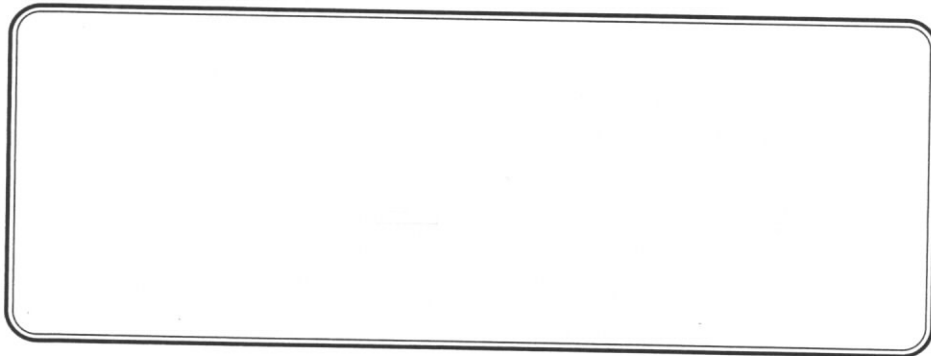




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DISSERTATION



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DISSERTATION

**“MEDICAL SOCIAL WORK IN IRELAND
AND GERMANY- A COMPARISON OF A
PERSONAL SOCIAL SERVICE IN TWO
DIFFERENT WELFARE STATES”**

BY ANDREA BUCKLEY

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Contents

<i>List of Tables</i>	IV
<i>List of Figures</i>	IV
<i>Abbreviations</i>	V
Acknowledgements	VII
Introduction	1
Aims of the Research	3
Methodology	4
Difficulties arising in the comparison of medical social work in Germany and Ireland	5
<u>PART I: THE SOCIETAL CONTEXT</u>	
A) Population	7
B) Economic Data	11
Germany and Ireland - differences and similarities in the two welfare states	13
<u>PART II: THE HEALTH SYSTEMS AND RECENT CHANGES</u>	
Description of the two health systems	16
Recent problems and changes in the two health systems	23
Efficiency of introduced cost-containment measurements	25
European and international influences on the health services	29
<u>PART III: HOSPITAL SERVICES IN GERMANY AND IRELAND</u>	
Hospital Services in Germany	30
Hospital Services in Ireland	33
Trends in Acute Hospital Care in Germany and Ireland	34
<u>PART IV: MEDICAL SOCIAL WORK</u>	
Definition of medical social work	36
Historical development of the profession in Germany	38
Historical development of the profession in Ireland	39
Similarities in the development of professional medical social work in Germany and Ireland	41
Organisation of medical social work within the hospitals at present in Germany and Ireland	41
Professional representation	42
Financing of medical social work	43

Duties of medical social workers in Ireland and Germany	43
Numbers of medical social workers in Germany and Ireland	45
Income, training and hierarchical structure in medical social work	51

**PART V: INFLUENCES OF RECENT DEVELOPMENTS ON
MEDICAL SOCIAL WORK**

The influence of the change in clientele on medical social work	54
The influence of changes in the health system on medical social work	54
The national differences in financing of hospital services on medical social work	56
The influence of legislation on medical social work	56
The influence of professional status on medical social work	58

PART VI: CONCLUSIONS 59

Glossary	60
-----------------	----

Appendix I 63

Hierarchy of social workers in Ireland	63
--	----

Appendix II 64

Territory of Germany and Ireland and organisation of their health systems	64
---	----

Bibliography	66
---------------------	----

List of Tables

- Table 1: *Population, area and population density in Germany and Ireland*
- Table 2: *Development of the population in GER and IRE 1970 - 1993*
- Table 3: *Asylum-seekers in Germany, Ireland and EU as a whole, 1985-1995*
- Table 4: *Age distribution in Germany and Ireland*
- Table 5: *Development of birth rates in GER and IRE 1970 - 1993*
- Table 6: *Economic factors*
- Table 7: *Overview about important steps in the development with regard to the social security provision and the health services in GER and IRE*
- Table 8 a: *Distribution of health expenditure in Germany in 1993*
- Table 10 a: *Financing of health systems in Germany, Ireland and EU-average, 1992*
- Table 11 a: *Health expenditure growth in Germany, Ireland and EU-average, 1970-1991*
- Table 12: *Health share in relation to GDP in Germany and Ireland, 1980-1990*
- Table 13: *Health expenditure and health expenditure shares of GDP in GER and IRE, 1970-1990¹*
- Table 14: *Non-capital expenditure on statutory health services for the years 1982 to 1996 in actual terms and as a percentage of Gross National Product in IRE*
- Table 15: *Institutions, beds and patient movement in Germany, 1970-1994*
- Table 16: *Numbers of hospital, of beds and average duration of stay in acute hospitals in Ireland, 1980-1991*
- Table 17: *Development of the no. of hospitals, beds and average length of stay in Ireland and Germany, 1980-1991*
- Table 18: *Medical social workers in German hospitals*
- Table 19: *Distribution of employment in Social Work*
- Table 20: *Qualifications held by social workers in post*
- Table 21: *Numbers of medical social workers in Ireland in 1985 and 1996*
- Table 22: *Registered Aids-cases in Germany, Ireland and the EU as a whole, 1985-1996*

List of Figures

- Figure 8 b: *Pie chart of the distribution of health expenditure in Germany in 1993*
- Figure 9: *Estimated percentage of non-capital expenditure by programme in IRE in 1996*
- Figure 10 b: *Bar chart illustrating the public proportion in the financing of health systems in GER, IRE and EU-average, 1992*
- Figure 11 b: *Bar chart of health expenditure growth in GER, IRE and EU-average, 1970-1991*

¹ OECD (1992): *Health Policy Studies No. 2*, extracts from table 10.1 on p. 132

Abbreviations

CCETSW	Central Council for Education and Training in Social Work ²
CDU	“ <i>Christlich Demokratische Union</i> ”, Christian Democrats
CQSW	Certificate of Qualification in Social Work
DBSH	“ <i>Deutscher Berufsverband für SozialarbeiterInnen, SozialpädagogInnen und HeilpädagogInnen</i> ” (in Essen), (German professional representation for social workers)
DM	“ <i>Deutsche Mark</i> ”, German marks
ECSPRESS	European Consortium of Social Professions with Educational and Social Studies founded in 1996
EHB	Eastern Health Board
EU	European Union
FDP	“ <i>Freie Demokratische Partei</i> ”, Liberal Party
GER	Germany
GRG	“ <i>Gesundheitsreformgesetz</i> ” (1989), Health Reform Law
GSG	“ <i>Gesundheitsstrukturgesetz</i> ” (1993), Health Structure Reform Act
IASW	Irish Association of Social Workers (in Dublin)
IDA	Industrial Development Agency (in Ireland with branches abroad, e.g. UK, U.S.A, GER, NL, Japan)
IRE	Ireland
JWG	“ <i>Johann Wolfgang Goethe</i> ”
ME	“ <i>Medizinische Einrichtungen</i> ”, medical institutions
No.	number
NQSW	National Qualification in Social Work (Irish Recognition)

-V-

² In the past, the U.K.'s CCETSW has monitored, accredited and validated Irish social work courses provided by Trinity College Dublin, University College Cork and University College Dublin. The relevant Qualification awarded was the British CQSW. This was the generally recognised qualification for employment. The NQSW is the Irish recognition which was established as a consequence of the decision by CCETSW to cease its involvement in Irish social work education and training.

OECD	Organisation for Economic Co-operation and Development
PflegeVB	“ <i>Pflegeversicherungsgesetz</i> ” (1995), Care Insurance Law
SPD	“ <i>Sozialdemokratische Partei Deutschlands</i> ”, Social Democratic Party
WHO	World Health Organisation
WWU	“ <i>Westfälische Wilhelms-Universitätsklinik</i> ”, name of university clinic in Münster

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Introduction

In my dissertation I would like to compare a field of social work performance: medical social work, a personal social service for patients in hospitals in two different European welfare states, Ireland¹ and Germany. I am interested in the different national context's in which the performance of this service takes place. Medical social work takes place in various contexts such as, the societal context, different welfare and health systems and the hospital service. These contexts are inter-dependent and have an influence on medical social work performance as well as the work with changing clientele and problems.

From my own professional background as a medical social worker, with experience of working in Germany, I noticed that this context and occurring changes in social policy in general have a direct and strong impact on the performance within social services. As Catherine Jones (1985) states: Social work represents the "micro" end of social policy and is influenced by the macro end, the decision-making in social policy and its implementation. The period of time, that I want to focus on, starts with 1980 up to the present. During this period the reform of the health services was started in Germany and a lot of relevant legislation was enacted. At the same time similar changes took place in Ireland. John Curry, Director of the Irish Social Service Board throughout most of the 1980s, stated: *"It was largely in the context of cutbacks in public expenditure that in the health services that a rationalisation of hospitals occurred in the late 1980s."*² A number of hospital closures took place at this time in Ireland.

The recent changes in the health systems of the two countries can be experienced by a social service on different levels. Changes on the macro-end of social policy are e.g. the enactment of new legislation or the overall distribution or allocation of resources to various areas within the health system. The changes within the framework of hospitals, in which medical social workers are employed, would be on the level of the mezzo-system. On the third level, this is the micro-system, changes in the problems that medical social workers have to deal with, e.g. more chronic diseases and changing social problems will be noticed by a personal social service.

¹ With using the term "Ireland" I refer to the Republic of Ireland.

² Curry, J.: (1993), Irish Social Services, Dublin: Institute of Public Administration, p. 130

With a closer knowledge of the German system, I am now curious to see if similar developments have taken place in Ireland. In Germany there have been many changes in the health system in general since the 1980s. The introduction of new legislation has been aimed at the limitation of expenditure in the health area in general and since the 1990s in the hospital services in particular. A major concern of the German government has been the rise of contributions for health insurance. Vocabulary which has been used increasingly in this context in both countries is cost containment, accountability, efficiency, transparency, co-operation, net-working, to mention just a few of them.

Demographic developments like ageing population are important variables which have to be considered in the organisation and planning of health services. In relation to an ageing population with the implicit picture of more and a different kind of demand in health care this is only one problem societies have to face at present and in future. In Germany the enactment of the health structure reform law (1989) and new care insurance law (1995), and the different steps of its implementation were among the answers of the government to these problems. In the case of the new care insurance law as an example, this act has had direct consequences on the performance of medical social work in practice: e.g.: the preparation for the discharge of elderly people into a nursing home involves more counselling and administrative duties according to the new legislation.

Another concrete present influence on medical social work in Germany is caused through the health structure reform act ("*Gesundheitsstrukturgesetz*", 1993). Present cutbacks in the health system and the pressure on hospitals to reach their goals within a financial budget, lead to more pressure on all professional groups in hospitals, but especially on non-medical professions, which are usually the minority in figural terms (e.g. social workers, speech therapists, psychologists, physiotherapists). Social workers are seen as an almost "exotic" group of professionals among the mainly medical professionals (nurses, doctors, therapists) as well as the administrative staff. The reason of their "exotic status" is a different approach to their work, due to different curricula and the ethos behind it.

At present hospital management, usually the administrative managers, ask social workers to make their service more transparent or expressed differently: understandable

for other professionals with a different approach to work, and to develop quality standards. On top of these requirements the caseload and the complexity of problems within the cases is growing³, with staffing numbers remaining the same or decreasing. This is one of the reasons why medical social work performance is in a state of change and facing new problems.

Aims of the Research

I want to show the context or so-called framework within which the medical social work service operates. This means the **societal context** as a whole, the **health system** in general and the **hospital setting** in particular. My idea is to give a short overview about the historical development of medical social work in both countries and some background information about what **medical social work** is.

Further on I would like to examine if there is a connection between the changes in the health area, especially for hospitals, and the influence of these changes on medical social work. The research question is: **Have changes in the health system in general and the hospitals in particular influenced medical social work?** With a close knowledge of the German system I am curious if something similar, i.e. increasing pressure on medical social workers can be found in Ireland, too? Are there budget constraints for Irish hospitals? And are there parameters, e.g. changes in the average lengths of stay in a hospital, that can demonstrate that there is a connection between changes in the overall work environment and the performance of medical social work?

This dissertation is an attempt to show differences and similarities of medical social work within the national societal context in both countries, this is **Part I**. In this chapter I would like to examine distinctive features of the two societies. In **Part II** the context of the health systems and recent changes in Ireland and Germany will be drawn up. In this context the following questions are of interest: What type of welfare system do the two countries have? and: What are the differences and similarities?

³ see Nau, H., "Die Krankenhaussozialarbeit am Scheideweg?" in Medizinische Einrichtungen der Westf. Wilhelms-Universität Münster, Dezernat 02.5/ Sozialdienst (1997), "Soziale Arbeit / Sozialarbeit im Umbruch? , Dokumentation der 2. Fachtagung für Sozialarbeiter am 27./28.2.1997 in Münster, (Germany), pp. 16 - 24

Part III goes into further detail, because now the hospital services in both countries will be compared, because the hospitals are the framework in which medical social work takes place. This chapter establishes the way in which the hospital services in Ireland and Germany are organised, with a closer look at current problems that hospitals have to deal with.

Part IV deals with medical social work in both countries. Questions of e.g. the definition of medical social work, the historical development of the profession and the duties will be answered. Furthermore the attempt at a quantitative cross-national comparison in regard to numbers of medical social workers will be made.

Followed by **Part V** the connection between Part I to III and Part IV will be made to analyse the influences of recent developments on medical social work. Another aim is to show the interdependencies between the macro-, mezzo- and micro-system. Finally **Part VI** will summarise the influences of the changes established in the previous parts on the medical social work service in both countries and show the **conclusions** from this research.

Methodology

The original intention of my dissertation was to focus on the actual performance of medical social work in Ireland and Germany and to analyse the differences and how they could be explained. During the time of collecting the data and while talking to practitioners in Ireland, I came to the conclusion that my original idea would not offer enough material because the differences in this social service aren't immense. There are more similarities than differences. With a deeper knowledge about the German situation and the changes which take place in the German health and hospital system, I came to the conclusion that a shift of the focus to changes in the overall framework in which medical social work takes place would offer much more material for a comparative analysis.

I collected publications about social work in general about Ireland and Germany, books, documentation about international conferences and information from the professional bodies. Furthermore I contacted the Ministries of Health and statistical offices in the two countries. The idea of this dissertation is to move from the general context to

the service in particular. Attention will be drawn to the overall context of the society, the welfare and health system, the hospital system and finally medical social work itself. The idea is to approach this cross-national study in a holistic way, which means to show the interdependencies of the above mentioned systems (society, health, hospital) and how these parts influence the whole system of social work in hospitals.

The interviews with the medical social workers, were semi-structured. The main aim was to collect information and to verify or falsify my hypothesis during the process of preparing my dissertation. The main questions are represented in Appendix I.

I decided to concentrate on variables which experts and practitioners of social work consider to be important to have an influence on their performance: these are the average length of stay in hospitals, numbers of hospitals, numbers of medical social workers, the distribution of employment in social work, the income of social workers in comparison to other professionals, etc.

