

Translating case management in a service for older people in Berlin

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Case management is a coordinating process designed to align service provision more closely to the identified needs of people requiring assistance in the context of complex care systems. It is an approach that has crossed the borders of different national welfare systems where it has been adopted to address ostensibly similar problems. This empirically based but primarily methodological article draws on the author's doctoral research during which he spent an extended period in Berlin investigating a citywide case management service for older people in the context of German long-term care policy and legislation. It explores the extent to which a specific case study can illuminate how case management adapts in differing national welfare systems, and highlights the particular methodological challenges of 'translation' and 'equivalence' in cross-national research. The article outlines how institutional context both shaped and constrained the Berlin case management service and highlights the necessity in cross country research for a critical contextual examination of apparently similar features. This is particularly relevant where English words and expressions are directly absorbed into the local language, an important yet rarely addressed complicating factor.

Keywords: Case management; comparative approaches; translation; older people

Im Kontext komplexer Pflegesysteme stellt Case Management ein koordinierendes Verfahren dar, wonach Dienstleistungserbringung an den individuellen Bedarf pflegebedürftiger Menschen angepasst werden soll. Seitdem überschreitet der Ansatz die Grenzen verschiedener nationaler Wohlfahrtssysteme, in denen er adoptiert wird, um scheinbar ähnliche Probleme zu bewältigen. Dieser empirisch begründeter wenn auch hauptsächlich methodologischer Artikel stützt sich auf die Doktorarbeit des Autors, der während eines längerfristigen Aufenthaltes in Berlin eine landesweite Case Management Dienstleistung für ältere Menschen unter den deutschen pflegegesetzlichen sowie –politischen Rahmenbedingungen untersuchte. Gefragt wurde, in wie weit eine Einzelfallstudie den Prozess, demzufolge Case Management sich in unterschiedliche Wohlfahrtssysteme übertragen lässt, beleuchten kann. Hier wird die besondere methodologische Problematik von ‚Übersetzung‘ und ‚Äquivalenz‘ hervorgehoben. Der Artikel schildert, wie die Berliner Case Management Dienstleistung vom spezifischen institutionellen Zusammenhang sowohl geprägt als auch begrenzt wurde und betont die Notwendigkeit in vergleichenden Studien einer kritischen kontextbezogenen

Untersuchung von angeblich ähnlichen Eigenschaften. Von besonderer Bedeutung ist hier die Übernahme englischer Fremdwörter und Begriffe in die lokale Sprache, eine wichtige aber selten thematisierte Komplikation.

Keywords: Case Management; Vergleich; Übersetzung; ältere Menschen

Background

The borrowing of welfare policies and practices that originate in other countries is not new. For example, Bismarck's social insurance-based reforms in late 19th century Germany had a profound influence on subsequent developments internationally (Briggs, 2006). Indeed, there is a 'general recognition of the importance of taking a more global perspective in a world in which social, cultural and economic manifestations are imported and exported across national borders' (Kennett & Yeates, 2001, p. 40), that has led to a degree of international policy convergence in areas such as community care for older people (Weiner, Stewart, Hughes, Challis, & Darton, 2002). Case management, originally developed in the USA, is an example of an approach that has departed from its country of origin and taken root in a variety of different national welfare contexts. The focus of the study upon which this article draws is a specific example of case management for older people in Berlin, undertaken as part of a professional doctorate in social work at the University of Sussex by an English social care professional. The article is concerned with its *translation* in two key ways, firstly how case management as a concept translated into this particular German context and secondly how the analysis of the case study highlighted specific translational challenges in the practice of cross national research across different languages.

In 2007 I was awarded a fellowship that enabled me to take a four month leave of absence from my then position as a manager in an English adult social care department, during which I spent three days per week based in one of twelve local

Coordination Centres in a Berlin-wide case management service for older people (*Rund ums Alter*—All about Ageing). Each office covered a specific local authority area (alongside an additional small office working across the city with the Jewish community), employing three to four staff, primarily social workers, to provide information, advice and case management to older people in the locality in need of care and support. I subsequently received a further bursary that enabled three week-long follow up visits during 2008. Although not bilingual I speak German fluently as a second language, sufficiently well for the conduct of research. I received additional academic support from the Catholic University of Applied Science Berlin during the initial four month fieldwork phase.

