation between all health partner (including individuals) and reaffirm the need to enable people : « This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to *take control of those things which determine their health*. » (my emphasis).

The issue of participation have been addressed by EU and WHO in the context of a discussion about issues of aging population, while the OCDE provides a more focused framework on long-term care for elderly. Regarding the general issue of **elderly**, the Charter of Fundamental Rights of the European Union (1993, 2000), the article 25 address on the rights of the elderly : « The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in

social and cultural life »³². Some reference to choice and empowerment can also be founded in the WHO report on elderly abuse, *Missing voice (2002)*. In that document, the *absence of choice* may be considered as abuse : « Participants agreed that institutionalisation needs to be a choice that is made by the older person. If someone else makes this decision, it is considered abusive. » (WHO 2002 : 16). Moreover, in the focus groups, elderly called for an *empowerment*. « Some reports emphasized the need for older adults to act for themselves and on their own behalf. Many participants felt strongly about the need for older adults to exercise their full citizenship rights and advocate for their own interests. In Sweden, organisations and associations of and for older people were seen as important ways of addressing the problem » (WHO op cit. : 22). But this was not explicitly taken back (back up ?) by researcher's recommendations.

A more explicit reference to participation can be found in **the Active Aging Framework** (WHO 2002 : 51ss) wich outlines « Independence », « Participation », « Care », « Self-fulfillment » and « Dignity ». The recommendation regarding participation consider three main objectives : « Provide education and learning opportunities throughout the life course » ; « Recognize and enable the active participation of people in economic development activities, formal and informal work and voluntary activities as they age, according to their individual needs, preferences and capacities. » ; and « Encourage people to participate fully in family and community life as they grow older ». This approach is at the basis of the 2012 *European Year for active ageing* proposed by the European Comission in 2010³³.

Regarding long term care, there is not specific reference to participation in **OCDE report « Long Term Care for Older People » (OCDE 2005)**. In the quality issue chapter, one finds references to enabling procedure in nursing homes. Nevertheless, a full chapter of the report is devote to the question of direct employment and consumer's choice.

We quote here the summary provided by OCDE (2005 b) : « Government have tried various ways over the past 10 years to allow dependent persons receiving care at home – and their families – more choice among care options. Often this involves providing **cash to pay for care**. These benefits come in various ways: **personal budgets** to employ professional care assistants, direct payments to the person needing care without constraints on how it is used, or as direct payments to informal care givers in the form of income support.

With **personal budgets**, or so-called “consumer-directed employment of care assistants”, older persons can employ a personal attendant, frequently with the option that this person can be a relative. (nb see Netherland). **Income support payments to informal care-givers** have been designed for the dual purpose of increasing flexibility and mobilizing, or at least maintaining, a broader carer potential that enables older persons to stay longer in the community and reduces the need for expensive institutional care.

Often these programmes are still experimental, covering only a small part of the population. But in Austria and **Germany**, a large part of the public scheme to provide for publicly funded long-term care is built around these concepts. These initiatives

³² http://www.europarl.europa.eu/comparl/libe/elsj/charter/art25/default_en.htm

³³ <http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=860>

enable more people with care needs to stay at home as long as possible, by mobilising or sustaining the contribution from informal care.

Consumer choice can improve the self-determination and satisfaction of older persons and increase the degree of independent living, even in cases of dependency on long-term care. In general, these programmes are appreciated by older people because they give people greater control over their own lives. Surveys have shown that greater choice and consumer direction can contribute to better quality of life at similar cost compared with traditional services, provided these programmes are well targeted to the persons most in need. Again, it is essential that sufficient additional services to support care givers are available, such as respite care and counselling. But providing enough funding to pay for all care needs is expensive, and most countries have confined such payments to selected groups in the population. » (OCDE 2005b).

As a **conclusion**, the concept of participation that is diffusing in the field of elderly care has no univocal meaning. Indeed, in order to be understood, it had to be put into the political and institutional context of its debate and implementation, that may differ strongly from one country to another, or from one field of care to another. Moreover, as it applies to the field of elderly care - specially home-based care long-term care- the participation appears as a particularly crucial challenge from a democratic perspective. First, the consumerist approach of participation is getting importance at the expense of the democratic one. Second, compared with other categories of marginalized people dependent, the frail elderly are the least likely to get included in participative program. Lastly, participation is linked to the territorial dimension of care and the devolution of social policies. Hence, apart from international, national or regional shift, one have to pay attention the local interpretation and implementation of participation.

Section B: Comparative Analysis

This section provides a comparative analysis of the situation of our three national cases towards the four defining debates we have chosen to focus on. The section is organised by issue. The presentation of all three cases ends with an integrated comparative analysis.

1. Governance issues in Germany, Scotland and Switzerland.

Germany (governance)

Governance in Germany happens under the restricting framework of joint decision-making of the federal and the State level, in case of long-term care connected with a strong corporatist component. A main feature of the German system is the high degree of fragmentation. Different actors are subject to different logics and regulations, which makes comprehensive governance even more difficult; the most important example surely are the different logics of health insurance and long-term care insurance that sets incentives to shunt costs of health insurance into long-term care insurance. Furthermore, the strong principle of provider competition leaves little room for decision-making on the development of caring infrastructures to the political realm. A general regulative framework is set at the federal level. Main issues, e.g. quality assurance, are framed here, and measures for cost containment are guaranteed. Decisions about implementation are left to the bargaining of providers, insurers and local authorities' associations at the federal and State level, e.g. regarding the reimbursement and definition of services, or quality issues. Thus, governance-induced innovations at the federal or State level with obligatory status throughout the country would need broad coalitions and are hardly expectable. General regulations leaving room for variations in local implementation are more likely in this context. Municipalities only are provided with soft instruments to influence the form of the local system of home based long-term care. However, this limited spectrum of opportunities still leaves local actors some possibilities for varying implementation and, thus, innovation at the local level.

Scotland (governance)

The governance of the Scottish long-term care regime is twofold. The design, the financing and the oversight of the policy program lie in the hands of the national Scottish government. The implementation of the program and the definition of the

provision are competences of the Scottish local authorities. There are lots of interactions, more or less contentious or cooperative, between both levels of government in the domain of long-term care.

Firstly, as a highly promoted national Scottish policy, the Free Nursing and Personal Care program is an attribution of the national government itself. The Scottish national regulation defines the big principles of the entitlements and of the financing of the long-term care for the aged. The rates refunded, the panel of services, the form of the assessment, etc. are defined at national level. The budgets dedicated to personal care and financed by the government are as well defined at this level, but in accordance with the representing body of the Scottish local authorities (COSLA). Quality insurance is part of direct oversight by the Scottish government. Beneficiaries' participation and diverse sensitive issues affecting the costs of personal care (commissioning, staff training, development of telecare, etc.) are also influenced by the national government agencies such as the Joint Improvement Team.

Outside this direct control or softer guidance by the central Scottish government, the local authorities enjoy a high level of autonomy to not only implement but also organize the logic of provision. The Scottish local authorities can provide services directly, they can commission these services, organize a market, set prices paid to the providers, etc. The central government has developed lots of its guidance instruments precisely to assist the weakest of those local authorities.

Besides this vertically segmented governance regime, the domain of long-term care is in Scotland segmented in the horizontal dimension as well. The poor coordination between cure and care, between the NHS controlled hospitals and GPs and the organization of domiciliary long-term care is a key issue in all of the UK. Various instruments and coordination strategies are tried out in the Scottish context to overwhelm these specific shortcomings.

Switzerland (governance)

The governance of the home-based long-term care system is framed by federalism and by the subsidiarity principle which both limit the power of the state. Unlike Germany, Switzerland has no mandatory, comprehensive, long-term care social insurance for the elderly.

While long-term care is largely regarded as an individual and family responsibility, part of the long term care expenditure is covered and governed at *federal level* by the mandatory health insurance (Health Insurance Law, LAMal), the Old-Age and invalidity insurance (AVS-AI), and the so-called supplementary benefits to AVS-AI pensions. In this context, the main responsibility with regard to health policy is with *the cantons*, which means that each of the 26 cantons has its own home-based long-term care policy. This responsibility has been increased after the new financial equalisation (“péréquation financière”) of 2008, which entailed a re-arrangement of competencies between the federal and the cantonal levels. The federal state now supports only national “umbrella” organisations in this field of HBLTC, whereas all support to cantonal and local organisations/branches is transferred to the cantons. The cantons can also provide allowances for the financing of the health insurance fees and of health care. Moreover, the actual implementation of home based long-term care lies with the

municipalities, however their exact responsibilities depend on the canton's decision. The HBLTC systems in the German speaking cantons are mostly organized on a municipal or even regional basis, whereas the HBLTC systems in the French and Italian-speaking cantons are organized rather on a regional or cantonal basis (Dietrich et al., 2009).

On the horizontal dimension, the governance of home-based long-term care is characterised by the importance of private insurance, not-for-profit organisations and family care. The principles of free market regulation and competition that have been introduced in the health care system in the mid-1990s and that have become ever more important since. The health insurance sector in particular is governed by market principles, and to some extent also the health care providers (including public hospitals and domiciliary care providers).

Then, the (not-for-profit) Spitex organisations are the main providers of HBLTC in Switzerland: they provide 90% of health/care services. The remainder is provided by independent nurses or by for-profit organisations (Gobet and al. 2010). Lastly, *private households* contribute heavily to the financing of health care: six times more than in the Netherlands or in France, four times more than in Germany or Sweden³⁴. The new federal legislation on *health care funding system* implemented since 2011 allows for a potential increase of the financial burden on long-term home-based care patients at cantonal level.

Comparative synthesis governance

The governance systems of long-term care for the aged imply different governance mechanisms in our three countries for the various specific tasks and functions making up the care regime. The architecture of the Scottish governance system appears to be the most simple. The financing and design of the entire system is in the hands of the central Scottish government. The steering of implementation as well as the governance regime of the providers are competences of the local authorities. There are of course various interactions between both policy scales. Unsatisfactory implementation by the local authorities or insufficient financing by the central government give for example way to tensions and negotiations between both levels of government. On a more regular basis, the central government seeks to influence the implementation by the local authorities by providing guidance, recommendations or expertise. Besides this rather simple Scottish governance design, the governance of long-term care regimes prevailing in both continental federal regimes appear to be much more complex. The Swiss regime and the multiplicity of institutions at stake appears the most complex at first sight. The multiplicity of financing and decision-making bodies (two federal insurance systems not primarily dedicated to long-term care, cantons, municipalities) seems to build a very intricate framework. However, multi-level and cross-domain cooperative governance is a very common feature of Swiss policy-making. In the case of long-term care for the aged, a clear repartition of tasks and competencies smoothens the functioning of the whole system. Finally, the German design may appear slightly simpler, as the long-term

³⁴ Mission d'études et de recherche 2007 *La participation des patients aux dépenses de santé dans cinq pays européens* Haute Autorité de la Santé, Paris: 11.

insurance law of the mid-1990's has clarified one very important element of the system: financing. However, the intricate interaction between federal and Land-level regulation as well as the lack of real power of the local authorities give way to a system based on negotiations between varied actors, which are not always transparent and accountable. The local care markets that had been introduced by the 1995 law on long-term care insurance are for instance rather poorly regulated via complex agreements between business associations of providers, insurance funds and the Länder. In our three systems, there is a strong fragmentation between the regulation of personal care and of health services. In Scotland, this fragmentation appears to be particularly critical as the governance mode of the NHS is very autonomous from other political instances.

2. Complementarity and coordination in Germany, Scotland and Switzerland.

Germany (complementarity and coordination)

Complementarity of services and methods of coordination are a weak spot of the German system of home based long-term care. Sectors (e.g. in-patient and out-patient care, health- and long-term care, rehabilitation) are separated by different financing and regulation rules. Standards for local integrated pathways, e.g. for hospital discharge or home care arrangements, are often missing or their implementation is criticized as insufficient. Together with insurers, Ländern and providers, local authorities are held responsible for guaranteeing a coordinated provision of in- and outpatient long-term care; yet they lack a clear legal mission as well as clear competencies for the steering of the local infrastructure of long-term care. Care and case management are neither consistently implemented in long-term care insurance, nor as a task of local authorities. These circumstances often lead to unclear patient pathways and **opaque** choice options. An initial change was introduced with the right to comprehensive care counselling by the long-term care insurers and with local long-term care support bases that should assume coordinating as well as counselling tasks (Long-term Care Further Development Act, 2008). Inter-professional and inter-organisational cooperation as well as intermediate or integrated care are underdeveloped. In most municipalities local negotiation processes and forms of local coordination such as round tables are underdeveloped.

Scotland (complementarity and coordination)

The networks of long-term care provisions, i.e. the welfare mix dealing with this public task are very varied across Scotland. The importance of local authorities control over the organisation and structuring of long-term care services, and more generally over most of social services delivery in Scotland, accounts for the diversity in provision networks. However, it is possible to say a few general things about welfare mix in this

Northern British region. In the first place, there has been in Scotland an influential tradition of philanthropy and charity, following the strong Scottish Calvinist culture. This tradition has fostered the development of a strong associative milieu, which is active in the context of long-term care. Secondly, there is in Scotland an important history of strong local social public services. The strength of the Labour tradition in this region from the early 20th century, but even more from the 1950's onwards, explains the development of this type of social intervention. The Scottish 1968 law on Social Work has further pushed this movement of development of municipal social work departments. Finally, from the 1980's through the 1990's to the 2000's, under the influence of the Conservatives dominating in Westminster for almost two decades, there has been an important wave of privatization of service delivery and of market development.

These three families of social services provision and the importance of the local regulation in that domain – this holds particularly true in the case of long-term care for the aged – explain the level of diversification in local welfare mix.

Switzerland (complementarity and coordination)

The federalist structure of Switzerland and the wide-ranging cantonal competencies in matters of health lead to a strong institutional and organizational fragmentation of the health and care system, and to the coexistence of a wide range of actors, practices and regulatory mechanisms. This is in itself a massive challenge for the coordination in HBLTC system. It is further reinforced by the liberal tradition of subsidiarity that induces wide-ranging responsibilities for private actors, often at the local level (implementation, monitoring, etc.). In the field of HBLTC, there are 600 cantonal and local home-based care organizations that provide basic services such as nursing care, counselling and house-cleaning help, and sometimes also additional services such as meal delivery. Moreover, the principles of free market regulation and competition have influenced the health insurance sector and to some extent also the health care providers.

This extreme fragmentation of the system, its decentralisation and reliance on private actors is often criticized for its lack of coordination at vertical level (between the federal state and the cantons) and horizontal level (between cantons and between public and private actors) but also at the operational level (as the Spitex organisation faces great coordination problems in their service delivery for each individual case). The financing segmentation between on the one hand nursing care (medical treatment) that is not refunded by the federal insurance and, on the other hand, the domestic service or care (that is not refunded) does not allow for inclusive care packages. This may be nuanced by private complementary insurance. This fragmentation leads to disparities in care provision. Depending on where a person in need of care lives, his/her trajectory within the care system (transitions from one state of vulnerability to another, his/her transfer to another type of care service or facility etc.) will be managed very differently.

However, some coordination mechanisms exist. One is the national Spitex association that gives a certain national unity to the system. It unites the 600 cantonal and local home based care organizations that provide basic services such as nursing care, counselling and house-cleaning help, and sometimes also additional services such as meal delivery. Apart from Spitex, four regional « conferences » group the cantons.

They serve as inter-cantonal coordination bodies that aim at some degree of harmonization of cantonal rules and legislations. Lastly, the national conference of cantonal health ministers CDS-GDK (Conférence suisse des directrices et directeurs cantonaux de santé) that reunites the members of the cantonal executives in charge of health for periodic sessions of discussion and coordination. However, home-based care is only one among many issues on the agenda of these bodies. A disputed new legislation on *managed care* is currently pending. In case it should be accepted, it will provide supplementary incentives for better coordination of the various care providers (doctors, independent nurses, private home based care providers) at the local level.

Comparative synthesis complementarity and coordination

The issue of complementarity and coordination encompasses the way provision is organized by either public instances and providers or by more or less regulated private markets. In our three countries -Germany, Scotland and Switzerland- a diversified welfare mix combining private firms, associations and charities, along with public provision is to be found. In the various national contexts, more or less recent reforms have changed the regulation of service provision. These reforms have to various extents changed the nature of service provision.

In Germany, in spite of the introduction of a market regulation from the mid-1990's, the traditional more or less corporative welfare associations have maintained a dominant role on care markets in most local markets, especially in West-Germany. In Switzerland the recent policy changes toward a decentralized regulation of care provision as well as the growing importance of the market norm, have not transformed the core of provision neither. The traditional, municipally-led, non-profit Spitex organizations still largely dominate the market. In some areas however, for instance in the regions close to the German border, new market actors are transforming the traditional balance. Finally, Scotland appears to be the context in which radical change happens very quickly in some regions. The regulation by local authorities of long-term care provision was rather related to a tradition of municipal, public delivery. However, since the introduction of the Free Personal Care program in the early 2000's, smaller local authorities that had up to then never developed these services chose to create markets rather than to develop the traditional Scottish "social work services". In other cases, the raising costs related to the new entitlement to personal care have led local authorities to privatize provision.

In the various settings, there is a more or less high level of differentiated provision. Specific provision for ethnic or linguistic minorities is an important public concern in Scotland. This is far less the case in Switzerland or Germany. Only in bigger cities in these countries is there a real debate about diversity and minority rights.

3. Quality in Germany, Scotland and Switzerland.

Germany (quality)

During the fifteen years of long-term care insurance in Germany, quality assurance has gained advergence as an issue of regulation. Particulars of the legal framework are again left to the bargaining of providers, insurers and local authorities at the Land level. Altogether, top-down concepts of quality assurance predominate. Further reforms introduced the obligation of care providers to implement systems of internal quality management, the development of expert nursing guidelines (e. g. decubitus prevention, wound treatment), more frequent external quality controls and the publication of reports on the aggregated results of such controls.

Additionally, actors of the intermediary sector as well as municipalities also developed bottom-up approaches, e. g. with the development of own systems of quality development, or the introduction of Ombudspersons.