Due to the limited amount of time for the dissertation I wanted to use mainly secondary sources: *“The benefit of an analysis based on secondary sources is that it allows the researcher to concentrate on the issue of the study rather than on the practical methodological problems of collecting new data.”*⁴

Difficulties arising in the comparison of medical social work in Germany and Ireland

The topic that I chose has not yet been researched, only issues regarding social work in general or the health and hospital services have already been analysed. Catherine Jones points out: *“...personal social care seems to be one of the least researched and least documented areas for comparative study.”*⁵ Nevertheless, the interest of dealing with social work in a European context seems to grow, if one looks at the increasing amount of publications, the development of cross-national networks and the number of international conferences.

⁴ Jones, C. (1985), *Patterns of Social Policy. An introduction to Comparative Analysis*, London: Tavistock Publications, p. 62

⁵ ditto, pp. 172/173

Problems arising throughout the preparation for the dissertation are e.g.: that statistical data about the numbers of social workers in general and medical social workers in particular are not or like in the German case not continuously available as will be shown in Part IV about medical social work. Both countries only deal with estimates or according to the number of permanent posts for social workers where in actual fact somebody else could work in this job.

Other difficulties are the comparison of cross-national data in general. Definitions can be different e.g. in regard to social work. In Germany due to a different system of training for social workers there are two titles for social workers: “*Sozialarbeiter/Sozialarbeiterin*” and “*Sozialpädagoge/Sozialpädagogin*”. In comparing statistical data I mainly relied on EU-sources, if they were available, to avoid the definition problem. In cases where I could only get national data, I explained what figures I used and for which period or point of time either in the tables directly or in the footnotes.

PART I: THE SOCIETAL CONTEXT

In the following paragraphs an overview about some characteristics of the German and Irish society will be given. The idea is to inform about the distinguishing features of the two states, about their population, the organisation of the two states and their welfare systems as well as their economic performance.

A) Population

Table 1: *Population, area and population density in Germany and Ireland*

	Germany	Ireland
Population in 1997⁶	82,190,000	3,559,000
Regional area	356,978,000 km ² ⁷	70,282 km ² ⁸
Population density per km² in 1995⁹	228	52

As we can see from the tables above Germany's population is more than 23 times that of Ireland and its population density is more than four times higher than in the case of Ireland. Ireland's size of 70,282 square km is comparable to the size of Bayern, a southern federal state of Germany.

Both countries are democratic states. In Germany the influence of the Nazi-regime and the Second World War had an impact on the further development and organisation of the government. Since 1945 the federal system with the division of power at central (*Bund*), federal (*Länder*) and local (*Städte, Gemeinden*) level has developed. Germany's government and its administration is much more decentralised than is the case in Ireland. Ireland became an independent state in 1922 after its experience as a British colony. The British influence is important to take into account when looking at the development of the Irish welfare state and at the development of social work as this will be shown in this

⁶ WHO (1998), *The World Health Report 1998: Life in the 21st Century: A vision for all*, Geneva: Report of the Director General

⁷ Weidenfeld, W., Korte, K.-R. (eds.) (1996), *Handbuch zur deutschen Einheit*, Bonn: Bundeszentrale für politische Bildung, p. 771

⁸ IDA Deutschland (1998), *Tatsachen über Irland 1998*. (Flyer)

⁹ Source: Eurostat (1997), *Die Europäische Union in Zahlen*, Luxemburg: Statistisches Amt der Europäischen Gemeinschaft, p. 7

dissertation. The unification of Germany in 1990 was an important occurrence. In the context of this dissertation, we have to know that the former health system in the GDR¹⁰ which was a centralised, integrated (see Glossary) and publicly financed health care model has been changed to the contract model (see Glossary) which had been used by former West-Germany.

On the Irish Island the division into two separate states: Northern Ireland and the Republic of Ireland, still exists. Despite peace talks and new political attempts recently to solve the problems there seems to be no end to the conflict, not to mention the possibility of a unification like it has happened in Germany. In this dissertation the focus is on the Republic of Ireland.

*Table 2: Development of the population in GER and IRE, 1970 - 1993
(Numbers in 1,000)¹¹*

	1970	1980	1990	1993
Germany	77,709	78,275	79,365	81,179
West-Germany	60,651	61,538	63,254	65,534
East-Germany	17,058	16,737	16,111*	15,645
Ireland	2,950	3,401	3,503	3,563

*Population, counted on 03/10/1990, at the same time average number for the year

The development of the population in Ireland and Germany is another distinguishing feature of the two countries. In Germany as a whole there has been a constant rise in the population figures from 77,709,000 in 1970 to 81,179,000 in 1993. The decline in East-Germany could be explained through migration to the Western part of Germany for mainly economic (workplaces, wages) reasons. In Ireland the development of the population is unique in Europe as there has always been a tradition to emigrate for mainly economic reasons. Ireland had from 1960 to 1990 a continuously negative migration figure, e.g. in

¹⁰ "The great bulk of pharmaceutical, ambulatory medical care and hospital services were organised under the State and were provided free of charge to patients.", OECD (1992), *Health Policy Studies No. 2*, p. 66

¹¹ Bundesminister für Gesundheit (1995), *Daten des Gesundheitswesens - Ausgabe 1995*, Band 51, Baden-Baden: Nomos-Verlag, p. 17

1989 of minus 10.2 per 1,000 inhabitants.¹² Since the economic situation has almost constantly improved in the country the population figures grew from 2,950,000 in 1970 to 3,563,000 in 1993. In comparison Ireland is rather a country with emigration and in Germany immigration plays a more important role.

One third of the Irish population lives in the Greater Dublin Area, so that there are big regional differences in the country in general: to put it simply: urbanisation and a good infrastructure in the Greater Dublin Area, leaving the rest of the country rural and with a lack of infrastructure especially in the west of Ireland. These regional differences are mirrored in the organisation of medical social work. In Dublin there is a well developed hierarchy and departments of social work in contrast to many hospitals without any or with only one medical social worker in the rest of the country.

Table 3: Asylum-seekers in Germany, Ireland and EU as a whole, 1985-1995¹³

	1985	1990	1992	1993	1994	1995
Germany	73,832	193,063	438,191	322,599	127,210	129,517
Ireland	---	62	---	91	355	---
EU as a whole	159,176	403,496	674,056	516,710	307,722	261,410

The Irish society is still a very homogenous society. Despite their ethnic minority, the so-called travellers, estimated to be between 20,000 and 30,000, the number of foreigners and asylum seekers are still low and have only increased in the past few years. The table above shows that Germany had the highest number of asylum seekers in 1992 with 438,191 people, which in this year was about 41 % of the overall number in the EU, whereas the 355 asylum-seekers in Ireland are a percentage of 0.12%. Due to a change in the German legislation in 1993 the number of asylum-seekers has constantly declined. In Ireland the figures about asylum-seekers are patchy and very low in an EU-comparison.

¹² Gabriel, O.W., Brettschneider, F. (eds.) (1994), *Die EU-Staaten im Vergleich*, Bonn: Opladen, p. 505, Table 11

¹³ Statistisches Bundesamt (ed.) (1997), *Statistisches Jahrbuch 1997 für das Ausland*, Stuttgart: Metzler-Poeschel Verlag, p. 42

This is completely the contrary case in Germany due to its geographically central location on the European continent in contrast to Ireland. Stability in its economic and political situation are further contributing factors to make Germany an attractive country for refugees and asylum-seekers.

Table 4: Age distribution in Germany and Ireland¹⁴

Age distribution		Age 65 and over in relation to < 5,				
		1997		2025		
		3.2	5.0	1.7	3.0	
	Population altogether in 1,000 and %	below 5 years in 1,000 and %	5 - 20 years in 1,000 and %	20-60 years in 1,000 and %	60-80 years in 1,000 and %	80 and older in 1,000 and %
Germany 31/12/93	81,338	4,328	13,180	47,237	13,331	3,263
	100 %	5%	16%	58%	16%	4%
Ireland 01/01/93	3,560	266	976	1,775	459	85
	100 %	8%	27%	50%	13%	2%

In contrast to Germany Ireland has a very young population and in the context of social security a very favourable dependency ratio as shown in the tables about the age distribution.

¹⁴ Bundesminister für Gesundheit (1995), *Daten des Gesundheitswesens - Ausgabe 1995*, Band 51, Baden-Baden: Nomos-Verlag, p. 21

Table 5: Development of birth rates in GER and IRE 1970 - 1993

	No. of live births (per 1,000) inhabitants			
	1970	1980	1990	1993
Germany	13.5	11.0	11.4	9.8
Ireland	21.8	21.8	15.1	13.7
Germany: Birth rate, average no. of births per woman ¹⁵	2.03			1994 1.26
Ireland: Birth rate, average no. of births per woman ¹⁶	3.93			1994 1.86

The development of birth rates in Germany and Ireland over the period from 1970 to 1993 shows a traditionally high birth rate in Ireland which was almost double as high as in Germany in 1970 and 1980: 21.8 (1970 and 1980) per 1,000 inhabitants versus 13.5 (1970) and 11.0 (1980). The birth rates in both countries have continuously decreased in both countries over this period. However, the background to the young population in Ireland has been its traditionally high birth rate in a European comparison. Naturally this has implications for the health systems in the two countries as Ireland's problems of providing and financing services for the elderly is not as much of a problem as it is forecast to be for Germany.

¹⁵ Source: Eurostat (1997), *Die Europäische Union in Zahlen*, Luxemburg: Statistisches Amt der Europäischen Gemeinschaft, p. 9

¹⁶ ditto

B) Economic Data

Table 6: *Economic factors*

General Government Total Expenditure (as a percentage of GDP, 1996) ¹⁷	50.0	38.6	EU-average: 50.6
General Government Deficit (as a percentage of GDP, 1996) ¹⁸	-3.9	-2.0	EU-average: -4.4
Gross Domestic Product¹⁹ at current prices and current exchange rates Average annual volume change	1996: 2354.2 Billion US \$ 1.1 %	1996: 69.2 Billion US \$ 7.0 %	
Unemployment quota, 1996²⁰	8.2 %	12.3%	EU-average: 10.9 %
Standard of living (GDP) per inhabitant 1994 (in a standardised ability of purchasing goods) ²¹	18,326	14,171	EU-average: 1,641
Expenditure for social security in % of GDP, 1993²²	29.70	20.44	EU-average: 27.52

Ireland has recently experienced an economic boom. This development is often referred to as the "Celtic Tiger". Reasons behind this success are among others the active measures of the government especially through the IDA (Industrial Development Agency) to attract foreign investment to Ireland. The IDA contacts prospective companies abroad and "sells"

¹⁷ Source: *European Economy, Supplement A, Economic Trends*, No.5/6. May/June 1996, cited in National Economic and Social Council (1996), *Strategy into the 21st Century*, Report No. 98, Dublin: Stationery Office, p. 92

¹⁸ ditto, p. 93

¹⁹ Institute of Public Administration (ed.) (1998), *Yearbook 1998*, Dublin: Institute of Public Administration, pp. 426-427

²⁰ Statistisches Bundesamt (ed.) (1997), *Statistisches Jahrbuch 1997 für das Ausland*, Stuttgart: Metzler-Poeschel Verlag, p. 48

²¹ Source: Eurostat (1997), *Die Europäische Union in Zahlen*, Luxemburg: Statistisches Amt der Europäischen Gemeinschaft, p. 11

²² ditto, p. 15

them Ireland as an investment country for branches of their company.²³ The Irish economic success is reflected in their well below EU-average percentage of government spending as a percentage of GDP: this was 38.6 % in Ireland, 50.0 % in Germany and 50.6 % as an EU-average. Equally low was Irelands general government deficit (as a percentage of GDP in 1996: - 2.0 % in comparison to -3.9 % in Germany and - 4.4 % as an EU-average value. The National Economic and Social Council²⁴ summarises the excellent performance of the Irish economy in the following way: *“The 1987-96 period is thus unique in its harmony of high growth, low inflation, impressive employment growth, improved public finances and balance of payments surplus.”*

Despite this success, Ireland still had a high unemployment rate of 14.4 % in 1995. However, this rate was reduced to 12.3 % in 1996. In comparison Germany had an unemployment quota of 8.3 % in former West-Germany and 9.4 % in East-Germany in 1995. The overall quota for Germany as a whole was reduced to 8.2% in 1996. The high unemployment quota in Ireland and a high proportion of social welfare recipients which is about one third of the population are the dark sides of Irelands success.²⁵

We still have to bare in mind that we compare two countries which are extremely different in size. The new German capital Berlin has for example a GDP of 140 billions of German marks which is higher than the GDP of Portugal, Ireland or Greece.²⁶

Germany and Ireland - differences and similarities in the two welfare states

Existing studies about welfare states and their development have led to attempts to classify the nation states into different categories. Germany and Ireland have been classified differently. Germany is regarded as belonging to the corporatist model, which means

²³ Through tax incentives, modern telecommunication network, English as a mother tongue of their employees, flexibility in educational systems, the advantage of the young and well educated Irish population, etc.

²⁴ National Economic and Social Council (1996), *Strategy into the 21st Century*, Report No. 98, Dublin: Stationery Office, p. 15

²⁵ This includes not only social assistance, but also social welfare top-up payments like income support and medical cards, *“... about one-third of the population is currently dependent on social welfare payments...”* in Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 52

²⁶ Weidenfeld, W., Korte, K.-R. (eds.) (1996) *Handbuch zur deutschen Einheit*, Bonn: Bundeszentrale für politische Bildung, p. 50

“relying heavily on social insurance contributions and more generally on a corporatist organisation of society where “subsidiarity” prioritises private initiatives,...”²⁷ In contrast Ireland has been categorised as belonging to the rudimentary welfare model, “where the division of state and private welfare responsibilities follows no overall agreed pattern.” Critics state, that there is a lack of social policy planning in Ireland²⁸ as well as a lack of co-ordination of existing services, especially co-ordination and development of networks between statutory and non-governmental organisations. Numerous voluntary organisations play a key role in the provision of social services in Ireland.²⁹ They fill the gap of insufficient or in some fields not existing governmental planning.

Social scientists like Stefan Leibfried (1992) include Ireland in the rudimentary welfare type. His reasons are the importance of agriculture, the influence of the catholic church and the peripheral location of the country.³⁰ Other authors like Mel Cousins emphasise for Ireland in particular its peripheral location and colonial past, factors, which in his opinion have been neglected by other studies. Esping Andersen (1990) mentions Catholic parties, general corporatist tendencies, a strong influence of leftist parties or a labour movement as important influences and actors in the development of welfare states. In the absence of a labour movement and strong leftist parties the Catholic Church in the mainly catholic Irish society (95%) certainly played an important role and has influenced social policy in general.³¹ Ireland has “a long tradition of voluntary activity, self-help, cooperative ventures, local fund-raising³² and informal care.”³³

The catholic principle of subsidiarity can be found in the existence of many voluntary organisations especially on community level in Ireland. This principle, “...which

²⁷ Lorenz, W. (1994), *Social Work in a Changing Europe*, London: Routledge, p. 10

²⁸ see Ó Cinnéide, S. (1993), *Social Europe - EC Social Policy and Ireland*, Dublin: Institute of European Affairs, 1993, p. 131

²⁹ “... and there is also a long tradition of voluntary activity, self-help, co-operative ventures, local fund-raising and informal care.”, Cannan, C. et al. (1992), *Social Work and Europe*, London: Macmillan, p. 52, see also p. 90

³⁰ See Cousins, M. (1997), “Ireland’s place in the worlds of welfare capitalism”, in *Journal of European Social Policy*, Vol. 7. No. 3, August 1997, pp. 223-235,

³¹ In relation to HIV/Aids the catholic influence became obvious through the reaction of and ethos in many catholic pressure groups. This hindered a non-moralistic and more scientific secular approach towards this problem.