Case Management

Case management can be described as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes” (Case Management Society of America, 2010). There are, however, other definitions that differ in both detail and specificity, including whether it is referred to as case management or care management, as its UK variant became more contentiously known (Challis, 2003; Huxley, 1993). Indeed, Austin (2002) notes several decades of literature have not settled case management's definition but identifies consensus around a set of core tasks, that (with some variation) comprise:

- Outreach
- Screening

- Assessment
- Care planning
- Plan implementation
- Monitoring
- Re-assessment

Case management's origins reach back to early practices in the developing professions of both social work and nursing. Its contemporary emergence, however, is frequently linked to the impact of deinstitutionalisation, i.e. the move away from providing care in institutions (originally in the USA in the 1970s), firstly in mental health and then in other social services. This shift from institutional to community settings framed case management's development as a distinct approach to helping individuals with complex needs (Ewers, 2005; Gursansky, Harvey, & Kennedy, 2003; Moxley, 1989; Onyett, 1992; Wendt, 2001). From 1972 the US federal government prioritised the improvement of coordination and integration within the system, commissioning a range of pilot case management schemes (Kaplan 1990, in Ewers, 2005) that represent the beginnings of case management's international career as an instrument for addressing the shortcomings of ineffective and inefficient health and social care systems at both the individual and organisational level. The adoption of case management into the federally funded Medicare and Medicaid programmes was critical in both establishing its legitimacy and facilitating its expansion (Ewers, 2005).

Case management remains a focus for investigation into its (contested) impact but as Gustafsson, Kristensson, Holst *et al.* (2013) point out, the results of many studies

are inconsistent, ranging from positive outcomes to no effect at all. They highlight a lack of detail regarding the case management intervention itself in such studies and argue the need for research that investigates and contextualises the actual practices of case managers. This study was an example of the latter approach, undertaken to explore how case management translated into a specific context in a different country and whether this has implications for learning from other countries' experiences.

Methodology

Cross national research

Reviewing the cross national methodological literature a number of key themes emerge. Hantrais (1999) emphasises the importance of analysing socio-economic phenomena in relation to their institutional and socio-cultural settings, drawing particular attention to issues of *conceptual equivalence* and *interpretation*, as well as to the potential impact of the researcher's own background. She cautions in particular that researchers need to counter the tendency to experience the welfare configurations of their own country as 'natural'. Baistow (2000) also identifies *equivalence* as a key issue in cross national work in social work, noting that without some level of similarity there can be no points of comparison. She identifies problems in establishing the equivalence of policies, structures, systems and professional roles, as well as the related difficulties of the linguistic and conceptual equivalence of terms like *welfare state*, *social services*, and *community care*, and raises the basic question of whether policies and practices can be translated into other contexts without losing their meaning.

Marsh (1967, in Kennett, 2004) suggests a useful distinction can be made between *formal* equivalence and *functional* equivalence, the latter of which requires an understanding of what something does rather than what it is meant to be. The theme of

conceptual equivalence is explored in more detail by Eyraud (2001), who foregrounds *translation* as the key issue, pointing out that in order to compare or transfer social policies one must first translate, an activity she argues draws on cultural as well as linguistic resources. Révauger (2001) in turn asserts that translation in social policy is not simply an abstract linguistic topic but a very practical concern. He singles out *conceptual confusion* as the main problem encountered in comparative work, outlining the need for combined expertise in both translation and the social policy context. Noting the considerable pressure for conceptual imports and exports, he states that social policies, like legal systems, are steeped in national cultures and both synthesise and symbolise the way a society reacts to economic or political constraints. From a social policy perspective Clarke (2005) sees translation more widely as a way of thinking about the movement of keywords, discourses and policies across sites, levels and agencies, and suggests that the *idea* of translation may provide a metaphorical insight into processes of transnational policy diffusion and policy transfer.

These linked themes of equivalence and translation framed the fieldwork for this study. Specifically, I was sensitised to the distinction between formal and functional equivalence and alert to the interplay between language and policy when translating, including noting what, how and when I translated.