Yet, there remains limitations of the current system of quality assessment, as there are: quality measures mostly regarding distinct care sectors (e.g. residential care) – comprehensive quality management instruments (for whole pathways) are still missing; in analogy to international scientific (public health/health services research) debates, the question of how to measure outcome quality of complex interventions as e.g. LTC remains unsolved. Indicators and instruments often concentrate on rather narrow outcomes (e.g. decubitus) or structural or procedural quality parameters. The “Charter of Rights for People in Need of Long-Term Care and Assistance” (Ministry for Family Affairs Senior Citizens Women and Youths 2007) may be regarded as an innovative qualitative instrument of quality assurance, even though its application is voluntary. It applies a normative concept of care. To facilitate its implementation, a manual for self-evaluation of home care providers has been developed (Konkret Consult Ruhr 2011).

Scotland (quality)

Quality insurance is an important topic in public discourses in Scotland. Up until very recently, there were many regulatory and controlling bodies: the Care Commission, the SWIA (Social Work Inspection Agency), the SSSC (Scottish Social Services Council) and the JIT (Joint Improvement Team). We could add to this list Audit Scotland that provides the Auditor General of Scotland and the Accounts Commission with assessment and control reports about the efficiency and effectiveness of public money use in the country. Those two institutions analyse on regular bases the implementation, effects or finances of the FPNC scheme³⁵ but this is not a body specific to the domain of care. As the competencies of these agencies were deemed complex and partly overlapping, two of them, the Care Commission and the SWIA, merged by the 1st of

³⁵ http://www.accounts-commission.gov.uk/utilities/search_report.php?id=230

April 2011. Before the introduction of this simplification step in the controlling and regulatory bodies, various joint committees were supposed to coordinate the activities of those sometimes concurring and overlapping bodies.

- the *Care Commission*.

Care is provided by various services, which were regulated by the Care Commission with whom all services have to be registered. The Care Commission was set up under the Regulation of Care (Scotland) Act 2001 in April 2002 to oversee all adult, child and independent healthcare services in Scotland. In order to assure that National Care Standards³⁶ are being met the Care Commission inspects all care homes as well as services and works closely with local authorities. The Regulation of Care (Scotland) Act 2001 also gives the Care Commission the power to enforce changes or to close care services. In practice, such enforcement is rare because the Care Commission supervises care services very closely. The Care Commission inspects all care services at least once a year. It regulates 15,000 services for 320,000 people. The National Care Standards have been developed as a means of quality control for every kind of care and requires regular inspections after which a report will be produced and published. The main principles are dignity, privacy, choice, safety, realising potential, equality and diversity.

- the *Social Work Inspection Agency* (SWIA)

The SWIA inspects all social services in Scotland. It was in charge of controlling the Social Work departments of the local authorities and other providers of long-term care. It plays a central role in the controlling and monitoring of care services, at local level. It started in 2008 a systematic work of inspection of social and care services in all 32 Scottish local authorities that was completed in 2010. Quality of “management”, “value for money”, “continuous improvement”, “excellence” were the keywords structuring the action of this agency. An important reorientation of the inspection practice from the previous logic based principally on scrutiny (external observation and inquiry) to a mix of scrutiny and supported self-evaluation has been launched in 2010 and was labelled “performance inspection”.

- the *Scottish Social Services Council* (SSSC)

The SSSC is a key agency in the Scottish quality insurance strategy. This agency is centred on the control, training and support of the work force of the long-term care sector. It has issued a strategic plan for the period 2011-2014. This plan claims to follow the following goals: “to set up registers of key groups of social service workers, to publish Codes of Practice for all social service workers and their employers, to regulate the education and training of the workforce, to promote education and training, to undertake the functions of the sector skills council, Skills for Care and Development (SfCD), this includes workforce planning and development³⁷”.

The SSSC is in charge of registering the people working in social services in Scotland and regulates their education and training. It sets standards in professional skills and procedures, and plays as such a key role in the staff centred work of quality insurance.

³⁶ <http://www.infoscotland.com/nationalcarestandards/21.html>.

³⁷ http://www.sssc.uk.com/component/option,com_docman/Itemid,486/gid,1988/task,details/

- the *Joint Improvement Team* (JIT)

The JIT was created in 2004, is part of the division of the Scottish government health directorates in charge of partnership improvement and outcome. It primarily assists and steers the local authorities implementation activity. The focus of the agency lays in “performance measurement and management” as well as on “performance support and improvement”. This institution deals with the implementation of specific targets by the local authorities that are set by the Scottish government. For the time being, the JIT works, with networks of care providers as well as with the local authorities on the following issues: care at home, commissioning, equipment and adaptations, governance and management, housing, integrated transport with care, intermediate care, managed care networks, performance improvement, reshaping care for older people, rural and remote, talking points: user and carer involvement, telecare.

- The *Care Inspectorate*

The merging of the Care Commission with the SWIA has been followed by a radical transformation of the forms of control activities. Systematic, annual control was abolished and replaced by random control of providers and by targeted self-assessment of the providers. In doing so, the new controlling body, the Care Inspectorate³⁸, has developed a policy it has initiated for a few years consisting in trying to draw the attention of providers onto specific issues (recruiting a professional carer for instance). As it has been organized up to now, the Care Commission was autonomous enough to pick those specific issues it wanted to improve. The publicity, accessibility of evaluation reports on the Internet was a key feature of the Care Commission.

Care services have to deliver an « annual return » which is a control of the activity of the providers (clients, financial situation, etc.), whereas the annual self-assessment, is centred on « quality themes and quality statements). This new organisation, along with the SSSC, now represents the bulk of the Scottish quality insurance strategy.

Switzerland (quality)

In line with the fragmentation of the legal, financial and institutional system, the quality promotion and control of HBLTC appears very fragmented too. The quality of services is officially defined by the LaMal and insured by the (private) health insurance companies. The cantons are responsible for devising and implementing policies of quality control in LTC services (Nies and al 2010 : 22). Municipalities can also evaluate the services. Moreover, quality may be monitored by professional service providers, such as cantonal Spitex organizations. The national Spitex tries to diffuse quality standards. In the field of HBLTC, there is only one instrument of need assessment that has been validated by the national Spitex: RAI-Home care. The national Spitex organisation encourages its members to use it but with limited success. First, most of the insurances have not formally approved of these instruments; second, some of the cantonal providers continue to use their own system and they have not yet approved of the concept of one quality control system. Lastly, Santé Suisse has not accepted it either.

³⁸http://www.scswis.com/index.php?option=com_content&task=view&id=7563&Itemid=363

The certification process is also characterized by the multiplicity of organisms. Three ISO standard are concerned by long-term care³⁹. Up to now, 5 German-speaking cantons and 5 French-speaking cantons have been accredited on such bases by an organism called SQS (Gobet and al. 2010: 14). In Switzerland *informal carers* are now recognized as very important to the system and new issues around the quality of family care are arising, especially in the context of recent reinforcement of *home-based* long-term care strategies in many cantons. In short, there is still a high level of disparity in dealing with quality issue at cantonal level in HBLTC in Switzerland (Giraud, Lucas, 2010).

Comparative synthesis quality

In all three national cases under investigation, there exist more or less pronounced top-down approaches to address issues of quality in home based long-term care; in all three cases, quality assurance is a legally fixed obligation. Notwithstanding, in all of the three countries there is a high degree of fragmentation of responsibility for quality assurance: the definition of aims, content, and responsibility of implementation, is shared among a range of stakeholders. In Germany and Switzerland, much of the necessary concretisation regarding instruments is left to the respective Länder cantons. In Germany and Scotland general regulations are much more detailed than in Switzerland. In both countries outpatient long-term care providers have to apply for accreditation as a precondition for reimbursement from public benefits; in Switzerland, whether accreditation is a necessary precondition is left to the cantons. In Germany, providers have to implement internal systems of quality managements and are subjected to annual external controls. In Scotland there has recently been a shift from obligatory annual external controls (as have been introduced in Germany since 2008) to random control of providers and targeted self-assessment of providers. In Switzerland, clear standards on federal level are missing. For instance, RAI home care was only agreed upon as a possible instrument for needs assessment in the contract of the insurers represented by *santé suisse* and the federal associations of the non-profit and for-profit Spitex organisations. Additionally, the federal association of the non-profit Spitex organisations provides an extensive quality manual with norms and indicators to develop quality, but its application is not compulsory to all Spitex organisations.

In Germany and Switzerland there has been raising public concern about the issue of quality assurance and development in long-term care over the past years. Similarly, in Scotland, the issue of quality assurance has led to recent reforms. In international discourse as much as in the investigated countries there has been raising concern about outcome-related indicators, even though on both levels the development of adequate, valid and reliable indicators for outcome quality has remained an unsolved task. It is against this background that the OECD argues – with the argument to save development costs – that there would be “a strong case for co-operation on quality standards and measurement at the national and international levels” (2005, p. 78).

³⁹ ISO 17020, ISO 17021 and ISO 17022 (Gobet and al. 2010: 13)

In Scotland as well as in Germany the publication of evaluation results is another (in Germany highly debated) instrument of quality assurance which is closely related to the general tendency to perceive and address care recipients as customers or consumers. An important precondition for this development is the Internet. Without neglecting the importance of transparency of information as a precondition for autonomous decisions, the remaining question is: to what extent (should) recipients of long-term care really correspond to consumers, and to what extent (should) the organisation of the delivery of long-term care services as part of the general systems of health care really correspond to consumer markets. Remaining in this logic, further development of consumer protection would be an important next step.

Besides the aforementioned top-down approaches, all three countries have more or less pronounced bottom-up approaches of quality assurance. One of these important bottom-up approaches is the question of training and support of the work force which is an increasingly relevant issue all three countries that has found institutional expression in the Scottish Social Services Council and its very task of control, training, and support of the work force in the long-term care sector. In Scotland, the possibility for care recipients to file complaints to the Care Commissions may be subsumed under the category of bottom-up instruments, while in some municipalities in Germany and Switzerland, we find Ombudspersons for the sector of long-term care. Yet they seem to be much more preoccupied with the inpatient sector than with the outpatient one. This prevalence of approaches of quality assurance for the inpatient sector corresponds to the international situation too. Another example of a – normatively based, subject-oriented – bottom-up instrument to assure and develop quality is the above-mentioned German “Charter of Rights for People in Need of Long-Term Care and Assistance” and its implementation instrument for the outpatient sector of long-term care.

A shortcoming that has only recently entered the agenda in Germany and Switzerland is the assurance and development of quality of care in informal care settings in home based long-term care – even though, providing long-term care at home is still the prevailing form of care provision. In Germany care recipients who opt for cash benefits from the long-term care insurance are obliged to accept regular inspections of the caring situation, and insurers shall offer free training for informal carers; nevertheless, these courses are seen as not taking sufficient account of the individual needs and interests of family carers (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen, 2009, pp., 363, 363 referring to Dörpinghaus and Weidner 2006).

All in all, even though there are widespread raising concerns about quality issues, these are addressed quite differently in our three countries. While in Germany, we find a variety in approaches to assure quality in long-term care and a slightly growing attention for the outpatient sector, in Scotland instruments of top-down control prevail, but have recently been complemented by demanding self-assessment procedures from providers. Switzerland seems to be the country providing the least concrete standards and leaves the bulk of decisions on implementation to the cantonal and thus partly municipal but also providers’ organisations’ level.

4. Participation in Germany, Scotland and Switzerland.

Germany (participation)

Legally, in Germany services under the long-term care insurance scheme are meant to help people in need for care to live as independently and autonomously as possible (§ 2 SGB XI). In practice, autonomy may be endangered by several factors like the quasi-taylorisation of services and the concentration of benefits on activities of daily living (ADL) and instrumental activities of daily living (iADL) which comes along with under-addressing needs for social attendance and social participation. Thus, even though activation and involvement of users is an acknowledged concept in nursing care sciences, the spectrum of services covered by long-term care insurance hinders its realisation. Another important principle of German long-term care insurance is free choice: Beneficiaries are free to select between cash benefits or benefits-in-kind. If they opt for the latter, they are free to choose between care providers. The freedom to change service providers is to enhance the providers' competition and striving for quality. Yet, the lack of useful and manageable information restricts 'informed choice' of beneficiaries. But this issue of lacking information has been addressed by recent reforms which included publishing the results of quality monitoring of providers. The German system of long-term care, especially the market of long-term care providers, suggests that care recipients would be consumers who were supposed to choose freely between benefits and providers. This construction neglects that benefits from long-term care insurance are strictly capped, and decisions regarding long-term care often have to be made under time pressure. Regarding quality assurance, beneficiaries' participation only recently is to be taken into account in the obligatory quality inspections that also include subjective evaluations of beneficiaries. Normative instruments of quality development like the above mentioned Charter of Rights address care recipients as citizens.

Scotland (participation)

There are three types of instruments supposed to improve the participation of beneficiaries and of their relatives in the domain of long-term care in Scotland. First, there are instruments of beneficiaries and clients information. There are as well instruments of participation to both the definition of the care needs and care packages and the steering of the policy itself at local level. Finally, there are instruments dedicated to frame the issue of participation. Those instruments are elaborated by agencies of the National Scottish Government.

The Scottish Government has put great emphasis on making **information** about the care system available for people who need assistance. After an informal super-complaint by the Which Consumer group, which criticised the lack of clear information on the care system, the Office of Fair Trading on the UK Care Home Sector took action to claim for the provision of ready access to clear and relevant information. The Scottish Government then set up a Steering Group which carried out a feasibility study. Since

2009 the Health Information and Self Care Advice for Scotland (NHS24) has provided a website⁴⁰ and a local rate telephone helpline. A lot of information can be found online, e.g. on the websites of the Scottish Government⁴¹ (and parliament), of the Care Inspectorate⁴² and of local authorities. On the website of the Care Inspectorate for instance, the procedure to complain about a care provider is very clearly explained and even directly made available. All information about the quality of provision by the various public and private providers are also available online. Under the headline and the keyword « Get involved!», the Care Inspectorate even invites the beneficiaries to participate to the evaluation process of the various care providers. This dimension of information about all types of providers is especially important in the cases of local authorities like Edinburgh that decided to organize a long-term care provision market. Furthermore, every care service also has to provide its customers with an introductory pack informing them about rights and issues of the Free Nursing and Personal Care program.

Secondly, the participation of care beneficiaries to the **definition** of their own care needs and of care packages is considered to be one of the most important element of the reform (Bell, Bowes, Dawson, 2007). The concept and the instrument of the Single Shared Assessment is not only the idea that only one assessment formula and procedure should be used by as many stakeholders institutions as possible, but also that the potential beneficiaries should be able to participate to the assessment it self, as well as to the definition of the care packages. According to our field research however, the effectiveness in terms of participation of this tool seems to be very limited. There are also instruments organizing the participation of beneficiaries to the **steering**, at local level, of the beneficiaries. This is for instance the case of the « checkpoint groups » in the case of Edinburgh. Those groups represent a form of consultation of the various stakeholders of the domain of long-term care. There are open to the participation of service providers and associations of all sorts, but also to the participation of beneficiaries representatives. In the case of our second local case study, in Fife, the users' panels are also an important form of local participation and direct consultation of users.

Finally, the Scottish government has developed various institutions that produce activities aimed at actively **defining and promoting** the issue of beneficiaries' participation in the domain of long-term care. In the first place, the Care inspectorate has developed the so-called « National Care Standards ». Explicitly, those standards are designed to raise the quality of long-term care delivery. However, the large publicity of those standards is also supposed to make beneficiaries aware of their entitlements in the domain. They are supposed to be written and issued « from the user's viewpoint ». Their content is also partly related to this dimension of participation: « dignity, privacy, choice, safety, realising potential, equality and diversity ». Those standards should also raise the awareness of all stakeholders of long-term care for the aged that they have to reach those standards.

Even more specifically relevant to the issue of participation in the domain of long-term care is the action started by the Scottish Human Rights Commission. This important

⁴⁰ <http://www.nhs24.com/content/>.

⁴¹ <http://www.infoscotland.com/nationalcarestandards/52.html>,
<http://www.scotland.gov.uk/Topics/Health/care/17655>.

⁴² <http://www.scswis.com/>

commission in the Scottish national debates has launched in cooperation with the organisation representing the private care sector a powerful senior citizens association, the Care commission and the active support of the Scottish government, an initiative aiming at « embedding human rights in care »⁴³. This program has produced various reports, guidance about various important policy issues in the domain such as commissioning. From this program, the Scottish Human Rights Commission has started a more operational program of training aiming at concretely assisting the potential beneficiaries to understand their human rights in the context of a care relation, and to empower them to make use of those human rights. This online training course, made of information texts and videos, is not only dedicated to older people, eventually in need of care, it is also designed for professionals or activists of the domain of long-term care. Besides, the whole instrument should improve the large public awareness and concern about the issue of public oversight and beneficiaries participation in the domain of long-term care for the aged.

Switzerland (participation)

The Swiss health care system is strongly focused on the curative dimension. This is often criticized for inducing an underdevelopment of prevention and of types of care other than purely individual and medical. In Switzerland, the debate on beneficiary participation has mainly concerned disability and new cash for care system is implemented since 2012 for disabled adults. Today, with the European year of active ageing, elderly social participation is framed in the context of the promotion of health and autonomy (the perspective is to delay the loss of autonomy). Forums, conferences and elderly councils are mostly used by the cantons (like at national level). Nevertheless, there is a lack of institutionalisation and 2/3 of these initiatives are private (Rielle and al. 2010).

Regarding care for the aged, and specially HBLTC, the debate is very weak. In 1995, a call for more participation was voiced in the national report « Vieillir en Suisse ». In 2007, issues of elder people's self-determination and participation were included in the new governmental strategy for old age policy (« Stratégie en matière de politique de la vieillesse de la Confédération »). This document also acknowledges the restrictions of autonomy that elder people suffer due to their dependency on others (people or institutions). Having to rely heavily on other people for their well-being is also recognized as a problem⁴⁴. Nevertheless, the report does not mention any choice instruments such as direct payments or cash allowances for care.

This lack of concern is also reflected in the INTERLINKS European Overview (Nies et al. 2010, op cit : 39) that reports an absence of evidence in the Swiss case regarding the following dimension : « Informed consent and shared decision », « Choice » « client satisfaction », « information ». Moreover, elderly policy does not

⁴³ <http://www.scottishhumanrights.com/careaboutrights/welcome-embedding>

⁴⁴ Conseil Fédéral (2007). *Stratégie en matière de politique de la vieillesse*. 29 août 2007, p.42

appear as a field that is strongly represented in the cantonal parliament except for issues like care/health care and euthanasia (Rielle and all. op cit).