³² Fundraising seems to belong to every day life, especially in bigger cities like Dublin in contrast to Germany where we are not [yet] familiar with this kind of organising finances for social services.

is the provision of help at the lowest level or by the least formal means, such as through family and informal care first, or by voluntary or private agencies, in preference to or by the least formal means, such as through family and informal care first, or by voluntary or private agencies, in preference to statutory services. This also relates to the basis of funding."³⁴

It is also found in Germany, however here "...we find a mix of Lutheran and Catholic influences".³⁵ The German state is obliged through its legislation to create the conditions to allow smaller units, e.g. private agencies like Church organisations (*Caritas*, *Diakonie*, etc.) to provide social and health care services. As a result there is a welfare pluralism in Germany more than in Ireland with a diversity of service provision, different methods of delivery and underlying philosophies.

³³ Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 52

³⁴ ditto p. 48. Another definition of subsidiarity (Lippa, 1983): "*Susidiarity should be understood to mean that whatever smaller and more individual institutions (e.g. the family), groups (e.g. associations) or public bodies (e.g. communities, Länder, churches) can do on their own must not be taken from them by a higher level of competence or by the power of the state, but that responsibility should remain as near a possible to the people involved. At the same time there is a challenge to take on the tasks at the grass roots level if they can be carried out there instead of leaving them to superior agencies, ...*" in Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 32

³⁵ ditto, p. 32

PART II: THE HEALTH SYSTEMS AND RECENT CHANGES

In this chapter I would like to describe the two health systems in Ireland and Germany. Both countries experienced similar developments of growth in medical care expenditures in the 1970s like most OECD countries did. The aim of this chapter is to show the differences and similarities of the two health systems with a particular emphasis on the recent problems and changes.

Description of the two health systems

At the beginning of the description of the two health system I would like to show important steps in the development of social security provision and in legislation regarding the health services in Germany and Ireland³⁶ as shown in the following overview. These steps will be commented during this chapter.

Table 7: Overview about important steps in the development with regard to social security provision and reforms in the health services in GER and IRE

Year	Germany	Ireland
1838		Poor Law (introduced under British rule)
1883	Health Insurance for workers	
1884	Accident Insurance	
1889	Old Age and Invalidity Insurance for workers (Insurance Scheme)	
1903	Health Insurance for employees	
1909		Old Age Pension (Assistance Scheme)
1911	Social Insurance for Employees, Establishment of one legal framework for the Social Insurance of workers, the so-called "Reichsversicherungsordnung (RVO)"	Unemployment benefit Sickness benefit
1927	Unemployment Insurance (=benefit)	
1933		Unemployment assistance
1961	Social Assistance and a guaranteed minimum income (means-tested)	Old age Pension (Insurance Scheme)
1966		Smallholder's assistance (similar to social assistance in Germany)

³⁶ Extracts from Curry, J. (1993), *Irish Social Services*, Second Edition, Dublin: Institute of Public Administration, p. 19 and Beywl, W. (1994), *Kontrovers: Soziale Sicherung*, Bonn: Bundeszentrale für politische Bildung, p. 12

1970		Health Act, re-organisation of the health services in Ireland, establishment of eight regional health boards (see appendix II)
1971	Legislation for the change within Health Insurance, the emphasis was put on prevention and early diagnosis of illnesses	
1976	Design of a comprehensive code of law for legislation regarding Social Insurance. General Part contents the Social Charta of the Federal Republic of Germany	
1977	Health Care Containment Act, among other things: establishment of a Concerted Action in the health services ³⁷	
1989	Health Care Reform Law came into force on the 01/01/89 (“Gesundheitsreformgesetz” (GRG))	
1990	Unification of Germany	Carer’s Allowance
1991		Extensions to compulsory insurance systems
1993	Health Services Structure Reform Act (“Gesundheitsstrukturgesetz” (GSG))	
1995	Care Insurance Law (mandatory, for financing long-term care) (“Pflegeversicherungsgesetz, PflegeVG))	
1996	01/01/96: Introduction of a new payment system for hospitals with case flat rates, special rates, rates for departments and basic rates	
1998		Budgets for Irish hospitals as well as for the health boards

The German health system is a plural one, traditionally heavily relying on social insurance systems. This means, that there are “*services from both private (usually non-profit) and public organisations financed mainly from compulsory health insurance*”.³⁸ “*Social security and social insurance were first established in the 1880s in Bismarck’s laws*

³⁷ which means a body of experts with representatives from the health insurance companies, from hospitals, from pharmaceutical companies, politicians from federal and community level, doctors, dentists and pharmacists. The Ministries for Youth, Family, Women, Health and Economy are also involved by their representatives. The duties of this body are to demonstrate priorities in health policy on the basis of medical and economical data and to show where future savings could be made.

³⁸ European Commission (1996), *The State of Health in the European Community*, Luxembourg: Office for Official Publications of the EC, p. 41

which attracted immense interest in the European countries.”³⁹ The experience of the Nazi-regime in Germany was a major influence for the development of a decentralised organisation of government and consequently of the health system as well in contrast to a centralised National Health System which we can find in the UK and in Ireland. Distinguishing features of the German health system are “a strong legal framework set centrally, within this, considerable devolution of power and responsibility to sickness funds, physicians’ associations and other bodies, and diffusion of the remaining government responsibilities between federal, Länder and local governments.”⁴⁰ Germany’s federal system of government is reflected in the regulation of health services, as this is diffused between these three levels. The responsibilities on the central level (*Bund*) are drafting laws, general policy and jurisdiction over the health insurance system. On the federal level (*Länder*) responsibilities like the approval of federal legislation through representatives in the Upper House (*Bundesrat*), local supervision of sickness funds and physicians association, the management of *Länder*-owned hospitals (e.g. university clinics) and teaching hospitals, the hospital planning and the regulation of standards in medical education belong to this level. Finally the local governments are responsible for public health services, management of and investment in local hospitals as well as the management and financing of public nursing homes.

It was a consensus among the German parties after the second world war to prefer a plural health system. “Yet, after the war, the German SPD (Social Democratic Party), like the conservative CDU (Christian Democrats), rejected the idea of a comprehensive health care system, preferring a decentralised plural system.”⁴¹ This consensus among the two big parties has remained until the 80s: “... and until the 1980s it was possible to speak of a consensus over the desirability of the German Sozialstaat (the social state), rather than the Wohlfahrtsstaat (the welfare state), which has negative, patronising connotations.”⁴² Additionally, in contrast to Ireland, the German government preferred in their social system earnings related benefits to flat rate benefits for the reasons of

³⁹ Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 28.

⁴⁰ OECD (1992): *Health Policy Studies No. 2*, p. 62

⁴¹ ditto, p. 27

⁴² ditto, p. 27

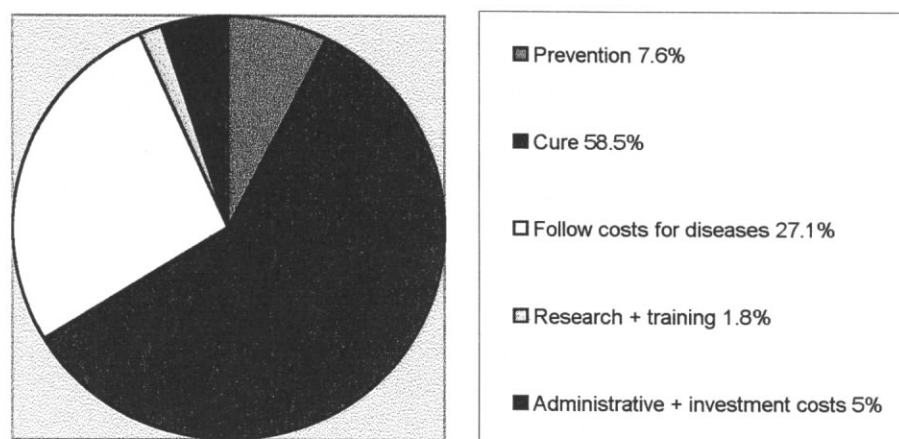
encouraging initiative and preserving status. The health system of West-Germany has been transferred to former East Germany. The financial support for the improvement of hospital buildings in the East amounts to 1,4 billion German marks, financed by the federal government and the statutory health insurance in a period of time from 1995 until 2004.⁴³

The development of the Irish health system has been influenced through geographical and linguistic closeness to Britain and certainly through the past British rule in Ireland.

Table 8 a: *Distribution of health expenditure in Germany in 1993*⁴⁴

Area	in billions of DM	percent
Prevention	33,4	7.6
Cure (ambulatory care, treatment in hospitals, pharmaceuticals, dentist treatment)	257,7	58.5
Follow costs for diseases (professional and social rehabilitation, sickness benefit, invalidity pension)	119,2	27.1
Research and training	8,1	1.8
Administrative and investment costs	22,0	5.0
Health expenditure altogether	440,4	100.0

Figure 8 b: *Pie chart of the distribution of health expenditure in Germany in 1993*



⁴³ Weidenfeld, W., Korte, K.-R. (eds.) (1996), *Handbuch zur deutschen Einheit*, Bonn: Bundeszentrale für politische Bildung, p. 629

⁴⁴ Block, E., Hillebrand, B., Wolf, C. (1997), *Wie funktioniert unser Gesundheitswesen?*, Reinbek bei Hamburg: Rowohlt Taschenbuch Verlag

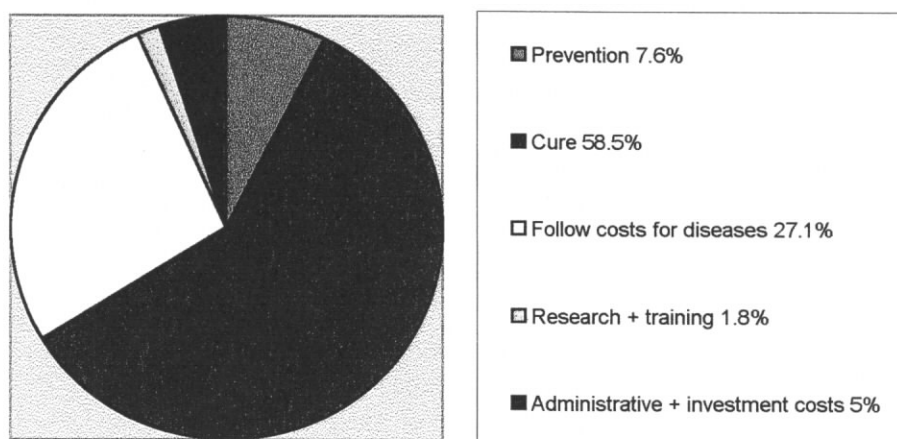
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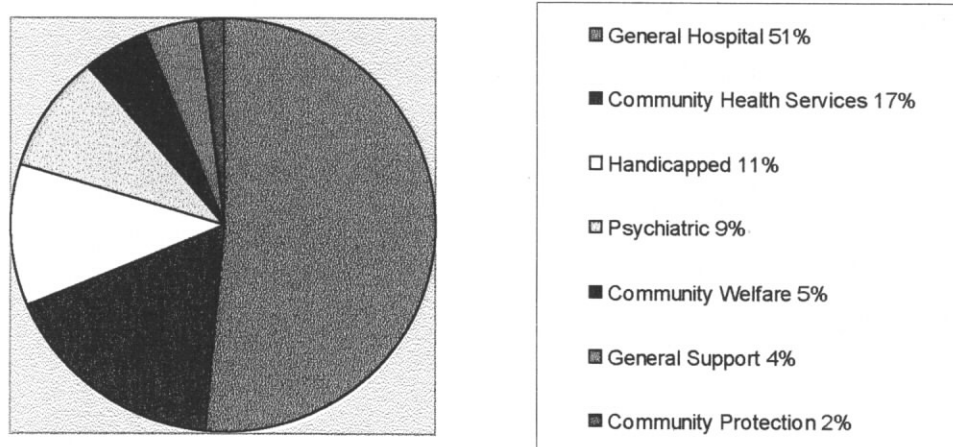
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⁴³ Weidenfeld, W., Korte, K.-R. (eds.) (1996), *Handbuch zur deutschen Einheit*, Bonn: Bundeszentrale für politische Bildung, p. 629

⁴⁴ Block, E., Hillebrand, B., Wolf, C. (1997), *Wie funktioniert unser Gesundheitswesen?*, Reinbek bei Hamburg: Rowohlt Taschenbuch Verlag

Figure 9: *Estimated percentage of non-capital expenditure by programme in IRE, 1996*⁴⁵



As we can see from figure 1 above the biggest proportion of non-capital expenditure in the health services are used under the General Hospital Programme.