Methods

I adopted a case study approach, i.e. an in-depth investigation of a phenomenon in its real life context (Yin, 2003), the ‘case’ in this study being the Berlin wide service *Rund ums Alter*, contextualised by the policy and legislative frameworks current at that time¹.

¹ This research took place prior to the implementation of the legislative reforms of 2008

From a comparative perspective, Mangen (1999) describes a case study as an analytical focus rather than a method *per se* because it generally incorporates several methods, typically combining interviews and documentary research in cross-national research. Additionally, there was a strong ethnographic component, given the degree of access I was granted. Lewis and Glennester (1996) coin the term ‘administrative ethnography’ to summarise an approach that incorporates observations of day to day activities, frequent formal and informal conversations, sitting in meetings as they happen, combined with mapping this softer material against documents, policy statements and other sources. Specifically, in addition to my day to day observations that were captured in (theoretically and methodologically reflective) field notes. I drew on range of documentary sources including policy and legislation, government publications, publicly available and internal organisational documents, e.g. leaflets, service specifications, evaluation reports, assessment documentation plus controlled access to service user records. Further sources included official care data for Berlin, facilitated semi-structured group exercises exploring specific cases with the local case managers, and the wider German case management literature. The local office functioned as an example of, and gateway to, the wider service, facilitating contacts both within the service and more widely at regional and local government level. Ten individuals became key informants, at the core of whom were the two social workers and team leader in the local office whose contributions were incalculable. Other key informants included case managers in *Rund ums Alter* offices in other localities, a senior social worker in a local borough and a senior planning officer in the regional government. The case management service was explicitly contextualised with regard to policy, systems and organisation, as Austin (2002) argues is necessary to ensure understanding.

I adopted the analytical approach of ‘process tracing’ *Rund ums Alter* within its

particular contexts in order to preserve the configurational nature of the case. In this approach “the analyst seeks to make sense of a congeries of disparate evidence, each of which sheds light on a single outcome or set of related outcomes” (Gerring, 2007, p.178). In this way the different elements contribute to the larger mosaic or map that is under construction. I additionally analysed my field notes thematically and checked my findings iteratively both informally and via presentations to key informants. One informant spoke English well enough to review the final draft of the case study, to check for authenticity and trustworthiness. The fieldwork was conducted in accordance with the ethical framework for doctoral students at the University of Sussex current in 2007 with additional reference to local guidance for the conduct of research at the Catholic University.

Published research and policy literature on care management in England provided a framework for exploring the linked issues of translation and equivalence in relation to the Berlin case study, the main focus of this paper. Care management in England is itself a variation of case management that drew on the US experience in early pilot projects (Challis & Davies, 1985). The study was also framed by my own practitioner knowledge (Pawson, Boaz, Grayson, Long, & Barnes, 2003) of English adult social care services that inevitably comprised part of my methodological ‘hinterland’ (Law, 2004, p. 46). Between 1990 and 1993 I undertook internal training at my then employing local authority as part of its implementation of the NHS and Community Care Act (NHSCCA 1990), key legislation through which care management was introduced and which shaped my subsequent career as a practitioner and manager in a further three local councils.

Limitations

Whilst findings from single case studies cannot be generalised they can raise important questions. This case study is also timebound, having taken place prior to further reforms to German long term care legislation that led to the incorporation of a version of case management (*Pflegeberatung*) into the care system and to the absorption of *Rund ums Alter* into a different organisational configuration (*Pflegestützpunkt*—care support centre). Single cross national case studies can, however, be regarded as comparative, or more precisely *comparable* (Rose 1991, in Kennett & Yeates, 2001), in so far as they can be examples of larger phenomena (in this case the adoption of case management in different welfare contexts) that have the capacity to inform debate beyond the country of focus, offering a detailed illustration of a theme or themes of wider interest (Hague et al, 1987, in *ibid.* 2001).

Care management and long term care legislation in England

The wider context for the development of the NHSCCA was the demographic shift in the UK population and its consequences for the organisation and funding of both health and social care. The key organisational interface then and now occurs between the National Health Service and local authority adult social services, the former ‘free at the point of use’ and the latter means-tested, a difference that has underpinned many years of conflict at both policy and practice level (Lewis, 2001).