Comparative synthesis participation

Participation is an issue that has been addressed very differently in Germany, Scotland and Switzerland in the context of home-based-long term care. At national level, there are huge differences regarding the advance of the debate and the instruments developed. Moreover, the mobilized approach of participation is not unified. Finally, the frailest elderly are not always included in the participative care framework.

Indeed, the *debate about participation* in care is very advanced in Scotland, while it proves quite recent in Germany and particularly weak in Switzerland. In Scotland, the Scottish Government and its national agencies have been strongly involved in the promotion and integration of participative instruments into the elderly care system. In Germany, the main debate is not about participation but about the debated marketisation of care. Hence, the concept of “autonomy” and “free choice” are now part of the National Health Insurance legislation. In Switzerland, participation does not appear as an issue in the field of elderly care. “Self determination” and “social participation” concepts were included in 1995 National report and in the 2007 National strategy. But they are not supported by concrete implementation strategies with regards to frail elderly and this strategy has no binding dimension for the Swiss cantons.

With the debate, the concrete *instruments* that may enhance the participation in the field of elderly care provide us with clues about the specific national understanding of this dimension. Interestingly, different approaches of participation coexist in each national context. First, participation is understood as a free choice, in the context of a long-term-care market. Hence, instruments aiming at diffusing information about the providers are developed in Scotland in this *consumerist approach*. In Germany, the issue of free choice is about choosing between cash benefits or benefits-in-kind. In this context, the importance of information the new consumers of the new market is a growing issue. In Switzerland, free choice appears as an important –and ambivalent - value (with both citizenship and consumerist dimensions) though unrelated to specific instruments in the field of elderly care.

Second, there are quite weak instruments of participation of the elderly to the definition of their care needs and care packages that are developed in a *citizenship oriented approach*. Scotland is clearly the more advanced case, as this is an important part of the Single Shared Assessment. Therefore, specific instruments aiming to allow participation of the beneficiary have been created. Nevertheless, their effectiveness is deemed rather low. In Germany and Switzerland, by contrast, there is no instrument at national level. The promotion of the autonomy of the beneficiary is a concept that is included within the nursing care science although once again its implementation is weak (in those cases, it is hindered by the organization of work and the spectrum of services covered by Health insurance).

Finally, we have seen that compared with other categories of marginalized people, the frail elderly are the least likely to get included in participative program. If we consider the *dynamics of this integration* issue in the three national contexts, we can observe that Scotland is the most likely to develop an effective policy. Indeed, the Scottish Government has been actively involved in promoting this issue of participation, and even more specifically so in the long-term care system (through the elaboration of standards by the Care Inspectorate and through the actions of the Scottish Human Right Commission). Therefore, even if the consumerist approach is important in Scotland with regard to the organization of market provision, the political and democratic dimension of participation is well developed regarding the level of need and services definition.

By contrast, in Germany, the inclusion of frail elderly is the frame of participation at national level mainly occurs through the development of the cash-benefits provisions for the elderly and the free choice of the care providers. Hence, elderly participation is more likely to be defined exclusively in a consumerist way. In Switzerland, the issue of participation has been debated for other categories of people only, to the exclusion of the frail elderly. First, cash allowance for care was elaborated and adopted strictly for disabled adults. Next, the recent political valorization of participation address the 65+. Hence, reference is made to social participation of the youngest and autonomous elderly. Long-term-care beneficiaries are not mentioned in this context.

Section C: Case Selection

The aim of the present study is to understand modes of change in terms of institutional innovation and/ or social learning regarding the four analytical issues in home based long-term care at local level. In doing this, we think that institutional innovation and social learning that address shortcomings at the federal and regional level can be initiated and developed at local level. Bearing this in mind, it is crucial to our selection of the local case studies to consider the embedded nature of the local cases in their respective national and regional contexts.⁴⁵

Against this background, case selection requires identifying the central “shortcomings” for each national case under investigation, starting from the mappings of the four analytical issues. Identifying under-addressed or contested issues thus led to a selection of two local cases for each country.

The mappings of the four analytical issues showed that some shortcomings are common to all three countries while others prevail just in one or two countries. A quite common shortcoming seems to be the fragmentation between medical and long-term care. The fragmentation issue stands out more clearly in Germany and Scotland where we do not only find fragmented practices, but also a strong institutionalised fragmentation between both sectors: In Germany, with the statutory social health insurance and the statutory social long-term care insurance the legal framework for health and long-term care are separated; this separation seems to be reinforced by relatively strong professional cleavages between the medical system and the system of nursing and long-term care. In Scotland, health care falls under the responsibility of the National Health Service (NHS), while the organisation of long-term care falls under the responsibility of the municipal social care departments. In contrast, long-term care in Switzerland is regulated as part of the health insurance law instead of having its own legal basis. According to this, the aim was to include at least one German and one Scottish local case of innovation or learning that would address the issue of governance, and here especially the issue of fragmentation between long-term care and health care. We thus turned to the case of the *dementia care net* in Aachen, Germany, and the case of the *reablement service* in Edinburgh, Scotland.

Another shortcoming, which is a very distinctive element of the German system of long-term care is the noticeable competition between outpatient long-term care service providers which has developed there since the introduction of the long-term care insurance. To address this aspect of governance that is also related to the issue of coordination and complementarity, we selected the local *care conferences* in Hamburg, Germany, to be the second German local case study. This aspect is also partly addressed by the Aachen case.

As the preceding analysis of the national cases has shown, the (underdeveloped) chances for user participation are a relevant shortcoming in all three national cases, but

⁴⁵ Throughout the whole study we treat Scotland as a “national” case on one level with Germany and Switzerland.

it appears even more clearly in the Swiss and the Scottish systems. Therefore, the selection criteria for each local case study in Switzerland and Scotland was to address the issue of users participation and specific needs. Matching local cases are the project “Around the table” (*lunch in the community*) in Geneva, Switzerland, and the *user panels* in the unitary authority of Fife, Scotland.

As, according to our mapping, quality assurance and development are especially under-addressed in Switzerland, with regard to the selection of the local cases at least one of the Swiss ones should present an innovative approach to this issue. The corresponding local case is the *organisation of knowledge transfer* by combining a specialist with a generalist approach to the local provision of outpatient long-term care in the municipality of Köniz, Switzerland.

The following table gives an overview of the shortcomings of the national cases as well as the selected local cases that address them and will be further investigated in the next chapters.

Table: Selection of the local cases

national case	shortcomings of the national case	matching local case
Germany	governance (coordination and complementarity)	dementia care net, Aachen
	governance (coordination and complementarity)	local care conferences, Hamburg
Switzerland	participation and specific needs	project “Around the table”, Geneva
	quality	organisational knowledge transfer, Köniz
Scotland	governance	re-ablement process, Edinburgh
	participation and specific needs	Users Panels, Fife

Part III : Explaining Change : Social Learning and Institutional Innovation at Local Level

This section presents the empirical research results of the local case studies picked for the sake of the analysis. Every case study is introduced by a brief presentation of the locality, of the situation of the long-term care system, and of the innovation at stake. The rest of analysis of each case study is provided according to the analytical grid of local dynamics, which is commented in the last part of the report: mechanisms of change (Tables A), discourses and coalitions (Tables B), scales as power resources (Tables C). Comprehensive versions of the case studies are provided in the Annex. The following sections deal with concluding remarks on our three analytical approaches.

Section A: German local case studies

The dementia care net in Aachen, North Rhine-Westphalia

Aachen is a middle-sized city in the Western part of Germany near the boarder of Belgium and the Netherlands. Together with the surrounding municipalities it is the so-called city-region of Aachen with altogether about 0.5 million inhabitants. The city is an important University site of technical and engineering professions what is also reflected in the now prevailing branches in the former coal and textile region. The population is growing slow, if at all, but getting older. The city as well as the former district has a long tradition in senior citizens policies with special departments in the respective administrations; since the end of the 1980's measures aimed at encouraging people in need of care to stay at home developed. Beneath other projects, a long-term care service provider that developed from a civil-society based movement built the first day care facility in the city and focused its services on the needs of persons with dementia. The hospice movement has also been strong in the city. Parallel to this, also the Land NRW set on active policies on ageing and long-term care by obliging municipalities to offer counselling, make social planning a basis for the development of infrastructure on long-term care, providing them with arguments for the municipal alignment of social planning, and establishing an initiative on dementia services with respective counselling centres. With a University chair for gerontology in Dortmund and an institute for

research and counselling on ageing-related issues, the Kuratorium Deutsche Altershilfe, there was also a scientific infrastructure allocated in the Land. Furthermore, several actors of high political influence, the former minister of health, the chairmen of several medical professional associations, come from the city of Aachen.

Against this background, in 2008 the medical director of a local hospital with psycho-geriatric department and the working group of the local GPs established the so-called "Dementia Care Net Aachen" (DCN) that should provide case and care management to home-dwelling elderly persons with dementia and their caring relatives.

This process of change was motivated by the interest of a community-oriented local hospital with psycho-geriatric specialisation to find an earlier access to elderly persons with a dementia condition whose home-based caring arrangement might be in danger of decompensation. The rationale behind this was to avoid hospitalisation, enhance the sustainability of home-based caring arrangements, and save costs in the system of health- and long-term care. During the process of change, beneath the initiating hospital and the participating GPs, all other actors that are engaged in dementia-related care in the city of Aachen and later on also the city-region were affected by this process because the case management entered the stage as a new player who would potentially refer patients. Regarding the planning of the project, the insurers had early been involved and were supportive, but at the same time seem to remain reserved as to the project. This might be attributed to their interest to avoid new costs that could be attributed to the health insurance if the project were transformed into a regular health care benefit.

The establishment of the project was facilitated by the pre-existence of network structures (as the GPs network or the plurality of dementia-related care infrastructure), the flexibility of the protagonists to look for modes of financing, to adapt their original project ideas several times to the respective logic of the funding source, as well as to lobby for their project on different political levels - that is: by making use of different scales and given opportunities there. The main barrier to the project, especially to its perpetuation, seems to result from the separation of health insurance and long-term care insurance in Germany with financing mechanisms that set an incentive to keep the costs for benefits in the (capped) realm of the long-term care insurance.

The establishment of the case and care management of the DCN in Aachen affected governance (reducing the fragmentation of health and long-term care on case and local level), and – according to the interim report of the DCN – complementarities and coordination (better coordination of services) as well as quality (stabilised caring arrangements, better quality of life of caring relatives, eventually reduced hospital stays) and participation (better informed patients and relatives, more room for autonomous decisions (consumer aspect), better access to services (citizenship aspect), better chance to social participation).

Aachen: Network for dementia care / A: Mechanisms of change

What segments / elements of change can be attributed to non institutional actors and to institutional actors?: The initiative for the change process was completely driven by semi-institutional actors from an intermediary sector with economic and professional interest: the protagonists of the professional long-term care net who partly have their roots in civil society. The broad horizontal network included non-institutional and institutional stakeholders from civil society, public agencies, and private economy.

The shift from the first phase of financing as a model project on national level to the second phase as a model project on Land level was still steered by the original, semi-institutional initiators of the project, but institutional actors

(public authorities from the Land level, insurers, and the local authority of the city region) contributed in shaping the content, scope and aim of the second phase of the innovation. What decision making arenas? informal, non institutional ones? An important informal arena for decision making is the informal network of providers of dementia-related services and counselling. The local authorities are loosely involved here, but do not seem to have a major voice. All these stakeholders are members of the board of advisors of the dementia care net and meet in further formal structures on dementia issues and other networks, e. g. the local association of general practitioners. The gps' association is described by a member as an arena for professional politics but also for further qualification and training in a trustful atmosphere. This could explain why in the dementia care net of Aachen it worked out to involve gps in networking. Informal contacts among representatives of the insurers and between the insurers and the chief medical director contributed to shaping the second phase of the project. Several interviewees suggested that the informal contact between the former minister of health who comes from Aachen and the chief of board of one big insurer had facilitated the second project phase. Institutional decision making arenas ? We could not retrace the internal process of decision making in the jury that positively decided to fund the first phase of the project as a lighthouse project; the decision was made at the executive at federal level (that is in the ministry of health whose minister came from Aachen). The ministry of long-term care of the Land NRW had to be involved to design the second phase of the dementia care net. In the second phase funding was provided according to a paragraph of the long-term care insurance act which aims at furthering the infrastructure of long-term care via model projects. Funding comes from the insurers and the public hand model. The arena that was built by insurers, Land government and project consortium, surely was a highly politicized one as interest conflicts about the structure of the system of health and long-term care were implicitly negotiated here. Direction of change and relation with change modes - vertical change (top-down/ bottom-up): The dementia care net started as a bottom-up initiative insofar as the initiative came from the (later) medical director at the Alexianer hospital. In a horizontal movement he then looked for cooperating partners at the level of the city of Aachen (the general practitioners) and in a second step, vertically, for financing opportunities. As the conditions of application of the federal program and the limited financing also contributed to shaping the project, there was also a top-down-element in this early phase.

The second phase of financing implied a stronger top-down element as the (prospectively) funding bodies required to adapt the project logic to their rationale, too. In doing so, the project consortium benefited from the implementation of the federal law on long-term care insurance by the insurers and the ministry of long-term care at Land level. Yet, the initiators did not succeed in including their model in the regular health insurance scheme and thus transferring it to the federal level. The suggestions about the engagement of the former minister for the further financing of the project also refer to a kind of top-down element, even though not a legislative one. horizontal spreading of change : While in the first phase of funding the dementia care net was limited to the city of Aachen, it was extended to the whole city-region in the second phase. This expansion had been promoted by the insurers' side and by the local authority of the city region that also gave some money for the project and therefore hoped to achieve a better integrated and caring infrastructure in the region. The first phase of the dementia care net was documented in the final report on the federal program of lighthouse projects on dementia care and thus may be regarded as a best practice example. Notwithstanding, the lighthouse projects had received some basic funding, and it is not clear how they should inspire other projects without such initial funding being provided. Modes and configurations of change: displacement, layering, drift, conversion (Mahoney & Thelen, 2010) displacement, layering, drift, conversion, exhaustion (Streeck & Thelen, 2005): The interest to avoid costs from misallocations of patients in hospital as well as the interest of the local GPs' association to reduce the "burden" and challenge that meant patients with dementia to their practices finally motivated the idea of the Dementia Care Net. Its concrete alignment was adapted several times according to the respective financing options. The logic of the Dementia Care Net thus followed a combination of conversion and layering: a known institution (the reimbursement of GPs to enhance their motivation to overtake new duties) was combined with the introduction of a new institution (the case management) that slightly and moderately changed the relation of the different professions who participate in care provision.

Aachen: Network for dementia care / B: Discourses and coalitions

Explicit logic of the change process: The explicit logic of the change process was to establish case management and a dementia care network in the city of Aachen to contribute to a better and more integrated care for persons with dementia in Aachen, facilitate their and their relatives' earlier access to diagnosis and existing services of social, long-term and medical care and social participation and thereby bridge the perceived gap between social, long-term, nursing, and medical care. A more implicit rationale to develop the dementia care net was the hospital's motivation to adapt to anticipated developments in financing priorities of the insurers and to avoid the obligation to pay back financing for persons that would have stayed in hospital without actually qualifying for hospital stays. How advocated: This logic has been advocated by its brokers (the inner core of a pre-existing, informal network related to dementia issues in Aachen around a chief physician at the local for-profit hospital with coverage obligation for psychiatric care for the region of Aachen, the "Alexianer hospital") by arguing that earlier access would enhance both the quality of care and the quality of life of persons with dementia and their relatives. The initiators also pointed to the probable preventive effect which could contribute to a reduction of hospital stays and thus to cost containment and more adequate care. Allies at the beginning: The project was initiated by the medical director of the unit for psycho geriatric care in the Alexianer hospital who could rely on the psycho geriatric centre of the hospital and its staff from

social work, nursing and psychology. Early on, cooperation was close with a member of the board of the local association of general practitioners who assured the association's collaboration. Known and valued representatives from other local networks in the field of dementia and long-term care were found who supported the idea and who were ready to participate in an advisory committee (such as the Alzheimer society, a local provider with almost 30 years experience in dementia care, the manager of the local hospice service point, the social planner of the local authority (and initiator of senior citizens policies' in the 1980s)). Furthermore, representatives of the long-term care insurers at regional level were involved, and the local catholic university for applied sciences was won to do the accompanying research. Allies during the process: With the change in financing (from model project funded by the federal level to a model project funded at the Land level from a special fund of the long-term care insurance) and the regional (from city to city-region) and thematic (from case to care management) expansion of the project, the local authority of the city region, the regional insurers (who seem to have partially stayed a little bit sceptical about the project), and the North Rhine Westfalian ministry for long-term care were gained as further allies. The federal minister of health, who in those days came from the city of Aachen, is said to have contributed to the second phase of financing by convincing the director of the biggest regional insurer to agree in further financing the project. Adverse positions and coalitions: While the initiator of the project aimed to establish in the long run the collaboration of general practitioners and case management in dementia care in the general health insurance scheme on federal level, the insurers doubted this. The insurer's side argued that networking between providers in general as well as cooperation in case management of medical doctors more specifically would belong to their normal, obligatory tasks that would already be reimbursed under the existing payment regime. The general practitioner's association contested this and claimed to only guarantee adequate care for the rising number of patients with dementia if they were to be reimbursed for the related extra-efforts. The local neurologists who were said to have been in latent conflict with the general practitioners in the city preferred a different mode of institutionalisation of providing better integrated care for patients with dementia (that is: via contracts on integrated care according to SGB V) in the initiating phase of the innovation. The initiating actors stuck to the explicit policy rationale from the beginning throughout the whole process and complemented it by arguments of cost containment and a better quality of life and care for clients. What is left from the initial intention? The initiators of the innovation are identical with those who implement it which may explain why the initial intention has persisted. For the second financing phase, the project consortium introduced access criteria to narrow the target group of case management. This should prepare a potential integration of the innovation in the regular health insurance scheme. Notwithstanding, this could not be achieved. New form of rationale? The association of general practitioners focused on the rationale of the repartition of tasks and remunerations. It incorporated integrated care delivery for persons with dementia in this more general discourse. Behind this there is a silent menacing scenario that general practitioners could refer dementia patients to residential care homes which would raise costs. The financing agents (not those who implemented the change) introduced new forms of rationales by promoting to expand the thematic (care management) and regional (city-region) scope of the dementia care net. What about adverse positions / discourses considering implementation? Due to the necessity to find further financing, content (care management) and regional scope (city region) of the initial policy rationale were adapted by the project consortium to the requirements of the financing agents in the second phase. Notwithstanding, the original policy rationale was maintained, too; thus, different rationales were pursued in the same time. There are opposing positions of general practitioners (and neurologists) and insurers on the repartition/ design of tasks and its reimbursement which are constitutive for the German health care system (for what should gps be paid extra money and what should be covered by their regular reimbursement).