The funding of the systems in Germany and Ireland are organised differently as shown in the following table 10 a with figures for the year 1992:

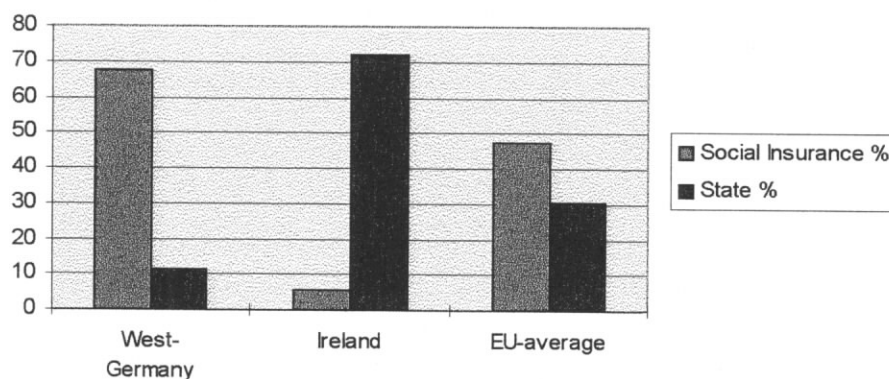
Table 10 a: *Financing of health systems in Germany, Ireland and EU-average, 1992*⁴⁶

State	Public proportion		Costs for patients	Private Health Insurance	Others	
	altogether	thereof:				
		Social insurance	State			
	Proportion of financing in %			Proportion of financing in %		
former West-Germany	79.0	67.7	11.3	12.0	7.9	1.1
Ireland	77.7	5.7	72.0	13.7	8.4	0.3
EU-average	77.6	47.2	30.4	15.3	6.4	0.7

⁴⁵ Source: Department of Health (1998), *Health Statistics 1998*, Dublin: Stationery Office

⁴⁶ Bundesminister für Gesundheit (1995), *Daten des Gesundheitswesens - Ausgabe 1995*, Band 51, Baden-Baden: Nomos-Verlag, extracts from table, p. 323

Figure 10 b: Bar chart illustrating the public proportion in the financing of health systems in GER, IRE and EU-average, 1992



In Germany the system is mainly financed by social insurance and we find a mix of private and public providers. Practically the whole of the population is covered by health insurance. The statutory sickness funds, which cover about 88 % of the population, pay providers directly for the services supplied to their members. The sickness funds can be separated into “*Reichsversicherungsordnung (state insurance regulation) funds, covering about 60 % of the population, and substitute funds covering about 28 % of the population.*”⁴⁷

In Ireland general taxation is the main source of funds and the major part of service provision is through public providers. Health insurance in Germany is obligatory: “*Membership of sickness funds is split about 85/15% between compulsory and voluntary members. Membership is compulsory for workers with income below a certain threshold...*”⁴⁸ The state, federal and local governments are included among the funders because of their role in financing public health services and hospital investment. In terms of sources of funds, about 60% of health expenditure is derived from general taxation, about 7 % from private insurance and about 11 % is represented by unreimbursed out-of-pocket expenditure.⁴⁹

“*Four-fifths of the population of the Western Länder are covered by statutory health insurance scheme, of whom two out of five are dependants of subscribers. About*

⁴⁷ OECD (1992), *Health Policy Studies No. 2*, p. 59

⁴⁸ which has been set at DM 75.600 in 1998

⁴⁹ ditto, p. 59

10 % of the population is fully covered by private insurance - mainly civil servants, the self-employed and high-income earners. Most of the remaining 2 % of the population, including the armed forces, the police and some individuals on social welfare, receive free health services. Less than ½ % of the population - exclusively well-to-do individuals - have no health insurance."⁵⁰

Germany is classified to belong to "*The public contract model, which in its commonest form has: sickness funds, financed by compulsory income-related contributions, which contract directly with independent providers for services supplied free of charge to patients*".⁵¹ Typical for the German health system is its self-government in contrary to the National Health System in Ireland: "*...the system relies mainly on self-regulation by establishing a balance of negotiating power between autonomous sickness funds and providers, and by allowing consumer choice to determine much of the flow of funds in ambulatory care.*"⁵² Germany is classified in the OECD (1992) Study of Health systems in seven countries as belonging to the countries which "*...combine moderate or high levels of per capita health expenditure with universal or near universal health insurance coverage, high levels of patient choice, and reliance, in the main on the public contract or public reimbursement models in which "money follows the patient."*"⁵³

Ireland's health system has been categorised as being "*The public integrated model, which in its commonest form has a public central fund, financed by general taxes, which pay doctors by salaries and public hospitals by global budgets for services supplied free of charge to patients.*"⁵⁴ In Ireland there has been up to recently only one public insurer: the Voluntary Health Insurance Board (VHI) and only 30 % (in 1987) of the population were insured this way. In Germany voluntary insurance are only optional and additional so that only about 23 % are voluntary insured, more than half of whom had joined statutory sickness funds.

⁵⁰ ditto, p. 60

⁵¹ ditto, p. 137

⁵² ditto, p. 69

⁵³ ditto, p. 135

⁵⁴ ditto, p. 137

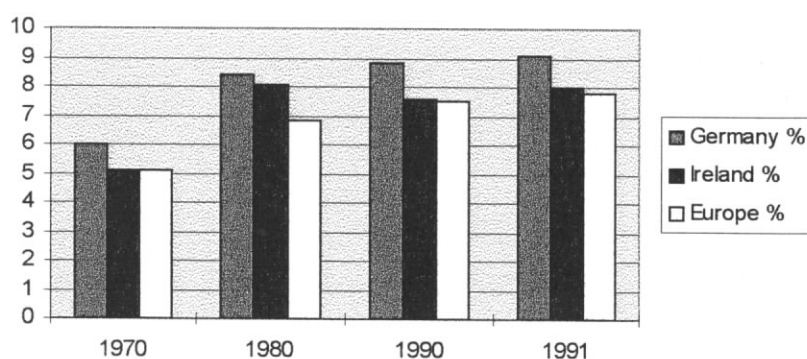
Recent problems and changes in the two health systems

The OECD found out in its study of health policy in seven countries⁵⁵ that “Most OECD countries experienced unacceptably high rates of growth of medical care expenditures in the 1970s.”, and “Moreover, more than a suspicion existed in many countries that demand had been induced by suppliers.”⁵⁶ This growth in health expenditure for Germany, Ireland and Europe is shown in the table 11 a below for the period from 1970 to 1991:

Table 11 a: Health expenditure growth in Germany, Ireland and EU-average, 1970-1991⁵⁷

	Share of Total expenditure on Health in Total Domestic Expenditure (%)			
	1970	1980	1990	1991
Germany	6.0	8.4	8.8	9.1
Ireland	5.1	8.1	7.6	8.0
Europe	5.1	6.8	7.5	7.8

Figure 11 b: Bar chart of health expenditure growth in GER, IRE and EU-average, 1970-1991



The increase in health expenditure led to active measures in the past two decades. In the 1990s public spending had to be limited as a preparation for the European Monetary Union to fulfil the entry requirements. In Ireland measures like the tightening of global,

⁵⁵ Examined countries: Belgium, France, Germany, Ireland, Spain, The Netherlands, the United Kingdom

⁵⁶ OECD (1992), *Health Policy Studies No. 2*, p. 139

⁵⁷ National Economic and Social Council (1990), *A Strategy for Competitiveness, Growth and*

block budgets in public hospitals, the reduction of beds, hospital closure and a greater reliance on salary payments for hospital specialists were introduced. The German government introduced several cost containment acts as well, e.g. in 1977, as shown in the overview in table 7, with the consequence of the establishment of a concerted action (*Konzertierte Aktion*) in the health services. Hospital expenditure wasn't really tackled in this act. Twelve years later a major act came into force, the Health Care Reform Law ("*Gesundheitsreformgesetz*") in 1989 bringing with it among other things the beginning of managed competition among hospitals. "*This [the 1989 act] is described as the most important statute on the statutory health insurance system since the 1911 law...*"⁵⁸ Further important acts are the Health Services Structure Reform Law ("*Gesundheitsstrukturgesetz*") in 1993. This act introduced managed competition for pharmaceutical products⁵⁹, another aim was that the expenditure of the obligatory health insurance should not increase more than incomes and wages of the people insured. In 1995 the new Care Insurance Law ("*Pflegeversicherungsgesetz*", *PflegeVG*) was enacted. The target group of this law are persons who are in need of long-term care. One pressure on the German health system at present and in future is its ageing population: "*Germany is facing a marked deterioration in the dependency ratio over the next four decades which will present financial problems for the pay-as-you-go social security and the health care system (Schulenburg, 1990b).*"⁶⁰ Its aim is to reach financial relief of social assistance funds and obligatory health insurance who mainly paid for long-term care before this legislation was introduced. Furthermore the aim of this act is to encourage care in the family and in the home of the patients as long as possible.

On the background of immense increases of costs in the expenditure of health insurance's in 1995, the German government started to tackle the growing expenditure in hospitals with the introduction of new legislation on 01.01.1996 and a new payment

Employment, Dublin: Stationery Office, extracts from table 17.1 on p. 502

⁵⁸ OECD (1992), *Health Policy Studies No. 2*, p. 64

⁵⁹ It was unique in a European context that in Germany no limitations existed for the prices of pharmaceutical products, so that in an international comparison the prices for these products were very high.

⁶⁰ OECD (1992), *Health Policy Studies No. 2*, p. 69

system. This new system included case flat rates, special rates, rates for departments and basic rates and aimed at containing costs.

A similar development started in Ireland in 1998 with the introduction of budgets for hospital and health boards. *“Health boards and hospitals are, for the first time, under legal obligation to stay within budget. Any deficit will now be clawed back from next year’s cash allocation.”*⁶¹ In the past two decades hospitals were in both countries largely excluded from cost containment measures. At present both countries have introduced budgets and changes in management structures within the health services.

Efficiency of introduced cost-containment measurements

In Germany and Ireland we find a sharp reduction of growth of health expenditure in relation to GDP between 1980 and 1990 compared with the decade between 1970 and 1980. This decrease is shown below in the following table, for Ireland the decrease from 1980 to 1990 amounted to 24 %:

*Table 12: Health share in relation to GDP in Germany and Ireland, 1980 - 1990*⁶²

	Germany	Ireland
1980	8.5 %	9.2 %
1988	9.9 %	---
1990	8.1 %	7.0 %

Slightly different figures, even though they are both from OECD sources, for Germany and Ireland in 1980 and 1990s health share in relation to GDP can be found in the table below. The slight differences in figures are probably caused by the use of estimates.⁶³ The conclusion of a sharp reduction in expenditure, however, isn’t influenced.

⁶¹ Irish Independent 12/03/1998: “Health cash curbs hit hospital waiting list”

⁶² OECD (1992), *Health Policy Studies No. 2*, p. 67 and 79

⁶³ ditto. There’s no explanation for the difference in the original report, the figures are from different chapters.

Table 13: *Health expenditure and health expenditure shares of GDP in GER and IRE, 1970-1990*⁶⁴

Health expenditure per capita at purchasing power parity 1990	Health expenditure as a percentage share of GDP			Percentage change in health expenditure share		Percentage change in GDP per capita at constant prices
	1970	1980	1990	1970-80	1980-90	1980 - 90
GER 1,487	5.9	8.4	8.1	42	-4	20
IRE 819	5.6*	9.6	7.5	71*	-22	39

* The 1970 level may be slightly underestimated, owing to a break in the series, and the change 1970-1980 consequently overstated.

“The two countries which mainly relied on the contract model, and which had adopted global budgets more comprehensively, Germany and the Netherlands, saw virtually no change in their health expenditure shares, despite an average rise of 14 % in real, per capita GDP.”⁶⁵ In contrast the advantage for the Irish state is that due to general taxation being the main source of funding “The government has considerable discretion over the rate of growth and expenditure.”

After the growth of health expenditure in Ireland in the 70s “...the government decided to make sharp cuts in real health expenditure in the 1980s.”⁶⁶ The results of these cutbacks become obvious in the following table 14:

⁶⁴ OECD (1992), *Health Policy Studies No. 2*, extracts from table 10.1 on p. 132
⁶⁵ ditto, p. 131
⁶⁶ ditto, p. 73

Table 14: *Non-capital expenditure on statutory health services for the years 1982 to 1996 in actual terms and as a percentage of Gross National Product in IRE*⁶⁷

Year	Non-capital expenditure on statutory health services (net) Pounds in m	Health expenditure as a percentage of Gross National Product %
1982	948.00	7.61
1985	1,169.30	7.44
1990	1,463.30	6.48
1995	2,298.98	6.80
1996	2,354.20	6.45

As we can see the health expenditure in absolute numbers increased but more important is to note the decrease in the health expenditure as a percentage of Gross National Product.

In Germany the whole expenditure on health (care and cure) as well as means for the mitigation of consequences of sickness (i.e.: professional rehabilitation, sickness benefit and the like) were in 1970: 69,7 billions of German marks and increased by more than six times the amount to 429 billions of German marks in 1992: 369 billions of marks were spent in former West-Germany. The health expenditure in 1992 in West-Germany is the equivalent of 86 % in the West and 14 % in the East of Germany. In 1989 the yearly increase in health expenditure was below 1 % due to the introduction of the health structure reform law introduced in the same year. *"...the federal government has been successful in meeting the financial objectives which it set in the 1989 Health Care Reform Act."*⁶⁸ This only lasted for a short period. From 1990 to 1992 the health expenditure grew faster again, so that a second law, the health structure law came into force in 1993. The biggest part of health expenditure was found in hospitals with almost 95 billions of German marks in 1992.⁶⁹

⁶⁷ The extracts are chosen to give an overview in a period of 5 year steps, 1982 is the first and 1996 the latest year mentioned in the original table, that's the reason why they are also used. Source: Extracts from Table 3: *"Non-capital expenditure on statutory health services for the years 1982 to 1996 in actual terms and as a percentage of gross national product"* in Department of Health (1998), *Health Statistics 1998*, Dublin: Stationery Office

⁶⁸ OECD (1992), *Health Policy Studies No. 2*, p. 67

⁶⁹ Bundesminister für Gesundheit (1995), *Daten des Gesundheitswesens - Ausgabe 1995*, Band 51, Baden-Baden: Nomos-Verlag, p. 277

The Irish government was successful with its policy measures during the 1980s. Ireland continued to cut back services from a high base despite vigorous economic recovery.⁷⁰ Not only did it reduce the growth rate of public expenditure on health but also succeeded in cutting the real expenditure during the 1980s. *“Public expenditure on health services actually fell in real terms in most of the years between 1980 and 1990 and by the end of this period it was down 8 % in real terms. This was accompanied by a 29 % decline in the number of acute hospital beds, a 29 % decline in average length of stay and a 13.5 % fall in admission rates.”*⁷¹

Present weaknesses of the Irish system and reasons for criticism are that political and executive functions are not separated in that an , *“... inappropriate balance between national and local decision-making...”* and *“...insufficient accountability”* as well as an *“... insufficient integration of related services.”*⁷² However, the government has recently started to introduce changes in regard to the organisation e.g. from health boards to health authorities and funding, which will be organised more decentralised, as a consequence of the Commission on Health Funding’s (1989) report and recommendations.

Present Pressures on the two health systems are to contain the costs. This is a difficult task due to :

- ageing populations (falling birth rate, increasing life expectancy) , which is a bigger problem in Germany than in Ireland,
- new technologies for diagnosis and treatment, new and costly pharmaceutical products,
- rising expectation and demand among the public and
- new diseases, e.g. terminal diseases like HIV.

⁷⁰ OECD (1992), *Health Policy Studies No. 2*, p. 131

⁷¹ OECD (1992), *Health Policy Studies No. 2*, p. 79

⁷² OECD (1992), *Health Policy Studies No. 2*, p. 81

European and international influences on the health services

In the international competition of economies the costs of the various national health systems are a key factor. Over the last two decades there has been a rapid rise in health spending in the European Community, but as already mentioned, the various EU-member states tried to stabilise their health expenditure quite successfully to meet the prerequisites for the entry to EMU.

Developments such as cost containment in the health services, the increasing importance of accountability and effectiveness, multi-professional teams, the definitions of goals and aims and consequently the measuring of outcomes, can be found in various EU-member states.

On a supra-national level the WHO makes very general statements regarding these issues: *"In 1984, 38 European health for all targets were adopted. The report of the 1984 European conference on planning and management for health was a watershed in the development of health planning philosophy in Europe. The point of departure was no longer to be resources or problems, but desired outcomes: improvements in health and the reduction of health hazards. It was acknowledged that health planning had to be multi-sectoral; was not bound to any specific ideology; could be centred on the national or local levels; and should include both the public and private sectors."*⁷³

The WHO-statement shows that desired outcomes are the centre of interest as well as that the emphasis lies on a multi-sectional approach in health planning. Nevertheless it is left to the countries if the health planning is organised on a centralised (like e.g. in Ireland) or decentralised like in Germany. Furthermore the public and private mix is recommended.

