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INTEGRATED CARE
– Integrating From Within –

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ABSTRACT

It is possible to identify a new approach that some termed as ‘post-Fordist’ as welfare systems mature. The initial Fordist stages were characterized by standardized approach and fragmented service delivery in which each agency responsible sought to deliver services at the lowest possible cost. It is very less likely for individuals, especially vulnerable individuals with complex need to receive an integrated service that provides continuity of care in such systems. The emergence of post-Fordist system is accompanied with aims to radically change individual experience of services so that users experience seamless services that are flexibly and promptly adjustable to their changing needs. While it is observable that health and social care agencies, focusing on their own specific tasks, working hard to reshape their method of intervention in order to deliver the contemporarily required types and criteria of services, it is also possible to note that within some countries there are efforts that are directed to identify a broader policy agenda that addresses the ways in which vulnerable and deprived individuals and groups should be related to the wider society and assisted through collaborative social action that is based on local social network. This policy agenda is driven by concerns that, on one side, as needs becoming more complex and diverse, and resources become limited, only by cooperation and collaboration that such needs can be fulfilled in the most efficient ways. The other concern being the existence of certain groups or individuals who do not engage with civil society and that this disengagement represents both wastage of resources and also a threat to the society. For example if grievances are not expressed through the normal political system they may be articulated as destructive behavior directed either at the self (suicide or self-harm), or others (vandalism and civil disorder).

Through a literature research, this thesis has aimed to bring forward the significance of the concept of instinct as a factor that determines the inner perception of individuals who as one member of the society are obliged to participate and mutually concern about certain sort of collaborative social action (in this context, integrated care provisioning) initiated to fulfill their needs requirement. The existence of certain types of instinct and their development strongly affect the personality and attitude of individuals towards the concept of solidarity, a preconditioned of any collaborative social action. For example, while sagregative instinct works to promote social segmentation, certain other more positive instincts promote individuals resiliency and community adaptabilities. The example of adverse instinct utilization as a guide is clearly manifested in our social systems
that tend to promote unnecessary categorization as a method of intervention. Effort to integrate must start from reconsidering to ameliorate these systems (by means of rebalancing the ‘power-relation’ between all players in the system), and then followed by the effort to sublimate (through education and care provisioning) the development of this unfavorable instinct (while nurturing the positive one). From the argument in this thesis, it is understood that instincts are something that is re-moldable through knowledge and education. Efforts to positively nurture individual instincts (in order to enhance both resiliency and chances for later social participation in any collaborative social action) must start at the earliest stage possible and through a continuous intervention. As such, the importance of the concept of attachment, social bond, and independency in care (both in formal and non-formal setting) must be acknowledged. Integrating to implement the process of integrated care is a process that must involve all members of the community. While integrating from the macro perspective (for example, the integrating of service providers and so forth) is something that can be implemented through policy, it is the integration in the micro perspective (involving individuals) that is more challenging. It is in this part that the concept of instinct is important because it is the understanding of this concept that can bring us into the self of every individual and allow us to bind and integration within the scope of their concern and agreement (consent). This is the type of integration that can sustain any collaborative social action, ‘the integration from within’.
LIST OF ABBREVIATIONS

BVPP - Best Value Performance Plan
CARMEN - Care and Management of Services for Older People in Europe Network
COS - Charity Organization Society
EHMA - European Health Management Association
EPR - Electronic Patient Record
ECJ - European Court of Justice
EU - European Union
HCSC - Home Care Support Center
HR - Human Resources
ICT - Information and Communication Technology
ICF - International Classification of Functioning, Disability and Health
IDS - Integrated Delivery System
IT - Information Technology
LA21 - Local Agenda 21
LAPS - Local Authority Planning Statement
LCSC - Locally Attached (Regional) Comprehensive Support Center
LGBT - Lesbian, Gay, Bisexual, and Transgender
LSP - Local Strategic Partnership
LTCI - Long Term Care Insurance
NGO - Non-Governmental Organization
NHS - National Health Services
PSS - Personal Social Services
STAKES - Research and Development Center for Social Welfare and Health
WHO - World Health Organization
LIST OF TABLES

Table 1  -  Partnership in Milton Keynes  p414

Table 2  -  The Division of Functions between Different Categories of Staffs in LCSC  p454

Table 3  -  The Changing Relationship between ‘Nature’ and ‘Individuals’  p541

Table 4  -  The Changing Relationship between ‘Welfare State’ and ‘Individuals’  p543

Table 5  -  The Changing Relationship between ‘Community’ and ‘Individuals’  p546

Table 6  -  The Changing Relationship between ‘Individuals’ and ‘Another Individuals’  p549
LIST OF CHARTS

Chart 1 - Relation between Council, LSP and Individual Partnership p410
Chart 2 - Milton Keynes Council Structure p411
Chart 3 - Milton Keynes Council Organization Chart
   – Overview Committees p412
Chart 4 - Local Strategic Partnerships in Milton Keynes p413
Chart 5 - The Division of Functions between Different Categories of Staffs in LCSC p455
Chart 6 - Changes of Relationships between Individuals and Their Surrounding Factors p540
# CONTENTS

Abstract

List of Abbreviations

List of Tables

List of Charts

Introduction 001

## Chapter 1 – Inescapability of the Trend towards Integration 026

1.1 – Integration Trend in Social Policy 028

1.2 – Integration Trend in Social Work Method 047

1.3 – Social Work and Trend towards Integration of Different Disciplines 079

1.4 – Integrated Care Implementation – The CARMEN Project 103

## Chapter 2 – Principles Underlying the Integrated Care 122

2.1 – The Eight Principles for Integration 124

2.1.1 – Need Responsiveness 127

2.1.2 – Individualized Chains of Care 130

2.1.3 – Continuity of Various Services 138

2.1.4 – Seamlessness 147

2.1.5 – Fluent Flow of Information 153

2.1.6 – Multidisciplinary Action 160

2.1.7 – Cooperation 168

2.1.8 – Flexibility 178

2.2 – Successful Ageing 187

2.3 – Instinct as Learned Behavior 208

## Chapter 3 – Instinct, Social Bond, and Integrated Care 225

3.1 – Reasons Underlying the Implementation of Integrated Care 228

3.2 – Theoretical Concepts Underpinning the Formation of Integrated Care 237

3.3 – Social Segmentation and Categorizing in Welfare 250
3.3.1 – Reforming the Segmented Framework of Intervention 270
3.3.2 – Reconsidering the Importance of Care and Social Bond 284
  3.3.2.1 – Improving Formal Care 285
  3.3.2.2 – Improving Informal Care 302
3.4 – The Significance of Instinct and Social Bond to Integrated Care Practice 320
  3.4.1 – Integration of understanding between physical and psychological well-being 323
  3.4.2 – Facilitating the conscious of self 326
  3.4.3 – Reconciliation of impartiality and individuality 329
  3.4.4 – Complementing the arguments on well-being attainment 330
  3.4.5 – Maintenance of social cohesion 333

Chapter 4 – The Systematization of Integrated Care 341
  4.1 – Integrated Care in Finland 344
  4.2 – Integrated Care in Britain 375
  4.3 – Integrated Care in Japan 415

Chapter 5 - Reconsidering the Process of Integration and Integrating from Within 458
  5.1 – Reconsidering the Process of Integration 461
  5.2 – Integrating from Within 509

Summary 555

References 618
Introduction

Integrated care has become an international health care buzzword. It is attracting considerable attention everywhere as an important framework to develop better and more cost-effective health systems. Integrated care has many meanings; it is often used by different people to mean different things. The word 'integration' stems from the Latin verb integer, that is, 'to complete.' The adjective 'integrated' means 'organic' part of a whole or 'reunited' part of a whole. It is mostly used to express the bringing together or merging of elements or components that were formerly separate (Kodner and Spreeuwenberg, 2002). Integration is at the heart of any systems theory in general and, therefore, central to organizational design and performance. All organizations (and systems) are, to some extent, hierarchical structures that are comprised of separate, but interconnected components; these components are supposed to play complementary roles in order to accomplish their joint tasks. However, the division, decentralization, and specialization found in the architecture of more complex organizations usually interfere with efficiency and quality goals. Therefore, the fulfillment of system aims necessitates cooperation and collaboration among and between the various parts of the
organization or system. In this sense, integration is the "glue" that bonds the entity together, thus enabling it to achieve common goals and optimal results. These ideas are, of course, applicable to the health care enterprise whether we are referring to its institutions and providers, or the health, social service and related systems in which they operate. Health systems and health care institutions are among the most complex and interdependent entities known to society. Without integration at various levels, all aspects of health care performance suffer. Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes.

Managers are not the only actors with an interest in health care integration. In the seventies and eighties, physicians became interested in applying systems theory to their own domain. This reflected concern that the then rapidly emerging trend of specialization would end up disintegrating professional practice and fragmented patient care. Policy-makers and payers in both the public and private sectors place great hope in its ability to save money, or at the very least, to ensure that health care resources are used more wisely. What health care integration generally means is the "bringing together
of inputs, delivery, management and organization of services as a means of improving access, quality, user satisfaction and efficiency." Integration allows for greater efficiency and effectiveness, less duplication and waste, more flexible service provision, and better coordination and continuity. In other words; Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care'. The overriding rationale is to solve the many problems arising from the complex presentation of chronic and disabling diseases and conditions. Behind this approach is the desire, above all, to enhance quality and provide a better level of service-that is more sensitive to the personal circumstances and wishes of the individual patient. The other parts of aims are geared to improving the efficiency, cost-effectiveness and organizational aspects of the
health system in which curing, caring and patient management takes place.

Continuums of strategies from the macro to the micro are necessary to foster integrated care. The application of these strategies is not only crucial to achieving more humanistic patient outcomes, but also better results in both efficiency and cost-effectiveness terms. There are varying degrees of completeness, comprehensiveness and formality in integrated care. However, the level, type, and combination of strategies used, would depend on the characteristics of the patient population and the specific challenges they face in obtaining appropriate, quality care. There are two different but overlapping ways of looking at integration process. In the first, integration reflects a largely hierarchical or "top-down" process driven by more generalized organizational exigencies for perfection or optimization. The second is a patient-centered and 'bottom-up' view, in which the characteristics and needs of specific patient groups, and their "fit" (or lack thereof) with existing systems of care and cure more or less determine the what, how, and where of integration.

A key characteristic of an integrated organization is a single point or portal of entry for potential users at which all their requirements can be assessed and an appropriate provision of services agreed. Modern technology, especially
information technology, can be used to create virtual organizations, that is, organizations which are formally separate but because they have full and rapid exchange of information, function as a single entity. Coordination in integrated care aims to achieve integration in various stages of process. Structural integration is managed by the development of a single access point (or office) that handles all initial enquiries from service users and their carers. Process integration is achieved through fostering joint working, and the intention is that person centered and ‘seamless’ services will be the outcome of the approach.

While all users of health and social care should be able to access and experience seamless or integrated care, for older service users integration is especially important. Older service users tend to suffer from a combination of health problems, and may at the same time experience increasing isolation, declining social support and increased personal vulnerability. The complexity of providing health care for older people requires collaboration between and integration of a range of different health and social care professionals and their skills. If these skills are not effectively integrated, there is at best inefficiency with one agency duplicating or undoing the work of another and at worst there may be serious harm for the older person because treatments interact
negatively or because they fall through the welfare net. These issues indicate a number of existing challenges to the ideal of a holistic and proactive (or preventative) approach towards helping older people stay healthy and socially integrated. In some European countries, there is evidence of policies that aspire to ever wider cross-departmental collaboration. For example, recent policies demonstrate the growing interest in housing and welfare issues, and recognize that these issues have been neglected. This approach is based on the premise that the needs of older people go beyond the basic provision of care. Frail elderly people also want suitable housing, and to be able to participate in society, social contacts and recreation. Participation in activities may prevent loneliness and depression, and consequently may reduce the demand for social care.

The risks to older people with long-term care needs are being exacerbated by the decline of social support in industrial societies. Social trends in such societies are now well established and recognized. At the same time as the population is ageing through increased longevity, the 'informal' support from families is reduced by increased economic migration together with the trend for women to remain longer in paid employment. Furthermore, changing social
norms and expectations mean that even where such family is available they are less likely to accept an obligation to provide care and support. In modern society, health and social care agencies have to deal with a major paradox. Major social changes such as the decline of infectious disease and improvements in nutrition have enabled an increasing number of people to live longer. Other social changes such as reduced family size, increased personal mobility and rising divorce rates mean that the level of social support for older people is falling. In these circumstances, improved integration is not an option - it is an imperative.

The main impediment to the provision of integrated care for older people comes from the fragmentation and lack of coherence of the health and social care system. The structure of health and social care systems in many countries tends to be divided horizontally between levels of government and vertically between agencies with different functions. Such structural divisions tend to reinforce conflicts between professions and with boundary and demarcation disputes in which professions often use their control of information and knowledge to maintain or increase autonomy and control. These tensions are heightened by competition between professions and agencies over the
allocation of scarce resources. For such reason, while the social care system should be a unified entity which responds in a coherent and integrated fashion to users, in reality it is highly fragmented and competitive with different parts ready to blame each other when things go wrong. In most countries it is possible to identify a vertical division of functions. Central government is normally responsible for policy making, setting the framework of resource allocation and establishing the legal framework of the health and social care system. The actual delivery of services is delegated to the sub-national level. At this level there tends to be a further split between regional/county level and municipal/district level. This split is particularly important for health and social care because the responsibility for the provision health care often resides with the larger regional/county government while the smaller municipal/district government takes responsibility for the provision of social care. This leads to widespread variations in service provision.

Professional expertise is one of the major assets of modern health and social care systems. Indeed systems are shaped by and based on areas of professional expertise. However reliance on such expertise can create impediments to integration especially when professional boundaries are
aligned with and reinforce organizational boundaries. While professionals may justify their status and control of resources in terms of their altruistic interests in providing services, the reality is rather different. In the welfare sector, it has been suggested that professionals have developed a dominant position through monopolization of specific skills and knowledge, and by excluding competitors who can undermine their dominant position. Thus professionals establish and police boundaries that maintain their status and rewards. While professionals provide the key skills and expertise for the care and support of older people, they may also act as an impediment to the development of an integrated service. Professionals groups seeking to enhance their status may seek to avoid low status clients who are considered to be professionally unrewarding. Furthermore, competition between professions tends to reinforce boundaries between care agencies as professions strive to create and maintain professional empires. This tendency reinforces the tensions between agencies and in particular restricts the flow of information as each profession claim ownership of the information it has collected and uses.

There is little evidence that the health and social care system has adjusted to or prioritized the needs and interested of receiving individuals (older people).
Instead, the increased pressure on resources combined with an increased emphasis of value for money provides agencies with strong incentives to avoid or pass on as quickly as possible older people. There is little evidence that the professionals employed by these agencies have sought to counteract these tendencies through anti-discriminatory practice. Approaches that discuss quality in terms of either structure or process are limited as they are describing the means not the end. The ‘ends’ of health and social care systems are their outputs, the care and support which older people receive. It is self-evident that health and social care systems for older people are designed to improve the lives of the people that use them. Traditionally, health services have focused on creating functional improvements in health of service users and quantitative or standardized approach is widely utilized to measure the outcomes. There is a risk that the key features of integrated care may be missed. The central theme is that integrated care should be defined by the way in which users experience it. They should experience it as continuous or seamless care that does not have gaps, waiting or overlap conflict between different components. While such care should help older people live a more effective life, improvements in functional ability may not necessarily be the most important
outcome.

The majority assessment of integration in older people’s services still tends to be very much within the traditional ‘need’ paradigm, in which the emphasis is on the functional deficits of individual users and the ways in which services respond to such deficits. An alternative way to thinking about the nature of the relationship between service users and health and social care agencies is in terms of risk rather than need. While the needs approach focuses primarily on functional deficits, a risk approach focuses on the change that an individual is likely to experience. In its narrowest form the risk approach is concerned with identifying and protecting individuals from harm but in its broader form it is concerned with individuals’ own aims and experiences. The ‘harm minimization’ approach was initially developed as a pragmatic response to serious problems that did not seem amenable to the more traditional ‘needs approach’. The most obvious example is drug use. The recognition of HIV/AIDS resulted in a shift from identifying drug use as a behavior that needed to be eradicated through police and other action to developing strategies to minimize the harmful consequences of drug use through needle exchanges and other schemes. The overall success of this approach is judged
in terms of the reduction of harm. Integrated care can be assessed in terms of harm minimization. It is possible to examine the ways in which health and welfare agencies contribute to the safety of the older service users by reducing the overall incidence of harm. Yet, while the harm minimization approach provides a more dynamic and more focused way of assessing the impact of integration on individual users, it is still essentially utilitarian, assessing and aggregating collective benefit in terms of the harm prevented. The individual experience still remains elusive. Such a narrow restricted approach treats risk assessment and management as a technical activity of identifying and counteracting hazards (such as the various factors that may result in falls). Little attention is played to the broader and far more complex issue of values. The starting point has to be users and carers desired and intended outcomes, and evaluation must include their experience of services and the ways in which they perceive their interaction with services assists or hinders achievement of their goals. It needs to be expanded to take account of the values of older people and their carers if it is to form the basis for fully person-centered approach. In this context, it takes the form of providing information to users, rather than merely adjusting the service to the wishes of the user.
Integrated care remains a one-way process where older people are the recipients of care (rather than empowered to take part in care provision processes) although there is evidence of programs to encourage more active consumerism in older people, including the provision of internet technology in older people's homes or facilities. The questions that lie at the heart of the person-centered approach are relatively easy to articulate, for example: 'What do older people and their carers want, and do they get this?' To answer such questions one needs to access the perceptions and experiences of older people and their carers. This requires the use of relatively costly and labor intensive research methodologies and at present there is little evidence of substantial investment of research time into these methodologies. Further, the diversity of definitions of ‘Integrated Care’ reflects the way that integrated care tends to be treated, especially in policy documents, as a self-evident concept that does not need definition or analysis. Such a taken-for-granted approach may be functional in policy statements that are aiming to construct a broad consensus and gloss over potential tensions but are not helpful to local service providers who are seeking to develop integrated services, or to researchers who are seeking to identify and evaluate integrated services.
The above are general characteristics of arguments relating to integrated care that are commonly discussed. Most of the contents center on the usual topic of ‘cost and services efficiency’ and the ‘need to collaborate or integrate between providing institutions and professionals’ that are mainly argued from their own perspective. This thesis intend to view the process closer to the viewpoint of individuals on the receiving side while at the same time considering the larger theoretical base that should sustain the process of integration and must be acknowledged. This is crucial on the fact that integration must be of mutual consent, both physically and psychology, and both by the sides who provide and the sides who receive. Chapter 1 begins by highlighting the fact about the inescapability of the trend of integration in welfare areas by looking back to the studies previously done in this field and to demonstrate that such previous studies are all pointing to the same conclusion, that: almost all are hinting the move towards networking and integration of policy and method. The first part of this chapter briefly looked into the general trend of social policy movements in contemporary situation and highlights the fact that despite of the varying approaches adopted in different areas and in different places such movements are pointing to the same general trend of integration. Perspectives relating to:
differences in terms of systems, models, policy and intervention methods among welfare states; collaborative and integrative functions of agents in social system through community work; the need to conduct a practice of social work through integrated approach that consists of a proper balance of research, theory and practice; collaborative an integrative organizational transformation in care setting (to improve the interconnectedness of the whole organizational network); integrating diverse interpretation on the meaning of quality of life (in this case, for the elderly) and so forth were discussed. It is understood that the lack of collaboration across various boundaries in the social system can lead to human suffering due to failure of providing a continuum of care (mainly exemplified through social and health care divide). The second part of the chapter further analyzed the integration trend by looking specifically into the area of social work. Observation are suggesting that the history of development in this area reflected the same trend of favoring integrative method in attempt to devise an effective framework of intervention. In this section, the development history of social work methods that started from the establishment of Charity Organization Society (COS) and Settlement House Movement, then continued by the introduction of: Scientific Philanthropy Method by Mary
Richmond; Psychoanalytic Method based on Freudian psychology; Diagnostic Approach; Functional Approach; Problem-Solving Approach (the blending of earlier approaches of Diagnostic Approach and Functional Approach); Group Work and Community Work Approach (Generic Approach); and finally Collaborative Model of intervention as among the most temporary is briefly explained. From this discussion, is noted that the development of knowledge in practice, along with the necessity to face complex needs has all along became the motivating factor for social work method to continuously improving and adapting. Practice has moved from pre-generic to generic practice. However, what is more interesting is the fact that such development did not occurs in a linear form. But, rather, in a ‘to and fro’ form, continuously bouncing from one end to another. This factor is reflected by existing arguments that point both the flaws of pre-generic and generic theory of practice in social work at the same time. This situation is expressing the fact that combination (that is the integration), rather than choosing a particular method is needed to respond to complex problems situations. Such integration process must be derived from a collective of multi-perspective knowledge and expertise. The third part of this chapter discusses about integrated care in general and highlights the fact that
the development of integrated care itself is actually one of the clearest reflections or actualization of the above said integrative trend. The term ‘integrated care’ has been given many definitions and can be found in various countries and under various names, such as seamless care, transmural care, case management, care management, partnership and networking. Generally, the term ‘integrated care’ is a helpful concept to describe coordination, cooperation and networking between health and social care services with the aim of improving services and quality of life from a user’s perspective. However, rather than definition, the more important issue that must be looked into is how to create an appropriate level of ‘joint-ness’ or coherence so that users (and carers) experience existing system as something that is a consistent and coordinated package rather than as fragmented and disjointed. Achieving this joint-ness depends on action at a number of different levels and can require a number of different types of joint working. And finally, this chapter provides information on the realization of integrated care ideology through the study of CARMEN Project (Care and Management of Services for Older People in Europe Network) conducted in European Union member states. This is a project that sought to improve the management of integrated care services for
older people and specifically focused on policy issues both at national and European levels. CARMEN Project has brought together a broad range of different stakeholders including professionals, purchasers, informal carers, and representatives of older people themselves. The dialogue between these diverse groups of experts formed the heart of the project. The network enabled them to reflect on the improvement of integrated care for older people from policy, practice, management and academic perspectives.

As a continuation from Chapter 1 that tried to elaborate and prove the existence of policy trend and tendency that emphasizes ‘networking’ and ‘integrating’ as the core conditional characteristics to implement efficient interventions and service delivery that will fulfill the requirement of contemporary social situation, Chapter 2 aims to, first of all, identify the main principles that will sustain the practice of integrated care. It is observable that there are at least eight identifiable principles that (should) underpin the practice of integrated care. The principles are: 1) need responsiveness, 2) individualized chains of care, 3) services continuity, 4) seamlessness, 5) fluent flow of information, 6) multi-disciplinary action, 7) cooperation between formal and informal network, and 8) flexibility. The interconnection between the eight
principles that underpin the implementation of integrated care could be understood in the following relation. Integrated care approach is intended to be a standardized point of reference for the implementation of a care management practice that is reflexive to needs through the multi-professionalizing and networking of intervention. The adoption of such approach is accompanied with the desire to create ‘need responsiveness’ through the provisioning of ‘individually tailored care’ that is characterized by ‘services continuity’. ‘Need responsiveness’ is made possible by the existence of factors such as ‘seamlessness’, ‘fluent flow of information’, ‘multi-disciplinary approach’, ‘cooperation’ and ‘flexibility’. Each of these factors are respectively discussed in this chapter. The following part of the chapter looked into the areas of successful ageing. The definition of ageism, the comprehensive definition of successful ageing that adresses individuals’ diversity, scaling the attainment of successful ageing, predictors and factors affecting longevity, and critics against the concept of successful ageing (for example, the standardized measurement of criteria of well-being as exemplified by ICF and its relation to successful ageing) are looked into prior to the discussion about its similarities and contrasts in terms of approaches and interventions as compare to arguments of
integrated care practice. Through this argument, it was identified that the potential factor capable of reconciling or synchronizing individuals’ autonomous efforts in their attempt to attain self-betterment to or with the others’ effort to assist such individuals in the process is the quality of instinct that innately exist in individuals, and the others’ (for example, service provider, policy makers and so forth) capability to understand and to acknowledge the importance of such instincts (as a crucial inner-driving force and motivation factor) to the individuals. For such reason, the third part of the chapter will elaborate about human instinct, and particular focus will be given to understand the ‘learned’ characteristics of such instinct.

Integrated Care, to a large extent, is actually a process of solidarity that should be founded by mutual consent and participation, fair reciprocity (reciprocal interdependency) and independency. In this context, participation must genuinely originate from one’s autonomous self-determination or self-direction. Question that need consideration are: where does the quality or inner power-drive of individual that can lead to the exercising of the above self-determination should originate from, and what are the processes and factors that can contribute to the forming of this quality? There is also a need to
look on ‘what is independency’ if viewed from the inner perspective of individuals so that their innate desire to attain self-betterment could be adapted to organized collective effort as an energy that will further enhance the dynamic of such process. If viewed as mutual process; further questions are about: where does the quality that can shape the independency and resiliency of individual should arise from? How do we acknowledge and utilize such quality to enhance the collective effort initiated through a policy practice? And, what are the understanding that should underlie and factors that will enhance the connection and synthesis of both of these efforts? In attempt to briefly answer these questions, Chapter 3 seeks, first, to understand what are the reasons that drive forward the need to adopt integrative approaches in care provisioning in general. In this context, population aging is given as one of the most basic reasons. However, population ageing does not exist in solitary and interconnected with other problems such as globalization in terms of trade, finance, technology, and communication. These changes to a great extent influence our population’s shape and characteristics through the marked decline in birth rates, the rise of single parents, and the high mobility of migration. There have been major changes in the labor markets too and they
are reflected through the increasing demand for higher education and skills, part-time and flexible labor, and female labor-market participation. All these changes are focusing to the elderly as a category that is especially affected in an adverse manner. The second part of the chapter worked on reconsidering what is the fundamental theoretical understanding that should found and reconcile the whole formation or implementation process of integrated care provisioning. It is understood from the discussion in this chapter that reciprocal interdependence based on individuals’ independency and resiliency is crucial to the formation of integrated care system, and both of these concepts are identified as originating from the existence of ample welfare instinct in individuals that is formable through such individuals’ proper attachment and social bonding process. The third part of the chapter attempted to analyze if the reality of contemporary societal environment is in the position to facilitate (or otherwise) the promotion of integrated care formation. In this part, the concept of sagregative instinct and the reason why our social systems incline to segregate individuals into categories are discussed. It is understood that the practice of segregating or categorizing reflects the existence of a certain spectrum of power balance between different social agents in our social
structure. The kind of categorization or segregation that typically works to segregate the elderly as an exclusive group from the main stream community is negative age stratification or ageism. The fourth section considered the necessary approach to be adopted in attempt to promote integration in the society. Methods on how the amelioration for currently sagregative social systems both from macro and micro perspectives should be conducted are discussed in detail. The attempts to ameliorate the segmented methods of intervention that are observable in our social system are conducted though many efforts. Some of them are carried out, for example, through the promotion of the concept of common citizenship that is respectful of diverse individuals’ particularity; by adding some flexibilities the to the rigid boundaries that surround different categories of welfare services and professionals; by practices that try to tear down the gap of social hierarchy between service providers and service receivers, and by integrating policies that is conducted at different levels of approaches. From the micro level, the amelioration is done based on reconsideration on the importance of care and social bond to individuals’ life process from the perspectives of both formal and informal care.

And finally, the last part of the chapter highlighted the importance of both the
concept of welfare instinct and social bond to the formation of integrated care.

There is different understanding towards the meaning that is given to the concept of collaborative actions. Many different words are used to explain the nature of such relations and these words are frequently used interchangeably. The aim of Chapter 4 is to look into a few different models of integrated care (in this chapter the following three models were elaborated: Finland models, British models and Japanese models) and identify how the respective models were developed and function in attempt to successfully cater their local needs.

The first part of Chapter 5 continues the argument by conducting a comparison between the three models of integrated care in order to identify their advantages and disadvantages in promoting the concept and practice of collaboration through integration. The argument is then followed by an important discussion that touches on ‘identifying what is the method and understanding that can promotes a genuine process of integration for individuals (genuine in a meaning that such process of integration is promoted from one’s within, and by acknowledging one’s inner perception – the instinct) before going to the summary of the thesis. In the final part of the thesis, the concept of ‘democracy of the emotion’ as a base in the provisioning of a
rational care necessary to form an individual with qualities that are resilient and adaptive to the process of collective action and social integration is discussed.

Finally, the summary part once again sketches the skeleton of the entire thesis while highlighting the core part of this thesis argument.
Chapter 1

Inescapability of the Trend towards Integration

The development of research in welfare studies is leading us towards a greater awareness on the existence of specific and particular needs of diverse individuals in contemporary community, and towards acknowledging the criticality of such factor. However, the same move revealed the actual fact about the incapacity of a single body (or single services providing side, to be more precise) to satisfy a service providing condition that is characteristically comprehensive and yet focused on various individuals’ particularity of needs. It is the attempt to fulfill these service provisioning conditions that necessitate the formation of collaborative and integrative efforts (in policy and practice) in welfare areas, involving from the most micro level (for example, integrating individuals’ / service users’ perspective in determining the best intervention; integrating various services in personal care provisioning) to the most macro
level (for example, national policy integration; international policy integration) possible. This chapter attempts to highlights the fact about the inescapability of the trend of integration in welfare areas by looking back to the studies previously done in this field and to demonstrate that such previous studies are all pointing to the same conclusion, that: almost all are hinting the move towards networking and integration of policy and method. The first part of this chapter will briefly look into the general trend of social policy movements in contemporary situation and highlights the fact that despite of the varying approaches adopted in different areas and in different places such movements are pointing to the same general trend of integration. The second part of the chapter further analyzes this integration trend by looking specifically into the area of social work. The history of development in this area reflected the same trend of favoring integrative method in attempt to devise an effective framework of intervention. The third part of this chapter discusses about integrated care in general and highlights the fact that the development of integrated care itself is actually one of the clearest reflections or actualization of the above said integrative trend. And finally, this chapter provides information on the realization of integrated care ideology through the study of CARMEN Project
Conducted in European Union member states.

1.1 Integration Trend in Social Policy

Acknowledging the necessity and importance of differences in terms of systems, models, policy and intervention methods among respective welfare states (even in the same category of regime) is noted as one of the most featured argument in contemporary social policy areas. Attempts to correctly map the diversity of welfare systems and models that was previously unrecognized or misinterpreted by western scholars are currently emerging. Yet, despite of their differences, welfare states are indeed facing challenges from a variety of similar sources such as global economic trend, ageing of population, community restructuring and so forth (Vivekanandan and Kurian, 2005). In facing these common pressures, some arguments are suggesting

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1 Arguments on East Asia Welfare Regimes that is most often simply labeled in a lump sum as ‘Confucianism Welfare States’ (Walker and Wong, 2005) is one of the examples of such misinterpretation. In this context of argument, it is argued that in addition to ‘class coalition of power’ (that is normally pointed out by western scholars), religion and ethnicity are suggested as the stratifying sources that explain the existence of diversity in welfare arrangements. Even within this single categorization of ‘Confucianism Welfare States’, closer scrutiny reveals that what we will see is more of a diversity rather than homogeneity. The Confucian welfare state label is therefore not a precise classification.
that such situation will necessarily lead to a ‘policy convergence’. However, studies are revealing that a ‘convergence’ thesis is not entirely precise (Rothstein and Steinmo, 2002; Taylor-Gooby, 2004). In reality, states are responding to these often similar challenges in quite different ways (Castles, 2004; Taylor-Gooby, 2004). Though social policy convergence to some extent may take place, the actual processes are not simple, uniform or even consistent. Arguments that attempt to clearly distinguish between ‘convergence’ and ‘divergence’ of policy respond risk over simplifying the actual policy process in which development in both direction co-exist. Different national economic and social context ensure that common measures produce different response, even when goals are similar (Taylor-Gooby, 2004). These differences are said to be originating from different political ideologies and policies introduced by respective states and regimes at earlier point of time (Rothstein and Steinmo, 2002). Identifying new social risks, shifting towards a new mode of welfare, and promoting the social dimension of policy (as against the bias attention towards economic dimension) are among the pursued countermeasures in responding to the above challenges (Taylor-Gooby, 2004b; Vivekanandan and Kurian, 2005). Though available fundamental knowledge
and techniques for conducting such countermeasures perhaps uniform in theories, the real implementation may differ from states or localities to another depending on governing various local conditions such as political ideology and institution, social norms, economic conditions and so forth (Castles, 2004). Welfare states need to look beyond merely covering traditional social risks, towards addressing new challenges as social norms undergo changes. New social risks emerge as a result from the transition to post-industrial society. Patterns of family life and employment is changing with implications affecting opportunities to develop new alliances for new form of welfare, and affecting the extent to which government can use welfare to promote national interest by mobilizing workforce and enhancing solidarity. In this situation, continuity and changes in countermeasures is observable, and the complex mixture of this continuity and change is slowly generating a shift towards a new mode of welfare. Recent social policy reform in relation to the notion of a ‘Third way’ reflects attempt to face the new social risks by forging a new political settlement which is fitted to the condition of modern society. The notion of ‘Third Way’ policy approach is underpinned with the concept of self-help, individual independency, active citizenship and interdependency (Lewis and
Surender, 2004). Apart from that, there is also movement that attempt to improve the social dimension of public policy. For example, the current interest in advocating the importance of ‘Social Indicators’ in European Community (Atkinson et al., 2005) to some extent improves the position of social policy comparing to the earlier situation where it used to be placed only as second important (receiving very limited attention and recognition). The utilization of Social Indicators allows the comparable assessment of social outcomes (in relation to social inclusion) between European individual state members in order to understand each others situation. The shared information will lead to the formulation of a more effective social policy that is tailored to state’s individual condition. The usage is an important tool for evaluating country’s level of social development and for assessing the impact of implemented policy. The possible creation of an efficient policy depends on the possible attainment of knowledge that will enable the identification and further enhancement of advantageous local criteria in order to satisfy the particular needs of respective models or localities. Learning from others through collaboration and readapting and integrating the gathered knowledge to suit specific and local situation are prerequisite.
Other than on the policy level as mentioned above, the same trend is also observable in the actual practice level of welfare: for example, in the area of community work, social care work, welfare for the elderly and in care provisioning generally. Starting with community work: the main theme about community work argument has been moving from a point that emphasizes the specific function of any specific agent in the process (i.e. community workers’ competency or the local authority’s function) towards an argument that emphasizes the importance of collaborative and integrative functions of all agents in the social system for the achievement and sustainability of any aims. Other than strongly characterized by the principle of ‘balanced opportunity and responsibility’ among all stakeholders; the adoption of generic perspective of practice (Taylor and Roberts, 1985), transparent assessment process (Mandelstam, 1999), community building through partnership (Austin, 2004), and adopting approaches that are respectful of diverse communities (Minkler, 2005) is observable. One of community work’s aims is to improve the social environment by providing needed services and organizing citizens to press for social reforms. The intention is to enable community groups to become active participants in the democratic process so that they could engage in
problem-solving activities or reform intended to change societal organizations and institutions. In effort to achieve these aims, social workers are expected to develop in themselves a skill of multifaceted approach, the generic perspective, to allow practice to occur on a macro and micro level simultaneously. The macro-micro continuum of the process is strongly emphasized. The multifaceted approach of community social workers should then be substantiated by a proper assessment practice to confirm the efficiency of their intervention and practice in different social settings and localities. As argued by some scholars, much about community care system revolves around assessment process. It should be the function of the local authority to conduct these assessments and during the process local authority has a duty to include, for example, health, housing, education, transport, ethnic representatives and all other related authorities to participate in order to ensure the transparency of the process. This shift towards welfare reform program by local authorities was made inevitable due to various challenges. One of the clear examples of such reformation policy is the implementation of ‘workfare’ where recipients are moved from welfare to work, and in this part, the main focus of argument has shifted from concerning about redistribution and eligibility towards addressing
barriers to work and sustaining employability. The desirability in terms of overall outcome resulted from this approach is still a debatable matters. However, if viewed from an optimistic point of view; along the process there is a noticeable increase in the involvement of non-profit and community based organization (i.e. education, child support, transportation etc. initially intended to bolster the possible implementation of workfare policy) that is slowly growing into a partnership relation that enables the process of community building and reorganization. In this partnership principle, the availability of the balance of strength of every stakeholder in the community is strongly acknowledged as the core factors for its successful implementation. For such reasons, efforts to groom and enhance the potentiality of every stakeholder, and to ensure a fair opportunity of participation among all occupies the main concern of argument, and this situation will lead to the creation of a ‘win-win’ situational approach. The idea of partnership create public concern and consciousness about the need to promote civil society, and in this part, there is a need to foster an approach to community care and organizing that is self-critical, integrative, and respectful of diverse communities in the contemporary society.

The necessity to pursue an integrated approach consisting of a proper
balance of emphasis on research, theory and practice in social work has been a constant focus of argument (Cooper and Lesser, 2005). Practice must be based on theoretical base and this theory must be examined through its application to social work practice with diverse clients in various setting of field. Devising a mean to evaluate the effectiveness of their work should then follow. The attempt to improve the professionality of social work practice involves, for example, the process of learning and such process is ongoing. There’s a need to develop professional learning to help practice move beyond mere routine towards creative and critical problem solving (Gould and Baldwin, 2004). The learning process involves systematic thinking, team-work learning and work-based learning that integrate the knowledge of social workers from different level and different areas of practices, and this necessarily calls for the consideration towards the importance of supervisory skills in social work practice that will coordinate and facilitate such integration process. Other than that, supervisory skills is one of the most important factors in determining the job satisfaction levels of social worker and the quality of service to clients (Tsui, 2005), but, somehow, has not received much attention as other components of

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2 Through research, practitioners must find the best evidence that will support the selection of their intervention method (Dominelli, 2004; Smith, 2004).
social work practice do. Less attention was also given to issues around service user’s involvement in research and theorizing the practice, and in informing or influencing future policy practice (Lovelock et al., 2004) despite this group’s position as one of the key stakeholders. Other than professional learning, social work supervisory skills, and service user’s involvement in determining the trend of future services; the necessity to conduct a social work approach that is ‘evidence–based practice’ is hotly debated (Dominelli, 2004; Smith, 2004). While majority of the arguments tend to focus on the merit, a few is concern on the viability of such model to produce a basis for a thoroughly comprehensive approach in social work field that is also strongly characterized by sociological, other than scientific aspects. It is believed that a part of the origins in the emergence of evidence-based practice in social work was due to government’s attempt to modernize and rationalize the provision of welfare services (i.e. agenda of New Labor’s government in Britain). In this situation, although medical field provides the model for such practice, the limited definition given to what count as valid evidence and the standardized approach to clinical decision that omit individual practitioner’s expertise and patient’s choice is firmly rejected in such field. However, this was not the case in social
work practice. The reverse trend is observable and the difficulties arising from such narrowly defined practice and its founding knowledge became more intense as social structure changes into a multiracial community with further diversified needs. Given the increasing diversity of ethnic groups as well as differences in gender, religion, identity, status, and affiliation groups, social work practice requires inclusive, integrative and multidimensional paradigm (Dorfman et al., 2004). This competency requires more than just the adaptation of existing framework of practice. Social workers need to rethink their approach in terms of capacity for critical and reflexive practice. They must be prepared to expand their theory base and learn new model of practices. Understanding the nature of changes that are reframing social work locally and internationally is crucial if social work is to survive a discipline and practice making a worthwhile contribution to human well-being. The key context is globalization (Dominelli, 2004). Engaging with others – from different field and level of practice in welfare and from different expert fields other than welfare – to reformulate an integrative practice requires contextualization at the local, national and international level.

The provisioning of formal care is usually mediated through a care
organization and for such reason organizational setting has been the focus in many attempts to improve the quality of delivered care services. The intention of organizational transformation in care setting is usually aimed at fostering collaboration and integration between all involving organization members in order to improve the interconnectedness of the whole organizational network. Effort necessarily involve different category of individuals from different field of expertise (Hankivsky, 2004; Baer, 2004; Cutler and Garber, 2004). The outcome and impact of this transformation process so far, however, is said to be less decisive and varies according to local institutional setting. The outcome of change that was intended to foster collaboration and integration was uneven because doctors retained a high degree of control over work practice and organizational reengineering was difficult to take shape (McNutty and Ferlie, 2004). The power base of professional workers (in this case, doctors) remains a crucial factor in the organizational context of change within health and care provisioning sector. Other than that, studies also highlighted that care provisioning team or organization is prone to stress, burnout, teams in disarray, and gulf between front lines and back officers. At this point, along with the improving of collaboration and integration between members, organizational
reformation is further aimed at structuring a care delivery team that is ‘resilience’ in its characteristic (Kahn, 2005). Resilience is the property of the collective and forming such organization particularly needs an improvement on the part of group and inter-group relations. In addition, as merely reorganizing within the organization proved to be insufficient, scholars have further argued the necessity for a wider scope of improvement. According to this stance: collaboration and integration between practice and policy where dialogues between academic researchers, health care experts from government and private sectors and others must be fostered (Cutler and Garber, 2004); consumers’ perspective (that can be generated by encouraging them to become active consumers that are more involved and with more say) must be valued as part of the evidence and guide (Burr and Nicolson, 2005) that should inform and determine the next strategy; and problem-oriented approach must be adopted. In effort to provide a quality care, such care must be based on consumers’ need and respect their particularity in terms of age, genders, ethnicity, disability and sexuality. Contemporarily, what count as evidence in the social care field should evolve to include consumers’ perspectives of knowledge (other than scientific knowledge). The other hard barrier that must
be crushed in attempt to promote a collaborative and integrative practice is the barrier that exists between public and private domain in terms of care provisioning. The public / private divide in terms of responsibility commitment has all along been the traditional challenge to care provisioning. The influence from liberal justice orientation of care has further complicated the balance by almost blindly pushing the axis of responsibility further towards the private spheres (Hankivsky, 2004). Relocating care at a proper policy sphere is argued to be necessary and this transformation of social policy relating to care should necessarily be conducted through and upon the understanding of care ethics that emphasizes on inherent human interdependence (rather than solely on self-independency), respect and social justice.

In arguing about the quality of live (for the elderly, as an example), integrating diverse perspectives of interpretation from different categories of viewpoints that defines the meaning of such quality should be acknowledged as one of the core factors that enable the possible formulation of efficient policies and practices in the related areas (Walker and Hennessy, 2004; Bond and Corner, 2004). The understanding should be carried out in relation with the impact of continuous personal and societal changes on the lives of older
person. Yet, only few studies have attempted to seek the understanding on this matter directly through the perspective of older person themselves (Bond and Corner, 2004; Reed et al., 2004). The fact that people does not age alone, but do so in families, communities and particular countries makes it inevitable for the matter of ageing society to be the concern for all. This is also true in the context of community and as such, it should be a part of the acknowledged community function to ensure that older adults are given enough support to enable them to continue living an independent and healthy life in their community (Antonucci et al., 2002). It is suggested in some of the study that community rather than institution should be the primary axis for care provisioning (Cox, 2005). In effort to provide such assistance, community or society may at times unintentionally exert an enormous amount of control over the freedom, the very lives of the elderly (due to perceived cognitive and emotional incapacity on the part of elderly by the society). Thus, emerge conflict between one’s dependency and one’s individual rights of autonomy, and one’s self-determination. Finding a correct balance (Kapp, 2004) between respect for personal autonomy (towards the elderly), and society’s obligation to step in when protection of the vulnerable is needed is highly necessary and
such balance must be attained with the condition that the process does not fail to properly considers and integrates (in the process) the affected individuals’ perspectives. The popularization of evidence-based practice in welfare practice is generally noticed and the field of study for elderly welfare is no exceptional in this case. Such is the example of the failure to find the correct balance. The need to pursue a practice that is based on so-called ‘proper’ evidence is stressed by some as a must. Again, as it is also observable in the development relating to this argument in other field of welfare studies, dispute on what should count as ‘proper’ evidence started to emerge (Reed et al., 2004). In this area, the discussion merely relating to scientific knowledge as the only acceptable form of evidence does not match the valuable material or information that could be generated directly from the elderly perspective. With some probability of lacking with sophisticated communication skill, elderly won’t be able to convey their message to people who might not be skilled or motivated to listen.

The quality of provided services to the elderly is strongly influenced by the competency and enthusiasm of care workers delivering the tasks. However, the inadequacy on this part is listed as the next problem that is hampering the
efficiency in this area. As it was noted by some scholars, care jobs in welfare institutions (i.e. nursing home) tend to lack almost all the attributes contemporary workers find desirable (Gass, 2004) and the result of this situation is reflected in the poor services that are delivered. Some of the nursing home is said to be replicating the condition of a poor house. And finally, social and health care divide is argued as still being a major problem (also) in the area of welfare for the elderly (Glasby and Littlechild, 2004; Wade, 2004; and Leichsenring and Alaszewski, 2004). The lack of collaboration across the boundaries can lead to human suffering due to failure of providing a continuum of care. Policies of integration may have been introduced but not yet become widely known at the ground level. Long-term care for the elderly needs perspective that goes beyond classic scholarly division with careful planning, resourcing and integrative coordinating of services and expertise. As the demographic explosion phenomenon is occurring in the current globalize environment, elderly population around the world will become more diverse racially and ethnically (Kolb, 2003), and diversity, thus, will become another challenge in care provisioning for the elderly. In many occasions of the above discussion, we repeatedly came across to expressions such as ‘lack of
collaboration and integration’ and such ‘lack’ is believed to be originating from
the existence of various boundaries that exist between various categories (i.e.
social status, field of expertise, organizational orientation etc.). Yet, what is the
principle that works to sustain the persist existence of these (some which are
unwanted) boundaries? As noted by some scholars (for example: Navarro,
2004; Navarro and Muntaner, 2004), it is the ‘power-relation’ that exists
between such categories\(^3\).

In sum, different types of integrations (i.e. research or intervention) that
are initiated at different levels of implementation (i.e. policy or practice) are
observable from the contemporary flow of argument relating to welfare studies
and its practice. On the policy level, despite of the denial expressed by some
scholars towards the possible existence of policy convergence among welfare
states; the same trend of awareness on the necessity to identify (and to
regulate) the new social risks that are posing challenges to the intractability of
the states and the need to shift towards a new mode of welfare with new

\[\text{They argue that integrated understanding in terms of political, economic and cultural perspective is crucial in defining the social problems of any locality. This is due to the fact that other than biological and social determinant, we need to consider the external political factors that determines any social problems. In this part, the analysis of power-relation between all agents or members in a particular locality is necessary.}\]
political settlement which is fitted to the respective condition of modern society are observable. For example, this understanding is strongly reflected through the adoption of what is termed as ‘open method’ of coordination – a method that allows individual states to collaborate and to share experiences on good practices in order to tackle identified common challenges and problems; yet, collaboration and integration is only in terms of constructing common understanding while definition, formulation and implementation of national strategies to face such challenges are independently and respectively conducted – in CARMEN Project that was conducted by European Union (EU) member states⁴. In other words, welfare states share a common understanding on the need to look beyond merely covering traditional social risks and towards addressing new challenges as social norms undergo changes. Such common understanding is actualized by the integrated movement that attempt to improve the social dimension of public policy through the advocation and actual utilization of ‘social indicators’ (in research and data gatherings) as exemplified in European Community⁵. Integration trend at practice level is exemplified by, 

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⁴ Please refer the fourth section of this chapter for more details on CARMEN Project.

⁵ The usage of such indicators allows the comparable assessment of social outcomes between European individual state members in order to understand
for example, the adoption of generic perspective of practice, transparent assessment process, and community building through partnership. These practices and processes emphasize the importance of collaborative functions of all agents in the social system for achieving and sustaining any intended aims and the medium for attaining such purposes is ‘dialogues between all’. The common actualization of this ideology is observable through the attempt to implement organizational transformation, for example in care setting, that is usually aimed at fostering mutual link between all involving organization members in order to improve the interconnectedness of the whole organizational network. By extending such collaboration with the involvement of non-profit and community based organization, the created mutual link will slowly grow into a partnership, and in the following stage, involvement of representatives from all related authorities and stakeholders in the community (in assessing process for example) is prerequisite in order to ensure the transparency of such integrative effort (the partnership).

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each others situation, and in exercising this research practice, it is understood that integrative contextualization at the local, national and international level is required.
1.2 Integration Trend in Social Work Method

The method of intervention in social work has been undergoing a constant tension between the belief that assistance should be rendered focusing to each individual in case-by-case manner in order to guarantee the efficiency and the professionality of such act, and the believe that such intervention should thoroughly incorporate consideration relating to environmental factors surrounding the targeted individual in order to deliver a holistic and humanistic service that will truly help. In many aspects, implicit and explicit, this is still a continuous debate in the spectrum of social work. Yet, if we were to trace back the history of social work’s development, in terms of its emergence as a profession and changes of intervention, the truth is revealing the existence of some particular trends that illustrate the integration of these supposedly contradicting practice methods.

Contemporary social welfare literature has stressed the humanitarian nature of social responses to social problems. But many problems, which could be regarded as worthy of sympathetic treatment today, have been subjected to penal measures in the past (Midgley, 1983). In England, the Elizabethan Poor Laws (enacted in 1601) are one of the earliest examples of the state’s efforts to
deal comprehensively with social problems through legislative and
administrative measures. But historically, government policies for dealing with
social problems have been formulated poorly, implemented sporadically and
dependent often on punitive sanctions. The practice of committing the poor to
institution characterized early public poor relief provisions in England and other
European countries and subsequently, these institutions became specialized;
different workhouses catered for the aged, women, the infirm, children and
other indigent people (and this resulted in the separation of families). Many
were owned privately and abuses were widespread. The appalling conditions in
the workhouses and the cruelties inflicted on the inmates by their custodians
became common knowledge and attracted much criticism from middle-class
philanthropists. Numerous charities were established in the nineteenth century
to provide outdoor relief to the poor and to prevent their committal to these
institutions. Historically, the mergence of social work was strongly associated
with attempt to ameliorate these situations. As the rural poor were drawn into
and concentrated in the industrializing cities during the nineteenth century, the
problem of urban destitution became more acute and conventional public poor
relief provisions were failing to sufficiently ameliorate the situation. Above that,
the statutory poor relief had been made unattractive purposely and public assistance was given reluctantly. Thus, social work attempted to provide an alternative of relief that is more humane and seek to rehabilitate the destitute. Though, the founders of social work too were critical of the large numbers of people who were dependent on state relief, more than that, they were also concerned about the punitive provisions of the Poor Law (enacted in 1834) and especially of the way these affected those who had become destitute through no fault of their own.

The early movement of Charity Organization Societies has been recorded as requiring volunteers to be able to work with community, group and individuals simultaneously (Hoffman and Salle, 1994). However, its later development advocated relief provisioning that was based more on individualism or individuation principal. This practice was coupled with the tendency to blame victim and to explain social problem by focusing on individuals' weakness (Midgley, 1983; Barber, 1991; Johnson, 1992; Hoffman and Salle, 1994). The early social work activity was marked by condescending attitude towards recipients (Morales and Sheafor, 1995) and based on preconceive views about the causality of pauperism (Barber, 1991; Johnson,
1992). It assumed that such situation was a result of moral turpitude and that moral teaching combined with minimal assistance (with intention to cure), given as the last resort of relieve, would support people in taking care of themselves (Midgley, 1983; Kirst-Ashman, 2003). It was only in the later part of development that the importance of recruiting trustworthy volunteers and preparing them in constructive ways to relate to clients through education and training was noted (Midgley, 1983; Morales and Sheafor, 1995; Kirst-Ashman, 2003), and this was the starting point of social work as a profession (paid staff specializing in providing services). From this stage onwards, Charity Organization Societies’ activities started to place strong emphasis on scientific practice and expert knowledge (Kirst-Ashman, 2003).

The intellectual origins of social casework are normally traced back to the publication of *Social Diagnosis* by Mary E. Richmond in 1917. Richmond’s work was based on social science (particularly sociology) and medical model (as such, diagnosis rather than assessment). Psychology had not yet developed and focus was more on family structure rather individual. Her intervention was based on thorough systematic and scientific method of investigation of evidence (from clients, families, neighbors, employers, medical
sources etc.) surrounding those in need of service, and then putting evidence together to gain the accurate picture of situation. Her method is termed as scientific philanthropy (Johnson, 1992). Yet, despite of the term 'social' that she used in the title of her publication, she believed that clients and their problems have to be individualized and casework could only be conducted on the case-by-case basis (Barber, 1991).

In the following stage of social work intellectual development, Freudian Psychoanalytic knowledge was incorporated and it (later developed into diagnostic school approach) changed the general understanding towards the meaning of diagnosis (as compared to Richmond's) in social work. The incorporation of such knowledge was initiated by the quest to embrace explanatory theories of human behavior which would further strengthen the profession's theoretical content (Midgley, 1983), and the intention to move beyond the social work's warm-hearted image in order to understand the physic conditions as the base of patient's distress (Morales and Sheafor, 1995). This method was mainly focusing on individual experience rather than social situation. The worker was far more concerned about 'value and meaning as individual experience'. The focus of attention was on the individual and
included a detailed study of behavior, attitudes, and relationships. Particular emphasis was placed on early childhood experience. The emphasis on the source of information was also shifted. No longer was a wide variety of information sources used; rather, it was felt that the individual must be primarily depended on for information if the meaning of experience to him was to be obtained. Assessment or diagnosis was better organized than in the past. At this stage, it was noted that the trend of intervention was changed from impulsive action to respecting client’s individuality – which lead to efforts of constructing meaningful interaction between worker and client⁶.

The following model, Diagnostic Approach; developed the concept of person-in-the-situation. Gordon Hamilton, an important theorist of the diagnostic approach to practice, clarified the term diagnosis as ‘working hypothesis for understanding the person with the problem as well as the problem itself’. This view of diagnosis led to the development of the concept ‘person-in-the-situation’ as mentioned above (an interpretation of the way a person meets the situation). Evaluation considered the resources available to

⁶ This development (of 1920s) reflected both individualism of the time and a decreased emphasis of social problems in social work intervention (Johnson, 1992).
the client and recognized that problems are both individual and social. Hamilton's statement of social casework theory in *The Theory and Practice of Social Casework* (1940, re-edited in 1951), remained for many years an important statement of one approach of social work practice. However, its frame of reference remained stick to ‘thinking about personality’ due to its origin from psychoanalysis thinking that emphasizes individualized diagnosis and treatment (Barber, 1991; Johnson, 1992). The broad prescriptions for practice during this phase are distinctly clinical and directed at engaging the client in treatment. Following the early work of Richmond, this model does promote indirect environmental interventions, but it retains a very narrow understanding of what constitute ‘social’ and ‘the environment’ (Barber, 1991). At almost the same time, Functional Approach (based on the work of Otto Rank) emerged objecting to what it considered to be mechanistic view of human nature inherent in Freudian psychology as reflected in Diagnostic Approach (Barber, 1991). It did not see the client as sick and deviant and the diagnosis was not intended for treatment or cure but on searching for a common ground for working together. It was aiming to develop opportunity from relationship building (Barber, 1991; Johnson, 1992). The different emphases found
expression in casework terms like ‘helping’ and ‘enabling’ that were mainly
used in this approach (rather than ‘diagnosis’ and ‘treatment’). The most
importance is its ‘agency function’ that primarily intended to administer
client-worker relationship and agency’s program. The client’s capacity for
positive self-direction is believed to develop as a consequence to his or her use
of service (Barber, 1991). In the following stage of development, the blending of
the Diagnostic and Functional approaches through Problem Solving Approach
(Barber, 1991; Johnson, 1992) ended the controversy between the two
methods. It is an approach which reduces the emphasis on psychopathology
and psychological legacy in casework (Barber, 1991). Problems are not seen
as pathological but as part of all life and aim was focused on developing human
competence (to overcome lack of motivation, capacity or opportunity to solve
problem). This era was indeed rich in theory development, just as it was rich in
the development of new service possibilities, concern for new problems areas
and new client groups, and in the use of old methods in new ways. At this stage,
the social-functioning focus of social work began to emerge too. Other than
that, it was also noted that at this stage scholars and practitioners begin the
search for a common ground of practice and unified profession (Midgley, 1983;

The probable explanation of why earlier practice by volunteers in social work field was characterized by preconceived ideas about pauperism (blaming the victim) was because of the absent of knowledge that can guide the correct (scientific) interpretation of human behavior. Thus, the emergence of psychology has in a way contributed to the elimination of such negative characteristic from social work practice. In other words, psychology has contributed to the development of intervention trend that ‘respects the clients’ individuality’ and the creation of meaningful interaction (between worker and clients) in treatment process. Yet, again, psychology has its own flaws, such as; limited scope of intervention due to its effort to seek solution to human suffering merely in psychopathology (focusing on individuals to the exclusion of social and contextual factors), and indifferences characteristics to broader political realities. That is, it fails to recognize the intrinsic social dimension of the human condition (Midgley, 1983; Barber, 1991).

Economic situation such as ‘depression’ is argued as part of the reasons that influenced the noted shift from merely psychological to social functioning focus in intervention methods of social work. Prior to such situation, social work
was close to becoming a profession of graduate degrees only and task was defined as ‘providing skilled casework services based on a thorough understanding of psychotherapy’ (Kirst-Ashman, 2003). Majority of client were not poor people but middle-class people who had adjustments problems (Johnson, 1992; Kirst-Ashman, 2003). The depression period had made it apparent that social work requires different skills than merely the ability to perform therapy (Kirst-Ashman, 2003). In this context, small-group focus began to become a major interest and relationship between clients and another person who is non-clients began to be considered (Johnson, 1992).

In the following stage, the use of social system theory and communication theory led to the important formulation of group work and community work and, in this context, the concepts that were universal to casework, group work, and community organization were emerging and utilized (Johnson, 1992; Twelvetrees, 2002). There was a noted movement from the use of medical term ‘diagnoses’ and ‘treatment’ to the more general term ‘assessment’ and ‘interventions’. The concept for intervention process evolved from ‘problem-solving process’ to ‘person-in-the-situation’ focus, later to ‘client-worker relationship’ focus, and finally to concepts that emphasizes
'social system theory'. The necessity for interactional skill began to be discussed. At this stage, theory was developed to fit for unified social work profession that was needed to respond to particular problems and needs - this became the origins of integrated methods or generic practice (Johnson, 1992)\textsuperscript{7}. Practically, as argued by Hoffman and Salle (1994), generic perspective of social work should work to engage clients in problem solving, evaluation and planning; assist clients to develop their own strength in problem solving; assist clients to become aware of their external resources and linking clients with such resources (such as human, services and policy); conduct evaluation of services by obtaining feedback from client system in order to create a mutually interacting social system; and to conduct services provisioning through person-in-the-environment perspective where clients are to be understood only in relation to their social environment.

The necessity to develop a practice from a generic perspective arise from

\textsuperscript{7} Generic or generalist models make the assumption that social work has an eclectic theoretical base which is grounded in a systems framework for assessing multiple points of potential intervention. The worker is directed to assess all aspects of a situation with special emphasis on the client system, which may be an individual, a group, a community, or even an organization. In addition to this, the generalist worker is supposed to be equipped with an understanding of the change process and a set of skills for facilitating this process at any and all system levels (Barber, 1991).
the fact that clients did not fit nicely into traditional casework, group work or community organization model. Rather, a combination of methods might be needed to respond to complex problems situations these clients were presenting (Barber, 1991; Johnson, 1992). The breaking down of the old alliance with psychoanalysis and medical model enabled this trend to develop. By using a social system framework, they were able to incorporate social understanding into their framework. New practice approaches such as crisis intervention, task-centered casework, and social-behavioral casework were developed. Intervention repertoire became boarder but intervention strategies were elaborated to a greater specific degree (Johnson, 1992). The various approaches in generic perspectives all contained a means of assessment, concern about relationship, a process, and a focus on the clients-in-a-situation, and all were a means to influence change (Johnson, 1992).

The next phase of history noted the resurgence of ‘social change’ activity in social work intervention methods (around 1970s) that were influenced by radical social movements involving rights movements such as civil rights, welfare rights, racial equality rights, and women's rights, and due to certain policy implementation (Barber, 1991; Morales and Sheafor, 1995, Twelvetrees,
2002). For example, the demand for expertise in community organization and administration became apparent through the implementation of ‘War on Poverty’ Policy in America. As a result, social work began to incorporate policy, planning and administration specialties in its spectrum (Kirst-Ashman, 2003). In this context the importance of relationship concepts are not seen only in those with clients but also relationships with significant social system and with person influential in the system (Johnson, 1992). However, the above resurgence was short-lived and social workers again turned towards a narrowly defined (and minimal) orientation of practice in the era of conservative political parties ruling. Due to inflation, unemployment, and concern with defense, the concept of assessment and targeting became a focus of attention, and blame for certain incapacity in individuals were once again rested on their shoulders. Assessment and targeting was seen as a core process that develops the understanding of the person-in-the-environment and as the basis for action to be taken. Assessment of the effect of cultural and ethnic factors, and of gender, was used to gauge the behavior of individuals and the capacity of the individual and family to use help.

However, despite of the above mentioned relapse trend, consensus that
this should be the standard bearer for practice was much less stronger than before due to already heightened awareness for the need to conduct a practice that is based on a wider angle of understanding and approach among social work practitioners and scholars. The popular argument on generic model of social work has brought the importance of community work approach to a more prominent level than before and moved it away from behind the shade of psychopathology casework’s dominance. The origin of generic approach and community work is traceable back to the Settlement Houses movements. Settlement Houses movements used educational (i.e. learning skills required for urban living) and enriching group activities, and worked within the political system by providing leadership in political action to bring about the needed change. This method saw problem as lying in the environment and lack of understanding to cope with one’s surrounding instead of individual pathology (Johnson, 1992; Hoffman and Salle, 1994; Morales and Sheafor, 1995; Kirst-Ashman, 2003). In its early emergence, community work was closely associated with social work. Today, it seems to link more with economic regenerating and planning, and seeking to involve the community much more in designing and evaluating services. Community involvement and consultation,
empowerment and capacity building is now widely acknowledged (Midgley, 1983; Hoffman and Salle, 1994; Twelvetrees, 2002).

Community work is the process of assisting people to improve their own community by undertaking collective action (Midgley, 1983; Twelvetrees, 2002). Community workers operate in two ways that are: community development approach (assisting the formation new autonomous group) and social planning (liaising and working directly with policy makers and service providers to sensitize them to existing needs). The techniques are primarily to do with establishing relationships with people, understanding how they see the world and finding ways ‘to assist them to help themselves’ (Midgley, 1983). The main concern is about promoting social justice. From the year 1990s, the method of ‘partnership’ became mainly focused. It was recognized that the public, private and community sectors all had to work together to bring about benefits for excluded areas and people. Communities began to be asked for the views. Argument on partnership necessarily calls for the reconsideration about power inequalities in social setting, and the need to find ways of working which are cooperative (Hoffman and Salle, 1994; Twelvetrees, 2002) rather than hierarchical and bureaucratic. Following this trend, local authorities begin to
develop equal opportunities policies. There is an equal concern to fight against inequality, discrimination and injustice as suffered by oppressed groups and individuals, and to build the power of such group and individuals. There is a wide ranging commitment to combat all forms of discrimination and exploitation.

Community workers emphasize core principles such as justice, respect, solidarity, access, equality and diversity difference. They also tend to emphasize the importance of having an analysis of power-relations and how these tend to reinforce the status quo on both macro and micro level. Without such analysis worker will not be able to identify targets for change (Twelvetrees, 2002).

For almost half a century, casework practice has been heavily influenced by physical and mental health treatment models that place primary emphasis on dysfunction. Within this approach, individuals and families have been viewed as service recipients rather than capable, active partners in the change process. In the current context, intervention must take into consideration the perspectives relating to environmental factors, client competencies, family development, and relapse prevention strategies in order to sustain efficiency of intervention. Each of these factors is important in effort to form enduring
worker-client partnerships. As such, models that emphasize collaborative
integration, client competence, individuals and environmental change,
solutions (rather than cures), and a mutually engaging relationship between
clients and professionals are enjoying rising acceptance currently (Christensen
et al., 1999; Austin, 2004; Minkler, 2005). This model is described as
Collaborative Model of intervention (Christensen et al., 1999).