Weiner *et al.* (2002) identify budgetary pressures as a policy driver, including funding anomalies that led to perverse incentives for older people to enter residential care, thus working against long standing policy objectives to provide more care at home (cf. ‘deinstitutionalisation’ above). Previous arrangements had led to a situation where government financial support (through means-tested social security payments) for private sector residential and nursing home care ballooned from £10 million in 1979 to

over £1 billion ten years later (Evans, 1994). All welfare services are tax funded in the UK, there is no social insurance.

Case management was trialled in England as part of the Thanet Community Care Project (Challis & Davies, 1985). Case managers were specially trained social workers in the local authority, to whom budgets were decentralised to facilitate the coordination of more flexible and cost effective services around a group of service users targeted because of an identified risk of entering institutional care. The project significantly influenced the subsequent development of community care policy including the NHSCCA (Onyett, 1992), in which case management, re-named 'care management', was incorporated into statutory guidance (Challis, 1999; Department of Health, 1991). Key elements of the original pilots were, however, not retained, with care management instead developing as a mechanism for delivering care to all service users rather than targeting specific groups (Challis, Weiner, Darton, Hughes, & Stewart, 2001). This incorporation of care management into the legal framework places England amongst European countries that have formalised case management within their care systems, as opposed to those where there is no entitlement and it exists only in model projects or pilot schemes (Engel & Engels, 1999; Leichsenring, 2004).

Glendinning (1998) notes the emphasis on assessment and care management as key methods for improving the targeting and coordination of services for older people, the former intended to promote a needs-led rather than service-led approach, the latter to maximise the appropriate tailoring of individualised packages of services to the assessed needs and choices of the older person, but highlights the subsequent use of assessment as a mechanism for prioritising needs and gatekeeping. Payne (2000) argues that the need for cost constraints was so influential that the assessment aspect of care management came to dominate practice, primarily as a way to ration services,

suggesting this is the key to understanding how care management became bureaucratised. In this respect, the re-naming of ‘case management’ as ‘care management’, ostensibly focusing attention back on the personal nature of the service (Gursansky et al., 2003), or emphasising the management of the care process rather than the individual (Onyett, 1992; Wendt, 2001), was seen as contentious by many (Huxley, 1993; Onyett, 1992; Payne, 1997). Core critiques concerned the privileging of managerial concerns over those of professional social work (Lymbery, 1998; Payne, 2000) and, for Huxley (1993), the removal of key reference points for comparative evaluation introduced by the change in terminology.

The NHSCCA sits within ‘a confusing patchwork of conflicting statutes enacted over a period of 60 years’ (Law Commission, 2010, p. 1), a recent consolidating reform of which awaits implementation in 2015 (Care Act 2014). The NHSCCA sets out a duty to assess adults in need of care but services are provided under other statutes (National Assistance Act 1948, Chronically Sick and Disabled Persons Act 1970 etc.). Subsequent statutory guidance introduced criteria for categorising levels of care need. Fair Access to Care Services, or FACS (Department of Health, 2003), specified criteria for establishing Low, Moderate, Substantial and Critical needs for care and allowed each individual local authority to determine its own threshold at which it would consider providing help. Most local authorities decide to provide publicly funded care or support only to those with needs identified as ‘Substantial’ or ‘Critical’, for example.

The NHSCCA provides no mechanism for the provision of care independent of an assessment of the recipient’s income (Department of Health, 2013), and their property in the case of residential care, to determine the service user’s contribution. Local authorities in England are the single gateway into long term care services under the NHSCCA, although those individuals with the means to do so may choose to

organise their own care entirely privately. Additional contributions to care costs can be made by the NHS ('continuing health care' funding is free if certain health related criteria are met) and an additional cash benefit known as Attendance Allowance (administered by central, not local, government as part of the social security system) can also be understood as a non-means tested contribution to care costs too.