⁷³ WHO (1998), *The World Health Report 1998: Life in the 21st Century: A vision for all*, Geneva: Report of the Director General, p. 179

PART III: HOSPITAL SERVICES IN GERMANY AND IRELAND

This chapter deals with the organisation, financing and trends within the hospital services in Germany and Ireland. At the beginning the two services are described and compared, followed by an attempt to sketch the most important trends in both countries around hospital care.

Hospital Services in Germany

In Germany there are three main types of hospitals, classified by ownership:

1. *Public Hospitals*, who are owned by federal (*Länder*) or local governments accounting for 51 % of beds,
2. *Private Voluntary Hospitals*, owned by religious organisations accounting for 14 % of beds and
3. *Private, Proprietary Hospitals*, who are owned by doctors, these hospitals account for 14 % of beds.

A further categorisation of hospitals distinguishes between size of the hospitals, range of service provision and catchment area:

1. Hospitals for basic provision (*Krankenhäuser der Grund- und Ergänzungsversorgung*). These are smaller hospitals with at least a surgical, gynaecological and internist department.
2. Hospitals for normal provision (*Krankenhäuser der Regelversorgung*). These are hospitals up to 600 beds with internist, surgical, gynaecological, anaesthetic, radiology, maybe even ear/nose/throat, ophthalmology, neurological, orthopaedic and pathology departments.
3. Hospitals for central provision (*Krankenhäuser der Zentralversorgung*). These are hospitals, with up to 600 beds with all departments mentioned under point 2.; but these departments are subdivided into more specialised areas, e.g. the internist department into cardiology and gastro-enterology.
4. Hospitals for maximum provision (*Krankenhäuser der Maximalversorgung*). These are huge hospitals with all possible departments, e.g. often university clinics.

Hospitals mentioned under 1. and 2. are responsible for regional provision and under 3. and 4. for supra-regional provision.

The costs of hospitals can be split up into costs for medical examinations, operations and care and operating or investment costs. The medical costs are covered by the health insurance's of the patients, statutory, voluntary and private health insurance and in fewer cases through social assistance and private payments. Operating and investment costs are mainly covered by the *Länder* governments.

Recent developments in German hospitals are the improvement of internal transparency of costs, and quality assurance which has become a major concern in Germany. A decentralisation took place in regard to investment costs for hospitals: *"Since 1986 all investment in hospitals accredited under the plans of the Länder governments have become the exclusive responsibility of the Länder."*⁷⁴ In the hospital plans of the *Länder* private hospitals can be included.

In the following table 15 the development of the number of hospitals, beds, patients who were treated, and the average length of stay in hospitals is demonstrated for Germany over a period of twenty four years from 1970 to 1994.

⁷⁴ OECD (1992), *Health Policy Studies No. 2*, p. 62

Table 15: *Institutions, beds and patient movement in Germany, 1970-1994*⁷⁵

Year	Institutions ⁷⁶		Patients movement	
	No. altogether	beds, no. in 1,000	patients treated on an in-patient basis in millions	Average length of stay in days
1970	4,213	873	11.2	24.6
1980	3,783	880	13.5	19.6
1985	3,635	844	14.3	18.0
1990#	3,510	818	15.1	16.7
1994	3,666	791	16.4	14.7
thereof only hospitals	2,337	618		

* Number of cases in hospitals, preventative and rehabilitation clinics, cases that were treated for hours only are not included.

Since 1990 without army hospitals.

The table above shows that

- the number of institutions declined from 4,213 in 1970 to 3,510 in 1990 and increased slightly from 1990 to 1994 to 3,666,
- the number of beds in general declined from 873,000 in 1970 to 791,000 in 1994,
- in Germany 2,337 hospitals with 618,000 beds were counted in 1994 out of 3,666 hospitals and in-patient preventative or rehabilitative institutions altogether with approximately 791,000 beds.

The German central statistical office established, that the number of hospitals has decreased in the past few years, whereas the number of preventative and rehabilitative institutions has increased. It is noteworthy that despite this above mentioned general decline in institutions and beds, the number of patients treated on an in-patient basis increased steadily from 1970 with 11.2 million cases to 16.4 million cases in 1994. The average length of stay was reduced from 24.6 days in 1970 to 14.7 in 1994. This latter

⁷⁵ Statistisches Bundesamt (ed.) (1997), *Datenreport 1997: Zahlen und Fakten über die Bundesrepublik Deutschland*, Schriftenreihe, Band 340, Bonn: Bundeszentrale für politische Bildung, pp. 189-190
Bundesminister für Gesundheit (1995), *Daten des Gesundheitswesens - Ausgabe 1995*, Band 51, Baden-Baden: Nomos-Verlag, extracts from table, p. 215

⁷⁶ The term *institutions* includes hospitals, preventative and rehabilitation clinics.

figure includes all clinics and not only acute hospitals. The average length of stay in acute hospitals is usually the shortest among all clinics.

In summary the evidence for Germany presented in table 15 shows, that more patient cases are treated in less institutions in a shorter period of time in 1994 than in 1970. The reasons behind these changes are not only an improvement and advancement in relevant technology but in medicine in general and the treatment of illnesses through new pharmaceuticals. Cost containment through legislative regulation, as shown in Chapter II, and a state regulated competition between hospitals and health insurances who pay most of the treatment are also contributing factors for this change. The shift in preference from institutional to community care, with more day care facilities and ambulatory care for patients and in particular elderly ones are further reasons behind the changes in the figures.

Hospital Services in Ireland

In 1838 the Poor Law was enacted. This legislation dating back from the time when Ireland was a British colony, formed the basis for the later hospital service in Ireland.

The administration of health services is conducted through three programmes, these are *community care*, *general (acute) hospitals* and *special (long stay) hospitals*. Each programme has its own manager (see Appendix II). Hospitals are run under the General Hospital Programme of the Department of Health, whereas the Special Hospital Programme includes hospitals for mentally handicapped people and psychiatric patients.

Similar to Germany there are three categories of hospitals in Ireland:

1. *Public Hospitals*. These are health board hospitals with some private beds. A county system of public hospitals was established after the abolition of the Workhouses in the 1920's who had their origin in the Poor Act of 1832. These hospitals receive an annual, global budget for operating costs which are not covered by fee-paying patients.
2. *Voluntary Public Hospitals*. These hospitals have also some private beds. They are largely run by religious orders and at present financed directly by the Department of Health. A number of these hospitals were closed in the 1980's. The majority of this hospital type can be found in larger urban areas, especially in Dublin. This is due to the

fact that in these areas the demand for them can be found in these areas and finance is more readily available.

3. *Private Hospitals*, who do not receive direct state subsidies. They are run mostly by religious orders as well. Sometimes they share a complex with voluntary hospitals. The opening of new private hospitals has on occasions been opposed by the Voluntary Health Insurance Board. Furthermore the Board has tried to influence private hospitals in regard to increase the use of day care and the reduction of the average length of stay. Since 1981 there are resource constraints for Irish hospitals, however, in difference to *Germany* “*Competition between public hospitals has not yet been encouraged in Ireland*”.⁷⁷ In Ireland like in Germany there has been a reduction of the numbers of hospitals, the number of beds and the average length of stay in acute hospitals, as shown in table 16.

Table 16: *Numbers of hospitals, of beds and average duration of stay in acute hospitals in Ireland, 1980 - 1991*⁷⁸

Year	No. of hospitals	No. of beds	Average duration of stay (days)
1980	157	19,183	9.7
1984	152	18,857	7.5
1987	121	15,225	7.3
1989	103	13,709	7.3
1991	104	13,806	6.8

The number of hospitals declined about 34 % from 157 in 1980 to 104 in 1991 and the average duration of stay was reduced by 30 % from 9.7 in 1980 to 6.8 in 1991.

Trends in Acute Hospital Care in Germany and Ireland

From the facts already established in this chapter the following table 17 is based on my own calculations. The aim is to illustrate the development of the number of hospitals, beds and average length of stay in Ireland and Germany from 1980 to 1991. The comparison is

⁷⁷ Department of Health (1989), *Health the wider dimensions: A consultative statement on health policy*, Dublin: Stationery Office, p. 12 and p. 81

⁷⁸ Source: Department of Health, Health Statistics cited in Curry, J. (1993), *Irish Social Services*, Dublin: Institute of Public Administration, p. 131

limited to two years, because of the difficulties arising in cross-national comparisons such as: figures are not available for each year in both countries or the usage of different units in the researched sources.

Table 17: Development of the no. of hospitals, beds and average length of stay in Ireland and Germany, 1980 - 1991⁷⁹

Year	No. of hospitals*		beds in 1,000		Average length of stay in days	
	IRE	GER	IRE	GER	IRE	GER
1980	157	3,783	19	880	9.7	19.6
1991 ⁸⁰	104	3,592	14	810	6.8	16.2

* The German figures include hospitals as well as preventative and rehabilitative clinics

Nonetheless table 17 illustrates the trend of the reduction of hospitals, hospital beds and the average length of stay in both countries from 1980 to 1991.

Another important trend is that the question of quality assurance has become a key concern in Germany and it was made a statutory requirement for hospitals as well as a subject of negotiation between sickness funds and the physicians' associations.⁸¹ Quality assurance in hospitals has not only influenced the medical professions like doctors and nurses, but has also started to influence medical social work which will be shown later.

⁷⁹ Sources of the figures have already been mentioned in previous paragraphs.

⁸⁰ Statistisches Bundesamt (ed.) (1997), *Datenreport 1997: Zahlen und Fakten über die Bundesrepublik Deutschland*, Schriftenreihe, Band 340, Bonn: Bundeszentrale für politische Bildung, pp. 189-190

⁸¹ ditto, p. 62

PART IV: MEDICAL SOCIAL WORK

This Chapter deals with the personal social service in hospitals: medical social work. I start with the definition of what medical social work includes and deals with, the historical development of this area of social work in both countries, the organisation, professional representation, the financing, the duties and the numbers of medical social workers, their income and the hierarchical structure in both countries.

Definition of medical social work

As Robbie Gilligan states in regard to social work in general: *“A complete and precise definition of social work is elusive.”*⁸², due to different values and ideas of people performing social work and the huge variety and contexts in which social work takes place. This is also true for medical social work, which is a branch of social work. Despite the mentioned difficulties an attempt will be made at this stage to present a few definitions. Before I start with the definition of medical social work I would like to introduce a general social work definition, as adapted in resolution 67 (16) by the Ministers’ Deputies of the Council of Europe: *“Social work is a specific professional activity that aims at favouring a better mutual adaptation of individuals, families, groups and the social environment in which they live, and developing self-respect and self-responsibility of the individuals utilising the capacities of persons, interpersonal relations and resources provided by the community.”*⁸³ From this general definition we receive the information about the main aim of social work, the improvement of the quality of living and the professional help for the clientele to enable them to help themselves in future. Medical social work in particular is a personal social work service in hospitals performed by professionally qualified social workers who are responsible for helping in cases of psycho-social problems of patients and their relatives of all different age groups and social classes during their stay in a hospital.

⁸² Gilligan, R. (1991), *Irish Child Care Services: Policy, Practice and Provision*, Dublin: Institute of Public Administration, p. 104

⁸³ Council of Europe, Steering Committee on Social Policy (1994/1995), *The initial and further training of social workers taking into account their changing role*, Co-ordinated research programme in the social field (1994/1995), p. 15

“Medical social workers provide a direct service to patients and their families where illness and medical care and treatment are complicated by social and emotional problems.”⁸⁴ The medical social worker will mobilise a wide range of resources in the hospital and outside in the community to help to ensure the efficient use of hospital beds and appropriate after-care for patients. In this context counselling about entitlements e.g. social assistance, etc. and help with administrative issues, e.g. filling out forms, and the establishment of networks inside and outside of the hospitals becomes more and more important. In Germany different expressions for medical social work are used. H.U. Senfleben, who undertook an empirical study of medical social work in hospitals in Hessen⁸⁵, refers to “*Klinische Sozialarbeit*”⁸⁶, which when translated means clinical social work. In the majority of publications, medical social work in Germany is referred to as “*Sozialarbeit im Krankenhaus*”, this means *social work in hospitals*. In Ireland the expression *medical social work* makes it immediately clear that one is dealing with a special branch of social work. The equivalent expression for medical social work in Germany simply indicates the place of work.

As shown in Chapter 3 the average duration of stay in hospitals has decreased both in Germany and Ireland. Because of the short period of time that patients stay in acute hospitals there are special requirements for medical social work:

- a high flexibility of time and organisational skills,
- acute crisis intervention,
- rapid assessment and
- adequate responses and behaviour with regard to patients problems with a broad variety of illnesses.

A very important part of the work is the close co-operation with other professionals within the hospital setting, but also with external institutions.

⁸⁴ Department of Health (1985), *Draft Questionnaire on the basis of Resolution (67) 16: Committee on Social Work Report June, 1985*, Dublin, p. 31

⁸⁵ a federal state in West-Germany

⁸⁶ Senfleben, H. U. (1988), *Klinische Sozialarbeit: Eine empirische Untersuchung in hessischen Krankenhäusern des somatischen Versorgungsbereich*, Band 5, Wiesbaden: Fachhochschule Wiesbaden

The recommended ratio of hospital beds per social worker (as recommended by the *“Deutsche Vereinigung für den Sozialdienst im Krankenhaus e.V.”*) are between 260:1 as an average value in acute hospitals and 200:1 in hospitals of maximum provision, e.g. university clinics (*Krankenhäuser der Maximalversorgung*). As far as I could gather information about Ireland there are no such recommendations in existence.

Usually the workplace of a medical social worker is within the hospital, but in some exceptional cases house visits may be necessary. Medical social work can be found in rehabilitation clinics, psychiatric and mental hospitals as well. In this dissertation, however, I concentrate on the medical social work service in general hospitals.