In sum, looking from the trace of history, the existence of several models
(among many more) of intervention in social work with their distinguish
characteristics could be identified. Though in their most simple form they could
be categorized as non-generic (mainly based on psychological body of
knowledge) and generic forms (with additional emphasis on the important
influence of environmental factors), differences between methods grouped
even in a similar category is observable. For example, pre-theoretical model of
practice that guided intervention methods in the early formation of social work
was based on Charity Organizations’ movements and volunteers’ individual
and sympathetic reaction against the existence of needs (specifically
pauperism). However, with the absent of accompanying theory, data and
evidence to clearly guide their practice, the noble intention was later identified
as tainted by misunderstanding and stigma against the needing individuals. The intervention at this stage was characterized by non-scientific approaches. The Scientific-Philanthropy model that was developed by Mary Richmond perhaps was the starting point where a written and transferable scientific thinking was injected into the spheres of social work practice. The scientific elements of approaches and intervention in this model were mirrored through the effort to accurately (in detail) conduct data gathering and to refer all decisions relating to intervention based on the readings of the accumulated data. However, the focus point for data collection was still broadly defined and blur, and to some extent, prejudice and stigma was noted as still accompanying interventions.

The adaptation of practice to Freudian Psychology has fashioned the Psychoanalytic Model in social work. This model was strongly characterized by it's almost 'totally therapeutic' and 'individualistic' approach. However, positively, due to the constructive understanding towards human behavioral perspective as offered by such body of knowledge, the stigma in practice was reduced and practitioners were required to conduct their intervention with some respect towards client's individuality. In its later development, Psychoanalytic Model
was further developed into two contradicting models of Diagnostic School and Functional School. Though the diagnostic model started to show interest and acknowledged the significance of environmental factors towards client’s deficiency, their understanding towards what the environment (and its social dimension) should consists of was still narrow and limited, and intervention methods were still very much focused on trying to therapeutically ameliorate individuals’ behavior. Opposing this very mechanistic and therapeutic view, Functional School was trying to develop methods that were non-therapeutic in its main aim. Instead, emphasize was placed more on the effort to believe in the client’s inherent positive self-direction and creating new opportunities through appreciable worker-client relationship.

The disagreements between the two models were ended with the introduction of Problem-Solving Approach Model which reduced the emphasis on psychopathology and psychological legacy in casework and focused its aim on nurturing individual's competency in problem solving. From the following stage onwards, the integration and unification of different models and approach in social work (casework, group work and community work) was conducted and the generic perspective of intervention that brings forward the prominence of
community work (as against the all-time-dominant psychopathological casework) – that is currently represented by the Collaborative Model – is placed in the front line of what is defined as desirable for an approach in the contemporary situation. Collaborative Model is an approach that should be based on mutually developing relationship between all stakeholders in the society in quest to search for mutual solution on issues (rather than curing relationship). The argument on what should characterize this ‘mutual relationship’ is still a lively going on debate in the area of social work studies.

Midgley (1983) argues that, though each method in social work relies on a specialized body of scientific knowledge, the different methods are said to be no more than different manifestations of a methodology which is common to all forms of social work. Although social workers have promoted a generic approach to professional practice, this methodology is derived from social work’s original dependence on casework method such as individuation and therapeutic concept. Further, according to Barber (1991), pre-generic casework theory, irrespective of approaches, contains at least four fundamental and interrelated flaws. First, the sole unit of concern is the individual, even when so-called ‘social factors’ have been identified and targeted for
intervention. This factor is acting as an obstacle to understand the reality of class conflict. Individuals are suffering problems which are related to structural (social and political) inequality. Second, the obvious emphasis is psychological change or development and clients continue to be held responsible for the problems brought into casework. Third, all approaches accept the prevailing social context as a given and seek only to work within current client’s microsystem. Following from this, the fourth problem is stating that all the approaches have extremely narrow understanding of what constitutes ‘the social environment’ or the ‘in-situation’ component of social work’s ‘person-in-situation’ tradition. However, this statement of referring to the flaws of pre-generic practice of casework does not necessarily reflect that generic practice is free from defect. In fact, it is far from that. The basic problem with generic model of practice is that it fails to distinguish between models of practice and models for practice (Barber, 1991). As definitions of practice, generalist model has been a much needed development in thinking about social casework because it reinforced the social work commitment to holism (thus, promoting the significance of community work). But as models for practice, generic approach is utterly inadequate and is incapable of guiding
action at any but the most general and theoretical of levels. What is urgently needed is a theory development at a level beyond mere description. Now, if both models are flawed, what then should be our solution?

What we could observe from the trend of changes in social work intervention methods is the constant tension that exist between, for example, individualistic approach (through casework) as against environmental perspective approach (through community work); favoritism towards scientific approach (based on human behavioral science) as against humanistic approach (based on welfare and care – social dimension – ideology); and between therapeutic approach (based on psychopathology method) as against collaborative or empowering approach (based on a more extensive and various body of knowledge) in effort to create the most efficient method for intervention at certain point of time and in certain need situation. From the trace of history, we could identify that the trend does not progress in a linear pattern of changes, but rather in a ‘recycling’ or ‘repetitive’ mode where trend of intervention that was taught to be appropriate and applied to practice at an earlier stage (be it non-generic or generic approach) vanishes and reappears (reapplied) again as time progress forward due to certain factors that I will briefly elaborate below.
There are various factors that are identified as responsible (partly) in structuring the ‘tension’. One of such is the continuous contradiction between principles and practice that exists within the spheres of social work itself. The common believe of how an intervention should be, must be made up of elements that appreciate: acceptable standards of social life, the use of normals of human life and human relationship (in intervention); the significance of social history as a basis; utilizing established community resources as part of human treatment; adaptation of scientific experienced; and the consciousness of the philosophy that determines the purposes, ethics, and obligations of social work. This consensus was stated in the year as early as 1929 (Milford Conference) in effort to create a common ground to synchronize practices (Hoffman and Salle, 1994). The later statement emphasize that principles of practice should be characterized among others by: self-determination of individuals; non-judgmental stance and attitude of value neutrality; confidentiality; and professional non-involvement (Midgley, 1983). In the early period of social work development, social workers dealing with the poor made no pretence towards what they believed to be ethical deficiency of needy individuals. To some extent, this tradition was continued into later stage of
practice where psychopathological method was dominant. As highlighted by some scholars, this method of intervention is indifference or blind to broader social and political realities due to its tendency to pre-determine the necessarily multi-dimensional complexity of individuals’ experience (before arriving to a ‘needy’ situation) in a rather standardized way through the knowledge of psychology. This context run counters with the principle of non-judgmental stance as advocated in social work. Also, the acceptable standard of social life, or the norms of human life differs significantly from one individual to another, thus, explained why the focus towards one’s social history and the involvement of one’s community as part of the resources in intervention process was (is) considered as inevitable. The earlier efforts through social work interventions to a certain degree bypass all the above facts. Practitioners were taught that: individual and social needs are reciprocal; they should not have preconceived ideas about moral standards; they need to develop individuals’ personality and strengthen their social relationship; bring about a healthy adjustment between individuals and society and to help them to participate in group life meaningfully; and aware of the need of others and teaches them ‘even’ to join with their fellow citizens to decide democratically how community needs can be
met (Barber, 1991; Morales and Sheafor, 1995, Twelvetrees, 2002; Hankivsky, 2004; Dominelli, 2004). Yet, the dominant environment of practice is almost neglecting the advocated priority to materialize such wisdoms. Educated and groomed by a different set of values but engaging in almost a different dominant set of intervention practices necessarily creates confusion and tension among practitioners.

Among external factors that are identified as capable of promoting a tension between advocated ethics and methods of intervention in social work areas are political (ideology and settings) and economic situation. The political ideology of reigning party has a certain capacity to determine the trend of social policy (thus, social work practice) at certain period of time. How Thatcherism influenced the trend of practice in Britain earlier clearly exemplified this situation. This fact is applicable in the context where social workers are mainly consists of, or categorized as, government officer. At times, statutory obligations impel social worker to intervene utilizing method that is in a way against their own advocated principles. Other than that, the implementation of certain government policy in certain economic situation will determine the shape of social work intervention regardless of what social workers themselves
believe on what their advocated principles tell them to do. For example, both the period of economic depression and the implementation of ‘War against Poverty’ policy has forced social worker to embrace a practice that is characterized by generic approach despite of their strong believe and the ruling consensus (at that point of time) that psychopathological approach was the most appropriate.

The next identifiable factor that possibly contributes in aggravating the ‘tension’ is the change of contemporary community structure that emerges with a set of new (more complex) needs. For example, the ageing of society, the multicultural restructuring society, and the heightening of social and political awareness (thus, demand) of different (competing) social groups in the community are all expressing the necessarily ‘diverse’ characteristic (thus, the particularity of individual’s needs) of contemporary community. In effort to embrace the principle of ‘diversity’ in social work intervention in order to produce the best suiting method that fulfills the requirement of any category of members in the society, social workers are often faced with dilemma. Such dilemma would also involve situations where social workers would find that none among the existing method of intervention is readily applicable to the
emerging complex needs from the contemporary society. Individuals do not suit into traditional intervention settings and a combination of methods is needed to respond to problems situations they are presenting. Since choosing from the existing list of intervention is no more an option, new approaches that must be derived from a collective of multi-perspective knowledge and expertise would be necessary. As argued by Gibbons et al. (1994), this approach must make use of a wider range of expertise, transdisciplinary, involves a variety of different skills in problem-solving and utilizes more flexible organizational structure. Rather than following the code of practice restricted to a particular discipline (as the conventional method of intervention does), problem solving in this context should be carried out around a particular application. Application in this sense would mean: solution should always be produced under an aspect of continuous negotiation that include the interests of various (all) stakeholders, or otherwise, the process would not be possible. It is quite ironical that as we know more, the more demanding and complex an issue will turn out to be.

The attempt to select or create a suitable method of intervention necessarily revolve around the question of ‘where and which part of the identified need (in individuals) should be defined and understood as deficient’.
Who will conduct and what is the base of knowledge to be utilized in the process will strongly influenced and determine the type of intervention (and its outcome) to be applied. In other words, those who have socially valued knowledge (scientific knowledge) and/or authority have the power to make decision (Reed et al., 2004). In the context where an intervention approach that involves all stakeholders in the community is considered as necessary (i.e. integrative model of intervention), the implementation of such practice inevitably calls upon the re-argument and consideration about power-relation (power-balance in terms of authority and knowledge) that is structured and established in the society or social system. Power-relation in this sense would refer to power-balance that exist between and within government sectors, between and within central government and local authorities, between and within service user and service provider, between and within expert and lay people (in terms of knowledge) and many more. Without the analysis of power-relations and understanding towards their possible influence in reinforcing the status quo of certain situation (of needs) it would be difficult to recognize object for alteration (Twelvetrees, 2002; Navarro and Muntaner, 2004; Navarro, 2004). It is arguable that the shift of trend observable in social
work intervention method is partly due to the influence of changes in power-balance (that moves towards further favoring service receiver) between service providers and receiving individuals. One of the earliest of such examples is the decision to adopt the principle of ‘respect towards client’ in Psychoanalytic approach, and believing in clients’ ‘positive self-direction’ as advocated through Functional school of approach. On a wider scale, it was later exemplified by the resurgence of social action in social work spheres through the support that was shown towards the movements of rights. The readjusting of power-relation both in term of authority and knowledge between the two in the contemporary context is exemplified by arguments that promote: social inclusion, citizenship and the rights of individuals (Innes et al., 2004); the finding of correct balance between respect for personal autonomy and society’s obligation (Kapp, 2004); the challenge towards existing public / private divide in care provisioning (Hankivsky, 2004); respect for individuals’ diversity by including their perception in what to be count as evidence (Burr and Nicolson, 2005); involvement of service user’s in research and theorizing (Lovelock et al., 2004); developing active consumer by increasing emphasize on customers’ choice as against one-size-fits-all model (Carnwell and Buchanan, 2005) and
so forth. The existence of such changes allows the breaking down of earlier trend where dominant involvement of service providers and experts in defining (needs) situation was considered as absolute necessity. The involvement of a larger circle of stakeholder (i.e. service users, expertise from other fields in social work) in decision making has shifted the approach of intervention from a strictly mechanistic method based on human behavioral science (i.e. psychology) into a more humane approach that is based on social realities. As a consequence from this readjustment, the aims of social work intervention has changed by embracing a bigger mission from simply ‘curing’ to forming a ‘societal integration’ so that individuals (and society) can fulfill their own need independently and in a respectable way. The meaning and definition given to terms such as inequalities, discrimination and justice – terms that are mainly advocated to be central for the concern of social work intervention aim – has departed from being associated merely to the situation of ‘material acquirement’s insufficiency’ to ‘opportunity creation and redistribution through the promotion of independency attainment’. Independency attainment rather than material assurance is set as the ‘starting line’ for fair entrance to the ‘field of play’ (Roemer, 1998). Individuals’ independency in the community is partly
constructed and preconditioned by the existence of interdependency (Ogasawara and Hirano, 2004), and such interdependency is believed to be attainable through social integration that appreciates and views all individual as capable and active partners in the process (Christensen et al., 1999). It is in this context that the crucial link between individuals and the society is understood and the humane side of intervention should be reflected.

From the above discussion, it is noted that the development of knowledge in practice, along with the necessity to face complex needs has all along became the motivating factor for social work method to continuously improving and adapting. Practice has moved from pre-generic to generic practice. However, what is more interesting is the fact that such development did not occurs in a linear form. But, rather, in a ‘to and fro’ form, continuously bouncing from one end to another. This factor is reflected by existing arguments that point both the flaws of pre-generic and generic theory of practice in social work at the same time. This situation is expressing the fact that combination (that is the integration), rather than choosing a particular method is needed to respond to complex problems situations. Such integration process must be derived from a collective of multi-perspective knowledge and expertise. Tracing from the
history of social work’s development, it was the blending of Diagnostic Approaches and Functional Approaches method in social work that among first triggered the practitioners’ interest towards searching for an integrated ground of practice under a unified profession. Later, this attempt was further accelerated by the use of social system theory and communication theory in social work practice. The usage of such theories has led to the important formulation of concepts that were universal to all category of social work. In other words, at this stage, theory was developed to fit for unified social work profession and this was the origins of integrated methods or generic practice. The various approaches in generic perspectives all contained a means of assessment, concern about relationship, a process, and a focus on the clients-in-a-situation. This trend continues to current context where emphasis on collaborative integration, client competence, individuals and environmental change, solutions (rather than cures), and a mutually engaging relationship between clients and professionals are valued.
1.3 Social Work and Trend towards Integration of Different Disciplines

There is different understanding towards the meaning that is given to the term of Integrated Care⁸. Terms (that are sometime confusing) such as ‘joint working’, ‘partnership’ and ‘interagency collaboration’ is used as a sort of shorthand to describe a way of working which is characterized by: 1) a desire to achieve benefits that could not be attained by a single agency working by itself; 2) recognition that some services are interdependent and that action in one part of the system will have a ‘knock-on effect’ somewhere else; and 3) some sort of shared vision of the way forward or shared purpose. Rather than definition, the more important issue is how to create an appropriate level of 'joint-ness' or coherence so that users (and carers) experience existing system as something that is a consistent and coordinated package rather than as fragmented and disjointed. Achieving this joint-ness depends on action at a number of different levels and can require a number of different types of joint working. Poxton (2003; cited by Glasby and Littlechild, 2004) suggests that

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⁸ The term ‘integrated care’ has been given many definitions…most of which concentrate on the design and development of techniques and models to establish both informal and formal collaboration between the health, and social care sectors. Such integration can occur at many different levels, including planning and policy making, funding, administration, and the provision and delivery of care itself (Goodwin and Shapiro, 2001; cited by Glasby and Littlechild, 2004).
health and social care are increasingly being required to work together at three different levels: 1) at a strategic level – agencies are required to plan together and share information about the use of resources; 2) at the operational management level – a demonstration of partnership is required by a range of policies; and 3) at the individual care and support level – operational requirements are taken further with expectations of a single point of access, shared information systems and joint training (Glasby and Littlechild, 2004).

Integrated care is a concept of providing care services in which the single units act in a coordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care. Means to this end include the reduction of inefficiency within the systems, the enhancement of continuity, tailoring services within the process of care provision and the empowerment of service users. In this context the term ‘unit’ can have multitude of meanings, for example care providers, strategies of care provisions or care services. The process of integration can aim at linking parts within a single level of care, i.e. the creation of multiprofessional teams (horizontal integration) or the linking between different levels of care, i.e. primary, secondary and tertiary care (vertical...
integration). Those links can work in one direction or include a feedback-mechanism. The concept of integrated care can be found in various countries and under various names, i.e. seamless care, transmural care, case management, care management, partnership and networking. In general, we can observe two larger streams within the integrated care discourse. On the one hand, there have been developments starting within the health care realm, on the other hand there is a broader approach putting increasing emphasis on social services and social integration. It is this broader approach that most practice have looked at, in view of opportunities to create a more equal inclusion of the social services realm in the integrated discourse. The above concept draws on the individual as the point of departure and tries to de-medicalise long-term care, focusing on the interface between independent housing and care (transmural care), inter-sectoral joint working and the development of service-networks to guarantee older persons’ participation in society.

In the United Kingdom, a variety of similar terms have been used to describe integrated care, including ‘joint working’, ‘Partnership’ and ‘Collaboration’, but the actual meaning of integrated care has never been
clearly defined within policy documents. According to Audit Commission’s definition ‘whole system working takes place when services are organized around the user, all of the players recognize that they are interdependent and understand that action in one part of the system has an impact elsewhere (Audit Commission, 2002; cited by Leichsenring and Alaszewski, 2004). Users should thus experience services as ‘seamless’ and providers share ‘vision, objectives, action (including redesigning services), resources and risk’. This concept is surely most remarkable, though its translation into practice will call for major efforts concerning organizational development and communication between players. This definition as such could in any case help to create a shared vision between scientists, policy analysts and practitioners. A triad of coordination, cooperation and networking is commonly found within a single integration effort. The three terms refer to ways of working together, within as well as between different sectors. The difference between the three expressions is the extent of working together, which increases from coordination over cooperation up to networking: while coordination still implies the existence of a hierarchy, cooperation hints somewhat more to working together on an equal level, whereas networking additionally requires a certain
closeness and continuity. In sum, the term ‘integrated care’ is a helpful concept to describe coordination, cooperation and networking between health and social care services with the aim of improving services and quality of life from a user’s perspective.

The most genuine method within the integrated care discourse is probably what has been described as case or care management, a technique derived from the social care sector, which aims at matching supply and demand for persons in complex situations. This idea is to build up a network of services (resources) over time and across services and to empower the patient and his / her relatives to use it self-reliantly. The methods used are client- and therefore demand-oriented. It should be noted that in this context the term ‘case’ refers to situation the person is in, not to the person itself (Davies, 1992; 1996; Wendt, 1991; 2001; cited by Leichsenring and Alaszewski, 2004). This approach was also taken up in other domains such as, in particular, the health sector where it is more known under the heading ‘care management’ or ‘managed care’ which is mainly to introduce steering mechanisms and economic thinking in medical care. The idea is to maximize the benefits derived from a given amount of money. This aim is reached by means of coordination
of the care delivery, thus avoiding loss of information and double treatments
and – eventually – leading to a cut-back of the utilization of care services.

As the need for care often occurs unexpectedly (mostly in relation to a
dismissal from hospital), and as frail older people (and their family) often do not
know where to turn to, rapid intervention and quick, unbureaucratic support
(that connects, for example, the hospital and community care) is an important
factor to obtain client-orientation quality assurance. If it is important to provide a
single point of reference for persons who have become chronically ill and / or
care dependent, it is at least equally important to cater for an assessment of
needs that considers both social and medical aspects, and all psychological,
mental and physical factors, i.e. by an interdisciplinary and multidimensional
team. In order to provide integrated care it seems only that from the very
moment a person is taken in charge by a service-providing agency, his / her
general needs should be assessed and matched with the existing resources.
This need to jointly conduct and assessment and planning by the
interdisciplinary and multidimensional team is the starting of complex
relationships but essentially important. If needs are assessed only in relation to
medical requirements, it is most probable that only medical remedies will be
prescribed (home nursing, medicine etc), and vice versa, if only social needs are assessed, social care interventions will be used. Furthermore, if needs are not assessed correctly, clients / patients could tend to make use of the most expensive but perhaps less efficient and less satisfying service – major underlying problems could thus be missed.

The process of joint assessment and planning (joint working) needs a practice that can shatter the cultural divide between all involving parties. Anybody who has worked with mixed groups consisting of medical, socio-medical and social professionals knows about the cultural cleavages between these groups but also about the fact that structural and hierarchical divisions are often much more significant. Once various professionals start talking to each other, conflicts and different perspectives often can be resolved. The mere fact that the different stakeholders are gathered around one table often helps to create an intensive exchange of ideas, trust in each other’s capacities and ‘a new understanding of the other sector’s work’. Unfortunately, the process of improving communication is usually quite time consuming. Future trends in social and health policy have to take into account the notion that the traditional emphasis on target groups and respective solutions will be
increasingly confronted with a focus on the solution of social and health problems that regard different target groups with the same type of needs. Furthermore, the increasing migration of family members will trigger the need for new types of support systems within the neighborhood and the community. Traditional nursing or old-age homes (total institutions) will hardly survive in this scenario, unless they become pro-active, open and innovative neighborhood centers providing all kinds of services and facilities to the public. At this level, opening the barrier of respective services body and integrating them (such as housing, welfare and care) will be necessary.

And finally, the role of families and / or informal carers in creating integrated care networks is crucial to their success. This is equally true for prevention and the actual care process as no care system will ever be able to completely cover all long-term care needs by professionalized services. While informal care was, for a long time, taken for granted by service providers, a number of initiatives now exist to ameliorate this situation. These mechanisms range from cash benefits (UK, some regions in Italy) and pension grants (Germany) to training and information, employment (Nordic countries), and respite services such as day-care or short-term care. The integration of
informal care therefore remains a critical area for integrated care delivery, partly due to the fact that family carers often do not even define themselves as carers, and also because professionals in many cases see the family of the person in need of care as an opponent, rather than as resource. Different combinations of ‘instruments’ or methods can be used to achieve integrated care, depending on national traditions and local conditions. It could nevertheless be suggested that in countries where more methods of integration are being adopted, the political will to achieve development of an integrated service delivery is likely to be stronger.

In sum, the fundamental aim of integrated care as understood from the above explanation is the attempt to create a seamless care provisioning that empowers service users and at the same time capable of guaranteeing service users’ (or generally, all individuals) participation in the society. Such implementation of integrated care necessarily needs a networking process that will link parts (multiprofessional teams) within a single level of care and a networking process that will mutually connect different levels of care. To be more precise, what is necessary in the process is the creation of a shared vision through coordination, cooperation and networking between health and
social care services with the aim of improving services and quality of life from a user’s perspective. There need to be a joint conduct of assessment and planning by interdisciplinary and multidimensional team in the complex relationships. And, in addition, the role of families and informal carers in supplementing the network of professional carers must be acknowledged in care setting that is not merely curative, but also preventive. There are resemblances that are significant between the aims that are pursued through the method of integrated care and aims that are pursued through social work in general. Social work has been described as the profession that helps society work better for people and helps people function better within society (Segal et al., 2004). The practice configuration of this profession is constantly affected by setting of practice, area of practice, characteristics of clients, presenting problems of clients, level of practice, and methodologies used in practice (Gibelman, 1998; Healy, 2005). Due to its broad concern, social work could be addressing multiple issues concerning to complex relation between individual rights, care, various welfare needs, expectation of society, inequality and oppression, and justice in social policy all together at one time (Parrott, 2002). Yet, in general, the main dual aims of social work are to help individuals fit
better into their environments, and change the environment so that it works better for individuals.

The necessity to integrate within a single level (in terms of knowledge or action – and in this context, the knowledge) is reflected in the advocation that emphasizes ‘a proper social work practice must be grounded on certain widely acceptable theoretical base in order to ensure and sustain its professionality’. Such effort include conducting a practice that incorporates, for example, general system theory (the failure of one human system often affects the functioning of other systems and of the body as a whole and every part of a system is so related to its fellow parts that a change in one part will cause a change in all of them and in the total system); ecological systems framework (focus on the intersection of client systems and the larger environmental context); strengths perspective (building on client’s strengths to create positive change as opposite to frameworks that encourage social workers to approach clients from a deficit or problem base with supposition that clients become clients because they have deficits, problems, pathologies, and diseases; that they are, in some critical way, flawed or weak); empowerment perspective (to assist individuals and community so that they are capable of doing things for
themselves, gaining increased control over their lives, and influencing events and situations that affect their lives); and diversity perspective (understanding cultural differences in order to work effectively with diverse client populations).

It is argued that, social workers must balance the rights of the individual with interests of society in a socially responsible way (Segal et al., 2004).

The necessity to create a multi level networking is reflected in the nature of a ‘proper’ social work intervention that necessarily intervene to deal with social issues that cut across the broad spectrum of problems simultaneously affecting individuals, groups, and communities at various levels. Social work practices should involve micro, mezzo, and micro levels of intervention where it is necessary. Micro practice refers to professional activities that address the problems faced primarily by individuals, families, and small groups. Most of the functions performed take the form of direct intervention on a case-by-case basis. Mezzo practice is the level concerned primarily with families and small groups. Related activities include facilitating communication, mediating, negotiating, educating, and linking people together. Macro practiced is oriented to bringing about change and improvement in the general society. The functions performed in this regard include political action, community
organizing, and agency administration (Gibelman, 1998). Practically, the above
would mean an intervention to (1) enhance the developmental, problem-solving,
and coping capacities of people (micro level), (2) promote the effective and
humane operation of systems that provide resources and services to people
(mezzo level), (3) link people with systems that provide them with resources,
services and opportunities, and (4) contribute to the development and
improvement of social policy (macro level). All social workers are normally
engage in all three levels of practice to some extent, even though the major
focus of their attention may be at one or two of the levels (Gibelman, 1998).

And thirdly, the resemblance between integrated care and social work’s
aim is exhibited in their acknowledgement towards the importance of informal
care (and informal carers) in their function to complement professionalized
services in providing care that is preventive orientated, but has for long
neglected and considered this core factors as insignificant. As argued by
Brechin et al. (1998), ‘care provisioning’ is one of the main concern in social
work practice and in effort to provide a seamless care (as both aimed by
integrated care and social work practice), ideally, the integration of all types of
care provisioning regardless of their level of implementation into the overall
framework of intervention is necessary. Yet, in reality, it is assumed (and to some insisted) by many practitioners that there supposed to be a separating professional boundary between the two due to their supposedly different level and thus nature of intervention. If border between agency and institution is identified as the major difficulties in integrated care area, the above said border between categories of functioning (in this case, between social work and social carework) is the main trouble with social work functioning. Caregiving refers mainly to the caring that is done on an unpaid basis within networks of family and friends (Cancian and Oliker, 2000), and caregiving on ‘paid’ basis is mainly referred to and conducted through ‘social carework’ (Brechin et al., 1998). In other words, ‘carework’ is used to refer to a variety of paid jobs in the health and personal service sectors and also to some jobs in the informal economy. The jobs of care assistants of various kinds in the home or in residential care, of home helps, of domestic servants and of childminders are included here and have a number of obvious characteristics. They remain largely women’s work, they exist outside any sustained training framework, and they attract a low status and low regard.

The most apparent contrasting points between social work and social
carework are reflected through the adopted methodology of practice and the extent of setting in which practices assumed to validly occur. For example, while social work practice shows a characteristic of ‘strictly a professional practice’ that must be accompanied by an intervention method based on applied science, carework is argued merely as a practice that exists outside any sustained training framework. And, while social work effort is usually inclusive of dual aims that intend to ameliorate individuals’ conditions simultaneously from micro and macro level of intervention, carework is mainly performed covering merely the micro and limited areas surrounding individuals such as residential and domestic care. In sum, it is generally understood by many that social work is the provision of services through intervention that could range from micro level to macro level, concerning from individual to the whole community needs, and involve attending a wide stretch of needs ranging from one's physical needs to community’s abstract needs. Services would involve the practice or implementation of case management and assessing people’s need for services. A social worker might arrange on going social support, involving advice and guidance around particular life crisis, such as bereavement. Such help may involve advocacy on behalf of a person with
another agency upon whose services they rely, for example, making a claim for social security benefits. Social carework, in contrast to the wide scope of concern as showed through social work method, concentrate on a smaller scale and level of intervention focusing to the provision of services to people in their homes. This is mainly involving the provisioning of domiciliary services to support people unable to manage basic living tasks, for example, shopping or general housework. Many believed that these distinctions should be the proper explanation for the inherent differences that exists within and between the two types of functions. However, as our knowledge, our understanding, and thus our interpretation towards the meaning of needs (even the needs themselves) evolved, we should reconsider if such categorization is still applicable in the current context of reality.

Divisions in social work occupational functions differ not only in their functions, but also in the resources and political support they attract (Parrott, 2002). The insufficient understanding towards the meaning and importance that is allocated to the concept of ‘care’ and its provisioning has resulted social carework to be ranked somewhat lower than other forms of social work practice.

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9 Meaning that, they have unequal professional status, pay and conditions of service (Brechin et al., 1998).
Care tends to be misleadingly idealized as something spontaneously occurring within families and kinship system (Brechin et al., 1998) and misleadingly conceptualized as a natural feeling and not skilled work (Cancian and Oliker, 2000). Shared assumptions about family responsibilities for looking after young, old, sick and disabled members of society are common across cultural boundaries and throughout history. Families, despite their varying forms and functions, are expected to ‘look after their own’ and generally they do, although the nature of that caring and the family structure underpinning it vary greatly (Brechin et al., 1998). This misleading belief can justify little training and low wages for paid caregivers and contribute to a lack of respect for caring work.

Women do most of the unpaid and paid caregiving, and caring feelings and actions are viewed as naturally associated with women. People tend to see caring as part of women’s biological makeup or as a fundamental personality trait that corresponds to women’s reproductive role. They do not view caregiving as skilled work that is learned through practice and shaped by cultural values and economic incentives (Cancian and Oliker, 2000).

The wrong idea about care contributes to the ‘blindness against the skill base’ that is involved in social carework, or more generally caregiving (Brechin
et al., 1998). The devaluation of paid caregiving is especially obvious (Cancian and Oliker, 2000). Though the importance of social maintenance as a part of social work’s core function has been strongly acknowledged in order to maintain people in the community (who would otherwise have to move into some form of institutional care), however, the skills (social care provisioning skills) involve have not always been recognized by social work professionals, particularly by those who argue that it involves less complex skills and tasks. For such reason, social carework has been devalued as the junior partner of social work, due to its lack of the same professional complexity (Parrott, 2002). For example, the low pay and lack of respect given to jobs such as child care worker or nurse’s aide shows the worth of this activity in our economy. Most workers who give hands-on care to our youngest children and our sickest or most disabled relative receive little training. We think of it as unskilled labor. The devaluation of caring is linked to seeing care as a natural, feminine activity. If caring is an instinctive ability of women that does not require skill and training, then it seems reasonable to require little training for (female) caregivers such as child care workers and to pay them low wages and give them little respect (Cancian and Oliker, 2000). Further, equally important is to realize the conflict
that such belief sets up when incorporated into a regular bureaucratic service deliver system due to its potentiality of generating a gender bias concept of practice (Brechin et al., 1998).

Here, the problem is not that caring has been somehow overlooked, and can be retrieved and added to a pre-existing framework. It is rather the denial of caring (the gender bias in conception of care) is central to the construction of the public world. In terms of policy, care has become a key concern and an expanding research area because of shifting demographic, economic and cultural factors; an ageing population, the growing numbers of women in paid work and a perceived fragmentation of family life, can be expected to have profound effects on the future demand for and supply of care. We should not presume that intimate relationships in which people care ‘about’ each other equal and ability or willingness to care ‘for’ them. Questions of gender and age, together with the nature of the personal relationship in which care is required or expected raise difficult issues. Care, as activity, can therefore be demanding and alien for both the carer and the recipient of such care. Care practices can evoke intense physical, emotional and psychological responses. Such responses clearly have implications for the definition and regulation of caring
relationships at the individual and institutional level. Difficulties might also be encountered in defining ‘carer’ as the concept has a relatively short history. The category of carer has come to have particularly narrow connotations in that it tends to merely refer to unpaid, intergenerational care by women (Fink, 2004). Bringing in caring means unmasking the binary gendered thought that bolsters masculinity (Brechin et al., 1998) because these commonsense beliefs about women, men, and caring undermine care and contribute to gender inequality (Cancian and Oliker, 2000). Improving care would mean the necessary to deconstruct the existing concept of masculinity that gives it shape (Brechin et al., 1998).

It is noted that there exist similarities about the struggles for improvement that are taking place in the area of integrated care, social work practice and social policy in general. The struggles are all conveying the same message about the need to reconstruct our understanding and framework of approach in social work (and in social policy generally) in order to formulate an intervention method that is more comprehensive (based on a wider range of practice but specified to needs particularity), practical (in a sense that it is capable of fully utilizing all existing resources in the most efficient way, for example, through
collaboration and networking), fair (in terms of responsibility distribution) and yet sensitive towards the needs of both service provider (including informal carer) and receiving individuals. Returning back to our earlier argument relating to contemporary social policy development trend; it can be concluded from the study that, generally, arguments are suggesting a move that can be illustrated as 'creating a comprehensive approach with respect to, and with the aim to satisfy the contemporary diversity or particularity of individuals' needs'. The 'comprehensiveness' of approach can be attained through collaboration, integration or partnerships between countries, localities, organizations, individuals, or even between person and environment (and so forth) that will assist the merging of necessary knowledge, skills, techniques, or even mutual understanding and perceptions. ‘Diversity’ in this sense is the diversity from the perspective of welfare models and systems, localities and their social structures / problems, organizational settings, or even individuals’ characteristics with relation to age, gender, physical and psychological condition, nationality, ethnicity and so forth. Promoting the respect to individuals’ particularity (the diversity) should be fostered through the guarantee in terms of the attainment of independency and interdependency.
(both physically and psychologically) of such individuals so that their capacity to autonomously express their respective concern and intention (relating to their own well-being, for example) could be sustained and such effort could be groomed into a self-motivating factors to attain their own self-betterment. Creating a comprehensive approach and respecting diversity is an interlinking process and the connectivity should be characterized by mutual consent, responsibility and understanding. From the policy observation, though respective states are moving in different directions due to differences in need and environmental settings, a similar trend towards an integrative approach in policy intervention and practice is observable. Although all are adapting in different ways, adaptations are guided by the same principle of resources networking (in terms of material and knowledge).

Now, returning back to the argument relating to struggle in devising the best method of intervention in social work practice; it is apparent that the noticeable ‘tension’ on what should be perceived as the best method of intervention originates from the attempt to choose only one among the existing models (of intervention) at the time when needs continue to evolve into a structure that is increasingly complex. The situation is suggesting for an
approach in which integration and a continuum of method utilization involving
the perspective of social casework on one side and social work on the other
should be made possible (rather than a clear cut of selection between the two).
In other words, there is a need for an approach to practice which conceives of
social work as a process that moves from casework to community work as the
intervention plan gathers momentum. One’s specialist contribution to case
must occur within broader case analysis and intervention plan (Barber, 1991).
The continuum utilization of methods should be attained through the
reconciliation of both non-generic and generic methods, and the reconciliation
requires the formation of collaboration that is actualized through integration
and partnership in the society. The involvement of all stakeholders from
different field of expertise and different level of society is indispensable in order
to ensure the possible formation of a social networking system that is
interconnected. The possible formation of such, in return, will further promote
the efficiency of intervention. What follows from this fact is the need for the
availability of a pool of multi-perspective data and knowledge that will assist the
formation of an ‘exact’ and ‘fit’ collaboration and integration for any particular
social setting and orientation of need based on transparency and mutuality. In
Britain, for example, the effort to ameliorate bias segregation between the significance of social work and social casework could be seen in the restructuring of health and welfare provisioning that came with the enactment of National Health Service and Community Care Act of 1990 (Brechin et al., 1998). This movement was initiated starting even since the late 1970s when main political parties at that time started to see state provision of personal social services (PSS) as necessary. National Health Service and Community Care Act 1990 confirmed this trend by requiring local authorities to transfer the bulk of existing service provision to the private and voluntary sector. The Local Government Act 1999 reinforce this trend by requiring local authorities to deliver PSS through a mixed economy of care, to achieve value for money and quality outcomes, described as Best Value (Parrott, 2002). In this policy move, since managerial responses are assuming increasing importance, social workers became predominantly coordinators of packages of care and managing the process of service provision rather than working directly with users. As social workers take on more case-management work, social careworkers are becoming increasingly involved in general social support and basic assessment (Parrott, 2002) and it is here that some part of the integration
are taking place. Next, we will look into the actual implementation of integrated care practice.

1.4 Integrated Care Implementation – The CARMEN Project

The policy of community or home-based health and social care for older people is favored by both policy makers and service users. The advantages of a ‘whole systems’ model that configures services around the user has been identified by the Audit Commission (2002) and are also found in policy initiatives in several European countries. Despite this level of agreement, there remain well-documented problems with care integration, including: 1) service fragmentation between health and social care providers, 2) the needed for rational allocation of care, and 3) problems of service quality, particularly where users have complex needs. Research evidence to support this policy is currently fairly limited, because of the wide variety of models that are represented by the term ‘integrated care’ (Kodner & Spreeuwenberg, 2002; Leichsenring, 2003; cited by Coxon, 2005), and because the field of home care provision changes very rapidly in almost any given area. CARMEN Project is one of the attempts to deal and ameliorate these problems. CARMEN (Care
and Management of Services for Older People in Europe Network) project sought to improve the management of integrated care services for older people (Tamsma et al., 2004; Tamsma, 2004). The project specifically focused on policy issues both at national and European levels. Managed and coordinated by the European Health Management Association (EHMA), 40 European organizations from 11 European countries participated in CARMEN between March 2001 and June 2004. Strategic management of services at policy level was an explicit focus of the project. Along the process, CARMEN Project has brought together a broad range of different stakeholders including professionals, purchasers, informal carers, and representatives of older people themselves. The dialogue between these diverse groups of experts formed the heart of the project. The network enabled them to reflect on the improvement of integrated care for older people from policy, practice, management and academic perspectives. Although finding common ground was not necessarily the main objective, there was striking agreement over the key challenges as well as over the key components of solutions leading to better and more efficient integration of services. The results of efforts from the project with regard to national policy are reflected in the CARMEN Policy Framework, and
this framework offers a checklist for policy makers at national and regional level.

Grounded in practice as well as theory, the insights acquired through the CARMEN project can provide solid building blocks for policy. Coordinated under the principle of subsidiarity, the organization and delivery of health and social care services are the responsibility of member states and the EU has no specific competency in this field. Consequently, there’s no such thing as an EU policy of health care (not to mention about long-term or integrated care). There are, however, many EU policy areas that do impact more or less indirectly on the further advancement of integrated care, such as Internal Market and social policy (including employment, social inclusion, pensions and social protection).

The principle of ‘open method of coordination’ was adopted as the background orientation that defines the common framework to support member states in the reform and development of health care and long-term care. Built on the principle of subsidiarity, the ‘open method of coordination’ of working allows member states to tackle common challenges and problems, while at the same time continuing to define their own national strategy, and benefiting from experiences and good practices of other member states. Through this project, it is suggested that EU member states should ensure three broad objectives
that are: 1) access for all regardless of income or wealth; 2) a high level of quality of care; and 3) financial sustainability of care system. Member states, since, have mutually provided information on how they deliver the three suggested objectives. The accumulated information was compiled in a joint report on supporting national strategies for the future of health care for the elderly (March 2003). The European Parliament confirmed the validity of the three key objectives for the modernization of health care and long-term care as well as the importance of further structured cooperation between member states. The coordination of this area of social protection would complement similar coordinating processes that are already ongoing on three other social policy areas: pensions, social inclusion and employment. The four processes could well be streamlined through the delivery of the Lisbon agenda (in Lisbon European Council Meeting, 2000). This could also provide an opportunity for further links to other social policy themes, such as gender equality and the organization of working time.

The EU Internal Market policy incorporates the freedom of individuals, goods, services, and capital. Numerous rulings of the European Court of Justice (ECJ) have clarified that the application of Internal Market rules does
impinge on health care and integrated care provision. The ECJ rulings led to
the publication of two different proposals from the Commission dealing with
services and patient mobility. While the proposed Directive on services in the
Internal Market is to provide a legal framework to eliminate obstacles to the
freedom of establishment for service providers and the free movement of
services, the Directive on patient mobility presents a set of concrete proposals
to address patient mobility as a consequence in the EU internal market. The
two Communications (report) complement each other. Together they initiated
the process towards the development of a shared vision for European health
care and social protection systems. The Communication addresses the
following four themes: 1) European cooperation to enable better use of
resources, 2) information coordination between patients, professionals and
policy-makers, 3) the European contribution to health objectives, and 4)
responding to enlargement through investment in health and health
infrastructure. The above developments towards a shared vision for European
health care and social protection services have a great potential to enhance
integrated care for the community, including older people. This potential should
be maximized by a broad focus which includes perspectives on empowerment,
prevention, social values such as equity and solidarity, and the role of informal carers. Such broad focus should also appreciate the contribution of all elements of the health and social care system to improving services.

CARMEN recommendations for EU policy can be basically categorized into the following four agenda which are: 1) to facilitate the community process on ensuring a high level of social protection with regard to health care and long-term care for older people, 2) to further address broader social policy agenda relevant to the perspectives for integrated care, 3) to address the impact of Internal Market policies to health and long-term care, and 4) to create information society.

The facilitating of community process on ensuring a high level of social protection with regard to health care and long-term care for older people is actualized by improving the position of older people in the community, supporting respective national strategies in the process, supporting formal and informal carers, and ensuring sufficient number of trained professionals to guarantee quality services. Given CARMEN’s commitment to put older people in the center of service development and delivery, its strong plea for the promotion of older people’s positive contribution to society may come as no
surprise. Older people should be seen as assets and not just as a burden. A stronger focus is needed on prevention instead of on crisis-driven patterns in helping older people. Policies should address the challenges of integrated care within a broader positive context which promotes health, active life and independence, and combats age discrimination. Older people should be seen as individuals, not a uniform group. A good balance between economic and social objectives is essential in order to protect vulnerable citizens and support independence. Supporting national strategies to facilitate community process should focus on devising mechanisms that can work across sectors and the embracing of a ‘whole system’ approach. Mechanisms that are workable across sectors are necessary due to the fact that; across member states of EU, administrative, financial and organizational compartmentalization of health and social care systems is acting as one of the most prominent hurdles to sustainable solutions for delivering care for older people. Country-specific problems highlighted in the project tend to follow the dividing lines of these system compartments, with the division between social and health care being particularly prominent and the problems in the acute health care sector often taking center-stage. Member state should be encouraged to establish
mechanisms and incentives to work across these two main pillars and their sub-sections, and to stimulate policy developments that encourage joint working and innovation at sector interfaces. Similarly, member states should stimulate clear and coordinated policy responsibilities across local, regional and national levels. In designing and delivering long-term services for older people, national policies should incorporate a whole systems approach, including perspectives on: client-centered design and provision of services; seamless service delivery within and across all relevant settings; collaboration across sectors, including families and informal carers; provider pluralism; local, regional and national responsibilities for provision and funding; support measures for carers; and streamlining care policies with other policy areas, such as housing and transport, employment, social security and pensions, and education. Nationally, solutions should focus on establishing a coherent system of services with a range of attractive and suitable options for all older people, including vulnerable people with multiple needs, regardless of socioeconomic status, ethnicity, gender and lifestyle. Support for informal carers is an essential element in achieving overall objectives with regard to accessible, good quality and financial sustainable long-term care. Being the provider of the biggest
share of care provisioning, the contribution of informal carers to the long-term care arrangements is highly considerable. Structural support for informal carers is essential in ensuring that older people can remain independent in the setting of their own choice. Against the backdrop of the demographic developments in the EU and the growing pressure on informal carers to participate in the economic workforce, support for informal carers is also essential to avoid further pressures on the professional care system and on carer themselves. Such support should include practical, emotional and financial measures. This includes employment policies that allow for flexible arrangements enabling people to combine caring responsibilities with paid employment. With regard to employment, active measures need to be taken to improve the image, status, remuneration and work pressures in the care sector, to stimulate employment and career opportunities in these sectors and to encourage a sustainable workforce. It is vital to have sufficient number of trained professionals and to give them quality jobs in order to meet the challenges posed by demographic trends and technological progress. However, the low status and poor payment of care work, shortage of personnel, lack of training or inadequate training, work pressures, etc. all put a strain on care provision. Tackling these issues
may well result in more people opting for a professional career in care work.

Integrated and holistic approaches to service provision should be encouraged, making more effective use of scare resources, offering new roles which combine professional skills and stimulating better job satisfaction.

Attempt to address the broader social policy agenda that is relevant to integrated care is reflected by the acting Commission through their report on health care and long-term care for older people. All the main objectives suggested in the report can be linked to other elements of the EU social agenda, such as social inclusion, employment, social protection and pensions, and gender equality. Streamlining cooperation between member states across these policy areas provides a unique opportunity to support a mutually reinforcing policy framework. Member states should stimulate coordinated policy and action across local, regional and national levels, maximizing the potential approaches at each of these levels. In relation to social inclusion matter: it is indicated that the existence of several policy instruments to reduce public care expenditure (and increase the costs borne by individual citizens) may posses in themselves a negative impact on access for people with less socio-economic resources. They also pose a danger to social inclusion
objectives, as older people in need of long-term support may have to spend a disproportionate amount of their resources on care. Older people may also be forced to sell their house or move away from their own neighborhood, putting them at risk of social isolation. Measure should be taken to prevent poorer health leading to impoverishment and low income, restricting to care. Older people in long-term care could be at risk of social exclusion, as could their informal carers. EU programs aimed at tackling social exclusion should facilitate projects that prevent this from happening and that encourage social participation and independence. In relation to employment: improving access to and quality of care is instrumental in mobilizing the potential work force. Hence, care policy should be acknowledged as a tool for active employment and as a key contributor to economic development. It increases the social and occupational integration prospects of jobseekers. Member states should actively stimulate employment and career opportunities in care sectors and encourage measures aimed at sustaining the workforce. This would include further education and training, accrediting prior learning or caring skills, and improving the attractiveness of professional caring as an arena of work. In a society that combines an ageing population with a modern workforce, most
potential carers will not be freely available as they are engaged in employment.

A system that fosters the role of cares thus needs policies in place that enable people to combine work and caring responsibilities. When in employment, carers need to be able to work part time, take carer’s leave, or at least be allowed to work flexible hours. Many member states are increasing co-payments in their health systems to reduce demand and public expenditure.

The Commission should call on member states to coordinate pensions and other forms of financial social security on the one hand and co-payment arrangements on the other. Accumulation of co-payments in health and social care should not lead to poverty. If health systems require older people to contribute more towards the costs of their care, they should be enabled to so.

Finally, gender equality, specifically in terms of older women’s health: financial and social resources may need specific considerations. Compared to men, life expectancy of women is higher and they can expect to live more years in ill-health. Consequently, their need for health care and long-term care services will be higher. At the same time, their pensions and other financial resources are often less than those of men. This fact make them particularly vulnerable to adverse effects of cost-shifting from public to individual budgets and reduction
of publicly funded standard care packages. Insofar as women also form the
majority of informal carers, their financial resources maybe particularly
endangered if no arrangements are made to ensure their income position and
employment rights.

The EU’s Information Society policy and programs are an example of
how integrated care objectives can be advanced through targeted efforts within
other policy areas. Until now, the ‘e-health’ label has primarily been applied to
look at the promotion of ICT (Information and Communication Technology)
applications in the health care sector, in patient education, and citizen
information on health issues. Innovation and application of ICT in the social
care sector and more particularly in care provision in the home setting
deserves more attention. Development with respect to telemedicine, telehealth,
telemonitoring and smart housing could help alleviate capacity problems in
both professional and informal care and could also be instrumental in
supporting older people to live independently in their own homes. Furthermore,
information technology with standard performance indicators should be
provided to facilitate the planning, monitoring and evaluation of integrated care
and should assist benchmarking between and within member states.
A few disadvantages on relation to integrated working are also highlighted. The first disadvantages identified are the one that arises from medical-social care boundaries. In this part, implementation has signaled more drawbacks than advantages to joint working. The disadvantage most commonly cited by staffs involved in integrated care was working alongside doctors, hospitals and the medical professional generally. This problem of the ‘medical / social divide’ is a recognized barrier to inter-agency working and continues to trouble front-line staff in the real world of care integration (Sullivan and Skelcher, 2002; cited by Coxon, 2005). The next disadvantage originates from the boundaries between organizations. This problem is particularly common in cross-agency models of integration (compares to ‘under one roof’ or stand alone integration model) the reason being ‘not enough time is allowed to achieve integration of care’. The situation is illustrating the significance of momentum and energy that are required to work at service integration with other agencies. Employment-related concerns such as ‘short-term contract

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10 The existence of boundary between health and social care providers is well documented in the literature, but integrated care staff identified a number of different manifestations of this conceptual boundary. The concept of geographical boundary (for example, between hospitals and model project schemes), the communication boundary that stems from this separation (IT and data transfer) and a status boundary between medics and their colleagues (Holtom, 2001, cited by Coxon, 2005) are also highlighted in the discussion relating to integrated care.
‘working’ and ‘lack of future career development’ were also highlighted where professionally qualified staff (nurses, occupational therapists, physiotherapists, care managers) tended to find themselves in flat organizational structures, where promotion depended on leaving the (integrated care) project organization. In other words, the relatively small size of integrated organizations contributes to improved multi-professional working, but at the same time limits the careers of those who work in them. There seemed to be a trade-off between present job satisfaction and future career progression; staff at integrated care sites enjoyed the first at the expense of the second. This suggest that the specific skills that are accrued by integrated care staff (autonomous practice, multiple assessment skills, specialist community or home-based expertise, etc.) need to be recognized and rewarded in the formal pay and career structure. For many in this area, the barrier to integrated working continued to impede service integration. For example, the problem of data transfer, geographical separation and professional tensions persist where health and social care providers remain separated. A range of difficulties such as insufficient time for collaboration meetings, not enough training and inadequate resources (staffing, equipment) is believed to be inhibiting provision
of integrated care.

Through various arguments that we have looked into in this chapter, it is obvious that the trend of integration and networking, be it in terms of policy implementations or practice interventions, is required as a base to device a comprehensive yet sensitive (for example, to individuals’ particularity) framework of approach that will (at least partially) satisfy the conditions set by contemporary social environments. The same trend of movements is identified in different level of practice, from the level of international policy to micro level of social work practice. CARMEN Project is one of the movements that clearly reflect this general trend. CARMEN Project was shaped with the purpose to study and to focus on matters relating to policy issues associated with the effort to reform health care and long-term care at national and European levels. In this attempt, member states were urged to acknowledge the importance and the need to stimulate clear and coordinated policy responsibilities across local, regional and national levels, involving all stakeholders in the society. It was suggested that dialogue between these diverse groups of stakeholders (lay people, policy makers, service experts, scholars etc.) should formed the heart of project. And, in the attempt to assist the elderly, efforts must includes
perspectives on empowerment, prevention, social values such as equity and solidarity, and the acknowledgement on the important role played by informal carers. In this context, people should be seen as individuals, not a uniform group. The point that needs to be highlighted in this part is; there is a noted ‘uneasiness’ between the effort to ‘coordinate’ (a comprehensive method of intervention but an approach that is standardized and with some possible connection to coercive and paternalistic characteristics) and the aim to ‘respect the individuality of affected individuals’. ‘Comprehensiveness’ and ‘individuality’ are two inherently different concepts that have become a constant focus of argument in social policy and social work areas. Various suggestions have been forwarded in effort to reconcile (or at least to bring them closer to one another) these two concepts. One of the most frequently cited is the suggestion to include or integrate lay peoples’ (affected individuals) autonomous perspective in formulating policy and devising approaches that directly affect their well-being (in CARMEN’s case, such integration is assumed to be attainable by the conduct of ‘mutual dialogues’). For an ‘individual perspective’ to be expressible, first of all, such perspective must exist in individuals. Perspectives do not simply appear in a vacuum. They are a kind of structured
thinking framework that is shaped by the influence of many factors internal and external to the self of such individuals, either in a conscious or subconscious ways. Thus, before we could expect individual to mutually voice out their autonomous perspectives in effort to form some kind of mutually meaningful networking or integrating process, we have to be sure that individual possess such perspective and possess the capability to conduct such act. And, if ‘voicing out individual perspectives’ would really be a basis that will be able to reconcile the concepts of ‘comprehensiveness’ and ‘individuality’, understanding the element that mainly shape and triggers the forming of individual perspective, devising some kind of intervention that will facilitate the shaping of such perspective, and ensuring that such perspective will develop into a pattern that is autonomous but more favorable to the process of networking and integration is crucial. What we need is to identify a single factor that is capable of connecting between the processes of meaningful integration, maintenance of respect towards individuality, and autonomous self-betterment attainment.

The next chapter intends to discuss in detail about the factor that should underpin the process of meaningful integration and to create an understanding
and awareness towards the significance of such factor in the process. Such understanding is hoped to be able to lead to the reshaping of integration into a social bonding process that autonomously awakes from individuals’ within and to transcend the earlier mere physical connection (of integration). How do we comprehend the content of this ‘within’ and how do we facilitate the ‘awakening’ in order to create a more meaningful integration with all is the core question that must be looked into.
Chapter 2

Principles Underlying The Integrated Care

The dynamics of an ageing population raise many challenges for the world and this is especially true for developed countries like European Union (EU) Member States. The CARMEN project has considered these challenges and has explored a range of avenues towards a future with high quality care, which is sustainable and accessible to the older citizens. The CARMEN Project undertook a 3-year cross-national comparison of methods for integrated care, which included methods of assessment of service delivery, new methods of planning care provisions, monitoring, and management of care performance and methods of network coordination. In its work the CARMEN Project closely examined the fragmentation, common to all the countries involved, which exist between care segments such as acute care, long-term care, social care,
housing and welfare. The proposed solution was networking and care integration through ‘integrated care’ provisioning.

As a continuation from Chapter 1 that tried to elaborate and prove the existence of policy trend and tendency that emphasizes ‘networking’ and ‘integrating’ as the core conditional characteristics to implement efficient interventions and service delivery that will fulfill the requirement of contemporary social situation, Chapter 2 aims to, first of all, identify the main principles that will sustain the practice of integrated care. Then, it will look into the areas of successful ageing (an areas with alike concern but characterized by a longer history of efforts in attempt to improve the living conditions of the elderly) and try to identify the similarities and contrasts in terms of approach and intervention as compares to integrated care practice. Through this argument, it was identified that the potential factor capable of reconciling or synchronizing individuals’ autonomous efforts in their attempt to attain self-betterment to or with the others’ effort to assist such individuals in the process is the quality of instinct that innately exist in individuals, and the others’ (for example, service provider, policy makers and so forth) capability to understand and to acknowledge the importance of such instincts (as a crucial
inner-driving force and motivation factor) to the individuals. For such reason, the third part of the chapter will elaborate about human instinct, and particular focus will be given to understand the 'learned' characteristics of such instinct.

2.1 The Eight Principles for Integration

Supported by the European Commission’s ‘Quality of Life and Management of Human Resources’ program, CARMEN project was formed with the aims, first of all, to explore the welfare systems and regional and local systems of care provision in European Union member states. Initiative of the project was then continued by the effort to study the interfaces between primary care and secondary care (in other words, between home and hospital), between primary care and residential care (home and care homes) and between residential care and secondary care (care homes and hospitals). And finally, they moved towards analyzing system’s integration at three levels of intervention: client level, organisation or network level, and policy level. Among the lesson to note is that there are no models that can be transferred readily to other contexts, but that there are some basic organisational principles or strategies of designing for more integration, and there are also solutions adapted to sometimes very
specific local situations. Typically, different strategies of integration and networking are called for in different problem situations. If we were to go through various materials describing details about integrated care practice that are available at European Health Management Association (EHMA) website (http://www.ehma.org), it should be observable that there are at least eight identifiable principles (among the many more complicatedly overlapping) that underpin such practice. The principles are: 1) need responsiveness, 2) individualized chains of care, 3) services continuity, 4) seamlessness, 5) fluent flow of information, 6) multi-disciplinary action, 7) cooperation between formal and informal network, and 8) flexibility. CARMEN Project was set up with the intention to device a new framework of approach in condition of restricted resources and population reduction trend. It was also intended to be used as a body to gauge the efficiency of existing care services or care management system. It was from this research project that the concept of integrated care was introduced and proposed for implementation. And also, it was in this occasion that for the first time the term 'integrated' was thoroughly and clearly defined in its usage (comparing to earlier stages where much blur terms to explain the effort of networking and collaboration were used).
Integrated care approach is intended to be a standardized point of reference for the implementation of a care management practice that is reflexive to needs (need oriented) through the multi-professionalizing and networking of intervention. The adoption of such approach is accompanied with the desire to create ‘need responsiveness’ through the provisioning of ‘individually tailored care’ that is characterized by ‘services continuity’ (a continuity that links between different but essentially necessary process or element in the attainment of individuals’ over all well-being such as cure, rehabilitation and care provisioning itself). ‘Need responsiveness’ is made possible by the existence of factors such as ‘seamlessness’ (sustained through the continuous process of information gathering from individuals situated closest to the origin of needs – regardless of their position – and to act based on such information), ‘fluent flow of information’ (through the proper development of ICT technology and information management), ‘multi-disciplinary approach’ (attainable through the collaboration that take place between different profession and field of expertise), ‘cooperation’ (between professionals, clients, families, and friends) and ‘flexibility’ (attained and maintained through continuous improvement and re-evaluation of care
plan). Next, we will look into these factors (that I believe to be among the principles that uphold the practice of integrated care) respectively.

2.1.1 Need Responsiveness

The characteristic of responsiveness or reflexivity in integrated care practice is most clearly reflected in its strong emphasis on the practise of need assessment as a starting point in intervention process. ‘Integrated care’ in this context is referred to ‘a well-planned and well-organised set of services and care processes, targeted at the multi-dimensional needs/problems of an individual client, or a category of persons with similar needs/problems’ (Ljunggren, 2004; in http://www.ehma.org). Integrated care for older people should be built up by elements of acute health care, long-term (health) care, social care, housing, and services such as transport and meals. It should also address empowerment of older persons, to enable them to live their lives as independently as possible. Yet, the existing services may not meet the client’s needs for a number of reasons. For example, if they are based on historical factors, they may be obsolete or out of line with the client’s current needs. Without re-evaluation of services, historical inequalities or errors may be
perpetuated. Another possibility is that the services may be too demand-led. In this case, only those who ask for the services receive them, and only the most urgent needs are met. Needs that are obvious at a first glance may not always be the ones that must be urgently covered first. This is where a proper and comprehensive need assessment practice needs to play its role.

The needs assessment process is one of the most important part of optimising care for the older person in integrated care. The information arising from the needs assessment will be the basis for organising and managing the chain of care to be delivered. To the client, the needs assessment is the grounds by which he or she is seen as an individual and can interact with the service provider and the funding agency, and can thus discuss and influence the care. To the providers, the needs assessment is a more objective tool with which they can balance the resources to the summarized needs of clients. On a systemic level, the needs assessment provides information that enables authorities to scrutinize costs of care in comparison to other costs in society.

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1 The challenge is to ensure that the client-centred assessment takes place within a ‘whole system’ that delivers the right assessment at the right time. This process should not be seen simply as a matter of data collection but also as a starting point for making priorities and optimising the resources – and thus the care – from the client’s various care providers (www.ehma.org).
and make priorities. The needs assessment is intended to support clinicians in planning care for individuals, and to support service planners to ensure that service developments are matched to greatest need as far as possible, and to prioritize between different needs. The proper conduct provides a reliable summary description of the area or agency workload for the purpose of more appropriate resource allocation.

The overall objective of the needs assessment is to obtain a picture of the client’s needs that balances their requests for services with an objective analysis of their needs (in the light of limited public funding), and spending decisions. This process involves ethical decisions, drawing on concepts such as equity, integrity, and autonomy. A comprehensive needs assessment provides a structure for collecting the information from all parties involved, where this ‘global’ information is used for all as a basis for visualising the needs for integration of services and shared responsibilities. It is carried out to control and develop quality of care later in the care process. In other words, the purpose is to obtain a view of the client’s needs that is fuller than that of the one-point of time’s eligibility assessment. The reason for this is that a broader assessment might highlight new needs that have not been dealt with earlier. At
first glimpse, this may lead to higher resource consumption, but evidence shows that identifying and handling needs earlier on improves the quality of care and quality of life. It also enables service providers to prioritize their activities better.

2.1.2 Individualized Chains of Care

The prevailing attitude in many countries is that there is a need for a comprehensive process that is more structured and standardized, to establish the basis on which the service packages are planned. This type of process makes it more difficult to overlook client needs that are important, or not immediately evident, which could decrease their quality of life in the future.

Care providers and professionals should not generalize and stereotype older people. For example, the majority of older people prefer to remain at home for as long as possible, and to have a large degree of self-direction. Others simply do not. In the interaction between the professional and the older person, these preferences have to be communicated. This interaction is the core of care. Individualizing of care in the context of integrated care practice is reflected by the existing awareness towards the need to carefully define and to properly
conduct a comprehensive assessment to determine the level of risks that respective individuals are facing, and to subsequently design an appropriate series of intervention and care programs (for example, through care pathways) for such respective individuals. Integrating are designed to enable common goals to be realized more effectively. From a user-oriented or client-centred perspective the basic goals to be promoted by such action are quality of life of clients, equity or social justice, financial sustainability and access to services for all, when and where needed (Pieper, 2004; in http://www.ehma.org). These goals have to be translated into specific ‘things to do’ and ‘outcomes to be realized’. Since the situation in national, regional or local care systems differs widely, there is not one set of outcomes that will indicate the achievement of more integration and better performance. Integration is expected to limit risks and increase benefits, and this has to be reflected in the objectives and procedures of an integrated structure.

From the perspective of professionals, some problems might have to be solved by specialists in special institutions. This is also true from the perspective of the clients, who will consent to greater restrictions to their freedom of choice if the risks for their health are high. These reflections on
risks highlight the importance of the clients and the nature of their problems. Generally, ‘clients involving high risks’ are understood as clients with serious problems and high dependency or disability. And, high risks for their future health condition typically also imply high risks for the provider and high possibility for the necessity to employ special knowledge and qualification. In other words, they require a higher level of organizational integration and accountability. The organization of acute hospitals is a typical case. In contrast, ‘clients involving low risks’ is considered as clients whose needs merely involve relatively low risks, such as those needing home-help services and other domestic services – tasks that are assumed to be accomplishable without enforced rules for accountability, with lower professional qualification, and treated in care arrangements that are less hierarchically regulated. Family or neighborhood support is a typical case.

The terms ‘low risk’ and ‘lower qualification’ are a matter of social and political definition. This also poses the more general problem of who has the right, and the responsibility, for deciding on which risks are considered high or low, who carries the risks, and who is accountable. The legal framework does not typically provide sufficient guidance. Some health risks (such as accidents)
or social risks (such as unemployment) may be very high, but they may or may not be adequately recognized by support systems, insurances, or society at large. Care providers have to cope with the fact that the term ‘low risk’ usually refers to circumstances that can be treated by someone with a lower professional qualification, offering lower prestige, and the fact that their roles can often be substituted by informal care – the characteristic situation of not-for-profit organizations in social and health care. This fact tends to make the coverage of ‘low risks’ under-financed and unattractive for the services.

Integrating services for both types of clients, or for clients with changing levels of problem severity over their care paths, can be expected to produce difficult integration problems and to require great flexibility in service provision. This is especially the case when the distribution of risks and responsibilities is seen to be unjust, and the effectiveness of the accountability system is questioned.

Arguments on care pathways (Vecchiato, 2004; in http://www.ehma.org) highlight the managerial and professional duties needed to transform the recognition of needs (through the above assessment) together with the available resources into personalized care interventions. Care pathways argument concerned with the integration of care at the individual level, where
services are coordinated in response to the assessed needs of an older person and their carer. Care pathways can offer a solution that allows us to look at the person as a focal point within a map. Within that map are managerial and professional figures and carers, who are committed to reaching good outcomes at a reasonable cost, continuity of care and – most important of all – the overall well being of the patient and their carers. Case management is one of the method in which the idea of care pathways is translated into real practice. The importance of case management is understood in its function that coordinates services or care packages in response to the assessed needs of older people and their carers, the core part of delivering integrated, person-centred care. Good, comprehensive assessment and care planning – undertaken in a way that properly engages with the older person and their carer, and involves them in decisions about their care plan – is crucial in ensuring that the most appropriate services are provided. Coordinating these processes and services can avoid unnecessary duplication and promote good continuity of care. Thus, in this context, the distinguish function of case management is understood through the fact that it assists to tailors services to the individual older person in order to improve the quality of their life, by also taking into account the wishes
and needs of their carer – be they a partner, relative or friend.