Case management and long term care legislation in Germany

The overall policy framework for long term care in Germany is quite different to the UK, sitting within a system constructed around compulsory social insurance, with both health and long term care services funded in this way. The main long term care legislation *Sozialgesetzbuch XI--soziale Pflegeversicherung*² (SGB XI, the eleventh book of the social law code) emerged as a result of similar policy drivers to the NHSCCA, i.e. financial pressures on key institutions in the context of demographic change, although within the decentralised context of the Federal German system. Specifically, both the statutory health insurance funds and the *Land*-level (i.e. regional) governments were under pressure. The former were responsible for providing care under specific circumstances that led, for example, to 'revolving door' hospital admissions because each admission triggered eligibility for four weeks post-discharge care. The regional governments in turn had to pay for care when individuals or their families could no longer afford to do so under the previous means tested arrangements (Morel, 2007). These pressures contributed to the decision to establish a new branch of compulsory social insurance in 1994 to cover the risks of long term care, alongside long standing health, unemployment, accident and pension insurances.

² This can be translated as either 'social nursing insurance' or 'social care insurance', but does not mean 'social care' in the UK sense).

SGB XI provides specific levels of benefit (in cash or as services, whether in community or residential settings) to insured individuals of any age (independent of income or assets) according to a specific national framework for assessing levels of care need (Care Levels 1, 2 and 3). However, benefits provide partial, not complete, coverage, unlike the other social insurances (Bundesministerium für Gesundheit, 2008). The assessment is conducted by medical staff employed by the Health Insurance Medical Service (*Medizinischer Dienst der Krankenkassen* or MDK). In addition, SGB XI sits within an interlocking framework of welfare legislation that has codified previously separate statutes in a continuing process since the early 1970s (Foster & Sule, 2010; Kievel, Marx, & Knösel, 2009). In particular, SGB XI cannot be considered in isolation from Chapter 7 (Help with Care) of the twelfth book (SGB XII) of the interlocking Social Law Code that provides a range of ‘safety net’ social security provisions that are administered by local authorities. The partial nature of SGB XI’s coverage results in significant numbers of recipients needing to apply for help under this tax funded social assistance legislation if they cannot afford to top up their care provision under SGB XI from their own resources.

SGB XI, however, made no provision (prior to reforms after 2008) for any kind of case management (Evans Cuellar & Wiener, 2000; Glendinning & Igl, 2009), leaving its adoption and development to pilot projects and/or regional developments, such as the Berlin example. This was funded by the city government to address a perceived gap in the local care infrastructure using powers set out in SGB XI (§9).

Case management’s roots in the Anglophone world were, however, controversial. Ewers and Schaeffer (2005), locating the emergence of case management specifically in German social work literature from the late 1980s, note an early attempt to introduce the term *Unterstützungsmanagement* (‘support management’) (Wendt

1991, in *ibid.*), under which various components taken from both US and British models were combined and incorporated into German health and social care services. They argue this development drew less from the older history of case management in American social work and more from the more recent developments they associate with neo-conservative health and social policies that emphasise cost containment and system (rather than client) orientation. Whilst recognising the opportunities this offered for the modernisation of social work in Germany at the time, they argue nonetheless that it was little more than an uncritical adoption of British and American models that took too little account of the differing welfare contexts of the USA, UK and Germany. Wendt (2001) refutes this, however. Having abandoned the use of *Unterstützungsmanagement* in favour of *Case Management*, he states unequivocally that whilst case management fits flexibly to changing circumstances and conditions in human services, its core concept remains independent of the specifics of the service areas within which it is implemented, i.e. the different shapes case management adopts in practice do not imply a fundamentally different conceptual underpinning.

Of particular note is the differentiation now made in German between the terms *das Case Management* and *das Care Management*, the former referring to the micro-level constructed around the needs of the individual service user and the latter referring to the system level coordination required to enable case management at the micro-level (Frommelt et al., 2008), an example of how the meaning of words adopted from another language can change in that process.

Translation and Equivalence

Austin's (2002) emphasis on the importance of policy, systems and organisation as context for case management suggests an analysis that addresses the equivalence and/or translation of that context is necessary when investigating the comparability of

specific examples. Identifying similarities and differences at each level helps to determine the degree of equivalence.