Historical development of the profession in Germany

The development of medical social work in Germany was influenced through existing services in America and other English-speaking countries. There are two different dates mentioned in regard to the employment of the first Almoner⁸⁷ (*“Fürsorgerin”*) in Germany. The first source mentions 1894⁸⁸ and the second one 1913, but both sources agree that the Charite hospital in Berlin was the first employer. In 1913 the first Employment of Almoners under the supervision of Dr. Alice Salomon, who was the first German social worker, took place in Berlin, followed by other German cities like Frankfurt, Hamburg, München, Dresden, Düsseldorf, Nürnberg and Stettin. In 1926 medical social workers were employed in hospitals in 35 German cities. In the same year the *“Deutsche Vereinigung für den Sozialdienst im Krankenhaus e.V.”* (German Association for a Social Work Service in Hospitals) was founded. Three years later, in 1929 the number of German cities with a medical social work service had increased to 97. For decades the employment of medical social workers took place only on a voluntary bases. In 1976, almost 50 years later, the first legal basis for a medical social work service in hospitals was enacted in Baden-Württemberg. It stated in the federal legislation for

⁸⁷ the former professional title for medical social workers

⁸⁸ Senfleben, H. U. (1988), *Klinische Sozialarbeit: Eine empirische Untersuchung in hessischen Krankenhäusern des somatischen Versorgungsbereich*, Band 5, Wiesbaden: Fachhochschule Wiesbaden, p. 1

hospitals (*Landeskrankenhausgesetz*) of Baden-Württemberg, that every hospital had to have a social work service.⁸⁹

Nowadays there are still federal states in Germany who don't have a legal basis for a medical social work service. In the 1970's the education of social workers and social pedagogues was upgraded as a academic course at the German "*Fachhochschulen*", schools of social work outside the universities, with the possibilities to obtain a diploma, the equivalent to a degree, and after a year of professional practice and the fulfilment of certain other prerequisites state recognition. There are still differences on a federal level in the curricula for social workers and social pedagogues, as well as differences under which prerequisites one can use these two titles, because this falls into the responsibilities of each federal government and isn't regulated centrally. In some federal states there is no differentiation between the titles, in others we find a strong separation between them. Even though the training usually enables graduates to work as both. Generally speaking, social workers learn more administrative issues plus law and with social pedagogues the emphasis is on pedagogical subjects and psychology.

Historical development of the profession in Ireland

With the background of overcrowded out-patient departments used by patients which could have been helped through the Poor Law outside the hospitals, a consciousness for the necessity of diverting these wrongly placed patients developed. The insight evolved that the medical officers themselves couldn't solve the problem, as problems were often caused or prevailed by social circumstances. This is where the occupation of Almoners started. With a thorough knowledge of the social and environmental aspects of illnesses and external social organisations, it was hoped that they could offer adequate help. The first professional social worker, who did case work, was employed by the Adelaide Hospital in Dublin in 1921. At the beginning of their work they were confronted with diseases like typhus and tuberculosis. In the following 30 years all remaining hospitals in Dublin started to employ Almoners and only women performed the profession. Since 1964

⁸⁹ Amtsblatt der Landeshauptstadt Stuttgart, "Amtsblatt-Sonderdruck: Seit 60 Jahren unentbehrlich: Krankenhaussozialarbeit", Nr. 43 vom 26. Oktober 1995, Presse und Informationsamt in Verbindung mit dem Sozialamt.

the profession was renamed as *medical social worker*. The majority of professionals completed their vocational training abroad, especially at the Institute of Almoners in London prior to 1968. The necessary professional qualification for the approximately 90 medical social workers, of whom the majority were employed in Dublin, was the CQSW, which means Certificate of Qualification in Social Work from the British Central Council for Education and Training in Social Work, CCETSW, who have monitored, accredited and validated Irish social work courses provided by the Irish universities. Nowadays the recognition is called the NQSW (National Qualification in Social Work, from the Irish body, The National Validation Body on Social Work Qualifications). The vocational training for social workers developed from Diploma courses in 1944 to degree courses in **1954** at UCD (University College Dublin), at TCD (Trinity College Dublin) in **1962**, followed by UCC (University College Cork) in **1966**. The possibility to obtain post-graduate professional training commenced at UCD in **1968**.

It is noteworthy in this context that the voluntary hospitals often run by religious orders played a very important role in the development of health services in general and as employers for medical social workers in particular. In **1970** the restructuring of the health boards took place, based on the new Health Act. This is of importance, because the health boards are a major employer of social workers. An important step in the professional development for social workers was the establishment of the Ad Hoc Committee on Social Work Qualifications in **1991**, appointed by the Minister for Health. The Report of this Committee to the Minister of Health published in **1993** recommended the setting up of a National Body for the recognition of social work qualifications in Ireland. One year later, in **1994**, this Body was established. Before the establishment of this Irish body the title *social worker* wasn't a protected title in Ireland. This development was certainly influenced by the EU on the basis of the promotion of mutual recognition of professional titles between EU-member states and the decision of the British CCETSW not to recognise Irish social work qualifications any longer. Meanwhile Germany and Ireland have agreements on the basis of EU-legislation to recognise the professional qualifications and to allow employment within both states.

Similarities in the development of professional medical social work in Germany and Ireland

As shown above the first almoner was employed in Ireland at the early stage of this century. The influence of religious denominations as employers of almoners can be found in both countries. The professional title of medical social workers has changed in Ireland and Germany. In the latter country social workers were originally called "*FürsorgerInnen*". With the change of the professional title the approach to work has changed as well, from an almost patronising approach, where the social worker is the expert to one that involves the patient or client much more, and recognises his/her resources and promotes the clients self-help potential. The beginning of academic training for social work took place in the 1960's in both countries. In the past and still today medical social workers have to deal with patients who are wrongly placed in hospitals. This means e.g. patients who would rather need long-term care than medical treatment or who occupy beds because of social reasons as e.g.: broken-down home situations, homelessness, etc. This is a major issue as cost-effectiveness and cost-containment become increasingly important in the hospital scene.

In addition to this, the trend in the Irish and German health system is to promote ambulatory instead of hospital care and to avoid institutional help like in hospitals as far as possible.

Organisation of medical social work within the hospitals at present in Germany and Ireland

The organisation of the medical social work services in Germany varies. The majority of services are directly organised within the hospitals and the reporting relationship is organised mainly to the director of administration. Usually the German hospitals have three directors: the nursing director, the medical director and the director of administration. There is no social work service with its own director of services. The position of the director of administration and his department becomes more and more important in the management of hospitals because of limited resources and cost-containment. In bigger hospitals there are social work departments with more than one

social worker and different hierarchical posts like in Ireland. However, the hierarchy among social workers in German hospitals isn't as distinct as in Ireland. In a few cases, especially with communities being responsible for bearing the costs for a medical social work service, it is organised as belonging to an external authority: e.g. a social welfare office (*Sozialamt*). In these cases the hospital is "purchasing" this service. At present there are considerations among some hospitals about purchasing medical social work on the external market, outside the hospital, as an alternative to fixed costs, e.g.: holidays, sickness, maternity leave) and permanent posts in the hospital budget.

In Ireland the medical social work service is organised within the hospitals. In bigger hospitals, especially in Dublin, they have their own medical social work departments with the various hierarchical titles from Head Medical Social Worker to Social Worker basic grade (see Appendix I). In the countryside where hospitals have no social work service, some of the duties of medical social workers would be fulfilled by the social workers in the community. In some parts of Ireland the social workers employed by health boards and placed in the community, have to fulfil statutory duties for the local hospitals who wouldn't have a social worker, e.g. in regard to child abuse cases.

Professional representation

In Germany and Ireland social workers have the possibility to join professional organisations. In Ireland this is the IASW (Irish Association of Social Workers) founded in 1971 in Dublin as well as the Trade Unions. In Germany the DBSH (*Deutscher Berufsverband für SozialarbeiterInnen, SozialpädagogenInnen und HeilpädagogenInnen in Essen, German Association for Social Workers, Social Pedagogues and Therapeutic Pedagogues*) exists with their main office in Essen. The possibility to join a trade union exists at the same time. However, trade unions are in contrast to professional organisations a melting pot of various professions and consequently they do not represent special interests of one profession in particular.

In both countries there were more than one professional representation. In Ireland the Irish Society of Medical and Psychiatric Social Workers was set up in 1964 and was amalgamated into the present IASW in 1971. In Germany the DBSH was formed out of

two professional associations, the DBS (*Deutscher Berufsverband der Sozialarbeiter und Sozialpädagogen*) and the BSH (*Berufsverband der Sozialarbeiter, Sozialpädagogen und Heilpädagogen*) in 1993. In the IASW 40 percent of all social workers are organised whereas less than 10 % of German social workers are organised.⁹⁰

Financing of medical social work

The legislative basis for the social care of hospital patients is written in the general social legislation (*Sozialgesetzbuch*) in Germany. The medical social work service is usually financed within the budget for nursing (*Pflegesatz*) in both countries. In Germany this is the case for all hospitals who are registered and recognised in the federal legislation for hospitals (*Landeskrankenhausgesetz*), similar to the health board hospitals in Ireland.

Duties of medical social workers in Ireland and Germany

Medical social work links patients with the services outside the hospital, organises after-care, e.g. for elderly patients with a broken down home care situation or homeless people. The “success” in performing these duties depends on the existence and /or level of provision of these services outside the hospital.

The duties of medical social workers in Ireland and Germany are very similar. There can be variations between them, depending on the focus and size of hospitals, where hospitals are situated, e.g. in urban or rural areas, and the availability of community and after-care services.

The duties of medical social workers in hospitals are listed below:

- They offer professional help to a patient and his family/friends, if problems occur in the context of a patients illness (acute or chronic), e.g. cancer, HIV, amputations, strokes, etc., accidents, handicaps, personal, emotional, social, professional, financial problems and / or problems within their families.
- Medical social work tries to activate resources and to enable their clientele to help themselves or organise contacts to external organisations, ambulatory care and

⁹⁰ Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 53 and 56

especially in Germany: organisation of rehabilitative measures, which take part in contrast to Ireland in special rehabilitative clinics.

- Medical social workers establish psycho-social assessments.
- They are responsible for the placement of patients in homes (e.g. nursing homes), in aftercare, organisation of rehabilitation (treatment), psycho-social counselling and care,
- for arranging economical, financial and materialistic help,
- for counselling in legal and social matters, in cases of bereavement,
- about entitlements, e.g. social assistance, etc. and for helping with administrative issues, e.g. filling out forms,
- for the establishment of networks inside and outside of the hospitals,
- in questions of everyday-life, assistance for self-help and learning of new behavioural patterns including special cases like suicidal patients and addicts.
- Social work methods are rarely group work but mostly case-work. Conversation/talking is the most important tool of social workers.

Numbers of medical social workers in Germany and Ireland

Table 18: *Medical social workers in German hospitals*

	altogether (in general and psychiatric hospitals, without rehabilitative clinics)	in preventative and rehabilitative clinics	male	female	part- time	in general hospitals
Social workers, 31.12.1980⁹¹	2,106	-----	740	1,366	----	763
Social workers, 31.12.1985⁹²	2,955	-----	-----	-----	----	-----
Social workers, 31.12.1986⁹³	3,286	-----	-----	-----	----	-----
Social workers, 31.12.1987⁹⁴	3,412	-----	1,190	2,222	----	1,408
Social workers, 1988⁹⁵	3,754	-----	1,305	2,449	----	1,599
Social workers, 31.12.1991⁹⁶	3,794	-----	1,040	2,754	1,151	2,501
Social workers, 31.12.1993⁹⁷	4,408	861	302 1,120	559 3,288	144 1,469	2,946
Social workers, 31.12.1995⁹⁸	-----	986	309	677	227	-----

⁹¹ Statistisches Bundesamt (ed.) (1982), *Statistisches Jahrbuch 1982 für die Bundesrepublik Deutschland*, Stuttgart und Mainz: W. Kohlhammer GmbH Verlag, p. 389

⁹² Statistisches Bundesamt (ed.) (1989), *Statistisches Jahrbuch 1989 für die Bundesrepublik Deutschland*, Stuttgart: Metzler-Poeschel Verlag, p. 394

⁹³ ditto

⁹⁴ ditto

⁹⁵ Statistisches Bundesamt (ed.) (1990), *Statistisches Jahrbuch 1990 für die Bundesrepublik Deutschland*, Stuttgart: Metzler-Poeschel Verlag, p. 409

⁹⁶ Statistisches Bundesamt (ed.) (1993), *Statistisches Jahrbuch 1993 für die Bundesrepublik Deutschland*, Stuttgart: Metzler-Poeschel Verlag, p.482

⁹⁷ Statistisches Bundesamt (ed.) (1995), *Statistisches Jahrbuch 1995 für die Bundesrepublik Deutschland*, Stuttgart: Metzler-Poeschel Verlag, p. 448

It becomes obvious from table 18, that there are many gaps in the figures which are available about medical social workers. Nevertheless the table above shows that the overall number of medical social workers has increased about 109 % from 2,106 in 1980 to 4,408 in 1993. The numbers of medical social workers in general hospitals, which are of interest in the context of this dissertation, rose from 763 in 1980 to 2,946 in 1993, an increase of 286 percent. The increase of 286 % in the number of social workers in general hospitals from 1980 to 1993 is enormous. For a detailed assessment of how the social work services in these hospitals have expanded we would need to know the number of permanent posts for and occupied by medical social workers over the relevant years.

The slight increase in the proportion of part-time medical social work, which was 1,151 or approximately 30 % of 3,794 in 1991 and increased to 1,469 or 33 % of 4,408 medical social workers altogether in 1994 can not contribute as an explanation for the enormous increase of medical social workers. The increase must have been caused by the enactment of legislation in several federal states in regard to the necessity of social services in hospitals, which took place during this period of time, starting with Baden-Württemberg in 1976.

Another fact becomes obvious while looking at table 18 is the existing gender bias in medical social work. Men are still the minority in this profession. From 1980 to 1993 for example the ratio of males to females is approximately 2:1 in each year.

In the German statistical yearbook of 1997 the numbers of social workers in hospitals are no longer listed separately among the paramedical staff, so that no comparison with more recent data is possible. In 1993 the statistics show the figures of both, the social workers in hospitals and in preventative and rehabilitative clinics, whereas in 1995 they only show the number of social workers in preventative and rehabilitative clinics instead. During my research I couldn't find any reasons for this statistical change. We have to bare in mind that the medical social workers are only a minority among the

⁹⁸ Statistisches Bundesamt (ed.) (1997), *Statistisches Jahrbuch 1997 für die Bundesrepublik Deutschland*, Stuttgart: Metzler-Poeschel Verlag, p. 448

various medical and paramedical professions in hospitals. However, this change would call for further research.

It has come to my notice that parallel to the change in statistics the number of preventative and rehabilitative clinics has increased. These clinics charge a cheaper per day rate for inpatient care than hospitals. This development represents a shift in emphasis in the health system.

According to the German Association of Social Workers in Hospitals (*Deutsche Vereinigung für den Sozialdienst im Krankenhaus e.V.*), in which 25-33 % of medical social workers are organised, the number of medical social workers in Germany is estimated to be 4,500.⁹⁹ This number includes the medical social workers in rehabilitation clinics and in general and special hospitals, so that this figure doesn't help us any further in making statements about the development of numbers of social workers in general hospitals.

The official number of social workers in Ireland is misleading, because in the Department of Health records are only kept about wage scales of social work posts. These posts are in reality not always occupied by a social worker. There is no record kept about the number of social workers in hospitals like we've seen in Germany. An important employer for social workers is the probation service for whom the figures are not integrated in the table below.¹⁰⁰

⁹⁹ Response letter of the *Deutsche Vereinigung für den Sozialdienst im Krankenhaus e.V.* in Mainz, 17/03/1998 to questions of organisation, financing, evaluation and quality assurance.