Different approaches and models of case management exist highlighting tensions between needs-led and resource-led methods. Such models include the: intensive case management model (coordination of services for older people/individuals with severe and complex needs, with aim to tailor services to the needs of such individuals across time and place of service utilization); the shared core tasks model (based on organizational procedures that ensure discrete tasks of assessment, individual care planning and regular reviews are carried out for older people – these tasks may be carried out by more than one person); the joint agency model (case management that is supported by a multi-disciplinary team, with workers drawn from different agencies in which one of the team acts as a case manager or keyworker); the brokerage model (an approach in which case managers are employed by an independent agency in a way that is similar to service brokerage) and the case management agency model (an approach in which a case management agency selectively contracts the services included in the client’s care plan with providers). In addition, there are also examples of how older person coordinates their own care. This effort involves introducing some form of direct payment or personal
care budget as an alternative to service provision being arranged by another body. It offers the option for older people (or their carers) to be their own ‘care coordinators’ and to buy in services that meet their needs. Evaluation of different models of case management highlighted many important facts which amongst are: there is no single model of case management that will suit all levels of need or service user group and it is necessary to differentiate between those older people with complex needs, who may be best supported by designated case managers (providing intensive case management) and other older people with less severe needs, who may best be supported through more effective organizational procedures (so these components of case management may be carried out by different workers). There is also evidence that supporting older people with a flexible intensive case management service that controls substantial levels of resource can significantly reduce the probability of admission to residential and nursing home care. In this context, case management systems that work on a single-agency basis and lack access to appropriate expertise in assessment are unlikely to be fully effective – particularly for people with complex needs.

2 It is also stated that continuity of involvement of the same case manager (based on required training, supervision, quality assurance, information, planning and
Staff from a range of professional backgrounds may be suited to taking on the role of case manager but will need certain skills and knowledge base. The ability to listen and work, and establish rapport and trust with older people and their carers (rather than merely making plans on their behalf) is one of the most crucially needed skills and such skills must be bolstered with the ability of professionals (in ideas and actions) not to be confined by their own professional role in order to take a holistic approach. Further, interpersonal and communication skills to work with others, good team and collaborative working skills, experience of working across a range of agencies and an understanding of their role, and a close working knowledge of the needs of the client group and local service and community resources (including eligibility criteria for access to these services) is also assumed as necessary. And finally, the spheres of skills should also include the ability to manage budgets and an understanding of relevant financial issues. Other staff in the service system will need to know about the role and responsibilities of case managers. In this context, good communication and trust need to be developed between different commissioning systems to support case management arrangements) with the service user is significant in terms of quality outcomes for the older person (www.ehma.org).
professionals and the case manager. Any fears about losing responsibilities must also be addressed. The success of any model of case management depends on local and national factors that ensure the provision of sufficient appropriate services to coordinate, as well as organizational and professional support for those undertaking the role of case manager. These factors include: national policy and financial incentives that are needed to promote partnership working and joint strategic planning between health, housing, social care and community agencies, supporting the integration of services at both strategic and operational levels; joint training across professions and organizations where involvement from users and carers are conditional in order to develop the skills and understanding of the case managers and professionals with whom they liaise; and excellent communication and shared information systems that will become the key supports to care management systems.

2.1.3 Continuity of Various Services

To orchestrate integrated care, a set of services needs to be linked, coordinated or integrated. These services are delivered by various
professionals and/or providers who may work in various sectors. Integration of services is necessary in effort to face the challenges post by the complexity of human needs web. Domains of needs that should be addressed in relation to comprehensive human functioning tends to include health care needs (physical function, nutrition, medical conditions), social needs (living arrangements, family involvement, social networks and activities, cultural needs), mental health and function (mood, cognitive function, emotional well being), environmental needs (housing or carers), psychological needs, spiritual needs, economical needs, and also preferences of client and informal carers. Ideally, a needs assessment should cover all these domains, which means taking behavioral, social, medical and psychological functions into consideration, as well as the social and physical context, such as availability, strengths, preferences of informal care, housing conditions, transportation needs and

3 Such services may include: short-term health care, long-term care, social care (social work, support groups, sitting services, education, leisure activities, peer advisers, housekeepers, carer support centres, day care or day centres, community centres), housing, supportive services (such as transport, leisure, education, domestic support, odd jobs, financial assistance), aids services (that may include walking aids, hearing and visual devices, communication technology, ergonomic adaptations in houses or household appliances, alarm systems), and health promotion and maintenance (practiced through preventive home visits, keep-fit exercises, regular check ups, self-help groups, friendship courses) (Nies, 2004; in www.ehma.org).
household needs. Even if a client’s needs change over time, it is important to keep in mind this dynamic approach of needs (Ljunggren, 2004; in http://www.ehma.org). The World Health Organization’s International Classification of Functioning, Disabilities and Health (World Health Organization, 2001) covers broad areas of functioning, and provides listings of domains that can be included in needs assessment process.

In developing well-linked, coordinated or fully integrated services, continuity is the key priority. The design of the services and the care pathways along which the services are provided needs to take into account that integration is a dynamic process. It changes over time and needs regular monitoring and adaptations. Both the content and timing must have continuity. Two dimensions of continuity are always at stake – the simultaneous and the sequential. The simultaneous dimension indicates the provision of multiple services that has to be coherent in its contents and its logistics. In this context, one can speak of ‘simultaneous’ linking, coordination or integration of services during the entire process. The sequential dimension indicates that care and services have to follow the needs of the user over time, but the stages of progression must appear seamless. Despite the desirability of integrated care,
incorporating it into day-to-day practice is not necessarily easy. Neither the care delivery system nor the professional systems is based on principles of integrating services. On the contrary, many have been fragmented as a result of specialization and task differentiation (Nies, 2004; in http://www.ehma.org).

In this context, the continuity of services is assume to be attainable through the mapping of respective individuals’ care needs based on care pathways method that is coupled by integrated strategic planning.

Continuity of care is particularly relevant for people who are unable to be self-sufficient, those who are terminally ill, older people suffering from dementia, stroke patients, and others with severe care needs at home. Apart from services and care individualization as mentioned earlier, care pathways (Vecchiato, 2004; in http://www.ehma.org) are integrated care strategies that offer means of achieving better integration among practitioners, community-based services, and other health and social care services. They can contribute to better continuity of care, whether simultaneously (where the services are all delivered at the one time) or sequentially (where they are delivered within a distinct period). Integrated care pathway should be designed based on process analysis. The pathway should be modified and supported by
the team and organization involved, as well as by the clients and carers. Where
decisions are unclear, rules should be established, so that policies are put in
place for every eventuality. The pathway needs to be constructed as a
multi-disciplinary plan and record of care should includes all key information.
All the relevant and required documentation and records must be taken into
consideration. The basic idea of a care pathway presents a global map of
decision-making process that is accompanied by its rationale. Care pathways
have primarily been developed in the acute care sector. However, they may
also be a promising instrument for long-term care and social care, by providing
professional and organizational solutions tailored to the problems of those who
need integrated long-term care, and those who move from cure to care. Care
pathways are need-related at the group level, and are helpful in finding the best
ways to match needs with services at the individual level, as well as in
managing chains of care. Care pathways are instruments that can reduce
improper access to hospital emergency services, inappropriate admissions and
unplanned discharges. So, to a great extent, they can help avoid unmotivated
and undesirable interruptions of care, which can damage people in need and
be a waste of resources. Wasted resources are particularly common in
situations where different professionals intervene without consulting each other, creating unnecessary and costly overlaps and confusion.

Care pathways serve multiple goals for all the stakeholders involved, such as clients, carers and managers in the health and social sector, public and private service providers, voluntary organizations and non-government organizations. Care pathways serve the needs of clients through provisioning of the continuity of care (towards individuals) that helps to ensure the maintenance of quality of life for the carers. This will later lead to the providing of added value to the quality of practice of informal care. Other than that, care pathways naturally work to increased client involvement and improved communication. Care pathways serve the needs of professionals and managers through its function that, for example, justifies professional activities and the means that are required. This will contribute to the situation where standards of care and expenditures will become explicit. Other than that, care pathways provide support to staff in daily decision-making and enhanced collaboration and decision-making.

Care pathways are about continuity of care. It is useful to distinguish between three types of continuity, that are: information continuity using
information about past events and personal circumstances to ensure that current care is appropriate for each individual; management continuity that is in a way consistent and coherent in approach of managing a health condition that is responsive to a patient’s changing needs, and a relational continuity in terms of an ongoing therapeutic relationship between a patient and one or more providers. To ensure information continuity, care staff should take part in developing and implementing care pathways. However, specialists in information flows, records and monitoring instruments also need to be involved. Management continuity requires those involved in integrated care to have special competencies, as well as a coherent view on care and the care pathway that is relevant to the particular client. Relational continuity also requires continuity of staff, and this needs to be deliberately planned, taking into account work and salary conditions, and other issues such as motivation of staff and in-service training.

Following care pathways, integrated strategic planning is indispensable in effort to sustain services continuity. Integrated strategic planning (Banks, 2004; in http://www.ehma.org) is not concerned with the operational management of services. Instead, it is about key stakeholders from the statutory,
non-governmental, private and community sectors working together to achieve a shared understanding of their local service system in order to redesign and improve the way it operates. This addresses the balance of services, the connections between health, social care, housing, transport and other community services, and the interdependence of services. Integrated strategic planning is not a static or one-off process but involves continual review, as plans are implemented and changes take place. Strategic planning seeks to achieve a balanced system of care that offers a comprehensive and coordinated range of services. The aim of strategic planning is to obtain a shared picture of the whole service system in order to plan and deliver capacity in the system, to offer older people choice, quality services and access to care. Integrated strategic planning also offers opportunities to focus resources on joint priorities.

In terms of implementation, after all the local stakeholders have agreed on boundaries for planning purposes, the ideal scenario is that all the stakeholders in the service system take the following four steps: 1) agree on shared values, principles and vision of the new system of services; 2) create a shared understanding of the service users’ needs, and a ‘map’ of services; 3) agree
priorities for change; and 4) plan change to achieve reconfigured services. In step 3, the challenge is to achieve agreement or reach a compromise about priorities when partners have different objectives. Success depends upon a number of factors reflecting the strength of partnerships, the perceived benefits of working together, and power imbalances. Step 4 involves identifying local resources (staffing, property and financial resources) and shortfalls, flexibility of resources and working out how these can be developed, reallocated or redeployed. It also requires all parties to agree a joint action plan that clarifies the objectives, identifies the stages and tasks to be done by whom and by when, agrees milestones for each stage, and builds in a systematic review of the plan.

To achieve change, upper authorities need to provide encouragement for ‘bottom-up’ or operational-level solutions that can improve services in ways that benefit older people and their carers. They can play a key role in enabling these types of development to take place (or providing incentives) within an agreed framework or vision for services, and in accepting an element of risk-taking. All partner agencies need to agree on what identifies success when evaluating innovatory practice and services. Strategic planning for integrated
care does not entirely depend on top-down, centrally driven planning, but in the absence of good collaborative working it does need incentives, including financial incentives, to promote local joint working. There may also be difficulties where values and cultures clash. Other than that, power imbalances, particularly relating to financial clout may make it more difficult to achieve planning partnerships and agreement on implementation. Strategic planning for integrated care should be supported by national policy that provides financial and other incentives to whole-systems approaches and that addresses legal and other barriers.

2.1.4 Seamlessness

The current moves and debates to involve older people in service and care planning, and empower them so that they can make their voices heard and acted on are getting more and more momentum. Along with this development, performance indicators or organizational policies start requiring providers and professionals to set up systems for consultation or advocacy. Professionals

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4 For example, where there is a lack of harmony between the values of health care personnel (www.ehma.org).

5 For example, between the acute health sector and others, or between commissioners and independent providers (www.ehma.org).
need to develop systems that address the views of individual older people and
groups or organizations of older people, and they need to be able to do this so
that the discussion relates to the whole system of care, not just their service.
Alternatively, they may also find that they need to do this to address problems
with service user satisfaction, the efficiency of resource use, or the systems of
care delivery. They may need to know and demonstrate that their service is
meeting the needs of older people in a way that is acceptable to them and
valued by them.

There has been a move away from thinking about service users as passive
recipients of care who do not challenge the assumptions that professionals
make about what they need. As private-sector companies become more
involved in providing services, they bring with them ideas about customer
choice that have also affected the thinking of other providers. As people
become more aware of the way in which they pay for services – either through
taxation, insurance or by direct payments – they become more likely to see
themselves as consumers, and therefore as people who should have a say in
what is provided. Consumerism is not the only driver for change, however.
Increasing challenges to the expertise of professionals and policy makers,
coupled with a movement to make services more democratic and accountable, have also led to calls for service users to be more involved in the way that services are run. Service user involvement, therefore, is an aim of services and systems that subscribe to the values of democracy and consumerism. It is a broad term that covers many other ideas and concepts, but essentially it is about making service users part of the decisions made by service providers. As part of the move towards involvement, we may also need to consider the concept of empowerment, and the particular strategy of advocacy (Reed, 2004; in http://www.ehma.org).

In integrated care, one of the ways to sustain its seamless characteristic is by focusing on the say by carefully absorbing and acting on the information that emanate from individuals who are the closests to origins of needs, be it front line social workers, carers or service receivers themselves (regardless of their position in terms of knowledge and social status). The accuracy of information that can drive responsiveness to situation is the critical part in this context. Working in an integrated care system, however, makes such process, especially the one relating to developing of users’ voice, more complicated. The concept of ‘empowerment’ has been developed against a background of
authoritarian services that have not listened to service users, and indeed have
developed systems of decision making that have excluded them, both as
individuals and as groups. ‘Empowerment’ means correcting this imbalance by
changing systems and structures and providing support for service users so
that they do have real power in the services they use. This may take several
forms. Advocacy is one specific form, where an advocate speaks up for
individuals or groups, and puts their case or expresses opinions on their behalf.
Though in actual context it may fall short of empowerment due to the fact that
service user is dependant on the availability and skill of the advocacy provision,
still in some circumstances, it may be the most useful approach.

In arguments that attempt to develop users’ voice, the terms ‘involvement’,
‘empowerment’ and ‘advocacy’ are used most frequently and interchangeably,
as if they were the same thing. While there is some overlap, the definitions for
respective terms present particular characteristics of each owns. ‘Involvement’
reflects the extent to which older people have a role in shaping services. This
may be quite minimal, for example, only being consulted, or on the other hand
they may take a major part in making decisions about services or their own
care. ‘Empowerment’ is the process by which older people are given the
support and resources that they need to become involved in care. This may involve providing information or material resources (such as transport and communication aids) or it may be simply about building confidence to participate. And, ‘advocacy’ is a specific strategy to support involvement. A person or team of people is given the responsibility to find out what older people want, and to present this to service providers. This is usually on an individual basis, but can be to represent groups, and can be a formal role or be an informal development.

Approaches that can be used to empower older people in shaping their own individual care include advocacy and information services, keyworker or care manager systems, person-centred care planning and direct payment schemes. Advocacy and information services is implying that services can be set up to inform and advocate of behalf of older people using services. Coordinating advocacy and information is very important in integrated care, as it ensures consistency across agencies. There are some debates about when an advocacy service should become involved. If advocacy only starts when there is a dispute or a problem and difficulties have already begun, this is in many ways too late. However, routine advocate support may be expensive and
beyond the means of individual services. One approach that may overlap with advocacy systems is to develop a system in which the older person has a named individual who is responsible for assessing their needs, planning their care, delivering their care and monitoring its delivery (keyworker or care manager systems’ approach). Someone who oversees care may be called a ‘care manager’, and someone who directly gives care may be called a ‘keyworker’ or ‘named carer’. Over time, a relationship between this person and the older person develops, which allows trust to be built up and communication to be effective. Where keyworkers have some control over resources, they can plan care and allocate resources with full negotiation and discussion with the older person. Where they do not hold budgets, they can act as advocates on behalf of the older person. Keyworker and care management systems need to be set up so that the relationship is sustained over time, and so that staff are aware of their responsibilities and have the skills to carry them out. This has implications for training and staff development, and also for the way in which work is organized within the agency. Staff must be able to maintain relationships, which means having a stable role and clear client responsibilities. They also need the skills to develop and manage relationships.
with clients, and the knowledge of resources and systems that will enable them to coordinate care effectively. Another way in which older people can be empowered is by having an effective care-planning approach that actively requires them to express their views and wishes. Many care-planning systems are written and carried out for the benefit of service providers, and choice is limited by the systems that have already been set up. A strongly user-focused care planning system starts of identifying the older person’s preferences and needs, as they define them, and then looks to see how these can be met. As with the keyworker approach described above, person-centred care planning requires staff with time and skills to do this, and recording systems that make the process of discussion clear. Care plans need to be negotiated carefully, with dialogue with the older person and, where appropriate, their significant family and friends. In integrated care systems, these may need to be extended across the system, to make sure everyone knows the aims of the care. This may raise ethical issues about the confidentiality of information, and practical issues of record design and accessibility.

2.1.5 Fluent Flow of Information
A mutual and good communication is essential for working in an integrated way. For such reason information management system is probably the most important supportive process to modern care. Some useful principles and tools for documenting and distributing patient information have already been developed in the field of acute and long-term care, but this is not the case in an integrated care system. Including not only medical professionals, but also care workers, occupational therapists, and many more, there are special requirements for information and information flow in such system. The importance of information management system is acknowledgeable in two perspectives. One, relating to the place where the information about a patient and the care process is stored (the ‘patient record’), and the other, about the ways in which this information is added, distributed and used by various health care workers that interact with the patient. This process is known as ‘information flow’, which can be formally defined as the transfer of documented client information and client-linked care information among professionals, or between professionals and managers, in an integrated care system. Together, these two components – the patient record, and the specification of information flows – comprise the ‘care information system’ (Huijbers, 2004; in
Information is important to all parties involved in integrated care provisioning, be it the professionals, organizations, even clients and their carers. In performing integrated care, the professionals generate information that has to be registered and documented, either to be used by themselves at a later date or to be exchanged with other professionals and with managers for administrative reasons. A good information system should be able to offer user-friendly methods of registering, retrieving and displaying information. It should be able to ensure that the information passed between members of staff is up to date, reliable, timely, and easy to understand. Good information management should make the integrated care process more efficient and effective. Using an effective information system to store and retrieve administrative information about a patient prevents duplication and saves time. Using an information management system opens up greater possibilities that can contribute to integrated working – for example, better planning, improve coordination, and better cooperation in assessing, treating and routing patients. A good information management system can benefit organizations in many ways. First, it can encourage care-providing organizations and their managers
to take greater interest in providing care that is higher quality and more efficient, and higher rates of client satisfaction. Using aggregated information in an information system enables organizations to assess the costs, cost-effectiveness and quality of their integrated care system. This creates the opportunity for administrative, financial, and strategic planning, and for quality improvement and research purposes. And finally, though patients or clients are usually not considered as direct users of a care information system, they do receive important indirect benefits from efficient information exchange, because of the increased quality of care that it may produce.

Three feasible approaches of distributing information exist in practice for integrated care system. In the ‘chain-like system’ approach, each organization has its own information system and files. Exchange is on an ad hoc basis, that is, on request only. Information is passed along in a standardized record to the next organization in the chain as the patient moves through the integrated care system. In the ‘centralized network set up’ approach, all organizations of the integrated care system organize their care information system according to agreed requirements, and files are managed centrally. And thirdly, in the ‘mixed central–decentralized’ approach, participants in the integrated care
system keep their own information system but make specified information accessible for their partners. Management of information and files is decentralized, but files are linked. This allows a ‘virtual’ electronic patient record (EPR) to be created, which is composed automatically and promptly when a request for information is made. Overall, the mixed approach seems particularly appropriate and attractive to the practice of integrated care.

The literature on computer-based patient records cites many advantages of Information and Communication Technology (ICT) systems. Compared to paper systems, ICT is more reliable, accurate, accessible, modifiable and manageable, and can be more easily protected\(^6\). In sum, ICT offers a number of new possibilities that are particularly important for integrated care. These include: (as mentioned above) the ability to make particular parts of information available to specified individuals and professionals; the possibility to monitor, receive alerts and work proactively; the capacity to synchronize the involvement of patients, clients, carers; the facility to support coordination and case management better than paper files; enabling the administrative and financial data of patients or clients to be easily combined; and enabling working

\(^6\) Concerns about privacy and non-disclosure are often expressed, but in fact a paper file is at least equally vulnerable to violation of privacy (www.ehma.org).
with aggregated data for the purpose of accounting, assessing cost-effectiveness and quality, and macro-planning and research.

It is too simple to say that all the information available to members of the integrated care system must be available to all the other members. Nor is it true that every member of the system needs to have access to all the available information about a patient. This would be impractical and cause information overload – and it may be forbidden by law or regulations. It is important to specify carefully what information is required, and by whom. The utilization of information requirement assessment is recommended and it should state what information the patient record should contain, when data may be added, changed or used, and by whom, and how it should be handled in information flows. Responsibilities and tasks should be clear for all staff. This is particularly true for staff who are responsible for feeding data into the system, and staff who are permitted to access certain types of data in the system. For other staff involved, the first competency required is awareness of working in an integrated care system network, and an awareness of interdependencies. Everyone involved needs to contribute to an optimal information exchange, ideally through support and training. The crucial thing about information is that,
it should be shared between all appropriate and necessarily related parties, while taking into account the individual's right to privacy. Other than that, information gathering is conducted through the process of assessment that necessarily requires the consumption of certain resources. For such reason, it is also important to consider the balance between the resources used (to carry out the assessment) and the information gathered. In other words, using information that is already available from other sources is usually very important and highly recommended. This will be more readily available in the future as more information technologies continue to develop.

The barriers to setting up a care information system tend to manifest themselves primarily in the implementation stage of the system, rather than at development or consolidation. Any new integrated care system is likely to meet with some resistance and reluctance from autonomous organizations, but implementing a care information system has some specific problems. Each organization that cooperates in a given integrated care system will have its own information systems, will use its own documentation, such as forms, and will follow its own procedures. It may be resistant to changing all this and implementing a new care information system. If an organization's cooperation
in the integrated care system forms only a marginal part of their total activities these organizations may be reluctant to have the rules dictated by other, seemingly minor, participants. It is important to find out who is going to adapt to whom, and how far they will go. Other than that, additional potential barriers to implementing a new information system include: failure to inform, motivate and train the people that have to implement the new system; a lack of awareness of the necessity of a formal and well-structured care information system; the implementation of new ICT that is not user-friendly or suitable, and is shunned by staff (remedied by involving staff in purchasing); and privacy legislation that may prohibit social care organizations from using existing health care data, or that requires consent for every single use of the electronic patient record. The obvious disadvantage to ICT is that it requires investment in hardware, and possibly dedicated software, training, management and maintenance which is costly. However, it should be acknowledgeable that the advantages outweigh the disadvantages.

2.1.6 Multidisciplinary Action

As argued in the earlier part of this section, care providers use the
comprehensive needs assessment to obtain a better picture of the client, and such information can be used to tailor a more professional care plan, alongside the other members of the care providing team. This can be more easily done if the assessment is carried out organizedly by professionals and all who are involved in the actual care delivery. Such comprehensive assessment provides the client with a better view of the types of preventative measures that care provider can offer. Evidence shows that multi-disciplinary groups that is formed through integration are preferable to single-discipline approaches in needs assessment even if they are still uncommon (Ljunggren, 2004; in http://www.ehma.org).

Whether integration is meaningful and the level of integration to be considered as most suitable depends on the client's characteristics and conditions. Client characteristics and conditions can be related to a frequently used typology of degree or intensity of connections between services or organizations that can be distinguishes at three different levels of integration: linkage, coordination, and full integration (Triantafillou, 2004; in http://www.ehma.org). The linkage level operates within the setting of the existing services. By and large, it accepts the existing division of labor in the
care system, and complies with eligibility criteria for the separate services. At this level, integration implies adequate referrals to guide older people to the right place at the right time in the system, as well as good communication between the professionals involved, to promote continuity of care when the person goes from service to service. Providers understand who is responsible for payments for each type of service, and costs and responsibilities are not shifted. At the coordination level, arises in settings is observable where regulating agencies and service organizations seek new balances in care provision, reDefinitions of core tasks, client flows, and eligibility criteria. This level is more structured than the linkage level, but it still operates largely through the separate structures of existing systems. Coordination identifies points of friction, confusion, or discontinuity between systems, and establishes structures and processes to address these problems. And thirdly, full integration level aims to develop comprehensive care programs or care packages attuned to the needs of specific client groups. It is connected with recently developed methods of care management. It creates new programs or units that pool the resources of multiple systems, define new benefits and use common records. The integrated services are directly and specifically
managed through one-to-one management, with no layers in between. Full integration may include specialized types of intervention, ‘fast-track’ access to them, and close cooperation between knowledgeable professionals. The most pressing issues at this level are defining the target group, assembling the necessary services and allocating appropriate resources.

The central pivot of integrated care for older people is the care provided by a team of service providers through integrated processes that overcome professional and organizational barriers. Workers of various professional backgrounds, and in different organizations, have to form collaborative teams in order to provide a full array of services that are integrated to meet the needs of older people. Integrated teams aim to address the gaps in care for older people with complex health and social care needs that can occur between traditional services. They achieve this by offering a comprehensive and seamless care service designed to organize the way the required services are provided around the needs of the older person and the informal family care network, rather than trying to fit the clients’ needs into an existing, set service system. Much of this care may be already provided by the older people’s family members and friends, so family and other informal carers are closely involved
in the work of the integrated team, both as co-providers of care and as clients with their own needs.

Many different models of integrated teams have been developed in response to specific needs and areas. They share the common characteristics and being composed by multi-disciplinary and inter-organizational care professionals working together. The composition depends on the designated service target group. Examples of different integrated team approaches include: specialist multi-professional integrated care teams (teams are based in the community, and operate at the interface between primary and secondary care, to assess and intervene and/or treat older people with complex health and social care problems); general multi-professional community home care teams (provide home help and personal care on a regular basis to dependent older people in their local community); specific disease-based integrated care teams (address the multiple problems of care for patients with a specific disease diagnosis such as Alzheimer’s, diabetes, or stroke); and community centers for older people. Local community centers for older people are well situated to act as coordinating and implementing bodies for integrated care service provision. The range of services provided includes preventive physical
and mental health programmes and primary health and social care, together with recreational programs, aimed at promoting social participation and well being among older people in the area.

The strategic background (supporting factors) for the establishment of an integrated team of professionals amongst many others should (at least) include factors such as: a national or local policy commitment to provide an integrated care service, backed by designated resources (budget and staff) funded over a set time period; a client-centred approach; an examination and identification of the main issues in the provision of care for older people in the area, by each agency or sector involved in the team; and practical experience, knowledge and skills in forming and sustaining integrated teams. The mix of staff in the integrated professional team depend on the team’s objectives and the allocated resources. However, the core team will usually include: a primary care doctor, a nurse, a social worker, a home care worker, administrative and other support staff, and definitely the managers. This core team may then be supplemented or expanded, according to need. Further, the manager will

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7 Core team may be supplemented with: a community geriatrician, a health visitor, a physiotherapist or physical therapist, a home help or domestic worker, a personal care worker, an occupational therapist or ergotherapist, a speech therapist, a psychologist, family carers, volunteers, workers in associated sectors such as
need the following systems to support the working process of the team: a standard referral system that is known and available to all local organizations and services working with older people; a multi-professional assessment team, with each member of the team taking referrals in rotation and using a common comprehensive assessment instrument; frequent and regular team meetings for exchange of information and feedback (the client and the family carer should be invited to participate at regular intervals); a weekly 'critical incident' review to improve listening skills and identify and discuss common problems, such as conflicts between older clients, their relatives and professional care providers regarding acceptable risks and needs; a budget that is discussed and agreed on by the team manager and staff representative (conflicts may often arise in relation to agreement on priorities); a clear and easy system of client access to the process; and a shared records system based on IT.

The main staffing issues that relate to integrated ways of working are concerned with staff competencies and qualifications, support and training, and leadership. In terms of factors relating to competencies and qualifications, these factors vary according to the different professional requirements that are transport or housing advisers; laboratory and technical staff; information technology specialists, and support staff including secretarial and office workers, and cleaners (www.ehma.org).
set at local and national levels. Although this issue has been well addressed for the standard health care professions, there is less agreement on training and recognition of ‘new’ caring professionals such as personal care and home care workers. Specific training for the staff of integrated care teams should involves: multi-professional gerontology training; practical experience in teamworking, with on-the-job support and training; training programs on teamwork building and role skills; and training/practice that can facilitate the transfer of experience to other co-professionals working with older people in the local area and in the wider field. Other than that, efforts should also include training family carers in caring techniques. Family carers have noted this as being of major importance in supporting them and improving their ability to care. In multi-disciplinary teamwork, one major difficulty is deciding who should lead the team. This issue is best approached with a management policy of equity between all team members, based on respect for the unique contribution to the team’s work of all the professionals involved. In this way, traditional professional hierarchies and rivalries may be abandoned in favour of a more egalitarian system based on the practical realities of the team’s working conditions and terms of employment.
2.1.7 Cooperation

The majority of care is provided by informal carers, such as next of kin, neighbours, and volunteers. There are a number of advantages to the client and their family and carers playing an active role. It enables them to assess how far the care pathway meets their needs and preferences, and to simply learn from experience how to better manage their condition, identify the ‘key person’ who they can rely on, and share an informed contract on the care pathway. Helping carers by involving them in strategies to overcome their stress can, in the long run, be fundamental in providing better assistance for the older person who is being cared for. However, professional care providers do not always acknowledge the contribution of these groups, and they are seldom regarded as partners in the system. Instead, they are considered as an ‘overflow reservoir’ when other elements of the system fail or are unavailable. The failure of such acknowledgement often lead to the negligence towards the importance of involving client and his or her relatives in the care planning process. In this situation, often, discrepancy between client needs and preferences arises. This situation should also be dealt with in team discussions,
to ensure a true balance between different interests. With a fuller picture of the client needs, it is possible to more easily make priorities and remodel different services. However, including family relations in integrated care creates special challenges, since they are a special network embedded in a respectively unique community background. Family relations are a resource to care provisioning because their traditional values that predispose members to see carrying burdens of care as a matter of fate, love or solidarity. Again, however, these family traditions are changing. In modern society, while these relationships are strong in some cases or local cultures, in others they are not. Family relations may also form a sub-cultural enclave, which creates barriers to cooperating with the care system.

Forming cooperative network that is initially lead by integrated organization, adopting cultural change to enable the sharing each other’s value patterns, and pursuing the right quality of leadership that suits the demand of integrative approach will facilitate the cooperation between different members involved in integrated care provisioning. As integrated care especially favours cooperative networks, it is therefore necessary to experiment with the design of integrated organizations (as well as with integrated networks) to find the
appropriate mix that fits the local circumstances (Triantafillou, 2004, in http://www.ehma.org). Designing integrated organizations is a typically top-down process. A kind of strategic alliance with an agreement on central goals and values is negotiated at the start, and the partners consolidate this into an integrated organization ‘under one roof’. Resulting integrated organization is internally structured into relatively independent units specializing in different types of services (such as social, health or rehabilitation services) and the important elements of integrated organizations are integrated management, pooled budgets, and the degree to which contracts between partners are exclusive. The facilitating condition for the formation of integrated organizations of care are: establishment of goals and policy guidelines respecting the basic values of integrated care which include not only the principles of care quality and cost containment (sustainability), but also of solidarity, social justice and access for all; establishing strong leadership and a clear management structure (governance) to support cooperative partnerships between very different professional and organizational interests and cultures; establish consensual and transparent regulations to guarantee a fair distribution of risks, costs and benefits;
implementing advanced and innovative technologies for information, communication and transport, to achieve the combined goals; providing education, training and incentives for staff, by structuring careers in such a way that cooperation is rewarded in order to groom appropriate professional culture and improve staff qualification; establishing effective and transparent regulations for quality assurance and external audits; and emphasis on client orientation (to clarify and make transparent the relationships between the organisation and the clients, and the boundary between the organization and the life world of the client and their broader community, with the aim to establish a respect for their dignity and privacy – including ways of protecting their data).

When two or more organizations, professions or teams from different backgrounds come together to provide needs-driven integrated care for older people, they have to work together in ways that are unfamiliar to them. These innovative ways of collaborating, between systems and across organizations, can bring about an added value that equals more than the sum of the efforts of all organizations. To realize this surplus value, the parties involved have to cope with and overcome their multitude of differences in mutual perceptions, status, work styles, organizational affiliations, employment regimes and
salaries, or in frames of reference. So in integrated care, the organizations and workers alike need to share each other’s value patterns in order to provide a coherent care package. In this context, there is a strong need to consider one’s cultural change in terms of thinking and functioning. The term ‘culture’ refers to the value patterns of a society, a system or organization, and to the attitudes of people and workers. ‘Cultural change’ in the context of integrated care is an intended process that supports the strategies of change in organizations and may follow as a result of collaboration and innovation. It is one of the mechanism to support the development towards needs-driven integrated care.

Cultural change in integrated care is designed to bring about: a fundamental shift in the paradigms about care for older people among the people and organizations involved in the integrated care process; a shifts of perception towards person-centredness among older people, their carers and staff in daily interaction; a shared purpose and vision that puts older people at the centre; and understanding, respect and sensitivity to cultural differences and mutual roles, for the work of each other between the different persons and agencies involved. Cultural change can either occur as a result of careful planning, or it can emerge through programs of integrated care, or through
collaborative behaviour among services and institutions. Implementing cultural
change for integrated care is a step-by-step process. Describing it as a process
that merely looks into building an unambiguous set of common values would be
an over-simplification. It should be understood as an evolution towards a
deeply rooted change in vision and attitudes of workers on collaboration and
integration of care. Such process includes: team building and team
development; the creating of transparent, mutually agreed management lines,
with the support of contractual clauses and codes of conduct; the creating of
staff appraisal systems that is linked to reform objectives; developing
sustainability criteria; promoting external facilitation to achieve changes
(especially in the starting phase); setting external monitoring by regulatory
bodies and insurers; developing joint protocols; and setting the procedures to
enable systematic reflection of achievement from time to time.

The involvement of all staff is a major prerequisite for developing cultural
change towards integrated care. Special efforts will be needed in the first place
to increase the awareness and sensitivity of the staff to the values and ideas of
integrated care. The ‘internalization’ by staff members of values and beliefs is
critical. This means that the ideas of integrated care must emerge as obvious
among staff, and are perceived as being their personal values and belief. It is important to take the following elements into consideration: an emphasis on innovation; team development; representation of all groups involved; a bottom-up approach; attention to the roles of volunteers and NGOs; training of professionals; and empowering frontline staff. Among the identified barriers that constantly hinders towards the achievement of cultural change in integrated care is professional cultures. Despite of widely argued and acknowledged necessity to adopt cultural pluralism in care practice, the values of the dominant groups tend to prevail (dominance by the traditional powerful groups based on their professional status or on their positions in the hierarchy, such as the dominance by medical profession). Other than that, general factors such as the prevailing cultural climate (due to poor understanding of the aims and instruments necessary to achieve integration with the prevailing belief that one’s own system and the traditional mechanisms are superior); resistance to change (due to reluctance to engage in unfamiliar structures and pathways and in programs, fear of one’s vested interests such as power and income being challenged by others); and the bias focus in funding on high-tech and acute care provision (this often means neglecting long-term care by concentrating
attention and resources to glamorous medical technology that promise high
profit margins) are also the potential sources of barriers.

And finally, in the context relating to pursuing the right quality of leadership
that can foster cooperation in integrated care; it is realized that many of the
discussions and ideas about current leadership are based on old ideas about
leaders as dynamic, decisive, authoritarian and competitive. Although this
model of leadership may have been appropriate in a world where services
were in competition with each other for funding or for clients, in a world where
the emphasis is on integration and working collaboratively, it has increasingly
become irrelevant and unhelpful (Reed, 2004; in http://www.ehma.org). Ideas
about leadership have changed over the years as the contexts of leadership
and the values and goals of societies have changed. Broader theories of
leadership have focused on organizational culture and the management of
change. In this context, the ability to motivate staff and influence behaviour is
regarded as parts of the key aspects of leadership.

Recent thinking on model of leadership that takes a ‘whole-system’
approach, looking at the way in which the system supports, sustains and
responds to leadership. This has led to an approach in which the direction and
motivation of the system is based not only on the individual qualities of the leader, but also on how they enable the whole system to be supportive of innovation. This perspective of thinking focuses on organic leadership, which involves nurturing and growing rather than dictating. New models of leadership have moved away from the ‘heroic individual’ idea to look at relationships, networks, and also ‘followership’ (the way in which everyone in a system or organization works together, towards a shared and mutually owned goal). These ideas are moving towards the idea of leadership as a team activity rather than the domain of one individual.

The development of theories of transformational leadership is also observable as complementing whole-system model. In this perspective, the focus of leadership involves in facilitating creativity and personal development for the leaders (themselves) and the others (members or followers). Some of this thinking is found in discussions on ‘learning organizations’, as an aid to effective working. A ‘learning organization’ is one in which there is a capacity to

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8 Further, in this new thinking the notion of collaboration extends within and across organizations. Instead of leaders thinking of their own organization only in terms of its being in competition with others, whole-systems thinking and leadership places emphasis on effective leadership, which involves promoting the collaboration of organizations across the system, for the benefit of needing individuals (www.ehma.org).
respond to changing contexts. Rather than assuming a competitive environment, they are more able to address issues of integration and collaboration, and in the emphasis on personal growth for all, they encompass issues of staff development and user involvement. These reflect the argument that leadership in service provision organizations differs from that in industrial organizations, largely because in service organizations it involves direct interaction with service users to set goals and strategies. So leadership in service organizations is more complex, and requires sophisticated negotiation and consultation skills.

The characteristics required for leadership in integrated care include an awareness and understanding of the complexity of integrated care, and the perspectives of all of the different stakeholders involved. In integrated care, the stakeholders include a range of staff with very different professional, educational and organizational backgrounds, and older people and their families, who will have different needs, preferences and experiences, as well as representatives of ‘the system’, such as government commissioners, inspectors and insurers. Leadership in integrated care needs to be: person-centred (making the older person the centre of the service); broad
rather than narrow in its scope (including the wider system of provision and setting long-term rather than short-term goals); inclusive of all members, partners and customers across the system of services; capable of negotiating shared visions and goals across the system; capable of sharing the leadership between key people across the system (‘leadership’ is not just one person); and capable of motivating staff in organizations to be reflective and committed followers of new collaborative goals. Implementing and managing integrated care involves responding to the growing understanding of the complexities of older people’s needs by adopting a set of values that advocate collaborative and open working. As the understanding of older people and the social contexts in which they live grows, integrated care is ever more strongly supported as a way of delivering effective services that will meet their needs.

2.1.8 Flexibility

The last identified principle discussed in this chapter is flexibility that is assumed to be attainable through continuous improvement and re-evaluation of process. Improvement and re-evaluation of process is a commonly conducted practice in the overall domain of integrated care and examples of
the implementation from the perspective of needs assessment, care pathways, case management and integrated team formation are given next in brief descriptions. Starting with the perspective of need assessment; here, the main emphasis is that it must be remembered that no instrument, however good, provides a complete answer to the needs of an individual. Clinical intuition and experience are still the main influencing factor and for such reason continuing education (for the assessors) is crucial. This education must consist of information being shared between different professionals and participation in team conferences on care planning. It is important to have a clear policy on which staff members are involved in the assessment, and how they will be trained and supported. Whether they work alone or in a multi-professional team, the assessors need suitable tools and training in how to use them. Providers need to collaborate with other actors on the local, regional or national level. These could include research or survey institutes to create client surveys or epidemiological studies, or software companies that could provide computerized support to the providers. Other than that, needs assessments practices should also be covered by legislation specifying when, and how, an assessment should be performed. Monitoring and evaluation is also an
essential part of working with care pathways because it provides a constant
review of the pathways of the clinical choices and their impact on the use of
resources. To monitor and evaluate the process and effectiveness of the
pathways, it is necessary to have practical instruments and methods that
identify the total needs of the person, before and after the intervention
(‘evaluation’ is a comparison that enables differences and changes to be
measured at the different stages of the care plan).

In the context of case management, it is emphasized that monitoring at
individual level should be able to assist in: obtaining direct feedback from older
people and carers about whether the objectives of the agreed care plan are
met; devising and using a regular review process as part of the case
management cycle to check delivery of outcomes for individual and their care;
auditing samples of case files at regular intervals to monitor case management
practice and review the match between care plans and service delivery; and
monitoring the quality of process from the perspective of service receiving
individuals and their carers. The effort is then continued at the system level
with task such as setting up monitoring systems and joint evaluation processes
across agencies, and systematically collating and feeding unmet needs into
planning and decision-making bodies. And finally, to enable the manager to evaluate the effectiveness and efficiency of the work of the integrated team, information needs to be collected regularly and routinely. The figures must relate to clearly identified criteria, and will be used to assess for performance management and for evaluation by the client. This means that the staff need to continuously monitor and maintain a high level of work performance, and there needs to be a clear system for the older person and the main family carer to participate in, and give their opinions on, the care process.

Other than emphasizing on the need to set up a joint system (for the purpose of monitoring and evaluation) and the need for legislation backup; the above stated efforts in attempt to monitor and re-evaluate process in various perspective of integrated care are generally pointing to the same trend of expressing the importance or significance of experience, devising suitable tool and method for training, ensuring continuity of education, performing research and survey and so forth in practice in order to enable process to be implemented in a more efficient manners. In other words, these are all pointing to the need to develop and support the human capital part in the organization and in the process. To improve integrated care, it is important to have the right
number of staff with the appropriate knowledge, skills and motivation to deliver services with expertise, empathy and efficiency. New or different professional roles, competencies, values and attitudes may have to replace the more traditional ones, as they do not necessarily fit the requirements for integrated care service provision. Integrated care provision is a service reliant on human resources. No matter what financial means, modern buildings, or state-of-the-art equipment an organization may have available, it is the workforce that can make service delivery take place, and will indeed make it take place, provided there are sufficient supportive conditions in place. Delivering this change puts the whole workforce to the test, in terms of knowledge, flexibility and attitudes. This requires commitment throughout organizations, from senior management to frontline staff. Managers need to facilitate changes, support and motivate their staff, and forge new partnerships with other organizations, as well as with service users.

Integration of services often implies that boundaries between provider organizations will become increasingly blurred. For this reason, sharing workforce-support mechanisms – including training – across organizations may be not only appropriate but also could be instrumental. And, prior to the design
and development of training, the organizations within an integrated care network will benefit from mapping all their training needs and developing a joint strategy for recruiting and training, or retraining. In addition, periodic review meetings need to be held to make sure that knowledge and skills are kept up to date and that they still adequately match the services needed. In looking at the needs of the workforce with regard to training, the person-centred approach can be useful in integrated care networks. This approach takes the individual client as a starting point to identify and map what services and staff are needed, what new roles need to be developed, and what training is necessary. It encourages process-oriented thinking across traditional boundaries of the various service organizations involved.

In operational terms, supporting the human capital needed to deliver client-centred integrated care implies: building, managing and sustaining a highly motivated, well trained, flexible workforce; incorporating new roles with shared vision, values and principles; embracing a client-focused perspective; and the ability to work efficiently across sectors and professions. In this context, changing vision and practice is a gradual and challenging process of learning, training and implementation. It requires the inclusion and acceptance of the
staff at all levels within each organization. Everybody's input should be valued in this process as shared vision and is an anchor for change. Interdisciplinary learning enables working across professional and organizational boundaries. For such reason, it should be a focus as well as an objective of the training program because developing a common language is an essential tool for integrated working (the training should be complemented by team-building programs and in this program, special emphasis should be put on communication between staff from different professional backgrounds, as well as between clients, carers and professionals). It must be understood that some problems in the development of inter-agency working are due to differences between staff in attitudes, background and professional language. Other than that, countries are seeing their populations becoming increasingly diverse. As client-centeredness and service delivery within individual's own living environments are key to integrated care provision, care needs to be provided in a culturally sensitive way. Thus training programs should address issues related to diversity in terms of issues such as language, culture and lifestyle. And finally, in terms of education, it is argued that preparing a balance category (of education: for example, university level and vocational level of education)
that satisfy different level of manpower requirement and different level of organizational functioning would be necessary.

It is true that the flexibility development of work force from the formal sector depends to a large extent on the provisioning of education, training and conduct of researches that is formally arranged as stated above. However, this is not the only determining and influencing factors. It is worth mentioning that such flexibility can be further enhanced by: encouraging the availability of professionalized support for carers; correctly mapping (and later matching) the needed capacity, skills and competencies off all parties involved in the process (especially of informal sectors); and considering the recruitment of staff with less conventional qualifications (in social work) but with supplementary skills and expertise suiting the requirement of integrated care process. This is due to the reason that such practice will stimulate the cooperative capability of individuals at the receiving side, be it informal carers or service users, and in return, such condition will encourage and further promote the compliance of staffs from formal sectors in performing their tasks. Developing and sustaining integrated care services is not a quick fix or 'one off', but a continuous process that needs time, and benefits from periodic review. In this context, setting aside
adequate resources in terms of time, finances and people is essential and should be perceived as a long-term investment.

The concept of integrated care is mainly associate with ‘a well planned and well organized set of services and care processes, targeted at the multidimensional needs / problems of an individual client, or a category of persons with similar needs / problems’. Category of person in this context mainly refers to the elderly citizens. Integration in the care of older people should take place at: the level of the individual client (processes around the individual client); the local / regional inter-organization level (linkage, coordination, and integration in networks of care providers); and the policy level (processes of legislation, funding and communication about choices). At all these levels accessibility of services (fair distribution of services, optimum entry systems, equal access for all who are in need of care), quality (user satisfaction, good clinical outcomes, system and process quality) and financial sustainability (including efficiency, public expenditure, common good) are values that should be pursued. Targetting to address the specific need of the elderly is an attempt that has long been observed (regardless of the comprehensiveness in term of their approaches) even before the implementation of integrated care practice.
One of the most frequently debated is the idea of ‘successful ageing’. Next, let us look into the argument of successful ageing due to its similar concern in the effort to promote the betterment of living condition for the elderly, and observe if there exist any similarity or contradictory in the trend of approaches as compares to the practice of integrated care.

2.2 Successful Ageing

The perception of ageing has changed throughout history. In the colonial era, old age is said to have connoted honor and esteem. With industrial revolution, older workers were increasingly viewed as redundant and expandable. Thus, emerged the concept if ‘Ageism’⁹. Ageism is elaboration about pessimistic old age that connotes poverty, isolation, and illness. Ageism could be defined as a process of systematic stereotyping and discrimination against people because they are old (discrimination against the aged), or, it is any prejudice or discrimination against or in favor of an age group (Gingold, 1992; Palmore, 1999) believes that ageism (after racism and sexism) is emerging as the third great ‘ism’ in our society; partly because it affects everyone, young and old, and partly because it involves basic questions of social policy. Racism became a burning issue in the 19th century and was attacked by the civil rights movements. Sexism became burning issue later on and was attacked by equal rights movements. Ageism is now being attacked by gerontologists and the aged themselves.

⁹ Palmore (1999) believes that ageism (after racism and sexism) is emerging as the third great ‘ism’ in our society; partly because it affects everyone, young and old, and partly because it involves basic questions of social policy. Racism became a burning issue in the 19th century and was attacked by the civil rights movements. Sexism became burning issue later on and was attacked by equal rights movements. Ageism is now being attacked by gerontologists and the aged themselves.
A major example of discrimination against elders (in this context, United States) is the policy of compulsory retirement for workers at age 65, regardless of their ability and health. This is an inappropriate differential treatment of those older than 65 because most workers still employed at age 64 are quite capable of continuing their work beyond age 65. There is no sudden or general loss of abilities at age 65 or at any other age. The losses that do occur tend to be gradual, affect some people only at extreme ages (90 and over), and some are even reversible with proper treatment.

Nevertheless, a growing movement in geriatrics and gerontology seeks to replace this earlier decline and loss paradigm of ageism with a newer emphasis on the potential and likelihood of healthy and successful aging. This concept of successful ageing has been helpful in focusing renewed attention on health promotion and the prevention of disease and injury as a means of improving the quality, and not merely the quantity, of the later years. It offers impressive evidence for a wide array of health promotion strategies that can help ensure a healthier old age (Minkler and Holstein, 2005). Earlier uses of the concept of successful ageing were related to the idea that successful ageing would be about factors such as good health, economic security and presence of friends.
and family (Havighurst, 1963; cited by Bond and Lynne, 2004). Or as argued by Palmore (2001; 2002), it has been equated with life satisfaction or happiness, and, sometimes with good health or with longevity (Palmore, 2001; 2002). However, there was disagreement about what constituted a good quality of life that defines successful ageing. Some believed that a good quality of life consisted of maintaining activity and involvement (activity theory) and others about retirement and release from activities of middle age (disengagement theory). As a result, later comprehensive definition of successful ageing attempted to combine longevity (without which successful ageing is impossible), health (lack of disability), and happiness (life satisfaction) all together in its elaboration.

Lawton (1983, cited by Palmore, 2001; 2002) has defined ‘the good life’ (in old age) as consisting of four independent dimensions: 1) behavioral competence in terms of health, perception, motor behavior, and cognition; 2) Psychological well-being in the context of one’s happiness, optimism, and the existence of congruence between desired and attained goals; 3) perceived quality of life based on the availability of support network such as family and friends, activities, work, and satisfying income; and 4) objective environment
that is related to satisfying realities in terms of housing, neighborhood, income, work, activities, and so forth. This understanding was then further developed by Rowe and Kahn (cited by Palmore, 2001; 2002) who associated the definition of successful ageing with the distinction between ‘usual’ and ‘successful’ aging within the category of normal, or nonpathological, ageing. They define ‘usual ageing’ as aging in which extrinsic factors heighten the effects of intrinsic ageing process (normal functional decrements); whereas successful ageing refers to ageing in which extrinsic factors counteract intrinsic ageing, so that there is little or no functional loss. In this context, the model of successful ageing highlights three hierarchically ordered characteristics viewed as necessary preconditions for its attainment that are: avoidance of disease and disability; maintenance of high physical and cognitive functional capacity; and active engagement in life10 (Minkler and Holstein, 2005).

However, the resurgence of the notion of successful ageing can be attributed to the pioneering work of Paul and Margaret Baltes (Bond and Lynn, 2004). They challenge the traditional social science perspective, which focuses

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10 Thus, the definition towards the meaning of ‘successful ageing’ should not merely mean free from illness or possible maintenance of ones’ physical functions. It has to be related with the possible chances for individuals to conduct a highly participative and active living (Oda, 2003).
on prescribed outcomes and ideal norms. In contrast, their approach focuses on the process older people use to achieve desired goals. Rather than measuring successful ageing exclusively in terms of life satisfaction and morale (the traditional approaches used in quality of life research), they focus on understanding the maximization of the benefits associated with ageing together with the minimization of the losses. They argue for a balance between quantitative and qualitative aspects of ageing and propose a number of key indicators such as: length of life, biological health, mental health, cognitive efficacy, social competence and productivity, personal control, and life satisfaction. A meta-model of selective optimization with compensation emerged from the work of Paul and Margaret Baltes. In this model success is defined as individual goal attainment and successful ageing as minimization of losses that occur as a result of reduction in physical, cognitive and social reserves and a maximization of gains that result through adaptation, mastery and the use of wisdom. Three processes have been highlighted: selection, compensation and optimization. The champion of this approach highlights a number of advantages. By taking a process-oriented approach individuals are able to define their own life world and set goals appropriate to their personal
needs and desires rather than the imposition of universal social worlds. The approach acknowledges the diversity of older people. The approach focuses on the individual strategies used to achieve goals rather than simply on outcomes (Maddox, 1969; cited by Bond and Lynn, 2004).

In the areas of welfare studies, a part of the justification to promote the distribution of services is 'to enable individuals to live the way of living that they have reason to value' (Sen, 2000; Ogasawara et al. 2005). However, they could be no limit that can describe what this ‘value’ should be. The value is infinite in a way that it is unique to different individuals, places and time. And, for such reasons interventions should be founded on concept that can guarantee this condition (a universal principle that can cater the unique condition). The same tendency is observable in argument relating to the meaning of ‘success’ in ‘successful ageing’. The meaning of ‘success’ differs according to individuals, time and it will continue to change according to social, cultural, even biological criteria in where or whom its concept is attached to. And, in order to guarantee the principle of universality (in terms of its application), the argument on ‘successful ageing’ attached the definition of ‘success’ to ‘the attainment of individuals’ aim’. For example, in a ‘successful
ageing’ model such as presented by Baltes, its attainment is not scaled through a generalized measurable standard, but determined through the possible control of ‘adaptation’ and ‘mastery’ (part of process) in individuals’ aim achievement process. As explained above, in this context, successful ageing is considered as ‘successful adaptation of mastering the process to master ones’ aim’ and ‘readjustment process towards attaining ones’ aim’, regardless of ones’ physical, psychological, and sociological function’s level. Baltes and Carstensen (quoted by Oda, 2003) identify this method as process-oriented approach, and it is through this approach that the proper evaluation of individuals’ attainment of their successful ageing could be conducted regardless of factors relating to social’s culture, sex, social class, race, ethnicity and even time. The individuality of individuals is acknowledged.

The component of successful ageing representing the quantity of late life has been studied through research on causes of mortality and longevity. Predictors of longevity include being female, being physically active, not smoking, having good cognitive functioning, higher than average socioeconomic status, high level of social activities, life satisfaction, and work satisfaction, a high happiness rating, and satisfying sexual activity. In general,
the predictors of longevity also predict better health (less disability). Other studies have focused on the subjective quality of late life, factors associated with life satisfaction. These factors include good health, higher than average socioeconomic status, being single or married, and high levels of social activity (especially organizational activity). It was found that factors most closely correlated with feelings of well-being were health and activity level. Usually there is little or no relationship between life satisfaction and age, race, sex, or employment once controls are gain in terms of health and income. There is probably a reciprocal causal relationship between all the predictors or factors identified in the studies stated above, that is: those who remain active are more likely to be healthy and happy, and vice versa.

It was asserted that older people, even the very old and weak have the capacity to increase their muscle strength, balance, walking ability, and other physical power. There are many things that can prevent or ameliorate the chronic diseases common in old age, including: early detection, healthful nutrition, vigorous exercise, safe driving, safe sex, vaccinations, and avoidance (of obesity, tobacco, alcohol abuse, and drug abuse). However, one of the main in this context is social support. Those who enjoy close (social) relationships is
believed to possess stronger tendencies to eat better, exercise more, and smoke and drink less. It is suggested that a supportive network helps people evaluate and overcome stressful event better. The essential component of successful ageing is frequently related to the maintenance of mental function. Studies found that adults continue to grow new brain cells throughout life. This has encouraged a shift from the old assumption that cognitive powers inevitably decline with age to new theories that older people can bolster their learning and memory abilities, and even stave off declines. Major ways to maintain mental function include: continuing education and mental challenges; maintaining fitness through daily exercise; engaging in useful satisfying work or voluntary activities (especially complex, challenging, and self-directed work); memory training; and maintaining appropriate social support (getting encouragement and help when needed).

In terms of engagement with life, there are two main aspects of active engagement which are defined as a component of successful ageing: social support and productive activity (or as Freud put it, ‘love and work’). Social support involves giving and receiving positive information, trust, care, love, esteem, network membership, and mutual obligation. In this perspective, two
kinds of support are important for successful ageing: socioemotional support (i.e. affection, liking, love, and esteem) and instrumental support (i.e. assistance or care when one is ill, help with household chores, transportation, loans, gifts). However, it is best if the support is mutual: receiving support should be balanced by giving support, insofar as possible. The importance of productivity activity is demonstrated through the fact that is understood from various studies stating ‘work satisfaction’ as one of the best predictors of longevity. Rowe and Kahn (1998; cited by Palmore, 2002) found three main factors that promote productive activity: health, social support, and self-efficacy. All three of these factors interact and reinforce each others. And, as was indicated previously, social support seems to help overcome stress and promote healthful lifestyles.

In terms of heredity, in general, most studies agree that successful ageing is, for the most part, not determined by genetics, but by lifestyle choices in diet, exercise, mental challenges, self-efficacy, and involvement with others. While it is true that genetics can cause inherited diseases, these tend to take their toll early in life. If one survives to middle age, one probably has a healthy set of genes, and at that age, the primary determinants of successful ageing
becomes the lifestyle, psychological, and social factors discussed above. This fact reflected the importance of person-environment relational perspective in successful ageing arguments. As argued by Oda (2003), the person-environment relation is a widely accepted concept in various fields of studies and this includes the field of integrated care and successful ageing itself. The early research relating to ‘successful ageing’ was centered at matters relating to ‘individuals’ life adjustment’ at old age. ‘Adjustment’ in this context generally means coping with environmental demand. However, the research that emphasize ‘personal and social adjustment’ was introduced in 1940s and in this context ‘successful adjustment’ was then defined as ‘the ability to autonomously satisfy one’s own needs and demands’ while ‘sufficiently responding to community’s needs and expectations’. In the early practice of gerontology, the phenomena of intrinsic ageing were taken as normal and mainly understood as natural genetic transformation process. No significant attention was given to the influence of external risk factors. However, this understanding was later acknowledged as untrue. Though the ageing process can be understood as age-related, it does not necessarily mean age-dependent. What is important in understanding the trend that determines
the ageing process is not the physical existence of illness and difficulties that one could observe, but the possible existence of risks that will lead to such situations. And, most of these risks originate from individuals’ life style, their environment and other non-genetic factors. It was based on this understanding that Rowe and Kahn categorized the ageing process as ‘normal’ (non-pathologic but high risk) and ‘successful’ (low risk and high function) as discussed earlier.

One might think that successful ageing would be a noncontroversial topic; one that everyone would agree is a good goal to pursue. Viewed more critically, however, the successful ageing model may be seen as contributing to and reinforcing a new form of ageism (Cohen, 1988; cited by Minkler and Holstein, 2005). Considerable controversy has arisen over its definition, causes, and consequences. This controversy has been fueled in part by the fact that as more and more people enter the third age (over sixty), concern has begun to shift from medically prolonging life to ensuring that a prolonged life is worth living (Palmore, 2001; 2002). In this part, generalized prejudice against and devaluing of the old is replaced by a more targeted ageism reserved for those who are ageing with a disability or in other ways failing to meet the criteria for
ageing well\textsuperscript{11}. The main critic of successful ageing is that it tends to blame those who do not measure up to high standards of ageing. In this context, the norms embedded in the notion of successful ageing are understood as problematic in the following two senses. First, in their tendency to assume the existence of a commonly recognized and accepted end point that makes one person’s aging a success and another’s usual or a failure. And second, even if there were agreement on a desirable and discreet end point (i.e. high physical and cognitive functioning) people clearly differs in the abilities and resources available to them for attaining such a goal (Minkler and Holstein, 2005).

The trend of pursuing this commonly recognized, or put in other words, standardized criteria of well-being (classification) is exemplified through the acknowledgement and adoption of the International Classification of Functioning, Disability and Health (ICF). ICF provides a standard language and framework for the description of health and health-related states. It is a classification of health and health-related domains – domains that help us to describe changes in body function and structure, what a person with a health

\textsuperscript{11} Indeed by naming their approach successful ageing and equating success largely with the achievement of such discreet end points as high-level physical and cognitive functioning, this perspective inadvertently stigmatizes whole groups of people, including those who may be ageing with a disability (Rowe and Kahn, 1998; cited by Palmore, 2002).
condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance).

ICF is WHO’s (World Health Organization) framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. The most important function is as a planning and policy tool for decision-makers. There are many acknowledgments towards the significant contribution of ICF to various fields of practices and studies. For example, this is reflected through its understanding that radically shifts the perspectives of policy making from emphasizing people’s disabilities, to focus on level of health instead. ICF puts the notions of ‘health’ and ‘disability’ in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of human. ICF thus mainstreams the experience of disability and recognizes it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric. Further, ICF is said to be utilizable as a scientific tool for consistent, internationally comparable information about the experience of
health and disability.

Other significant contributions from ICF are as stated below. From the perspective of policy development: ICF is said to be providing the basic framework for comprehensive and coherent disability-related social policy structuring. The function of ICF is fulfilling the condition of various sectors (health one of them) that require valid and reliable data collection and comparison on functional status for policy development. From the perspective of economic analysis: the consistent and standard classification of health and health-related outcomes (that can be calculated and compared internationally) offered by ICF makes it possible to determine whether resources are effectively used in health care and other social services sectors. In terms of research uses: generally ICF assists in scientific research by providing a framework or structure for interdisciplinary research in disability and for making results of research comparable. Traditionally, scientists have measured the outcomes of health conditions by relying on mortality data. More recently, the international concern about health care outcomes has shifted to the assessment of functioning at the level of the whole human being, in day-to-day life. The need here is for universally applicable classification and assessment tools. One of
the major innovations in ICF is the presence of an environmental factor classification that makes it possible for the identification of environmental barriers and facilitators for both capacity and performance of actions and task in daily living. With this classification scheme, which can be used either on an individual basis or for population wide data collection, it may be possible to create instruments that assess environments in terms of their level of facilitation or barrier-creation for different kinds and level of disability. With this information in hand, it will be more practical to develop and implement guidelines for universal design and other environmental regulations that extend the functioning levels of persons with disabilities across the range of life activities.

Generally, two major conceptual models of disability have been proposed. The medical model views disability as a feature of the person which requires medical care provided in the form of individual treatment by professionals. Disability, on this model, calls for medical or other treatment or intervention, to ‘correct’ the problem with the individual. The social model of disability sees disability as a socially created problem and not all an attribute of an individual. On the social model, disability demands a political response, since the problem
is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment. On their own, neither model is adequate, although both are partially valid. Disability is a complex phenomenon that is both a problem at the level of a person’s body and at the level of social, and both medical and social responses are appropriate. A better model of disability, in short, is one that synthesizes what is true in the medical and social models. ICF is believed to be able to provide this synthesis (through what might be termed as biopsychosocial model of disability).

As manifested above, the significant of ICF contribution in various perspectives are undeniable. Yet, the temptation to devise a method to enable internationally consistent data comparison lead to the adoption of the principle of standardizing. This is where the problem lies. The structuring of ICF is an attempt to classified individual functions. It is structured based on a scientific research (on human various functions) that works to decode or fracture the human complex function in order to identify the composing elements and tries to define the concept of disability for the individual elements. In these attempts, on one hand, there are possibilities that the (necessarily important) focus towards individual’s totality tend to be overshadowed by other more scientific
concern. And, on the other, it is noted that the structured functional classifications are too statistical and cover the ranges (of function) that are too elementary in nature. This approach has in a way insensitive to the fact that human function is more complex and possessed in it a huge ‘potential power’ that science can’t understand. There is a need to pursue an understanding (through observations) which exceeds the ‘mere’ scientific approach and to promote individuals’ overall ‘liveliness’ so that such ‘liveliness’ can be acknowledged as an autonomous ‘driving force’ that will allow individuals to lead a life they have reason to value. Thus, the contemporary social system should work to create a framework that will enable the provision / attainment of this ‘driving force’ to individuals. The origin of human liveliness is believed to lie in the possible conduct of one’s autonomous psychological justification (on one’s own) in deciding and attaining one’s desired aims.