Aachen: Network for dementia care / C: Scales

Analysing the content of change in the context of the national system. The innovation of the dementia care net in Aachen addresses the fragmentation between social and medical care which is a strong characteristic of the German system of health and long-term. It does this successfully at local level by involving general practitioners in a network that aims at enhancing not only medical treatment, but also social care and participation for the persons affected by dementia and their relatives. But regarding sustainable implementation, the stakeholders seem to fail precisely because of the gap which shall be overcome as the fragmentation between medical and health care is strongly anchored in the basic construction (structure, relation and financing modalities) of the regime of health and long-term care. Additionally, it is backed by professional cleavages and relations of subordination of professions that are enforced through rules, regulations, practices and resources. At what policy scale does change happen? Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority, etc.) ? What specific scalar dynamic ? In the first financing phase, change took place at municipal level with the modified and more comprehensive treatment of patients who are referred to the network. The second financing phase induced change at the regional level as the case management now is extended to the city-region (but to a narrower target group), and the managing office of the dementia care net is additionally responsible to investigate chances for a regional, dementia related care management. Tensions seem to exist between the regional/ Land level of insurers and the project consortium at the local level, but also with the national level where the fragmentation of the regime of health and long-term care regime is anchored. The adaptation processes to assure financing show a specific scalar dynamic. To secure further financing for a second project phase the initiating actors at the local level have to adapt their plans and intentions at least partly to the

requirements of the financing insurers at the Land level. In doing so, the project consortium benefited from the implementation of the federal law on long-term care insurance by the insurers and the ministry of long-term care at Land level.

The care conferences in Hamburg

Hamburg is a wealthy service-centred state-city. The social-democratic party has won most of the Land elections since World War II and influenced much of the social policies at Land level. As in most West-German cities, the welfare mix in charge of the long-term care delivery is diverse, but the traditional welfare associations (*Wohlfahrtsverbände*) have developed a very strong position. Those associations are clearly related to the Protestant Church (Diakonie), the Catholic Church (Caritas) and the labour movement (Arbeiter Wohlfahrt) (further: German Red Cross (DRK) and some others). The case study focuses precisely on care conferences as an instrument of governance of the long-term care system at local level. This instrument can be used for various purposes. Initially, care conferences were aimed at balancing the influence of the private market in long-term care introduced by the federal law on the compulsory long-term care insurance. In the system prevailing until the introduction of the 1995 reform, local authorities were a key actor both in the planning, organizing, and financing of long-term care providers. German municipalities had integrated their key role in this precise domain of long-term care in various complementary services such as transport or leisure for instance. The 1995 federal law introducing a private care market has been viewed as a serious attack on the local tradition of care delivery. The instrument of care conference was imported from the West-German Bundesland even more marked by the social-democratic political tradition: North-Rhine Westphalia. This instrument has been developed from the 60's onwards in the context of this social-democratic fortress to serve the objective of strengthening the efficiency and the equity performance of social service delivery by raising the coordination among service providers. In the late 90's in the Hamburger context, this instrument was conceived as an answer to the threats to solidarity and equity associated at that time with the introduction of a private market in long-term care delivery.

The content of the care conference principally encompasses the governance structure of the long-term care domain. It is supposed to improve the coordination of the care providers. It is not supposed to implement concrete action but it should mainly foster mutual understanding and a common view on the local situation of as many local actors as possible. It can be interpreted as a cognitive policy instrument aiming at triggering change by persuasion, mobilisation and coordination of actors. From this betterment in coordination are expected positive outcomes on specific issues such as care management, planning, quality, etc.

As a governance instrument primarily, the care conferences target in the first place organized actors. All groups, organizations, providers, companies, associations, professionals of the health sector, etc. who are active in that domain of long-term care are invited to take part the care conferences. In Hamburg, care conferences are organized at the level of boroughs, which are rather big units in this big state-city: for example Eimsbüttel has almost 260 000 inhabitants and Altona, more than 240 000.

As the mission and the competencies of the care conferences are not defined in further detail, leaders or heads of these micro-local instances might do the most various things with those. The following activities are for instance provided by various Hamburger care conferences attached to various boroughs: common reflexion in the network of providers about a specific issue (such as nutrition, leisure or sports activities, palliative or terminal care, etc.); provision of information about the neighbourhood (addresses, contacts, statistics, needs, epidemiology, etc.);

information of beneficiaries and families about the themes and issues of reflexion (dementia, health care and personal care, quality issues in care, etc.).

Both the first two types of activities are dedicated to professionals of long-term care delivery. But, the third one should be open to the public. Those information sessions should indeed play a part as an activity of public health, mostly concerning itself with prevention or the promotion of health maintenance.

Hamburg: Care conferences / A: Mechanisms of change

What segments / elements of change can be attributed to non institutional actors and to institutional actors?: The bulk of the change process was carried out by institutional and by elected actors. The introduction of the care conference as an instrument of the long-term care policy of the city-state of Hamburg was the result of a political and institutional process. It was obviously a key step in the process of change.

There are however at least two as important steps that are much less univocal than the first one. In the first place, care conferences had to be implemented at the level of the boroughs, constitutive administrative but as well political units making up the city-state of Hamburg. This borough level implementation was not compulsory. Some boroughs have been very early adopter (Harburg) of the instrument whereas others did so only 7 to 8 years later (for instance Altona or Eimsbüttel). The boroughs decided to found care conferences on the basis of personal initiatives, projects and networks that were only in few cases carried out prominently by administrative or institutional staff. In most cases, small teams built around actors working for private companies, GPs, researchers, managing staff of associations, etc. were important leaders in the process of constituting the care conference at the level of the borough. Finally, the last and concretely operational level of the care conference is the one of the working groups. These groups do the job of network constituting and organisation of the local debate on specific issues. In the vast majority of cases – this is for instance clearly the case in the borough of Eimsbüttel – the majority of the working groups are run by volunteers, professionals, managers of private long-term care providers, etc. As a policy instrument, care conferences are consequently the result of an institutional process. But as an operational instrument, there are clearly a grass-root instrument anchored in the local civil societies. What decision making arenas? non institutional and institutional arenas: The arena that crafted or more precisely adopted the care conference as a regular policy instrument was clearly an institutional and a rather politicised one. The level of the borough, as a rather “low politics” oriented grass-root mode of governance, appears at first sight to be less institutionalised and politicised. The influence of local actors representing the policy domain itself is stronger at this level. Finally, the operational level of the working groups is clearly related to the arena of the local and specialised segments of the “civil society” stakeholders of long-term care. However, those participants to the working groups may and do indeed represent a high variety of values, interests, needs etc. The level of politicisation of this level should consequently not be underestimated. Direction of change and relation with

change modes - vertical change (top-down/ bottom-up) and horizontal spreading: The vertical logic of change is clearly a top-down one. The instrument of the care conference was meant to be adopted by the boroughs at a decentralized, grass-root level. Precisely, the autonomy of the boroughs in the choice of the implementation form they make of the instrument has been preserved over the years and in the two laws of the city-state of Hamburg on the implementation of the federal system of long-term care insurance. The top-down dimension of this process was clearly balanced by the autonomy of the boroughs and by the fact that the implementation of the instrument was not mandatory. In that context, the level of homogeneity or constraints in the horizontal dimension of the development of the care conferences developed in the horizontal dimension over a long period is rather weak. Moreover, the boroughs adopted various systems of management of their care conferences. Some models are more centralized and the possibility of control by the administration of the borough is more important. Some other (this is for instance the case in the borough of Eimsbüttel picked for the sake of this study) organised an network-like governance system of the care conference, via a collective direction committee (Lenkungsgruppe).

Modes and configurations of change: displacement, layering, drift, conversion (Mahoney & Thelen, 2010) displacement, layering, drift, conversion, exhaustion (Streeck & Thelen, 2005): According to the typology in terms of mechanism of change, the introduction of the care conference is clearly a process of layering. The introduction of this specific policy instrument does not replace a former one, nor is it the reinterpretation or the reframing by local actors of specific agreements or institutional rules.

Hamburg: Care conferences / B: Discourses and coalitions

Explicit logic of the change process: The explicit logic of the change process was to improve the coordination of the various stakeholders of the aged policies and especially of the long-term care policies at the point of delivery.

How advocated: The Hamburg government had added this policy instrument in the context of his long-term care policy in 1998 in the context of the implementation of the by then new federal law on long-term care insurance. The instrument was aimed at balancing the negative effects for social coordination expected from the introduction of the market principle in the aftermath of the new federal law. Care conferences were associated with an improvement in coordination, a useful decentralisation of the steering of the implementation, an improvement in the quality of service delivery, and less explicitly, with an easier participation of all stakeholders, be they providers or users of the policies for the aged and more specifically of long-term care policies. The instrument was then integrated in the second version of the official law on implementation of the federal law on long-term care insurance. It was voted by the first conservative majority in the Land of Hamburg for decades and it was much less emphatic about the instrument. The instrument of care conference was however kept in the law. The explicit objective set to the instrument is the improvement of quality in service delivery.

Allies at the beginning: The need to improve the coordination between the actors of the implementation of the German system of domiciliary long-term care at the point of delivery is not a point of disagreement. In the Hamburg network of long-term care providers, there are harsh debates about the “usefulness”, the “efficiency” or the “dangers” of the market principle, but the necessity to better coordinate the actions is acknowledged by all. The private providers, but as well in an increasing manner, even the semi-public providers are however more and more sceptical about the effects and finally about the necessity of coordination instruments.

Allies during the process: The care conference has convinced a big number of allies over the years, as many actors of all status, importance, professions or activities, have joined the various working groups in the different boroughs of the city-state of Hamburg.

What adverse coalitions ? A relative hostility or indifference has developed over the years about the instrument of care conferences. The lack of concrete outcomes of the process, the raising tensions in the competition among actors, the worsening of the situation of most care providers are the reasons cited for the downturn in the interest for this instrument. This raising hostility or indifference has however not developed to a resolute opposition. There is not so much at stake in the case of this instrument. The care conferences are as good as not financed by public budgets. They just get a few hundreds euros a year to pay for very little expenses. It is actually a totally voluntary instrument of mobilisation. As such, there probably never will be any explicit radical tension about this instrument.

How has the initial policy rationale been transformed all along the change process? In the first official texts by the Land of Hamburg (not integrated into the law), the initial design of the instrument was very open, and made way to an important potential for a very decentralized definition of the tasks to be done by the care conference itself. This first version of the care conference was not very successful, probably because the decentralization of the city-state administration was not achieved by then.

Considering implementation, what is left from the initial intention? Has a new form of rationale been developed by the actors of implementation? The initial rationale of the instrument has not been modified in the formulation of the goals of the care conference. Care conferences should improve the coordination of the various stakeholders of the long-term care domain via a collective thinking and elaboration. However, the autonomy of the care conference, and notably, the capacity of its members to define its own attribution and to influence the power relations with the borough administration have been restricted. The capacity of the rationale as it was originally formulated is presently however getting weaker and weaker.

What about adverse positions / discourses considering implementation? The debate about governance of long-term care service delivery in Germany is still very much centred on the coherence of the choice of the market principle as the basic guiding principle. In that context, debates and oppositions about care conference, that appears to be an instrument aimed at balancing this market principle, is only a marginal discussion. The debate is restricted, at individual level, to the opportunity of participating to this collective process or, at a more general level, to the opportunity of maintaining this instrument.

Hamburg : Care conferences / C: Scales

Analysing the content of change in the context of the national system. Care conferences can look back to a rather long history. This instrument developed in West-Germany in the Bundesland (state) the most clearly associated with the influence of the social-democratic party. The concept of soziale Stadt, typical of the social-democratic repertoire of the 70's aiming at combining social justice (Gerechtigkeit) and efficiency via a better coordination and an improved democratic functioning of social policy implementation is at the heart of the of the social-democrat social policy tradition. This objective has found a new relevance in the context of the new federal law on long-term care insurance. Under those circumstances, the care conferences have been re-framed in the mid 90's as a way to balance the effects of the introduction of the market principle as the key principle of service delivery in the new framework. This context explains the adoption of this instrument by the – then SPD led – city-state of Hamburg. The tensions around the regulation of the welfare mix at the point of delivery were not solved by the implementation of the care conference. On the contrary, those tensions seem to have grown, notably about key issues such as the patients discharge, the

structuring of the competition between types of providers, etc. At what policy scale does change happen?
Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority... etc.) ? What specific scalar dynamic ? Care conferences are an institutional innovation that first makes sense in the national German context. The relevant policy scale at stake here is however not the one of the national institutions but is the one of party politics. The social-democratic tradition and networks are the inspiration of the model adopted by the SPD led city-state government of Hamburg in 1996. The integration of the instrument in the Land's legal system has constituted a new scale of policy regulation. Within this new frame, and from a rather open legal and institutional basis, the actors intervening in the context of the boroughs have developed their own versions of the instrument of care conference. Finally, the boroughs are constituting a frame within which the local actors are constituting, at grass-root level, the networks which are the real targets of the instrument. Naturally, at this apparently micro-level scale, the various actors at stake are related with their own traditions, political networks, or panels of clients. It can appear as a paradox at first sight, but the variety of opinions, values, expectations, needs, etc. is much higher at this micro-level scale, than this is the case at the scale of the policy choice in favour of the instrument of care conference.

Section B: Scottish local case studies

The re-ablement service in Edinburgh

Within in the Scottish context, Edinburgh is a wealthy service-centred city. It has long been marked by the labour tradition. The conquest of the city council by the Liberal-Democrats, in a coalition with the National Scottish Party in 2007 was a big event in Edinburgh's politics that triggered many policy changes.

The reform analysed in the case of Edinburgh is precisely one of those changes initiated in the aftermath of this political change. The "Home care Re-ablement service" consists in providing six-week long intensive care principally to people leaving the hospital or referred by General Practitioners or by other instances. The explicit aim of the program is to "*empower*" the beneficiaries and to help them to "*gain autonomy*" at a further stage of their life at home. This service is in fact a new type of patient's journey implying a specific type of coordination of various services of care providers. It is also part of a much more ambitious program of reorganization of the health and care provision system for the aged in Edinburgh.

The re-ablement model implies a strong co-ordination of various services representing an important break with the traditional organization of care delivery in the context of the Scottish Free Personal Care scheme. One of the most difficult issues intensively discussed in the British health system, specifically about the frail older population, lays in the coordination between the National Health Service and the *social care* which refers to the whole of the home-based long term care. The "Home care Re-ablement service" tackles this structural issue and addresses the intricate matter of coordination between acute care (NHS) and social care, which often delays patients' discharges from the hospital (bed-blocking issue).

However, the introduction of this instrument is part of a broader reorganization strategy of service delivery at the level of the Edinburgh City Council. This reform aims at a far-reaching privatisation of long-term care services. Only the re-ablement service should be kept by the City Council's own services. The rest of the delivery is attributed via a tender (negative auction), benefiting private companies most of the time. This strategy of privatization of service delivery is a break from the tradition of strong municipal social work department. The organisation of a tender has lowered the prices paid to providers. It is also said to have lowered the quality of care delivery.

The implementation of the re-ablement service is still recent and the privatisation of the long-term care service provision has yet not been completed. 50% of domiciliary care provision for the aged is presently still in the hands of the public. The objective of the City Council is to reduce this amount to the lowest possible rate.

What segments / elements of change can be attributed to non institutional actors and to institutional actors?: The initiative for the change process was **completely driven by actors from the institutional sector**. The change in the orientation of the political majority resulting from the election of 2007 has triggered the decision of shift in the structure of delivery of the domiciliary long-term care.

The origin of the reform content is however a more debated issue. The head of the social service department in the City Council, who is simultaneously the head of the regional NHS (Lothian), but various over high-ranking officers of the City Council claim to be the architects of the re-ablement program. In any case, the various segments of reform at stake (re-ablement, cost reduction, privatisation of the service delivery, betterment of the coordination with the NHS) should be seen as a package reform, all initiated from the centre of the City Council administration. The influence of the Scottish government, via the Joint Improvement Team, has as well played a major role, but does not fundamentally change the nature of the actors at stake. No non institutional actors.

What decision making arenas? non institutional and institutional arenas: In the case of Edinburgh, the clearly most important decision-making arena has been the one of the Local Authority. All relevant actors are directly linked with the City Council of Edinburgh.

The notable influence of the Scottish Government is mentioned. The relations between both arenas make up an interesting scale of reform. The relations between the NHS and the City Council as well as the Scottish government are framing a further scale of power. Direction of change and relation with change modes - vertical change (top-down/ bottom-up) and horizontal spreading: The re-ablement program is clearly a top-down process. Initiated, coordinated and implemented by political, hierarchical actors who impose their decision on the social actors they control in the policy domain. If one considers however the pressure expressed by the central Scottish Government to obtain from the local authorities a reduction in the costs of the Free Personal Care (Scotland-wide program), then, the re-ablement program appears to be a decision-making process happening a specific context, activated and oriented by the central Government. The horizontal spreading of change is in this case included in the reform itself. The introduction of the re-ablement program has taken place at the scale of the entire territory of the Edinburgh City Council.

The privatisation of the provision has been launched via the organization of a tender structured horizontally. Most of the zones (territorial divisions) of the City Council territory have been won by private firms. One zone is still under the responsibility of the City Council's own services. The introduction of the re-ablement service itself has been extended to the whole territory of the local authority after a short experimentation in a specific neighbourhood. Modes and configurations of change: displacement, layering, drift, conversion (Mahoney & Thelen, 2010) displacement, layering, drift, conversion, exhaustion (Streeck & Thelen, 2005): In the case of the Edinburgh re-ablement program, the pattern of change seems to correspond to the most radical form of change among the categories proposed by Streeck and Thelen. It is clearly a case of "replacement". The old institutions – in this case, the classical patient journey and the public service delivery – has been replaced by a new regular trajectory (first re-ablement and then regular personal care) and a new type of service delivery. Various institutions or policy instruments can be considered as complete innovations in the context of Edinburgh. The tender procedure is one of those innovations. The specialization of the Councils' own services on the activity of re-ablement away from the delivery of regular personal care, can be considered as a displacement.