Policy

The policy drivers were broadly similar in both countries, with a shift towards providing care in the community as part of the response to demographic change, the ‘deinstitutionalisation’ that has framed the development of case management (Moxley, 1989). Additionally financial pressures on key institutions were drivers of more or less contemporaneous major reforms to both legislative frameworks (Evans, 1994; Götting, Haug, & Hinrichs, 1994; Morel, 2007), in each case under conservative governments. The legislative frameworks are, however, very different.

As noted, whereas the NHSCCA incorporated care management into the system it was excluded from SGB XI (Evans Cuellar & Wiener, 2000; Glendinning & Igl, 2009). In Germany, case management tended to be regionally and/or project based (Frommelt et al., 2008), as in Berlin, creating a very different contextual relationship with the overarching legislative framework. SGB XI established national criteria for determining ‘care level’ (*Pflegestufe*), something that happened in England only with the introduction of FACS, with its contrasting locally determined ‘thresholds’ for provision of care. SGB XI has tightly focused domains and a medical orientation in its definition of need for care (Klie, Guerra, & Pfundstein, 2003; Zippel, 2003), whereas FACS criteria address wider social engagement and family roles alongside physical needs and tasks of daily living (SCIE, 2013). The two sets of criteria do not map easily against each other, despite both being mechanisms for rationing access to services.

The NHSCCA provides no mechanism for the provision of care independent of an assessment of the recipient’s means (Department of Health, 2013), unlike SGB XI. It is also tax-funded as social insurance plays no role in the UK’s welfare systems. This

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

Table 1 Legislative Similarities and Differences

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

Table 1 illustrates the difficulties inherent in establishing equivalence. The respective legal frameworks, each of which is shaped by specific historical and cultural influences (Révauger, 2001), e.g subsidiarity or the roles of families and religious institutions, in turn frame the structures and mechanisms for care provision at

subordinate levels, creating a differential partitioning of care processes that requires micro level investigation to determine comparability (Schunk, 2001).

Systems

At the system level differences arise from those historical and cultural influences that must be taken into account, specifically the presence of religious organisations as key actors in the welfare system and the related status and nature of the six *Freie Träger*, influential state-recognised independent welfare organisations with no direct equivalent in British social policy. These include Catholic, Protestant and Jewish organisations, plus secular and labour movement equivalents. Additionally, important differences derive from Germany's federal structure compared to the UK's centralised state. There are three levels of government in Germany, federal (*Bund*), regional (*Land*) and local (*Kommune*), each level of which has different responsibilities in relation to long term care. The regional governments exert considerable influence in their own right, as illustrated by Berlin's regional government commissioning a case management service to work within the prevailing care system by using its statutory powers to develop infrastructure. This landscape is further complicated by the presence of not only the *Freie Träger* and other provider organisations (including, since SGB XI, private sector care providers) but also the multiple independent care insurance fund organisations (*Pflegekassen*) and their health insurance fund partners (*Krankenkassen*). The insurance funds are the payers within the social insurance system, not the government.

By contrast structures in the UK are simpler, if complex in other ways. There are two levels of government in England of relevance to long term care, the national UK government and those local authorities that have adult social services responsibilities. One complication lies in the fact that the latter can be either so-called unitary authorities that have responsibilities for all local council functions (usually in urban areas) or

county-level authorities in rural areas where more local district councils have responsibility for particular functions such as housing and refuse collection. In an additional complication it is often necessary to explain to those from outside the UK that there is no separate government for England, a quirk that remains after the other constituent nations of the UK gained their own legislatures following devolution. Long term care policy is now different in each of the nations but England's policy is voted on by the UK parliament.

The organisational landscape in England then is, despite the presence of a range of private and voluntary sector provider organisations, less crowded, particularly when the interface with health services is taken into account. Healthcare in Germany, provided under the fifth book of the social law code (SGB V), is also a multi-actor system with a range of health insurance fund organisations and competing providers as compared to the relative simplicity of the National Health Service, although recent reforms in England are increasing the number of private providers at a local level (NHS and Social Care Act 2012).