Returning back to the argument of successful ageing; one must consider that many elders cannot equally measure up to the high standards of externally defined successful ageing on some or all dimensions, through no fault of their own\textsuperscript{12}. The question than need to be reconsider is: should they be blamed and

\textsuperscript{12} There are accidents, genetic weakness, psychological blocks, ignorance, lack of resources, and other external factors that prevent successful ageing in many
made to feel guilty for such ‘failure’? The new model of successful ageing minimizes structural understandings of the problem of ageing, which would call attention to the lifelong inequalities that help determine health and life chances in late life. The focus on personal responsibility for health that is implicit in the successful-ageing model risk ignoring the environmental and policy contexts that can facilitate or severely limit an individual’s ability to achieve and sustain high functioning in society (Minkler and Fadem, 2002; cited by Minkler and Holstein, 2005). The concept of successful ageing has received considerable media attention, where it has been oversimplified and used to reinforce the dominant Western mind-set which frequently measures individual worth in terms of personal accomplishments. The translation of an individualistically couched strategy into societal vision risks rendering whole groups of individuals marginal. Such marginalization can encourage damaging comparisons. In sum, the concept of successful ageing has enjoyed widespread acceptance among both professional gerontologists and nonspecialists, and has made an important contribution in focusing renewed attention on health promotion and its potential for a healthier old age. But it is elders. Since how people live – and how they age – are heavily affected by socio structural factors beyond their control, success is more difficult for some to achieve than for others (Holstein, 1998; cited by Minkler and Holstein, 2005).
problematic as well in its inadvertent tendency to promote a new form of ageism directed at those who are ageing with a disability or otherwise failing to age successfully.

If we were to flash back our attention to the argument relating to principles underlying the practice integrated care (discussed earlier in this chapter) and relate the gained understanding to the idea of successful ageing, it is not hard to realize that there are a few similarities in the ideology and framework of approaches. To mention it very briefly; both are committed to promote the improvement of elderly citizens’ well-being and in the attempt to attain such aims, the emphasis towards the importance of networking and person-environment relation (generic approach) is very strongly reflected. However, if deeper observations are to be made, a difference between them, at least in one perspective, is noticeable. While aiming to attain the same goal, focus of approach emphasized as crucial by respective spheres of practice tend to focus on different perspective of intervention methods. That is: while integrated care tends to focus more on macro extrinsic factor (i.e. system and policy approaches) in its advocation of practice, it seems that successful ageing tends to highlights the importance of micro intrinsic factors (i.e.
individuals' efforts and struggles) greater. Following from this argument, it is understandable that while efforts to assist individuals from the perspective of 'others' (for example, through integrated care practice), be it service provider, professionals, policy maker and so forth, are to some extent driven by the characteristics of empathy (other than responsibility), the individual efforts to achieve one's own self-betterment originates innately from one's survival instincts. These two driving force (empathy and instincts) and their combination in forming the proper social bond are the unifying factor between the two perspectives of efforts. If we are to stand from the service providing side point of view, reconciling or synchronizing individually initiated efforts to the networking or integrated method of intervention that we structured with the good intention to assist individuals must be done through acknowledging the importance of such individuals’ instinct (as an inner driving force or motivation) in their autonomous effort to attain self-betterment because it is the instinct that gives them 'reason' to move forward. Thus, understanding the characteristics of human instinct is necessarily essential and this matter will be looked into in the next section.
2.3 Instinct as Learned Behavior

There was a good deal of emphasis on the concept of instinct among philosophers since long ago. The utility of understanding human motivation has long been appreciated by political and religious leaders due to the fact that ability to predict human behavior meant one could manipulate individuals, large groups, and even nations of people. This knowledge was power and it was necessary for political stability and for maintaining control. By the mid-1800s, the old ways of explaining human behavior were no longer congruent with the social scientific facts that were emerging. Our universe (including our understanding towards the concept of instinct) has never been viewed the same since the introduction of natural selection theory (that drives the evolutionary process) was introduced by Darwin through his famous book of *On the Origin of Species* (1859; cited by Cherry, 1994). Regardless of the reaction received, Darwin offered the first plausible interpretation of human existence that was explainable within the realm of natural law, a concept of development and function that could be applied to human as well as other animals (rationalism). Darwinian concepts\(^\text{13}\) have been used on many occasions.

\(^{13}\) Other theorists, who could not see the relevance of natural selection in the complicated world of human beings, turned to the work of philosophers such as
occasions to justify physical and economic suppression of individuals, ethnic
groups, and races. For example, scholars employed natural selection to justify
power politics, or as he described it, “survival of the fittest”.

The concept of instinct was earlier used mainly referring to the influence of
nature not nurture – biology not environment. The different schools of thought
about the causes of human behavior have fought it out over the centuries. The
results have been a back-and-forth struggle between two basic schools of
thought, ‘nature vs. nurture’. From these debates, it is clear that external forces
are important to the process that shapes human behavior (including instinct).
But just as surely, these external forces are not sufficient in this formation
process. Nature and nurture are equally important; they are inextricably
intertwined. For example, in the beginning of life, the process of shaping of

John Locke. They generally conceived of human behavior as being caused by
external forces (as against innate instinct). Most of these theories were related to
what could be called a human, economic law of supply and demand. Capitalism,
democracy, and communism became examples of workable political
conceptualizations using these philosophies. For other theorists such as Sigmund
Freud, human behavior and development was caused by internal perceptions of
the outside world (Fine, 1973; cited by Cherry, 1994). Human personality was
shaped by the individual's inter- and intrapersonal experiences and his or her
interpretation of those interactions. Personality resulted first from the relationship
with a mother or mothering person and then from the object relationships (personal
experiences with others) that spun throughout a person's early life.
personality depends on individual genetic characteristics to provide the basic elements of behavior. Nonetheless, after the first experiences with the environment, genetic characteristics become less of a direct influence and more of a general standard by which new behavior is judged acceptable to human organism. The debate about nature vs. nurture has come to its logical conclusion. It is obvious to all that this concept is an exhausted dichotomy and has nothing more to contribute to our understanding of human behavior. Human development and behavior are the outcome of 1) genetic traits and characteristics (the innate instinct), 2) the environment (external stimuli), and 3) the learning that produces new and synthesized behavior (acquired behavior). This is a process where all three forces contribute to who we are and what we do.

In its history of development, the earliest understanding of human instinct was based on theological concept. As proposed by Albertus (cited by Cherry, 1994): animal lacked reason and were controlled by their instinct. Therefore, animals could not act freely. According to Saint Thomas Aquinas, human behavior was based on reason while other animals were driven by instinct. Humans, therefore, were classified as rational, social beings gaining
knowledge from sensory experience as compares to animals. Rapid increase in scientific knowledge in the 1600s gave birth to Intellectual Revolution and also provided the next basic changes in the concept of instinct. Revolutions were spurred by the numerous abuses of the church and nobles and the empiricist movement. The main idea was that: humans were the product of their environment. At this stage, the decline of theology and the rise of rationalism were noted. For example, Darwin rejected the accepted theory that species were fixed categories and that plant and animals had been made by the Creator as separate organisms. Instead, he proposed that animals were capable of variation and change, and this occurred over time in much the same constant way that the earth's geography changed. John Locke, the farther of nurture argument, went further with the rejection. For Locke, all personality characteristics and features were derived from experience and those experiences were knowledge. He proposed that all men were by nature equal and independent and that society was a mutual contract entered into for the common good of all. A democratic government was the only form of government that was not a threat to humans' inalienable rights to life, liberty, and the pursuit of happiness.  

14 Although Locke denied the existence of innate ideas or innate behavior, he did
Instincts are behavior patterns that have become centrally built into a particular species because of their importance of survival. They consist of action patterns, classes of stimuli which release or trigger these actions, and variable periods of time during which patterns become firmly established. Instinctual patterns make it more likely that an animal will do – and in the case of human beings, that we will want or feel we must do – those things most essential for species survival (Breger, 1974). One of the best and oldest definitions of instinct is by William James (1890; cited by Cherry, 1994). He proposed that ‘instinct is usually defined as the faculty of acting in such a way as to produce certain ends, without foresight of the ends, and without previous education in the performance’. He believed that the behaviors called instinctual are general reflex types of actions. He thought that instinctual behaviors are called forth by determinant sensory stimuli when the environment and the organism come into contact with each other.

Instinct can be understood based on the principal of homeostasis. That is: when an organism’s homeostasis is disturbed by the need for food it becomes concede that there were inborn differences, tendencies, and capabilities in humans. However, he maintained that what really determines humans’ behavior is their education (Cherry, 1994).
more and more agitated until it weakens, become immobile, and dies; or as an alternative the organism may strive to acquire food and returns to a state of homeostasis. Some instincts, such as the socialization instinct, work in a similar fashion. In this context, there are noted connections or links between biological structures (bodily functions), psychological state, and environmental stimuli. Regarding the role of instinct on behavior: some behavior seems to be pure instinctual and occur without any direct and or indirect learning. Some seem to be simple drives, like biological impulses. Others seem a mix of the two. There are few behaviors that can be attributed solely to instinct only in the first few occurrences of these behaviors. For example, after a child connects smiling with receiving pleasure stimuli, it will smile to obtain more of the pleasurable stimuli. These instincts remain a part of us and influence our later development and behavior. Instincts are noted to affect the behavior of a species in a stereotypical way (i.e. mothering, hunting, and gregariousness – socialization instinct). The characteristic of these instincts are observable among members of a species in the present and throughout history. For instance, instinct like social bonding affects individual behavior throughout the life of the individuals. The structure of the socialization instinct in humans is the
need to be with other people. This desire never leaves us. As a result, the function of the instinct (a combination of a stereotypical instinctual influence and various other learning experiences) will result in many different approaches or behaviors intended to satisfy this biological need. These events also demonstrate that; behaviors that have specific instinctual characteristics can be modified. Learning increase the frequency of occurrence of a behavior influenced by instinct, and as a result the behavior will increase in accuracy.

Instincts are understood to operate in at least two distinctive ways (through maturation and stimulus-activation). The first is maturation. In this perspective, the verification of the schedules of development of instincts between different species is the keyword. It was verified that genes regulate the timing of the occurrence of the development event of instinctual maturation in organisms. For example, the human has a longer development phase and this allows for more physical development of the brain. This longer developmental phase results in more complex learning. Maturation types of instinct become active as a result of the passage of time and must occur during a specific period of development. The second type of instinct is activated when the correct stimulus is present (stimulus-activated instinct). Typically, this instinct first depends on
maturation and then on the occurrence of a stimuli. For example, the mothering instinct comes to full form when stimulated by the birth of a child. Almost all of us, including males, feel the lure or emotional pull of a newborn child.\textsuperscript{15}

There are two well defined viewpoints in the social sciences regarding the importance of a theory of the instincts as a basis for the development of social theory (Bernard, 1979). One group of writers and teachers contend that the instincts are of secondary importance in the motivation of social conduct and in the organization of institutionalized control (known as the environmentalists). They maintained that whatever instincts human possesses are too elementary and too decidedly biological in character to be primarily determinative of his / her social adjustments. Those supporting the opposing view (known as the instinctivists) contend that human is still the creature of instinct, although he / she have learned for the most part to guide his instinctive impulses into more efficient and socialized channels of expression in keeping with the expanded needs of civilization. Instinctivists further point out that man’s great historic institutions are the product of the organized struggle for the satisfaction of his studies have shown that deviant activities such as sexual self-abuse are typically developed as a result of a distortion of the sexual bond. They may be related to a lack of individual bonding opportunities in the developmental stage or to harmful bonding attempts (Breger, 1974).
organic and animal impulses. They contended that his / her economic institutions have grown out of his organic need for food and that the family is built upon expanded and rationalized sex interest and upon the instinctive attitudes between parents and children. Other institutions, such as war, is said to be traceable back to the instinct of combativeness; the political state, to instincts of fear and gregariousness. In fact, they have an instinct for almost every well defined or institutionalized human activity. Without some such strong organic impulse at the base of each social institution, social continuity would be impossible and the social world would be merely chaos, fitting from one type of organization or disorganization to another. Social conditions, without the cementing powers of instinct, would be so disorganized and social continuity would be so interrupted that the individual would be unable to perceive society as a logical whole.

The environmentalists admit the contention of the instinctivists that the instincts afford a basis upon which man’s adjustments to his social environment are made. They also admit the contention that man’s great historico-social institutions, at least in their earlier stages of development, have arisen out of the endeavor to satisfy organic and animal impulses. But on the other hand
they deny that these adjustments of man to his social environment are, in their more complex or institutional aspects, themselves purely instinctive acts or processes. The institutions are not now, in their present-day highly developed forms, mere simple and direct reactions to the organic needs of man. They are exceedingly indirect responses thereto and are in the main controlled either by ideals and highly conscious aims or by tradition, custom, and conversation rather than by simple appetites, as would be the case were they directed merely by instinct. It is psycho-social environment, rather than instinct and appetite, which functions primarily in modern civilized controls.

Environmentalists further admitted the possibility that certain institutions, such as the family, the state and private property, may never be dispensed with in human society, regardless of what other changes may take place. They would deny, however, that the stability and permanence of such institutions are due wholly or even primarily to the presence of instincts in man which demand these institutions for his subjective satisfaction or which rigidly organize his activities in ways which constitute collectively these social institutions. Whatever instinctive or subjective adjustments of an inherited character we have in these institutions, whether primitive or recent, were developed through
a selective process as a means of adaptation to these environmental pressures. Environmentalists would consider our development of these types of institutions as a selective and survival process, somewhat biological and hereditary in nature, but primarily of a social and rational adjustment character. They were developed and perfected through the accumulation of experience on the one hand and a sort of blind selection and survival of the fittest among adjustments on the other; and the term fittest here refers to the demands of the environment as well as to those of the individuals. The above arguments is reflecting the tension between two different understandings that, on one hand, emphasis that instinct should be understood in its purely innate and natural form (un-modifiable), and on the other, the emphasis that it is a process that can be influenced (for example, by learning and experience) by some extrinsic factors. And, as shown below, both characteristics exist (though at different phases of development) composing the structure or quality of our instincts, thus our behavior.

Central to the vast majority of scientific theories and assumptions about human development and behavior is the idea that behavior originates in individual learning based on person’s interaction with other people and
environment. However, there was more involved in the process of human
development and behavior. The above theories do not explain the substructure
that supports or allows this learning to take place. Computers must have
read-only memory (ROM) to learn. ROM cannot learn, but it allows learning to
take place and specifically influences the process of learning. ROM in the
computer could be thought of as analogous to instinct in human. The ROM
influences how the computer goes about learning and defines the given range
of learning. It does not influence the content and context of what computer can
learn. Likewise, instincts influence how humans go about learning (and other
individual behavioral pattern). Instincts do not influence the content and context
of what humans can learn. The environment is the component that determines
the content and context of what both the computer and humans learn. Instincts
do not determine behaviors, but influence the form of individual behaviors.\textsuperscript{16}

The structure of instinct may be inherited but the function cannot be. For
example, the motor activity of sucking can be genetically transferred from

\textsuperscript{16} Behavior as viewed in social bond theory is thought to be influenced by instincts,
learning, and the environment's impact on the individual. When analyzing a
human's need to perform an activity, it is as important to determine the meaning of
the behavior to individual as it is to identify the rationale each person gives for
performing the activity (Cherry, 1994).
generation to generation but the result of the sucking, its function as a means of nourishing the new born baby’s body, can never be inherited. It must be learned. The development and transfer of instinct from generation to generation is shaped by evolutionary circumstances and regulated by genetic law. Instincts influence behavior in a stereotypical way. As a result, the effect of instinct on individuals of the same gender and group behavior of species can be identified as a characteristic of behavior (but almost never as a fully formed behavior). The effect of this influence is that different behaviors in different circumstances may have common characteristics that are found in the majority of the individuals of a species. Many instincts influence behavior throughout life in a regular and uniform way, although environmental forces counter and modify the effect of instinct in most individuals and species.

Instinct can be distorted or in some cases suppressed (modified). Something is considered as ‘instinctive’ when they happen or occur with no evidence of previous practice or learning through watching. Yet, instinct can be supplemented by learning. Therefore, although instinct may drive the process, learning gives it a new form and a different look. The drive to act on something is influenced by learned behavior that develops in an environment favorable to
the development of specific stereotypical behavior skills (i.e. the attainment of one’s self-betterment). In other words, instincts were not always considered to be blind or to occur inevitably. There were a greater number and variety of instinct in humans than in the lower animals, and any one of these instincts taken by itself was considered to be as blind as instinct in the lower animals. Because of human’s memory, power of reflection, and power of inference, however, once the instinctive behavior occurred and the person experienced the results, it was held that from that point on the knowledge of the results of such behavior (the experience) played an important role in the future occurrences of the behavior. The fact that human possess greater number of instincts as compares to lower animals is explainable through the concept of ‘instinctual boundaries’. Tendencies are showing that the more complex the animal is, the less mature it is at birth, and the longer it takes to reach maturity (Breger, 1974). More complex organisms have larger and more complex brains and nervous systems and these, too, take longer to mature. In terms of instinctual behavior patterns, there is a wider array of actions and a wider array of releasing stimuli interacting with each other over longer period of time. Because of these factors we should think of instinctual boundaries rather than
(merely) instincts when referring to primates (both ape and human). Boundaries refer to the limits circumscribed by the instinctual evolution of species. As species become more complex, the boundaries become wider. Human are perhaps the least fixed in this sense (with largest possible boundaries) and are certainly the most able to adjust and readjust their way of life as environmental circumstances change. In this context, an instinctual behavior was acted on in part because of the anticipated results of the act. The results would be modified if the animals combined instinctual drive with the knowledge of the experience that would result. It was clear that because of previous learning experiences, instead of plunging into action at the first sign of stimulus, humans almost always assess the situation before acting in one way or the other. As a result, the behavior or action to a degree depends on the circumstances of the situation. Whatever the conditions, learning would mask the elementary construction of the instinctual behavior. Finally, following from the above argument, it is also understandable that instinctual action patterns formed the basis of psychological development. The range and complexity of perceptual faculties increased as the instinctual reactions were combined into more elaborate behaviors. The combining and consolidating of instinctual
action patterns was the basis of learning, and provided both the material and
the motivation for higher forms of learning.

Thus it is understood from the above arguments that instinct is the inner
driving force or motivational factors that give reasons to individuals’ pattern of
behaviors and such instinct is modifiable through the process of learning and
experience gaining. Instinct is necessarily related to the emotional part of
individuals. Thinking and intervention methods that are based on conventional
science and medicine have concentrated on the physical aspects of life style,
for example, encouraging people to eat healthy foods, to exercise regularly and
not to smoke. While these things are important, they do not provide the total
answer. From the above understanding regarding the significance of instinct to
individual’s motivation in terms of autonomous self-betterment attainment, we
need to investigate the profound effects emotions and the social environment
may have on a person’s health and well being in later life. Understanding a
person’s mental attitude, though complex and difficult, is important in this
context. From observations, it is understood that those with positive attitude,
who live independently and are able to make their own decisions on which
direction their life will take; tend to be healthier people regardless of any age.
Thus, if the stereotypes of ageing are rejected and people consider themselves special and unique individuals, it is likely they will age in a distinctive and non-conformist manner (Gingold (1992). For this purpose, we need to understand the factor that will contribute to the creating of positive attitude and independency in the individual (in this context, the elderly). In the next chapter: the factors that facilitate the development of individuals’ instinct; the connection of such process to the formation of individuals’ identity and characteristics of social bond; the influence from the formed identity to individuals’ capability and interest in social participation will be discussed. The notion of social bond is crucial in this context due to the fact that networking or integrated care is itself actually a founded on the principle of reciprocity and solidarity (through social participation).
Among the objectives that are aimed to be obtained from the implementation of integrated care are: to optimize opportunities for the self-determination, integration, and participation of older people in society by maintaining independent living in a secure environment and by exerting significant choice over their own lives; and to support carers who provide the majority of care to older persons and to promote inter-generational and intra-generational solidarity. These are advocated social goals that have to be achieved for all citizens, irrespective of their needs. There are four keywords that we could identify from the above elaboration, that are: self-determination, integration, participation and solidarity. These are four interrelated concepts and the possible relation between them could be described as: to a large extent
integration is actually a process of solidarity that has to be conditioned by participation. Genuine participation in this context is a type of action that must originate from one’s autonomous self-determination or self-direction.

Thus, the important question that needs consideration in this context is: where does the quality or inner power-drive of individual that can lead to the exercising of the above self-determination originate from and what are the processes and factors that can contribute to the forming of this quality? And, if integration, or more specifically integrated care, is the process of solidarity, then, it is understood from various early studies (relating to solidarity) that such solidarity must be based on members’ fair reciprocity (reciprocal interdependency) and independency that is durably formed. Further, consideration about fair reciprocity and independency will finally lead us to the arguments relating empowerment (that will enable independency) and readjustment of social power imbalance (that will promote true reciprocal interdependency). The process of empowerment, as it is currently understood, is an effort (regardless of the methods utilize) to intervene that is initiated and imposed from the point of view that is external to individual (believed by others need to be empowered). At times, the process inadvertently act to block or
deny the innate capability and resiliency that individual are born with, and fail to consider individuals' unique perspective of thinking (relating to decisions and attainment that they wish to make for their own life) due to professionals' overly exerted enthusiasm. The process at times destroys the fit that should exist between autonomous self-action and collective efforts. There is a need to look on what is independency if viewed from the inner perspective of individuals so that their innate and autonomous desire to attain self-betterment could be adapted to organized collective effort, as an energy that will further enhance the dynamic of such process.

In the perspective of integrated care that is considered as mutual process, the following matters need to be discussed: Where does the quality that can shape the independency and resiliency of individual (that can lead to the desire to autonomously attain self-betterment and to better qualify individual in the process of collective action) should arise from? How do we acknowledge and utilize such quality to enhance the collective effort (that similarly aims to improve the condition of such individuals) initiated through a policy practice? And, what are the understanding that should underlie and factors that will enhance the connection and synthesis of both of these efforts? This chapter
seeks to: first, to understand what are the reasons that drive forward the need to adopt integrative approaches in care provisioning in general; second, to reconsider what is the fundamental theoretical understanding that should found and reconcile the whole formation or implementation process of integrated care provisioning (it is understood from the discussion in this chapter that reciprocal interdependence based on individuals’ independency and resiliency is crucial to the formation of integrated care system, and both of these concepts are identified as originating from the existence of ample welfare instinct in individuals that is formable through such individuals’ proper attachment and social bonding process); third, to analyze if the reality of contemporary societal environment is in the position to facilitate the promotion (or otherwise) of integrated care formation; fourth, to consider the necessary approach (both from macro and micro perspectives) to be adopted in attempt to promote integration; and finally, to re-state the importance of both the concept of welfare instinct and social bond to the formation of integrated care.

3.1 Reasons Underlying the Implementation of Integrated Care

The phenomenon of population ageing is one of the most common reasons
representing the concerns towards the necessity to integrate policy and approaches (thus, services). Population aging in its most direct manifestation refers to alterations in the age structure of a population, which results in increasing proportions of the population at older ages, and consequently, decreasing proportions at younger ages. It occurs first through declines in fertility levels: as adults have fewer children, the number at younger ages relative to those at older ages decreases. Once low levels of fertility are reached, declines in death rates contribute further to an older age structure (Hermalin, 2005). The speed of fertility decline exceeded the expectations that many observers held in the early 1970s and led to reflections about whether the emerging low rates could be sustained into the future in societies that relied so heavily on children for old age support (Hermalin, 2005). For example, studies in United States show that a ‘demographic explosion’ is taking place and the number of older adults will become larger and more diverse ethnically and racially in the twentieth-century (Kolb, 2003). And further, this phenomenon of rapidly increasing older adult population is not limited to United States; it is

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1 In other words, the recorded fewer numbers of children that are born and fewer numbers of children that die during childhood are both contributing significantly to the steadily increasing proportion of older people in our society (Antonucci et al., 2002).
part of an unprecedented change that is occurring throughout the world and definitely true in the case of Japan. According to the latest future population estimation figure in Japan, by the year 2050, the number of elderly ageing 65 years and above will occupy 35.7% of the overall population (Kurota and Fuji, 2002). Japan has finally about to achieve it longed dreamt status of ‘country with the longest life-span period’ in the world. However, such title comes with its own price. The shortage for future manpower to provide sufficient care services against the rising trend of needs originating from the diminution of family unit and the decline of social solidarity (that consequently leads to the increase of living-alone elderly couples and living-alone single elderly) is lurking in the darker side of this so-called achievement and creating a huge challenge for the current social system (Fukushi Mura Corporation, 2004). In a situation where the graying of society is advancing with high speed, the earlier method that is simply based on pathological intervention became less efficient. Most of the frail elderly who need regular help with the simple activities of daily living – eating, dressing, going to bathroom – are cared for by family members or friends, outside the paid labor market or the ken of government program. But a growing number of old people have simply outlived most of their families,
friends, and assets, as well as their physical health and cognitive competence (Gass, 2004).

In societies (for example, Asian societies) in which generally older people rely to a large extent on children for economic, physical, and emotional support, a sharp reduction in number of children raises concern about the continued welfare for the elderly. Gender differences in the older populations were noted too and they intersect with differences in the labor force histories of men and women, as well as differences in patterns of authority and inheritance arrangements, in affecting well-being, service demand, and policy needs. This is one of the areas that are mainly looked into in CARMEN Project. Labor market and socioeconomic changes also brought about another type of demographic transformation in developing countries especially, that is; a rapid urbanization fuelled by a high rate of rural to urban migration\(^2\). These changes conjure images of isolated rural elderly residing in economically stagnant areas.

In facing these situations, the most commonly observable type of responses to ameliorate the demographic imbalance includes efforts to raise birth rates, encourage marriage, and influence immigration pattern. Program to expand the

\(^2\) These movements led to aging population structures in rural areas, a phenomenon sometime referred to as ‘aging in place’ (Morrison, 1990; cited by Hermelin, 2005).
availability of childcare have been adopted in Japan and other countries, both to encourage childbearing as well as female labor force participation\(^3\).

The fact that people do not age alone, but rather in families, communities, and countries is well acknowledged. Problems faced by older person are, therefore, problems their families, communities, and countries also face. As such it is critical to create a society that meets the needs of all its members, rather than pitting one age group against another. Society must be prepared to both meet the needs of, and capitalize on, the resources of older persons. Older people should be able to continue to develop, to maintain their independence as long as possible, and to participate energetically in social activities and be allowed to contribute to society in a constructive and productive manner. This is another area of concern in earlier discussed CARMEN Project. As proportion of older persons in most societies around the world increases, it is critical that we recognize the effect of these changes on the health and well-being of the entire society. We should focus on creating a society for all ages, a society that values, is responsive to, and applauds all its

\(^3\) Yet, it is not expected that these plans will radically alter the levels of fertility and hence future age structures, but rather, at its best, they will only capable to slow down the rapid rate of population aging by modestly increasing the average number of births (Hermalin, 2005).
members. In order to do so scientists, activists, and policy makers must identify those issues that are critical to and device a system or mechanism that can facilitate the development of a society for all ages, that is, a society in which individuals of all ages can uniquely contribute.

Even though population ageing is identified as one of the motivational factor that geared the progress of researches on ‘integration’, population ageing is not the only reason. Scholars such as Taylor-Gooby (2004; 2004b) is urging that we look into a wider dimension of the situation, for the problem of population ageing does not exist in solitary. It is interconnected with other problems. For example, there have been vast changes in global trade, finance, technology, and communication and these changes to a great extent influence the changes that occur to our population’s shape and characteristics (as stated earlier) through the marked growth of the aged, the decline in birth rates, the rise of lone parents, and the high mobility of migration. There have been major changes in the labor markets too and they are reflected through the increasing demand for higher education and skills, part-time and flexible labor, and female labor-market participation. These changes have brought both opportunities and risks (Handler, 2004), that is; opportunities for more skilled work, for increase in
employment, but also, bring about the increase in lower wages and labor insecurity. These changes are assumed by some as the origin for the occurrence of certain complications and inefficiency that burdens the social system. The economic establishment and most political leaders think that a major problem is the costs and inflexibility of the labor market, caused, in part, by an overly generous welfare state which discourages work and feeds a dependency culture. To them, the traditional welfare states have not adjusted to the changes. Certain countermeasures that are believed to be capable of providing relieves to such situation are devised and introduced from time to time. The approach that is based on the idea of workfare is one of the countermeasures that were introduced. Yet, it was not long before scholars started pointing out that the effort to promote the so called inclusion through workfare obligations is contradictory. That is; positive acts of inclusion necessarily result in exclusion for those who cannot negotiate the barriers. Some barriers are structural but many barriers are individual – health and mental health, lack of skills and education, child and other family care, transportation and so forth. The importance of the deficits in individual capacities is obvious and this is especially true in the case of the elderly
In other words, the problem of population ageing is deeply connected with other complex sociological phenomena such as population shifts, labor market shifts (to the disadvantage of the less-skilled), economic globalization, enhance economic competition through free market exercise, social exclusion, and so forth – our transition to the post industrial society. We should focus our attention to the new social risks that result from this transition. Arguing about the new social risks, Vivekanandan and Kurian (2005) state that, welfare states need to look beyond covering traditional social risks such as unemployment, disability, old age and so on, towards addressing new challenges as social norms undergo change. State policies need to factor in changing social patterns such as the erosion of the idea of family as conventionally understood with the growing incidence of single parenthood, households without children, single-women households, and the growing participation of women in the labor force. That is; patterns of family life and employment are changing, with implications for the risks that different groups of citizens experience in everyday life, for opportunities to develop alliances to promote new forms of welfare, for the interests and roles of the traditional policy actors, and for the
extent to which government can use welfare policy to promote national interests. The policy making is shaped by the basic tension between economic and social goals, where earlier, social policies received mere attention and to a large extent exist only as a means of achieving ‘other’ objectives (Atkinson et al., 2005). The tension ultimately reaches back to fundamental differences in the understanding of how capitalist societies work and of how they deliver welfare to their citizens. Population ageing together with other dimension of complex situation as mentioned above created several barriers that hinders the smooth implementation of services delivery necessary to fulfill the (elderly) community’s needs. These problematic situations are interrelated and they confront individuals and societies simultaneously rather than individually and one at a time. For such reason approaches intended to assist should be organized in a holistic environment and through comprehensive way that transcend the traditional method (where focus of intervention was mainly characterized by a standardized framework of approach in a categorized intervention environment). In other words, approaches that are integrative and capable of producing a series of seamless services are necessary. This was the origin for the emergence of the concept and practice of integrated care.
3.2 Theoretical Concepts Underpinning the Formation of Integrated Care

The eight principles of integration as discussed earlier necessarily require mutual consent and fair reciprocity (other than capacity or competency – for example, the creativity and resilient quality in individuals) from involving parties for their actualization. Both, mutual consent and fair reciprocity exist in a sphere where there is awareness towards the sense and importance of social solidarity. Social solidarity is an area that has long been argued in the area of welfare and social studies and such argument, for most of its part, is characterized by its special concern towards the perspectives of rights and responsibilities. The argument relating to social solidarity (in a context where a single state / welfare state is counted as a unit) regained a new momentum in recent years due to globalization phenomenon, and differences in understanding within this scope of argument are observable. While some believe that globalization process act as a threat to existing social solidarity or social order, others believe that the real pressures are actually originated from

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4 The eight principles are need responsiveness; individualized chains of care; continuity of services; seamlessness; fluent flow of information; multidisciplinary action; cooperation; and flexibility (refer to Chapter 2).
within. Rather than the problems that arise with the increase in internationalization of economic activity (globalization), some scholars believe that pressures for future social solidarity are pressures internal to national welfare states. Consequently, various efforts to sustain (the existing solidarity) or to formulate new approaches for the formation of a new type of solidarity that is more compatible to the contemporary social environment are being initiated. In this process, the conventional wisdom that act as the base of solidarity and yet tend to sponsor and disseminate a morally questionable ‘duty-free’ conception of citizenship (overemphasizing citizens’ rights as against their duties) need to be reconsidered (Roche, 1992).

Basically there are three philosophies that mainly shape the debate of citizenship that founds the concept of social solidarity (White, 2003). The first one is Libertarianism that believe in a conception that a good society is a society based on the institutions of private property, the free-market economy, and a limited but strong state (limited in that its functions are narrowly confined to the definition and protection of private property rights; strong in that it must

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5 The identified pressures are deindustrialization; the shifting from a manufacturing to a service-based post-industrial economics; demographic changes: in particular population ageing; and maturation of many existing welfare programs (Esping-Andersen, 1996).
have the capacity to carry out these limited functions effectively). However, this philosophy do not command clear majority support even in relatively liberal capitalist societies like Britain and United States because many citizens in these countries continued to experience substantial economic inequality and social exclusion. The next philosophy is Communitarianism that mainly concern about ‘social cohesion’ and the need of interventionist government to secure this cohesion in the face of market forces (to halt and reverse the problem of social exclusion allegedly produced by the policies inspired by the New Right in the 1980s). Citizenship cannot, on this communitarian view, be collapsed into market; the very point of the citizenship is to embed the market, to constrain its processes and outcomes, so that society remains cohesive and inclusive (remains a community). State has a responsibility to ensure that all citizens have genuine access to a wide range of basic goods such as education, training, health care, and a decent minimum of income (putting a floor under rising economic inequality). Individual citizen who stands in potential receipt of the basic goods also has a set of responsibilities parallel to those of the states. Moreover, state may, and should, condition eligibility for the goods on the individual’s performance of these responsibilities. The keyword of
this ideology is ‘welfare contract’; that is: social rights are one side of a contract between citizen and state on the other side of which stand certain responsibilities. These are centrally related to paid-work, and the citizen must perform them as a condition of enjoying the benefits secured by these rights. Welfare contractualism is rejected by many on the left who see the shift as a fundamental reorientation of the welfare state away from the broadly emancipatory purposes supported by philosophy of social citizenship articulated by T. H. Marshall (seen as a revival of the spirit of Victorian Poor Law). The point of social citizenship and its accompanying rights is to expand individual freedom, but they fail as instruments of freedom by making the access to the relevant benefits conditional on conforming to conventional standards of responsible behavior, in this context, employment-centered way of life. The third philosophy is Real Libertarianism that is promoted by the Radical Left. This ideology clearly differs with communitarians on the conditionality of social transfers in a way that they are more egalitarian in their effort. The ideology is mainly expressed and actualized through Unconditional Basic Income (UBI) program: an income grant paid to each citizen as of right without any test of means or willingness to work or to make any other form of
productive contribution to the community. The entitlement is directly linked to the objective of personal freedom. In the perspective of this philosophy, real freedom requires more than the formal liberty of action to which the conventional libertarian is committed. Real freedom also requires that individuals have assured command over scarce resources, and it is argued that UBI, set at the highest sustainable level, is the fairest way of assuring such command. Finally, in addition to the above stated three philosophies, of lately, a new ideology that is said to be shaping the fourth philosophy is emerging. It is this fourth perspective that I believe crucial to the formation of integrated care system. The fourth philosophy, characterized by the concept of ‘fair reciprocity’, shares with the Communitarians an emphasis on the responsibilities that accompany citizen’s social rights, but closer to some real libertarian thinkers in its commitment to a radical form of egalitarianism. In short, it holds that:
citizens are properly possessed of various social rights and opportunities;
these rights and opportunities are instrumental to an ultimate distributive goal that is highly egalitarian; and where these rights work to secure citizens a sufficiently generous share of the social product, and sufficiently good opportunities for productive contribution, citizens have definite, potentially
enforceable obligation to make a productive contribution to the community in return.

Integrated care is itself a process of social solidarity, and both such social solidarity and the practice of integrated care must be founded by the concept of fair reciprocity. The actualization of the concept of fair reciprocity in this context could imply two meaning, that is: the requirement for individual members to contribute their concern and to participate in the collective action (the process of integrated care); and the fair and mutual acknowledgement of involving individuals' inner perspective in relation to such processes in order to ensure that participation is meaningful to them (and to all in the community). Participation necessarily needs competency (maybe durability, resiliency, creativity or other kinds of competency) on the part of participating individuals and the performance release of such competency is in many ways associated with or influenced by the frame of reference that individuals possess in them (the inner perspective). As such, knowing about this inner perspective in terms of where it originates from and how its existence will influence the practice of integrated care is important (especially for individuals who are standing on the side of service provider and policy maker). And, as it was discussed in earlier
chapters, such perspective originates from individuals’ instinct; to be more precise, their welfare instinct. What is welfare instinct?

Contemporary arguments in welfare are hinting a common move for the necessity to create approaches that are ‘comprehensive yet capable of addressing individuals’ diversity and particularity in the contemporary society’\(^6\). While it is generally argued that ‘comprehensiveness’ is attainable through partnership of many sorts\(^7\), bonding the psychological partnership of mutual understanding would be the most challenging yet the most fundamental to partnership or integrated approach. What is urging in the current social context is the fact that: the evolving contemporary community structure necessitates the creation of a more sensitive care and social system in order to ensure practical, efficient and fair services distribution. The implementation of such

\(^6\) ‘Diversity’ in this sense could be the diversity from the perspective of welfare models and systems, localities and their social structures / problems, organizational settings, or even individuals’ characteristics with relation to age, gender, physical and psychological condition, nationality, ethnicity and so forth. ‘Contemporary’ in this perspective is a situation or environment that is characterized by globalization; interconnectedness; high technological, information and individual’s mobility; and cosmopolitan society with multi nationalities, cultures and ethnicity.

\(^7\) For example; partnerships between countries, localities, organizations, individuals, or even between person and environment and so forth, that will assist the merging of necessary knowledge, skills, techniques, or even mutual understanding and perceptions.
care system will not be guaranteed its full success unless it is founded on the possible fostering of a mutual consent or mutual agreement between all members in the community. And, the situation indicates the need to shift from the conventional practice of welfare to a concept of practice that promotes and respects individualities.

In effort to implement practice that promotes and respects individualities, approaches must be characterized by the following conditions. Intervention must not be restricted by a set of externally and rigidly fixed (standardized) problem solution method but to look into attending the respective individual’s (internal) concern, agreement and dynamism of life pattern (Ogasawara and Hirano, 2004). Then, intervention’s conception should not only aim to promote physical remedy but also expanded to improve individual’s overall quality of life (individual’s liveliness) in ways that consider the possible enhancing of individuals’ adaptability skill to attain individually valued self-betterment in relation to the continuously changing environment. And, finally, intervention must work not only to facilitate the external enabling factors for individuals’ self-betterment achievement (in a way that is assisting) but also to nurture the internal (psychological) factors for such purpose (in a way that is more to
supporting). This would mean a need to acknowledge the innate capability and working to groom such potential capability in order to bring it into full play for the benefits of every respective individual.

There are two principle factors identified as necessary in effort to collectively support (in this context, through integrated care) the attainment of self-betterment of individuals. Those factors are: 1) to structure an intervention method that is practical, efficient and fair; based on mutual consent and agreement; and free from paternalism and rigidly standardized framework of approach, and 2) to guarantee the respect for individuals’ diversity, the promotion of individuals’ liveliness, and the nurturing of individual’s internal psychological factors for self-betterment. These factors have to be bridged by a kind of motivation or inner self-drive that will convince individuals to agree and to participate in the collective effort and such motivation or inner self-drive has to spark or originate from the internal self of affected individuals. This is where the greatest possible freedom in deciding the factors (thus, nurturing the motivation) relating to the attainment of one’s desirable and valued aims in life can be assured free from any types of external coercions. As such, there is a need to device an approach that can stimulate such motivation or inner
self-drive (for achieving self-betterment) and to guide or re-direct such internal self-drive to the direction that benefits the individual and his or her surrounding.

This motivation or inner self-drive is what I termed as the ‘welfare instinct’.

Welfare instinct is the natural inclination or tendency to attain self-betterment\(^8\) that every individual innately possess in them. Such inclination involves a series of multi level and mutually interconnected biological action and psychological reasoning ranging from the most basic of self-maintaining bodily process\(^9\), to the development of intellectual faculties (the development of cognitive powers) that was made possible due to the success of earlier self-maintaining process, and finally, this wills for the preservation of the individual self accompanied by the development of intellectual faculties tends to pass into a will of self-maximization\(^{10}\) through a higher and more complex functioning, such as the creation of social bond.

Though welfare instinct may be characterized by a low degree of

\(^8\) For example, through the acquirement and fulfillment of all sorts of individual needs ranging from material: such as enjoyment from material utility – to sociological: such as acknowledged the right for social participation – and to psychological needs: such as the securing of health, comfort, happiness, independency, self esteem and so forth.

\(^9\) Of which the chief part is the function of nutrition acquirement in the face of impediments of various kinds or in face of changed external circumstances.

\(^{10}\) A will for all-around self-culture, for the development of all the various human capacities in a harmonious personality (Allen, 1999).
consciousness in its initial stage, environmental adjustment that can facilitate learning strategy along the process is hoped to be able to transform such instinctual impulse into a positive acquired habit that can equip individuals to coop with the demanding pressure from his or her immediate environment in effort to attain self-betterment. The link of the whole process can be briefly understood in the following connection: in the first place nutrition intake (self-maintenance instinct) allows the maintenance of physical liveliness; in the next stage, physical liveliness facilitates the development of intellectual faculties that will contribute to mental or psychological liveliness; and consequently, psychological liveliness will work to stimulate the individuals’ inner self-drive and will-power for the attainment of further self-betterment. This is where the welfare instinct of / in individuals originates from. The extent to which welfare instinct exists in individuals will influence and determine individuals’ capability (for example, in terms of creativity and resiliency) in handling challenges that they face in life and in improving their (biological and psychological) functions. Such functions (improvement) necessarily include nutrition intake function (improvement), the basic function most important in the early cycle of instinct nurturance, and from this point the whole process goes
again in circle, repeatedly. The understanding and acknowledgement towards
the importance of instinct is useful in effort to device an intervention approach
and ideological framework that is universal, non-coercive, and capable of
maintaining the respect towards individuals’ diversity. It is also a knowledge
that is generally helpful and applicable as a guiding principle to the delivery of
an efficient social work services. Instinct is an element that is universal due to
its existence in every living animal (including the human); non-coercive due to
its natural existence in respective individuals (rather than externally imposed or
established); and capable of respecting individuals’ diversity through the
freedom and motivation that it guarantees in the process of decision-making.
Upon acknowledging its significance as a driving energy for self-betterment
attainment, our next endeavor should focus on further understanding the
criteria of instinct. Such knowledge will allow us to manipulate (in a good
intention) it in order to redirect such instinct into a motivation and energy that
will further assist the efficiency and effectiveness of our intervention, and assist
individuals to better attain their social aim (their well-being).

In sum, it would be most ideal to the contemporary social situation if we
are able to precisely identify the characteristics of instincts that exist in
respective individuals and utilize such knowledge to reconcile individually initiated efforts for attainment of self-betterment to the collectively initiated effort (of intervention) in our attempt to create an intervention method that can comprehensively look into the unique needs of individuals, while at the same time fostering social solidarity (as discussed in last chapter and this chapter). It would also be ideal if we could utilize such knowledge to create services that are free from standardized framework of intervention in order to justly address the totality of individuals (including their valued internal perceptions) as explained above. The society should work to acknowledge the significance of instinct that exists in respective individual in effort to actualize the advocated meaningful relationship that is said to be attainable through the process of integrated care. However, the reality is showing a trend that is far from this ideal expectation. Different kinds of instincts simultaneously exist in individuals (including sagregative instinct that we will discuss in the next section) and are competing for supremacy. Due to the superiority of certain instinct against the other, the tendency to categorize or segregate (thus dividing the society) rather than initiating to address the totality of individual is more common in our social system and social setting. Such practices further aggravate the social divide
situation rather than promoting integration and solidarity.

3.3 Social Segmentation and Categorizing in Welfare

The reason why our social system incline to segregate individuals into certain categories (with the assumption that such segregation will increase the efficiency of intervention) is due to the segregative instinct that we innately posses in us. Some understood such instinct as part of our genetic code inherited from generation to generation. The development of such instinct (influenced by imprinting and bonding process) is derived partly from the environmental evolutionary process and this phenomenon was termed as natural selection by the famous Charles Darwin (1859; cited by Cherry, 1994).

It is a strategy for survival of the tribe or species (by prioritizing the survival of the fittest) that is created to fulfill the requiring and challenging conditions of certain environment\textsuperscript{11}. Often, when we study ourselves, we begin with the premise that we are unique individuals that is different from each others. This

\textsuperscript{11} For example, in the wild animal world, we often noticed that a member of the tribe that is injured, or an offspring that is born with deforms, often become the target of attack by other ‘fitter’ tribe members in order to reduce the extent of burden that the whole tribe has to bear (in dealing with the possible threat from their enemies) and to increase the likely chances of survival for the whole tribe (Cherry, 1994).
consideration tends to strongly shape and influence our perceptions of the human being and human needs. As stated earlier, evolutionary strategy of segregation and the compulsion to rationalize these segregationist behaviors in our culture and social organization has often taken the form of discrimination against humans who are different sexually, racially, ethnically, or religiously. In its worst extent, an abuse of the theory was/is also witnessed. Evolution theory on this perspective has been exploited by political conservatives and bigots to infer a scientific rationale for racism and other forms of social segregation. Evolution theory has been distorted so as to allow the continuation of discrimination against out-groups and to maintain the status quo of the mainstream.

The practice of segregating or categorizing reflects the existence of a certain spectrum of power balance between different social agents in our social structure. The existence of this structure of power balance influences our social system and our life in many ways. For example, while most arguments relating to welfare system's integration and its implementation are so focused in arguing about the workability, or efficiency of such systems in its delivery functions, I strongly hold that the structure and balance of power relation
(sometimes manifested as social hierarchical position) that is characterized and determined by factors such as social position, knowledge, gender, age, and so forth could be the ultimate determinant factors that decide the final shape of any intervention and collaborative effort. Vicente Navarro and Charles Muntaner (2004) pointed this fact most clearly when they criticize the famous work of Amartya Sen in his book ‘Development as Freedom’. Navarro and Muntaner suggest that Sen’s work, while representing a major break with the dominant neoliberal position reproduced in most national and international development agencies, is insufficient to explain the key relationship between freedom and development. The absence of an analysis of the power relations that cause and reproduce underdevelopment leaves Sen’s work wanting. Sen’s thesis stresses in very strong terms, that the main objective of development is freedom: freedom is the goal of development (what he calls the constitutive role of freedom), by which he means the capability to develop one’s own potential, unrestrained by circumstances outside one’s control. Freedom is thus understood as developing one’s own capabilities. But for Sen, freedom is even more than the objective of development; it is also the means of achieving that development. He thus considers freedom as instrumental in, or an instrument
of development, and he designates as instrumental freedoms the following five freedoms: political freedom, economic facilities, social opportunities, transparency guarantees, and protective security. Sen’s description of these five freedoms, in a way resembles the famous five freedoms articulated by President Franklin Roosevelt. A major difference, however, between the two is that Roosevelt had a distinct priority in the ordering of the five freedoms. There is no such ordering of priorities in Sen’s list, however. Sen refers frequently to the relationship among his five freedoms but never establishes a scale of relationship among them. He established the need for and interdependence among these rights, but nowhere does he explain the nature of the relationship or the reason for the interdependency. In this respect, Sen moves within the classical economic tradition, based on Adam Smith, in which the individual is the subject and object of analysis; collective agents and subjects such as social classes do not appear, nor does any analysis of what articulates these collective agents such as exploitation or domination. Issues of power and how that power is reproduced are rarely, if ever, touched on. Listing the five instrumental freedoms without explaining the frame in which the matrix of those freedoms is positioned has seriously weakens Sen’s analysis. This weakness
is based on his reluctance to focus on the sources of power in a society and how that power is reproduced. Navarro and Muntaner (2004) believe the sources of power in our societies are multiple (class power, gender power, race power, national and regional power, and so forth). But this multiple focus of power does not mean that structurally, under capitalism, some powers are not more important than others. Class power is the frame within which the power matrixes operate. And class power is based on ownership of resources, be they means of production, knowledge, or organization. Sen’s work is a major step toward challenging the conventional wisdom in human development studies. But it does not go far enough. It leaves untouched the core of this conventional wisdom, without penetrating the question of how power is produced and reproduced in the world today. And, that is the question we need to ask.

From a perspective closer to welfare areas, the practice that mirrors the concept of social segregation or social categorization is more commonly associated with the term or aim of ‘intervention efficiency’. Such practice is manifested in many different forms; from the macro to the most micro practice of interventions. Some of the examples are the categorizations that are
observable between people of different nationalities and race; between different boundary of services and expertise in welfare areas; between service providers and service receivers; and between different levels of policy intervention (central as against local policy implementation). The nationality and racial segregation is characterized by the long established view about ‘races’ that predicts them as fixed and given, unchanging and unchangeable. This assumption differentiates human species largely in biological terms, and ranks such groups in a superior and inferior social hierarchy base on the suppose possession of intelligence. This has a conspicuous history in Western culture, developing in the wake of European exploration and colonization during the fifteenth and sixteenth centuries (Torres et al., 1999). The categorizing instinct is also the characteristics that underlie the formation of nation state and its accompanying social system. Historically, national integration and nation building have been founded on the possible development of collective social provision. However, in such efforts states differentiate certain group of population as citizens in attempt to control access to its territory, and provision of various benefits including welfare is given to these citizens in exchange for the ‘internal loyalty’ (Heater, 1999). In current
situation democracies are faced with the need to reinterpret their often outmoded democratic traditions to attune them to a more modern age of increased cultural diversity combined with a greater global interdependence\textsuperscript{12} (Lynch, 1992).

The segregative instinct that exist within individuals possessing different kind of expert knowledge is reflected through the existence of categorizing boundaries that separate them from one another on the notion of professionality. For example, the problematic nature of the division between health and social services agencies has been one of the most controversial and enduring issues of contemporary social policy. The effect could be devastating. For frontline workers, the need to overcome a tangle of legal, administrative and organizational obstacles in order to work effectively across service boundaries with colleagues from other profession and background is an almost daily struggle. For individual service users who find themselves trapped between these two large and powerful agencies, the experience is

\textsuperscript{12} What is alarming is the fact that in contemporary theorizing of ‘citizenship’, the ideas actually increase rather than decrease the likelihood of social injustice and exclusion. For example, on what ground should full rights of citizenship be denied to individuals who live, pay taxes, speak the language, and obey the laws of a country in which they were not born? Yet, this is the situation today (Calabrese and Burgelman, 1999).
frequently one of frustration, disillusionment and despair. The boundaries between these services are an almost constant source of difficulty, debate and consternation in both cases (Glasby and Littlechild, 2004). In the clinical practice arena, the experts seriously disagree among themselves about which standards are generally acceptable while the clinical standards put to use are not always consistent with a jurisdiction’s stated legal requirement (Kapp, 2004). This is especially problematic in a situation where complex social needs are the focus of intervention (care for dementia is one them).

The example description of how complex it is to create an environment where a holistic approach that is capable of disseminating the type of seamless services necessarily required to fulfill the complex need of elderly citizen (in the case of elderly with dementia) is elaborated by O’Shea (2004). O’Shea highlights his concern relating to the gap that exists between the needs of people with dementia and the services provided by the state to meet these needs (based on Ireland’s case). First of all, to set out a vision for the care of people with dementia that emphasizes their rights as human beings to self-respect and dignity and their rights as citizens to care and support services that allow them to maximize their well-being within the constraints of the
condition is the crucial starting point. This move should be followed by the effort to create a positive and holistic environment for the planning and development of dementia services, heralding a new and sustained person-centered approach to the support of people with dementia and their carers. And above all, policy responses must be multi-disciplinary and multi-layered. Unfortunately, fragmentation of services for people with dementia is common to most European countries, where the main providers of care and support for people with dementia remain family members. The medical model offers a very partial understanding of dementia since the meaning given to the disease will be conditioned by the socio-cultural environment within which people live and communicate which, in turn, will influence individual, family and institutional responses to the disease (Downs, 2000; cited by O’Shea, 2004). The interpretation of dementia will also be tied to the social meaning of ageing generally and to the understanding of disability in society (Oliver, 1990; cited by O’Shea, 2004). There is a serious supply-side problem in the provision of community care and residential care services for people with dementia. The main challenge is to find ways to stimulate the supply of community-based services both inside and outside of traditional statutory routes. On the
assumption that all of the gaps in social services provision for people with dementia and their carers will not be met by the public sector, nor by the private sector, there is an imperative to explore new ways to grow the social care system in the year ahead.

In the mid-1990s, public sector organization in United Kingdom undertook a serious and sustained effort to achieve a reformation in order to improve the segmented condition of public services provisioning. However, the impact was less decisive. The process of change was highly contested and the outcome of change was uneven because certain categories of professionals (in this case doctors) retained a high degree of control over work practices that reengineering found difficult to reshape over very short time scales. The power base of professional workers remains a crucial factor in the organizational context of change (McNulty and Ferlie, 2004). Moves to increase the emphasis on client or ‘consumer’ choice is also observable and part of the reason for this refocusing on clients as active consumers rather than passive recipients or services may simply be that health and social problems have become more complex and multidimensional and that the older more static models of welfare have outlived their usefulness. In the past, the Department of health has
focused on ‘health’ issues, while social services have reacted to the rise of ‘social’ problems. This is increasingly seen as too simplistic way of tackling more difficult and intractable problems (Carnwell and Buchanan, 2005). Satisfying needs that arise from complex situation such as long-term care provisioning (that should be characterized by interfaces between health and social care, between institutional and community care and between primary and secondary health care) calls for a broad scope of experience and perspectives that often goes ‘beyond’ classic scholarly divisions (Leichsenring and Alaszewski, 2004).

The hierarchical gaps that exist between service providers and service receivers are most clearly manifested through the current rush to champion evidence-based practice argument. In this context, questions about what is to count as evidence, and what it is evidence of, are inherently disputable. Drakeford (2000; cited by Smith, 2004) noted the tension between evidence-based practice and a commitment to attending seriously to service users’ views. He argues that the emphasis on evidence-based practice risked devaluing these views, encouraging an over-restrictive view of what evidence is, and giving priority to the outcomes and definitions of effectiveness that are
of most interest to providers and policy-makers. Despite of the recognition towards service users’ as key stakeholders little explicit attention is given to issues around service users’ involvement in research and theorizing, and / or in informing / influencing policy and practice. Dialogues across academy, profession and other divides need to be highlighted (Lovelock et al., 2004).

Further, despite the long tradition in social gerontology areas of study (for example, in the study of quality of life) of listening to the voice of older people, the same trend of neglect are also observable. There are only very few studies that have attempted to seek the perspective of older people about their quality of life. Population surveys of older people rarely focus on the lay definition of quality of life. Rather, they use the standard social epidemiological framework encompassing expert definitions and concepts (Bond and Corner, 2004).

Generally, most people would agree that clients should participate and be involved in the choices that affect their lives, and a shift to encourage the ‘problem-oriented’ approach to health and social care is necessary to allow such situation to take place (Carnwell and Buchanan, 2005). The discussion about ‘problem-oriented’ approach in health and social care touches on the connections between knowledge and power. In earlier approaches, those who
have socially valued knowledge (i.e. scientific knowledge) have the absolute power to make decision, change opinions and define reality. In effort to create a rational and efficient care, equalizing this difference in power between service receiver and those who provide services or research their lives is necessary (Reed et al., 2004).

Finally, the segmentation between different levels of policy intervention is reflected through the practice of policy decentralization. Despite of the fact that all levels of government (local and central) should have an equally important roll to play in order to sustain an intact social system and to bring particular skills and abilities into the public arena for the community’s benefit as a whole, recent efforts has shown a different perspective of movements. The implementation of policy devolution that aims to limit the roll of the central government threaten the ability of lower levels of government to do their job properly by forcing them to take up functions that the central government is better equipped to perform. This progress will aggravate the stability of the whole system. For example, devolution of federal government’s responsibility in welfare provision could increase fiscal disparities and many forms of inefficiencies in most area of welfare across and within state (Blank, 1997).
The kind of categorization or segregation that typically works to segregate the elderly as an exclusive group from the main stream community is negative age stratification or ageism (Palmore, 1999). Age stratification is the system that classifies people by their age. All societies stratify their members by age (as well as by sex and economic status, and often by race). In all these stratification systems, there is an implicit or explicit ranking from higher to lower strata. The extent to which age stratification are ageism depends on whether the assumptions on which they are based are prejudicial or not; and whether the expectations are realistic and appropriate or not. In other words, ageism is a prejudice or discrimination against or in favor of an age group.

Still less is known about the interrelationship between the old and his family and society at large, especially the rejection that he or she experiences once retired and no longer has any voice in the course of events around him (Knopf, 1975). Many are prejudiced against the elders in various ways as shown in their belief in many negative stereotypes and their use of ageist language (Palmore, 1999). The result of these circumstances is a general pessimism among the aged that comes with: the personal costs of demoralization, a loss of self-respect and self-esteem, loss of function,
inactivity, physical and mental decline, and a feeling of being a burden to their families and to themselves (Knopf, 1975; Palmore, 1999). Many factors that enter into the negative attitude toward the aged – especially the psychological ones – need investigation and explanation if more than perfunctory improvement is to be achieved.

It is characteristic of human nature that we feel most comfortable with the familiar. When confronted with anything unknown and foreign, we have to overcome an involuntary flight reflex before we can make contact with it. An old age is something foreign to almost everyone who is younger, even if he has spent his childhood years in close contact with a grandparent or other aged relative. Because such early contact is easily forgotten as times go on, the mere idea of the existence of the aged, especially in large and ever-increasing numbers, is extremely upsetting to the people who have to deal with them as a group. Aversion to the aged is not limited to the young; it is universal, shared even by many who have to treat the aged professionally. There are many reasons for the conscious and unconscious rejection of the older generation. Early conflicts with parents and parent figures that are never completely resolved may recur to plague the relationship between the generations, just
when the elder ones are most dependent on the younger (this situation explains the importance of attachment concept in the formation of individuals’ behavior and the importance of continuous focus towards the significance of such concept in structuring a proper social bond). That is why no child, regardless of age, can tolerate his parent ageing.

Some of the mechanisms in our social setting lead to a withdrawal from too close an association with the aged, to an effort to force the aged into the status of a social minority, though their numbers are growing constantly. Stratification of society has always existed; groups have been formed to unite people who share mutual interests as well as prejudices created by values the individual member acquired in childhood. By excluding the outsiders, groups protect their own way of life and avoid contact with anyone whom they regard as different from themselves or inferior. The barriers raised against people of a given ‘race, color or creed’ have plagued mankind forever. And behind these barriers, people can retain their prejudices and organize their own lives in such a way that they have little or no contact with a group they do not like. But no such isolation is possible in the long run in dealing with people in this minority – the aged (Knopf, 1975). Ageism is an increasingly important issue because of
the rapidly increasing numbers of older people (Palmore, 1999). They penetrate every barrier, because they occur everywhere, regardless of the mentioned ‘race, color or creed’. Everyone is bound to join their ranks sometime. The relationship between the old and the young greatly dependent on the younger one’s attitude towards his own aging. A bridge must be found between the younger and older generations, or otherwise we will term the situation of the aged hopeless.

Now, a few points to ponder: though it is acceptable to certain context that the principle of segregation that is exercised today is capable of driving in some kind of intervention efficiency, we need to re-question ourselves; are we interpreting the need to differentiate one from another in a correct way? And if we do, are we implementing the right type of categorization that our contemporary environment requires? The acceptability of rational linkage that exists between such interpretation and the purpose of such categorizing act is the point that requires careful consideration – whether such linkage is suiting our social sanction and environmental condition. Although we are striving hard to create a better and more efficient service provisioning systems that try to further understand nature, thus, satisfy the needs that emerge from it, the
comprehension and knowledge on which current social institutions and social policy are derived do not usually result from a consideration for the instinctual needs or instinctual drive that influence human development and behavior. As argued by Cherry (1994), we have not explained very much about human behavior regarding causal mechanisms that influence human instincts. The absent of this component (understanding about human instincts) in most theories on human behavior renders them anthropocentric, if not culturally isolated. A contextual approach (based on biological, status or any externally visible factors of segregation as explained above) is obviously inadequate and can only explain short-run and culturally bound behavior. While this situational approach might explain events in one situation for one culture at one point of time, such approach that is grounded in current events has unacceptable limitations. Segregation is an instinct that in certain situation must be sublimated or redirected. Knowledge and logic are the tools most commonly employed to supersede such instinctual tendency and learned habits. Segregation is an instinct that can be easily manipulated using education and social pressure (Cherry, 1994). From the above, it is arguable that we have the tendency to, first, segregate, and then, (purposely or inadvertently)
paternalized approach by standardizing intervention procedures in our efforts to create a social system that we thought might be comprehensive, inclusive and fair to all. The created social system to a certain extent has fail to grasp the dynamic of individuals instinctive inner-drives or instinctive urges (concerns) that determine the way they value and cherish their respective way of living. These are the innate strengths that individuals are endowed with within themselves and by denying these strengths the system actually kills the motivational root and limits the resiliency and creativity of individuals in effort to independently improve their own well-being. Base on such reasons, there is the need to reform the segmented system and to acknowledge the importance of instinct due to its potentiality to act as a factor that can promote solidarity, a factor that can reconcile individuals’ and collective effort, and a factor that can be an inner-driving force to stimulate individuals’ capacity in attaining their well-being in a non-coercive manner. The amelioration of our understanding towards the importance of the concept of instinct in relation to individuals’ totality is important

To a large extent, efforts to assist individuals that are extended through our social support system are focusing and emphasizing on facilitating the external
factors for self-betterment that is forwarded from the external point of view. What is equally important is to ensure if there exist a match or fit between the externally provided opportunities and the (self-determining) internal perception that inherently lies within each individual. In this context, once again the understanding towards the concept of instinct is crucial. The instinct or the internal perception that individual possesses act as an important switch or the starting point that determines his or her characteristics of later engagement in utilizing or benefiting from the opportunities provided to them by others (for example, through a collective effort such as integrated care). Such engagement (that must be based on individual’s autonomous agreement and concern) is presumed to be able to assist in stimulating and improving the growth of individual’s capacity, to name one among many, his or her resiliency in dealing with the challenges faced in the effort to fulfill their needs and to attain their well-being. Resiliency in this context involve actions that is not merely physical or psychological (for example, to think), but a complex combination of both so that the coordination or the matrix that is created from both can satisfy the totality (in terms of needs) of the individual. Attempt that aims to assist the development of this resiliency must acknowledge the
importance of both sides of perspective to individual capacity. As such, the attempt must be based on intervention that can address the totality of individual and founded on a series of seamless services (rather than a partially segmented intervention as we have discussed earlier). This is where the necessity to integrate services and the necessity to reconsider the needed intervention approaches and skills emerged from. What we will look into in the next part is how such reconsideration (to improve the segmented system) should be conducted from the perspective of action (the practice and system) and from the perspective of ideology (the instinct or inner perspective of individuals).

3.3.1 Reforming the Segmented Framework of Intervention

The attempts to ameliorate the segmented methods of intervention that are observable in our social system are conducted though many efforts. Some of them are carried out, for example, through the promotion of the concept of common citizenship that is respectful of diverse individuals’ particularity; by adding some flexibilities the to the rigid boundaries that surround different categories of welfare services and professionals; by practices that try to tear
down the gap of social hierarchy between service providers and service receivers, and by integrating policies that are conducted at different levels of approaches. The conventional practices in social system that differentiate or categorize individuals according to their nationality or to a worse extent their race is questionable in the context where the great majority of nation-states are in reality multi-ethnic or multinational states. Following this fact, the necessity to embrace a wider meaning of citizenship is unavoidable. To build a solidarity that is based on real trust, government must defend the rights of every group in the community to prosper within the shared social contract and within national boundaries. Government must also look into the interest of all individuals and attack anti-immigrants appeals that are often based on racial chauvinism, prejudice and ignorance. In the contemporary situation where multiculturality and multiraciality is a common phenomenon, shared citizenship is fundamental mechanisms for making and enforcing claims and acknowledging mutual obligations. Any government movement that remains silent in the face of division over who should belong to the country and that does not discuss what shape the nation needs to take in order to include everyone, is bound to fail. The government will be measured by how well they promote the causes of a
common citizenship and justice for all in present time (Torres et al., 1999). The interplay between factors such as class, gender, disability and ethnicity, and their combined impact on an individual's status within any given society is complex. The possibility that the concept of citizenship can be extended beyond the level of the nation state to engender a system of global citizenship has exercised the minds of theorists since the last decade. For example, the establishment of ‘Social Europe’ or European Citizenship and its future potential to enhance the welfare rights of EU migrant citizens are currently being addressed (Dwyer, 2004). In arguing about community and the best way of how such community should be organized in the contemporary environment, the kind of hard questions and ethical challenges that should be reflected upon continually is the needed attempt to foster an approach to community organizing that is self-critical, reflective, and respectful of diverse communities (Minkler, 2005).