Edinburgh: Reablement service / B: Discourses and coalitions

The explicit aim of the program is to "empower" the beneficiaries and to help them "*gain autonomy*" at a further stage of their life at home thanks to the intensive use of re-ablement. Concretely, re-ablement mostly consists in treatment by Occupational Therapists.

How advocated: The explicit aim of the program is the rationale presented during the whole reform process / The objective is to re-able, re-habilitate the beneficiaries. There are however at least two explicit and central complementary goals to this reform. The reduction of expenses in long-term care at a further stage of the patient's journey is a first key complementary goal. The improvement of the coordination between the NHS and social care is a second very important goal directly related to this reform agenda. It is worth mentioning that there is another goal to this reform, which might be less explicit and which is much less advocated by the Council, but which was a strong motivation for the introduction of the program, is the privatisation of the service delivery. The City Council's own social work department has been put in competition with market actors via the organisation of a tender with private providers (negative auction). The social work department of the City Council will keep 100% of the implementation of the re-ablement program. Allies at the beginning: The City Council of Edinburgh has been the most direct and active actor of this reform. The reform was introduced after a political change in the 2007 local authority election. The core of the re-ablement program has been introduced by the Council itself, and has been decisively supported by the Government of Scotland and by the support agency the central Government has set up (Joint Improvement Team) to assist the local authorities to master more effectively the costs of implementation of the Free Personal Care program (national Scottish program). Allies during the process: During the process, the City Council has implemented its decision with a very steady hand and has benefited from the support of the Government. It has also looked for the support of the regional NHS to implement the dimension of the re-ablement program concerning the issue of bed blocking that can only be tackled with the active support of the NHS. The local private care providers have become active supports for the reform. Summarizing, the allies for this reform were rather weak. They were mostly concentrated at the core of the institutional network of social care governance, i.e., in the City Council, in the Government and in the Joint

Improvement Team. Other allies, such as the NHS were more reluctant to join and less active in the implementation. What adverse coalitions ? Discourse on the need to preserve a public provision: The City Council has faced a very weak opposition to its plan to shift the balance of care away from public services to new forms of private provision. Academic evaluation has been the only public source of explicit critical appraisal of the change process. The ground for this negative appraisal was an evaluation of the services and rests on issues of quality. The employees of the City Council services were very critical as well of the whole privatisation process but did not have a real opportunity to influence it. How has the initial policy rationale been transformed all along the change process? The implicit logics were targeted at mastering / reducing the raising implementation costs of the Free Personal Care program. The improvement of the coordination between the NHS and the social care, as well as the tackling of the bed-blocking issue and the privatization of the care service delivery, are the two important goals of the program. The initial goal that has triggered the whole process, is indeed the one that was the less explicit, or at least the least advocated by the local authority. The re-ablement program appears to be a way to justify the reorganization of the service delivery via arguments of efficacy (capacity of the program to concretely improve the health situation of the beneficiaries). The privatisation of the care delivery is the result of this rationale. The fact that the City Council's own social-work services have kept the implementation of the re-ablement activity, which is certainly an explanation for the weak opposition of the employees. The «success» of the Edinburgh experimentation of re-ablement has been taken up by national institutions (Joint Improvement Team, Government of Scotland), as an example other Scottish Local Authorities should implement. Considering implementation, what is left from the initial intention? Has a new form of rationale been developed by the actors of implementation? In this case, the initiators of the innovation were also the actors of the implementation of the decision. This might explain why the initial intention seems to have persisted through implementation. The decision to introduce the re-ablement program could not be blocked by external actors. The new political majority in the City Council took and implemented the decision. Over time, the actors of implementation have changed as, private providers are now almost prevailing and continuously improve their market share. Those actors are naturally satisfied by this progression. The relative achievement of the initial policy goal and the way it has been implemented without drifting much from the initial goals has made the formulation of a new kind of rationale rather superfluous. What about adverse positions / discourses considering implementation? Two adverse and rather critical discourses have been disclosed during the research. In the first place, the employees (i.e. the street-level bureaucrats) of the City Council's social work department are rather sceptical about the success of the privatisation and suggest that the quality of provision has seriously worsened since the introduction of the re-ablement program. The second critical discourse comes from an academic evaluation of the quality of domiciliary care delivery since the privatisation of the provision.

Edinburgh: Reablement service / C: Scales

Analysing the content of change in the context of the national system. As programs of re-ablement (previously called rehabilitation) have been practiced for decades in the Western world it can hardly be considered as a innovation. This program might however be understood as an innovation (but again, not “from scratch”) in the Scottish context, as it is here clearly associated with a goal of cost reduction. In that context, the example of the English Local Authority of Leicester has inspired very much the Edinburgh case. The other dimensions making up the case of Edinburgh re-ablement program an “innovative” one can be understood like this rather in the Scottish context than in the British one. Indeed, the almost complete privatisation of the service delivery is rather infrequent in Scotland, but is much more common in the rest of Britain, and specifically in England. Lastly, the betterment of the coordination between the NHS and the social care provision has been for decades a very debated and complex problem. The Edinburgh model of a unique control of both services of the NHS and of the social services of the City is a radical innovation as well, much commented in the national British press. At what policy scale does change happen? Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority, etc.) ? What specific scalar dynamic ? The re-ablement model makes specifically sense in the context of the relations between the Scottish central government and the City Council of Edinburgh. Those relationship are structured by the Joint Improvement Team and by COSLA (association of Scottish Local Authority). The context of decision-making process was hence influenced by those institutions. However, the core of the decision rests with the Edinburgh City Council and its decision to radically transform the nature of domiciliary care delivery in the context of the Scottish Free personal care program.

The Fife Users Panels : participation of frail elderly people in community care

In the UK, the 1980s and beginning of the 1990s witnessed a policy shift from producer to consumer led interests in social services. This shift was materialized by the 1990 NHS and Community Care Act which required, among other things, the increased consultation of social care authorities with users, carers and voluntary organisations. User-led participation was seen as a means to ensure responsiveness and accountability on the side of public services.

The User Panels were created in 1992 in Fife by the Scottish Branch of Age Concern, a UK wide voluntary organisation representing the interests of older people to policy makers. The organisation ran the panels from 1992 till 2009. In the beginning of the 1990s the organisation had begun to change its views with regards to the forms that elderly participation could take. It began recognising the importance of ensuring that older people, in particular frail elderly people, have the possibility to speak out rather than having staff decide what they think their views are. In 2009 Age Concern decided that the User Panels were no longer a priority and decided to stop running them. Later that year Age Concern and another UK wide organisation called Help the Aged decided to merge, becoming Age UK. As a result, Age Concern Scotland no longer exists and has closed its operations in Fife. Faced with this situation, Fife Council and NHS Fife agreed that the User Panels were useful in particular with regards to consultation for service planning and delivery. The requirement of the 1990 NHS and Community Care Act on social services departments to listen to users in service planning and delivery was also still in effect.

Today there are 6 User Panels spread out throughout Fife. Each panel has between 8 and 10 panel members. The criteria for selection are still the same as when the panels were first established: older people over 65 who are frail and have mobility problems, meaning that they make considerable use of community care services and are not able to be active in other types of elderly fora.

It should be mentioned that today still, there are very few examples in Scotland of house-bound frail elderly people's involvement in the consultative process. This is not only due to the health and reduced mobility implications of their frailty, but also because opportunities to take part are rarely designed with house-bound people in mind.

The introduction of the User Panels regards mostly the dimension of participation. If we were to link the User Panels to a model of participation of elderly in social services and research they would now mainly correspond to a consumerist approach, in the sense that at least from the part of Fife Council and NHS Fife (as was revealed by interviews) the User Panels and user participation in general are seen as means to enhance efficiency and reduce costs. Listening to the User Panels and users in general is seen as a means to an end: the end being making services more responsive to older people so that resources are well allocated and that money is not badly spent in particular in a financial climate dominated by austerity measures. The focus in Fife is on welfare needs and not participatory rights. With the Free Personal Care demands for services exploded in Scotland and in Fife and there was also an important increase in spending. For all the

interviewees financing and budget were deemed as the main issue affecting home based care for the elderly. The debate is how to reduce costs while maintaining a high level of quality. The User Panels and user participation in general are seen as means to do that. When looking at the degrees or levels of participation, it should be noted that the Fife User Panels are mostly partial, in the sense that although they might influence service planning, the final power rests with the Social Work department and NHS Fife. Both these agencies are the ones that decide to what extent the User Panels' views and input will be taken into account.

Fife: user panel / A: mechanisms of change

What segments / elements of change can be attributed to non institutional actors and to institutional actors?: The initiative for the change process was initially fully driven by Age Concern Scotland. Yet Age Concern Scotland workers consulted with elderly people from the beginning onwards regarding the overall organisation of the meetings. For example, the members-to-be were the ones asking for monthly meeting rather than the initial proposition that consisting in holding a forum once every 6 weeks. In the first years of the panels' existence, older people themselves set the meetings agenda. As a result, though the change did not stem from the elderly, they nonetheless had a say at all stages of the setting-up process. The local social and health authorities never interfered with the how the Panels worked or never decided upon eligibility criteria. These decisions have always been down to Panels coordinators (officers from Age Concern Scotland first then, from 2009 onwards, the Fife Elderly Forum). The very continuing existence of the Panels has been maintained and ensured by institutional actors, namely Fife Council and NHS. After Age Concern Scotland decided to close down all operations in Fife and to stop funding the Panels, Fife Council and NHS transferred the Panels under the responsibility of the Forum so that that they would not be discontinued. What decision-making arenas? The setting up of the Panels has not necessarily led to institutional change or landmark decisions. Interviews revealed that although the panels are consulted, this is not done in a systematic way and does not always necessarily lead to concrete results. Consulting and involving the panels is more of an encouragement than a requirement. Although interviewees from social and health authorities welcomed the work of the panels and their responses showed a change in the credibility and usefulness accorded to the panels, the influence that panel members have on service provision seems to largely depend on the saliency of issues. When the issues raised by panel members resonate with issues that have also been identified by local social and health authorities as being important, then it is more likely that the concerns and ideas raised by the panels will be reflected. In addition, It should however be noted that at this stage of the research it is still too soon to provide a solid basis for this assertion and thus it will be further explored.

Fife: User panel / B: Discourses and coalitions

Explicit logic of the change process: The explicit logic of the change process was to encourage the participation of frail older people in community care by providing them with a meeting place where they could both discuss or review services and get access to better flowing information on the care-related services. Age Concern Scotland (a UK wide voluntary organisation which initiated and supervised the change process) was concerned that house-bound and frail elderly people were not being consulted enough (or not consulted at all) on service planning and service delivery. How advocated: Age Concern Scotland advocated the change by putting forward the fact that although local authorities were encouraged by the National and Community Care Act to consult more with users about service planning and delivery, they were not doing enough when it came to elderly people who were too frail to get out of their homes. At the time, user involvement was becoming a statutory requirement. As a matter of fact, following the 1990 piece of legislation which required, among other things, the increased consultation of social care authorities with users, carers and voluntary organisations, groups of vulnerable people had started emerging in Scotland yet Age Concern Scotland officers argued that only frail elderly people were never given an opportunity to articulate their own concerns and opinions. The panels were more specifically designed with house-bound people in mind. Allies at the beginning: Initially the panels were supported and financed by a fund-raising charity called Charity Projects which granted Age Concern Scotland around £125, 000 for the setting up of the panels. Local service providers at different levels also helped overseeing the overall organisation of the panels as stakeholders ranging from home carers, health visitors or GPs to social workers and districts nurses provided Age Concern Scotland team of workers with names of older people likely to fit the eligibility criteria for panel membership. Allies during the process: Three years after the panels started, Fife

Council and NHS Fife began funding them. The User Panels were well received by local social work and health authorities whose representatives would sometimes be invited to attend the panel meetings. Due to the merger of Age Concern and Help the Aged at the UK level and the constitution of New Age Scotland, Age Concern Scotland stopped operating in Fife in April 2009 and the Panels now fall under the responsibility of the Fife Elderly Executive. Today, the Panels continue to be funded by Fife Council and NHS Fife, which goes to show how they are now deemed an essential feature of community care planning.

Fife: User panels / C: Scales

Analysing the content of change in the context of the national system. In the UK, the 1980s and beginning of the 1990s witnessed a policy shift from producer to consumer led interests in social services. This shift was materialized by the 1990 NHS and Community Care Act which required, among other things, the increased consultation of social care authorities with users, carers and voluntary organisations. User-led participation was seen as a means to ensure responsiveness and accountability on the side of public services.

Today the Fife User Panels continue to be quoted as a best practice example and are quite unique in nature, in the sense that there are very few examples in Scotland of house-bound frail elderly people's involvement in the consultative process. This is not only due to the health and reduced mobility implications of their frailty, but also because opportunities to take part are rarely designed with house-bound people in mind. At what policy scale does change happen? Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority, etc.) ? What specific scalar dynamic ? Today there are 6 User Panels spread throughout Fife, with 8 to 10 panel members for each. The Panels have influenced, been consulted on and had input to health and social work service provision within Fife. They have also sometimes been consulted or mentioned in/by Scotland-wide projects such as the NHS Quality Improvement Scotland Draft Standards or the Scottish Executive Joint Future Group on joint working in delivering community care services, among others. Typically, they would be cited as best practice example to be followed and implemented elsewhere. Yet in terms of concrete change and practice, the Panels have only been operating in Fife and have engaged in working with the local network of health and social care workers in Fife only.

Section C: Swiss local case studies

The Geneva Lunch in the community

The city of Geneva is the capital of the canton of. It is the biggest of all 45 municipalities. While the canton is more oriented to the centre-right, a left-wing majority has long governed Geneva. In Switzerland, a federalist country, the canton of Geneva pioneered the centralisation and development of home based long-term care. The canton adopted its own legislation on home-based care as early as 1992, while national shift occurred in 1995.

The innovative service of home based long-term care called « Around a table »⁴⁶ is the result of a collaboration between the City of Geneva and the cantonal home-based-care association FSASD. The aim of this project is twofold: on the one hand, it aims to prevent the isolation of elderly receiving HBLTC and on the other hand, it aims to prevent malnutrition, as both issues have been identified as crucial issues –even as unintended consequences - of HBLTC policy development in Geneva. It is inspired by a *community action model*, as part of new attributions of the social service of the City from 2002 -the municipality is supposed to focus on community action while the canton is mainly responsible for individual care.

The project was first implemented as a pilot project in a City borough in 2005. The experience then spread to other areas of the City and in 2011, the City of Geneva and the FSASD agreed on a convention that made their collaboration on this project official. Meanwhile, the project spread to other municipalities. Today, this new service provides the opportunity for people requiring a meal-on-wheel service to eat lunch outside their home, in a restaurant and in the company of other people. The project is built as a collaboration between the social service of the City of Geneva and the cantonal Spitex organisation.

The development and implementation of the project “Around the table” can be understood as an innovative process, strongly influenced by social learning and by the political will to develop community action at local and sub-local level. As a result, new collaborations have been built between local and cantonal actors, as well as between private for profit actors, city social service and informal volunteers. Nevertheless, the analysis of the evolution of the project can also be understood as a process of normalization and standardization of its most innovative content, mainly regarding quality and participative dimension of HBLTC policy.

Geneva: lunch in the community / A: mechanisms of change

What segments / elements of change can be attributed to non institutional actors and to institutional actors? The first impulse for change process came from the political and institutionalised actors at both cantonal and municipal levels. On the one hand, the cantonal health department minister asked the main HBLTC non-profit organisation (FSASD) about the possibility to develop such project. The FSASD initiates a learning process about its meal-on-wheels services by mandating an
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⁴⁶ « Autour d’une table ».

academic research from the University. One result of the report was to design of the project “Around the table”. Meanwhile, the social service of the city was developing community interventions, in the context of the 2001 law that has divided the health and social activities between the canton and the City. As the canton was mainly responsible for individual help, the City was in charge of community action. This new configuration represented an opportunity window for the leader of social service of the City to develop the project. For this project was inspired by the experience of the canton of Bern 20 years ago (Stamm-Tisch). Hence, at a second stage, the process of change was driven by the concrete collaboration between the social service of the city and the FSASD. It then follows the logic of a *pilot project* and was first tested in one borough of the city. At that level and from that moment, the development of the project can be attributed to motivated social workers with the support of the person in charge of the sector in the FSASD. The project is included in the specific activities or functioning of each UAC. Hence, the social workers – inspired by community care – constituted the grass-root network and developed the concept with the FSASD officials. Lastly, in a third stage, the experience in one specific borough inspired the social service of the City that attempted to develop a new concept at the City scale, providing services complementary to the one of the FSASD. The social service created a specific association, *Entourage*, including the different partners of the associative and institutionalised field. But this attempt failed for political reasons. What decision-making arenas? informal, non institutional ones? institutional, politicized, public ones? At an operational level, the project “Around the table” was officially included in the list of services of the FSASD and financed the same way as the regular meal-on-wheels. Regarding the City, the level of decision is the UAC, which can decide to develop a project or not. 6/8 UAC developed a project. In a second step, the setting of the project and its development at the borough level led to an official cooperative agreement between the City of Geneva (its social service) and the FSASD in 2011. This agreement reflects better the current practice that has been developed since 2005 than the result of a political compromise. Therefore, its degree of politicisation is low. Nevertheless, this agreement confirmed the main position of the FSASD (and therefore the canton) in this project and the role of support of the City (through its Unity of Community action). By contrast, the setting of the new project *Entourage* – which was a City level project - was highly politicised and for this reason, was finally cancelled. The issue was both the financing of the project (instead of the individual complementary allocation for elderly provided by the city) and the type of jobs that should have been created (jobs for long-term unemployed). Significantly, the project was backed up by socialists, and contested by other socialists. Modes and configurations of change: layering, replacement, displacement, exhaustion (Streeck, Thelen) Regarding its development in the general context of HBLTC, the project can be considered as the result of a *learning process*. The FSASD reconsidered its meal services and decided to add a new service to take the new information into account. Regarding the transformation of the social service towards community care, the project can be analysed as *conversion* process, as we observe a rearrangement of the structures towards new purposes and new audiences (namely frail and isolated elderly receiving HBC). Nevertheless, as an institutional change inside the FSASD, the mechanism is the one of *layering* as it is simply added to regular services.