Local councils in England have the duty to provide adult social care services under the NHSCCA, whether directly or through commissioning other providers. By contrast, the role of local councils (*Kommunen*) in German long term care, whilst variable, is often restricted to their responsibilities for the administration of Chapter 7 (Help with Care) SGB XII, the means-tested social assistance component of the system. For those individuals with the financial means to augment the partial benefits of SGB XI's social insurance-funded provision the entire process takes place without reference to a local authority. Individuals in need of care apply to their own care insurance fund which then arranges for their care needs to be assessed by the Health Insurance Medical Service. If successful, they can in principle contract directly with a care provider using

the benefits received under SGB XI. The division of responsibilities in long term care legislation constrained the Coordination Centres' ability to coordinate all service inputs and benefits on behalf of individual service users. If service users needed to apply for additional support under SGB XII (Help with Care), their cases had to be referred to the local council.

Organisations

The complex multi-actor organisational landscape in Germany is a historical consequence of both subsidiarity and the structures of the social insurance based welfare system founded by Bismarck. *Rund ums Alter* was essentially a virtual organisation, a horizontally integrated service with a common logo and branding, funded by the regional government but provided by a partnership of three of the *Freie Träger*. *Rund ums Alter* provided services supplementary to SGB XI that individuals could choose to use, a very different relationship between case management practice and its wider policy and organisational context than that between care management and the equivalent contexts in England. Each Coordination Centre was required to provide the following (Rund ums Alter, 2007): information; advice/consultation (*Beratung*); case management, and networking at an organisational level (in German *Care Management*), the boundaries between which were in practice variably interpreted between different offices. Other potentially problematic boundaries were the interfaces with the local boroughs, some of which provided competing advisory services for older people.

Translating Case Management in *Rund ums Alter*—Beware “False Friends”

There is a concept in translation studies of ‘false friends’ (Munday, 2008), words that confuse people learning a second language because of their close resemblance to a word

in their mother tongue, for example ‘*sensibel*’ in German, which means ‘sensitive’, rather than ‘sensible’. Encountering English words adopted into another language can be even more challenging, as meanings accrue and develop in relation to the word’s new linguistic context. The terms *das Case Management* and *das Care Management* have both been absorbed into German social work but, as noted, are not used interchangeably. *Case Management* refers to practice at the micro-level, constructed around the needs of the individual service user whereas *Care Management* refers to system level coordination (Frommelt *et al.*, 2008). This differentiated usage was the norm in *Rund ums Alter*, with *Care Management* the specific responsibility of the team leader, a demanding and time-consuming role in a complex multi-agency environment.

Case management was described in the service information leaflet (Rund ums Alter, 2007) in terms of the steps outlined below, written in a typical combination of German and adopted English terms that shows the penetration of *englische Fremdwörter* (English foreign words) into German social policy and social work discourse, a problematic development that is a consequence of the emergence of English as a global language (Groterath, 2011) and which poses particular translational problems. I have left the original German explanations provided by *Rund ums Alter* for service users unfamiliar with English (in normal brackets) and have in turn included additional explanatory translations in English [in square brackets] where useful:

Table 2 Comparing the Tasks of Case/Care Management

Dept of Health 1991 Guidance	<i>Rund ums Alter</i> Service Specification
Providing information	Intake (Aufnahme)
Assessing need	Assessment (Bedarfsanalyse) [Analysis of Need]
Care planning	Hilfeplanung [Care Planning]
Implementing the care plan	Implementierung (Organisation und

	Koordination)
Monitoring the care plan	Monitoring (Leistungssteuerung und – überwachung) [Managing and overseeing services]
Reviewing the need and altering the care plan if necessary	Evaluation der Ergebnisse [Evaluation of Outcomes]
	Entpflichtung [Closure]

These steps map well both against each other and the tasks identified by Austin (2002) as common to most definitions of case management. The table was originally constructed based on research undertaken at a distance prior to applying for the Fellowship and framed my early conceptions of what I might find. Writing the original proposal, I surmised that *Rund ums Alter* had been ‘commissioned’ by the ‘local authorities’ to provide ‘assessment services’ (my conception of which was, I discovered, clearly structured through my English experience of care management) within the German care system in Berlin. Baistow (2000) rightly cautions against using one’s own familiar system as a yardstick. Yet without that yardstick as a starting point, the process of navigating a different system, shaped by a different history and culture but with broad similarities (e.g. developed welfare systems, specific care legislation etc.), would be arguably more, not less, difficult (Crossland, 2008). The pitfalls, however, are many, as the experience of this case study illustrates, not least because of the ‘false friends’ that disguise themselves as apparently English words and expressions. The tasks of case management appeared (from a distance) equivalent, offering a point of comparison that turned out to be very different up close.