One of the difficulties in achieving seamless services is that a combination of imprecise legislation, rigid organizational structures and, the complexity of people’s need can lead to overlaps between services. ‘Gray’ areas can result, which at worst lead to cost-shunting between agencies; that is, agencies will
not take responsibility for certain type of provision, usually because of the costs involved. The result can be delay, and some time non-provision of certain services – as well as confusion amongst both service users and providers of services about who can or should provide what, and who is going to pay for it (Mandelstam, 1999). Yet, it is observable that the urge to break down the rigid boundaries between professional is urging and such urge is becoming more prominent as time passes by\textsuperscript{13}. To some extent, effective joint working between major stake holders in welfare provisioning (for example, between health and social sectors) has been initiated by some governments. As part of this process, a wide range of new policy initiatives has been introduced, many of which will significantly affect the work of frontline practitioners. However, the actual practice of such joint working concept has not yet become widely known at ground level (Glasby and Littlechild, 2004).

\textsuperscript{13} For example, of recently, the projected federal budget surplus for health care (in United States) had been replaced by budget deficit while at the same time commercial health insurance premiums continued to rise. Along with rising health expenditures, the number of uninsured increased. These contemporary health policy challenges necessitate the fostering of dialogues between the academic researchers and health care experts within government and private organizations. Collaboration of practice and policy, and between different approaches, in order to cater the diverse need is emphasized (Cutler and Garber, 2004). In this context, an effective management of such situation must incorporate the viewpoints of all major stakeholders (O’Shea, 2004).
Arguing from the perspective of evidence-based practice, Rapport (2004) states that, while a great deal is expected of evidence-based practice, it is no panacea. The complex, multidimensional issues raised by current social issues demand the cooperation of people from many disciplines, and this raises profound questions about how evidence is defined, data collected, interpretations elaborated. The adoption of ‘problem-oriented’ approach that gives more spaces for the evidence collected from users and lay people to be utilized as valid evidence is suggested. However, the intention to encourage ‘problem-oriented’ approach must be supported by simultaneous participation of various expertises from various field of knowledge due to its complicated and interlinking process. A new method of knowledge production and intervention method to sustain the possible practice and its requirements is demanded. Gibbons et al. (1994) termed this new method of knowledge production as Mode 2 knowledge production (as against the conventional method of knowledge production).

Most of current research structures are supported by a set of research practices which ensures that results are sound. These research practices set the terms of what shall count as a contribution to knowledge, who shall be
allowed to participate in its production, and how accreditation shall be organized. Together, these practices have generated what we know as the disciplinary structure of science, and what follows is the fact that the disciplinary structure is specialist. The disciplinary structure is an organizing principle for teaching in universities and also the essential link which connects teaching and research. Most of the institutions of science whether universities or research establishments, are built upon a model of knowledge production that has a disciplinary basis. This form of knowledge production, as termed by Gibbon et al., is labeled as Mode 1 knowledge production. A new mode of knowledge production is appearing across the board in the sciences, the social sciences and the humanities (the above mentioned Mode 2 knowledge production) and the method comprises a different set of research practices. In Mode 2, knowledge is produced in the context of application. It is transdisciplinary, involves a variety of different skills in problem-solving and utilizes more flexible organizational structure. Mode 2 knowledge production is more socially accountable and, makes use of a wider range of expertise in its quality control processes.

There are five principles attributing to the formation of Mode 2 knowledge
production. First, knowledge is produced in the context of application. The main contrast between Mode 1 and Mode 2 of knowledge production is in terms of their problem solving. While Mode 1 carries a problem solving following the code of practice relevant or restricted to a particular discipline, Mode 2 carries it around a particular application. The other contrast is in the aim of knowledge production. In Mode 1, it is carried out in the absence of some practical goal, while in contrast, in Mode 2, knowledge results from a broader range of considerations, and such knowledge is intended to be useful to someone whether in industry or government, or society more generally. This imperative present from the beginning. Knowledge is always produced under an aspect of continuous negotiation. Meaning, it will not be producible unless and until the interests of various actors are included. Such is the context of application.

Second, transdisciplinary: the determinants of potential solutions in Mode 2 involve the integration of different skills and the consensus may be only for temporary, depending on how well it confirms to the requirements set by a specific context of application (for problem solving). The shape of final solution will normally be beyond that of any single contributing discipline. It will be transdisciplinary. Third, heterogeneity and organizational diversity: Mode 2
knowledge productions are heterogeneous in terms of skills and experience people bring to it. The composition of a problem-solving team changes over time as requirement evolves and this is not planned or coordinated by any central body. In Mode 2, flexibility and response are the crucial factors, and because of this, the types of organization used to tackle these problems may vary greatly. Characteristically, Mode 2 research groups are less firmly institutionalized; in a meaning, people come together in temporary work teams and networks that dissolve when a problem is solved or refined. The main point is that; no one single person or groups were in control to dictate the pace and direction of advance. Fourth, social accountability and reflexivity: growing awareness about the variety of ways in which advances in science and technology can affect the public interest and has increased the numbers of groups who wish to influence the outcome of research processes. Social accountability in terms of knowledge production becomes highly prioritized and it permeates the whole process. It is reflected not only in interpretation, and diffusion of results, but in the definition of the problem and the setting in research priorities. In Mode 2, sensitivity to the impact of the research is built from the start and it forms part of the context of application. Working in the
context of application increases the sensitivity of scientists and technologists to
the broader implications of what they are doing. Operating in Mode 2 makes all
participants more reflexive. This is because the issues, which forward the
development of Mode 2 research, cannot be specified in scientific and
technical terms alone. The research towards the resolution of problems has to
incorporate values and preferences of different individuals and groups which
have been seen as traditionally outside of the scientific and technological
system. In this situation, individuals cannot function effectively without
reflecting all other actors involved. Finally, fifth, quality control: quality in Mode
1 is determined through the peer review judgment. Control is maintained by
careful selection of those judged competent to act as peers, which is in part
determined by previous quality of contribution to the discipline. The peer review
process is one in which quality and control mutually reinforced one another.

Further, there is professional control over what problems and techniques are
deemed important to work on, as well as who is qualified to pursue their
solution. In quality control of Mode 2, additional criteria are added to the above.

There are further questions of: Will the solution be competitive in the market?
Will it be cost effective? And, will it be socially acceptable? Quality is
determined by a wider set of criteria that reflects the broadening social composition of the review system. This characteristic urges for institutional change and poses serious challenge to the conventional organization of research. However, it is not to argue that the new practices will eliminate the old; but rather, Mode 1 will eventually succumb to Mode 2.

The transformation of knowledge production is one of the central processes characterizing the societies of advanced industrial world. In this context, knowledge production is becoming less and less a self-contained activity, and has spread from academia into all institutions that seek social legitimation. In other words, it's becoming an increasingly a socially distributed process. Massification of the university as a teaching institution is a prerequisite for this wider distribution in society of the capability to produce and use knowledge. However, some changes in emphasis are necessary. For example, university must enlarge its view of its role in knowledge production from that of being monopoly supplier to becoming a partner in both national and international contexts.

The attempt to reduce the gap of hierarchy between service providers and service users is mainly exercised through the endeavor of including service
user perspective in what count as evidence in social care practice. Other than practitioner experiential knowledge, and scientific knowledge that is gained through research, service user perspective should be recognized as one of the main basis that should sustain the practice of evidence-based practice in welfare provisioning. There should be a continuous awareness and frank acknowledgment about the existence of unequal power relation between professionals and lay people, and such awareness must be accompanied by constant effort to re-balance the situation. In this context, users should be seen not simply as a source of data but as active shapers of knowledge and subsequent action (Burr and Nicolson, 2005). Respecting individuals’ personal autonomy is the next point that merits consideration in this effort. For example, in the case of care provisioning intended for the elderly, we should understand that the choices that older persons either enjoy or are confronted with may involve a difficult constellation of medical, residential, financial, or other matters. For any of these kinds of decisions, what’s crucial is to find the correct balance between respect for personal autonomy, on the one hand, and society’s compassionate obligation to step in when protection of the vulnerable is necessary, on the other. This process is a delicate task that value both
individual self-determination and social responsibility (Kapp, 2004).

Finally, the attempt to synchronize approaches and policy implementation is actualized through the practice of service provisioning that is characterized by networking and integrating trend. Looking at the development of social policy argument in United Kingdom, the Third Way reflects an attempt by contemporary social democracies to forge a new political settlement which is fitted to the conditions of modern society and new global economy, but which retains the goals of social cohesion and egalitarianism. In social policy terms the model attempts to transcend the fixed alternatives of the state and the market. Instead, civil society, government, and the economy are viewed as interdependent and equal partners in the provision of welfare; and the challenge for government is to create equilibrium between these three pillars. The individual is to be pushed towards self-help and independent, active citizenship, while business and government must contribute to economic and social cohesion. In this context, greater egalitarianism is to be achieved not through income redistribution but by action to affect the initial distribution of knowledge, skills, capacities, and productive endowments (Lewis and Surender,
2004). The actualization of (some part of) the Third Way ideology is manifested through the practice of local strategic partnership (a method that to certain extent resembles integrated care practice). It is argued that such practice is one of the most efficient ways to reorganize our social system due to its wider consideration towards the practice of equal participation. In this perspective, partnership is understood as a rational response to divisions within and between government departments and local authorities, within and between professions, and between those who deliver services and those who use them. Approaches need to be based on clarity about roles, powers, and accountability requirements of stake holders at all level. If power imbalances persist, partnership can fail because for partnership to work, all parties need to feel they have an equal voice and be able and willing to share power. Process of developing the strategy should include meaningful two-way engagement

14 Such policy reform requires an organization with a: 1) new operating philosophy and mission – a social development approach to investing in community resource development; 2) an expanded agency mission – that creates a public forum and consciousness about promoting a civil society and open dialogue about future public policy directions; 3) a shift from a preoccupation with the individual to focus on the family and neighborhood – in the form of neighborhood-based family support services; and 4) changing roles of agency staff – in order to acquire more community-building knowledge and skills (outreach, interagency collaboration, local economic development) as well as to transform public social service agencies into learning organizations (Austin, 2004).
with all relevant stakeholders group (Seden and Reynold, 2003). The complexity of client problems requires an input from a number of services at the same time. In this new way of working, both health and social care need to join up to provide seamless ‘one-stop shop’, which meets clients’ needs. People’s needs may change over time and place and so partnership may be formed in a flexible manner to meet particular problems (Carnwell and Buchanan, 2005).

The practice of partnership is typified by its main concern to place clients (individuals) experience at the center of health and social care. In the case of United Kingdom, such effort is materialized through the implementation of the National Health Service Plan 2000. Services are shaped around the needs and preferences of individual patients, their families and their carers. This focuses delivery of care on consumer’s needs, and respects their diversity in terms of age, gender, ethnicity, disability and sexuality. Consumerism in this context should be presented in terms of personal empowerment and freedom of choice, and it should mean the whole population and not simply those who are ill. It is believed that consumer involvement in research can result in a synergistic relationship in the overall process and new insights can be gained to improve
the condition of the consumer. This is however, to assume that user and professional perspectives ‘come equitably to the table’. Understanding the quality of life that one has reason to value is necessary in our effort to produce services that meet the satisfaction of such individual. Our knowledge about the valued quality of life is important. Yet, from whose perspective that this quality should be determined is equally important\textsuperscript{15}.

3.3.2 Reconsidering the Importance of Care and Social Bond

Other than hoping that it would act as a countermeasure that will assist in blocking the development of unwanted quality of instinct (for example, the wrong interpretation and actualization of the view relating to sagregative instinct as discussed earlier) that adversely effect individuals’ inner perception regarding others and his or her environment (thus reducing the chances of his or her social participation due to internally constructed prejudice and stigma), the importance of comprehending and carrying out the process of care in a continuous manner (from early attachment process during one’s childhood to

\textsuperscript{15} Bond and Corner (2004) is suggesting that we should ‘take the perspective of the other’ in this effort. Hence, individuals’ perspectives on quality of life should have precedence over experts. But from a societal perspective the view of the experts in terms of, for example, resource allocation will remain important.
his or her later social bond formation) rather than as a segmented approach lies in the acknowledged necessity to create a proper social bond for the yielding of resilient individuals with proper social qualities. How care is delivered (be it by formal or informal care providers) and whether the continuity of the process is sustainable is strongly influence by the kind of environment where such care is situated. Upon identifying the flaws in the social system that originated from the unnecessary categorizing, and upon initiating efforts to rectify such flaws, our focus should be continued by identifying the factors that will facilitate the creation of environment that will sustain care continuity (thus facilitate the enhancement of individual's instinct positive development).

3.3.2.1 Improving Formal Care

From the perspective of formal care, such effort can be materialized thorough the formation of suitable care team-work (and the accompanying approach) that is multidisciplinary and resilient in structure and capability. Information sharing is crucial in this formation. Other than that, reforming the social worker’s competency profile, in other words, preparing the suitable kind of manpower that will sustain the efficiency of future social work practice, is also
The acquirement of skill and approach necessary to fulfill the totality of needs of individuals that are complex in order to facilitate the development of their capability requires improvement of mechanism involving care organization and its function. ‘Team Approach’ and a high degree of ‘functional-expertise’ are believed to be the needed method in achieving the aim, which is; the building of a resilient team-work in service provisioning. This resilient team-work is characterized by the existence of shared or collective ideology among its members, a sense of shared and equal responsibility, and the sharing of standardized method in provisioning a high quality of service. The formation of team-work necessarily needs information sharing and sustaining a highly resilient and professional team-work needs reflective learning.

Observing the situation in Japan; the acute problem of manpower shortage in the country has impel the embrace of service provisioning that heavily relies on team-work. It is quite uncertain at this stage whether the shortage of manpower is actually due to the small number of available social worker or due to misdistribution of available manpower. However, it is quite certain, as argues by Doi (2004), that this situation (insufficient of manpower to appropriately fulfill
the existing needs) is to some part, is the result from the difference that exist in
the policy style of welfare in Japan if compares to the policy in other countries
such as United States and Northern Europe. While the policy in both countries
demands the ratio of 1:1 in terms of provider-user ratio in care provisioning,
Japan only requires the ratio of 1:3. Even this low ratio of 1:3 is not strictly
maintain due to the influence of several factors such as staff rotation, staff
annual leave, staff switch between shift hours, and so forth. Doi further argues
that, in this kind of situation, the policy to provide an ideal care (a care that
carefully considers values that individual cherishes) is almost impossible to be
actualized. Yet, this impossible situation has to be made possible somehow.

Efficiency, as suggested by Doi (ibid), is the formula to enable the
provisioning of a high quality of services (even) in a lack of manpower situation.
What is meant by efficiency in this context is; that adoption of a need attending
style through a highly standardized method in order to eliminate unnecessary
demand of extra manpower consumption in the process. Yet again, as Doi
realized, this method requires an almost complete ignoring on the necessity to
look at individual’s unique needs, and therefore is completely against the
principle to provide care that considers the values that individual cherishes.
This contradicting situation is especially true in most of the special nursing home environment in all over Japan. To subdivide the unit of care according to specific individuals’ needs (in order to reduce the number of service users in one unit) is one of the methods suggested in effort to cope with both situation of; lack of manpower and the need to provide services that suit individuals. The subdividing of care unit is then followed by the permanent placement of staffs to such unit while at the same time the practice of ‘information sharing’ between all staff in the unit (regardless of their job function) is practically exercised. This method is especially crucial from the point of: staff efficient distribution, nurturing their coping strategies, and providing them with learning enthusiasm. The subdividing of care units according to needs category is hoped to be able to help social worker (in that specific unit) to better realize on what are the more specific issues (of care) that they will have to encounter in performing their daily tasks. Recognizing these issues or challenges that they will need to cope with is hoped to be able to trigger the interest in individual social worker to put an effort to gain more knowledge in order to increase their scope of professionality for fulfilling their specific tasks to specific individuals. And lastly, Doi suggests that there’s a strong need to create a complete occupational
category barrier-free working environment between all members (regardless of their function and designation) in the care unit. In sum, in a dual situation where manpower resources is so limited and there exist a strong need to deliver services that are more humane to diverse individuals, Doi is suggesting for the professionalizing and specializing of social worker’s function through practice-led information gathering and occupational category barrier-free information sharing in a subdivided care units with defined category of needs. It is in this context that the method of team-approach in care provisioning is very relevant to Japan’s situation. For this reason, there’s a strong need for us to probe further into the question of: what is team-work; what is information sharing, and how a proper information sharing could be exercised.

Ogasawara (2005) emphasizes that information sharing plays a vital role in the forming of the above multi-professional team with resilient team-work capacity (that is characterized by the existence of shared and collective ideology among its members, a sense of shared responsibility, and the sharing of standardized method in providing a high quality of services). Information sharing is an essential factor in ensuring the possible success of coordinated collective decision making, and in assisting smooth implementation of task
delegation process between various parties in social services provisioning in order to carry out an efficient practice. Information sharing is also relevant in the context where the focus and concern of contemporary service delivery system has now expanded to include service outcomes to ensure its efficiency\textsuperscript{16}.

The next enabling factor for the creation of resilient and highly professionalized team-work in care provisioning is reflective learning. Gould and Baldwin (2004) emphasize the need for social work to improve their professionality through reflective learning to help practice to move beyond mere routine towards creative and critical problem solving. Although the term of reflective learning as argued by Gould and Baldwin is mainly discussed in term of organizational context (learning organization), I do believe that it has some relativity (may be in a much more simple extent) to the argument of resilient team building in care provisioning. The concept of the learning organization

\textsuperscript{16} However, the lack of capacity of our information systems to meet the challenge of providing accurate and useful data for decision making of this purpose is evident (Austin, 2004). Information that is strategically obtained from the process of various care provisioning must be obtained and beneficially utilized in effort to carefully analyze the result of services and to identify the exact criteria by which all types of suitable care services can be judged and measured. The availability of this information determines the possible planning and implementation of a proper and continuous care.
originated in response to the needs of commercial enterprise under conditions of market turbulence to achieve continuous improvement in productivity and profit. It is the learning organization’s (learning team in my context) engagement with systematic thinking, teamwork and work-based learning that is relevant to social services and social work. At the heart of this idea is the problematic concept of learning; what it means and how it relates to team structure and behavior. There are two fundamental premises that explain the relation of learning process with a team. First, individual learning is a necessary but not sufficient condition for team learning – the latter is a collective process which means that the team has not automatically learned as a result of an individual’s learning. Second, the learning experience is more pervasive and distributed than that delivered through a specific, designated training or educational event; learning incorporates the broad dynamics of adaptation, change and environmental alignment of teams, takes places across multiple levels within the team (and larger organization), and involves the construction and reconstruction of meanings and views within the team. Being the factor that will determine the quality of care to be delivered, nurturing a highly professionalized and resilient social worker team through this concept of
reflective team learning is therefore necessary.

Reforming social workers’ competency is achievable through a combination of process that includes the preparing of a suitable future manpower that will efficiently shoulder the task of care delivery; reconsidering the needs access pattern to ensure its suitability with the current trend of needs; and supporting the career path of social work in order to shape it into a profession that is attracting and at the same time rewarding. As much as an individual needs a social system in order to continuously lead the way of life he values, likewise, the existence of a social system needs the support of all its individual members (especially social workers) as the energy to continuously function up to the desired performance level. Thus, the securing of manpower through professionalizing social work education is necessary. Yet, there remain a question of how this education should be and what it should look like. In the year as early as 1915, it was stated by Abraham Flexner that social work did not meet the essential characteristics of a major profession (Meinert et al., 2000) and his statement was based on the fact that (to some extent still evident until today) activity in social work are so numerous, diverse and unspecific that it would not be feasible to design a program of organized education. The main
factor underlying this statement is the absence of a proper organizing theory in social work practice. For this reason, social work, as argued by some scholars, should be viewed as a form of art (due to its lack in scientific theory) rather than as a profession. For example, the dominant approach to the relationship between knowledge and practice in United Kingdom’s social work, as argue by Lovelock et al. (2004), probably may still be characterized as ‘applied social science plus social work values and skills’. Much of the argument has focused on the role and relevance of research in relation to day-to-day professional practice and the use and appropriateness of different research methodologies and techniques. Until relatively recently, rather less attention has been given to the pervasive deeper assumption that research and / or theory are, could, or should be somehow foundational, to be ‘applied to’, or in, practice – as evident, for example, in some prominent conceptions of ‘evidence-based practice’. Quoting Usher and Bryant (1989), Lovelock et al. further state that this conventional view (relating the three factors of practice, research and theory in social work) has been characterized via the notion of ‘a captive triangle’. However, acknowledging an inescapable three-way interaction between research, theory and practice does not necessitate picturing the links in terms
of a triangle with theory and research situated at its base corners and practice at its apex. Rather, re-conceptualization in terms of ‘an open triangle’ allows alternatives ways of thinking about these elements of social work without any implication of privileging research and / or theory as the basis of practice. Moreover, it provides a means of exploring all three in a more creative and interactive fashion (Lovelock et al., 2004).

The same element is echoed in Japan’s effort to reconstruct the workability of its social work education system. The educating of future social workers, as stated by Tohoku Fukushi University ‘Kansei’ Research Center, must be conducted based on a curriculum that is rearranged and generated through the combination of curriculum oriented-education (theory and research) with practice-oriented education. It is believed that this process will work as an efficient method to rectify the flaw of policy making by the government that is usually based solely on theoretical knowledge. The main task here is to identify the most efficient method in utilizing information and knowledge gathered from

17 At this point, I am still unable to identify any equivalent word in English that can precisely explain the meaning of ‘kansei’ due to my limitation of knowledge. However, I identified that while the nearest words that can explain the meaning of ‘kansei’ from the perspective of an individual (behavior) are sensitivity and / or sensibility, the nearest word that can explain the meaning of ‘kansei’ from the perspective of a (i.e. social) system is reflexivity.
work-place and front-line workers (that is rather in a form of individuals’ sensitivity or art rather than scientific) in constructing this practice-oriented education. Differing from professions such as doctors and nurses that is articulately based on scientific knowledge and theories, the level of competency or professionality of social work profession is evaluated mostly based on level of performance (in providing services) largely depending on unrecorded or un-articulated tacit knowledge that individual social worker possesses. The neglect towards the significant impact of this tacit knowledge (that is essentially different according to respective individual social worker) in determining the outcome of produced services is leading to the incapability of the management to effectively coordinate the staffs overall aims and possessed competency. Other that that, this situation also hinders the formation of a proper educating framework for social workers, while on the other hand, encouraging the creation of education framework that is in a way paternalistic (one-sided) and merely based on theoretical assumption (neglecting the invaluable tacit knowledge generated from day-to-day practice that is discovered by front-line workers).

The possible discovery of innovative solution in social work depends on
how far the professionality of social workers manages to understand and appreciate their diverse clients’ everyday patterns of meaning and how sensitive they are in considering this fact in their effort to plot the suitable services to the clients. The competently functioning professionals will be able to perform situation-close social work better if they are not confronted with organizational (bureaucratic) constraint (Otto and Flösser, 1992). Other than that, needs accessing pattern in social work must flexibly and continuously reflect the contemporary needs of society. The insensitivity towards the changing structure of needs, or even the community itself, possesses some possibility to create a bias and monoculturally oriented social work practice with wrong assumption of needing to serve the need of only a racially homogeneous and static community that faces a ‘common risk’. In addition to that, there is a strong possible tendency that the concentration forwarded in trying to deal with the so-said ‘common risk’ will create a situation where certain method of practice will be favored upon the others. For example, the Japanese government excessively concentrated effort in trying to solve (mainly) the population aging problem has contributed towards the development of social work practice with priority mainly directed to the provisioning of clinical services,
that to some extent neglect the possible application of empowerment and
generic approach in its practice. In order to fulfill the reflexive characteristic of
the desired social system, social workers are required to possess the
knowledge to cater various categories of needs that emerge at different levels
of society and emanate from diverse individuals in the complexly structured
community. Diversity and generic perspectives are the core concepts that must
be acknowledged in social work's day-to-day practice. Over the last decade the
concept of diversity has included multicultural dimensions, in addition to
concerns related to such particular client groups as: American ethnicities
(ethnic of colors); lesbian, gay, bisexual, and transgender (LGBT); persons with
disabilities; age group; and gender groups (Dorfman et al., 2004). In short,
diversity in this context refers to ethnic heritage, cultural background, group
affiliation, identity (sexual and other non-ethnic identities), and status (biosocial
and socioeconomic status, including the state of disability and social status).
Given the increasing diversity of ethnic groups as well as differences in gender,
religion, identity, status, and affiliation groups, our focuses on diversity in social
work practice requires inclusive and multidimensional paradigms. What must
be understood is that, diversity is not a static entity. One’s cultural identity may
not be clearly defined in terms of race, gender, sexual orientation, or any one variable. It is more likely the intersection and overlapping of multiple variables that form the overall identity of individuals, thus making the use of paradigms that do not assume or impose identity from the outside important in honoring diversity. Competence in working with and on behalf of diverse populations requires more than just the adaptation of existing frameworks of practice. The generic importance of a ‘multicultural’ perspective as the first step in developing competence as a service provider is mirrored in the reality of how similarities and differences can be identified in how a single matter is viewed and managed across cultures. In this context, the skill of ‘culture brokering’ (a process of facilitating and mediating between the culture of the consumer and the host-culture of the provider) is of crucial importance (Stone, 2005).

Effective intervention of social work necessitates consideration that is not merely focused on affected individuals, but also the environmental factors surrounding the individuals. Generic perspective of intervention is thus necessary and social worker who adopts this perspective (also known as ecological perspective) is expected to develop multifaceted approach which allows practice to occur on a micro level (individual family) or a macro level.
Reminiscent of the early settlement approach (client-oriented), but reinforced by theories such as human ecology, general systems, and exchange, the ecologically trained social worker is expected to focus on total problem configurations, including the identification of stressors and the mobilization of interventions that serve to remedy person: environment problems. The growth-oriented, developmental approach specifically encourages social workers to assess presenting situations from a transactional perspective which mandates the necessity for working to achieve change at both the individual and community levels. This approach is primarily directed to clinical practitioners, encouraging them to expand their roles, functions, and skills due to the absence of generic approach from this end. Further, this approach also emphasize on moving towards problem, population, or institution specializations. This radical departure from social work’s traditional reliance on methods specialization assumes the professionals will develop knowledge and skills that will facilitate their ability to work with individuals, groups, organizations, or communities in relation to problems (such as delinquency) or populations (such as the aging). Such integrated methods approach requires a
reconceptualization of practice roles and functions, restructuring of the majority of social agencies, and the synthesis of micro and macro practice.

The attractiveness of social work as a rewarding profession is the key to secure the manpower that will support the community and drive the future social system. As such, there should be a proper system that support and justified the effort of social workers in upgrading their knowledge and skills (in order to perform their task in par to the expectation that arise from the intention to deliver a continuous care that understands individual's totality). Salary scale and reward system for social workers must fairly reflect the difference of skill level and professionalism they perform in carrying the tasks. For this proper system to be in place, a second thinking towards the current rewarding system that places the unit of ‘hour of services performed’ as a base of rewarding calculation for social workers (i.e. salary) must first of all be considered. The current reward system fails to acknowledge individuals' skills and work experiences, thus encourages the decline of work attitudes among social workers. An appropriate standard for skill indicator and its evaluation method that is generally applicable to all welfare fields must be created in order to ensure fair evaluation of social worker’s individual skill, knowledge and
competency, so that reward system will be able to reflect a fair rewarding. The next point that must be considered is the preparing of a proper recruitment and competency development guideline that is also must be generally applicable cross-cutting the various fields of social work. The guideline needs to be able to facilitate the formation of social workers’ individual career and to assist them to visualize their career prospect so that they will be able to set a proper aim for its development. The setting of the aim could be expected to motivate individual social worker to strive hard in order to achieve this personally set aim, thus encouraging for a further space of non-paternalistic and independent learning (Ogasawara, 2001). Other than ensuring that the real needs are fulfilled and service users are enjoying a highly satisfying quality of services at all time, social work profession must be able to become an attractive and a rewarding career that can encourage the formation of individuals’ competency along their career life line in order for its professionalism to continue developing (Ogasawara, 2002).

3.3.2.2 Improving Informal Care

In books for parents about child-rearing, it is repeatedly pointed out that a
necessary condition for activities associated with child-rearing is an affective relationship, in which trust between caregiver and child can develop. The caregiver must succeed in winning the trust and affection of the child through interaction preceding intentional child-rearing activities. Raising a child to become an individual that is filled with positive instinct, resilient and equipped with self-determination necessarily requires a child-rearing (care) process that understands the significance of ‘continuity’ perspective in its implementation and such process starts from care at home. In this context, understanding the significant of the concept of attachment and social bond to the formation of individuals’ personality and their quality for later social participation is crucial.

Mother-infant attachment is part of an instinctual-emotional system of central importance to all primates. Lacking the security of the mother-infant bond, as well as the stimulation of human contact, the infant’s curiosity and exploration were curtailed. Perhaps the most worrying is the later adverse effect that may arise from the restriction of emotional expression (Breger, 1974). Attachment is the term for a relatively durable affective relationship between a child and one or more specific persons with whom it interacts regularly (Tavecchio and IJzendoorn, 1987). Attachment researches involve
observations of how a very young child behaves towards his mother, both in her presence and especially in her absence (Bowlby, 1982). Using as primary data observations of how very young children behave in defined situations, an attempt is made to describe certain early phases of personality functioning and, from them, to extrapolate forwards. In particular, the aim is to describe certain pattern of response that occur regularly in early childhood and, thence, to trace out how similar patterns of response are to be discerned in the functioning of later personality. The change in perspective is radical. An event and experience deemed to be potentially pathogenic to the developing personality.

From researches, it is observable that children attached to a caregiver will try to remain in his or her direct vicinity, in particular at moments of sadness, fatigue, tension, and fear. In more or less unfamiliar surroundings the attachment figure is the secure base from which the examination is explored, and only this person provides a sufficient feeling of security for the child to play freely. Especially under circumstances of stress, the child will resist separation from this person. It is clear that it must have felt a particularly strong tie to the care giver and that breaking the tie has considerable consequences for its feelings of security and (self-) confidence. Factors that lead to different types of
attachment relationships and the short- and long-term consequences those relationships have for a child’s social-emotional and cognitive development are the crucial points that must be probed into (Tavecchio and IJzendoorn, 1987).

Understanding of the response of a child to separation or loss of his mother-figure turns on an understanding of the bond that ties him to that figure, and later to the larger social group (the social bond). In psychoanalytic writings discussion of this theme has been conducted in terms of object relations. For long, psychoanalysts have been at one in recognizing a child’s first human relationship as the foundation stone of his personality; but there is as yet no agreement on the nature and origin of that relationship (Bowlby, 1982). There is good evidence that in a family setting most infants of about three months are already responding differently to mother as compared with other people. Yet we can hardly say that there is attachment behavior until there is evidence that the infant not only recognizes his mother but tends also to behave in a way that maintains his proximity to her. Proximity-maintaining behavior is seen at its most obvious when mother leaves the room and the infant cries, or cries and also attempt to follow her. Further, although there is abundant evidence to show that the kind of care an infant receives from his mother plays a major part
in determining the way in which his attachment behavior develops, the extent to
which an infant himself initiates interaction and influences the form it takes
must never be forgotten. This behavior explains the learned part of instinct in
the infant.

An increase in an infant's perceptual range and in his ability to understand
events in the world around him leads to changes in the circumstances that elicit
attachment behavior. One change is that a child becomes increasingly aware
of an impending departure. He becomes able, by noting the mother's behavior,
to anticipate her imminent departure, and starts to protest before she goes. By
most children attachment behavior is exhibited strongly and regularly until
almost the end of the third year. Then a change occurs. They are usually much
better able to accept mother's temporary absence and to engage in play with
other children. A main change is that most children become increasingly able in
a strange place to feel secure with subordinate attachment-figures, for example,
a relative or a school teacher (even so, such feeling of security is conditional).

The increase in confidence that comes with age is well illustrated. There is
an increase in the power that a child exerts, and exerts successfully, to attain
his own ends. During adolescence a child's attachment to his parents again
changes to the next level. Other adults may come to assume an importance equal to or greater than that of the parents, and sexual attraction to age-mates begins to extend the picture. As a result individual variation, already great, becomes even greater. At one extreme are adolescents who cut themselves off from parents; at the other are those who remain intensely attached and are unable or unwilling to direct their attachment behavior to others; between the extremes lie the great majority of adolescents whose attachment to parents persists but whose ties to others are of much importance also. For most individuals the bond to parents continues into adult life and affects behavior in countless ways. Finally, in old age, when attachment behavior can no longer be directed towards members of an older generation, or even the same generation, it may come instead to be directed towards members of a younger one. During adolescence and adult life, a measure of attachment behavior is commonly directed not only towards persons outside the family but also towards groups and institutions other than family. A school or college, a work group, a religious group or a political group can come to constitute for many people a subordinate attachment-figure, and for some people a principal attachment-figure.

In sum, attachment is the product of a primal human instinctual need for
physical contact with another. This is a fairly obvious need and a need that develops is shaped into what can be termed as ‘social bond’ (through attachment behaviors that are directed towards a larger circle of society). This bond is the mature response of the neonate’s need for physical contact. It influences behavior throughout life. Therefore, it is considered a force that has an effect on both individual and group behavior. First, it is shaped by the mother-child bonding process and by interactions with the environment. Second, it is shaped by the family, friends, and community, and by increased interactions with the environment. Finally, to some degree, behaviors are consciously or unconsciously selected that result in either strengthening or weakening one’s attachment with subgroups in his or her primary environment (Cherry, 1994).

The significance effect of attachment process to the shaping of individuals’ behavior is clearly illustrated in Bowlby’s report about the case of ‘neglected’ children in postwar Western Europe. In this report, he concluded that ‘maternal love’ was as important for the mental development of children as were proteins and vitamins for their physical development (Bowlby, 1951; cited by Tavecchio and IJzendoorn, 1987). Being deprived or separated from the
mother was usually as damaging for the child’s mental health as were contagious diseases for ‘physical’ health. The absence of a durable attachment relationship in the first year of life would have irreversible consequence for what is called ‘mental health’ or ‘adaptability’. It would result in an unfortunate form of maladjustment to its surroundings and a lack of confidence in itself and its fellow human beings in times of need. In the field of psychology, the work of Bowlby and his colleagues (1969; cited by Cherry 1994) related to attachment and separation in infants as the basis for the human phenomenon called the mother-child bond. This maternal bond is now understood to shape infant behavior and to be important in child development. The far-reaching conclusions concerning the short- and long-term effects of ‘maternal love’ and ‘maternal deprivation’ is elaborated in Bowlby’s two research projects that concerned with clinical studies about the background of juvenile delinquency\(^\text{18}\) (Bowlby, 1940; 1944; cited by, Tavecchio and IJzendoorn, 1987). In reconstructing their life histories, Bowlby noticed that many of them had quite a bit of experience with separation in the first three years of their lives. It was in

\(^{18}\) In this framework, he gave a profile of ‘petty thieves’ on repeated offense, concentrating upon their seeming lack of emotions. As these children were insensible to guilt feelings or sympathy for their victims, their capacity for theft and other criminal was nearly boundless.
this very stage of life that these children appeared to have spent their time in poorly equipped institutions or to have been sent from one caregiver to another like parcels. The absence of a continuous attachment relationship appeared to have led to a hardening of these youths’ emotional lives, and to have facilitated the step to delinquency. Bowlby generalized this effect of ‘unfeeling’ character development to all educational situations (in life process) in which the child is unable to develop confidence in the availability and accessibility of a caregiver, that is, to develop attachment relationship of durable nature.

That attachment behavior in adult life is a straightforward continuation of attachment behavior in childhood is shown by the circumstances that lead an adult’s attachment behavior to become more readily elicited. For example, the function of mother or mothering figure as a secure base (that used to characterized a child attachment process) is strongly recalled or reflected in situation where sickness or calamity strike such individual. In this situation adults often become demanding of others; in condition of sudden danger or disaster a person will almost certainly seek proximity to another known and trusted person. Kahn (2005) explains how the same principle (the primacy of relationship based on attachment) applies to effective providing and receiving
of care in general. The understanding of this fact is especially crucial in institutional care setting because the process of caring for others is, at its heart, not simply a technical matter. It involves countless of emotional, psychological and technical actions at the same time. The essential technology by which such task should be performed is that of the relationships between caregivers and those who need their help.

People best grow, heal, and learn in the context of meaningful relationships. Such relationships are a primary determinant of how well needs for support, knowledge, healing and growth are met. It is at the point of contact between caregivers and care seekers that the latter experience themselves as meaningfully taken in (or not) and cared for (or not). The emphasis here on such relationships is based on the premise that growth, healing, and learning often involves risk and vulnerability for people. For many of them to move ahead on the face of their anxieties requires, often enough, a safe-enough relationship with others they experience as caring. Without a sense of safety, it is difficult for people to move toward engaging their own growth and development. Such active engagement is crucial. The possibilities of careseekers to venture forth to engage their journeys toward health, growth,
and learning depends on relationships with caregivers who offer careseekers a sense of security, a place to which they can return should they become momentarily overwhelmed. This pattern is rooted in the earliest process of people moving toward their own growth and development: the childhood. Mary Ainsworth developed the idea, based on attachment theory (Bowlby, 1980; cited by Kahn, 2005), of a secure base to explain how children were able to move away from their caregivers, usually mothers (Ainsworth, 1967; cited by Kahn, 2005). Children who receive effective caregiving engage in exploratory behaviors, consisting of movements away from attachment figures in order to investigate surroundings, gain knowledge and skills, and cope with or control the environment (Ainsworth, 1990; cited by Kahn, 2005). Secure base relations enable children to engage in unworried explorations, trusting their parents / attachment figures to come to their aid should difficulties arise (Ainsworth, 1967; cited by Kahn, 2005). Attachment figures create secure base relations when they act as effective caregivers, consistently performing behaviors that lead their children to feel secure and able to explore.

While secure base concept was developed in relation to children and their attachment figures, as stated earlier, it applies to adult relations as well
(Ainsworth, 1990; Weiss, 1982; cited by Kahn, 2005). The search for a secure base occurs throughout the life cycle, especially in emergencies. Adults as well as children seek out familiar individuals willing and able to offer aid in emergencies (Bowlby, 1988; cited by Kahn, 2005). Such points are only possible, of course, to the extent that caregivers have created trusting relationships through repeated acts of caregiving. In doing so, they create themselves as secure bases, to which others may momentarily repair what they find themselves startled, temporarily overwhelmed by anxiety. Acts for caregiving appear differently in different institutions. Any such act offers the ground for caregiving interactions. What is crucial is the underlying, essential gesture of caring: an attention to the person in ways that leave them feeling valued.

People are more likely to fully receive care when they feel securely held by others. The notion of holding is central to effective caregiving relationships. Winnicott (1965; cited by Kahn, 2005) developed the concept of the holding environment to describe the nature of effective caregiving relationships between mothers and infants. ‘Good-enough mothering’ involves physically holding infants, whose subsequent experiences of feeling safely encompassed,
enable the initiation and movement of developmental processes. When mother (or other primary caregivers) creates reliably safe boundaries that protect infants from potentially disruptive stimuli, they enable their children to experience themselves as valued and secure (Winnicott, 1960; cited by Kahn, 2005). They experience a protective space in which to safely examine and interact with what their world present, particularly when they are startled and temporarily need a source base to which to retreat (Bowlby, 1980; cited by Kahn, 2005).

The reliable meeting of infants’ physical needs – and later, of children’s psychological needs – provides a way to develop and strengthen their egos and enable them to gradually learn to meet, ‘the difficulties of life’. Individual development is thus a gradual strengthening of one’s capacity to handle environmental impingements. The child’s ability to strengthen his ego is founded upon the original experience of being securely held (Kohut, 1977; Winnicott, 1965; cited by Kahn, 2005). The original holding environment is the mother’s arms and all that enables those arms to be a safe: father’s provision of an indestructible home and his enjoyment of the mother-child relationship, the lack of disruption from others, the physical space that presents

The holding environment concept has been broadened to describe other settings, just as the secure base concept has been broadened to describe adult relations. The premise is the same: individuals, across their lives, will at times require places in which they can safely experience and work through difficulties. In caregiving organizations, holding environments allow careseekers to experience reliable care giving.

The next is about social bond. In one of its functions the bodily process points beyond its own individual self-maintenance. Growth leads to reproduction; a separation from the living body of portions which become other living individual bodies. It is in this function (and the activities thereto) that there is a certain primary breaking down of the isolation of the individual life; it feels itself bound to, and interested in, other life. There emerge an awareness of the individual self as forming part of a larger unity, and a need to live and act for the interests of that larger whole (Allen, 1999). This is what is termed as gregarious instinct; the origin of individuals’ group behaviors and the formation of their social bond. The instinctual characteristics found in the individual’s behavior result in group behaviors and species behaviors that are almost always
beneficial to the survival of the group and the species. There is a noted structure in terms of hierarchy of survival. First, instinct influences behaviors in such a way as to promote individual survival. Then the individual instincts influence behavior in such a way as to promote the survival of a primary group. Finally, instincts influence behavior in such a way as to promote the survival of the species. It is this hierarchy perspective that helps to explain the existence of altruistic instinct or altruism to the others in individuals. It is also a law of nature that for an organism to exist over a long period of time, it must be able to respond to changes that originate within and outside of its domain. Changes in the environment that include changes in individual, family, and social bonds create tensions because they disrupt the homeostasis that all organisms tend to seek. Homeostasis is one of the natural laws that humans and many other organisms depend on for survival and development. The bonds that the individual can develop tend to be important in adapting to the changes. Humans, similar to all animals, tend to thrive when both their natural and social environments are disrupted and in imbalance situation. For the purpose of adaptation to such changes, social life is necessary for the human species; it is an important as food, water, air, and warmth (Cherry, 1994).
The other reason why social bond exists is explainable through the fact that the need to fulfill such instinct innately exists in every individual. Although it is generally agreed that the importance of resources (in terms of material or help or support) are the basis for survival, this is not the only reason (to gain access to more help and support) individuals seek out and establish natural support system. We reach out and establish bonds that develop into our natural support network because we also must meet our instinctual need to bond and maintain bonds with others. Further reason is explainable from the perspective of humans' biological nature. Social bond is necessary to human due to the fact that our younger generations take a relatively long time to reach maturity and functional independency. For such reason, primates exist to be social animals; from birth to death their lives are intimately bound up with the other members of their group for dependence of survival (and instinct fulfillment). The specific shape of perceptions and actions that are required for participation in the group has to be acquired through a long process of social experience. The social-instinctual area is thus central in this context. Group existence is a major adaptive mechanism in primates, and bonds to the group are promoted in several ways. The first social relationship is that attachment between the infant
and its mother (Breger, 1974), and this relation will eventually involve other family members in its later stage to form family bond. In addition to the physical needs, there are psychological needs that family members should mutually nurture, if the family bonds are to be maintained and strengthened. Psychologically, the family bond meets many of the individual’s needs, especially after the individual has established strong bonds with a mother figure. Individuals with very strong individual and family bonds feel much more secure and are more able to be contributing members to both units.

In the next stage of its development that is accompanied by increasing social experience, social bond moves beyond that particular relationship of family bond and establishes a bigger role and wider connection with other group members that are outside the circle of family unit. Such development will lead to the formation of social networking. Social networks have been consistently shown to affect both individuals and families, particularly those individuals and families considered at risk. Among social work practitioners, it is widely accepted that social supports and natural networks\(^\text{19}\) can make the

\(^{19}\) Natural support systems typically include relatives, friends, neighbors, and fellow workers. Other types of ecological support structures are churches, reference groups, recreational organizations, and political activity groups, to mention a few (Breger, 1974).
difference between at-risk families that survive and those that do not. To survive, individuals, families, and groups need to have the ability to mobilize natural and formal support networks. As well, they must develop new ones. With these support networks, individuals, families, and groups will have access to survival resources. These are the economic and social resources that must be present in an environment suitable for humans.

To define our bonding instinct; bonding is a class of specific biological activities that are related to the socialization instinct. Many activities may be related to the socialization instinct; however, bonding is a specific activity that affects social behaviors. And, as explained earlier, social bond theory is a logical elaboration of Bowlby’s concept of the attachment instinct in the newborn. Social bond is an expression of a human instinct that first appears as attachment to the mothering figure and continues to develop in concert with social experiences in the family, with friends, at school, at work, and in the community at large. Social bonds are the enduring ties that ‘unite members of a

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20 A list of the problems precipitated by an inadequate support system would include: 1) a weak sense of belonging; 2) fewer opportunities to develop significant group affiliations and social relationships; 3) little emotional support in times of stress; 4) no respite or help with heavy responsibilities; 5) no direction and counsel related to troubling situations; and 6) little or no concrete assistance (Cherry, 1994).
species in couples, in groups, and in complex social organizations (Lorenz, 1967: cited by Cherry 1994). The concept of a bonding instinct is predicted on the certainty that humans are not born with fully developed behaviors like many other animals. Even the gregarious nature of the human is based on the development of an instinctual preference. The instinct or potential to develop a behavior is inherited; however, the actual behavior is not inherited. Furthermore, within a given range, these behaviors differ from individual to individual, but are characteristic of the stereotypical behavior of group members in general. Behaviors differ in both their form and function because of the environment in which they develop.

The influence of social bonds can be shown to have support in the field of sociology. Research findings suggest that social uncertainties can create confusion, anxiety, and self-destructive behavior within the individual. The fear of weakened or broken bonds creates a sense of confusion and anxiety. For such reason, the reason why men support the state is partly understandable through the fact that they wish to avoid dishonor and loss of bonding relation (Hakim, 1992; cited by Cherry, 1994). In this context, if the community standards are so happened to be different from accepted codes of society at
large, behavior will follow the norms of the community rather than the standards of the larger society. Deviant behavior occurs when an individual's bond to society weakens or is broken. Consequently, this broken bond is what frees the individual to violate the norms of society.

3.4 The Significance of Instinct and Social Bond to Integrated Care Practice

While some believed that an adequate control of social progress and of social and individual welfare lies mainly through the analysis and organization of the environment, the others would argue that the understanding and control of heredity (the utilization of social controls to regulate natural and instinctual inclinations) would be more promising (Bernard, 1979). Such approach is believed to possess more tendency to improve human environmental strategy. It is advocated that social control is capable of making the instinct more effective and this will improve the chances of survival for both the individual and group genes. Nevertheless, there has also been some theorizing with regard to the possibilities of the combination (between the two) and utilization of instinct tendencies in action and Freudians have had much to say about the adverse
effect of repressing instincts, and something about the possibilities of the
sublimation of instinctive trends. All of these discussions might be expected
ultimately to bear some fruit in the organization of social controls and social
ethical standards, provided we could determine the true nature of the instincts.

The more positive and fruitful method of utilizing the instincts for purposes
of rational and progressive social control might, perhaps, appear to many to lie
in the direction of a rational and purposive breeding of instinctive tendencies.
This, however, must necessarily be a very slow process and must be carefully
planned continuously through the whole stretch of such process. One main
thing that must be noted is, to a large extent instinct improvement is not
self-directive and self-executing, but rather influenced by environmental and
learning factors. And, the environmental method of social improvement and
control operates much more rapidly. If it be found that the environment,
especially the psycho-social environment, is the chief source from which new
and valuable traits to be used in social improvement and social progress must
come, then, the method of social advance and social control in the future
should be determined by a close analytical study of the environment, and by
the application of the principles discovered to the control of the social situation.
However, this is not the case. Approach should cover the psychic transformations within the individual which are essential to the readjustment of social and environmental institutional progress (for the institutions are the abstractions of the organized functioning of individuals).

Understanding and acknowledgement towards the importance of the concept of instinct and social bond in our life can be significant in many ways. From this argument so far, such importance is manifested through the capability of both (or one of the) concepts to assist in: first, putting in sequence and connecting between our split understanding towards the concept of physical well-being and psychological well-being that has long been placed in a contradicting position; second, acting as an inner motivation that continuously generates the consciousness of self which will eventually lead to the striving (in efforts) of individuals to attain autonomous self-betterment; third, reconciling between the principle of impartiality (exercised based on collective effort) and individuality (exercised based on individual effort) in social work intervention; fourth, providing a complementary view of argument against the mainstream framework of intervention that merely focus on extrinsic environmental factors for promotion of self-betterment; and fifth, maintaining social cohesion for the
possible formation of solidarity and practice of fair reciprocity that should founded the practice of integrated care. Now, lets look at all the above in sequence; starting with the integration of understanding between the concept of physical and psychological well-being.

3.4.1 Integration of understanding between physical and psychological well-being

The fundamental of instinctive equipment of human starts with the self-maintaining bodily process, of which the chief part is the function of nutrition. The food seeking acts became an essential part of the vital activity. Such process has to be maintained in the face of impediments of various kinds and in the face of changed external circumstances. The development of the intellectual faculties, even in its earliest stage, to a large extent depends, and is based on the possible maintenance of this self-maintaining bodily process. The development of the cognitive powers, the necessary part of all mental life, must have been in its earliest stages of development, departed due to the advantages which intellectual power gave in the struggle to maintain the bodily process. It is in this context where the indivisible linkage between physical and
psychological well-being is observable. The development of one part sustains the development of the other (in a mutually reinforcing way).

At a certain stage of evolution, as the result of selection in the struggle of existence, there appears an animal (and definitely so in the case of human) with the intellectual capacity to plan ahead for its future and to remember its own past in order to guide these plans. As soon as this stage has been reached, it becomes possible for there to emerge from the automatically self-maintaining vital process a will for the preservation of the individual self. This will for the preservation of individual self tends to pass into a will to self-assertion and self-maximization (power). Power becomes a separate object of pursuit. The satisfaction of the will to power then also enters as an element into the satisfaction of a number of other instincts, originally subsidiary to self-preservation and adds to them an additional value.

The linkage of developmental process that departs from the preservation of one’s individual self (physical well-being) to self-assertion or self-maximization or the higher extent, self-respect (psychological well-being) is observable in the following example. For living animal in general, to be supplied with food but without effort of their own means, would result to a great
deterioration in the nature rule of life; and this would be applicable to the great majority of mankind. For such reason, among the races highest in intellectual development there are a number of persons who can, when no longer under the necessity of earning their own living, find occupation and enjoyment in some form of activities (other than food seeking). But, even most of these activities take the form of an imitation of earlier forms of food seeking, for example, in the shape of hunting and other kinds of sport. For those successfully earning their own living, a great part of the pleasure felt is contributed by satisfaction of the impulses of self-assertion (rather than merely self-maintaining bodily process). The man who feels that he is filling a place in society as an equal among equals and contributing his share to the maintenance of the whole, derives therefrom a glow of pride and self-respect (while the failure suffer proportionately from a sense of inferiority in relation to others). He who is successfully maintaining life by his own activity, who feels himself adequate to the demand of self-preservation, looks forward to the future with hope and confidence. Conversely, when the level of vital activity is depressed, the looking forward tends to be anxiety and dread (Allen, 1999).
3.4.2 Facilitating the conscious of self

Many writers insist upon the existence of an element of consciousness in the instinct (Bernard, 1979). They argue that the human adult seldom behaves in a purely instinctive manner and their activities are largely modified and controlled by individual perceptions and experiences (Warren; cited by Bernard, 1979).

What is known from various studies is the fact that instincts are modified (or modifiable) into habits through the pressures of the environment. Perhaps the most frequently quoted definition of instinct from the conscious content standpoint is that of McDougall (Bernard, 1979). He says, 'We may, then, define an instinct as an inherited or innate psycho-physical disposition which determines its possessor to perceive, and to pay attention to, objects of a certain class, to experience an emotional excitement of a particular quality, upon perceiving such an object, and to act in regard to it in a particular manner, or, at least, to experience an impulse to such action'. Consciousness in such a case is the sign of the transformation which takes place in the instinct upon its first attempt to operate, and therefrom we are dealing not with an instinct (an inherited action pattern or mechanism), but with a conscious habit, the essential adaptive elements of which have been made over under the pressure
of the immediate environment.

As stated above, the existence of an instinct of self-assertion has often been considered the most important of the human instincts. Above that, it is difficult to discuss the nature of self-assertion without at least touching on the question of the consciousness (with which it must be closely connected). Self-consciousness could arise through the mere fact of adaptation to the external forces. If we can assume a gradual increase of intellectual power, there would go with it (the adaptation) the capacity to hold a given object (aim) before the mind and to pursue its attainment during a period of time by varied means and against various obstacles. Self-consciousness in its more complete form appears to arise as the result of relations to other living beings. Relations of cooperation may be supposed to play some part. In any form of cooperative work, there must be some awareness on the part of the agent of himself in relation to outside agents other than and yet similar to himself. It is however from relations of opposition that self consciousness arises in that clearer and more definite form which leads to the sense of power (however, failing to control such sense of power will facilitate the development of adverse segregative instinct in individual).
The initial consciousness of some weakness or deficiency (in individuals) gives the starting point for the development of all self-assertive tendencies. In some way, initially, this weakness or deficiency may work to lower one’s self-esteem. But, it is just out of this lowered self-esteem that there arises the struggle for self-assertion which assumes forms much more intense than one would expect. It must be obvious that, for an inferiority to be felt as humiliating and unpleasant there must have pre-existed some impulse towards self-assertion, even if only in a latent or subconscious form. In the struggle to escape the lowered self-feeling due to consciousness of inferiority or failure, a greater effort is called out. This effort, once elicited, will tend to continue beyond the point at which an initial failure is repaired and equality with others is felt to be restored. It will be carried out over into an aggressive effort towards others, an effort towards ‘maximization of the ego-consciousness’.

Self-maximization is a will for all-around self-culture, a will for the development of all the various human capacities in a harmonious personality. If this exists as a conscious human motive, it is only at the highest intellectual levels, even of human beings, nor could it exist, unless the other instinctive impulses were already present, each with its driving force. Human instinct is the departure
point from where the consciousness of self to attain self-betterment (expressed as self-maximization above) originates from.

3.4.3 Reconciliation of impartiality and individuality

As discussed earlier in Chapter 2; while efforts to assist individuals from the perspective of ‘others’ (than the individual) are driven by the characteristics of empathy and responsibility, it is understood that individuals’ efforts to achieve self-betterment departs from their natural instincts (that will later develop into consciousness of self). These two driving force (empathy and instincts) and their interaction in forming the proper social bond are the unifying factor between individually organized and collectively organized efforts (that must be based on the principle of impartiality). If we are to stand on the service providing side point of view, reconciling or synchronizing individually initiated efforts to the impartially arranged networking or integrated method of intervention must be done through acknowledging the importance of such (individuals’) instinct. In other words, a comprehension towards the conceptual of instinct is crucial in our attempt to ensure if there exist a match or fit between the externally provided opportunities to attain self-betterment and the
(self-regulating) internal instinct or perception of individuals to whom such opportunities are forwarded to. Unless such relationship is properly linked, there won’t be any true integration.

3.4.4 Complementing the arguments on well-being attainment

To enable individuals’ self-determination is one of the most argued perspectives in social work practice. However, not many have argued about where such determination should depart from and what are the factors that can assist and sustain the exercise of such determination. Gibelman (1998) defines social work as: ‘the professional activity of helping individuals, groups, or communities who do not command the means to human and social subsistence by enhancing or restoring their capacity for social functioning and creating social conditions favorable to this goal through applied science so that they would attain the effective level of psychosocial functioning and highest possible degree of independence to effect societal changes that will enhance the well-being of all’. In this context it is understandable that, generally, the definition of social work include the dual aims of helping individuals fit better into their environments, typically known as micro practice, and changing the
environment so that it works better for individuals, referred to as macro practice. The primary mission of social work is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (Segal et al., 2004). The definition does not indicate where the stated independent should originates from and what are the basis that allows / explain the existence of such independency. Therefore it is necessary to supplement by arguing in further detail about: in which part of the individual that we should understand or focus for such independency to take place and what are the conditions that will permit the occurrence of a true independency in every respective individual. The adoption and comprehension towards the concept of instinct is definitely crucial in this context.

Empowerment can be defined as a process whereby the social worker engages in a set of activities with the client, that aim to reduce the powerlessness that has been created by negative valuations based on membership in a stigmatized group. It involves identification of the power blocks that contribute to the problem as well as the development and implementation of specific strategies aimed at either the reduction of the effects
from indirect power blocks or the reduction of the operations of direct power blocks (Lee, 2001). From this definition of empowerment, it is understood that the main aim of such process is to promote the affected individuals’ inner potentiality in dealing with the faced oppression. The main focused of argument in this approach is the identification of such external power blocks or oppressions and the methods necessary to eliminate them (through a network of resources existing in the social system). The understanding from the perspective of welfare instinct is trying to supplement the empowerment principle by directing its focus to how the inner capability of individuals should be enhanced in order to increase their potentiality and creativity to deal with the oppressions. The argument is seeking to ensure whether the environment is correct or suitable to enable the process of inner capability enhancing (through purposive breeding of instinctive tendencies) rather than merely focusing on trying to utilize the existing network of resources.

3.4.5 Maintenance of social cohesion

People live in families and cooperate in large groups. Yet it is observable that while one social order may have a religious orientation, another may be
dictatorial, and another may use an egalitarian arrangement of some type.

Regardless of the method, these are the cumulative forms that result from the socialization instinct, culture, and the environment. Instincts shape culture, and in turn culture contributes to the evolutionary process that has resulted in shaping instincts. This includes the hierarchical strategy and the part it plays in bonding our social organizations. It is this bonding that has work to sustain the stability of our society (Cherry 1994). The question about how do the dynamics of social bonds play out in what we see as a social problem moves instinct theory from the realm of speculation and pure research, to that of an applications perspective. The rising problem of child abuse and growing level of violence between adolescent exemplifies the urge for us to understand the significance of both concepts and their impact to our social setting.

The proposition that attachment behaviors are vital for the survival of an infant is essential to social bond theory. A lack of infantile attachment would foretell the death of the neonate. If bonding theory proposes that it is necessary for infants to form an individual bond with the mother and later with the others, then it would predict that a child with insufficient bonds (bonds not within a normal range) would grow up less able to function at an interpersonal level.
The deprived child would also be less able to function among others who had experienced adequate bonding with others. If we were to ask a question about: what is the effect on the infant when the infant is adequately fed and kept dry and warm but deprived of reactions that comfort it emotionally (attachment and bonding), or when the reactions occur less frequently than would be expected in a normal situation? It is predictable that the deprived infant would develop angry, demanding, and cold relationship with others\(^2\).

In other words, it is predicted that human infants who are deprived of bonding opportunities would grow up to be dysfunctional adults. Additionally, if they became parents without psychosocial therapeutic intervention, they would be likely to raise dysfunctional children. Research has repeatedly shown that parents who abuse or neglect their children often have many unmet physical, economic, and emotional needs. They also tend to lack adequate support systems. Significant amount of variance in child care can be attributed solely to

\(^2\) From earlier researchers; we know that separation anxiety (a deprivation of an emotional bond with another) is the type of disruptive experience that has been shown to be extremely damaging. The importance of connection and interaction with others, particularly a mothering person, lies in its importance to assists child to develop his or her independence and ability to explore. It is also clear that the mothering person becomes the secure base and place for retreat when threats are encountered by the infant (Cherry, 1994).
weak and inadequate individual, family, and social bonds. Such way of caring would bring up children who are suspicious of others and (as a result of weakened social bonds) would act more violently toward associates and others. Furthermore, if the child's environment was not proper and healthy (as what is found in the ghetto environment), and if the child's attachment and bonding efforts failed, then social environment would not be able to compensate for the loss of individual and small group bonds. Observation is suggesting that the extremely high level of violence among young teens in the mid-1990s would be explainable utilizing the social bond theory (deprived of bonding opportunities).

It has been observed that early attachment deprivation can prevent human children from developing and functioning emotionally and socially as adults. In both cases, social networking has been shown to be an effective way of reducing the severity and frequency of situations. Recruiting and utilizing natural helping networks (relatives, community support groups, and social institutions) are as essential for reducing child abuse and adolescence violence as parenting education and psychotherapy.

Individuals are born with different biological capacities, but these capacities are not fixed designs that determine behavior. The capacities
interact with the environment, which results in differences in behavior. Thus, it would be important to examine the environment and see what elements are responsible in activating which instincts in the process of behavior formation. Psychotherapy is known to be extremely beneficial in understanding the formation of human behavior and assisting to comprehend any emotional problems relating to it. In addition to that, social bond theory will enhance the psychotherapies being utilized for such purposes. The awareness of the association between many dysfunctional behaviors in life and the person’s instinctual needs (as promoted by social bond theory) offers many opportunities for a psychotherapist to explore these associations in ways that enable the person in therapy to work toward a sense of cohesion and adaptive differentiation. Understanding the dynamics of his or her social bonds will facilitate the evaluation of the source of client’s anxiety and of his or her overall level of functioning. In exploring the source of the client’s anxiety, a chronological account with the details of specific bonding experiences could promote a more accurate understanding of the meaning of the client’s behavior. Events and perceptions that have been distorted or suppressed by the client can then be cognitively restructured. The other advantage of social bond model
(especially in the context of psychotherapy) is that it does not operate on blame, nor does it require that the person, the environment, or the behavior be designated as invidious or disordered. Instead, the concept of mutual aid is a better tool with which to assess human behaviors. This concept proposes that mutual aid exists between the individual and social institutions, and requires that each reach out to the other for mutual self-fulfillment.

Instincts that exist in individual can be influenced and shaped into (positive) acquired behaviors through learning processes (experiences) and environmental facilitation, and instincts are the initial and crucial determinant factors that influence decisions relating to individuals’ engagement in certain behavioral patterns as against their external world (for example, in agreeing to utilize opportunities forwarded by others and in deciding to participate in any collective action such as the practice of integrated care). Instinct is an energy that is assumed to be capable of driving individuals' inner motivation to autonomously seek and attain self-betterment due to its position that is free from any external coercion. It is also both universal and at the same time exclusive in nature due to its existence in every individual. The understanding towards the concept of instinct is important in any collective action due to its
capability to act as a factor that can consolidate both individually initiated and collectively initiated efforts, and promotes solidarity and reciprocal interdependency (which are the founding concepts and principles for the formation and implementation of integrated care). Instinct development in individuals has to be promoted through a process that takes account the totality of a person and such process has to be conducted through a comprehensive and continuous, rather than segmented approach in both formal and informal setting. What follows from this logic is the need to ameliorate the currently segmented social systems and their framework of approaches and interventions. Sensitivity towards the significance of instinct is hoped to be able to assist the development of the instinct itself. The development in such perspective is expected to (later on) contribute to the heightening of individuals’ overall capabilities development, and ensure (creates) the existence of fits between delivered opportunities and individuals efforts to attain self-betterment. What is really needed in creating this fits is to integrate from the within of individuals.

In sum, instinct is an inner-drive that constantly exists in individual through out his or her stretch of live influencing many significant aspects of such
individual's psychological and physical dimension of action. Thus, a continuous and constant focus and understanding towards the far-reaching influence that it can exert to individual's behavior and pattern of action is necessary. Moreover, the continuous and constant focus is necessary due to the fact that the quality necessary for individual to enable him or her to participate in collective action such as integrated care – through solidarity and reciprocity – is not a quality that can be shaped instantly. The comprehension on the concept of instinct and social bond is important to understand the psychological characteristics of individual members in the society in effort to secure the stability of social structure so that solidarity can be sustained and fair reciprocity can be performed for collective action to be implemented. All the above mentioned five factors are necessary in our attempt to better grasp about individual's totality so that a better approach to collectively assist them can be devised. Upon understanding the factors and the concepts that should sustain the structure of integrated care practice, next in the following chapter, we will look into existing models of integrated care to observe how their practices are actually conducted.
Chapter 4

The Systematization of Integrated Care

The attempts to ameliorate social problems through universal principal were identified as helping the system more rather than the people who need the help (Carnwell and Buchanan, 2005). These critiques have in part resulted in an increasing emphasis on client or ‘consumer’ choice. In this perspective, providers have been encouraged to allow consumers to become more involved and to have more say in the design and provision of services. It is in the context of putting clients at the center of the process that collaborative actions such as partnerships and integrated care have become necessary. The complexity of client problems naturally requires an input from number of services. In addition to that, recent policy reforms have also encouraged different professional groups to break down barriers and work together collaboratively. It is these
changes that have given way to the development of more formal partnerships and integrated actions. As stated in the earlier chapters, there is different understanding towards the meaning that is given to the concept of collaborative actions. Many different words (for example, work together, joined-up thinking, joined-up working, partnership, integrated approach, and so forth) are used to explain the nature of such relations and these words are frequently used interchangeably. All these words are used as a quick way to describe a way of working which are base on multi-agency working (due to intention to achieve benefits that are unattainable through single agency working), interdependent of action and shared vision (for attaining shared purpose). In identifying the continuum nature of ‘sharing’ in the process it is useful to consider Hudson et al.’s (1998; cited by Carnwell and Buchanan, 2005) model view that identified the stretch of process as varying from isolation, through encounter, communication, collaboration, and to integration. In the successful process of ‘sharing’, individuals consider themselves to be members of a team working towards a common goal, sharing their expertise and responsibility for the outcome. Fundamentally, the relationship between members must be non-hierarchical, and shared power is based on knowledge and expertise,
rather than role and title (Hennemen et al., 1995; cited by Carnwell and Buchanan, 2005). In this context, it is worthwhile for our easy understanding about the process (of collaboration and integration) to distinguish broadly between what something ‘is’ (the noun), that is a partnership and what one ‘does’ (the verb), that is to collaborate, or integrate, or work together. There are possibilities where theory (what a partnership is) and practice (what it does) can often drift apart. Sometimes partnership may be little more than rhetoric or an end in itself, with limited evidence that theoretical partners are genuinely working together. Equally, it is possible for different agencies to work collaboratively in an integrated manner together without any formal partnerships being in place. Along the process, there will inevitably be some tension between different partners’ identities and all partners’ commitment to a shared vision. What determines differences between partnership and collaborative models is the nature of each partnership’s commitment. Types and tendency of partnership and collaboration can be different according to the type and level of commitment they undertake. Thus, different types of partnership or integrated care models exist. The aim of this chapter is to look into a few of these different models (Finland models, British models and
Japanese models) and identify how such respective models were developed and function in attempt to successfully cater their local needs. The existence of these models of collaborative action clarify the universal characteristic of contemporary social policy’s tendency in promoting and pursuing integrated care as an (assumed) effective countermeasures in dealing with many arising challenges. Though all three models of collaborative actions (to be explained in this chapter) posses their own distinctive method of operation, nevertheless, it would be observable from the following discussion that all are fundamentally based on the same principal; the ‘integrated care’.