Geneva: lunch in the community / B: discourses and coalitions

Explicit logic of the change process: As a new concept, the project “Around the table” was presented first as the result of a learning process at cantonal level as it was conceived through a scientific evaluation of HBLTC services, in the context of a more general reflexion on the consequences of the HBLTC cantonal policy. Moreover, part of the project was grounded on the importance to develop community action at local level. Hence, the explicit objectives were to prevent the isolation of the frail elderly and to promote healthy alimentation, though collaboration between cantonal and local services. Even though the cantonal authorities may have prompted the first idea, the development of the concept was clearly part of the operational side of HBLTC. Hence, it did not generate political debates. How advocated: In its first stage, the active promoters were social work scientists and professionals. They argued that HBLTC had an un-intended consequences, namely *isolation of frail elderly* and that meal-on-wheels services did not solve the under-alimentation problem, as the solution was more in *conviviality* than in nutritive elements. The FSASD argued it needed local collaboration in order to develop and implement the concept and the City government got involved. The city social service presented the project as part of its new general political attempt to develop local community care. This was a way for the city to profile itself in the context of a strong cantonal HBLTC policy and to try to preserve historical proximity relations with the aged population of the city, especially regarding isolation issue. Allies at the beginning: The alliance between the FSASD and the City social service on the project was easy to realise, as both actors were looking for such a new concept. Allies during the process: The first alliance of FSASD and the City were consolidated during the process. If they were no opposition, the project did not generated neither a very encompassing alliance. New punctual alliances were created with the sub-local UAC and especially with the more convinced social workers. The scientific actors that were present at the beginning did not participate in the debate any more. What about adverse positions / discourses? The project was not contested frontally, neither criticised at the beginning. Some actors of the network, regarding its relatively limited quantitative development and the difficulty to measure its success, may have considered it with indifference. How has the initial policy rationale been transformed all along the change process? For the City social service, the policy rationale has been transformed independently of his specific project. In the beginning, the project was part of a new set of activities that was supposed to define the new scope of community action regarding the elderly. The frame for community action was quite open and some UCA would have liked to

develop the *empowerment* dimension of the project. In a second time, the City developed its approach of community action as way to impulse and make projects more autonomous. The project “Around the table” does not fit this new definition but it has developed along its own logic (as a collaboration with the FSASD). Hence, it was not at the heart of this model. For the canton and the FSASD, the rationale has shifted from a social learning process with political commitments to a discourse about institutionalisation and normalisation of a new service. Considering implementation, what is left from the initial intention? Has a new form of rationale been developed by the actors of implementation? Through the implementation of the project, the initial intention to develop alternative services for the elderly has been conserved as well as the idea to develop collaboration between city and cantonal actors at the level of the UAC. Nevertheless, a more general reframing of HBLTC services conception (regarding isolation and alimentation) did not occur as the service was just added to existing and main structures. Moreover, the community care paradigm did not fully apply to the project as it was finally designed as a top-down solution to top-down defined problems. In short, the content of the project was slowly normalized and included into the more general discursive and institutional structures of HBLTC in Geneva. What about adverse positions / discourses considering implementation? During the diffusion process, two critical discourses emerged. One we could call *realistic criticism* and the other the *criticism of technocratism*. The first critical discourse comes from actors of the HBLTC cantonal institutions (FSASD) with regards to the real possibility of its extension, specially regarding the population targeted. Hence, idealism is the unformulated but obvious criticism. At the other end of the spectrum, another discourse criticises the implementation of the project -as lacking in important elements, namely the need for elderly to get contacted and accompany. This critical reaction comes more from social workers of the UAC concerned. Then, there is a criticism regarding the leadership of the FSASD on the project and the formalism of its organisation, and lastly, a critique of the limit imposed by the health insurance federal system in the development of such innovative projects.

Geneva: lunch in the community / C: scales as power resources

Analysing the content of change in the context of the national system (or cantonal / national system in the case of Switzerland). The development of this project reflects the vivacity of the Swiss federalism (it was initiated at both cantonal and local levels) but also on the importance of the subsidiarity principle in Switzerland (priority to localism and proximity, importance of association as the actors of development and implementation of services in health and social care). Lunch in community is a project that first addresses the risk of isolation of frail elderly in urban areas. As such, it is an historical preoccupation of the City of Geneva, which can be traced back to the 16th century. The reference to community care in elderly field was first diffused at cantonal level in the hospital context but the idea to territorialize home-based care was also at the heart of the first HBLTC cantonal legislation. For the City, the new 2001 law that attributed individual care to the canton and community care to the municipality and favour ambulatory care was taken as an opportunity window. The social services developed new community projects in each of its 8 sectors (UAC), including projects for frail elderly. With regard to the national system, the changes brought about by the innovation are clearly restricted to the domains that precisely are loosely covered by the federal financing system (prevention vs treatment, social action vs individual care, social inclusion vs cure, conviviality vs nutrition, domestic service/nursing). As a consequence, the change at best offers a complement with regards to the national and even the cantonal HBLTC system. This complement is still marginal and limited to the sub-local scale. Moreover, it is much dependent on specific sub-local dynamics. At what policy scale does change happen? Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority, etc.) ? What specific scalar dynamic ? At what policy scale does change happen? The project was developed at three scales simultaneously, but without reference to the national one. First, the *cantonal scale*, as the new service concept was initiated by cantonal authority and the new services development was integrated in the official services of the FSASD. The canton assimilated the new service to classical meal-on-wheels service and hence, pay for its functioning and provides means-tested subsidies for needy elderly. Lastly, the FSASD tries to diffuse the concept in all the municipalities of the canton. Second, the project developed at *local scale*, as part of the new community action of the City of Geneva. In such context, the social service re-interpreted its old activities in favour of aged in a community perspective. The social service officially impulse the diffusion of the project in the 8 sectors (UAC). It worked for 6/8 of them. Third, the implementation is left to the *sub-local scales* (UAC). This means that the project can take different forms, and succeed more or less depending on the community dynamics, socio-economic characteristics and social workers’ motivation. Tension between various policy scales are relevant. As it developed on three scales simultaneously, the project was at the heart of important tensions between those scales. The first one is the tension between the *cantonal and the local scale*. Clearly, the City is fighting to preserve its competences and develop its own expertise in the field of old age care –even in the subsidies for the poorest elderly. Moreover, there is a tension around the targeted population of each actor. Hence, the cantonal FSASD “owns” the HBLTC clients while the city is in touch with the more general population of 65+ but can not reach the most frail elderly. In the case of the lunch in community project, the necessity to share the same population and to build collaboration was not sufficient and the collaboration could not be developed in a constructive way. Moreover, there was a *tension between sub-local and local level*. This refers mainly to the locally promoted concept of community action which was quite ambivalent and was interpreted differently in each area. The lack of leadership also has been deemed as generating frustration at sub-local level, as initiatives were encouraged but not supported

further. Specific scalar dynamics In short, there were different dynamic regarding the scale of change. At the cantonal level, after the first social learning and reflexive process that gives a decisive top-down impulse to the project, the main dynamics was the institutionalisation of the project and its inclusion into the hierarchical, operational and financial structure of the FSASD. At the local level, the dynamisc was more political, as the socialist City on the one hand tries to profile itself on community care and on the other hand politicised new elderly care labour market (new project *Entourage* presented as a social measures for aged *and* unemployed was finally rejected because it was build on the idea of second class job for unemployed). Finally, the sub-local level generates their own creative dynamics regarding the project but in a quite disorganised way. They mainly failed to promote systematic horizontal diffusion as well as to valorise their experience on a larger scale (local or cantonal).

Knowledge management in Köniz, canton Bern

The not-for-profit provider of outpatient services in long-term care (not-for-profit Spitex organisation) in the city and region of Köniz (Bern canton, Switzerland) has developed organisational structures and processes to generate expert knowledge and facilitate knowledge transfer between staff members to thereby contribute to a high quality of service delivery as well as good working conditions; besides, it provides community-based psychiatric care which may be regarded as a way to assure comprehensive care under tendencies of economisation and quasi-taylorisation of care delivery.

The municipality of Köniz is situated South-West of the city of Bern between the rivers Aare and Sense in the canton Bern in Switzerland. Its about 38.000 inhabitants are spread over 23 localities in an area of about 51qkm which is divided in a lower part next to the Swiss capital Bern and an upper, more remote part in direction of the mountainside. There is much commuting and about two thirds of the employed inhabitants work outside the municipality. Even though the municipality generally is well-off, recently cost containment in public spending has become an issue. The local authorities historically had invested in ageing related services and in the late 1990ies there was developed a concept for ageing policies which was renewed during the first decade of the 2000s.

Outpatient long-term care in Switzerland is financed by the social insurances, especially health insurance and old age and survivors' insurance, as well as by public subsidies of the cantons and municipalities and by private households. Recent changes of the repartition of the cost burden between the different levels and bodies as well as in the basic principles of financing (from object-related financing to subject-related financing) have given the cantons the responsibility and power to decide to privatize a certain share of the costs for outpatient long-term care. Notwithstanding its promotion of the principle of "outpatient before inpatient care", the government of the Bern canton was in favour of doing so. This attitude as well as the newly introduced centralisation of contracting with long-term care providers, the intention to reduce cantonal subsidies for clients receiving domiciliary care and the transition to a performance-based remuneration logic set the non-for-profit providers of long-term care in the canton under pressure to define, delineate and legitimize their concrete services and respective costs in front of the canton.

Thus, the basic discourse and political process in the canton at the moment is on delineation, definition, valorisation, and financing of services of home based long-term care. The political conflict at stake is about how to define quality, what quality is in

whose interest, and who has to pay for what.

The change which is under investigation here – the development and definition of the above mentioned additional services of the local long-term care service provider – may be regarded as an answer to this development. It has been facilitated by the sufficient financial resources under the former financing regime as well as by a pronounced professional self-understanding, a very engaged and multiple qualified management and a supportive providers' association at local as well as at regional level. In addition, the historically strong roots in the population and the quasi-monopoly of the provider in its single-catchment area seem to have contributed to a strong position and for long sufficient financing.

The parallel processes of professionalization and economisation that take place in the canton thus have ambivalent effects: While professionalization seems to contribute to quality and comparability of services, economisation seems to lead to a semi-taylorisation of service delivery. The protagonists at least perceive that services have to be delivered under more pressure and with trade-offs regarding the relational quality.

The strategy of the local not-for-profit long-term service provider which is under investigation here may be described as making use of the ongoing trends of professionalisation and economisation to oppose parts of their consequences.

Köniz: knowledge management / A: mechanisms of change

What segments / elements of change can be attributed to non institutional actors and to institutional actors? The local Spitex organisation and its supporting association (Trägerverein) are in themselves an informal decision making arena, and the manager of the organisation perceives the support of the board of the association as decisive. A loose network of actors who are affiliated to different organisations and interest positions shape long-term care at cantonal and local level. Decision making is both consensus-oriented *and* conflictual

Some aspects facilitate consensus: several actors have known each other for years and are able to assume different perspectives on the issue of long-term care due to their former working-experiences. Almost all have at least some training in business economics and management, which provides them with a shared culture and language and thereby facilitates communication despite of differing interest positions. Conflictual potential results from the strong roots the Spitex organisations have historically in the population, especially in the more remote and rural areas. Additionally, the relatively high self-esteem of the caring and nursing profession makes it a relatively strong counterpart in negotiations. The meetings of GEF and the not for-profit Spitex organisation of Köniz that accompanied the evaluation of additional services of the Spitex organisation were a further arena for informal negotiation and decision making. At the local level of Köniz, providers negotiate shared interests and report to develop project ideas informally at the "coffeetable", and then contact actors in politics. The relatively small number of actors on the local level (four to five persons) facilitates informal contact and cooperation. From these informal cooperations, a semi-institutionalised arena was built with a Round Table on long-term care. institutional, politicized, public ones? The issue of financing of services in outpatient long-term care and its consequences are a highly politicised and publicly discussed issue in the Bern canton which is attributed by our interview partners to the strong local anchorage of the not-for-profit Spitex organisations, especially in the rural areas. An example given is the failure of the first attempt of the cantonal government to introduce a cost share for patients regarding long-term care services which are prescribed by the doctor but above the limit the insurers pay for. Due to intense mobilisation by the local Spitex organisations and its cantonal roof association, the governmental initiative could be fended off (but was modified and passed one year later); moreover, party politics had been addressed, and a coalition from far right to the middle voted against the obligation in the cantonal parliament. Direction of change and relation with change modes: vertical change (top-down/ bottom-up)

Qualifying the staff of the Köniz Spitex organisation to a mixture of "generalists" and "specialists" and establishing a referring organisational structure was an organisational top-down and bottom-up process that – according to the management – can be attributed to both the professional commitment of the manager and of the staff. The development of the service quality of the non for-profit Spitex was facilitated by the context of professionalization and business management of Spitex organisations in the canton which was implemented by the local provider. The supportiveness of the local authority of Köniz to let the local non for-profit Spitex organisation offer services for a price at the limit which was set by the cost cap may also be regarded an aspect of top-down facilitation. A twofold top-down process changed this context: At federal level fixed prices per hour to be paid by insurers in three categories of care services were introduced; at cantonal level a cost share for patients for the costs which were not covered by the health insurers was introduced. Both put the local non for-profit Spitex under financial pressure and menaced it with

loosing an important path of client acquisition.

A second top-down process was the reorganisation of the financial balancing between the canton and the municipalities, in which the canton assumed the competence to contract outpatient long-term care services with the local Spitex organisations and required from the local Spitex organisations to let additional services undergo an external evaluation that should suggest if they would provide a common good or if they would mainly be of economical interest to the Spitex organisation itself. horizontal spreading of change: Until today we cannot observe a horizontal spreading of the mode of qualifying or the organisational structure itself. This might be explained by the lack of resources in other organisations in a general context of austerity. What still spreads horizontally is the professional knowledge of the organisation's staff which is transferred via several professional networks of providers in the Canton (e. g. on wound treatment or nursing care). Modes and configurations of change: displacement, layering, drift, conversion (Mahoney & Thelen, 2010) displacement, layering, drift, conversion, exhaustion (Streeck & Thelen, 2005) The most adequate description for this case seems to be displacement: the issue of quality was of slowly rising salience and was actively cultivated by the local organisation inside the existing institutional setting; management practices that before had been foreign to the organisation are adopted.

Köniz: knowledge management / B: discourses and coalitions

Explicit logic of the change process: The explicit logic of the change process was to provide and assure a high quality of outpatient long-term care of the local not-for-profit care provider (Spitex organisation) by combining generalist and specialist knowledge in the organisation, promoting professional exchange and communication between the staff. This was pursued by measures of organisational development and by delineating provided services and defining their quality against the overall background of processes of professionalization and economisation of outpatient long-term care in the canton. These processes changed the financing modalities for the providers and menaced them to lose budget. How advocated: This logic was advocated by the management of the local Spitex organisation and its cantonal roof association by referring to professional ambition (delivering good quality of care) and the principle of “outpatient before inpatient” which is advocated by the canton. Another argument was to avoid later costs by facilitating early access to complementary services, counselling and prevention via assuring early access to a comprehensive range of low threshold services, including preventive domiciliary care. Allies at the beginning: The comprehensive service delivery of local non-for-profit Spitex historically had been facilitated by sufficient financing from the public hand thanks to a combination of single cost-caps per delivered hours and the opportunity for municipalities to include their expenses for outpatient long-term care services in the mechanism of financial balancing with the canton. Insofar, the local authority of Köniz was an early ally of the local – formerly municipal – not-for-profit Spitex organization in Köniz. Allies during the process: The cantonal association of the not-for-profit Spitex organisations aims at further developing the professionalization of service delivery by introducing instruments of organisational development and business management and therefore was a quasi-natural ally of the local Spitex organisation.

The local unit of the red-cross was an ally because it shares the argument of the preventive value that complementary services would have which therefore should be included in the mechanism of financial balancing between canton and municipalities.

With a revision in the repartition of responsibilities between municipalities and the canton, the responsibility for contracting on outpatient long-term care was centralized at the cantonal level. The cantonal department for health and welfare (GEF) was an ambivalent ally and demanded the local Spitex organisation to let its services evaluate before admitting them to public subsidies.

What about adverse positions / discourses? There is a public, also medial discourse on the preventive effects of certain services, especially of services of domiciliary. While the local Spitex organisation (and its cantonal roof association) argues for the preventive effects of domiciliary care which is delivered by Spitex organisations, the GEF and for-profit Spitex organisations doubt this. How has the initial policy rationale been transformed all along the change process? During the process of change, the local Spitex provider also referred to the quality discourse against the background of changing financing modalities and its given interest to assure the own financial situation in a context of rising financial pressure. The evaluation of the services was linked to the question of which kind and quality of services would be to the benefit of the single patient, the provider itself, or the society – as the answer to this question should be translated into funding recommendations for the canton. Another rationale for the revision of the organisational structure of the local Spitex organisation resulted from the two mergers which the enterprise had undergone and required thinking about how to organise the new, bigger organisation. The professional aim to provide a certain care quality has more and more been also set into the function of guaranteeing adequate financing. Considering implementation, what is left from the initial intention? Has a new form of rationale been developed by the actors of implementation? In looking for the sources of the relatively high costs per hour of the local Spitex organisation, already existing and habituated practices, such as communication structures and routines in the enterprise, were brought into conscious and made explicit. This process in itself may have led to a higher degree of reflexivity of service delivery; and it allowed integrating existing practices in a new narration about good quality of care. What about adverse positions / discourses considering implementation? The cantonal government focused on

the costs for services and on the question of who would benefit from them; this criterion shall orientate cantonal decisions on which additional services should be subsidised. This discourse resembles the issue of knowing if and which complementary services could be included in the financial balancing between the municipalities and the canton (the municipalities are responsible for the contracting and financing of complementary services). A further issue that is discussed similar to this is the question what would be subsumable under the concept of psychiatric care. Background for this is the question of which kind and quality of services is at all reimbursable. Strongly related to the discourse on quality of services was that on standards and competition between providers: The canton promoted competition between providers and wanted to treat all providers the same. (on a modest level of quality requirements). In the evaluation logic, the canton differentiated between the provider's economic interest and the public interest. In this logic, high service quality might contribute to both aspects (given that competition would work); thus, if high quality of service delivery contributed to the economic well-being of the single enterprise (and also to the public) than this quality level would not have to be financed by the canton, but by the provider. On the other hand, the duty to provide care to everyone asking for care – also with low needs or in remote areas – was acknowledged by the canton as an issue of public concern and therefore is extra-paid.