The use of ‘*das Assessment*’ in the definition proved particularly problematic. Before becoming aware of the interface of SGB XI with Chapter 7 (Help with Care) SGB XII, its impact on local service arrangements, the extent of the role of the Care Insurance Funds and specifically the role of the Health Insurance Medical Service in

determining the need for care, I was lulled into a false sense of ‘similarity’. My English conception of ‘assessment’ was furthermore highly shaped by the overwhelming emphasis on assessment in English care management practice (Payne, 2000), demonstrating the tendency to perceive one’s own system as ‘natural’ (Hantrais, 1999). In fact, the assessments undertaken in *Rund ums Alter* as part of their case management practice were not equivalent to the assessment process in English care management at all. Instead they were separate from and additional to the determination of need for care under SGB XI §18, undertaken by the Health Insurance Medical Service and routinely referred to using a different German word for assessment, *die Begutachtung*, demonstrating how English neologisms find their own niches amongst pre-existing synonyms which are not necessarily displaced. This *Begutachtung* in turn is functionally equivalent to assessments under section 47 of the NHSCCA, in the sense of being the mechanism through which access to care services is controlled through the use of criteria. What had appeared equivalent based on formal definitions of case/care management looked very different when, in Austin’s (2002, p. 78) term, ‘unbundled’ in a specific context. *Case Management* in *Rund ums Alter* was independent of the process for determining the need for care within the German system, unlike care management in England.

In terms of their roles, case managers in *Rund ums Alter* routinely engaged in assisting older people with identifying, securing and coordinating both health and care services, including the organisation of adaptations in the home (*Wohnungsanpassung*) such as the installation of level access showers or the removal of door thresholds to aid indoor mobility, activities more usually associated with occupational therapists rather than social workers in England. Practice was framed by the principles ‘rehabilitation before care’ and ‘community based care before residential’ as enshrined in §3 and §5 of

SGB XI and the *Rund ums Alter* service specification. However, the lack of legitimation of case management within the system constrained practice as some agencies were reluctant to acknowledge the role, a common complaint amongst practitioners.

Each local Coordination Centre adhered in principle to the definition of case management outlined above. Beyond the formal definition, however, it became clear there was some disagreement between the different local offices in terms of how the definition was operationalised and defined in relation to the other services offered by the project, particularly *Beratung*, i.e. providing advice/consultation. This *Abgrenzung* or delineational issue was a key theme during the fieldwork period and was debated in a number of forums. The working definition in the local office was a simple heuristic that, if a request for service concerned more than one distinct area of need and required some level of coordination, then it would be recorded as *Case Management*, including the arrangement of adaptations. This variation in operational definitions between offices in Berlin is in turn reflected in different English local authorities' highly variable implementations of care management (Challis et al., 2001; Weiner et al., 2002).

Conclusions

This study clearly demonstrates the determining impact of policy, system and organisational context on the construction of case management in *Rund ums Alter*. The study also shows how similar definitions of the core tasks of case/care management used in Berlin and in England can be very different when 'unbundled' (*pace* Austin) in relation to specific contexts. Additionally, it questions whether problems of definitional variability in multi-site examples are solely due to local influences or perhaps derive from the long standing variability in definitions of case management identified by Austin (2002). Each of these conclusions at the very least raises questions for any study

using case management as a key variable, illustrating the potential inconsistencies identified in various studies by Gustafsson *et al.* (2013). Finally, and of particular salience for monolingual English speakers, it has shown how the adoption of English words and expressions into non-English language welfare vocabularies, the meanings of which continue to shift and refine in relation to their new social and linguistic contexts, may not necessarily resolve the central problem of establishing equivalence in cross-national social research. Indeed, it may simply make translation more complex.

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