4.1 Integrated Care in Finland

Equality, social integration, economic independence and safety, and fair treatment are the values underlying care policy in Finland. The main aim of the policy is to promote the well-being and functioning ability of individuals, and to ensure that everybody have a fair access to good care and service when they need it. In Finland, the national policy provides standard for local policies to be carried out in respective municipalities, and in return, the municipalities are obliged to respond to local needs according to the nationally set standard.
However, such obligation is balanced with municipal priorities in decision making and resources availabilities.

In Finland, like in many other countries, the organizing and financing of health care and social care has long been considered a public responsibility. However, the development of both services took place separately until the year of 1990s. Generally, the development of the health care system began earlier in the 1940s. Then, it was given a push through the development of hospital system starting from the year 1950s. The most significant progress of health care is said to have took place in the following decades. Yet, despite of the progress achieved in organizing health services during that period, visit to a doctor and medicines were noted as expensive, and subsistence during illness was felt to be insecure. A National Health Insurance (NHI) scheme was therefore introduced in the 1960s. In the late 1960s and the beginning of the 1970s, striking differences in the availability of health services were still noted, most of which were concentrated in urban areas. There was also an imbalance between primary and secondary health care. A network of specialized hospitals with high standards existed, but supply of outpatient services and primary health care was insufficient. Consequently, there was a clear need to do
something about the situation. All the above factors led to the introduction of
the Primary Health Care Act in 1972. It is a National Planning System, with a
rotating five-year plan that was annually updated. The introduction of the Act
was one of the major milestones in the history of Finnish health care. It took a
wider perspective on the provision of primary care by comprising preventive
and public health care. As stated above, the Primary Health Care Act obliged
municipalities to provide primary care, including public health care services and
family planning, in what was a completely new type of a provider organization
at that time, a ‘health center’.

A health center can be defined as a functional unit or an organization that
provides primary curative, preventive and public health services to its
population. It is not necessarily a single building or a single location where care
is provided. Health center activities are often organized at several places and
the size of a health center varies, depending on the number of people it serves.
The personnel consists of general practitioners, sometimes medical specialists,
nurses, public health nurses, midwives, social workers, dentists,
physiotherapists, psychologists, administrative personnel, and so on. Health
centers offer a wide variety of services such as outpatient medical care,
inpatient care, preventive services, dental care, maternity care, child health care, school health care, care for the elderly, family planning, physiotherapy and occupational health care. Health centers are usually well equipped and the inpatient department of a health center works in much the same way as a hospital department. All primary and public health care, which until then had been provided in a fragmented way, were brought together under the administration of health centers. From this part, it is understood that multidisciplinary and well equipped centers did not exist before the introduction of the law. The 1970s saw a comprehensive build-up of primary health care facilities throughout the country.

In the 1970s and 1980s, increasing attention was paid to occupational health care, with the aim of extending it to all workers. The content of and resources for rehabilitation were also developed and strong emphasis was placed on prevention. Hospital care was included in the national planning of primary health care in 1974, and in 1984 new legislation brought social services into the same planning and financing system as health care. Since then, the collaboration of social and health care has been emphasized at both local and national level (a larger scale of collaborative development between
social and health sectors began in the year 1991, when the Ministry set up a working group that is mandated to prepare a proposal for an action program to help improve both service structures – the program recommended, for instance, the improvement of cooperation between social and health care services by uniting the municipal health committees and social service committees). Until the end of the 1980s, the development of the Finnish health service was marked by continuous and diversity growth of services. Regional differences in the supply and availability of services diminished and the quality of services improved. One of the measures undertaken in this period was the introduction of the ‘personal doctor’ system.

After the 1972 Primary Health Care Act came into force, priority was given to financing the establishment of health centers in the remote and rural areas (due to earlier imbalance situation where services were concentrated mainly in large city areas). As a result, the development of municipal health centers was first more rapid in rural areas than in the large cities. By the 1980s, reversely, problems of access to health center doctors and of continuity of care were particularly apparent in the larger cities. To overcome these problems, a number of projects were launched and one was the development of the
personal doctor system. It is an initiative in some municipalities to improve access to health center doctors and continuity of care; it was not a reform brought by changes in legislation. In this system, a person or a family is always assigned to the same health center doctor. Doctors have to organize their practice so that patients on their list are able to see them within three days. The method of payment of doctors has also been altered, to relate better to the workload, expertise and experience of the doctor and the population structure he or she is responsible for. The results of the personal doctor projects in health centers were encouraging. The experience and results of the personal doctor system contributed to a further development in health centers and the system was later developed further towards a system that is so-called as ‘population responsibility’, a model whereby a team of doctors and nurses is responsible for the health care of a geographically specified populations. Most health centers are now moving towards the principle of population responsibility.

During the late 1980s and 1990s, regulation by the state gradually decreased and the possibilities for municipalities to choose how to organize social services and health care were further reinforced. In 1993, there was a
major reform in the financing of health care and this is one of the most important steps in the deregulation process. Subsidies started to be allocated to municipalities according to demographic and other need criteria. The reform was intended both to give more responsibilities to the municipalities and to improve efficiency. As regulation by norms further decrease, steering through information (based on research and evaluation, evidence-based practice, education and training, performance indicators and other activities based on information development) became increasingly important for the government as a means of monitoring the health care. The first Finnish strategy for developing seamless local and regional services with help of information and communication technology was published in 1996. It was followed by three expert teams set to finding out how to organize integrated services across organizational boundaries, and how to ensure data security and users' personal data protection. The main concern touches about how to develop, amongst other things, electronic patient records system, e-referral and online consultation services, disease management, laboratory automation, the digitization of radiology, picture transfer and archiving, and distance diagnostics. It is targeted that by the end of 2007 the electronic patient records
and an interoperable regional (Information and Communication Technology) ICT system connecting healthcare organizations and part of social service units will be taken into use in all healthcare regions and districts. The development work is supported by a special legislation on integrated care and regional information systems.

The Finnish current development of integrated care has had a strong political support\(^1\). It is a part of unanimously approved national healthcare and social services programs going on in Finland. The work is organized nation-wide but is based on a regional approach. Main innovations of the Finnish development work include interactive regional information system, integrated care models in the form of seamless service chains for specified groups of service-users, and technology to support independent living.

Significance of the competent and able personnel was emphasized in the Finnish strategy for the utilization of information technology compiled in 1996 by a working group set up by the Ministry of Social Affairs and Health. The working group pointed out that the development of information technology

\(^1\) The Ministry of Social Affairs and Health and STAKES (Research and Development Center for Social Welfare and Health) are responsible for the national coordination, embedding innovations and disseminating good practices (www.stakes.fi/english).
would change procedures and the organization of tasks, which would increase the need for planning and training in both the utilization of information technology and the management of new procedures. The age structure of the personnel in social welfare and health care is higher than average. Coupled with increasing demands for work productivity and the introduction of developing information technology, the effort creates pressure and stress among the employees. For this reason, the introduction of information technology should include training for the entire personnel as well as development of working methods and management systems. The Finland's Government has decided in the context of national healthcare development program that employers have to arrange three to ten days of supplementary training for every health care worker each year.

Regionally integrated care models and (Information Technology) IT systems require shared use and transferability of medical and other client records. Information technology requires the acquisition of new skills and information by professionals. This requires new designs for further training, for example in web training and virtual learning environments. In 2002 STAKES launched TIVA project to reinforcing the IT skills of social welfare and
healthcare personnel. There is a need for further training in workplaces, especially among older professionals who have not received training in IT skills. In addition, there is still not enough IT equipment in healthcare units, and in many places the equipment is already outdated. In the social welfare and healthcare sector there are also great differences and differentiation in IT skills between the sexes, the different occupational and age groups, and the various regions in Finland. The prevention and reduction of these differences require considerable increase in IT training aimed at the personnel equally throughout the country. The general objective of the project is to increase the attractiveness of social welfare and health care among young people, and to reduce gender differentiation in training and the working communities in the field. Controlled introduction of new working methods and technology solutions will improve the quality of service and image of social welfare and health care, and increase the number of people wishing to train in the field. In order to support this change, the IT know-how and work management skills of people working in the field need boosting, which will improve their career opportunities.

The desired changes should be obtained through the revision of policies on Human Resources (HR) of the healthcare and social sector employers.
Exhaustion at work is often the result of a conflict between personal skills and the experienced know-how requirements. For such reason, HR policies in social welfare and health care are to be influenced so that opportunities to learn and practice new information and communication skills are organized for professionals in workplaces during working hours. A good HR policy improves the image of the field, which also requires the reduction of untypical short-term employment relationships. The use of information technology in social welfare and healthcare can reduce multiple recording and searching for patient data, copying and sending between various organisations. The introduction of regional data systems will improve communication and the availability of information. By developing personnel IT skills it will be easier to follow the evidence-based clinical practice programs and the integrated care models.

Back to the history of health and social policy development; at the beginning of the 1990s, a major reform in the state administration of social welfare and health was conducted. The rationale for this was the simplification and streamlining of social and health administration. In 1991, the National Board of Health and National Board of Social Welfare, which until then had both been important in guiding state administration, were amalgamated into
one organization and soon thereafter abolished (the earlier mentioned bigger scale of collaboration that was conducted in 1991). Other than that, the developments in the Finnish health care system in the 1990s were further marked by the exceptionally severe economic recession. The national economy was in great difficulties, as reflected in the health care system by numerous cuts in resources and unforeseen redundancies among health personal. Due to the adverse economic situation and service quality problem, a shift towards the trend of emphasizing non-institutional health care and social services was initiated. The main effort was to turn away from institution-oriented care. In this context, non-institutional services were set to provide appropriately graduated services, integrated care chains and coordinated service packages for all. In a later stage of development it is observable that various kinds of projects addressing quality assurance have raised growing enthusiasm, both in primary and in specialized care. National guidelines on quality assurance in social welfare and health care were published in 1995 and 1999 by the Ministry of Social Affairs and Health, the National Research and Development Center for Welfare and Health and the Association of Finnish Local and Regional Authorities. The principles behind
the guidelines are the promotion of patient-oriented services, the incorporation of quality assurance as part of daily activities, and the use of knowledge as the basis for monitoring, measuring and evaluating activities in social welfare and health care.

The provision of most social welfare and health care services is statutory, meaning that there are laws requiring the municipalities to provide certain services. Although the legislation does not set detailed requirements for the extent, content or method of provision, definition is made on how access to services must be ensured in practice. National guidelines (The Target and Action Plan for Social Welfare and Health Care for 2000–2003) to help local authorities to develop their service systems were published. It contains the targets set for care and actions together with recommendations and instructions to reach the targets. The Plan focuses on the services in non-institutional care, stating that the individuals should be given a possibility to receive services at home instead of institutions, whenever non-institutional care is justified. It further suggests that all services and care should incorporate a preventive, promoting and rehabilitating aspect with attention paid especially to home nursing, home help services, supported living at home and
possibilities for rehabilitation. Other than that, the creation of seamless, customer-oriented, effective and functional care chains; suited gradation of care; use of new technology; conducting preventive home visits are also included in the recommendation. The “National Framework for High-quality Care and Services for Older People” is part of the new target and action plan. The Framework was designed to help local authorities to plan and evaluate their own activities. It sets national guidelines for developing good services for individuals, and requires that local authorities should base their future care and services on local needs and conditions. According to the Framework, the main emphasis is laid on home care, service housing and residential care. Living at home will be supported with rapid-access professional social and health care services, the focus points being in the arrangement of high-standard and well-timed care to support a good quality of life and the right to self-determination and independent life regardless of the individual’s functional capacity. Services should be ethical and based on user needs, using rehabilitation as an integral element; they should rely on applying evidence-based procedures and recommended care practices, be specified in written service plans or care agreements, and implemented in smooth
cooperation between the various service providers and the client’s family.

A new special Act that promotes seamless service chains in Social Welfare and Health Care Services was enacted in the year 2000. The purpose of the Act is to allow municipals to gain experience in arranging seamless service chains in ways that optimizes the use of information technology so that they respond properly to the needs of the clients. Seamless service chains are defined as an operating model, where all the services necessary for individuals are integrated into a flexible entity which will satisfy the client’s needs regardless of which operating unit provides or implements such services. The idea of seamless service chains emerged as one of the most essential definitions in the Finnish national policy at the end of the 1990s. In the service chains, cooperation between social and health care organizations is emphasized, to which both public and private providers equally contribute their know-how. The central areas for consideration were to reorganize the production of services, development of customer orientation, multiprofessional teamwork and networking. Further core issues are the improvement of cooperation between clients and professionals, clients’ possibilities to influence decision-making and seamless chain of services.
In Finland nine out of ten older persons (75 years of age or older) suffer from some chronic disease or disability. Especially the number of people with dementia increases among older age groups. During the 1990s services for the aged were cut even though the proportion of ageing people in the population increased. The cuts affected mostly home help services, where the ten-year trend shows that the coverage has been reduced almost to a half of the 1990 level\(^2\), and consequently there is a tendency to turn to less expensive solutions in long-term care (for example, by further utilizing patient’s informal network). Problems are reflected in the difficulty of finding permanently employed certified physicians, especially in small municipalities, because of a general lack of medical doctors. This tendency seems to be spreading also among other professionals due to the baby-boom generations now approaching retirement age, and the fact that there are not enough younger trained professionals to enter these positions. The trend is already seen among social

\(^2\) Equally troubling is the fact that the proportion of old people is growing in the regions that are being abandoned. The financial basis for arranging basic services is likely to weaken as the number of working-age people diminishes in these regions. The demand and supply of care services in these areas meet each other poorly because the availability of care is strongly influenced by and depends on factors such as population size (other than wealth, age structure of municipality, state of health of residents, and number of personnel available to deliver services) (www.euro.who.int/observatory).
workers. Further, the situation is made worse by the fact that there are regional and municipal variations in the present public system, which presents problems regarding the level (quality or quantity), availability and arrangement of services.

The provision of social services has traditionally been the responsibility of the public sector, or to be more precise the responsibility of the municipalities. Social services comprise such services as children’s day care, child welfare, care for the elderly, home help services, income support (social assistance), and services for the disabled and substance abusers. The social services are financed from municipal taxes, state subsidies and user charges. The state subsidies for social services are paid to municipalities prospectively according to needs. The criteria for social services are the number of inhabitants, the age and economic structure, and unemployment within the municipality. As with other social and health services, social services provisioning suffered greatly from the severe economic crisis of the 1990s. In many cases, there have been cuts in resources and thereby reductions in services. The changes in the provision of services for the elderly is worrying because the population in Finland is aging and there is a clear need for a system that supports people
living alone and provides care for the elderly. It was noted that the supply of services has not improved especially among individuals living in their own homes. At the same time, it has become clear that the level of services does not fit personal needs, nor does the care or services support ‘independent initiative’.

The changes and need for services have been similar in mental health services. The implementation of new measures such as publication of national quality guidelines for elderly care (to help municipalities to assess the realization of targets set for care) and discussion on the possible implementation of long-term care insurance (as a possible means of supplementing public services and an additional option for financing the future costs of elderly care) was initiated. Subsequently, the new legal grounds that emerged from the above mentioned situation and the growing number of older persons who need more services have increased the demand for services provided by the private sector, especially in the 1990s. Given the legally defined public responsibility to provide social welfare and health services in Finland, it is common for the production of services to be based on a close cooperation between the central state, local municipalities, private sectors and
the community. Local municipal councils, in this context, hold considerable autonomy in deciding on their service policy. Municipalities can provide health and social care services independently or jointly, or buy them from private non-profit or commercial service-providers (private health care services are located primarily in the larger municipalities in which private medical services, medical doctor’s practices and physiotherapy units are the most typical providers). In the year 2000 for example, 78% of social services was arranged by municipalities, 17% by non-governmental organizations and 5% by private companies. Home help services are still mostly provided by the public sector, but even in this area the number of private providers has increased recently.

Home help services, which are some of the most typical services needed by the elderly, were the most commonly provided services purchased by municipalities from private companies. The law concerning the support for domestic work (a tax exemption for citizens) has also enabled citizens to buy more services directly from private companies. It seems that the tendency towards private provision of social services will continue, because the demand for these services is growing more rapidly than their supply by the public sector.
There have been marked changes in the social structure of Finnish society over the past few decades. There has been a large internal migration as well as many changes in working life and employment. More and more people attend higher education and for a longer period. Both longer education and the difficulties on the onset of working life have led to the later onset of child bearing. In actual fact, the stability and structure of families have changed, as seen in the growing number of single-parent households. Nevertheless, family unit and family members are always considered as important sources of support and assistance, and as well as important cooperation partners in care provisioning in Finland. There have even been arguments that the service contribution, which by social legislation is today the responsibility of society, has to be moved back onto family members. Despite of the changes in structure, it is undeniable that at any rate, the responsibility of family members as caregivers will (or will need to) increase. The municipality can support the person providing care by paying a fee for the care and/or by arranging diverse social welfare and health services that support the care giving. It is observable that in recent years cooperation has intensified between family members, volunteer workers, the public sector and services producing organizations. The
example of such cooperation is explained in the following paragraph.

In Finland, the cooperation between home help and home nursing services has become common, especially in those municipalities which have multiprofessional teams for defined areas. In some municipalities, home help service and home nursing have been combined to form a home care unit. Usually the arrangements begin by the hospital sending the patient’s profile of needs to the health center physician, and by client’s personal nurse (from the hospital) sending her referral to the home care or home nursing unit. This action is accompanied by the transfer of further medical care responsibility from the hospital side to the health center side. After receiving the information, the need for and decision on home care is prepared in a work group which usually consists of a general practitioner, social worker, home help worker and health visitor, but the size and tasks of the group may vary (the arrangements for home care or home help services and home nursing services vary in different municipalities, and decisions on the social welfare services needed by clients are made by individual municipal civil servants). The physician makes the decision concerning home nursing together with the client and his/her relatives. After the decision, an individual care and service plan will be drawn
up by a civil servant together with the client and his/her relatives. The plan also serves as an action plan and contract on arranging the care and services. It includes a combination of home help and home nursing services that best suits the client's present situation. The individual care and service plan includes an assessment of the client’s situation, and specification of targets, implementation of the plan, evaluation of the implementation, and evaluation of how the targets have been fulfilled. At the same time the possibilities and prerequisites for family members and volunteers to take part in providing care will be determined, and the information about the division of labor between the different care providers will become part of the plan.

A successful discharge process from hospital to home care was identified as an essential factor to ensure the coping at home and the continuity of care. In the year 2000, Helsinki started an elderly research care project concerned with the discharge of elderly patients from hospital to home, with the purpose to develop cooperation between hospital and home care. A working group, including nurses from hospitals and home care, made an operations model which could be applied in different working units in social and health care. The aim is to actualize a discharge process with improved customer-orientation,
safety and flexibility. During the discharge the main focus is pointed to support patients to reach optimal independency with the help of their relatives. Particularly important is that all needed phases will be done according to planning and everyone participating in the process knows her/his duties.

Scientific researches concerning home care, or integrated home help and home nursing services for the elderly have been published to a lesser degree so far. However, after the Target and Action Plan for Social Welfare and Health Care and the National Framework for High-quality Care and Services for Older People were introduced, the Ministry of Social Affairs and Health together with other organizations has started development projects on elderly services. Preventive home visits, quality of care for demented people, as well as recommendations for care and service planning are the key issues of these projects. Projects and research have also been started or carried out on the municipal level concerning subjects such as case management in the integration of social welfare and health services, organization of home care and its consequences and quality of home care. For example, ‘Home Care 2005’ projects, as well as projects on ‘Preventive Home Visits’ are on-going research projects. The evaluation of elderly services is also one of the study themes in a
large on-going research program on ageing by the Academy of Finland that is coordinated by the University of Tampere. All these activities are certainly geared to improve or solve some major shortcomings in the continuity of care, in coordination mechanisms and eventually the integration of health and social care systems.

From the above, it is evident that proper home care requires cooperation between many professionals and networks. At the moment, however, the situation still varies greatly in different municipalities. In some municipalities cooperation has been successful both between social and health care sectors as well as between them and other services producing providers, while in other municipalities cooperation has been poor. Generally speaking, cooperation works well when home help and home nursing units cover either the same area or the same population. Difficulties appear especially when members of a joint municipal board have one common health centre and home nursing service, but every municipality has a social office and home help service of its own. Other reasons for the difficulties in cooperation, besides the organizational structure, may be factors of competition and defense of professional territories between different occupational groups, arising perhaps of a fear that new or
other occupational groups might ‘rob’ work from the incumbent group. In particular, resistance appears when the change threatens relations between different professionals. Other reasons may be attitudinal, meaning that; it is not easy to recognize that one does not work alone.

Well-arranged home care can yield different kinds of benefits and interests for political, professional and user groups. Improved health status and functional capacity promote coping of the elderly at home and in non-institutional care. The use of more effective medicines and rehabilitation, and the development of technical aids and equipments as well as of support services have improved the capacity of non-institutional care. However, these are not the only factors that can and should sustain the delivery of a well-arranged home care service. Such services quest for cooperation and synergies that originates from the cooperation. That is; as the work in home care became versatile and demanding it requires independent yet cooperative work. In this situation, the possibility for workers or manpower to improve their professional skills is important. However, there’s a noted problems with the organizational structure of health care in Finland relating to areas in the planning of manpower, and in the coordination of operational costs and capital
investments. The Ministry of Education partly plans and finances the education of health personnel, but neither the municipalities, which employ health personnel, nor the Ministry of Social Affairs and Health has strong influence on manpower planning. The crucial point about strengthening cooperation in manpower planning between the three parties is strongly argued. This is especially important due to the fact that well-arranged home care that comes along with well trained and well coordinated health worker enables the elderly to live at home longer, while at the same time better preserving their autonomy.

The aim to transfer older persons from institutional care to non-institutional care has brought along the challenge seek for new ways of organizing services as the number of people with care needs is increasing and the level and availability of services has been insufficient. At the municipal level this results in the attempt to find synergies in closer collaboration between social care and health care.

As a summary; the long term objectives of Finnish social policy have always been to provide a series of seamless services to individuals in order to achieve the best possible health of the population and to reduce disparities within different social groups through the practice that emphasizes cooperation
and integration. Up to the 1970s, policy issues were mainly about building the service system and improving accessibility to services. From the health perspective, for example, the introduction of the Primary Care Health Act at the beginning of the 1970s formed the basis for further development of the health care system and health policy in Finland. In the 1990s, developments of care were influenced by external circumstances such as severe economic recession, Finland’s membership of the European Union (EU), and socioeconomic turbulence. As a solution; while a broadly based policy of preventive care that is pursued through integration of efforts and collaboration should be pursued, at the same time it is argued that health should be taken into consideration in all aspects of public decision-making. The importance of efficient and accessible health services available to the entire population also continues to be emphasized. Through such effort, it is observable that the health of the population as a whole has improved considerably, although differences between social groups still remain. While there has been no major reform of the health care system in Finland, there have been a number of changes to deal with specific problems. A ‘personal doctor’ system that was introduced in the 1980s is one of the examples.
As noted above, one of the characteristics for policy development in Finland is the placing of the concept of health as the basic and core principle across its spectrum of policy development and interventions. That is to say; health and health promotion have been taken into consideration in sectors other than health care, particularly from the 1970s onwards. With the publication of Finland’s own national health for all program in 1986, a more streamlined and clear health policy emerged. The main guidelines of the program were the promotion of healthy lifestyles, the reduction of preventable health problems and appropriate development of the health care delivery system through integration of efforts. The World Health Organization (WHO) made an evaluation of the Finnish health for all program and highlights the areas where Finland had not succeeded. It was noted that health for all had been restricted to health professionals and health experts, even though the program should have been extended to other sectors as well. There was also insufficient local input, weak management practices and poor public and private sector coordination. The program was reviewed according to WHO recommendations and the revised health for all program was approved (1992) as the basis for the development of Finnish health and care policy. The main
targets were, among others, to improve the functional capacity of the population, to reduce differences in health between population groups, to improve the functional capacity of the population, to encourage intersectoral cooperation and collaboration in preventive and other areas of health policy, to improve the cost-effectiveness of the health services, and to further amend the competencies of health care staff. In another strategy for social policy that was issued in 1995, these targets were not changed. Later, a further new policy program entitled ‘Health 2015’ was published in May 2001, setting guidelines for public health and care policy for the next 15 years.

In Finland the integration of health and social care for older persons has emerged as an actual topic during the 1990s, but only since the end of the 1990s with the National Target and Action Plan and the National Framework being launched, more attention has been paid to the respective issues about integrated care in many municipalities. However, because the issue is new, many development projects and studies on integrated care or hospital

\[\text{3} \text{ The emphasis is on the promotion of health rather than the development of the existing health care delivery system. The main idea is that health will be taken as one of the factors that steers and influences public decision-making (for example, in relation to the possible implementation of collective and collaborative action) (www.euro.who.int/observatory).}\]
discharge are yet to be conducted and evaluated. The fact that cooperation between different professionals and units is quite a new issue in Finland may best be reflected in the project called “Discharging from hospital to home care” which has the purpose to develop cooperation between hospital and home care with the help of a new operational model developed by persons who are actually occupied in elderly care. The report clearly displays how confused the situation was in Helsinki before the project. One of the most important matters in this report was that the concepts were determined so that according to the description of the model everyone who participates in elderly work knows the basic concepts and issues. The other, maybe the most essential part of this project was the new operations model which can be used in different settings, and with the help of which the practical work becomes easier, more flexible, safer, and presumably cheap. As conclusion it can be stated that in Finland, because of a rapidly growing number of aged people, the main concern is how all the needed care and services will be arranged. In Finnish elderly care system, the proportion of institutionalized persons is quite large with respect to the number of old people. A large part of them is placed in hospital for long-term care. It is obvious that in the future, municipal resources are merely
not adequate for providing all elderly care, including both institutional and non-institutional care. Many municipalities have already initiated to develop cooperation with care providers others from the government sector. Services are also becoming partly outsourced where parts of the services are acquired from private companies, and this trend of service provisioning is expected to continue growing in the future. A part of the services (like cleaning, transport and escort services) which traditionally have been provided by municipalities have been cut down during the 1990s due to poor economic situation. Consequently, the role of family members (and other relatives) as provider of informal care has increased and will increase further in the future. The important issues is how or what form of cooperation, collaboration and integration practices that should be adopted in order to efficiently utilize the existing (but scattered) resources in order to fulfill the society’s care requirements (refer to the website of PROCARE, STAKES, and European Observatory on Health Care System as listed in the reference list for further details).
4.2 Integrated Care in Britain

Caring through the community or ‘community care’ has been the trademark of social policy in Britain. The origin of such collaborative and autonomous effort that started from the grass root level (instead of governmental intervention) could be traced back at least as early as the late 19th century (Hiraoka, 2003). The formation of Charity Organization Society (COS) that mainly organized earlier un-organized various charity movements was a part of the starting of locality based activity in the country. In 1884, another collective action known as Settlement Movement started and the main aim of such movement was to assist the needy in a less paternalistic way. Rebuilding of individuals’ consciousness and self-help mechanism (through self-autonomy) was / is believed to be most efficient if efforts were / are pursued through the creation of mutual trust and cooperation based on solidarity. Both COS and Settlement Movement were founded by the ideology of voluntarism, the ideology that later founded community care movement.

The moves towards the early structuring of community care practice in Britain were observable starting in the beginning of 20th century. However, it was a report that was written by Curtis Committee in 1946 that became the real
triggering point of the implementation. In the report, Curtis Committee elaborated the need to transfer child care back to community and emphasized the need to implement a care system that is based on a smaller group. In 1948 Child Act was enacted and this was the first created policy relating to community care in Britain. In 1957, a recommendation was issued by the Royal Commission to transfer the care for the mentally challenged individuals from care facilities to community. Such recommendation became the first officially written statement relating to community care. And following to that, the same recommendation and eligibility was forwarded by Department of Health for the care of elderly citizen in 1958. There was a noted series and trend of policy shift before integrated care (through partnership) took its shape in Britain. The trend of policy in the 1960s was the emphasis on efforts to reduce the admission of, and to encourage the discharge of mentally challenged individuals to / from the hospitals. This effort was reflected through the enactment of ‘A Hospital Plan for England and Wales’ that was done in 1962. The main aim was to reduce the bed numbers in all hospitals for mentally challenged person to half in 10 years time. At the same time, efforts to build sheltered housing and to down-size the care unit in welfare institution was
observable in the area of welfare for the elderly citizens.

Entering the years of 1970s, Seebohm Restoration was implemented and through that process a system that enables the provisioning of welfare services to be conducted by local authorities was set up. From the year of 1960s to the years of 1970s, there were three times of attempts where a National Welfare Planning System (Guideline Approach Planning System) were introduced and implemented. The first one was Ten-Year Health and Welfare Plan that was introduced in 1962; the second was 10 Years Development Plan 1973~83 that was introduced in 1972; and the third one was Local Authority Planning Statement (LAPS) that was introduced in 1977. The above planning systems were based on the idea of community care and were initiated with the aims to extend and improve the condition of all welfare services. They were characterized by a ‘guideline approach’ where the central government was responsible for the setting of service targets and objectives and where local authorities were fully obliged to enthusiastically achieve such targets. A later development of all the three efforts were showing an unsuccessful attempt and were abolished in the middle of their implementation due several reasons such as: lack of planning skills, financial restraint, and central government’s cabinet
(political administration) shift. However, the main purpose to increase the volume of provided services were to a certain extent achieved. Further, apart from the above said National Welfare Planning, other methods such as Resource Transfer Approach was also introduced and implemented in the mid 70s in order to promote and improve welfare planning. A council responsible to coordinate welfare services and insurance services between local authorities and government insurance departments was set up and a Joint Funding System to enable the transfer of resource from (centrally controlled) National Health Service program to locally managed community care program was created for the implementation.\(^4\)

Entering the era of 1980s, most of the earlier implemented policies were meeting their deadlock and various problems were identified. For example, the following problems were identified mainly in the areas of welfare for the elderly.

First, while the rising trend of aging rate that came along with the decline of family function is observable on one hand, government, on the other, was

\(^4\) Regarding the result; although government insisted that such efforts did manage to bring in some success, the capability of the approach to fulfill government’s initial aim to create a support system for the future discharging patient with a history of long term care (in hospitals) and the capability to prevent individuals’ admission to facilities due to societal factors (rather than medical) was doubted (Hiraoka, 2003).
pushing forward the effort to reduce the trend of long term hospitalization among the elderly. The situation created a stronger demand for institutionalized care but the government's restrictive financial policy was against that situation and local authorities were unable to improve facilities and residential care setting due to their un-encouraging financial condition. As an alternative, a focus was directed to the possible function of informal care network to supplement the existing system. However, it was later noted that though informal network possessed the expected possibility to supplement government and local authorities' function as care provider, the development was not rapid enough to close the opening gap between demand and supply in care services. In the following attempt to balance the situation, solutions were sought from the capability of private sectors to equally shoulder the burden as care providers. Again, however, it was noted that the adoption of such measures ended up bringing about the reverse effect. Despite of local authorities' original aim to expand the capacity of their residential care services, policy supporting the development of care provisioning by private sector resulted in the restraint of the development of such services. The implemented policies were contained with perverse incentive and leaded to opposite result
(increased in the volume of institutionally provided care).

In 1986, a report was submitted by the Audit Commission, and in the report, the overall factors leading to the weak development of community care practice was explained. Upon receiving such report, the government forwarded a request to Sir Roy Griffith to conduct a thorough study and reevaluation on the existing policies relating to community care, and subsequently, in 1988 Sir Roy Griffith submitted the Griffith Report to the government as the result of his observation. Suggestions to improve policy flaws hindering the effective implementation of community care practice were precisely elaborated in the report. In 1989, a white paper (Caring for People: Community Care in the Next Decade and Beyond) was published by Department of Health to materialized suggestions for policy improvement as stated in Griffith Report. In the month of November 1989, the government submitted the Proposal for National Health Service and Community Care Act to the Parliament. The proposal was prepared together with the white paper with the aim to reform existing National Health Service Program. The proposal was prepared as an attempt to translate the suggestions for policy improvements as stated in Griffith Report into an actual implementation of system’s reformation. A part of the Act proposal was
amended and it was passed by the Parliament in the following year of 1990. The system’s reformation (as suggested by the Act) was scheduled to be conducted in the beginning of April 1991; however, due to the insufficient preparation by some local authorities to engage in the action, the implementation was delayed until a later stage and was finally conducted gradually from 1991 till 1993. The National Health Service and Community Act that was enacted in the year 1990 leaded to a huge reformation of health and welfare policy in Britain\(^5\).

The attained achievements and remaining concern from the above act can be briefly concluded as the following. First, regarding home care and institutional care services: the main aim to transfer the trend of care provisioning from institutional to home-based care was partially achieved. However, such action had inversely leaded to the transfer of additional care burden to care-givers, the down-grading of home care quality and the neglect

\(^5\) The main content of such reformation are: the placing of welfare planning duty and obligation upon local authorities; to implement comprehensive care assessment and care management practice; to encourage the development of private sector ( in this context, it is argued that local authorities’ function should be shifted from service provider to service enabler); to improve facility inspection system; to adopt a professional grievances procedures (complaint processing system); and to implement the transfer of resources from central government to local authorities (Hiraoka, 2003).
towards individuals requiring lower degree of care. It was also noted that the reduction of publicly provided services would always mean an increased in the limitation of services deliverable to individuals. For example, this is also observable in the area of home care services. There was a noted limitation (may be reluctance) in the capability of private sectors to entry such area of services if they were located away from the urban areas. In other words, the developments of home care services by private sectors were only visible in and limited to urban areas. Other than that, it was observable that the percentage of service delivery from the private sectors was mainly supported by the delivery of services that were conducted by small and individually owned organizations. However, the tendency of government to reduce (lower) the price of purchased services from private sectors (mainly dominated by small and individual organizations) made it difficult for these small organizations to maintain their function. The incapability of small organizations to maintain their operation (thus, retreating from the market) increased the share of huge organizations in such areas and it encouraged monopoly of services. A one-sided development of institutional care (for example, in terms of facility scale) that comes along with some possible monopolization of services is naturally contradicting to the
intended practice of community care. In terms of responsibility and function: the collaboration between the Health Department and local authorities in care planning was somehow improved. But the implemented reformation was not able to completely integrate all the related parties and the ‘division of responsibility’ (especially between health and social care) remained as the main critical issue. Lastly, the changes that affected the practice of inspection were as followed: the implemented policy reformation required for an independent Inspection Unit to be set up within all local authorities in order to assure neutral judgment and to improve local authorities’ monitoring function. A series of policy amendment were further conducted in the year of 1994 and 1995, and what is important to note was the adoption of ‘lay assessor’ system where a measure to allow the participation of non-professional assessor in the assessing process was devised. The non-professional lay assessors are individuals from the public who are not a professional or the local authority’s council member, and appointed as assessor by local authority. It was assumed to be most ideal if such lay assessors body were to consists of and include service users themselves or their family members.

The trend of 1990s was also characterized by somewhat bleak situation.
Despite of the above efforts to improve the flow and workability of community care practice, in the mid of 1990s (from the year of 1995 onwards), the implementation of policies relating to community care were once again meeting their deadlock. In March 1997, a white paper termed Social Services – Achievement and Challenges was announced by Major’s Administration with the intention to improve situation but was not continued and implemented by Blaire’s Cabinet that was formed on the same year in May. Blaire cabinet did not attempt any prompt and major policy reformation in relation to the practice of community care. But rather, their efforts were concentrated on improving existing policy framework by introducing a few new policy approaches and organizations. The aims of improvement were to reinforce the collaboration and integration between local authorities and welfare department; to strengthen the support system for carer; to improve assessment implementation; to conduct a proper performance evaluation; and to set a clear standard to guide service delivery process. In general, the aims and efforts were the continuation of what was attempted by the earlier cabinet. In November 1998, a white paper called Modernizing Social Services – Promoting Independence, Improving Protections, and Raising Standards was announced
by Blaire’s Cabinet to set the general standard of their approach through social policy. The aim to improve social care through the pursuance of ‘The Third Way’ was announced in the white paper and such aim should be attained through its seven principles of: support for independence through dignity and respect; catering of diverse individual needs while guaranteeing user’s right; standardization of national care service’s organization, its accessibility and resource allocation to ensure impartiality, transparency and consistency of services; assuring social equality for children; protection from abuse and intentional neglect; social work education to educate professional social worker; and clear and precise standard to maintain service quality.

Basically, there were four policy aims (promoting independency, improvement of protection for children, improvement of service standard, and the consistency of impartiality) that were placed as central to guide the reformation process of the Third Way as intended by Blaire’s Cabinet. For example, in terms of ‘promoting independency’, the need to conduct a revision against the excessive practice of ‘targeting’ policy that limits services only to individuals with high need for care while neglecting others with lesser need and the necessity to adopt a preventive policy such as extending support to care
givers were highlighted. Other than that, the ‘Best Value’ evaluation system was adopted in order to evaluate the performance of local authorities and to monitor the standard of service delivery conducted by such local authorities. Despite of its critics against earlier implemented policy that was elaborated in the white paper that was issued in 1998, the New Labor’s trend of policy movement was more towards the sustaining of those (earlier) policies rather than producing new changes. On one hand, it was likely that the role of competitive service provisioning (through market mechanism) will stay intact. On the other, however, efforts to set-up national standards relating to service rights and allocation of service cost burden, efforts to expand the implementation of policy measures relating to preventive and rehabilitative care, and efforts to further coordinate the collaboration between medical and welfare authorities were also observable. The New Labor was / is aiming to improve the community care practice through the collaboration of both market mechanism and planning mechanism while at the same time preserving and optimally utilizing both mechanisms’ potentiality. This was the ideology that later directed policy approaches towards the implementation of a more integrated care provisioning through the method of ‘Partnership’.
Meeting complex care needs requires a multi-agency approach that is attainable through collaboration and integrative approaches (Seden and Reynolds, 2003). In this context, collaboration should be promoted to pervade all aspects of task such as monitoring and audit, service user consultation, and managing change, and also draws on a range of management skills and knowledge, such as decision making, communication, negotiation, leadership, measuring outcomes, managing information and finances. As stated earlier, in the case of Britain, the National Health Services (NHS) and Community Care Act that was set up in 1990 provided new impetus to developing partnerships by requiring social services department to involve other agencies in the assessment of individuals’ community care needs (especially in the collaboration between health and social services). In the year of 1997, the New Labor government came into power and the restructuring of public services was based on a discourse of partnership and joined-up policy. There was a change of ethos from competition to collaboration. However, the truth about the fact that cumbersome legal framework, different funding regimes and costs hindered much collaborative activities was noted and its significant impact to practices was un-ignorable.
It was argued that the only means of dealing with complex care issues successfully is through collaboration or joint-working between organizations, with one organization acting as a ‘strategic bridge’ to bring them together. In this context, three levels of joint working is said to be required. The collaborative effort should take place at the level of strategic planning, service commissioning, and service provision. Collaboration, or joint-working, or ‘inter-agency working’ usually occurs because there is a need to go beyond involving known individuals or professionals and to invite wider representation and expertise (perhaps because of government guidelines, or because there may be a realization within an organization that previous policies have been unsuccessful owing to limited resources or expertise). In other words, collaboration is initiated because one organization needs the input (and invariably resources) from another sector, such as voluntary and community groups. The government agenda for collaboration in 1990s (in the context of Britain) was based on a drive to improve service, reduce costs and duplication, add value, increase accountability and respond to the complexity of service users’ needs. This is a part of where the practice of ‘partnership’ originates from.
Partnership is a rational response to divisions within and between government departments and local authorities, within and between professions, and between those who deliver services and those who use them (other than that, it also a response to the fragmentation of services that the introduction of markets into welfare brought with them). In pursuing partnership, it is important to maintain a clear focus on the potential results attainable and not to regard it as something that will automatically generate results. There is much rhetoric about collaboration, but in reality it can be difficult and many people have experienced failed partnership (often failed by lack of mutual communication and information). Approaches need to be based on clarity about roles, powers, and accountability requirements of stakeholders at all levels. Approaches also require an understanding of the different expectations different players bring to the partnership and factors that support or create barriers to partnership working at different stages in the process. The matter relating to ‘power imbalances’ are crucial in this context.

‘Power imbalances’ apply to the relations between partners (from the public, private, voluntary and community sectors). However, they can also apply to relations within the sectors engaged in partnerships (between one
grouping within a community and another, between representatives and those they are supposed to be representing, between majority groups and minority interests, between those with the most extensive networks and those with the least extensive). If imbalances persist, partnership can fail. ‘Professional difference’, for example, explores issues of power; illustrating difference of status, pay and conditions among professionals, and how threats to them may engender conflict. Furthermore, gender, class, ethnicity and disability cut across power relationships and effect different people’s capacity to participate fully in policy making. If imbalances such as ‘power imbalances’ and ‘professional difference’ persist, partnership can fail because for partnership to work, all parties need to feel they have an equal voice and be able and willing to share power. The very nature of collaboration means organizations have different aims, objectives and reasons for being involved in working with others and this is actually the source of strength of their mutual interaction⁶.

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⁶ Normally, two goals come along with the formation of a partnership. Those goals are ‘meta-goals’ (goals for the collaboration and the reason why collaboration exists) and ‘organization-specific goals’ (goals each of the organizations wants to achieve through the collaboration but separate from the collaboration, such as rising their own organization’s profile). Both types of goal may need to be addressed in order to achieve a successful partnership (Seden and Reynold, 2003).
Finally, there are nine characteristics that are identified as crucial in attempt to pursue an effective practice of partnership. The key characteristics are: building and agreeing on shared values and principles through the integration of key services; agreeing specific policy shifts through a single operational policy; preparedness in terms of exploring new service options; clear about aspects of service and activity that are inside and outside the boundaries of the partnership arrangements, so that there is a focus on the real added value of joint working; clear about organizational roles in terms of responsibilities (including clear financial arrangements); identifying agreed resource pools; ensuring the continuous existence of effective leadership (commitment to the partnership agenda); providing sufficient dedicated partnership development capacity for everyone involved; and developing and sustaining good personal relationships that can promote mutual trust. We will next look into the actual implementation of joint-working or partnership that is conducted in Milton Keynes. Such observation is significant due to the fact that Milton Keynes is a national demonstrator project, the first of its kind, proving how a sustainable community can be built through the practice of partnership (information obtained from Milton Keynes Council website).
Milton Keynes is a new town situated midway between Birmingham and London. Despite of its urban reputation, two-thirds of the area is rural areas that are consists of farmland. The population is approximately 210,000 and 46% of the population is under 30 years old. A distinctive feature of Milton Keynes is its success in building partnerships with both public and private sectors. Milton Keynes could be a national demonstrator project for how a sustainable community can be built through partnership, and how a fully modernized range of public services can be created through such effort. The origin of partnership working in Milton Keynes was MK2020. MK2020 commenced in 1995 and this has been the starting of community planning process through which the business, public and voluntary sectors in Milton Keynes work in partnership. Following to that, a special conference entitled ‘MK2020: Partnership in Action’ was held in 1998, and, in 1999, a number of meetings were further held and at that stage participants agreed to the notion of developing a community partnership plan that addressed the collective needs and concerns of local people. Subsequently, the MK2020 partnership group evolved into Local Strategic Partnership (LSP) for Milton Keynes. The partnership was formally constituted on 25th June 2002. An LSP is a single
body that brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors so that different initiatives and services support each other and work together.

The Council of Milton Keynes comprises 51 Councilors (each representing a specific area of Milton Keynes known as a ‘ward’). All Councilors meet together as the Council. Meetings of the Council are normally open to the public. At Council meetings, Councilors decide the Council’s overall policies and set the budget each year. At the Annual Council Meeting\(^7\), the Council appoints the Cabinet and the regulatory Committees, and during the year, the Council holds the Cabinet and the Committees to account. There are four Overview Committees\(^8\) which support the work of the Cabinet and the Council as a whole (Environment, Transport and Localities; Housing Social Affairs and Health; Learning, Community and Economic Development; Treasury).

Overview Committees monitor the decisions of the Cabinet. They may

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\(7\) The public has wide access to Council meetings through attendance, submission of deputations, questions and opportunity to contribute debates in the meetings (www.mkweb.co.uk/mkcouncil).

\(8\) They allow public to have a greater say in Council matters by holding their meetings in public, and enquiring into matters of local concerns (meeting is held once in every 3 months). These lead to reports and recommendations which advise the Cabinet and the Council on its policies, budget and service delivery (www.mkweb.co.uk/mkcouncil).
recommend the Cabinet to reconsider the decision or refer the matter to the Council. In terms of decision making; the Cabinet is the part of the Council which responsible for most of the day to day decisions. The Cabinet is made up of the Leader, who is elected by the Council, and up to 9 other Councilors, that are also elected by the Council. When major decisions are to be discussed or made, these are published in the Cabinet’s forward plan in so far as they can be anticipated. If these major decisions are to be discussed with Council officers at a meeting of the Cabinet, this will generally be open for the public to attend except when confidential matters are being discussed. In order to give people a greater say in Council affairs, the Council intends to establish Area Consultative Forums. These forums have an important role to play in the overview and scrutiny of Council decisions. They will involve Councilors for each particular area, together with representatives of local parishes, and meetings will be held in public. The Council believes that community needs can best be met by working in partnership with parish and town councils. Parish Councils have been set up covering the entire area of the borough and there are now 351 seats on Parish Councils in Milton Keynes. The new arrangements mean that the benefits of closer working can be realized across
the borough. The following series of charts will assist in better understanding about the practice of partnership in Milton Keynes. The relationship between Milton Keynes Council and its implemented Local Strategic Partnership is illustrated in Chart 1 (page 410). The structure for Milton Keynes Council is illustrated in Chart 2 (page 411). Chart 3 illustrates the Overview Committee of Milton Keynes Council (page 412). Chart 4 illustrates the overall flow of process of Local Strategic Partnership in Milton Keynes (page 413). And finally, Table 1 explains the content of main partnership activities that are currently conducted in Milton Keynes (page 414).

In 1992, an Earth Summit was held in Rio de Janeiro out of a growing concern for the rapidly deteriorating state of the environment, widespread and growing poverty and social inequalities. In this summit, a comprehensive plan of action for the 21st century was drawn up and the plan was called ‘Agenda 21’. It recommended that all countries should produce national strategies for implementing changes and two thirds of the action proposed in the plan of action were thought best to be carried out from / at the local level. As a consequent from the above, all countries were urged to develop ‘Local Agenda 21 Plans’. In the year 1998, the Prime Minister of Britain requested all local
authorities in the country to produce a ‘Local Agenda 21 Strategy’ for their area.

Local Agenda 21 (LA21) is about action in the 21st century by local communities working together to: tackle the needs of local citizens (in terms of social progress); to respect and protect the local and wider environment (environmental protection); to use natural resources more responsibly (prudent use of natural resources); and to encourage a vibrant and sustainable local economic growth. These four approaches to future development are the elements that consists what is termed as ‘sustainable development’. Local Agenda 21 strategies are being developed in countries throughout the world and all are about developing local partnerships and thinking creatively about ways of developing while safeguarding the future. The efforts that are pursued through Local Agenda 21 are in line with Britain’s domestically initiated (sustainable development) strategy that aims to ensure a better quality of life for her local communities. Triggered by both, the central government mandated local authorities with a new responsibility (Local Government Act 2000) to prepare the ‘Community Strategy’. It is an approach that aims to promote the economic, social and environmental well-being of local communities in a more integrated way. ‘Community Strategy’ then became an important element in the
The implementation of integrated care through Local Strategic Partnership in Britain.

The 'Community Strategy' is the heart of Local Strategic Partnership and is to be set in the context of the Government's Communities Plan 2003. The strategy needs to reflect and integrate the work of the key strategic partnerships and must include action plans that show how the strategy is to be delivered. The whole process must include engagement with key stakeholders at local, regional and national levels. In particular, hard to reach groups such as minority ethnic communities, young people and local business must be engaged. A ‘Vision Element’ (long term objectives) to describe what success for each aim should be attainable through the practice of partnership would look like by 2030 was drafted and the vision element consist the following 8 aims:

Aim 1: Sustainable and high quality development

A sustainable society is one that balances social, environmental and economic factors. It tries to ensure that we do not leave social and environmental problems for future generations and that they are able
to enjoy a high quality of life. There is a need for specific action to protect the environment and make prudent use of resources.

Aim 2: A community for all

Milton Keynes is prosperous, but there remain large numbers of people and some communities that do not benefit to the same extent as the population overall. People are socially excluded when they, or the areas they live in, suffer from a combination of linked problems. In such context, a community development approach that is based on collaboration has an important contribution to make in both new areas of housing and in deprived areas\(^9\).

Aim 3: A healthy and caring community

The significant demographic trend changes will have substantial implications for care services. Improving the demographic trend are initiated based on a special focus directed to the situation of high

\(^9\) This involves working with communities and developing their ability to address their own problems. Arts and sports activity, for example, are believed to be able to make a strong contribution and help engender a sense of local identity and pride (www.mkweb.co.uk/mkcouncil).
teenage conception rates, high smoking rates, lack of physical activity, and poor diet among community members because these are important avoidable causes of ill health. Inequalities in health are also seemed to be strongly linked to social and economic factors. Poorer people are more likely to suffer from ill-health. In this context, the main focus is to reduce health inequalities between different communities and population groups.

Aim 4: Create a high quality learning community

It was generally agreed by all the education standards are important and must improve if Milton Keynes is to be successful. Statistics show a relationship between deprived areas and lower educational achievement, low participation in adult learning and lower expectation about the value of education and training. This is the main area that needs consideration. The fast growing population means that there is a school building program that has at times lagged behind pupil

10 Other than that, currently, the number of hospital beds is lagging behind the expansion of population. The home care market is also under considerable pressure. For such reason, efforts to improve people’s capacity for self-care should be increased (www.mkweb.co.uk/mkcouncil).
numbers in some parts of the city. Discussions are taking place about developing a ‘university’ in the city that combines further and higher education. The aim is to increase local participation in both.

Aim 5: Sustainable and effective transport systems

MK was designed in the late 1960’s at a time when it was expected that the car was the future of transport. Combination of low density housing and dispersed employment areas makes it very difficult to operate a commercial public transport. As the city grows there is the risk that some areas may become congested to a level where business, leisure or retail activity start to suffer. The need for a significantly enhanced public transport system is generally perceived.

Aim 6: Housing that meets everyone’s needs

House prices are increasing beyond many local people and the starting salaries for key workers such as teachers and nurses that need to be attracted to the area as the community growth (reasoning to too many people chasing too few houses). The supply of housing
need to grow in line with the planned growth of Milton Keynes but should not run ahead of the development of essential community facilities and infrastructure. The most vulnerable in the community should be able to access the housing they need with appropriate levels of support for older people and those with disabilities.

Aim 7: A prosperous economy

Milton Keynes has been enormously successful in economic development terms. However, much of the growth has been in lower paid jobs. Unemployment is very low, but skill levels are below the national average (due to low staying rate in education). Excellent education and training opportunities, and good transport and communication links will be needed to create an adequate supply of labor with the appropriate skills, living within a reasonable commuting distance.

Aim 8: A safe community
There tends to be a concentration of crime in shopping and leisure areas. Areas with greater level of social deprivation tend to suffer higher crime and disorder than the more affluent areas. Although total crime has fallen significantly, offences of violence have actually increased. Reporting of racial incidents has also increased. Emphasis will be done on working with communities to prevent crime and the fear of crime. Effective multi-agency working at the neighborhood level in particular is hoped to deliver measurable improvements in the quality of life for local communities.

Generally, the aims of Local Strategic Partnership are: to represent the wider interests and needs of the area, both within the region and nationality in order to secure the well-being of the area; to promote and facilitate multi-agency working by helping to overcome the barriers between organizations; to work towards the more integrated provision of mainstream services in partnership with the community; to address social inclusion, regeneration and development; to coordinate contributions of individual partnerships to the community strategy and other priorities; to share
information on key policy and budget issues that will have major implications for partners; to develop shared approaches to consulting and engaging the local community; and to develop responses to major issues (affecting the Borough of Milton Keynes) that is beyond the scope of any existing single partnership. The key requirements to ensure the success of growth in such effort would include factors such as: formulating of future (common) community vision; building of strategic infrastructure (to link both within and beyond the sub-region); improving the local infrastructure (along with new housing development); engaging with environmentally responsible development (i.e. energy efficient); conducting continuous revision on housing needs forecast, planning and supplying (a review of national migration policies and patterns is also necessary); creating an attractive public transport system that provides a realistic alternative to the car and accessible to all; creating enough high quality employment near homes; creating a coherent local health and social care services network; guaranteeing that education does not lag behind population (pupils) growth; ensuring that the capacity of local criminal justice system is sufficient and in line with the population expansion; supporting local community and cultural trend; improving administration in order to accommodate the
increased administrative needs of public services and the voluntary sector; renewing the neighborhood in order to transform it into a mechanisms to promote social inclusion to enable local people to access work and enjoy high quality housing and local environments; and allocating enough resources to fund growth (traditional funding systems have not served the city well as resources have lagged behind rather than anticipated the predictable population growth).

Local Strategic Partnership is actually a respond to government announcement on additional growth. In the case of Milton Keynes it is a high level of partnership covering the whole borough. It brings together a wide range of public, private, voluntary and community interests. Its overall aim is to promote a sustainable social, economic and environmental well-being of the people of Milton Keynes. Process of developing the strategy should include meaningful two-way engagement with all relevant stakeholders group. Meaning that; proposals should be presented comprehensively and lucidly to allow widespread understanding and participation and those consulted must be informed of the outcomes. Involvement of community in bottom-up strategy, and proper consultation approaches will help to build confidence among
consultees and will increase their capacity for ongoing engagement across the lifetime of the strategy. Strategic Partnership is defined as a ‘joint activity of its participants’ who amongst other issues agree to cooperate to achieve common goals, and in effort to attain such goal jointly plan and implement an agreed program. Conditions and circumstances that should apply in partnership are: improved efficiency and effectiveness; sharing risk and controls; clearly identified powers and resources to undertake work and deal with any challenges that might arise as the partnership develops; and involvement of service users in the search for improved quality.

Government impose a duty on local authorities to deliver services to clear standard (in terms of cost and quality) by the most economic, efficient and effective means. And, the performance and achievement of local authorities (and all the involving parties) in delivering such services through the implementation of Local Strategic Partnership needs to be evaluated from time to time. In this context, the method of Best Value was adopted for such purposes. Best Value is a performance framework that requires local authorities to publish Annual Best Value Performance Plans (BVPPs). The Best Value Performance Plan (BVPP) is the tool by which the Council sets how it is
going to deliver services to citizens and what improvements it aims to make in the short, medium and long term. Further, the Best Value Performance Plans are subject to review (through Best Value Review) in every 5 years. The objectives of exercising Best Value Review are: 1) to establish and maintain a database of Strategic Partnerships; 2) to establish protocols for: i) establishing a partnership/ making appointments to a strategic partnership, ii) undertaking an annual review of council involvement in individual Strategic Partnerships, iii) ending (Council's involvement in) a partnership; and iv) ensuring regular feedback from Council representatives; 3) to establish an evaluative mechanism to enable the Council to assess that its involvement in each strategic partnership is achieving its aims; and 4) to ensure corporate ownership of the Council's involvement in Strategic Partnerships. Other than that, 4Cs of Best Value must also be applied in every Best Value Review exercise. The 4Cs are: Challenging (why and how a service is being provided); Comparing (their performance with the others); Competition (embracing a fair competition as a means of securing efficient and effective services) and Consulting (with local taxpayers, customers and the wider business community). Generally, the purposes to conduct such evaluation process are
to: enable the public to see whether best value is being delivered; enable the inspected body to see how well it is doing; enable the government to see how well its policies are working on the ground; identify failing services where remedial action may be necessary; identify and disseminate best practice; and to investigate what are the barriers to working in strategic partnership and how those barriers could be broken down.

Like many other policies that are on experimental basis, the implementation of Local Strategic Partnership in Milton Keynes is not free from problems and critics too. Some of the problems identified as hampering the efficient practice of partnership are as follows. First, review commented it identified that there was a lack of knowledge of the council's current position in terms of partnerships and there were no policies or structures to guide the working of a strategic partnership as a whole. Second, inconsistencies in the record of the council's involvement in strategic partnership were highlighted. The methods for appointment of council representatives and how they report back from partnerships were identified as unclear. Third, issues were also raised on the inconsistency of action plan and protocol for decision-making (framework for decision making). Action plan, protocols and the existence of a
proper database must be in place to enable involvement in each strategic partnership to be monitored. Fourth, the legal frameworks for Strategic Partnership were unclear. There were no overall general legal framework and the existing framework are incomplete or partial. And finally, no national performance indicators exist covering the overall management of the council’s role in partnerships. The existing performance indicators only reflect the outcome of individual partnership and these could not be applied to Strategic Partnerships overall. The critics against the implementation of Local Strategic Partnership are insisting that: first, the implementation of Local Strategic Partnership is a rush into a so-called partnership which is little more than a vehicle for a large scale outsourcing contract, a privatization by partnership. Second, by outsourcing to a private sector provider, the local authorities are in danger of weakening and diluting their power and capacity to improve the well-being of the community in total. Third, outsourcing increases the risk of service failure. Although some risk is transferred to a private sector, most of the consequences of failure are born by service users, staff and the councils. Fourth, there is an alarming tendency for ‘asset stripping’. Valuable public assets (i.e. staff, knowledge) will be transferred to a private firm for free or with
very cheap payments. Fifth, it is worried that the democratic accountability will be severely weakened because the partnership will create a separate board to oversee the contract which will be governed by ‘commercial confidentiality’. It is like creating a government within government and the Partnership Board is nothing more than a small clique which operates behind close doors. Sixth, a strategic partnership will reduce internal capacity to respond to change and increase reliance on the private sector. As the contract proceeds, private firms will negotiate for more services to be outsourced. It is foreseeable that this will produce a spiral of declining internal capacity and further erodes democratic accountability in the system. And, finally, critics’ worries are directed to the problem of job loss among community members. According to them, if a private firm wins additional contracts it will already have a core staff. Economies of scale will ensure that it will require fewer additional staff every time the company wins a new contract and the surplus manpower will be left without any mean for a career alternative.
Chart 1 – Relation between Council, LSP and Individual Partnership

Among Involving Bodies in LSP Planning and Implementation

- MK Council
- MK Racial Equality Council
- MK Council of Voluntary Organizations
- MK Primary Care Trust
- MK General Hospital
- MK College
- MK Association of Urban Local Councils
- MK Association of Local Councils
- MK Parks Trust
- MK & North Bucks Chamber of Commerce
- Buckinghamshire Health Authority Age Concern
- English Partnerships
- Learning & Skills Council
- Thames Valley Police
- Jobcentre Plus
- The Pension Service

Group Representation:

- Community Representative
- Minority Ethnic Communities
- Younger People
- Older People
- People with Disabilities
All councilors are trained and advised by Standard Committee to follow a Code of Conduct (high standards in the way they undertake duties).

Full Council Members will appoint the Cabinet and Regulatory Committees.

- Cabinet members meet every 2 weeks
  - (Full Council meets once a month)

Councillors who are not in the cabinet may sit in the one of the Overview committee.

Function:
- Monitor the decision made by Cabinet
- Recommend Cabinet to reconsider decision

- Overview & Scrutiny of Council’s decision
- Involve Councillors of each particular area + representatives from local parishes

COUNCIL CONSTITUTION

Full Council:
- 51 Councilors representing 51 Wards in MK Borough

Cabinet
- (1 Leader + 7 Councillors)
- Regulatory Committees

Overview Committee
- Environment, Transport & Locality
- Housing, Social Affairs & Health
- Learning, Community & Economic Development
- Finance & Corporate Support

Area Consultative Forums

Public Access for Community
- Mainly through Annual Council Meeting
- Meetings are open to public and public has the right of:
  - Attendance / Submission of Deputations / Questions & Opportunity to Contribute to Debate

- Citizen’s Advice Bureau – a body responsible to provide advice on individual’s legal rights

Public Access for Community
- Meeting will be held in public once in 3 months
- Inquiry of local concern will be conducted
- Annual Staff Survey

- Reports and Recommendations to Council

- Future Plan for Better Public Access for Community
- Other methods:
  - Citizen’s Panel
  - Youth Forum
  - Listening Day
Chart 3 – Milton Keynes Council Organization Chart – Overview Committees

Directorate Sub-Functions (Overview Committee)

<table>
<thead>
<tr>
<th>Environment, Transport &amp; Localities</th>
<th>Learning, Community &amp; Economic Development</th>
<th>Housing, Social Affair &amp; Health</th>
<th>Finance &amp; Corporate Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Development &amp; Design</td>
<td>• Children’s Services</td>
<td>• Housing Strategy and Needs</td>
<td>• Human Resources</td>
</tr>
<tr>
<td>• Environmental Services</td>
<td>• Education</td>
<td>• Commissioning &amp; Customer Care</td>
<td>• IT Management</td>
</tr>
<tr>
<td>• Planning &amp; Transport</td>
<td>• Community &amp; Economic Development</td>
<td>• Adult Social Services</td>
<td>• Legal &amp; Property Services</td>
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<tr>
<td>• Technical Services</td>
<td>• Finance &amp; Performance</td>
<td>• Finance &amp; Performance</td>
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</tbody>
</table>
Chart 4 – Local Strategic Partnership in Milton Keynes

Earth Summit 1992 (Rio de Janeiro)
- Local Agenda 21 by local authority in UK

Government Act 2000
- Requesting local authority to prepare Community Strategy

Community Strategy Towards 2030
- Prepared according to Govt. Community Plan 2003
- Created through consultation with local communities and reviewed every 3 years
- Final Strategic Plan to be approved by March 2004
- Vision: To Promote the Sustainable Social, Economic & Environmental Being of People in MK

Milton Keynes Council

Local Strategic Partnership (LSP)
- Partnership between Private/Business Sector, Voluntary Sector, Public Sector & Community
- LSP has relation with all major partnerships in MK and aims to coordinate them
- LSP involves in 60 strategic, 81 operational & 10 professional partnerships
- Definition of strategic partnership: responsible for setting strategies and policies

External Inspection:
- Best Value Inspection (Best Value Inspection Service)
- Peer Review (IDeA)
- Comprehensive Performance Assessment (Audit Commission)
- Others

Information Dissemination across Council and Partnership E-Government Steering Group

Key Partnerships in MK
- CMK Partnership
- MK Crime & Community Safety Partnership
- Joint Health & Social Care Board
- MK Housing Partnership

- MK Economic Partnership
- MK Lifelong Learning Partnership
- MK Transport Partnership
- Others

Points to Ponder
- Long Term and Middle Term Objectives

Points to Ponder
- Definition
- Classification of Partnership
- Characteristic for Effective Partnership
- Key Requirement for Success
- Main Aim
- Long Term and Middle Term Planning and Aims
<table>
<thead>
<tr>
<th>Strategy Aim</th>
<th>Key Agencies</th>
<th>Partnerships</th>
<th>Key Plans</th>
</tr>
</thead>
</table>
| Sustainable and high quality development | All individuals and organizations in MK                                        | MK Environmental Partnership (about to be established)  
MK Council, CMK Partnership                                             | Local Agenda 21 Strategy                           |
| A healthy and caring community  | MK Primary Care Trust, MK Council, MK General Hospital, Buckinghamshire Health Authority Age Concern | Joint Health & Social Care Board                | Health Improvement & Modernization Program 2002-2005, Joint Review Management Action Plan, Primary Care Investment Plan, Reforming Emergency Care and Maximizing Capacity Plans, NSF (and Learning Disability) Implementation Plans, Local Authority Performance Assessment Framework |
| High standards in education and lifelong learning | MK Council, MK College                                                        | Mk Lifelong Learning Partnership, Early Years and Childcare Partnership | MK Education Development Plan, School Organization Plan, Lifelong Learning Plan, Early Years and Childcare Plan, Adult Learning Plan, Annual Library Plan |
| Sustainable and effective transport systems | Mk Council                                                                   | MK Transport Partnership                           | Sustainable Integrated Transport Strategy, Locality Transport Plan |
| Housing that meets everyone’s needs | English Partnerships, MK Council                                                   | MK Housing Partnership                               | Housing Strategy, Housing Investment Program                              |
4.3 Integrated Care in Japan

The welfare system that was re-established immediately after the World War 2 period in Japan was strongly marked with the aims to manage the after-war situation. This was the period during when the most basic policy framework for Japan’s current welfare system was established (i.e. Social Welfare and Services Law and Three Basic Welfare Laws) and the core part of this framework remained intact for along time. Only in late 1990s (i.e. Child Welfare Act Reformation in 1997, and Fundamental Structure Reformation of Welfare in 1998) that a full-scale reformation was conducted (Nakamura and Ichibangase, 1998).