Köniz: knowledge management / C: scales as power resources

Analysing the content of change in the context of the national system (or cantonal / national system in the case of Switzerland). The innovation addressed (indirectly, not by intent) the weak preoccupation in Switzerland with general and binding standards for quality assurance in outpatient long-term care. There are only small quality requirements at national level. In the case of the Bern canton there are also only small explicit standards at the cantonal level, and staff for controlling that they are followed by the providers is lacking. At what policy scale does change happen? Or what tension between various policy scales are relevant (Local authority / region ? Regional / national frame ? Neighbourhood / Local authority, etc.) ? What specific scalar dynamic ? In the case of the local Spitex organisation of Köniz and its mode of providing a good quality of care, change took place at local, even at organisational level. Nevertheless, this change is situated in the context of several changes in the financing modalities that stem from federal as well as from cantonal level: The federal level set a limit to reimbursement of long-term care services by the insurers with the introduction of fixed prices for three types of provided outpatient long-term care and delegated the decision about introducing a cost share for patients to the canton. This led to heavy tensions between the cantonal government and the cantonal parliament regarding the project involve patients in the payment of domiciliary care nursing and social care. There is a clear tendency in the Bern canton to centralise public responsibilities regarding outpatient long-term care by depriving municipalities of the competence for contracting outpatient long-term care services with the providers (even though they are left with the competence to contract complementary services as meals or mobility services).

Section D: Mechanisms of change

The comparison of the change processes of our six local case studies sheds some light on the interplay of social learning and institutional innovation during change processes; it reveals insights into the significance of the degree of institutionalisation and politicisation for the feasibility and sustainability of change processes; and it helps to understand the relation between vertical and horizontal dynamics of change. Last not least, the change processes can be assigned to different modes of change; to analyse this, we make use of concepts of gradual change as they have been suggested by Streeck and Thelen (2005) and Mahoney and Thelen (2010).

Institutional vs. non-institutional actors and corresponding segments/ elements of change

The local cases that we selected represent a broad spectrum regarding the significance of institutionalised and non-institutionalised actors during different stages of the change

process: The change process in Edinburgh (re-ablement program) was completely driven by institutionalised actors who commanded over hierarchical steering instrument that allowed them to fully implement their aims. The processes of change in Aachen (dementia care net) and Köniz (knowledge management) were indeed mostly driven by non-institutionalised actors, but through different stages of the process were yet considerably influenced by institutionalised actors as dependencies resulted from the need of assuring further financing. Thus the non-institutionalised actors had to adapt their original ambitions partly to the interests of the interfering institutional agents. The change processes in Hamburg (care conferences) and Geneva (lunch in community) were resulting from the initiative of institutionalised actors, but implemented by non-institutionalised actors, partly in close cooperation with institutionalised ones. In these processes, the original ideas could be pursued by their promoters as they were compatible with the interests of the institutionalised actors. This holds also for the last but not least change process which we researched. In the Fife case (user panels), the change was almost entirely driven by non-institutionalised actors with for long no interference by institutionalised ones. This may partly be explained with the fact that the process did not obviously endanger the interest or aims of affected institutionalised actors. Also in this case, as in most of the other cases, the non-institutionalised actors could make use of a discursive scale which had been provided by institutionalised actors.

Institutionalisation and politicisation of decision making arenas. Comparing the six selected local cases provides two insights when it comes to the possible effects of institutionalisation and politicisation of decision making arenas: The first is that one change process may take place in (or affect) several decision making arenas at once, but also consecutively. Different arenas may vary in their levels of institutionalization and/or politicisation, and the same arena may change in its level of institutionalization and/or politicisation. Thereby, changes may take place in a broad spectrum of contexts which can range from almost no institutionalisation and politicisation (as the cases of Fife, Geneva, Aachen and Köniz in their beginning) over a medium degree of politicisation (as the Hamburg case) to a high degree of politicisation (as in Edinburgh or, in later phases, the Aachen, Köniz and, in its end, the Geneva case). The second insight is, that both, institutionalised decision making arenas and a high degree of politicisation as well as the opposite, may facilitate change: A high politicisation brings along the strong risk of rejection of new ideas (as in the end in the cases of Aachen and Geneva, not yet clear in the Köniz case) but also may facilitate them (as in the Edinburgh or Hamburg case). However, the latter requires that the new ideas are supported by the underlying power relations or at least do not endanger them. Less institutionalised decision making arenas and little politicisation may facilitate change as this can just happen without raising too much attention of institutionalised arenas (as in the Fife and Hamburg as well as - in the beginning - the Geneva case); on the other hand, also an originally rather little politicisation may be limited by the ambition of the promoters of the change process to expand their influence also to more institutionalised and politicised arenas (as in the case of Aachen). Thus, we may conclude that either low levels of politicisation or the correspondence of new ideas with underlying power relations allow local actors with clear ambition and engagement (a shared element of all our six local cases and perhaps a necessary condition for change at all) to initiate change

processes according to their aims; the further process then is shaped, beneath other, by the degree of institutionalisation and politicisation of the arenas which are further affected as well as on the underlying power relations.

Direction of change. We investigated local, that is: municipal processes of change. In almost all our cases beneath this local level, also higher levels – be it the regional, the cantonal, or the Land-level – were relevant to the implementation or continuation of the local innovations; and equally, in almost all our cases also lower levels, mainly the level of boroughs, have been affected but even turned out to be an own scale of implementation which offers room for manoeuvre to local and very local, mostly non-institutional, actors. Thus, each level provides a possible scale for influencing the concrete shape of the investigated innovations. The six case studies show that the chances to shape the implementation of innovations at several levels do not only depend on the governance mode at stake at each level, but are affected by the combination of the vertical and horizontal logics which are at stake. The Hamburg and Geneva case study show e. g. how (sub-)local autonomy may horizontally balance a centralised process of top-down introduction (or better: provision) of a new instrument. In this regard, it seems e. g. central if implementation at a subordinated level is mandatory and how much room for discretion is left to this very local level.

Modes of change. In four of our six case studies – in Fife, Hamburg, Aachen and Geneva – we observed processes of layering (Mahoney & Thelen, 2010; Streeck & Thelen, 2005): New elements were attached to already existing institutions that gradually changed status and structure of the institution. In the two latter cases, the layering process was combined with conversion (ibid.). In Geneva, the modes were different depending on the institution that underwent the change. In Edinburgh, surely the location of the most radical change that we investigated, we found a process of institutional replacement (ibid.) which was combined with a process of displacement (ibid.). And in Köniz, where we observed change at the very unit of an organisation which is responsible for the long-term care in the whole municipality, we also retraced a process of displacement (ibid.). The comparison of the change processes and their results suggests that layering is the kind of change mode which is not only most probable to occur but also quite probable to be successful. The preceding explanations also suggest a possible reason for this: processes of layering do neither obviously, nor immediately endanger the old institutions and therefore do not cause too strong resistance. In cases where this happens (e. g. in cases of replacement), supporting power relations are necessary (as in the Edinburgh case). In our case studies, underlying power relations were more supportive for institutionalised actors. Therefore processes of social learning which were initiated by non-institutionalised actors had difficulties to achieve, even if they followed the logic of layering, in those cases where they were confronting the institutionalised actors and putting in danger their interests (e. g. in the Aachen case or the late Geneva case).

Section E: Discourses and coalitions

Innovation is about framing. In the case of elderly care, innovative projects are the ones that challenge the dominant discourses regarding governance, coordination, quality, and participation of HBLT care. As such, a project is not « innovative » in itself, everywhere and forever. Its innovative dimension is a discourse construction that is related to debates belonging to the place where it is promoted and that can be contested and transformed. In the analysis of the six case studies in contemporary European context, this constructivist dimension of innovation appears clearly, as it is directly related to the political content of the innovative dimension of the project. Political struggles are at the heart of the framing of innovation (a), as well as they orient the construction of cleavages lines about the changes (b). As a result, it proves difficult for social innovations to keep their first innovative insight and they tend to be normalized or integrated into the new referential of marketization or rationalised governance (c).

Framing innovation: social driven innovation vs governance driven innovation

The six projects that have been analysed in these local case studies first appear as innovation that derives from the grass-root experience of professional concrete home-based-care delivery network. As such, they are first framed as innovations that could improve the quality of elderly care and/or the efficacy of the network (improving coordination).

Indeed, the *situation* of frail elderly is at the core of the projects presented in Geneva, Fife, Edinburgh and Aachen. In Geneva, the project is designed to improve health and social integration of the home-bound frail elderly, while in Fife the aim is to allow their participation in the context of the service delivery. In Edinburgh, the intensive care period explicitly aims to empower the frail elderly and help them to gain autonomy at a further stage in their life. In Aachen and Köniz, the aim to improve the quality of care for the frail elderly (in the case of Aacheen, for dementia patients and their relatives) is coupled with reference to performance and efficiency of the *care network*. Only in Hamburg does the patient fail to appear explicitly in the first rationale, as the care conference is clearly framed as a way to improve the coordination of the various stakeholders.

Nevertheless, these references to the frail elderly well-being as well as the arguments about better coordination have to be understood in their discursive context. That is to say that these innovative discourses were not only rooted in the concrete professional experiences, but were also linked, politically, to more general debates at regional or national levels. With regard to this context, we can identify two different positionings of the local innovation.

First, the reference is made as a way to *complement or balance the regional or national policy*. In Fife, the project is about including the frail elderly in the implementation of the 1990 National community care act. Hence, the vocabulary of participation and inclusion is borrowed from the national context. In Aachen, the project is designed as an answer to a call from the federal ministry for health for "lighthouse projects" on issues of dementia care. Meanwhile, in Hamburg, the care conference was designed as a way to balance the implementation of the 1996 Federal law on long term

care insurance, with regards to its market oriented principles; and in Edinburgh, the explicit reference is made to a national well diffused concept of « reablement» while the implicit rationale was to master or reduce the raising implementation cost of the Scottish Free Personal Care Program at local level. Only in Switzerland, a highly federalised country, is the innovative argument built with exclusive reference to local and cantonal discourse (even if the innovation, in its content, can be further interpreted as challenging the national frame). Hence, in Geneva, the project is first presented as the result of a learning process as it is conceived through a scientific evaluation of the hbltc services, in the context of a more general thinking about the unintended consequences of the cantonal elderly care policy. Meanwhile, the city of Geneva has adopted the project as a way to profile itself in the old cantonal/city competition and to use community action as a new instrument to provide services for its ageing population. In the case of Köniz, during the change process the cantonal policies have become an important point of reference as the local level sees itself in the need to legitimize their spending with the special quality of their services.

Finally, the innovation discourse is characterized by its two levels of understanding. At the first level, the argument is constructed as innovation that is focused on the quality improvement for the well-being of the frail elderly (be it through intensive care, participation, convivial lunch, early diagnosis or knowledge exchange and management). Nevertheless, a more careful analysis reveals additional rationales that are quite similar in the six cases. Theses rationales may be explicitly added to the first rhetoric, or they may implicitly frame the project.

The first of these other rationales is the adjustment to the *increasing marketisation* of the field. This rationale frames the project of Aachen, as one reason to develop the dementia net is the hospital motivation to adapt and anticipate developments in the financing priorities of the insurers and to avoid the obligation to pay back financing for persons that would have stayed in hospital without actually qualifying for hospital stay. The same can be said about the Edinburgh project that appears as a way to justify the reorganization of the service delivery towards a privatisation via argument of efficiency. In Hamburg, the same argument of adaptation to the increased marketization is used, by contrast, to balance the negative effects of this process. Apart from this rationale, the *cost-containment argument* is also strongly embedded in the project of Edinburgh, Aachen but also in Köniz, where it is about legitimizing relatively higher costs.

In the cases of Geneva, Fife and Köniz, these added rationales are not present in the first conception and advocacy of the projects. In Geneva, the « lunch in community » project is strictly conceived –at least in the beginning - by reference to social isolation and health issues in line with the development of the hbltc services in the canton. This may be partly explained by the genealogy of the « isolation of frail elderly » discourse that has deep historical roots. In Fife, the participation of frail elderly is also constructed as an innovative dimension of the policy independently of the marketization of the field. In Köniz, the added rationale was formulated only with the changing demands from the cantonal level.

Hence, it seems we can distinguish two ways of emergence of innovative discourse. In the first case, the innovation discourse is articulated to the new discourse of marketization, rationalisation and cost-containment that frames the new European governance of home-based long-term care. We can refer to it as a *governance-driven*

innovation. In the second case, the innovative discourse is elaborated as a social learning process that is articulated with the life experience of care giving and care receiving, namely with quality issues, rights promotion and social integration. In this perspective, we can talk of *socially driven innovation*. This type of discourse is grounded in grass-root experience of professionals in contact with the frail elderly, universal rights or critical academic thinking. As we shall see, if the six projects analysed all included a social innovation dimension at the time of their first formulation, the process of debate and implementation transformed them into market-rationalising projects.

Discourses coalitions: the public interest survivals

The innovative process can be analysed as a struggle between competitive discourses or interpretations of the reality of home-based long-term care. If we consider our six cases in such perspective, we can observe that the local innovation development generates different discourses coalitions that will draw three different cleavage lines. In these debates, a public sphere argument is opposed to marketisation, rationalisation and control. Interestingly, the variety of cases shows that innovation discourse on home-based care can be used to support different sides of the coalitions, depending on the local context.

The first of these emerging cleavage lines opposes the discourse *in favour of the marketization of care and the discourses against marketization or for public services*. This division is strongly linked to the issue of quality. Indeed, this kind of cleavage is structuring the debate in Hamburg and in Edinburgh. In Hamburg, the care conference instrument (as a way of balancing the market principle) is not contested, but its single existence clearly refers to the background of the national debate on the marketisation of care. In Edinburgh, the critical coalition was quite weak and was focused, more defensively, on the need to preserve the public provision. It was supported both by academics and by street-level bureaucrats of the City Councils, that both were sceptical regarding the future of the quality of care in a privatised market. In Köniz and Aachen, this structuring opposition took a slightly different form, as the quality argument of the professionals of care were confronted by the discourse of the cantonal authority about *cost issues* and about the promotion of competition between providers (in Köniz) and by the discourse on cost containment of the health insurance in Aachen, that did not agree on a continuous reimbursement of coordination activities. In Köniz, the canton supports marketization by differentiating between the private interest of the providers and the public interest. According to this argument, some kind of quality contributes to the public interest but also the interest of the providers and this justifies the fact that quality does not necessarily have to be financed by public contribution and has to be negotiated.

The second cleavage line opposes the discourse of the social innovation promoters (various coalitions of academics, associations, street-level bureaucrats) to the discourse of the administration at the local, regional or national level or even to the discourse of the political authority. In these cases, *social integration arguments* are opposed to *marketisation or to the technocratization* of care. The case of Geneva is a good illustration. In that case, the innovation was clearly promoted differently by the coalition made of academics and street-level bureaucrats that first conceived and tested

it as a pilot project at sub-local level on one side, and by the social service of the City and the main cantonal Spitex organisation on the other side. A contentious example here would be the need to finance personal services in order to accompany the elderly to the lunch. On the one hand, this is presented as a measure that belongs to the heart of the project; on the other hand, it is evaluated as a measure that can not be integrated into the category of financing or as a measure that would be too costly. But this cleavage can also be noticed in the case of Edinburgh, Köniz and Aachen.

A last cleavage is revealed by the case of Hamburg and Fife and has to do with the reluctance of the powerful side of the network towards innovation that may challenge the traditional power sharing. Indeed, in the cases of innovation that aims at improving participation – the promoters are first confronted to reluctance if not opposition. Hence, those debates oppose the *participative argument* to the *control dimension of care policy*. This was obviously the case in Fife as the panels were supposed to increase the power of the frail elderly in the definition of the services by opposition; and this was the case in Hamburg, as the care conference was first designed in such a way that its members could define its own attributions and influence the power relations with the borough administration.

Changing discourses: from social innovations to instruments of governance

The most striking point regarding the evolution of the innovative project concept from their promotion to their implementation in our six cases is the process of normalizing of the innovative discourses. Moreover, this process is complemented by the discursive transformation of social innovation into an instrument of governance.

The *normalizing process* can be identified in at least four of our six cases. It takes the form of a reduction in the scope of innovation in terms of discourse contents or in terms of scope of influence: in Geneva for example the argument about the general redefinition of quality in hbltc (regarding both isolation and alimentation) simply disappeared with the implementation of the project, as well as its empowerment dimension that was defended by part of the social workers. Hence the innovation was normalized as a new services attached to meal-on-wheels sector. In some other cases, the normalization occurs by reducing or mastering the scope of influence: in Fife, the panels won their credibility as soon as they proved they were only focused on marginal issues and that they would not challenge the power of the social workers or of the City council regarding the definition of the programs. In Hamburg, the scope of the care conference was progressively restricted, in order for them not to challenge the power relationship in the areas. In Aachen, the project was adapted to the requirement of the financing agent and for example, the access of the target group was reduced by the introduction of new criteria.

Secondly, the *instrumentalisation process* is linked to a reinterpretation of the project or we could say to its re-articulation into the hegemonic discourse that frames the new governance of elderly care in contemporary Europe. Here, we observe how a project may be re-interpreted into the discourse of « cost-containment » or « rationalisation » of the governance, or as a new instrument of « privatisation » strategy. In Edinburgh, the reform was considered as a success and should be normalized as a best practice example in national discourse. In the course of this process, the focus on the well-being of the elderly has been reduced in favour of a

discourse about the reorganisation of the service delivery and its growing efficacy as well as in favour of the privatisation of hbltc. In Köniz, the first professional aim to provide care quality has more and more been also set into the function of guaranteeing the financing conditions.