¹⁰⁰ Information from an interview with Augusta McCabe, Social Work Adviser, Department of Health, Dublin, 10/06/98

Table 19: *Distribution of employment in social work*¹⁰¹

Organisation	Total number of posts	Part time posts	Job shared posts	Temporary posts
Health Boards	499 (68.73%)	6	47	95
Local Authorities	58 (7.98%)	--	1	3
Hospitals	82 (11.29%)	6	7	13
Voluntary Organisations	87 (11.98%)	19	--	3
TOTAL	726	25 (3.4%)	55 (7.5%)	113 (15.5%)

Table 20: *Qualifications held by social workers in post*¹⁰²

Organisation	Number with CQSW or equivalent	Number without professional qualification	Qualification unknown	Total Number employed
Health Boards	386	65	48	499
Local Authorities	36	22		58
Hospitals	77	5		82
Voluntary Organisations	68	19		87
Total	567	111	48	726

The table above shows the results of a questionnaire organised by the Ad Hoc Committee on Social Work Qualifications in which 50 organisations took part (8 health boards, 16 local authorities, 16 hospitals, and 10 voluntary organisations) and was aimed at getting an overview about the present situation of qualifications among social workers. This survey showed at the same time how the employment of social workers in different sectors is distributed:

The health boards are the major employers of social workers amounting to 68.7 %, followed by hospitals and voluntary organisations, both with a proportion of 12 % and local authorities with almost 8 %. It is important to note that these tables can only give an idea about the distribution of employment in social work because the social workers employed by the Department of Justice, who work e.g.: in the Probation Service, are not

¹⁰¹ Table I, p. 39 in Report of the Ad Hoc Committee on Social Work Qualifications (1993), Dublin.

¹⁰² Table II p. 40 ditto

included in this overview.¹⁰³ The number of social workers in the Department of Justice amounted to 163 according to Reive in 1987 cited in Cannan et. al (1992) in their study: *Social work and Europe*.¹⁰⁴

Table 21: Numbers of medical social workers in Ireland in 1985 and 1996

	No. altogether	Place of work County Dublin	Place of work Outside County Dublin
1985 105	90	70	20
1996 106	150	121	29

The latest available list of medical social workers in Ireland from 1996 has 150 professionals listed, of whom 121 are employed in County Dublin and 29 in the rest of the country. In a report of the Social Work Committee in 1985 the number of medical social workers working in County Dublin were 70 and 20 in the rest of the country. If we interpret this data carefully, because the numbers include part-time and full-time employment of medical social workers we can see an increase of 67 % in absolute figures from 1985 with 90 medical social workers in the whole country. The numbers increased to 150 eleven years later in 1996. In 1985 and in 1996 the majority of medical social workers (4/5) work in County Dublin and only 1/5 in the rest of the country.

The employment of medical social workers within the country shows differences in numbers employed in different hospitals, e.g. there are 19 medical social workers employed in St. James' Hospital Dublin and only one medical social worker in smaller hospitals or hospitals outside Dublin, e.g. in the Orthopaedic Hospital, Clontarf in Dublin or as another example in Mayo General Hospital in Castlebar.

If we relate the number of medical social workers in German general hospitals (2,946 in 1993) to the population as a whole (82,190,000 in 1997) we get a ratio of 1:

¹⁰³ Interview with Ms. Augusta McCabe, Social Work Adviser in the Department of Health, Dublin 10/06/1998

¹⁰⁴ In Cannan, C. et al.(1992), *Social Work and Europe*, London: Macmillan, p. 52

¹⁰⁵ Department of Health (1985), *Draft Questionnaire on the basis of Resolution (67) 16: Committee on Social Work Report June, 1985*, Dublin

¹⁰⁶ List of medical social workers, which I received of Mr. David Willow, Director of Clinical Support Services, former Head Medical Social Worker in the Adelaide Hospital, Dublin, and

27,899 (medical social worker : inhabitants). If we calculate this ratio on the basis of the present estimate of medical social workers in Germany including social workers in preventative and rehabilitative clinics which is said to be 4,500 medical social workers to 82,190,000 Germans in 1997 the ratio would be 1: 18,264. In comparison to Ireland with at present approximately 150 medical social workers and a population of 3,559,000 the ratio is 1: 23,726. These calculations demonstrate the difficulties of a cross-national comparison. It depends on what we define as medical social work or if we include or exclude the German preventative and rehabilitative clinics for a comparison. As there is no equivalent to these clinics in Ireland, it would be safer to use the ratio of 1: 27,899 (medical social worker : inhabitants) and compare it to the Irish one of 1: 23,726. Both latter ratios exclude psychiatric social work in hospitals. Under these conditions the ratio in Ireland seems to be more favourable. Nonetheless we have to bare in mind that the social services in the community for example in the civil service as well as other external institutions like nursing homes, ambulatory care services in Germany occupy social workers so that a transfer into after-care and on-going availability of social work service outside the hospitals is bigger in Germany than in Ireland, where there aren't as many social workers, especially in services for elderly persons in the community. This statement is supported through information from interviews with Irish social workers, but it would be more interesting to support it with actual quantitative data about the numbers of social workers in the different services, which isn't available for both countries.

Ireland and Germany have no statutory register for the number of social workers actually employed in various services and both countries only deal with estimates. It is not possible to calculate the proportion of medical social workers to overall social workers in post, because estimates which are available give information about how many qualified social workers there are in each country but not how many are working in the profession..¹⁰⁷ This lack of information would offer a big field for further research.

¹⁰⁷

Mrs. Eilis Walsh, Director of the National Validation Body for Social Work Qualifications. Cannan, C. et al. (1992), *Social Work and Europe*, London: Macmillan, p. 52: 1,000 in IRE and p. 55: and 800,000 in GER, this figure seems to be far too high, according estimates from the DBSH, there are 154,000 qualified social workers in GER

Income, training and hierarchical structure in medical social work

During my research I noticed that the income of medical social workers in Ireland and Germany are almost alike in real terms, but differences do exist in comparison to other professionals. In Ireland e.g.: salaries for social workers are comparable to those of psychologists and are significantly higher than those of nurses. In the German case, salaries of social workers are generally speaking lower than those of psychologists even in cases where social workers have leading positions. The salary of a German social worker, basic grade, is not much higher than that of a qualified nurse.

Another difference with regards to social work in both countries is the location of training, which is a university education in Ireland and the so-called “*Fachhochschulen*” in Germany. In Ireland the possibility exists to achieve a Master Degree in Social Work, this means with the perspective to aim for an academic career in Social Work itself. In Germany the education of social workers has been established at “*Fachhochschulen*”. If social workers want to pursue an academic career they have to aim for an university degree, e.g. in pedagogic (in this case most of their course would be taken into account and only a few more semesters would be necessary). In very rare cases social workers are employed as full-time teaching staff in institutions for social work training. Usually social workers are taught by holders of degrees in other disciplines, e.g.: pedagogic (with a university degree), sociology, psychology and law. However, the possibility exists to do a Ph.D. directly after the social work degree at a university, but this has only developed recently as a possibility and is rarely pursued in practice.

Even though the contents of social work courses are almost identical in Ireland and Germany the distinguishing fact that the education of social workers in Germany doesn't take place at universities has from my point of view a major influence on the acceptance of the profession among professionals with a university degree. The wages for graduates from *Fachhochschulen* are much lower than for example for university graduates. This was a political decision in the seventies where the education of social workers was upgraded to the level of “*Fachhochschulen*” instead of universities. The background must have been the cost factor because many social workers were employed

in the civil service and received the same salaries like other administrative staff, who had been trained at “*Fachhochschulen*”, which are owned by the *Länder* or the *Bund*.

The information which I gained through interviews with Irish social workers regarding a social work hierarchy in medical social work was, that there is a difference between urban and rural areas, basically Dublin and surrounding area and the rest of the Republic of Ireland as well as a difference between health board hospitals and voluntary hospitals.

There are five different hierarchy steps within (medical) social work in Ireland:

1. Principal/ Head Social Worker,
2. Team Leader,
3. Senior Social Worker,
4. Social Worker,
5. Trainee Social Worker.

The necessary qualification and experience as well as the main functions for the different levels are shown in Appendix I. This hierarchy can be found in larger hospitals mainly in Dublin. There is a different or no hierarchical structure in smaller hospitals and hospitals outside Dublin, where sometimes only one social worker is employed. In Germany social work services in hospitals can have the following hierarchy steps:

1. Principal/ Head Social Worker,
2. Social Worker,
3. Trainee Social Worker.

There would be usually one in some cases two leading positions for social workers depending on the size of a hospital and the social work service. In German hospitals there is a medical social work service (= “*Sozialdienst*”), but this is rarely a department (=“*Abteilung*”) on its own. The leading position is in most cases a Senior social worker (“*Sozialdienstleitung*”) and if there is a social work department it would have a Head Social Worker (=“*Abteilungsleitung*”).

The income situation, the training and the hierarchical differences in both countries give me reason to believe that the Irish colleagues in general have a better status and recognition than their German counterparts. Especially in organisations like hospitals,

where hierarchy and status are very important it certainly makes a difference, if there is a hierarchical differentiation among social workers. Additionally the classification and comparability through salary scales, university education and career perspectives as shown in the Irish case contribute to a better co-operation between doctors and social workers.

In the German case, there are hardly any career perspectives for social workers in regard to an academic career, except if social workers leave their discipline as this is confined to "*Fachhochschulen*". The confinement of training at "*Fachhochschulen*" also limits the classification of social workers into higher salary scales in Germany. In my opinion these factors contribute to difficulties in co-operation between doctors and social workers on top of different approaches to work, which was mentioned earlier.

PART V: INFLUENCES OF RECENT DEVELOPMENTS ON MEDICAL SOCIAL WORK

The influence of the change in clientele on medical social work

The change of clientele of medical social workers is one aspect which could be researched much further. In the interviews with medical social workers in Ireland they all agreed that there has been a change in their clientele over the past twenty years. One change is for example in regard to patients suffering from Aids. This is one statistically very well documented disease. The table below shows the increase in numbers over a period of eleven years from 1985 to 1996. In Germany the number of Aids-cases increased almost 30 times from 1985 to 1996 with 15,308 cases in total, in Ireland it increased 49 times from 1985 with 11 cases to 1996 with 549 cases. Even though not every Aids-patient will have contact with a social worker, the probability grows with the increase of patients suffering from it. Especially with this illness there are often many social problems involved. There is stigma attached to the illness, ambulatory care may have to be organised, financial and legal entitlements can become important for example in regard to securing a patients income, workplace or flat, etc.

*Table 22: Registered Aids-cases in Germany, Ireland and the EU as a whole, 1985-1996*¹⁰⁸

Country	1985	1990	1995	1996	per 100,000 inhabitants
Germany	522	5,500	13,665	15,308	18.7
Ireland	11	161	491	549	15.4
EU-countries altogether	2,683	38,801	143,528	167,021	44.9

In Germany, literature from scientists in the public health field mention the increase of patients with chronic diseases and multi-morbid patients.¹⁰⁹ These patients have different

¹⁰⁸ Statistisches Bundesamt (ed.) (1997), *Statistisches Jahrbuch 1997 für das Ausland*, Stuttgart: Metzler-Poeschel Verlag, p. 119

¹⁰⁹ Badura, B., "Gesundheitspolitik im Zeitalter chronischer Krankheiten", in Meier, J. (ed.) (1994),

needs, especially in regard to long-term changes and approaches to problem solving in regard to mitigation of their problems. This is not only true for the medical treatment but also for contacts with medical social workers. The change of the clientele of medical social workers could be further examined through the evaluation of statistics from medical social workers in both countries in various hospitals, e.g. the increase in numbers of cancer patients, of homeless people, unemployed people or social welfare recipients, who had contact with a medical social worker.

In the context of this dissertation I indicated the change of clientele due to demographic alterations. As shown in part I: the societal context, the Irish society is still quite homogenous in contrast to Germany. This was elaborated from the number of asylum-seekers as one example. In Germany the figure was much higher than in Ireland. The increasing number of asylum-seekers has an influence on the practical work in the social services in hospitals, because asylum-seekers may need hospital care while their applications are being processed. If social workers will meet them as patients, language problems often arise and the question of who is going to finance their stay in hospital or the necessary after-care has to be solved, etc.

Furthermore with regard to clientele, the proportion of elderly people in the population as a whole in both countries has increased in the past twenty years and is projected to increase further. In Germany the dependency ratio is already causing problems in the social security systems with regard to secure future financing. This is especially the case for the health system.

The influence of changes in the health system on medical social work

The treatment of more patients in less hospitals in a shorter period of time as established in both countries have certainly had an impact on the German medical social workers in that they have less time to prepare e.g.: after-care or for counselling processes. These processes can often only be initiated during a patients stay in hospital.

The national differences in financing of hospital services on medical social work

From the interviews which I conducted with Irish social workers, I received the information, that medical social workers don't notice any different pressure or effects on their performance due to cost constraints within hospitals in recent years. Mary Kennedy, the Head Social Worker in St. James' Hospital, thinks this is different to the situation in the UK, where the pressure to discharge patients with an unclear home or social situation is much greater than for the Irish colleagues.

A possible explanation for this situation would be the influence of the difference in financing of hospitals in Ireland, which is mainly public and as shown in the chapter about the health systems voluntary insurance is only playing a minor role. There has not yet been competition introduced between the hospitals as is the case in Germany, where in contrast to Ireland mandatory health insurance plays a major role in financing of hospitals and consequently in bargaining for finance as well. Additionally in Germany the issue of quality assurance has become a key concern and a statutory requirement for hospitals as well as a subject of negotiation between sickness funds and the physicians' associations.¹¹⁰ The idea of value for money has started to influence social services in German hospitals in that hospital management asks for concepts of their work and the promotion and initiation of co-operative structures inside the hospital as well as with external organisations.

We have to consider that financial pressure on Irish hospitals is in comparison to Germany only a recent development, with obligatory budgets since 1998. This contributes as an explanatory factor to the situation that there have not yet been experiences of changes or pressures on Irish medical social work.

The influence of legislation on medical social work

The development of federal legislation for hospitals (*Landeskrankenhausgesetze*) in several German federal states in regard to the provision of a medical social work service in hospitals, which started in the mid 1970s in Baden-Württemberg, certainly played a role in the increase in numbers of medical social workers in Germany. Nevertheless there are still federal states without such legislation and regional differences in the ratio of medical

¹¹⁰ ditto, p. 62

social workers in regard to the number of hospital beds. There are only recommendations in existence in regard to numbers of social workers to the number of hospital beds. On the other hand in comparison to Ireland where there are no such recommendations it doesn't really make a difference for the German colleagues as these recommendations are not binding.

Furthermore in contrast to Germany, where a strong legal framework is set centrally, I found out that in Ireland there is hardly any legislation in regard to social work in general except for the child care area, where changes took place in the 1990s. As a possible consequence of the lack of legislation for social work I consider the preference and prevalence of informal solutions in Ireland, which were mentioned by all interview partners as a distinguishing feature in Ireland. The fact that Irish medical social workers have not experienced an increasing pressure for example: to discharge patients with an unclear or broken down home situation, could be due to more possibilities of discretion and informal solutions. Ireland is a small country with not so many social workers who know each other and are known by colleagues from different professional backgrounds. Another factor is that the knowledge of legislation administrative procedures and their usage has become much more comprehensive than this was the case 25 years ago.