The trend on services coverage was witnessing an expansion in terms of covered range for intervention and targeted group for relief as Japan was experiencing a high growth in its economic development (Training School Committee for Social Worker in Japan, 2003). A rise in life standard that was brought by the economic upturn released the public from the constraint of absolute poverty and relatively pushed the popularity and demand for social

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11 Relief was mainly based on the provisioning of public assistance for coping against the after-war’s poverty and joblessness problems (Tamai, 2005).
12 Improvement of the living standards of the public citizens were achieved through the construction of stable employer-employee relationships based on the principal of full employment and upgrading of social security (Tamai, 2005).
insurance system forward. The establishment of National Insurance System, National Pension System, and the amendment of Three Basic Welfare Laws to Six Basic Welfare Laws was implemented (in the late 1960s). Observing the policy trend of this period, it is arguable that policies initiated for handling categorically differentiated welfare needs were to a certain extent efficiently functioning, and menu of services was in a way comprehensive enough in covering the necessary areas.

The above growing trend was halted due to the oil shock crisis that took place in 1973 (Tamai, 2005). The trend of practices were reversed in order to cope with the economic downturn and the term ‘Reconsidering Welfare’ with recommendation for the pursuance of ‘Japanese Welfare Model’ since then became very acquainted with welfare policy argument. However, the tendency of this argument was not focusing on the attempt to merely conduct a cut-back on the provided services, but rather, to thoroughly reconsider the need for social restructuring and policy implementation that would correspond to the low economic growth through the re-strengthening of independency, self-help, reciprocity and solidarity in the family unit and the community (Nakamura and
Ichibangase, 1998). This effort was even placed as priority in the political agenda by the leading political party in Japan during that time.

The policy development in 1980s was characterized by the government’s effort to develop and involve private sector in service provisioning in order to create an alternative service provider that can together shoulder the responsibility that was previously maintained by the public sector alone. The Social Welfare Worker and Care Worker Act that lay down the qualifying standard for welfare practitioners in Japan was enacted in 1987, and a report entitled ‘The Future Trend of Welfare’ was published by the Joint Planning Committee (a sub committee of Welfare Advisory Committee) in 1989. In this report, suggestions outlining the trend and methods for the possible implementation of necessary welfare reformation were highlighted and suggestion among others includes: attaching core responsibilities for welfare provisioning to be equally shouldered by local authorities; setting the homecare services; grooming the private sectors; strengthening the collaboration and integration between social and health services; securing the appropriate numbers of qualified welfare practitioners, and finally, establishing welfare
information sharing system in order to improve the services’ entire integrity and efficacy.

The revision of laws and setting up of measures to actualize the earlier suggested reformation (in 1980s) was the movement that marks the 1990s’ policy progress. In the year 1990, the biggest law and measures amendment after World War 2 known as ‘The Revision of Eight Welfare Basic Law’ was implemented in Japan. The main aim was to implement coordinated and well planned services consisting of integrated services from both health and social services areas, and the implementation were focused on efforts such as: giving a clear and definite placing for, and to actively promote home care services in all areas of welfare (through law amendments); and creating the structure or mechanism that can enable the provisioning of both home care services and institutional care services at the level of local authorities. The need to shift from earlier practiced social security maintenance provisioning methods that were mainly based on pension system and medical model to approaches that are based on social perspectives (i.e. social relation) and a more humane care support was also proposed through these efforts. An effective relief mechanism (including preventive care) should consider the needs of individuals not from a
view of point that label them (the individuals) as passive objects with needs that are categorically manageable, but as active subjects with various needs that arise from the socio-environmental and social relationship they engaged in (Okamura, 2003).

The devolution of welfare planning system from a centrally controlled to locally administered procedures and process was central in the above reformation. In the year 1998, two reports (Fundamental Structure Reformation of Welfare – An Interim Conclusion, and Promoting Fundamental Structure Reformation of Welfare – Additional View) were published by Social Welfare Structural Reform Committee (a sub committee of Central Social Welfare Advisory Committee). Seven core suggestions on how the above said reformation is attainable were highlighted and the suggestions include: establishing an equal relationship between involving parties, providing a comprehensive support at local levels, promoting the active participation of all involving parties, improving quality and efficiency, guaranteeing transparency, fair and equal shouldering of responsibility, and developing the culture of welfare in the community. What was attempted to be actualized was the epoch-making transformation of service delivery system from earlier practiced
bureaucratic and centrally controlled referral system, or the ‘old placement system’ (called as ‘Sochi’ system in Japanese) to a provider-user contract-based system.

Decentralization, privatization and nationalization were the three key words that represent the development of welfare policy in the era of 1980s and 1990s (Nakamura and Ichibangase, 1998). Decentralization is reflected through the effort of trying to shift the process for policy decision-making and its implementation from the central government to local authorities. In order to devolutionize the Japanese welfare system that is strongly characterized by ‘centrally controlled service delivery’ (Okamura, 2003), the approach of decentralization from three different perspectives are inevitable (Ogasawara and Takegawa, 2002). Decentralization of authorities within and between public sectors, decentralization of service provisioning authority from public sectors to private sectors, and the decentralization of decision-making prerogative relating to provided services from service provider to service receiver (individuals) must be considered in this attempt. The decentralization of service provisioning authority from public to private sectors was attempted through the implementation of welfare-mix policy. Intention to achieve privatization was
reflected in the effort that tries to promote the active participation of NGO and private sectors to act as an alternative service provider in order to replace the earlier practiced mechanism where government controlled operation and service provisioning was central. And, nationalization or integration of citizen was worked out through the attempt that tries to reform the earlier un-coordinated and separated various social insurance system (Nakamura and Ichibangase, 1998).

The following decade witnessed a further advance towards the attaining of earlier proposed reformation (especially in the 1990s) through a more concrete measure involving law amendments. For example, the Social Welfare and Services Law was amended to Social Welfare Law in the year 2000, and it was through this law amendment that the contract-based Long Term Care Insurance (LTCI) System was introduced in the field of welfare for the elderly, and also, for the first time the contract-based Expenses Aid System was introduced to the field of welfare for disabled person (Training School Committee for Social Worker in Japan, 2003). Since then, Long Term Care
Insurance (LTCI) has been one of the major pillars\textsuperscript{13} that support the running and strongly influence the shape of social policy in Japan.

Care for the elderly differs from care for other age groups in several important ways. Both community-based care and institutional care play especially substantial roles. Given the often complex and multifaceted needs of the elderly, reliable coordination among different types of care - physicians offices, hospitals, nursing homes, residential care facilities, and home care in the community - is particularly essential for successful long-term care. The implementation of Long-Term-Care Insurance (LTCI) on 1 April 2000 in Japan was an époque-making\textsuperscript{14} event for the history of the Japanese public health policy, because it means that Japan has moved toward socialization of care in modifying its tradition of family care for the elderly (Matsuda and Yamamoto, 2001).

Because of the ageing of the society, the Japanese social insurance system requires a fundamental reform. The introduction of LTCI was the first step in the coming series of health reform in Japan and the scheme requires

\begin{flushleft}
\textsuperscript{13} LTCI is the third pillar of social security in Japan following health insurance and pensions (Ikegami, 2005).
\textsuperscript{14} It is said to be the biggest and most radical program of public, mandatory long-term care insurance in the world (Campbell and Ikegami, 2000).
\end{flushleft}
each citizen to take more responsibility for finance and decision making in the
social security system. Everyone age forty and older with an income must
contribute, and all older persons with even a relatively mild disability are
eligible, regardless of income or family situation. The program will cover nearly
the full cost of institutional or community-based care (formal services only),
depending on the level of disability. The first factor that drives the need to
introduce such system was / is the rapid graying of the Japanese society15. The
second factor is both demographic and sociological16. And, the third factor is a
financial crisis of the social security fund17. The introduction of LTCI is regarded
as the first and important step of a radical reform of the social security system
in Japan.

The first modern programs for older people in Japan date back to 1963,

15 Japan has the most rapidly aging population in the world and soon will have the
largest percentages of the elderly and of the oldest old in its population (Ikegami,
2005).
16 That is; with fewer children, more women working, and changing attitude toward
family responsibilities, the traditional system of informal care-giving that is mainly
provided through family unit is widely perceived as being in crisis, or at least
inadequate to take care of the increasing number of the frail elderly. This situation
naturally requires the socialization of care (Campbell and Ikegami, 2000).
17 The average health expenditure per capita of the elderly is about 5 times more
than that of the young generation. Furthermore, it is estimated that the Japanese
public pension system that adopts the pension benefit imposition system will be in
crisis in the near future because of the maturation of the scheme (Ikegami, 2005).
but the major expansion came in 1973, when, in response to rising public concern, medical care was made virtually free for persons age seventy and older. At that time social services, including nursing homes and home care, were still means-tested and not usually available to anyone who could be cared for in the family. From 1963 to 1993 the number of hospitalized older persons increased tenfold, and they occupied nearly half the hospital beds. Japan’s rate of institutionalization is about 6 percent of the population over age sixty-five, similar to other rich nations, but most are in hospitals paid from medical insurance even though many do not require much medical supervision (a situation unique to Japan). These inappropriate, expensive ‘social admissions’ and the inadequate supply of both home care and nursing homes under social services were seen as serious problems in light of Japan’s rapidly aging population and the perceived decline in families’ capacity to provide care. In response, the ruling Liberal Democratic Party came up with the Gold Plan in December 1989. The Gold Plan, more formally called the “Ten-Year Strategy to Promote Health and Welfare for the Aged,” set targets for major expansions of services, such as more than double the number of nursing home beds, triple the number of home helpers, and ten times the number of adult day-care
centers. Also added were some new programs such as local agencies to coordinate home care. The political significance of the Gold Plan was that this was the first time that care for frail older persons had become a major public issue. The policy significance was that the government had now taken on a big new responsibility to provide long-term care to all frail older persons, not just the poor or those without families.

It is interesting to look that most of the decision-making process leading up to LTCI was carried out within a fairly narrow group of organizations and individuals who had long been active in social policy. At the level of interest-group politics, representatives of physicians and local governments bargained hard (and successfully) to be sure that their concerns would be reflected in the new system. Perhaps the liveliest battle was a rear-guard action by much of the old social welfare establishment to preserve the tax-based, direct-service-provision model. Their arguments, based in part on protecting current recipients of services, lost out to proponents of social insurance. There also was much consideration of what kinds of services would be provided in what quantities. The issue that drew the most attention was whether or not cash allowances for family care should be included. Although
polls showed support for a cash allowance, it was rejected. The new LTCI program departs from past Japanese practices in several important respects. It aims to (1) shift a major responsibility for caregiving from the family to the state; (2) integrate medical care and social services via unified financing; (3) enhance consumer choice and competition by allowing free choice of providers, including even for-profit companies; (4) require older persons themselves to share the costs via insurance premiums as well as co-payments; and (5) expand local government autonomy and management capacity in social policy.

The government plans to expand the new program gradually over ten years, leading to a major expansion of community-based care, a fundamental reform of financing and regulation of institutional care, and, more generally, a flexible approach to social policy based on individual entitlement and choice.

To be more specific, LTCI is different from the earlier system in various points, such as financing method, eligibility requirement, co-payment and so forth. The budget of the insurance is based on fifty percent from the general tax and another fifty percent from the premium of the insured. There are two types of insured; the first category of insured covers who are above the age of 65, and the second category of insured covers the age between 40 and 64. The
The first category of insured is required to pay a premium deducted from pension or direct payment for insurer according to their pension status. In the case of the second category of insured, his or her premium is withheld from the medical insurance premium. The benefit includes social welfare services such as home help and bathing service, stay in nursing home, as well as the use of medical services such as visiting nurses and institutional care in long term care hospitals. In more detail, the services covered by the LTCI scheme are services related to home care (home help services, visiting nurse services, visiting bathing service, visiting rehabilitation services, etc), respite care (day care services, medical day care services, short stay services) and institutional care (nursing home, health service facility for the aged – rehabilitation facility).

There is a difference in eligibility requirements between the first and the second category of insured. For the former there is no requirement related to the causes of dependency, but for the second, the eligibility is limited according to fixed 15 ageing-type disabilities (for example, Alzheimer's disease, stroke, and so forth). The eligibility process begins with the individual or his/her family applying to the insurer (usually municipal government). Eligibility is determined by an objective assessment of physical and mental function. Neither the
willingness and/or ability of family and friends to provide care, nor income are taken into consideration (Ikegami, 2005). A two-step assessment process follows and determines the limit of benefit. The first step is on-site assessment using 85 items of a standardized questionnaire, each with a choice of three or four levels, plus space for comments on any particular aspects to be remarked on. The 85 items are analyzed by an official computer program to classify the applicant into one of 6 levels of eligibility or non-eligibility. The lightest level is ‘assistance required’ which is subject to preventive services; the other five levels are called ‘care required’. The second step is the assessment conference by health care professionals. The conference reviews the classification made by a computer program by taking into account the descriptive statement plus a report from the applicant's home doctor. The eligibility decision is then communicated to the applicant within 30 days of applying. In the situation where applicants feel dissatisfied with the result of assessment, the applicant may appeal to an agency of re-evaluation at the prefecture level. Upon qualification each eligibility level entitles the applicant to an explicitly defined monetary amount of services. The table below (Matsuda and Yamamoto, 2001) shows the amount of benefit for home care (in the case
of institutional care, the amounts for each level is set about 1.4 times higher). The recipient has to pay 10% of the cost as co-payment. Theoretically, users are free to choose services, but in reality, the care-manager who constitutes a care plan (a weekly time schedule of services) intervenes in this process and coordinates the services for the applicant.

<table>
<thead>
<tr>
<th>Eligibility Status</th>
<th>Amount of Monthly Benefit for Home Care</th>
</tr>
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<tbody>
<tr>
<td>Assistance Required</td>
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In policies concerning integrated care for the disabled elderly, care management has become an important topic for consideration. Standardized care, continuity of care, flexibility of care, and finely tuned coordination between the different kinds of care providers are a central part of care management in order to realize high quality care for the disabled aged and to enable them to continue to live independently in their own homes for as long as possible. This is the most important reason that the Japanese LTCI scheme has formalized the care management process. Moreover, Home care requires
a lot of bookkeeping. First, recipients must select providers which can provide services in their place of living at desirable time. Then they have to keep book to verify the claims of providers. So majority of recipients entrust these time consuming tasks to professional care managers. In other words, the care manager is entrusted with the entire responsibility of planning all care and services for individual clients. According to the results of a needs assessment of the client and his or her wish, a care plan is drawn up. As mentioned above, the care manager organizes the care specified in the care plan and works with the client, supervises and evaluates the care process (monitoring). When necessary, the care plan is adjusted. In this way the care manager plays a pivotal role in the LTCI scheme. Care management fee will be fully paid by insurers with no co-payment and there is no additional cost for recipients.

The various decisions about eligibility and services are not made by the municipal government, even though it is the insurer and the one that bears the financial responsibility. The expert committee is named by the mayor but includes no municipal representatives; it usually has five members: two physicians plus social workers (care managers), nurses, and others. In real practice, however, in many municipalities the initial assessment is carried out
by care managers who work for a provider organization. This pattern raises the question of whether eligibility determination will have a built-in upward bias or whether care plans will have a tendency to favor providers’ rather than clients’ interests. Though care managers are expected to act as an agent of the recipient and select providers as neutral buyers, majority of care managers are at the same time employees of home care providers. So they tend to act more like sales agents to channel service orders to the companies which employ them. This is a crucial difference from the British care management system, in which all care managers are civil servants who are separate from service providers mostly in private sector. Municipal governments do have considerable autonomy in these arrangements, and some have already decided to have their own employees do the assessments or serve as care managers for difficult cases, to prevent undue provider influence. They cannot, however, go so far as the British pattern, where the care manager is a local official who controls a set budget and apportions it among clients in accordance with some definition of their needs. In the Japanese program the amount of the benefit is decided strictly on the basis of physical and mental condition, by a relatively objective process, and the client has ultimate control
over how that benefit is spent. More and more care managers in Japan are aware of their difficult position: a dilemma between split loyalties. Care management is perhaps the best achievement of Japan's LTCI system. However for the care management to be able to fulfill its intended mission, it is necessary to establish care managers as independent professionals with high standard of skills and morale.

Two fundamental structural changes are observable in the Japanese health system after the implementation of LTCI; development of Integrated Delivery System (IDS) and informatization of health system. The past decade has witnessed considerable growth in the development of IDS in the Japanese health care sector. They provide a wide range of services from acute health care to long-term care including intramural and extramural care for the aged. At the first stage of the development of IDS in Japan, many private acute care hospitals constructed or bought the long term care facilities in order to ameliorate managerial efficiency. Furthermore, as the Japanese government has been trying to develop home care services as a substitute of institutional care services during the past decade, these facilities have developed extramural health services, such as visiting nursing services, visiting
rehabilitation, day care services, short stay services, and so on. The government has offered several financial incentives in order to develop the home care services, such as low interest loan, subsidies, and relatively higher tariff schedule. After the introduction of LTCI, many social and health care organizations have been entering into the market. Most of them are mono-service providers, such as home help services and visiting nurse services, and they are competing with the existing Integrated Delivery Systems (IDSs). Under the LTCI scheme, the drawing-up of a care plan is required, and within the care plan, various types of services should be organized according to the needs and demands of users. Compared with mono-service organization, the IDSs are conducting this coordination of task more easily, because they have several kinds of health and social services in their own organization. Especially to be equipped with intramural services is an important merit for them, because the frail elderly and their family always fear an emergency situation. From the viewpoint of ability and experience of care managers for the service coordination, the IDSs are much more advanced. The users, on the other hand, welcome the development of IDS, because this type of organization offers one-stop services for the client. Further, the LTCI scheme
will facilitate informatization of the Japanese health system because the scheme requires in principle electronic transmission of bills from service providers to the insurers. A number of private companies are competing for the development of software which integrates needs assessment, care management, reimbursement procedure, internal resource management, and so on.

Other than the above, a few transitional problems (relating to eligibility for services, competition among providers, and balancing supply and demand) are identified along the development and application of LTCI schemes in the social system. First, many current recipients of long-term care services are not frail enough to qualify for LTCI benefits, at least not at a high level, and these persons also face the 10 percent co-payment (most had been paying little or nothing). Various steps have been taken to ease this situation, such as allowing residents classified as non-eligible (about 3 percent so far) to remain in nursing homes for five years and lowering the co-payment to 3 percent for persons who had been receiving community-based social services. Also, many municipalities will continue to provide services to those not qualifying for LTCI under their own social welfare programs. Second, relating to provider
competition: on the supply side, the big change is with the former social services such as home care, which had been dominated by monopoly providers (local government, highly restricted types of nonprofit organizations, or contracted-out private services), but which are now open to for-profit companies and voluntary groups (subject to licensing by the prefecture, which is supposed to be liberal). Traditional providers are worried about their ability to compete, while potential new entrants are hungrily looking toward what they hope will be a vastly expanded market. Competition is supposed to be on the basis of quality, since services are all regulated by a fee schedule established by the national government. As with institutional care, price levels have been set to minimize disruption for providers, based on current social service budgets and reimbursement under health insurance. And finally, the third transitional problem is relating to supply and demand balance. The most important transitional problem will be balancing supply and demand. Municipalities have a generalized responsibility to plan for the supply of services, but they now must do so indirectly, by encouraging providers and perhaps selectively investing in new facilities, rather than through a routine budget process. For the entire nation, it appears that the current available
supply of home-care services roughly matches up to the government’s estimate of initial demand under LTCI. However, great variation exists both across local areas and across types of services. If more persons than expected apply and become eligible, the municipality must either ration services among beneficiaries (politically quite difficult) or somehow scramble to increase services. Or if beneficiaries make choices that are different than anticipated—in particular, if many now in the community opt for institutional care—local officials might be faced with severe complaints from dissatisfied frail older persons and their families. Generally, contemporary situations necessitate a move to reform the scheme as more anticipated and unanticipated complications emerge along the process.

After 5 years of implementation, about 15 percent of persons above the age of 65 have been certified as eligible in 2005 under the scheme of LTCI (Ikegami, 2005). This ratio has grown from 10 percent when the program started. Expenditures have increased greater than the original government’s projection. In an effort to contain costs, the government has made revisions in 2005 that consisted of levying modest hotel (accommodation) costs for institutional care, and restricting the provision of home-making services in the
two lightest eligibility levels. For the latter, a new package of “preventative” service has been introduced that include exercise training, oral health and nutritional counseling. Whether these measures would succeed in containing costs remain doubtful but there has not been any demand to tighten the eligibility criteria or reduce the benefit amount. This may be due to the fact that the program has been popular with the public, perhaps more so than health insurance, because the benefits are more tangible.

An ‘Act for Partial Revision of Long-Term Care Law’ in Japan was officially announced at end of June 2005. Though all the points for revision were illustrated, the implementation of revision for each respective matter were (are) intended to be conducted gradually in step by step manner. The main aims of Long-Term Care Revision that is scheduled to be fully implemented by April 2006 are to create a sustainable LTCI system that sensitively corresponds to the changing society that is characterized by a fast speed of ageing, and to actualize the creation of a society that preserve the respect and dignity for the elderly and allows the conduct of individuals’ independent living (that corresponds to respective individuals’ capability). In order to attain these aims; revising the content of preventive assistance, revising all cost of insurance
payment relating to meal and dwelling (hotel cost), and upgrading the efficiency of insurance payment in order to device approaches that can yield a new type of needed services will be necessary. Thus, the law revision was initiated. In brief, the main contents of the currently pursued Long-Term Care Insurance System’s revision are: reconsideration towards insurance benefits payment relating to meal and dwelling expenses; reconsideration towards matters relating to preventive care; reconsideration towards matters relating to locality adapted services (Chiiki Miccyakugata Sabisu); revision on matter relating to care requirement eligibility and support to attain eligibility authorization; reconsideration towards matters relating to the appointing of designated home service provider; revision on matters relating to public release of care services information; revision on matters relating to local community support action (Chiiki Shien Jigyou) and others. To mention it more briefly, the central concern for revision are: a switch over to a method that emphasize preventive concept, to reconsider the portion of insurance cost to be burden by individuals, to establish a new system setting, to secure and upgrade service quality, and to revise both insurance’s premium and the organization’s operation. The actualization of preventive concept in services and approaches, and the
implementation of locality adapted model of intervention are strongly emphasized. First, let’s take a look at the arguments relating to preventive concept in welfare services in Japan’s system on how it was earlier adopted prior to discussing on how the concept is again reflected through the LTCI law revision.

It is a well accepted fact about the likely that the cost to be incurred in preventive method would be of a lower degree if compares to the cost to be incurred in curing process. Moreover, in a situation where available resources (in terms of material and man power resources) are limited in numbers as in Japan, a highly efficient distributional practice is required, and the concept of preventive care in this situation is hoped to be able to assist in identifying an effectively early, comprehensive and reflexive intervention methods that can lead to the slow-down consumption of the limited resources. Prevention, as argues by L’ Abate (1990), consists of any approach, procedure, or method designed to improve interpersonal competence and functioning of individuals, and the objectives of prevention are to minimize harm to the individual and the community through the improving and sustaining of certain functioning (such as economic productivity) necessary for the living of the individual (Jahiel, 1992).
Prevention is also a process that comprises a continuum of interventions (L’Abate, 1990). In this context of argument, the intended effort to minimize community’s harm should be worked out through the improvement of interpersonal competence (rather than merely of individuals’). This relation signifies the need for a systematic, comprehensive and reflexive mode with reciprocal action in order to ensure preventive approach’s continuity. This effort must be founded on, and set to achieve the acquirement of solidarity (through the minimization of individuals’ and community harm) that in return will create the environment for the possible implementation of the above stated systematic, comprehensive, reflexive and reciprocal mode of action.

Among enabling factors that are believed to be able to support the possible pursuance of preventive approach in welfare areas can be identified as the following five factors which are: service delivery system restructuring (Meredith Davies, 1995; Glasby and Littlechild, 2004), social workers’ competency profile reforming (Otto and Flösser, 1992; Gould and Baldwin, 2004), information sharing (Austin, 2004; Ogasawara, 2005), community and social network reorganizing (Seden and Reynold, 2003; Glasby and Littlechild, 2004; http://www.mkweb.co.uk), and finally, the need for an understanding
towards the concept of contributive obligation for reciprocity as a social duty in
the mutual effort to implement social action such as ‘prevention’ (Dréze and
Sen, 1989; Roche, 1992; White, 2003). The interconnection between these five
factors can be understood in the following relation: the organizational
reformation of institution (both internal and external) aiming to remove the
bureaucratic rigidity is a necessary factor to allow a higher capacity of
professional functioning in care profession. It is through this shift of
competency profile that social workers are expected to reform their framework
of professionality from a primarily interventive and controlling activities to
activities directed toward assistance, support, activation and prevention. The
possibility for information sharing will further enhance the professionality of
social workers by allowing the formation of care provisioning team with resilient
team-work capacity that is equipped with a shared sense of ideology and
responsibility. However, sharing just between the professionals has proved to
be insufficient since effective intervention with preventive orientation requires
accurate information and mutual commitment from individuals and their
community. This is where professionals have to put up an additional effort to
drive the community into a participative mode and assist them by building their
confidence that will later on assure the development of their capacity to continuously engage, participate and contribute towards the implementation of preventive measures for their own society. And above all, the possible actualization of this idea will largely depend on the understanding of the importance of such efforts by individuals and the acceptance of participation in it as a duty to oneself and a duty that community members owe to each other. The translation of this wisdom into a practice can only stand on the positive response from the majority of individuals who sustain the community.

As observable from the above explanation, the simplistic notion of ‘earlier’ intervention is no longer placed as the dominating and main defining concept of ‘preventive strategy’ as it is currently understood in the contemporary social work and social policy issues. As argued by Otto and Flösser (1992), the argument has developed into a more complex thinking that aims to implement holistic, lifeworld-related action strategies with further additional consideration towards individual’s socio-political and socio-economical factors. Rather than merely focusing on person-to-person therapeutic relationship, the nurturing of a reflexive environment (Beck, 1986) – where a fair redistribution of responsibility and participation opportunity in understanding, deciding and implementing
preventive actions between all parties in the community is possible – is placed as the main factor that should characterize the process.

The concept of Community-Based Welfare (Chiiki Fukushi) was first introduced by scholar Okamura Shigeo in Japan. His definition of community-based welfare strongly highlights the important roles of ‘preventive actions’ along with the concept of community care and social organization. Prevention is one of the elements that have all along been placed as central in the forming of local social system in the country. The term ‘preventive care’ was first used by Japan’s Ministry of Welfare in the year 1999 and it became widely used since the institutionalization of Preventive Care and Living Support Task Policy in the year 2000 and the implementation of Community-Based Welfare Planning Policy in the year 2003. Generally, other than the prevention of illness, the aim of preventive care in Japan (in this case for the elderly) is to delay the physical, psychological and social functions’ decline due to ageing process and to support the continuation of independent living of elderly even after their falling into the ‘situation of needing for care’. The effort has to be pursued through the creation and maintenance of ‘a relationship of mutual trust’ that can be achieved through the creation of mutual communication based on the
understanding towards: the service recipients’ thought, emotions and hope; the provisioning of psychological support when and as necessary; and the sharing of information (Kurota and Fujii, 2002). In this situation, the ideal function of a social worker in delivering preventive care is to lead a role as a total care coordinator through a multifaceted approach which allows practice to occur on a micro-level and a macro-level simultaneously (Taylor and Roberts, 1985; Ohashi, 2002).

In terms of preventive care aim setting, what is most important is not to regard it as a ‘single’ service. It should be regarded as a ‘total’ service that is composed from various services that are systematically linked to each other in order to create a synergistic effect to individuals; and, the forming of common understanding through collaboration in terms of ‘clear aim setting’ and ‘organizational cooperation’ between all related parties are required to ensure the ‘totality’ of preventive care in terms of its quality. In addition, aims should not be merely the aims of service providing institutions, but to be widely diffused and articulated that it becomes shared by the whole locality and community for the fostering of participation and collaborative action. In sum, preventive care practice needs social net-work based problem solution,
collaboration and partnership, situation-close intervention, coordinated and collective decision making, interdependency, a fair task delegation and meaningful two-way engagement between all members, and so forth for its effective implementation. In other words, preventive concept needs a comprehensive and at the same time reflexive policy in its exercise and these characteristics of policy can only be sustained in an environment where there exist solidarity, reciprocity and independency.

Seeking to implement an approach that is closer to practice (rather than merely conceptual) and more situational-adapted, preventive care in the new context of LTCI system are understood as a kind of service that can be segregated into two categories: ‘general preventive care services’ (that consists of 12 different services which amongst are: home visit preventive care, nurse visit preventive care, rehabilitation visit preventive care, home medical treatment’s supervision preventive care; and other preventive care activities that are related to institutional care services, institutional rehabilitation care services, institutional short stay, institutional medical treatment’s short stay, admittance to special nursing home, welfare equipments rent, and welfare equipments sale) and ‘locality adapted preventive care services’ (that consists
of 3 different services which amongst are: preventive care for ‘dementia institutional care’, preventive care through ‘small scale multi functional home care’, and preventive care initiated to cater the needs of people with dementia that that lives together in a designated care unit or care institution). A new concept and practice of ‘preventive care support’ was established and introduced in order to assist the actualization and delivery of both general preventive care services and locality adapted preventive care services. It is an action where the social worker or care manager in-charge prepare a care plan that clearly states the composing services that are necessary in terms of their (the services) types, contents, and appointed person that will be responsible to assist the actualization of such plan, and the coordination of preventive care service providers in order to secure the provisioning of such services so that the needing individuals will be able to adequately utilize such services. Another new category of services that was laid down in this revision is ‘locality adapted services’. Locality adapted services are services that consist of six different types of services of which amongst are: night visit care, dementia institutional care, small scale multi functional home care, care for people with dementia who lives together in care unit or care institution, care for individuals who are
admitted to local special nursing home, and care for individuals who are admitted to local nursing homes. The costs for utilizing all the above stated newly introduced services are to be born my individual municipalities.

Further, municipalities are also mandated to conduct newly established ‘local community support action’ that is aimed at attending the need of those who are still healthy and preventing (reducing the speed) them from an early enter into the stage of care needing. That is; municipalities are to conduct preventive care action, comprehensive support action (preventive care management, general consultation support action, and comprehensive / sustainable support management action) and other local community support action in order to prevent individuals (who are the members of the locality) from falling into the situation of ‘needing for care’, or otherwise, to provide support in order to enable the continuation of individuals’ independent living in the neighborhood that one is familiar with to the most maximum extent possible even though after falling into the category of ‘needing for care’. In this context, the municipalities have the right to charge individuals in providing these services and have the rights to commission the provisioning of these services to any selected institution such as elderly care support center or others. In
effort to actualize this new support action, municipalities are allowed and required to set up or establish Locally Attached (Regional) Comprehensive Support Center (LCSC). LCSC can act as an agent to represent individuals, for example, in the process of eligibility authorization application. The center must act as a center to provide the above mentioned services of: counter for general consultation, preventive care management, and delivering comprehensive / sustainable (continuous) support. Staffs working in LCSC are obliged to protect the confidentiality of their clients.

Other than earlier explained ‘prevention’, a ‘new’ understanding of the category of ‘preventive actions’ in the context of practice in Japan was introduced along with this revision of LTCI Law. The additional categories of preventions are: restoring and improving individuals’ physical mobility function through (muscle-building) strength training, nutritional improvement through nutrition guide and consultation, and improvement of oral (mouth) health in order to maintain and restore individuals’ (in this case, the elderly) living function, providing means for independency, and to prevent fast deterioration of health. Intervention managements are done continuously and based on respective individuals’ situation (Health and Welfare Department of Sendai City,
The establishment of LCSC is crucial as a body or center (sustained by a close collaboration and cooperation between different field of functions and expertise that are mainly represented by personnel from insurance, welfare and medical areas) that can help to facilitate the actualization of the new category of prevention through the total management of locally provided cares (comprehensive local care). Comprehensive local care in this context would mean: the provisioning of a comprehensive care that is defined in a wider meaning (a care that looks into more than merely providing the authorized care), and achievable through the collaboration that takes place between different field of experts (as mentioned above), through collective actions that include in them the participation from various sections of the society (such as volunteer sectors or private individuals), and through the integration of all natural resources available in the society (while continuously placing the LTCI services delivery as the pivotal means of catering the needs) (Health and Welfare Department of Sendai City, 2005).

LCSC are facilities that are established in respective localities with aim to comprehensively support the promotion of well-being and improvement of medical condition of individuals (who are the local community members) by
putting into practice the provisioning of ‘comprehensive support action’ (or any others tasks that are required to be performed by Ministry of Labor, Welfare and Health) and by extending all support necessary for the preservation of their liveliness (both mentally and physically) and stable living conditions. LCSC was established with the aims to strengthen or supplement the function of earlier established Home Care Support Center (HCSC). Despite of the very early advocation towards the need for home care services in Japan, it was only in the early 90s that such services were thoroughly provided. HCSC was established around the same years and mandated with the duties to support the running of home care services. Various reasons on why home care services (thus, the establishment of HCSC) were not successfully implemented in the earlier years was highlighted, which amongst are: vertically divided bureaucratic hierarchical system, hard access due to limited number of centers and locations that were remotely located from local community’s network, insufficient number of services and unsuitability of existing services to community members’ needs, the societal norms and attitude that conceived care as something ‘private’ and should be fulfilled by family members (thus, created hesitation and rejection against the significant function of public care), and others. However, as needs
continued to rise and became extremely urging, centers that can function as a
general (welfare) consultation counter and capable of delivering 24 hours
(welfare) services around the year were built, with a unit of center aiming to
cover one ‘junior-high school territorial zone’ service area. The centers were
placed under the jurisdiction and responsibilities of municipalities. The services
provided by the centers expanded along with the development of welfare
provisioning in general, and such expansion was especially significant at the
point when Home Care Support Services were introduced into the system. It
was from that point onwards that existing centers were all officially upgraded (in
terms of their functions) and converted into what were known as Home Care
Support Centers (HCSC). The basic function of HCSC was to provide supports
through general (overall) consultation on matters relating to local community’s
well-being (in this context, the elderly), and such aspects of functions covered
matters relating to: elderly rights protection, abuse prevention, isolated elderly
monitoring, as a facility to assist early detection of dementia symptoms that can
lead to early treatment, as a facility that cope with individuals who were facing
difficulty with social participation, as a facility that worked to bring care closer to
those who were far away separated from care resources and to those who
were difficult to approach, and as a center that responded to needs that aroused from various obstacles individuals faced in their daily lives. In this context, the fact that the roles to be played by care managers are significant was beginning to be acknowledged by the community in general.

The roles to be played by care managers are even bigger in the revision of LTCI Law that will be fully implemented from this coming April 2006. And so do the roles that need to be played by (will soon become 'previously know as' – I would like to consider now as the transitional period) Home Care Support Centers. This is especially true in the context where the government is aiming to (and in need of the skills for) coordinate the whole functions (for example, the functions of respective service providers that produce different types of services in the system) that structure a comprehensive service provisioning, and synthesize the social and medical perspectives of care in the areas of home care through a new framework of service delivery system that will be implemented upon the completion of currently pursued law revision exercise. HCSCs were earlier mandated with the duties and functions to educate and support care managers. In the new system where it will be known as Locally Attached (Regional) Comprehensive Service Center (LCSC), the scope of
functions and duties will again be extended to include (this time) the promotion and the actualization of the concept and practice of preventive care, thus, further upgrading the functional strength of the centers as compares to their earlier form (as HCSC). According to the Long-Term Care Insurance Law (upon revision to be conducted on the April 2006), the LCSC are mandated to exclusively perform the provisioning of ‘preventive care support’ and ‘comprehensive support action’ (intended to be delivered as one of the services that comprise the newly introduced ‘local community support action’ explained earlier in this section). All centers are legally required to station the following three categories of staffs: social worker, supervisory care manager, and public health worker. Though in terms of occupational designation and function (literally) these categories are clearly differentiated, this is by no mean that their daily (actual) work function in the centers must be organized in rigid manners that exclusively separate them from each others. Overlapping of functions is to be expected (and indeed ideal due to the current need for integration). The following table and chart explain in brief the division of functions between the three categories of staffs to be stationed in each LCSC.
Table 2 - The Division of Functions between Different Categories of Staffs in LCSC

<table>
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<tr>
<th>Task Classification</th>
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<td>Preventive Care Support</td>
<td>Public Health Worker</td>
</tr>
<tr>
<td></td>
<td>Supervisory Care Manager</td>
</tr>
<tr>
<td>Preventive Care Actions</td>
<td>Public Health Worker</td>
</tr>
<tr>
<td>General Consultation and Support</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Preservation of Rights</td>
<td></td>
</tr>
<tr>
<td>Local Community Care Support</td>
<td>Supervisory Care Manager</td>
</tr>
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</table>
Chart 5 - The Division of Functions between Different Categories of Staffs in LCSC

- **Insured Individual**
  - General Consultation Services and Support Action
  - Abuse Prevention, Early Identification of Symptoms, Rights Preservation

- **Social Worker**
  - Team Approach
  - Supervisory Care Manager
  - Public Health Worker

- **Supervisory Care Manager**
  - Comprehensive and Continuous Management
  - Individual guide and consultation
  - Guide and advice for difficult cases
  - Creating a care manager network

- **Public Health Worker**
  - Preventive Care Management
  - Implementation of assessments
  - Drawing-up care plan
  - Re-conducting assessments

- **Locally Attached Comprehensive Support Center**
  - New Prevention, Preventive Care Actions
  - Long Term Sustainable Care Management
  - Connecting with necessary services obtainable from government bodies, health center, medical facilities, child-welfare consultation center etc

- **Developing Cross-cut Support on Systems**
Finally, as mentioned earlier in this section, care managers are expected to act as an agent of the recipient with a neutral and independent standpoint. Yet, the reality is showing that most care managers are trapped in a difficult position of the need to choose between split loyalties (to choose between recipient and the organization, usually providers, where they are employed and represent). The need for care managers to be independent professionals with high standard of skills and morale are further required by the nature of various new services conducted through the LTCI law revision. It is in this context that LCSC is hoped to be able to developed itself into an independent body that will later capable of educating a new breed of care managers with professional authority and independency – the quality necessary for the enforcement and implementation of the new method of intervention structured from the law revision (for example, collaboration between different field of expertise in order to provide a series of seamless and comprehensive services to individuals; and an approach that is based on preventive concept and actions). However, since the experiment has just begun, it is too early to make any predictions relating to the future achievements of LCSC. The results of implementations are yet remained to be seen. A comparison between the three models of integrated
care in order to identify their advantages and disadvantages in promoting the concept and practice of collaboration through integration will be conducted in the next chapter. The argument is then followed by an important discussion that touches on ‘identifying what is the method and understanding that can promotes a genuine process of integration for individuals’; genuine in a meaning that such process of integration is promoted from one’s within, and by acknowledging one’s inner perception.
Chapter 5
Reconsidering the Process of Integration and Integrating from Within

The understanding towards the concept and meaning of ‘partnership’ that suppose to found any collaborative effort (including integrated care) has changed over the past few decades; from an emphasis on an equitable, just and free society enshrined within the International Declaration of Human Rights, through the need to enable citizens to become more self-reliant and take control over their own health, to contemporary commentators who point out how a better educated and informed public have begun to challenge the quality of services provided and are searching for more meaningful interactions with service providers (Carnwell and Buchanan, 2005). What the above implies is the quest for a shared interest with the accompanying commitment, where all partners have an equity and obligation to participate and will be affected
equally by the benefits and disadvantages arising from the mutual relationship termed as partnership. Partnership tends to evolve into integration (where partners no longer see their separate identities as significant) in its more advanced form. It is commonly argued that the attributes to partnership in general are trust in partners; respect for partners; joint working; teamwork; eliminating boundaries; and being an ally. These attributes illustrate the share commitment that characterizes such action and show that it has a substantive ethical content. All partners need to have trust, respect and acceptance (acknowledgement) for other partners.

The above may mean the gradual erosion of current profession identities in favor of new, more problem-oriented professional partnerships or even professions. This has led to difficulties with some potential partners feeling that their individual identity is under threat. Key to the process of collaborative action is the involvement of partners in power sharing and negotiation (Gallant et al., 2002, cited by Carnwell and Buchanan, 2005). This process might involve considerable negotiation in order to arrive at a shared understanding of roles and responsibilities across multidisciplinary boundaries, as well as relinquishing of power relationships. Equally important, the negotiation of
power relationship should also occur in private life boundaries for the promotion of a genuine individual independency that will lead to the shaping of individual quality that is instinctively adapted to the principle of solidarity and reciprocity that are essential in the formation of an intact community.

Other than individual initiative, local directives or social policy changes, it is understood that antecedents for collaboration may include a number of personal and environmental factors (rather than merely the willingness of one party to work jointly with the other). In this context, personal factor may include: sufficient educational preparation, maturity and experience to ensure readiness to engage in collaboration; clear understanding and acceptance of their role and expertise; confidence in ability and recognition of disciplinary boundaries; effective communication; respect for and understanding of other’s roles; sharing of knowledge, values, responsibility, visions and outcomes; trust in collaborators, and so forth. These are skills and quality that every individual must possess in order to be able to participate competently in any collaborative action (including integrated care) and to attain their well-being in a way and towards the end that they have reason to value. However, the formation of such skill and quality (attitude) is a continuously interlinking process from an
individual's early life cycle towards the end, and from individual's most micro environment towards his or her most macro (for example, social policy) social environment. To maintain the continuity of such process and to cope with all the needs that will emerge along the process could never be a simple task. The aim of this last chapter is to: first; conduct a brief comparison between the earlier mentioned (in previous chapter) three models of integrated care in order to observe the similarity and differences of their approaches in implementing policies related to integrated care, and to grasp where Japan is situated in this context. And, second; to reconsider the point of origin or the basis for the formation of a genuine and mutual bond of collaboration that will help to sustain the formed integration to last longer.

5.1 Reconsidering the Process of Integration

Similarities (in methods and approaches) are most striking from the perspective of policy struggles that all the three countries are facing in order to device and actualize a set of integrated care system that best suits their unique needs. The main efforts are devoted and concentrated in attempts to bring all players in the social system, be it the groups or individuals, into an active and
fair participation in the initiated collective and collaborative actions. The struggles are to balance the division of duties among all actors in a condition where everybody acknowledge their mutual duties while balancing the availability of various kinds of services that are necessary to cater various needs originating from diverse parties and individuals. Particularly important in such context is the fact that the whole process need to be done according to proper planning and everyone participating in the process know their mutual duties and understand that the completion of every single segments of the duties are interrelated with other parts and affect the structure of process as a whole. Complex care issues can only be handled successfully through collaboration between organizations with one organization acting as a ‘strategic bridge’ to bring them together. In forming such collaboration, it is highlighted that matters relating to power relation or ‘power imbalance’ is crucial because it affects different people’s capacity differently in their participation to collaborative action. If ‘power imbalances’ persist, partnership can fail because for partnership to work, all parties need to feel they have an equal voice and be able and willing to share power. It is this effort to strike a
point where the power balance between all the players is in favorable condition (to all) that is the most difficult.

In order to ensure the existence of power balance, attributing ‘power’ to all is necessary, especially in the case of hard to reach minority and individuals. The attempt to ‘attribute power to all’ could be done in many ways, and as exemplified by the practice in Milton Keynes, such efforts are reflected through the councils’ openness by allowing public to have a greater say in Council matters by holding their meetings in public, and by regularly conducting ‘enquiring into matters of local concerns’ meeting. Such effort is also exemplified through the preparation of ‘Community Strategy’ (the main document that determines the contents and directions of Local Strategic Partnership practices) in which the whole processes of its formation are conditioned to be pursued with the engagement of all key stakeholders from all levels. However, what is further complex, and yet quite often neglected, is the matter that is related to power relation that affects individuals in their very own private environment (for example, in terms of child rearing in a family setting). We will return back to this argument in the later part of this chapter.
Generally, common to all the three models discussed in earlier chapters, the effort to constantly device and initiate new methods of interventions from time to time (in this context, integrated care) become necessary due to the continuously evolving characteristics of needs at any particular point of time. This tendency is then further strengthen by the incapacity of individuals to cope along with the changing environments in their effort to fulfill their own needs. In the following stage, it is generally observable that initial attempt to ameliorate such situation from the policy perspective is conducted by partially decentralizing the earlier implemented centralized administrative system (through the promotion of cooperative and collaborative relationship between different levels of system), and by encouraging public participation from grass root level (to remedy the community’s passive attitude towards any collective actions and to promote a sense of sharing in terms of responsibilities and contributions between all). The success (and emerging new needs along the process) in this stage will then encourage the introduction of a larger scale of reformation in policy where common views, mutual responsibilities and social solidarity are promoted in a more clear manner for the possible implementation
of a more comprehensive collaborative and collective social actions that are guided by a proper policy structure.

From our earlier observation, it is noted that the trend of ‘growing number of older persons requiring more services’ that came along with the ‘decline of family function’ are common in both Finland and Britain (even Japan). Yet, despite of such reality, family unit and family members have always been expected to play the main role and as important sources for the production and support of (informal) care. Despite of the changes in structure, the responsibility of family members as caregivers were required to remain intact, and in some cases, even argued that the level (of responsibilities) should even be increased. Equally, in Britain, while the rising trend of aging rate that came along with the decline of family function is observable on one hand, government, on the other, was pushing forward the effort to reduce the trend of long term hospitalization among the elderly. Both situations in Finland and Britain had led to an increasing demand for services to be provided by sources other than the centrally managed public sector. In the case of Britain, a focus was directed to the possible function of informal care network to supplement the existing system as an alternative. However, due to the slow speed of
development, it failed to close the opening gap between demand and supply in care services. Britain was left with no choice but to sought solutions from the capability of private sectors in her following attempt to balance the demanding situation. In Finland, such solution was sought from the cooperation that was conducted between the central state, local municipalities, private sectors and the community.

Other than the above, the changing trend of needs that was reflected by the striking differences in terms of care and health services available (most of which were concentrated in urban areas) for the public had also brought forward the need to conduct a system reformation. In Finland, the introduction of Primary Health Care Act in the year of 1972 exemplified this attempt. After such act came into force, effort was concentrated to financing the establishment of services in the remote and rural areas. By the 1980s, reversely, problems of access to services and continuity of care were particularly apparent in the larger cities. In attempt to again re-balance the situation, a ‘personal doctor system’ was launched. Reformation in Britain was conducted through the promotion of ‘community care’ which since then has become the trademark of social policy in Britain. From this perspective, it is
believed that mutual trust and cooperation would be most efficient in effort to re-strengthen individuals’ self-help mechanism. What is important to note here is that both reformation actions that were brought by not through the changes in policy or legislation, but initiated from the grass root level. In both cases, interests were shown by local authorities and communities to autonomously initiate reforms in order to improve their coping ability against evolving needs. In both cases, meaningful two-way engagement between all community members, and involvement of community in bottom-up strategy were noted as the underlying factors that help to build confidence among community members and will increase their capacity for ongoing engagement in the process.

The structure of medium (type of provider organization) that was (is) adopted to actualize the above effort in Finland was a ‘health center’. It took a wider perspective on the provision of primary care by comprising preventive and public health care in its intervention\(^1\). In Britain, such collaborative effort was (is) materialized through the formation of ‘partnership’\(^2\). In this perspective,

\(^1\) Japan’s effort to revise its Long-Term Care Insurance system by setting up the Locally Attached Comprehensive Support Center and by promoting the concept of prevention resemble this approach and trend to some extent.

\(^2\) Local Strategic Partnership in the case of Milton Keynes.
it is noted that as collaboration progress, members will gain more capabilities and authorities will become further deregulated. In Finland for example, during the late 1980s and 1990s, regulation by the state gradually decreased and the possibilities for municipalities to choose how to organize social services and health care were further reinforced. Entering the years of 1970s, Seebohm Restoration was implemented in Britain and through that process a system that enables the provisioning of welfare services to be conducted by local authorities was set up. Both practices were characterized by a ‘guideline approach’ where the central government was responsible for the setting of service targets and objectives and where local authorities were fully obliged to enthusiastically achieve such targets. A Joint Funding System to enable the transfer of resource from central government to local authorities was also devised. In this context, though authority is decentralized or delegated to locality, central government did not simply let go their responsibilities and continue to support locality in collaborative ways.

The introduction of a larger scale of reformation in policy with the implementation of a more comprehensive collaborative action that is guided by a proper policy structure become necessary as needs become more complex
and diverse. At this stage, cooperation between different organizations (for example, between social and health care organizations) is emphasized, to which both public and private providers equally contribute their know-how. Reorganizing the production of services, development of customer orientation, multiprofessional teamwork and networking are the central areas for concern along with issues relating to the improvement of cooperation between clients and professionals and clients’ possibilities to influence decision-making in service provisioning. In Britain, the National Health Service and Community Act that was enacted in the year 1990 leaded to a huge reformation of health and welfare policy. The main content of such reformation are: the placing of welfare planning duty and obligation upon local authorities; to implement comprehensive care assessment and care management practice; to encourage the development of private sector; to improve facility inspection system; to adopt a professional grievances procedures; and to implement the transfer of resources from central government to local authorities. The trend of reformation is continued by Blaire’s cabinet in their attempt to promote the idea of ‘Third Way’ that aims to reinforce the collaboration and integration between local authorities and welfare department; to strengthen the support system for
carer; to improve assessment implementation; to conduct a proper performance evaluation; and to set a clear standard to guide service delivery process. In this context, further direct (and significant) involvement of public community in the process is reflected through the adoption of ‘lay assessor’ system (a measure to allow the participation of non-professional assessor in the assessing process) and ‘Best Value’ evaluation system (an evaluation system adopted for the purpose to evaluate the performance of local authorities and to monitor the standard of service delivery conducted by such authorities).

The above flow in terms of policy struggle relating to, first, evolving needs and devising ways to attend them, then, followed by initial attempts to conduct reformation through collaborative action, and finally, ended with the implementation of comprehensive reformations that are backed by legislation are also observable in the development and struggles of Japan’s social policy. Welfare policy development in Japan, like its other counterparts, has been struggling all along in order to continuously devise methods and measures that are the most compatible according to needs at any point of specific time. However, challenges remain as needs continue to evolve. As the environment,
political relationship, composition of community and the identity and social
background of community’s individual members changes – and they will
continue changing – earlier political, policy and social setting becomes
increasingly less efficient; solidarity weakens and its capability to provide a
sensitive and reflexive environment where members would understand each
others circumstances, thus share the information that enable collaboration
oriented action is becoming less possible. Japan is currently challenged by a
series of factors that emerged along with these shifts.

Among mainly identified problems that challenge Japan in its effort to
formulate a sound policy in welfare provisioning are bureaucracy and passive
community participation. The changes in demographic pattern due to
socio-economical environment and the persist existence of conservative
ideology in the community (Furuta et al., 1996) are believed to be among the
main underlying reasons. The most urging need for reformation in welfare
policy in Japan, as argued by Nagata, can be traced back as starting from the
early 1960s due to the emergence of societal and socio-environmental adverse
transition that originated from the drastic restructuring of economic and
industrial structure – the consequence that was brought by the implementation
of policy that was tailored during the high growth of economy (Japanese Research Association for Community Development, 1987). The rising demand for employment motivated labor force migration, and as a result, the speed on the formation of nuclear family and the down-sizing of family unit were accelerated, while at the same time, the family unit's traditional capability to provide support to its dependent members became deteriorated. The larger extent of this adverse affect was the negative impact that could be seen through the weakening of local community solidarity – due to the de-population and graying of rural society (Nakamura and Ichibangase, 1998). This breakdown on the sense of solidarity in the locality – as the consequence from industrialization and urbanization – underlies and brings forward the need to reconsider the existing social arrangement. Arguing from the view point of community organization, Sasabe and Sonoda (in Hashimoto and Miura, 1973) emphasize that the need for such practice (of community organization) in Japan is reflected in the expanding phenomenon of social structure breakdown as the result of drastic urbanization. Due to this situation, the capability of individuals to resolve the obstacles in their life and to fulfill their personal needs hit its limitation and effort to collectively cater these various unmet needs is
therefore necessary. The necessity to create a solution mechanism for individuals’ hardship through the network of society and in the society itself is suggested and this is justified due to the fact that this would be a foundation that will support the ideology of ‘common mutuality of living basis’, imperative for the creation of solidarity (Hashimoto and Miura, 1973). The arguments on ‘Japanese Welfare Model’ was one of the effort to thoroughly consider this situation, however, the pursuance and achievements of propositions as stated through this argument were not possible on the reality, due to the fact that the expected function of family unit and the community intended to be relied on was already in decline (Nakamura and Ichibangase, 1998).

As stated by Uda, the underlying reasons behind the lag of progress on the development of independency of actions (thus, interdependency that can lead to collaborative action) among local authorities in Japan was due to, on one part, by its conservative and bureaucratic social and system make-up, and on the other, due to community members’ slow awareness towards the importance of being able to conduct a self-governing and autonomous practice (Japanese Research Association for Community Development, 1987). The reason why bureaucracy and dependency to some extent remain intact and still
capable to strongly influence the social system in Japan is because of its strong tradition on the pursuance of a centralized administrative system that leaves (and encourage) the citizens’ awareness towards the need to be autonomous remain weak. On the other hand, it was also noted that most of the community participation practices that were conducted by the citizens were characteristically passive (i.e. initiated by a government directive rather than through autonomous initiative) and defensive rather than promoting and exploring new possibilities. It is to some extent arguable that this situation originates from the lack of inner self-determination for one’s own self-betterment and / or due to the incapability of individuals to fully adapt to the radical and drastic introduction of plans and policies that emphasize local participation and autonomy (Hashimoto and Miura, 1973).

As argued by Okamura, in order to create the sense of solidarity through reciprocity – quality that determines the direction of any collective effort – it is most vital to set a ‘common point of view’ against the targeted issues among all related parties in order to develop their common understanding. This could be initiated by bringing the focus of each related parties towards the common

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3 Even today, this criterion is to some extent still visible in the running of social welfare administration at local authority level in Japan (Furukawa, 2003; Ohashi, 2003).
awareness of issues, and complemented by the proper planning of social resource’s mobilization and the laying out of certain procedures that will encourage cooperative action (Japanese Research Association for Community Development, 1987). In this situation, the involvement of local authorities, private and volunteer sectors, and individual community members are inevitable in government’s effort to create and provide a collaborative welfare services (Furukawa, 2003). Sasabe argues that this collaboration between all related parties should be achieved through the fostering of ‘mutual welfare values’ in the society. According to him, the fostering of the value should be based on respect for constitution and acceptance of mutual responsibility between central state government and local authorities, and should be complemented by citizens’ community action, the formation of consulting bodies and coordination for mutual communication. The need for a balance approach between administrative (i.e. through policy implementation) and actual practice from the ground level is argued by Sonoda. To put it more precisely, the mentioned actual practice from the ground level would include efforts to promote the active participation and initiatives of local community, local participation encouragement, conducting discussions about obstacles
that hinder any implemented measures and methods for the achievement of
aims, and the nurturing of local authority’s awareness on the importance of
autonomy. On the other hand, the important role of administrative function
(from the public sector) is to assist in preparing and improving the facilities (i.e.
institutions) necessary to support the living environment of individuals,
coordinating the mobilization of local social resources, strengthening the local
community’s collaboration and solidarity, and to help to integrate and organize
it (Hashimoto and Miura, 1973).

In relation to the above, Nagata states that the capability of (only)
administrative effort from the public sector in order to cope with the drastic and
ever changing social welfare needs is very limited. The collaboration from
private sectors is therefore necessary (Japanese Research Association for
Community Development, 1987). For this reason, decentralization with aims to
reduce bureaucracy and independency, and to promote participation and
collaboration was initiated and reflected through the efforts that try to shift the
process of decision-making for policy and its implementation from the central
government to local authorities. Among the factors that heavily determine the
success or failure of this decentralizing efforts are; individuals’ participation in
decision making regarding the policy, the flexibility in terms of resources mobilization, and the existence of administration staff with professional knowledge. However, looking at Japan’s current condition, it is rather hard to agree that these factors sufficiently exist (Furukawa, 2003). As argued by Nakamura and Ichibangase (1998), the practices were nothing more than just a ‘controlled or regulated decentralization’\(^4\). Efforts were limited to the creation of alternative service providers that only function as a mechanical service producer (at the service output end), while the rights to decide the direction of allocation of resources to be distributed remain intact under the monopoly control of the bureaucracy.

In addition, it is also worthy to note that the changing structure of contemporary Japanese community is also posing a challenge to the comprehensiveness and validity of its social policy. The process of globalization with its characteristics of increased individuals’ mobility is working

\(^4\) Even though the process to decentralize decision-making rights from central government to local authority was initiated, law requirement and source of revenue became factors that continue to tie local authority under the control of central government. Further, even in most of the exercise involving privatization, the processes were limited only to certain part of private sectors and were conducted based on special terms and dealings with the government. It was merely a ‘consignment with no competition’ (Ogasawara and Takegawa, 2002).
towards transforming the contemporary Japanese community into a structure that is more complex, multicultural and even multiracial (Japan Immigrant Association, 2003). States are loosing their capacity to bind their citizens to the state, loosing control over access to their territories, and being unable to maintain clear distinctions between citizens and non-citizens (Bommes and Geddes, 2000). For this reason, the reshaping process of the community ideology in order to re-strengthen the loosening solidarity (to promote collaborative action) must be conducted upon a comprehensive understanding and consideration about the changing structure that is now taking place. Unless the re-fostering of social solidarity is made possible, no mutual understanding and reciprocity will emerge and consequently there will be no possible (or very less possible) implementation of collective effort (including preventive measures) in the social system. The maintenance of social cohesion in the contemporary social setting is likely to depend largely on the comprehensive understanding of the community structure and possible creation of a new relationship that is fair and inclusive to all its diverse members regardless of genders, age categories, physical conditions, nationality, races, cultures, and believes. It is through this maintenance of
social cohesion that solidarity will be formed and it is through this solidarity that an intervention that is based on collaborative action will be possible. Other than rearranging the service provisioning mechanism to make it less bureaucratic and to provide more spaces for community participation, it is vital to ensure that individuals in the community understand about the importance of such collaborative action and its significant relation to the improving of their own condition. This effort could be done through ample information sharing that will reduce their ignorance, and it is hoped too that this effort will be effective in reducing the resistance and passive-reaction from the community.

In its more recent stage of development, Japan has moved towards the socialization of care in modifying its tradition of family care for the elderly. Each citizen are required to take more responsibility for finance and decision making. For this purpose Long-Term Care Insurance (LTCI) system is utilized as the base policy for services delivery and the scheme has formalized the care management techniques for the running of process. However, the development of process was then in its later stage troubled by a great variation in standards

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5 The noticeable major changes includes shift of responsibility for caregiving from family to state, integration of medical care and social services, enhance consumer choices, requirement for sharing of costs from service using individuals, and the expansion of local government autonomy (Matsuda and Yamamoto, 2001; Campbell and Ikegami, 2000).
and availability that exist both across local areas and across types of services. Other than that, expenditures have increased greater than the original government’s projection. In an effort to improve situations, the government has made revisions on the LTCI system in 2005. The central concern for revision are: a switch over to a method that emphasize preventive concept, to reconsider the portion of insurance cost to be burden by individuals, to establish a new system setting, to secure and upgrade service quality, and to revise both insurance’s premium and the organization’s operation. Locally Attached (Regional) Comprehensive Support Center (LCSC) was established in localities as a unit that is mandated with the responsibility to facilitate the actualization of the above revision program through the total management of locally provided care replacing (to be more precise, upgrading) the earlier Home Care Support Center (HCSC).

From the above it is noted that the same tendency of policy struggles and the same trend towards employing integrated care methods as policy base for delivery of efficient services is observable in Finland, Britain and Japan. It is generally understood that ‘integrated care’ should be regarded as a ‘total’ service that is composed from various services that are systematically linked to
each other in order to create a synergistic effect to individuals. The forming of common understanding through collaboration in terms of ‘clear aim setting’ and ‘organizational cooperation’ between all related parties are required to ensure the ‘totality’. The differences between the three are only exhibited in methods utilize to materialize such aims and in the different level of comprehensiveness shown in approaches (covered area and range of services) in each country setting. Though the aims are the same, the chosen mechanisms for the means of implementation and the extent to which an implementation is conducted and pursued is different. It is assumable that such differences are strongly influenced by the attitude and quality of individuals who participate and control the process.

The existence of a network of professionals that is highly skilled combined with ample utilization of high technology precondition a proper practice of a large scale of integrated care. Generally, as task relating to care providing became diversified and more challenging, the accomplishment requires a highly professional task performance that is based on cooperative net-working. In this situation, ample opportunities for skill improvement (of staffs) are determining factors for success. Further, methods of staff compensation must
also be altered so that scale will suit their level of professionality. As argued by Ogasawara (2001), the attractiveness of the task as a rewarding profession is the key to secure the manpower that will support the actualization of aims and plans. A proper system that support and justified the effort of social workers in upgrading their knowledge and skills, and in performing their tasks is thus necessary. Japan is still a few steps behind in materializing this point though awareness towards the importance of its actualization no doubt exists. In Finland, for example, the implementation of Personal Doctor System was accompanied by an altered method of payments for doctors in a way that it relates better to the workload, expertise and experience of the doctor and the population structure he or she is responsible for.

The next part that is crucial in determining the existence of ample number of manpower with sufficient professionality is manpower planning, particularly in terms of training. Exhibited in earlier observation; it seems quite general in the observed three countries that different bodies will be responsible for training process and recruitment exercise of manpower. And, it is also quite general in all the countries that there seems to be a lack of cooperation and coordination involving the bodies and both the process. There’s a noted
problems in the same area in Finland and strengthening cooperation between all the related parties is suggested as one of the solutions. In Japan, this context of argument necessarily touches the area of care managers' manpower planning due to the highly expected function from them in assisting the running of LTCI system initiated by the government. However, as argued by Ohashi (2003), the current situation seems not to be so promising.