Even in the Fife and Geneva projects, that appear first as social innovation, we can observe such re-interpretation and instrumentalisation in the context of a rationalized governance. In Fife, the panels are now mostly used as a means to enhance efficiency and cut costs, given both the wider austerity context and recent political shifts. In Geneva, the project is now presented by the cantonal Spitex association as a means to support the new policy that aims at shifting the balance of care from hospital and nursing home to the home, in a context of financial austerity.

Section F: Scales as power resources

The analytical tool in terms of policy scales stimulates a specific view on change and dynamics in policy making. This approach can be fruitfully applied to our study about local home-based long-term care systems for the aged. The concept of policy scale is about the idea of embeddedness and relations. Ideas, actors, organisations, policy instruments, institutions, service providers, administrations, localities... the whole range of elements put under scrutiny in most policy analysis share some key characteristic. They all are elements belonging to specific contexts, milieus, networks, territories, etc. They all fit to ensembles that are determining to them in at least two crucial manners. On the one hand, policy scales are frames of reference that aim at building specific legitimacy associated with specific policy scales. On the other hand, policy scales are systems of concrete constraints, organized around specific power relations that affect the most various forms of social and institutional dynamics. Those constraints are mostly constructed in national contexts.

Firstly, any element of a policy system is embedded in a cognitive environment. Actors (market actors as well as professionals), organisations (firms as well as administrations), or institutions act in reference to the norms of the system they belong to. Dominant frames help the various actors make sense of their action context. Those frames are structured at various scales that we need to identify as the scale at which a frame is formed, which influences its legitimizing capacity in two complementary ways. Any policy frame refers to a specific social space. A local business association can hope to catch the support of its clients. Any attempt to reach supplementary supporters would imply to broaden the scope of the association. Social support is an important dimension of political legitimacy. However, the symbolic dimension of frames is at least as important. For instance a local business association that is not branch specific, but that tries to represent all types of private business across branches may appear to be credible when talking as the representative and consequently the voice of the whole

local economy. Moreover, the forms of collective action, in some cases the logic of solidarity used by various social groups, could match the content of the frames they advocate for. In such cases, the coherence between the content of a claim or of a policy program and the logic of organisation of its promoter would reinforce the latter. For instance, grassroots democratic social movements might be credible advocates of participatory democracy. On the other hand, central level public actors have a strong legitimacy when formulating positions in terms of general or national interests. As such, policy scale is not only a discourse it is also both the social basis formed by the range of the supporters and addressees of a discourse and its coherence with the nature of the organisation itself.

Secondly, various constraints, be they financial, administrative, electoral or market-centred structure the policy domain of long-term care. Reform proposals or reform projects are embedded in a web of relations and interdependencies that influence any concrete trajectory of change. Administrative or market actors, beneficiaries and providers, local authorities as well as federal, central or states governments have to compel to rules, power and all forms of bounds. Again, the scalar dimension and the relations of this scalar dimension to specific power resource or power logic influence very much the capacity to trigger change, even at local level. Administrative, political, market, ideational, cultural, etc. spaces are organized around specific power relations. Institutional systems, markets, political parties or professions might be very decentralised or highly centralised. In spite of this variety in scalar arrangements, there are in most countries national frames, marked by the dominant scalar logic of institutional policy arrangements that should be borne in mind when looking at the scalar dynamics of a specific policy domain.

Scales as frames of reference for institutional innovation and social learning

In our local case studies, the frames of reference for the institutional innovation or the social learning process are embedded in specific scalar dimensions. In the case of Hamburg for instance, the *care conferences* were inspired by the West-German social-democrat political tradition of the ‘social city’. This frame of reference is political and makes sense in the context of German federalism. It was imported in the by then SPD run Bundesland of Hamburg from the social-democratic fortress of North-Rhine Westphalia during a period of change at national scale in the domain of long-term care. This change at federal level was initiated by the Christian-democrat dominated federal government through the federal law on long-term care insurance that foresaw the introduction of care markets in the delivery of care services. This law was perceived by the Hamburger actors as a threat to the traditional local way of organizing care delivery and to the local traditional welfare mix. The policy scales of party politics, at both federal and state (Land) level played an important role in this German case. The case of Edinburgh shares some features with Hamburg. The inspiration for the *re-ablement service* introduced recently in the capital city of Scotland lies as well in another region, i.e. in England. Similarly, the decision to couple the introduction of the re-ablement service with the privatisation of long-term care delivery is more of English or British than of Scottish inspiration. Scotland is indeed the region of the United-Kingdom that had the most preserved its tradition of public, municipal social work services, whereas

big waves of privatization / marketization had already transformed the long-term care delivery sectors as soon as the 90's in the rest of Britain. In the case of Hamburg, the mobilisation of the political (SPD) repertoire of policy instruments was an answer to marketization. On the contrary, the use made by the Edinburgh City Council of English or British repertoire of policy tools is not primarily understandable in the national-Scottish context. The dynamic makes sense in the local context of political change at local scale. In the case of Hamburg, the reference to the national social-democrat repertoire unveils a strategy of resistance to change initiated at federal level. In the case of Edinburgh, the mobilisation of national repertoires is aimed at triggering change at the local level. The case of the users panel in Fife is rather similar to that respect to the Edinburgh one. National debates – rather at UK level – are mobilised locally to trigger change and to legitimize series of decisions in the domain of long term care.

In the Swiss case, the social innovation of *lunch in community* is inspired by a kind of *longue durée* tradition of community action in Geneva. The importance in local history of the tradition of community thinking in social service delivery is the bottom line of the social learning process. Of course, this re-invested and revitalized local tradition also makes sense in the context of the Swiss subsidiarity. The local level is in this typical Swiss way of conceiving policy making, and specifically social policy making, a scale that should actively promote local ways of life. But still, the frame of reference is in this specific case the local level apprehended in its historical dimension. Both the local scale and the historical references are important legitimizing frames in the case of Geneva. Those dimensions enable to build a legitimacy that can be appropriated by the various stakeholders and institutional actors of the Geneva policy network.

The case of Köniz of *knowledge management in care provision* is of course also to be apprehended in the context of Swiss federalism and subsidiarity. However, the frame of reference is in this case primarily located outside the context of political institutions. It is related to the professional scale of care management. Similar conclusions can be drawn from the case of Aachen. The core of the initial social learning process in the case of the *network for dementia care* lies as well in a professional frame of reference. In those professional spaces, not directly related to political values or to political institutions, the personal networks and relations play a bigger role than in our local cases. The legitimizing character of the professional frames seems to have been sufficient to launch the change process in both cases of Köniz and Aachen.

In the case of the Hamburger *care conferences*, we are dealing with an instrument of governance that is aimed at fostering efficiency, equity thanks to the mechanism of grass-roots democracy. The local, or even infra-local scale of democratic participation is a key legitimizing factor in that case. The same small scale democratic frame is as well at stake in the case of Fife. In Edinburgh, the coupling of *re-ablement* service with privatization appears as a balanced package deal. Micro scale interests of the beneficiaries seem to be conciliated with the local interests advocated by the city council centred on privatization and cost control. In Geneva, the scale of the community (*lunch in community*) is both the relevant legitimizing scale and the relevant operational scale.

Scales as concrete power relations

Policy frames are related to structural scalar power relations. Those scalar relations are marked by regular patterns in the various national contexts. Organizational, discursive, financial, in terms of social mobilisation or of political support are key resources making up those power relations. However, the institutional and administrative dimensions of power relations form a reference frame to consider when looking to account for dynamics in a policy domain.

The federal state plays an important role in the organization of the insurance systems that finance part of the provision. Germany represents an interesting mix of national, regional and local norms. Besides the constitutional and national principles of homogeneity of living conditions over the whole federal territory, and the national social insurance systems, the regional and local traditions of welfare provision are very important. The long-term care system is characteristic of that concern. The federal insurance regime builds a defining frame that is adapted by the various Bundesländer via implementation laws and specific agreements with the insurance funds that are organized at the scale of the Länder. The municipalities are clearly the weak tie of the German system of long-term care. In spite of strong local traditions in the steering of care delivery, the present regime does not grant any decisive role in the policy domain of long-term care to the German local authorities.

The case of Scotland is especially interesting as it is a case where the scalar relations are for the time being both uncertain and contested. Together with France, the United Kingdom had long been characterized as an archetypical case of political and institutional centralization. Since the revolution of devolution in the late 1990's, this picture has changed radically. This is particularly the case in the domain of long-term care. Considered as the flagship policy of the "national" Scottish government, the long-term care policy domain has been almost completely taken out from the British policy system. The financing of the system and the design of the bulk of the institutions have been transferred from Westminster to Edinburgh. In charge of the implementation and of the organisation of care delivery, the Scottish local authorities are probably the most powerful local actors among our three cases.

In Switzerland, according to the principle of subsidiarity, decentralization, small-scale arrangements, and even private solutions are almost systematically privileged over federal policies. In the long-term care policy domain, the bulk of regulation is centred at cantonal level and the local scale (municipality) plays a central role in the organisation of service provision in most of the Swiss cantons.

• German cases

The scalar logic of Aachen and Hamburg are very different despite their belonging to the same national system. Aachen is a medium size local authority (260 000 inhabitants) that is located in the most populated German Bundesland of North-Rhine Westphalia (18 millions inhabitants). Being a city-state, the scale of power relations is in the case of Hamburg much clearer. There are no powerful local authorities in Hamburg, but simply boroughs with limited competencies and legitimacy. In the case of Aachen, the division of the various relevant institutions – the federal state, the Land, the Land-based

insurance fund and the local authority – rather benefited to the promoters of the *network for dementia care*. At various stages of the development of this pilot project policy, specific arrangements, financial or administrative supports have been developed. The discontinuities of the German federal system turned out in this case to be a positive resource rather than an impediment. In the case of Hamburg, the concentration of institutional capacities at local scale have enabled a smooth process of institutional change. In a second step, the implementation of *care conferences* at the infra-local level of the boroughs was more or less successful. At this infra-local level, the capacity of the various borough administrations and of leaders to create active coordination of local stakeholders is very heterogeneous.

• *Scottish cases*

In the context of the Scottish logic of power centred scalar relations, the local authorities enjoy a high level of autonomy. The change process witnessed in both Fife and Edinburgh are typical of this pattern. In Edinburgh, the innovation of the *reablement service* came along as a direct consequence of the change of political majority in the City Council. The support of the national Scottish government might have played a small role. But the concentration of power of the local authorities on the organisation of long-term care delivery was strong enough to trigger change.

In the case of Fife, the promoters of the *users' panels* were not institutional actors, but leaders of a local charity, important as well at national level. The implication of the local authorities has on the one hand lowered the autonomy of this instrument, but has on the other hand strongly stimulated its relevance and visibility. The case of Fife is then particularly interesting not so much to conclude about the vertical scalar relations in the context of the Scottish power system but to think of the logic of the local public sphere in that context. The users panels are a local public forum initiated by private actors. This forum deals however with a public issue that is particularly salient in the Scottish public debate – long-term care being in the Scottish context a defining debate for national politics. As such, this participatory instrument was seen by the local authority at the same time as a threat and as an opportunity. Local governments are usually keen on mastering more or less closely the public forum on their territory. The transformation of this forum into an instrument of legitimation at local level was one way to raise control over this local public sphere. The legitimacy of the local user's panels was however strengthened by its character of "model", that was also consulted for Scottish wide reforms.

• *Swiss cases*

In the case of Switzerland, we are, if to a lesser extent, looking at contrasted configurations of relative power relations, in spite of their situation in the same institutional context. In the case of Köniz, we are (as in the case of Aachen) dealing with a small local authority in a rather big and populated Swiss canton, Bern. Moreover and this corresponds to one pattern of scalar relations in Switzerland, the canton of Bern is a rather centralized one. This tendency to control various tasks of the local authorities is especially developed in the policy domains benefiting from important budgets, which

is clearly the case of long-term care. The *knowledge management in care provision* project, unlike in the German case of Aachen, was rather hindered by the uncertainties and the conflicts in the Swiss federal system of outpatient financing. The scalar power relations in Geneva are more typical of the decentralized version of Swiss federalism and of its present many contradictions. On the one hand, the institutional tradition of decentralisation and the present discourse in valorising participation, promotes the local autonomy of the various municipalities making up the canton and even of the various boroughs of the those communes. On the other hand, the logics of financial, administrative, technical rationalization imply a standardization and an integration of services. The project *lunch in the community* has suffered from this contradiction that is typical of contemporary decentralized scalar systems.

Conclusion

This research focused on the local scale dimension of the regulation of home-based long-term care for the aged. The main aim was to analyse how concrete actors networks deal at local level with the conflicting goals structuring international debate, in spite of specific constraining national institutional settings. We were able to precisely observe how these local systems address the most important shortcomings of their national settings.

Empirical conclusions:

Ambivalences in public debates about long-term care. One of our initial observations was that most of the debates in the policy domain of long-term care are characterised by a high level of ambivalence. The second part of the report was dedicated to an analysis of the most defining debates in this domain: governance, network and diversity, quality and participation. For each of these issues, we mapped out the contemporary debates and found a high level of plurality of concepts, applications or instruments, but even more importantly, of values associated with these debates. This wide range of concrete meanings but also of politically relevant values eventually gives way to various interpretations and to various logics at a more operational level.

Quality, participation, governance and coordination appear to be also potentially contentious and ambivalent in the national context. The next step of our research consisted in analysing our three national cases and their most noticeable shortcomings concerning the issues at stake. Every issue is discussed in each country in a specific logic and is understandable only from the perspective of the recent or medium-term history. For instance, in Germany, the introduction of private markets as the dominant regulation principle of long-term care service provision from the mid 1990's has shaken the whole system of long-term care but could not erase the power of traditional welfare associations that have played a key role in modern German social policies since they were modernized by the state, by the end of the 19th century. Those various configurations, made up of actors' systems, traditions and modern institutions, work as filters that reframe the political and academic debates in each national context.

Innovation at local level should be apprehended in a multiscale context

The central assumption of this project was that the policy actors present at local level are the closest to the implementation of the policy at stake or directly deal with the implementation of the policy. At the local level, change is triggered by actors and actors' coalitions that frame their reform proposal according to a specific frame of reference. The national frame has already been mentioned. In a national context, no policy instrument, no policy proposal has a chance to come through unless it is formulated according to the notions and along the cleavage lines that are understandable from the national point of view. However, this first positioning is not enough to impose a change process. In some situations – for instance the local Councils in the Scottish context where local authorities are powerful and control the bulk of the implementation process – strong power positions exempt those who hold those positions to build strong

coalitions to impose their view. Every policy proposal and process of change is nevertheless formulated according to a frame of reference – the historical tradition of community care in Geneva, the professional competence and values in the case of Köniz and Aachen, the powerful capacity of coordination related to both the efficiency and equity of the famous "soziale Stadt" from the SPD repertoire of policy instruments in Hamburg, the strength of the discourse in terms of beneficiaries participation in the case of Fife, etc.

However, the narratives built around reform processes have to deal with the constraints of the institutionalization process. Social learning as well as institutional innovations have to make their way through local political arenas or more or less rigid local authorities administrations, which often leads to the transformation of the initial projects (Geneva, Fife). Besides, reform processes have to comply with national or cantonal constraints so as to fit into the often uneven contracts that the local authorities have to sign with insurance funds or national administrations (Köniz, Aachen). But, in some other cases, open policy instruments have to be appropriated by social actors at an "infra-local" level (Hamburg), which brings about other kinds of transformations of the initial intentions.

This last empirical conclusion reveals how difficult it can be for local actors to actually derogate from national or regional institutional patterns. There are lots of both normalizing procedures and normalizing discourses, which very often outmanoeuvre reforms ambitions. International master tales in terms of cost containment, market or organisational rationalisation play a very important role and appear to be able to impose themselves in various circumstances and in many contexts.

Analytical conclusion:

In order to avoid focusing on only one form of policy dynamics and one type of actors, of decision-making arenas, we decided **to look both at institutional forms of change and at dynamics entailed by non-institutionalised social actors.** Apart from the radically institutional case of Edinburgh in which the reform was formulated, decided upon and implemented by institutional actors in the aftermath of a political change in the City Council, most cases combine phases of social learning and phases of institutional innovation. For instance, in the cases of Geneva or Fife, projects initiated at local or infra-local level by a charity or a modest street-level care unit have had to face trajectories of institutionalisation.

In some cases, we have to do with a reversed dynamic. For instance, in Hamburg a policy instrument is made available by institutional actors (institutional innovation) and infra-local social actors can make use of these instruments (social learning). Some procedures, such as the financing of local projects via institutional and often centralised actors represent entangled configurations. These alternating or mixed sequences of social and institutional processes show how both dynamics can hardly exist without a counterpart in the contemporary world of social policies. **Institutional powers need to steer the welfare provision by social actors but they also need to benefit from the terrain legitimacy of those social actors.** Conversely, social actors have to abide by the various regulations and public norms in the domain of social policy (quality,

security, health, human rights, public finances, etc.).

Beyond the classical model in terms of "scambio politico", **care provision has to deal with a double nature**. It has to be private, because it has to respect the singularity of every personal situation and because it has to be efficient according to the norms of market competition. But at the same time, it has to be public, as it must demonstrate that all norms of public health, quality control and human rights have been respected.

Our various local case studies provide a comprehensive overview of these enmeshed forms of legitimacy of long-term care arrangement or instruments in coupling three forms of complementary and theoretically grounded analysis.

In the first place, the analysis of change mechanisms has to **decompose the various phases of change**, to show the actual dynamics at stake and the various dimensions of change (top-down or bottom-up but also in the horizontal dimension). **Secondly, the analysis of discourses unveils the political logic of those change dynamics**. In most cases, (institutionalized) discourses bear a double function. On the one hand, they fit in the meanings that social actors understand and are motivated by. On the other hand, they induce logics of compliance and integration into public frames connected to other matters. The analysis of this process of discursive institutionalisation exemplifies the political usefulness of discursive ambivalence. **Lastly, the analysis in terms of scales as concrete power relations focuses on the connections between the discursive aspects and the more directly constraining dimensions of policy making**. The bulk of legitimacy derives from discourses. Those are related to specific power resources attached to specific policy scales. On the other hand, the various policy scales function according to institutional constraints.

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