Germany has established the care insurance law in 1995 as already elaborated in the previous chapters as an attempt to relieve the health system of costs, especially for long-term care. The implementation of this law has had a major impact on medical social workers in Germany. The German social workers have to have a thorough knowledge of the new legislation. New administrative duties occurred in the process of organising after-care for elderly patients or those in need of long-term care. The pressure on the social workers in hospitals increased to find fast solutions for this clientele in particular. The health insurance could stop payments because it was no longer medical treatment needed by the patient but long-term care financed mainly through this new care insurance budget. However, the payment out of this new source had to be initiated by mainly the medical social workers. In Ireland the issue of financing long term care especially for elderly patients has not reached a problematic stage like in Germany. As we have seen earlier Ireland has a very favourable age distribution and dependency ratio in contrast to

Germany. This goes along with the information which I received out of interviews with Irish social workers.

The influence of professional status on medical social work

Certainly the influence of status of medical social workers (see paragraph: Income, training and hierarchical structure in medical social work), which I would generally consider to be higher in Ireland than in Germany, plays a role in explaining, why medical social workers in Ireland have not experienced pressure on their services.

The differences among the federal states in Germany in regard to the education and training of social workers are disadvantages with regard to the promotion of the professional status in hospitals in contrast to Ireland, where there is a unitary system of education and a much higher proportion of membership in their professional organisation, the IASW, where 40 % of the Irish colleagues are organised whereas less than 10 % of German social workers are members in the DBSH. It is therefore much more likely that the input of the IASW into an active career policy is bigger than that of the German counterpart the DBSH.

From my point of view the variations within the profession of social workers in Germany in contrast to Ireland are especially a disadvantage in an organisation like a hospital, where the education and training of the other professional groups and their hierarchical organisation are far more standardised.

PART VI: CONCLUSIONS

Returning to my research question: Have changes in the health system in general and the hospitals in particular influenced medical social work? The answer to this question is “Yes they have. However the influences are much greater in Germany than in Ireland. The trends towards hospital closures, reduction of beds and the average length of stay in hospitals was found to be very similar in both countries. Ireland seems to be lagging behind the development in Germany. The finance and organisation of the health system was established as an important reason behind the differences in the influences on medical social work in both countries. Ireland considers to introduce new more decentralised organisational structures starting with the re-organisation of the health boards to health authorities and the possibilities of extending the role of voluntary health insurance schemes.

Keeping in mind that the developments in Germany in regard to changes in medical social work are only recent but nevertheless big changes it would be interesting and probably more successful to examine the same questions again in a few years time, especially with the focus on changes in Ireland.

I would like to finish with citing Walter Lorenz, professor and lecturer for social work at UCC, who states that remarkable changes in social work services are only at the start:

“Equally challenging is the profound transformation not just of the nature of social services and how they are managed and delivered, but of the nature of social solidarity itself as the boundaries between private and public responsibility are being redrawn in Europe.”¹¹¹

¹¹¹ Lorenz, W. (1997), “ECSPRESS - The Thematic Network for the Social Professions” in *Irish Social Worker*, Spring 1997, Vol. 15 No. 1, pp. 11-12

Glossary¹¹²

- Almoner:** former professional title of medical social workers, the title was changed to medical social worker in Ireland in 1964. In Germany as there never was and still is no expression for medical social workers in particular. Only the title social worker/ social pedagogue (*Sozialarbeiter/ Sozialpädagoge*) exists. The former professional title for social worker/social pedagogues was “*Fürsorgerin*”.
- Bilateral monopoly:** a market in which a single buyer faces a single seller.
- Compulsory health insurance:** health insurance under an obligatory public scheme. Payment for such insurance amounts to a tax. The obligation may be placed on an employer to pay contributions on behalf of his or her employees. Contributions are usually income-related. Compulsory insurance is usually administered by public bodies, but it can be administered by private insurance carriers, as is the case with the scheme for civil servants in the Netherlands.
- Contract model:** the term used in this study for compulsory or voluntary health insurance which involves direct payments, under contract, from the insurers or third parties to the providers for services rendered to insured persons...This means that benefits are supplied in kind to patients, often free of charge. In this model the providers are often independent and the contractual payments to them are often by capitation or by fee for service...

¹¹² Mainly extracts from Glossary in OECD (1992), *Health Policy Studies No. 2*, pp. 9-11

	Germany belongs to this model.
Contribution:	tax payment levied for compulsory health insurance, often as part of a social security scheme. May be split between employer and employee. Often set at a fixed proportion of income between a floor and ceiling level of income.
“Fachhochschule”:	German expression for polytechnic
Integrated model:	the term used in this report for compulsory or voluntary health insurance or third-party funding in which both the insurance and provision of health care is supplied by the same organisation in a vertically integrated system...In this model, doctors are typically paid by salary and hospitals are typically funded by global budgets. As in the contract model, benefits are supplied to patients in kind, often free of charge. ...
	Ireland belongs to this model.
Progressive taxation:	a tax which takes an increasing proportion of income as income rises.
Public health insurance:	see “compulsory health insurance”.
Regulation:	intervention by government, by means of rules, in health care markets or systems. There are two main types of regulation: pro-competitive or pro-market regulation (generally with encouragement of choice among consumers, and of autonomy and competition among insurers and /or providers); and command- and-control regulation (often with discouragement of choice among consumers, and of autonomy and competition among insurers and/or providers).

Reimbursement model:

the term used in this study for compulsory or voluntary health insurance involving cash reimbursement of patients for all or part of the cost of medical care received. Otherwise known as “indemnity insurance”... In the pure form of this model there is no connection between the third parties and the providers.

Voluntary health insurance:

health insurance which is taken up and paid for at the discretion of individuals or employers on behalf of individuals.

Voluntary insurance can be offered by a public or quasi public body, as is the case in Ireland.

Appendix I :**Hierarchy of social workers in Ireland¹¹³**

<u>Title/Description</u>	<u>Qualification</u>	<u>Main Function</u>
<u>Principal/Head Social Worker:</u>	C.Q.S.W or equivalent. Minimum 6 years social work experience. Proven management ability.	Manager of the social work service in an area or large institution - budget holder for service.
<u>Team Leader:</u>	C.Q.S.W. or equivalent. Minimum 4 years social work experience. Capacity to lead small group (3/5 persons).	Team leader, responsible for staff supervision, establishment and maintenance of good standards and for personally handling a small number of the most difficult cases/issues.
<u>Social Worker (Senior):</u>	C.Q.S.W. or equivalent. Minimum 4 years social work experience. Proven effectiveness as field worker.	Field worker carrying high-grade, demanding work; student supervision and in-service training.
<u>Social Worker:</u>	C.Q.S.W. or equivalent	Discharge of assigned workload: has regular access to advice and guidance from more experienced social workers.
<u>Trainee Social Worker:</u>	B. Soc. Sc. or equivalent	Limited workload under constant supervision

113

Source: Department of Health (1985), *Draft Questionnaire on the basis of Resolution (67) 16: Committee on Social Work Report June, 1985*, Dublin, pp. 83-84.
There is no comparable information available for Germany.

Appendix II

Territory of Germany and Ireland and organisation of the health systems in the two countries¹¹⁴

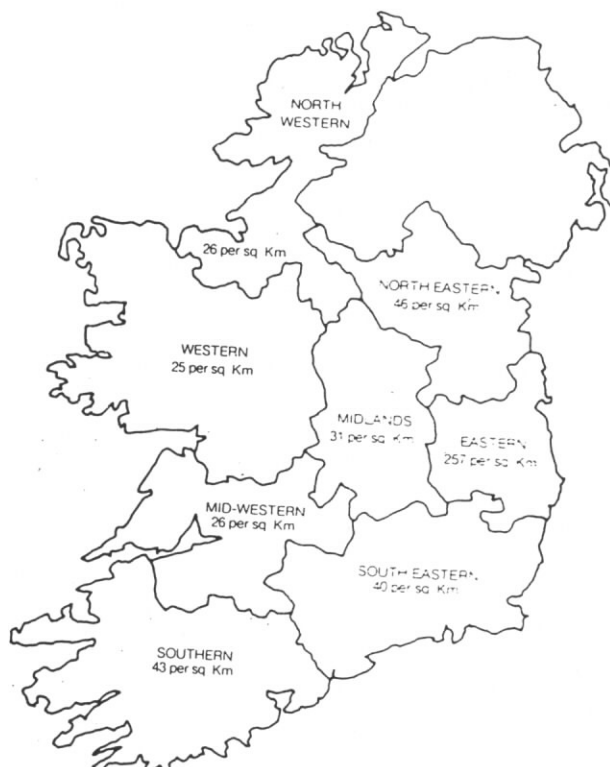
(Different scales, Irelands size of 70,282 square km is comparable to the size of Bayern, a southern federal state of Germany)

HEALTH BOARD AREAS AND POPULATION DENSITIES, IRE

Germany



Ireland



114

Weidenfeld, W., Korte, K.-R. (eds.) (1996), *Handbuch zur deutschen Einheit*, Bonn: Bundeszentrale für politische Bildung, map of Germany on p. 770

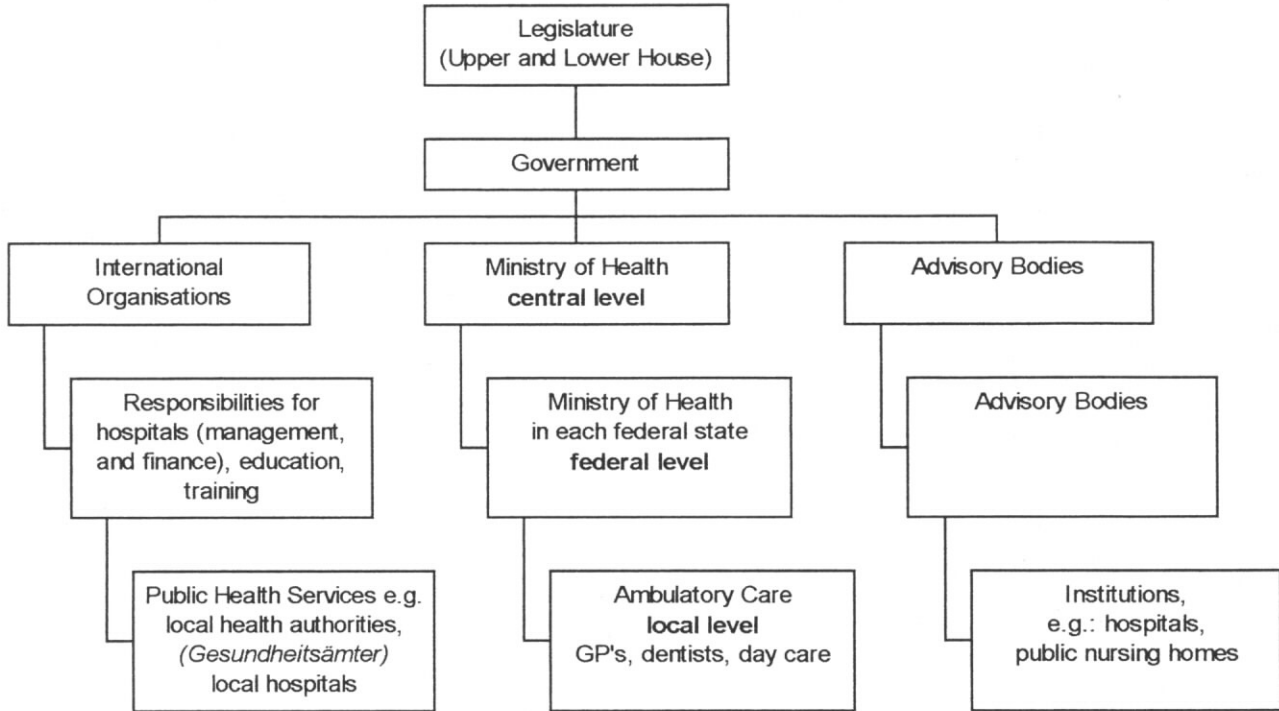
Gilligan, R. (1991), *Irish Child Care Services: Policy, Practice and Provision*, Dublin: Institute of Public Administration, health board areas and population densities, general structure

of Ireland's health care system, health board programme structure, community care structure p. 97, general structure of Germany's health care system own design

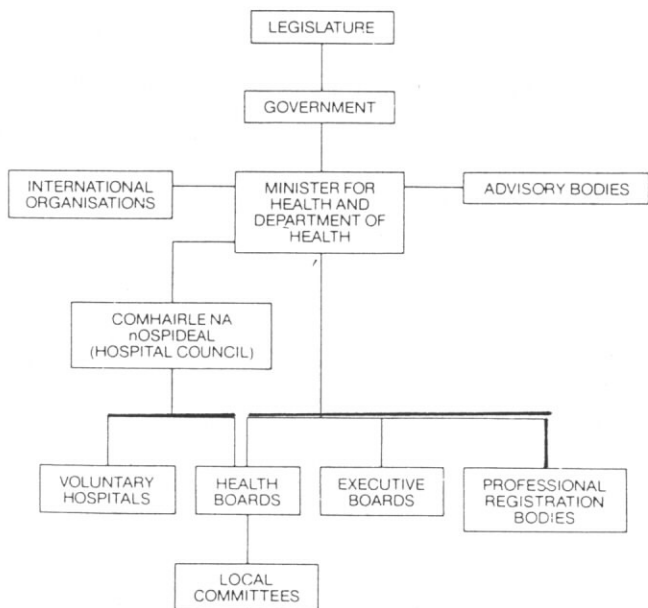
Appendix II (continued)

Territory of Germany and Ireland and organisation of the health systems in the two countries

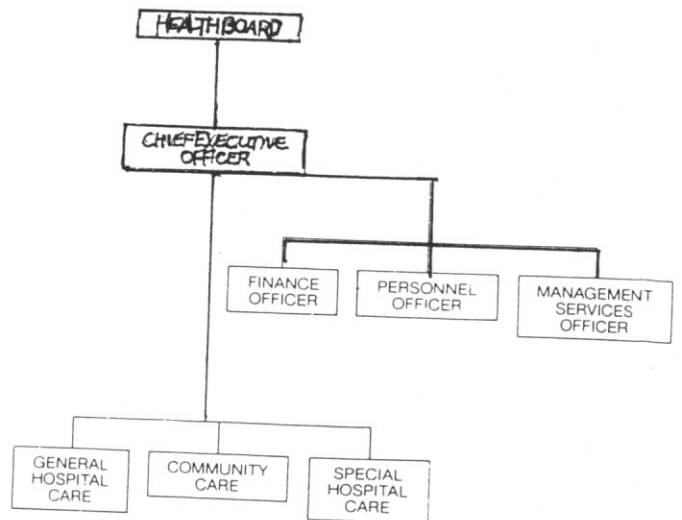
THE GENERAL STRUCTURE OF GERMANY'S HEALTH CARE SYSTEM



THE GENERAL STRUCTURE OF IRELAND'S HEALTH CARE SYSTEM



HEALTH BOARD PROGRAMME STRUCTURE



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115

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