As it is well argued; welfare provisioning in Japan was implemented through a centrally controlled placement system (‘Sochi’ System) until the year 1987, leaving local government with almost no authorities in the process. The development of a proper social work practice with emphasis on and utilization of knowledge relating to social resources management method was substantially very weak due to the mainly developed bureaucratic administrative measure as stated above. Further, it was only in recent system reform that home care services in Japan were finally acknowledged in a legally written statutory form. The area of practice for home care services is expanding and its significance is acknowledged in its capability to offer a specialized practice with methods that are effectively connecting between provided care and the actual condition that service users are facing by using
‘care-management’ techniques. The competency rating system for social worker in Japan was only established in 1987 with the enactment of Social Workers and Care Workers Law (Syakai Fukushishi Oyobi Kaigo Fukushishi Hou). Earlier, the term ‘social worker’ reflects nothing more than ‘merely’ (read as less important) one of the government officers’ designation, and the attachment of the post was never accompanied by a proper regard for the necessary competency skills needed for the implement of proper social work tasks. In its next stage of development, it was noted that the welfare practice in Japan was developed in the absence of a proper connection between policy relating to the administrative system, and policy regarding to manpower planning (who will be responsible for the running of system). The situation substantially created almost no room for a proper social work practice to develop. Even in the case of care managers and their practice; the importance of relation between training and qualification, even between qualification and competency of care managers was not positioned as sufficiently significant in day to day processes. In short, there exists no virtually available system that could assist care managers or other welfare professionals to be trained and granted with proper qualification.
The method and approach of care management started to receive much attention in Japan since LTCI was introduced into practice. However, it is still hard to justify whether the current practice of care managers in the country is in line with the originally expected function. Such doubt arises from how the LTCI system is applied to practice. The implementation of LTCI comes along with the enforcement of care expenses payment limit. Due to this rigid regulation, care managers in Japan tend to overly concentrate on applying their effort to the part that mainly concern with cost management in their daily practice in order not to exceed the fixed allowed budget. This regulation and attitude consequently restrict their action to truly provide the necessary support. For example, in the case where certain needed service is not institutionalized, in such situation it is assumable that care professional will choose to either pioneer the new service with the cooperation from volunteer bodies or simply give up their care plan and redirect/reconstruct their care policy merely to suit the existing regulation. In most cases in Japan, however, care managers choose to give up rather than challenging to initiate something new. Due to the incapability of care professionals (in this context, care managers) to deliver a proper standard of service, the possibility for elderly to continue a living in one's
own home by utilizing the scheme from LTCI doesn’t seem to be totally promising. In addition, under the condition where LTCI Law prohibits the application of its service to other family members, the capacity of care manager to provide the type of care that connects and advantageously utilizes the existing relationship between individual who needs care and informal care provider from family members, and the existing relationship between individual and his or her surrounding community network is doubtful. Unless a care package that acknowledge the above explained relational factors is developed, question will remain as whether functions conducted by care manager in Japan is in line and fulfilling the originally expected standard and aim of care manager’s practice.

As argued in earlier chapter, care management is a method of intervention that was developed along with the practice of integrated care. Integrated care are services that must be directly and specifically managed through one-to-one management with no layers between. For such reason, the implementation of an effective practice of integrated care needs care managers who are professionally independent and equipped with enough authority to conduct a proper distribution of care and resources. In Japan, however, though care
managers are expected to act as an agent of the recipient and select providers as neutral buyers, majority of care managers are at the same time employees of home care providers. They are obliged to serve the employer and without ample authority that will enable them to conduct a proper practice. LCSC is the organization where majority of care managers in Japan will be attached to in the near future. The setting up of LCSC as an independent body or organization is hoped to be able to groom a new breed of care managers who are equipped with multifaceted approach which allows them to conduct practice on a micro- and macro-level simultaneously, and with professional authority and independency. Reconsideration on matters related to training, for example, would be crucial in attempt to produce care managers with the required quality and capacity.

Integrated care provisioning is a service reliant on human resources (that necessarily refers to care managers’ function in principal). It is the workforce

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6 The situation is exemplified in the decision-making process leading up to the implementation of LTCI system where most of the process was carried out involving merely a limited group of organizations and individuals, failing to reflect the general point of view of care managers despite of the main role that they are mandated with. This could be a continuation from an old trend where decisions making were influenced by, and done in a setting where there was a hierarchical bureaucratic system (Campbell and Ikekami, 2000).
that can make service delivery take place provided there are sufficient supportive conditions. For such reason, the right number of staff with the appropriate knowledge and skills is prerequisite for the implementation. In this context, knowledge and skills should include new professional roles, competencies, values and attitudes in order to replace the more traditional ones as they may not fit the requirements for integrated care service provision. Other than matters relating to interaction and dialogue with client, building awareness that working together with all key players in the care system will lead to more efficient, better-quality care should be the basis of the training. In addition, interdisciplinary learning that enables working across professional and organisational boundaries is also necessary because developing a common language is an essential tool for integrated working. This effort should then be followed by special emphasis that is put on building communication skills between staff from different professional backgrounds.

In the context of integrated care, sharing workforce-support mechanisms, including training, across organizations is instrumental. Organizations involved in integrated care will benefit from mapping all their training needs and developing a joint strategy for recruiting, training, and retraining. Providing staff
with some generic training during the first stage of the implementation period, or to set up a job-rotation program to develop the necessary skills would be wise because working in an interdisciplinary team often implies taking over tasks from other professionals. The next point that merit acknowledgment is the fact that needs of the care system do not always match the output of the education system. For example, basic vocational training courses that directly prepare students for practical work are becoming less popular. As a consequent, this puts pressure on the demand for staff providing domestic and hands-on care services. On the other hand, care providers may need more personnel with university-level education to keep up with the development of new methods of working, treatment, care and support. As such, preparing a balance category of education that satisfy different level of manpower requirement and different level of organizational functioning would be necessary. Finally, since that care needs to be provided in a culturally sensitive way, training programs should address issues related to diversity such as language, culture and lifestyle.

The function of technology in the delivery of integrated care is especially significant in a situation where services need to cover a large area of
intervention but conditioned by the availability of only a limited number of staffs (this is especially relevant to Japan’s situation). Information technology that allows ‘steering through information’ became increasingly important for the government as a means of monitoring the system. In Finland, such innovations include interactive regional information system, integrated care models in the form of seamless service chains for specified groups of service-users, and technology to support independent living of the elderly (this is again a situation that is relevant to Japan). The informatization of health system that came along with the development of Integrated Delivery System (IDS) is also observable in Japan after the implementation of LTCI. However, nothing much about this perspective was further argued from that point onwards despite of the acknowledged importance of this subject.

A mutual and good communication is essential for working in an integrated way, and information management system is probably the most important supportive process to modern care. In performing integrated care, professionals generate information either to be used by themselves or to be exchanged with other professionals for many reasons. It is in this context that there is special requirement for information and information flow in the system.
Using an effective information system to store and retrieve administrative information about a patient prevents duplication and saves time. Using an information management system also opens up greater possibilities that can contribute to integrated working, for example, through better planning, improve coordination, and better cooperation in assessing, treating and routing patients.

From the perspective of organization benefits; using aggregated information in an information system enables organizations to assess the costs, cost-effectiveness and quality of their integrated care system. This creates the opportunity for administrative, financial, and strategic planning, and for quality improvement and research purposes. Other advantageous that are particularly important for integrated care include: the ability to make particular parts of information available to specified individuals and professionals; the possibility to monitor, receive alerts and work proactively; the capacity to synchronize the involvement of patients, clients, carers; the facility to support coordination and case management better than paper files; enabling the administrative and financial data of patients or clients to be easily combined; and enabling working with aggregated data for the purpose of accounting, assessing cost-effectiveness and quality, and macro-planning and research.
In integrated care, the accuracy of information that can drive responsiveness to situation is critical. For example, collecting information from all parties involved is necessary in the process of comprehensive needs assessment, one of the process most crucial at the starting point of integrated care provisioning. This ‘global’ information is then used as a basis for visualizing the needs for integration of services and shared responsibilities. Since legal framework alone does not provide sufficient guidance for deciding on which risks are considered high or low, who carries the risks, and who is accountable, information collecting (through a proper utilization of information technology) could (and should) provide a crucial complementary function in this context. The importance of information system in practice is reflected in the difficulties faced in efforts to integrate various necessary services to a single client. This is especially true in the case where client’s needs are characterized by changing levels of problem severity over their care paths. Since great flexibility in service provisioning is required, in this context, ‘care pathways’ method is generally utilized. Care pathways are about continuities of care in which one of them (the continuities) is ‘information continuity’. Information about past events and personal circumstances are used to ensure that current
care is appropriate for each individual. To ensure information continuity, care staff should take part in developing and implementing care pathways. However, specialists in information flows (IT specialists) also need to be involved. This is another part in integrated care that requires a proper information technology utilization. The obvious disadvantage to information technology is that it requires investment in hardware, and possibly dedicated software, training, management and maintenance which is costly. However, it should be acknowledged that in the future the advantages will outweigh the disadvantages.

The next difference that is observable in the delivery processes of integrated care between Japan and the other two countries (Finland and Britain) is in terms of their range of interventions or comprehensiveness of approaches. Among the three, Japan is identified as the one with most limited range of interventions. This is clearly reflected through the (number of) category of staff required to be stationed at each unit of LCSC, and through the provided services that are restricted to the area of welfare for the elderly (despite of the widely argued intention to device and to conduct a cross-cutting intervention in welfare). In Finland, it is observable that the health center team
are usually consists of a wide categories of professionals working together including general practitioners, medical specialists, nurses, public health nurses, midwives, social workers, dentists, physiotherapists, psychologists, and administrative personnel. Because of this wide categories of staff composition, health centers are capable of offering a wide variety of services including outpatient medical care, inpatient care, preventive services, dental care, maternity care, child health care, school health care, care for the elderly, family planning, physiotherapy and occupational health care – providing almost all kinds of cares that are necessary for a community and not restricting provision to only one category of service users. Again, this possibility has to be supported by a condition where the health centers must be well equipped. The health centers in Finland are generally well equipped and the inpatient department of a health center works in much the same way as a hospital department. Health center in Finland function as a single body that integrates all categories of care that was earlier provided in a fragmented way under a single administration.

The approaches in Milton Keynes (Britain) are conducted even from wider perspectives where social, economical and political aspects of the community
as a whole are clearly considered, and where the needs of a community as a whole (involving all categories of individuals who are the member of the community regardless of age, gender, race and so forth) are carefully looked into in a interlinking or integrated ways. The wide perspectives of approaches are reflected through the key requirements that are generally advocated in the main policy structured for the attainment of growth which includes factors such as: formulating common community vision; building and improving infrastructure; engaging with environmentally sensitive and responsible development; conducting continuous revision on housing needs; creating an attractive and realistic public transport system that is accessible to all; creating enough high quality employment near homes; creating a coherent local health and social care services network; guaranteeing a proper education system for future generations; ensuring that the capacity of local criminal justice system is sufficient and in line with the population expansion; supporting local community and cultural trend; improving administration in order to accommodate the increased administrative needs of public services and the voluntary sector; renewing the neighborhood in order to transform it into a mechanisms to promote social inclusion to enable local people to access work and enjoy high
quality housing and local environments; and allocating enough resources to fund growth.

In the above explained both cases (Finland and Britain); the creation of policy and the attainment of aims are conducted based on the involvement of society as a network and as a whole (in a fair manner) in matters relating to decision making and implementation process. Locally Attached Comprehensive Support Centers (LCSC) in Japan was (is) established with (exclusively) mandated duties to implement the series of reformations that was proposed and decided in the revision of law conducted in 2005 involving the LTCI system, and such duties cover a rather wide perspectives of intervention involving matters such as: acting as an agent to represent elderly individuals in the process of eligibility authorization application, and acting as a center to provide: general consultation, preventive care management, and delivering comprehensive and continuous support. However, this scope of intervention is still limited if compares to what is happening in Finland and Britain in the fact that the minimum requirement (as stated in the amended policy) for the placement of staffs that determines the composition of professionals in each centers only involves three categories of professionals that are social worker,
supervisory care manager, and public health worker. The scope of intervention that is limited only in catering the exclusive needs of an elderly is another matter of concern. There are worries on the possibilities of outcome from the implemented policies that the good intention to treat the elderly in a special manner will unintentionally end up segregating them from the mainstream society (or the environment where the elderly are familiar with) due to the failure of approach to consider all the necessary perspectives in balance. What is important in this part is the understanding about the fact that efforts must be founded on fair reciprocity and solidarity where all actors in the community (including the elderly) work together collaboratively in way that minimizes individuals’ and community’s disadvantageous. The attainment of this situation in return will create the environment for the possible implementation of further integration and collaboration. Above all, the possible actualization of this idea will largely depend on the understanding of the importance of such efforts by individuals and the acceptance of participation in it as a duty to oneself and a duty that community members owe to each other. And as mentioned earlier, the translation of this wisdom into a practice can only stand on the positive response from the majority of individuals who sustain the community.
Comprehensive approach in the context of integrated care could mean comprehensiveness in terms of ‘range’ of approaches and in terms of ‘continuity and in-depth’ of approaches. First, let’s discuss a comprehensive approach in terms of its covered range of interventions. From earlier discussion, it is understood that the central pivot of integrated care is the care provided by a team of service providers through integrated processes that overcome professional and organizational barriers. Workers of various professional backgrounds, and in different organizations, have to form collaborative teams in order to provide a full array of services that are integrated to meet the needs of individuals. The array of services needs to be linked, coordinated or integrated, and these services may include services such as: short-term health care, long-term care, social care, housing, supportive services, aids services, and health promotion and maintenance.

The mix of staff in the integrated professional team depends on the team’s objectives. However, the core team will usually include: a primary care doctor, a nurse, a care manager, a social worker, a home care worker, and administrative and other support staff. This core team may then be supplemented or expanded, according to need, with a community geriatrician,
a health visitor, a physiotherapist or physical therapist, a home help or
domestic worker, a personal care worker, an occupational therapist or
ergotherapist, a speech therapist, a psychologist, family carers, volunteers,
workers in associated sectors such as transport or housing advisers; laboratory
and technical staff; information technology specialists, and support staff
including secretarial and office workers, and cleaners. Domains of needs that
should be addressed include health care needs, social needs, mental health
and function, environmental needs, psychological needs, spiritual needs,
economical needs, and also preferences of client and informal carers. Ideally, a
needs assessment should cover all these domains, which means taking
behavioural, social, medical and psychological functions into consideration, as
well as the social and physical context, such as availability, strengths,
preferences of informal care, housing conditions, transportation needs and
household needs.

Professionals need to develop systems that could relate individual to the
whole community and entire system of care, and not just to the particular
services they need. This process is actualized through a method that is known
as integrated strategic planning (refer to local strategic partnership in Milton
Keynes for more similar details). It is about key stakeholders from the statutory, non-governmental, private and community sectors working together to achieve a shared understanding of their local service system in order to redesign and improve the way it operates. This addresses the balance of services, the connections between health, social care, housing, transport and other community services, and the interdependence of services. Integrated strategic planning is not a static or one-off process but involves continual review, as plans are implemented and changes take place. Strategic planning seeks to achieve a balanced system of care that offers a comprehensive and coordinated range of services. It requires all parties to agree a joint action plan that clarifies the objectives, identifies the stages and tasks to be done by whom and by when, agrees milestones for each stage, and builds in a systematic review of the plan. Strategic planning for integrated care should be supported by national policy that provides financial and other incentives to whole-systems approaches and that addresses legal and other barriers.

Another part of the needed comprehensive approach in integrated care practice is the kind of approaches that are characterized by their capability to cater needs through in-depth ways and yet in a seamless manner. Such
approach should be able to address needs through the whole intervention process in a systematic way. In developing well-linked, coordinated or fully integrated services, continuity is the key priority. In the context of integrated care, two dimensions of continuity are always at stake – the simultaneous and the sequential. The simultaneous dimension indicates the provision of multiple services that has to be coherent in its contents and its logistics. It is the coordination or integration of services during the entire process. On the other hand, the sequential dimension indicates that care and services have to follow the needs of the user over time, but the stages of progression must appear seamless. Needs assessment is the starting point in intervention process, and in this part, the main challenge is to ensure that the client-centred assessment takes place. To the client, the needs assessment is the grounds by which he or she is seen as an individual and can interact with the service provider and the funding agency, and can thus discuss and influence the care. To care organizations, the practice of needs assessment would assist in the balancing of resources to the summarized needs of clients, and to the government authorities, such practice assist in scrutinizing costs of care in comparison to other costs in society. The needs assessment is also intended for the
attainment of information to assist the prioritization between different needs. A comprehensive need assessment is useful in effort to obtain a view of the client’s needs that is fuller than that of the one-point of time’s eligibility assessment.

The prevailing attitude in many countries is that they tend to promote a process of care provisioning that is more structured and standardized, to establish the basis on which service are planned in packages. However, from earlier discussion, it is understood that professionals should not generalize and stereotype individual needs because such practice necessarily limits the comprehensive quality in approaches and interventions. To an extent possible, preferences have to be communicated. And this interaction is actually the core of care. There is a definite need to carefully define and to properly conduct a comprehensive assessment to determine the level of risks that respective individuals are facing. Arguments on care pathways highlight the managerial and professional duties needed to transform the recognition of individual needs together with all the available resources into personalized care interventions. In this context, interventions that work on a single-agency basis and lack access to appropriate expertise in assessment are unlikely to be fully effective –
particularly for people with complex needs. In order to ensure comprehensiveness of approaches, care pathway should be modified and supported by the team and organization involved, as well as by the clients and carers. Where decisions are unclear, rules should be established, so that policies are put in place for every eventuality. The pathway needs to be constructed as a multi-disciplinary plan and record of care should include all key information. All the relevant and required documentation and records must be taken into consideration.

And finally, cooperation is another factor that is crucial in sustaining the comprehensiveness of approaches. This is especially crucial due to the fact that the majority of care is provided by informal carers, such as next of kin, neighbours, and volunteers. There are a number of advantages to the client and their family and carers playing an active role. With a fuller picture of the client needs (attainable with the cooperation from informal carers), it is possible to more easily make priorities and remodel different services. However, professional care providers do not always acknowledge the contribution of these groups, and they are seldom regarded as partners in the system. As a consequent, often, discrepancy between client needs and preferences arises.
This situation should be dealt with in team discussions that involve all categories of service providers (including service receivers), to ensure a true balance between different interests can be reached.

In sum, the implementation of integrated care as illustrated from the discussion above (and in previous chapters, for example in CARMEN Project) is reflecting a process where three different functions that are crucial to the needs of elderly – cure, care and rehabilitation – are closely linked in a seamless process. The process also emphasizes the importance of need responsiveness that should be attain through a continuous series of care conferences that fairly involve all related parties in the process of care provisioning. Other than that, the characteristics of CARMEN Project also reflect and expect interlink between the process of ‘Pre-Care’ (preventive care) and ‘Post-Care’ (physical care). The importance is understandable from the fact that physical and psychological condition of the elderly changes and fluctuates constantly, and for such reason, need monitoring and feed back that is conducted from both perspectives of care are frequently necessary in order to provide a care that is comprehensive and affective. These are the characteristics from which the practice of integrated care in Japan has much to
learn. In Japan, despite of the wide acknowledgement regarding the importance to connect and link between the process of care, cure and rehabilitation in service provisioning (for the elderly especially), in reality, there is not much effort that is concentrated in order to conduct the necessary seamlization. In this context, Japan should ameliorate the situation by targeting to input seamless integration function within the day to day process of clients life. The practice of integrated care in Japan is also aware about the importance of need responsiveness in the process. In Japan, the attainment or the conduct of such responsiveness is expected to take place at the level of care management, and to be conducted by qualified care managers. This over expectation (towards the function of care managers) has consequently created a care coordinating / provisioning system that is personally managed or controlled by individual care managers. The most striking difference that can be observed in this perspective is that while the CARMEN Project has been advocating and acknowledging the importance of ‘care conference method’ in its needs attending strategies, Japan has been obsessed by individually controlled ‘care management’ technique. And finally, the point that needs reconsideration in Japan’s practice of integrated care is the part where the
process in Japan (through the practice of Long-Term Care) is exhibiting a clear cut division between prevention (pre-care) and post-active-care (a characteristic that is opposite to what is practiced in CARMEN Project). The differences that exist between the two originate from the different understanding that is given to the concept of care in Japan as compares to European Union (EU) member states (reflected through their participation in CARMEN Project). Through such observation, it is noted that the operating method in CARMEN Project (of integrated care) is always characterized by a feed-back system that is performed through a team-work; and based on a care plan that is never too rigid and flexibly altered from time to time according to the most contemporary situation of individual needs. This is another perspective that is contradicting to practice in Japan, thus, should be regarded as another point of reconsideration.

The possible development of individuals’ independency is also conditioned by the extent of (psychological) autonomy that one posses and such autonomy is likely to originate from the existence of ones instinctive freedom, or to put it in an easier words, individual mind’s creativity. The more such instinctive freedom is obtained (in this context, of course, necessarily supplemented by experience
gaining and learning process), the more it is likely for autonomy, thus, independency to be developed. The attainment of independency is crucial because it preconditions the conduct of reciprocity, one of the core factors that sustain the possible implementation of any collaborative and collective social action. For this reason, it is in this part that the most formidable challenge to the practice of integrated care (as a collaborative social action that depends on solidarity) would lies – that is; to acknowledge individuals’ inner strength (their instinct) in the attainment process of their own independency that will become the base to sustain the possible exercise of reciprocity for the formation of solidarity. The flow of welfare policy development in Japan has shown numerous efforts to promote, attain and sustain the concept of solidarity together with reciprocity (interdependency) and independency. However, most approach and arguments were conducted from the view point of providers or scholars; view points that were external from that of citizens’ own. Though arguments relating to the subject of solidarity and even reciprocity to a large extent were strongly reflected in the policy arguments, much was not done on the effort to acknowledge the part of independency and its significant roles in the formation of quality that can lead to the discharge of practices relating to
reciprocity and solidarity. For example, the enactment of Social Welfare Law through the implementation of Fundamental Structure Reformation of Welfare has attempted to place the argument relating to the attainment of individuals’ independency as core. Nonetheless, this effort has only succeeded in placing the position of individuals’ independency up to the status of ‘service user with rights’ under the contract-based of welfare provisioning system, and at its best with some ambiguity. For a long time the argument of solidarity in Japan was carried out and halted at the theoretical level in the absence of thorough efforts to further actualize the ideology through arguments on, and practices of reciprocity, and the pursuance of self-independency. The argument relating to individuals’ independency attainment and its necessity was conducted with lack of theoretical consistency (Ogasawara and Takegawa, 2002). This lack of the discourse of independency and reciprocity tainted the authenticity of the formed solidarity. In most of its parts, the formation of solidarity in Japan was more of a guided process from above, rather than a process that arose upon the genuine understanding of the two. In the next section, we will look into what are the basic principles (of understanding and ideology) that permit or should
guide the development of independency in individuals, especially in the boundary of private life that is quite far from the reach of policy intervention.

5.2 Integrating from Within

Integration from the macro perspective (by means of equalizing power balance), though not a simple task to be implemented, can be pursued through policy interventions and policy reformation as explained in the previous sections. What is more complicated to pursue is a reformation in the informal spheres, in individual’s private life boundary that involve, for example, a family unit and the setting. In other words, it is the integration within the most micro level within the family unit that is most difficult to be reformed (in situations when such action is needed). Yet, this has always been a part of the larger scale of integration pursued in the macro level and without which full integration process in the macro level will not be attainable. Since that the necessary quality for integration (individual's resiliency and independency that sustain the possible conduct of their fair interdependency) must exist in every individual, the issues of power balance (crucial for the process of integration) discussed in earlier chapters has to be tackled from the very early process of
individual's identity formation. Such process necessarily starts from, and influenced by the quality of attachment and social bond forming chances of individual in their family unit. A focus even from this very early stage of development is crucial reasoning to the necessary condition for individual's participation in collective social action is his or her certain quality that is formed through a continuous process in his or her life cycle and such process necessarily starts from home. The crucial part in this context is to develop a person with characteristics that is instinctively adapted to the formation of a resilient individual (independent and creative in dealing with faced life obstacles and in fulfilling one’s own need), and adapted to the principle of fair reciprocity (interdependency) and solidarity that are essential in the formation of an intact community. The whole process takes the freedom of individual's instinct development that will later lead to the development of such individual's independency as a starting process. For such reason, the effort to develop and sustain individual's independency is one of the most crucial issues to be looked into. The correct process will assure the possible nurturance of positive instinct development, the shaping of resilient characteristics, and guarantees the attainment of independency in individuals. In other words, it will create the right
quality necessary for later social practice and social integration. Only by this
mean that a true integration, integration based on the quality that exists in
individuals' inner-self (integration from within), can be developed. At this point,
we are aware and acknowledged the fact that individual's instincts (and its
development) is important in shaping his or her individuality and characteristics
that are needed for the survival of both the individual and the society where the
individual belong. The next difficult question is how or in what way do we
translate this knowledge and apply such knowledge into a practice in general –
in a form that is understandable to lay people (who are not scholars, policy
makers or even a person who is proficient with social work or welfare policy
knowledge) and their personal environment. And, what is the fundamental or
concept of care that is suiting to the contemporary community’s requirement
(based on various social changes that we are continuously experiencing).

In order to exercise an implementation of integrated care practice that is
truly affective and sustainable, we need to first of all, promote the concept of
integrity and solidarity in our social system by sublimating the adverse
development of segregational instinct that we naturally posses in us. This effort
should be accompanied by attempts to nurture community members to grow
into an individual that is equipped with the required quality necessary for the formation of social solidarity and other collective social action. In such attempts, early and continuous engagement in the process (of care), and understanding the importance of the concept ‘attachment’ and ‘social bond’ to the process (of care – both in formal and informal setting) is crucial. Further, the process of promoting the practice of integrated care also need to focus on the concept of independency upon understanding that it is the precondition to solidarity. In this context, providing the type of rational care that is capable of guaranteeing individual's independency, equipping individuals with the quality of resiliency, and preparing individuals to exercise social solidarity should be an ultimate concern. In providing such care, it is most important to understand and acknowledge what are the principles that will guide carers to provide the most suitable kind of care as against the need in contemporary situation.

Integrated care is a process of social solidarity. This is quite straightforwardly reflected in the eight principles of integration as discussed earlier in chapter two. These factors necessarily require mutual consent and fair reciprocity from involving parties for their actualization. Both, mutual consent and fair reciprocity exist in a sphere where there is awareness towards the
sense and importance of social solidarity. It would be most ideal to the contemporary social situation if we are able to precisely identify the characteristics of instincts that exist in respective individuals and utilize such knowledge to reconcile individually initiated efforts for attainment of self-betterment to the collectively initiated effort (of intervention) in our attempt to create an intervention method that can comprehensively look into the unique needs of individuals. However, though at this point we do understand that certain human instincts such as segregational instincts must be controlled in order to promote solidarity for the effective implementation of collective action such as integrated care practice, the tendency to categorize or segregate (thus dividing the society) rather than initiating to address the totality of individual is more common in our social system and social setting. The adverse development of such instinct will develop an attitude where individual will discriminate and treat certain categories of other individual who is different from him or her in a ‘special manner’. The worse example of result from the development of this attitude is ‘ageism’, and in its less extent this negative attitude is even reflected through the process of care provisioning where our good intention to treat an individual ‘specially’ will sometime inadvertently turns
into a process that will isolate the person from the main stream society. Such practices further aggravate the social divide situation rather than promoting integration and solidarity.

We have a strong tendency to consider that we are unique individuals that is different from each others. This consideration strongly shape and influence our perceptions of the human being and human needs. Segregationist behaviors in our culture and social organization have often taken the form of discrimination against humans who are different sexually, racially, ethnically, or religiously. The practice of segregating or categorizing reflects the existence of a certain spectrum of power balance between different social agents in our social structure. The existence of this structures of power balance influences our social system and out life in many ways. In welfare area, the practice that mirrors the concept of social segregation or social categorization is more commonly associated with the term of ‘intervention efficiency’. The segregative instinct that exist within individuals possessing different kind of expert knowledge is reflected through the existence of categorizing boundaries that separate them from one another on the notion of professionality. The boundaries between these services are an almost constant source of difficulty.
The hierarchical gaps that exist between service providers and service receivers are most clearly manifested through the current rush to champion evidence-based practice argument. The emphasis on evidence-based practice encourages an over-restrictive view of what evidence is, and giving priority to the outcomes and definitions of effectiveness that are of most interest to providers and policy-makers. In this context, those who have socially valued knowledge (i.e. scientific knowledge) have the absolute power to make decision, change opinions and define reality. The kind of categorization or segregation that typical works to segregate the elderly as an exclusive group from the main stream community is negative age stratification or ageism. Many are prejudiced against the elderly in various ways as shown in their belief in many negative stereotypes and their use of ageist language. The result of these circumstances is a general pessimism among the aged that comes with: the personal costs of demoralization, a loss of self-respect and self-esteem, loss of function, inactivity, physical and mental decline, and a feeling of being a burden to their families and to themselves.

Though it is acceptable to certain context that the principle of segregation that is exercised today is capable of driving in some kind of intervention
efficiency, we need to re-question ourselves; are we interpreting the need to differentiate one from another in a correct way? And if we do, are we implementing the right type of categorization that our contemporary environment requires? The acceptability of rational linkage that exists between such interpretation and the purpose of such categorizing act is the point that requires careful consideration – whether such linkage suits our social sanction and environmental condition. The attempts to ameliorate the segmented methods of intervention that are observable in our social system are conducted though many efforts. Some of them are carried out, for example, through the promotion of the concept of common citizenship that is respectful of diverse individuals’ particularity; by adding some flexibilities the to the rigid boundaries that surround different categories of welfare services and professionals; by practices that try to tear down the gap of social hierarchy between service providers and service receivers, and by integrating policies that is conducted at different levels of approaches.

Segregation is an instinct that in certain situation must be sublimated or redirected in order to promote interdependency and solidarity that sustain any collective action. Segregation is an instinct that can be easily manipulated
using education and social pressure. Assuring the correct process of such manipulation (to sublimate segregative instinct) from the early stage of development of individual's personality and in continuous manner is crucial due to the life-time affect that the developed personality or characteristics will have against individuals. In this context, the quality and process of care is necessarily significant. How care is delivered and whether the continuity of the process is sustainable is strongly influenced by the kind of environment where such care is situated. Upon identifying the flaws in the social system that originated from the unnecessary categorizing, and upon initiating efforts to rectify such flaws, our focus should be continued by identifying the factors that will facilitate the creation of environment that will sustain care continuity. From the perspective of formal care, such effort can be materialized through the formation of suitable care team-work (and the accompanying approach) that is multidisciplinary and resilient in structure and capability. Information sharing is crucial in this formation. Other than that, reforming the social worker's competency profile, in other words, preparing the suitable kind of manpower that will sustain the efficiency of future social work practice, is also deemed necessary. What is more challenging, however, is improving care at home (in
informal setting). Raising a child to become an individual that is filled with positive instinct, resilient and equipped with self-determination – qualities that can better guarantee the conduct of effective social participation of individual – necessarily requires a child-rearing (care) process that understands the significance of ‘continuity’ perspective as mentioned earlier. In this context, understanding the significant of the concept of ‘attachment’ and ‘social bond’ to the formation of individuals’ personality and their quality of social participation is crucial.

Mother-infant attachment is part of an instinctual-emotional system of central importance to all primates. Lacking the security of the mother-infant bond, as well as the stimulation of human contact, the infant's curiosity and exploration were curtailed. Perhaps the most worrying is the later adverse effect that may arise from the restriction of emotional expression. Factors that lead to different types of attachment relationships and the short- and long-term consequences those relationships have for a child’s social-emotional and cognitive development are the crucial points that must be probed into. Understanding of the response of a child to separation or loss of his mother-figure turns on an understanding of the bond that ties him to that figure,
and later to the larger social group (the social bond). Attachment is the product of a primal human instinctual need for physical contact with another. This is a fairly obvious need and a need that develops is shaped into what can be termed as 'social bond'. This bond is the mature response of the neonate’s need for physical contact. It influences behavior throughout life. Therefore, it is considered a force that has an effect on both individual and group behavior. First, it is shaped by the mother-child bonding process and by interactions with the environment. Second, it is shaped by the family, friends, and community, and by increased interactions with the environment. Finally, to some degree, behaviors are consciously or unconsciously selected that result in either strengthening or weakening one’s attachment with subgroups in his or her primary environment.

Being deprived or separated from the mother was usually as damaging for the child’s mental health as were contagious diseases for ‘physical’ health. The absence of a durable attachment relationship in the first year of life would have irreversible consequence for what is called ‘mental health’ or ‘adaptability’. It would result in an unfortunate form of maladjustment to its surroundings and a lack of confidence in itself and its fellow human beings in times of need. That
attachment behavior in adult life is a straightforward continuation of attachment behavior in childhood is shown by the circumstances that lead an adult’s attachment behavior to become more readily elicited. For example, the function of mother or mothering figure as a secure base is strongly recalled or reflected in situation where sickness or calamity strike such individual. In this situation adults often become demanding of others; in condition of sudden danger or disaster a person will almost certainly seek proximity to another known and trusted person. The same principle (the primacy of relationship based on attachment) applies to effective providing and receiving of care in general. The understanding of this fact is especially crucial in institutional care setting because the process of caring for others is, at its heart, not simply a technical matter.

People best grow, heal, and learn in the context of meaningful relationships. Such relationships are a primary determinant of how well needs for support, knowledge, healing and growth are met. It is at the point of contact between caregivers and care seekers that the latter experience themselves as meaningfully taken in (or not) and cared for (or not). The emphasis here on such relationships is based on the premise that growth, healing, and learning
often involves risk and vulnerability for people. For many of them to move ahead on the face of their anxieties requires, often enough, a safe-enough relationship with others they experience as caring. Without a sense of safety, it is difficult for people to move toward engaging their own growth and development. Such active engagement is crucial. The possibilities of careseekers to venture forth to engage their journeys toward health, growth, and learning depends on relationships with caregivers who offer careseekers a sense of security, a place to which they can return should they become momentarily overwhelmed.

The reliable meeting of infants’ physical needs – and later, of children’s psychological needs – provides a way to develop and strengthen their egos and enable them to gradually learn to meet, ‘the difficulties of life’. Individual development is thus a gradual strengthening of one’s capacity to handle environmental impingements. The child’s ability to strengthen his ego is founded upon the original experience of being securely held. The original holding environment is the mother’s arms and all that enables those arms to be a safe place: for example, father’s provision of an indestructible home and his enjoyment of the mother-child relationship, the lack of disruption from others,
and the physical space that presents comprehensible stimuli. The holding
environment concept has been broadened to describe other settings, just as
the secure base concept has been broadened to describe adult relations. The
premise is the same: individuals, across their lives, will at times require places
in which they can safely experience and work through difficulties.

In certain level of individual development, there emerge an awareness of
the individual self as forming part of a larger unity, and a need to live and act for
the interests of that larger whole (Allen, 1999). This is what is termed as
gregarious instinct; the origin of individuals’ group behaviors and the formation
of their social bond. Social bond theory is a logical elaboration of Bowlby’s
concept of the attachment instinct in the newborn. Social bond is an expression
of a human instinct that first appears as attachment to the mothering figure and
continues to develop in concert with social experiences in the family, with
friends, at school, at work, and in the community at large. We are faced with
many changes that happen in our environment everyday. Such changes
(including changes in individual, family, and social bonds) create tensions
because they disrupt the homeostasis that all organisms tend to seek. For the
purpose of adaptation to such changes, social life (through social bond) is
necessary for the human species; it is as important as food, water, air, and warmth. The specific shape of perceptions and actions that are required for participation in the group has to be acquired through a long process of social experience.

Group existence is a major adaptive mechanism in primates, and bonds to the group are promoted in several ways. The first social relationship is that attachment between the infant and its mother, and this relation will eventually involve other family members in its later stage to form family bond. Individuals with very strong individual and family bonds feel much more secure and are more able to be contributing members to both units. In its higher stage of development that is accompanied by increasing social experience, social bond moves beyond that particular relationship of family bond and establishes a bigger role and wider connection with other group members that are outside the circle of family unit. Such development will lead to the formation of social networking. Social networks have been consistently shown to affect both individuals and families, particularly those individuals and families considered at risk. Among social work practitioners, it is widely accepted that social supports and natural networks can make the difference between at-risk
families that survive and those that do not. A list of the problems precipitated by an inadequate social network support system would include: a weak sense of belonging; fewer opportunities to develop significant group affiliations and social relationships; little emotional support in times of stress; no respite or help with heavy responsibilities; no direction and counsel related to troubling situations; and little or no concrete assistance. The influence of social bonds can be shown to have support in the field of sociology. Research findings suggest that social uncertainties can create confusion, anxiety, and self-destructive behavior within the individual. Deviant behavior occurs when an individual's bond to society weakens or is broken. Consequently, this broken bond is what frees the individual to violate the norms of society.

As stated earlier, the extent to which instincts are allowed to develop in individual influence or determine the amount or quality of autonomy such individual is likely to attain. And, the extent to which autonomy is attainable will in return decide the amount of independency that an individual can enjoy. The attainment of independency is crucial because it preconditions the conduct of reciprocity and solidarity. The question that must be looked into in this context is how do we deliver the right kind of services (how and based on what kind of
basic understanding) that will promote the attainment of independency in a way that is appreciable from the perspective of service user (or anybody receiving the care), or non-coercive, while utilizing the inner strength that every individual posses in them to strengthens the efficiency of the process.

Recent studies of welfare agree that currently visible various service provisioning do have important consequences for the achievement of self-independency of individuals. However, studies also noted that most of the services provided are defined and determined almost entirely from the perspectives of service provider. Therefore, it is hard to justify whether the end result from these action of services provisioning, will truly contribute in the achievement of the type and meaning of self-independency as valued by individuals. The defining on the meaning of self-independency from the perspective of welfare provisioning has never been easy. The achievement of individuals’ self-independency involves many interlinking factors that exist in the individuals and the factors that exist between the individuals and their surroundings where they belong. As suggested by Ogasawara (2003), individuals’ independency is a concept that is reconciled by two different but interlinking perspectives. One of the perspectives defines the meaning of
self-independency as; being independent in terms of one's physical and psychological condition. This is termed as 'self-help' or 'self-reliance' independency. The other perspective define self-independency in a much wider scale connecting individuals with the environmental and surrounding factors, in this case, the community. This perspective stands on the premise that; even if the 'self-reliance' independency is achieved, the success achievement of only this type of self-independency will not be a full guarantee for an individual (as a social-being) to be able to live meaningfully as part of a community. Accepted by the community and at the same time capable of living as an independent agent in it is another important aspect to an individual's meaning of independency. This perspective of independency is known as 'mutual-interdependence' or 'collective independency' (Ogasawara, ibid).

The above argument refers to and suggests a shape that frames the definition on the concept of self-independency. Yet, there is a further need to identify the final aims that give body to the meaning of self-independency, to understand the process that attribute to the achieving of these aims and to critically question the relation that exists between 'the process of achieving these aims' and 'the quality of the achieved final aims’ that articulated
self-independency. The argument of ‘Development as Freedom’ by Amartya Sen (2000) provides an excellent framework of reference for this purpose. Sen argues that the success or failure of a development process should be judged and evaluated in its possible contribution to the attainment of freedom in every individual. The desirability of freedom in this sense is not only in its achieved end, but also in the matrix of processes that relate or contribute to the achieving of such end. Understanding the possible influence that the criteria and quality of ‘freedom achieving process’ will impose on the criteria and quality of the ‘to be achieved final end of freedom’ is a critical matter. Freedom, as argues by Sen, is necessary even in the process, not just the end.

Other than income, technology and industrialization, there are many other factors that attribute to the achievement of individuals’ freedom. Social and economic arrangement (in terms of education and health), political and civil right, and the removal of unfreedom (i.e. poverty, systematic social deprivation, neglect of public facilities etc.) could be some of the attributive factors. The freedom to participate in social and economic activities (to generate the necessary individual income); to participate in political activities that enable the engagement to public discussion and scrutiny; and to have resources for the
elimination of unfreedom that blocks the final achievement of freedom, for example, are required in the attempt to achieve individuals' freedom. In other words, it is the power to control, to choose and to determine the process that will lead to the achieving of the final objective that should counts as the real freedom, and this freedom significantly influence the quality of freedom to be obtained in the final end of the process. Freedom must be in the process, not just the end.

On the risk of being over simplified regarding the nature of their connections, let's replace the idea of 'development' as argued by Sen with 'care' and, the idea of ‘freedom’ with ‘independency’ in order to better understand this ideological framework from the perspective of welfare provisioning. Let us focus on the definition attached by service providers to the process of ‘care’ and how the methodology of delivery that is derived from this definition can influence the meaning of independency resulted in the end of the process. In this part, I wish to suggest that the renewal of understanding towards the meaning of ‘independency’ (through the process) by service providers is significant in the following three senses: to reshape the concept of services in order to avoid the creation of paternalistic services; to upgrade the
professionality of service providers by fostering the understanding towards the wider meaning of independency as to allow them to be more sensible in performing their duties; and to further acknowledged the rights of individuals (in this case, service user) by understanding and respecting the way of life that they have reasons to value.

Reshaping the concept of services to be provided in order to prevent the unintended creation of paternalistic services must be done in a way that provides more spaces for individuals so that they can have more of their voices being heard, especially in determining the type of services to be provided and in the manners of how the services should be delivered. Upgrading the professionality of providers to make them be more sensitive in performing their duties can be achieved through a shift of fundamental understanding that acknowledge the fact that wider meaning of independency is characterized not only by the final indicator of independency as defined by service providers, but also by the sense of satisfaction and fulfillment derived from the autonomously controlled process of achieving the end (including final indicator of independency as defined by service providers) by service users. And, to further acknowledged the rights of individuals; this should be fostered through
respecting the freedom of individuals to autonomously choose (upon the provisioning of ample knowledge by service providers in order to avoid ignorance) from the available option of processes (made available by service providers) in the effort to achieve their diverse aims in life. Only by the comprehensive understanding on this meaning of independency that a service provider will be able to better grasp the real needs, in other words, the ways of life (that is usually inexpressible or difficult to express through words) that other individuals has reasons to value.

In sum, a wider meaning of independency is an independency that is also in the process and not only in the final result. Independency is the freedom to choose the processes that can lead to the ways of living that diverse individuals have reasons to value. The true meaning of independency should be composed from the process that includes understanding and acknowledging the importance of ‘the sense of satisfaction and fulfillment’ derived from the fact that individuals are able to autonomously choose, determine, control, and complete the ‘processes to achieve’ their aims (independency), other than ‘achieving the aim’ itself. As a ‘social animal’, humans have urges to display affection. Satisfaction from achieving leads to the feeling of independent; and,
different from the prevailing definition of independency that mainly focuses on the possible creation of physical independency, the achieved independency in this sense reflects to both psychological and physical independency accomplishment.

The need for care is generally understood and it involves different kind of cares that need to be fulfilled at different levels. According to Darwall (2002), in the context of care provisioning; the good of a person (what benefits him) differs from what a person himself values, prefers, or takes an interests in, even rationally. As such, he continues, when we care for a person, we should desire his good for its own sake. However, this should not be for it’s (the good) sake only, but also for his sake. The object of care should be the individual person himself (and not the good). A desire for someone’s good rooted in care has, in addition to the ‘direct’ object of the person’s good (and the state of its being realized), an ‘indirect’ object: the person himself. In other words, we should desire his good for his sake. A reflection of the difference between a person’s good and what is, or seems, good from his point of view is the possibility of pursuing values one cares deeply about even at some cost to oneself. If there were no difference between what a person valued and what
benefited him, self-sacrifice would be impossible. We should distinguish between how much a person values or takes an interest in something (or would rationally do so), on the one hand, and it’s (the value) benefit to him or contribution to his good, welfare, or interest, on the other. Much of life involves investments that are warranted, even in one’s own rational view, by values that bear no direct proportionality to personal benefit (i.e. raising one’s own children). Still, even though a person’s good and what is good from his point of view are two distinct things, we shall promote the first by promoting the second.

Understanding individual perceptions and promoting a care that recognizes his values significantly determine the result direction of such care. What this illustrates is the need for a care that is not paternalistic and a care that respect individuals’ perspectives. The argument on the ethic of care as suggested by Julie Anne White (2000) has many insights to offer on this part. White argues by stating that, in the current context, the question of how care should be organized is of public (i.e. by local authority) not merely private (i.e. by family members), political (i.e. through a proper policy) and not merely psychological (i.e. through altruism). However, the public care in current context, she continues, tends to replicate the authority relationships of a
traditional family, and that therefore it produces paternalistic practices of care. This statement is proven from the fact that the institutional context of public welfare policy tends to practice care that assumes the dependence of its subjects. The root of this problem can be identified as originating from the current system that tend to be more bureaucratic rather than democratic, and from the tension that exists between the political and the professional authority in the process of designating the ‘needy’ and defining their needs. In the context of current institutional practices, the authority to define what counts as welfare, to determine what recipients need belongs to a class of professionals; and this authority is justified by reference both to the specialized knowledge of professionals and to the lack of competence on the part of dependence. Study demonstrates the existence of critical disparity between the needs of recipients as defined by professionals and the needs as articulated by recipients themselves. A more adequate version of care requires an explicitly wider understanding of the process of interpreting needs that involves all related parties in the care provisioning setting (and this definitely includes the receiver). The corrective, as argues by White, is not ‘just care’ as we have traditionally conceived it, but rather, the fostering of ‘non-paternalistic care’ that comes
together with the institutionalization of a democratic politics of care. This conception of ‘fostering non-paternalistic care’ is a concept that should also be applied in care provisioning in private life areas.

Lastly, upon understanding the necessity and importance of properly pursuing the whole set of process – from the most micro level to the most macro level of intervention – in effort to promote individuals’ resiliency, independency, fair reciprocity (interdependency) and solidarity that allows the possible exercise of a collective action such as integrated care, we must also understand that these efforts need and should be bolstered by a principle of care that suits the contemporary social arrangement and requirement. The main question that need to be dealt with in this perspective is; what is the basic quality, or the fundamental principle that can guide the production of care that will promote the total development of individual (as stated above) and his or her awareness towards the importance of ‘to meaningfully participate’ in actions relating to social collectivity. The concept of ‘democracy of the emotion’ as argued by Giddens (1994) is useful in providing some valuable ideas and clues on this part. To grasp what is the principle that suits the contemporary social requirement in terms of care provisioning; we need to look at what are the
changes that take place within our society and how do the changes affect us as one member of the society. Then, upon understanding such facts, we need to initiate changes within our personal or internal approaches (in relation to care provisioning) so that they will fit into or match with the conditions that emerged from the changes that occurred (are occurring) in our public or external social setting. The necessary changes that we need to pursue include fostering a care that is different from the conventional authority relationship of a traditional family as argued by White (2000) because we are now in a world where every individual are possessing a higher level of reflexivity or social awareness due to the availability of information and a wider social exposure. Changes are needed because individuals (of all ages) are currently more sensitive to occasions that take place within their life spheres and have a higher tendency to question the reality around them to a higher extent than they (and we) used to, comparing to before. The concept of ‘democracy of the emotion’ that is applied (by Giddens) in family care setting for the purpose to bolster the changes of care characteristics required in a contemporary situation is a principle that is derived and structured from deep considerations upon the
complex changes that occurs in the most macro spheres of society, including the huge phenomenon of globalization.

Globalization is not only, or even primarily, an economic phenomenon. Giddens defines it as actions at distance, intensifying due to emergence of instantaneous global communication and mass transportation. It also concern with the transformation of local, and even personal, contexts of social experiences. Globalization tends to evacuate out local contexts of action. The evacuation of local contexts of action can be understood as implying processes of intensified detraditionalization. This is called as post-traditional or postmodern. The newly formed society in the globalizing environment is called post-traditional society and it is not just a national society. What we are talking about here is a global cosmopolitan order. Nor it is a society in which tradition cease to exist; there are also noted movements towards the sustaining or the recovery of traditions. However, in post-traditional society tradition changes its status. In the context of globalizing cosmopolitan order, traditions are constantly brought into contact with one another and forced to ‘declare and explain themselves’. There are a few noted changes and effects that took place due to the progress of globalization process. First of all, there is the emergence
of a post-traditional social order. As explained above, a post-traditional order or society, is not one in which tradition disappears. It is one in which tradition changes its status. Traditions have to explain themselves, to become open to interrogation or discourse. Tradition is forced into open view and, reasons and justification have to be offered to them. Following the emergence of post-traditional order, the next noted change is the expansion of social reflexivity. ‘Reflexivity’ here refers to the use of information about the conditions of activity as means of regularly ordering and redefining what that activity is. It concerns a universe of action where social observes are themselves socially observed and it is today truly global in scope. The third noted change is the appearance of manufactured uncertainty and manufactured risks. The spread of technology along with globalization process accelerate human attempt to control and rule the environment and nature. This attempt has resulted in the producing of manufactured risks\(^7\) and uncertainties. There are four main

\(^7\) Manufactured uncertainty is the outcome of the long-term maturation of modern institutions; accelerated as the results of a series of development that have transformed society and nature. The appearance doesn’t mean that our existence, on an individual or collective level, is more risky than it used to be. Rather, the sources, and the scope, of risk have altered. Manufactured risk is a result of human intervention into the conditions of social life and into nature. The uncertainties it creates are largely new. They cannot be dealt with by age-old remedies; but neither do they respond to the Enlightenment prescription of more
contexts in which we confront high-consequence risks coming from the extension of manufactured risks and uncertainty: the impact on the world’s ecosystems; the development of poverty on a large scale; the producing of weapons of mass destruction and possibility of collective violence; and the large scale repression of democratic rights (even though the military rule seems to be on the decline, yet, according to some reports, people were imprisoned for matter of conscience – solely because of their religion, language or ethnic origin).

The globalization, detraditionalization of society and the spread of social reflexivity has undermined all the previously existing various (social) orders and political ideologies supporting those orders, and for this reason, Giddens argues that a new ideology and a new order is urgently required. This is what he termed as Radical Politics. To be radical means to break away from the past. The new social and political movement as argued by Giddens is heading towards a new ‘stage’ of social development beyond the existing orders. Giddens suggested the political ideology of Philosophic Conservatism (philosophy of protection, conservation and solidarity) as the necessary knowledge, more control. Collaborative action and mutual consent is said to be part of the effective ways of dealing with it (Giddens, 1994).
fundamental idea. An easier way to understand this concept of Philosophical Conservatism is by observing the changes that took place along the relationship between individuals and their surrounding factors due to globalization, detraditionalization and social reflexivity\(^8\). In this context I identified four surrounding factors that are relevant, which are; nature, the state, community and other individuals (Chart 6, page 540). Detraditionalization, as stated earlier, takes place due to the evacuation of local contexts of action that happens along the emergence of instantaneous global communication and mass transportation, and the expansion of individuals’ social context experience because of the cosmopolitanism. A detraditionalizing social order is one in which the population becomes more active and reflexive. In a society of high reflexivity the regular appropriation of expertise tends to replace the guidance of tradition.

\(^8\) Refer to explanation on page 537 (Giddens, 1994).
Chart 6 – Changes of Relationships between Individuals and Their Surrounding Factors

**Relationship in Simple Modernization**

- **Key Words:**
  - Cybernetic Model of administration
  - Passive Welfare State
  - Deal with External risks
  - Conventional Aid Policy

- **Political Ideology:**
  - Socialism
  - Conservatism
  - Neo-liberal
  - Liberal Democratic

- **Characteristics:**
  - Low reflexivity, fixed life style
  - Bureaucratic organization and command system
  - Conservatism and Traditionalism (Fundamentalism)

**Relationship in Reflexive Modernization**

- **Key Words:**
  - Positive Welfare and Generative politics (Reflexive engagement)
  - Deal with Min. risks
  - ‘Post-search’ policy

- **Political Ideology:**
  - Philosophic
  - Conservatism
  - Deliberative
  - Democracy through dialogue (Dialogic Democracy)

- **Characteristics:**
  - Post-traditional social order
  - Social reflexivity
  - Highly complex lifestyle with cosmopolitan attitude
  - Relationship based on Principal of Autonomy in communication
### Table 3 – The Changing Relationship between ‘Nature’ and ‘Individuals’

<table>
<thead>
<tr>
<th>Simple Modernization⁹</th>
<th>Reflexive Modernization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing nature as External Risk</td>
<td>Changing nature as Manufactured Risk</td>
</tr>
<tr>
<td>Enlightenment inspired human control over nature (ecological threat)</td>
<td>Reflexive engagement with nature (humanized nature)</td>
</tr>
</tbody>
</table>

First of all, let's take a look at the changing relationship between nature and individuals. The very real and difficult issue to be faced here is the problematic relation between the limit of human knowledge and the unlimited desire to control, exemplified by the spread of manufactured risk. Manufactured uncertainty refers to risks created by the very development the Enlightenment inspired, that is our conscious intrusion into nature. The various high-consequence risks which face us in the present day are social in origin, which means, originate from the very own act of human ourselves. Ecological questions should be understood in terms of reflexive modernization in the

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⁹ Simple modernization: these were circumstances in which ‘industriousness’ and paid work remained central to the social system; where class relations were closely linked to communal forms; where the nation state was strong and even in some respects further developing its sovereign powers; and where risk could still be treated largely as external and to be coped with by quite orthodox programs of social insurance – none of these conditions holds in the same way in conditions of intensifying globalization and social reflexivity; the reflexive modernization (Giddens, 1994).
context of globalization, and problems of ecology cannot be separated from the impact of detraditionalization (what we do effect the other side of globe). It raises the question of ‘how shall we live?’ in a situation where the advance of science and technology, coupled to economic growth mechanisms, force us to confront moral problems which were once hidden in the naturalness of nature (nature was largely still intact) and tradition (when tradition was still a close unquestionable practice in a geographically segregated environment).

Understood as external risks, environmental degradation is seen by scientists (and laypeople alike) as in terms of ‘side-effect’. It was assumed that industrial development and the risks involved can be assessed and danger levels can be controlled. ‘Acceptable levels’, however, are possible to determine with any accuracy only at a given time or place. There is a question of; how can anyone know what effects a particular process or set of chemicals might have on earth or human bodies in the very far future? Modern civilization proceeds through the attempted imposition of human control through environments of action, including the natural environment, which was once largely external to such action. This orientation to control, strongly bound up with a stress on continuous economic development, come up against its limits.
as it is generalized and globalize. One such limit concerns the prevalence of manufactured uncertainty, which compromises the very control orientation itself. Another, concerns the effects that such a control orientation has on basic moral questions and dilemmas of our existence. Ecological crisis is a material expression of the limits of simple modernity; repairing the damaged environment can no more be understood as an end in itself. What we actually need is the repairing of our morality in the era where nature is no more natural and tradition is no more traditional.

Table 4 – The Changing Relationship between ‘Welfare State’ and ‘Individuals’

<table>
<thead>
<tr>
<th>Simple Modernization</th>
<th>Reflexive Modernization</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Passive welfare state + cybernetic model of administration</td>
<td>• Positive welfare and generative politics</td>
</tr>
<tr>
<td>• Conventional (economic based) aid policy</td>
<td>• Post-scarcity ideology based aid policy</td>
</tr>
<tr>
<td>• Deals with external risks</td>
<td>• Deals with manufactures risks</td>
</tr>
</tbody>
</table>

Conventional welfare system as portrayed by socialism worked tolerably well when most risk was external (rather than manufactured) and where the level of globalization and social reflexivity was relatively low. The system was based on ‘cybernetic model’ of social life: a system (in the case of socialism, the economy) can best be organized by being subordinated to ‘directive’
intelligence (the state). This set up might work reasonably effective for more coherent system (in this case, a society of low reflexivity, with fairly fixed life style habits), but it doesn’t so for a highly complex ones. What welfare state needs in its relation with individuals in the era of reflexive modernization is the concept of Positive Welfare that is based on generative politics, aid policies that is based on post-scarcity ideology, and to deal with risks that are not external but internally manufactured by the very own act of human beings. A post-scarcity order or ideology starts to emerge where over focused continuous economic growth (economic based assistance in terms of welfare provisioning) becomes harmful and manifestly counterproductive; and where the ethos of productivism\(^\text{10}\) begins to be widely called into questions. This situation created a pressure for the society to realize and develop other life values than just simply pursuing economic related achievements. Totally economic based aid provision or program of welfare sometimes destroys local traditions and means of livelihood. Recipients may not only become demoralized, but develop attitudes of welfare dependency (where the intervention is delivered with no reciprocal expectations, the result can be dependency). Positive welfare is the\(^\text{10}\) An ethos where work is autonomous and where mechanisms of economic development substitute for personal growth, for the goal of living a happy life in harmony with others (Giddens, 1994)
idea that places great emphasis on the mobilizing of life-political measures, aimed once more at connecting autonomy with personal and collective responsibilities. Reorganizing welfare system in a post-scarcity order and reconstructing it to become positive would mean; such system would have to escape from reliance on 'precautionary aftercare' as the main means of coping with risk; be integrated with a wider set of life concerns than those of productivism; develop a politic of second chance; create a range of social pacts or settlements, not only between classes but between other groups or categories in the population; and focus on generative conception of equality. And lastly; generative politics is a politics which seeks to allow individuals and groups to make things happen, rather than have things happen to them, in the context of overall social concerns and goals. Such a politics depends on the building of active trust (to be explained in a later part of this section). Generative politics implies a number of circumstances which are: fostering the conditions under which desired outcomes can be achieved, without determining those desires, or bringing about those outcomes, ‘from the top’; creating situations in which active trust can be built; according and developing autonomy to those affected by specific programs or policies; generating
resources that enhance autonomy, including material health; and the decentralization of political power.

Table 5 – The Changing Relationship between ‘Community’ and ‘Individuals’

<table>
<thead>
<tr>
<th>Simple Modernization</th>
<th>Reflexive Modernization</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Culturally diverse with geographical segregation</td>
<td>▪ Cultural diasporas</td>
</tr>
<tr>
<td>▪ Traditionally pre-established social order (i.e. conservatism)</td>
<td>▪ Autonomy, active trust, dialogic democracy</td>
</tr>
<tr>
<td>▪ Civil society within state boundary</td>
<td>▪ Civil association in cultural cosmopolitan</td>
</tr>
</tbody>
</table>

The changing relationship between community and individuals (and between individuals and another individual) are the changes that are most closely related to the argument that I brought forward in this thesis. As illustrated from the diagram, the world marked by simple modernization was a culturally diverse one. And further, its cultural diversity was noted to depend in a substantial way on the continuance of geographical segregation. As reflexive modernization appears, in contrast, there is a noted emergence of Cultural Diasporas. In a world of reflexive modernization that comes with high social

11 A situation where individuals with certain cultural backgrounds live together in places and cultures different from their origin (Giddens, 1994)
reflexivity, an individual must achieve a certain degree of autonomy of action as a condition of being able to survive and forge a life, and autonomy in this situation implies obligation, reciprocity and interdependence. Enhanced solidarity in a highly reflexive and detraditionalizing society depends on what might be termed as active trust\(^\text{12}\), coupled with a renewal of personal and social responsibilities for others. Where the level of social reflexivity remains quite low, political legitimacy continues to depend in some substantial part on traditional symbolism and pre-existing ways of doing things. In a more reflexive order however, such practices are liable to become called into question. Therefore, the forming of solidarity for a highly reflexive and detraditionalizing community has to be based on what is termed as dialogic democracy. Dialogic democracy is not primarily about either the proliferation of rights or the representation of interests as it is in liberal democracy. Rather it concerns the furthering of cultural cosmopolitanism and connecting autonomy with solidarity. Dialogic democracy is a situation where there is developed autonomy of communication,

\(^{12}\) Active trust is trust which has to be won, rather than coming from the tenure of traditionally pre-established social positions or gender roles, as it was practiced in the period of simple modernization. Active trust has to be actively and continuously produced and negotiated. Active trust presumes autonomy rather than standing counter to it and is a powerful source of social solidarity, since compliance is freely given rather than enforced by traditional constraints (Giddens, 1994).
and where such communication forms a dialogue by means of which policies and activities are shaped. It is not necessarily oriented to the achieving of consensus. The intention is to let matter of interests to remain essentially contested. Dialogue should be understood as the capability to create active trust through an appreciation of the differences and integrity of the other.

One of the most important changes that took place in terms of community solidarity is the transformation of community identity from civil society to civil association. Some argues about the necessary of reconstructing civil society to regenerate social solidarity. However, several problems exist for those who call for a regenerating of civil society as a means for the rediscovery of community: the idea of civil society, and its reality, was bound up with the state and its centralization and nation-state comes up against forms of globalization; a renewal of civil society could prove dangerous – rather than emancipatory it might encourage fundamentalisms. Civil society was the product of social arrangements that no longer exist. The key element to ease the problem of social solidarity is the generating of active trust. Social solidarity can effectively be renewed only if it acknowledges autonomy and democratization. And, such a renewal must recognize obligations, not just rights. Civil association in a
globalize world is not simply a community. It is a new breed of community that
depends on ‘intelligent relationships’. Intelligent relationship means living along
with others in a way that respects their autonomy. The civil condition in a
post-traditional order depends on the ‘positive appreciation of difference’. A
cosmopolitan attitude would not insist that all values are equivalent, but would
emphasize the responsibility that individuals and groups have for the ideas
they hold and the practices in which they engage.

Table 6 – The Changing Relationship between ‘Individuals’ and ‘Another
Individuals’

<table>
<thead>
<tr>
<th>Simple Modernization</th>
<th>Reflexive Modernization</th>
</tr>
</thead>
<tbody>
<tr>
<td>⬦ Traditionally pre-established social position and gender roles</td>
<td>⬦ Active trust + pure relationship</td>
</tr>
<tr>
<td></td>
<td>⬦ Democracy of the emotions</td>
</tr>
<tr>
<td></td>
<td>⬦ A new social pacts between class, sexes and generation</td>
</tr>
</tbody>
</table>

The key words that explain about the changes of relationship between
individuals in highly reflexive world are active trust, pure relationship, the
democracy of emotions, and the forging of new social pacts between class,
sexes and even generations. As reflexive and post-traditional society further
develops, there is a stronger tendency of movement towards what can be
termed as pure relationship\textsuperscript{13} in sexual relations, marriage and the family. A pure relationship is a relationship that is entered into and sustained for its own sake (pursued for the rewards that association with another, or others, can bring). Forming pure relationships and ensuring their continuity draws in an inherent way on active trust. Pure relationship depends on the compatibility within the context of a mutually rewarding relationship. In its wider meaning, it is a relationship sustained through the open discussion of political (or any other) issues; issues of mutual involvement and responsibility. Dialogue, between individuals who approach one another as equals, is a transactional quality central to their mutuality.

The shortcomings of liberal democracy in a globalizing, reflexive social order suggest the need to further more radical forms of democratization. It is in this context that Giddens stresses the importance of dialogic democracy. As further stated by Giddens, democracy has two main dimensions which are vehicle for the representation of interest and a way of creating public arena in which controversial issues can be resolved through dialogue rather than through pre-established forms of power. While the first aspect has probably

\textsuperscript{13} Pure relationship is an extension of the principle of dialogic democracy into the area of personal life (Giddens, 1994).
received most attention, the second is at least equally significant. The extension of dialogic democracy would form one part of a process of what might be referred to as the democratizing of democracy. As stated earlier: where the level of social reflexivity remains quite low, political legitimacy continues to depend in some substantial part on traditional symbolism and pre-existing ways of doing things. In a more reflexive order however, such practices are liable to become called into question. Greater transparency of government would help the democratizing of democracy. Outside the arena of the state (politics), dialogic democracy can be promoted in several main contexts, for example, in the area of personal life that involve parent-child relations, sexual relations, and friendship relations. Such relationships are ordered through dialogue rather than through embedded power. Giddens terms this as ‘democracy of the emotion’. Democracy of the emotions depends on the integrating of autonomy and solidarity. It presumes the development of personal relationships in which active trust is mobilized and sustained through discussion and the interchange of views, rather than by arbitrary power of one sort of another.

To the extent to which it comes into being, a democracy of the emotions
would have major implications for the furtherance of formal, public democracy.

Individuals who have a good understanding of their own emotional makeup, and who are able to communicate effectively with others on a personal basis, are likely to be well prepared for the wider tasks and responsibilities such as conducting meaningful participation in any organized collective action. From this statement, it is understood that the formation of characteristics necessary to support the participation of the individual in any collaborative or integrative efforts starts from home, through the conduct of care that takes the principle of ‘democracy of the emotion’ as its basis. Other than its capability to lead to the type of care that respects individuality (thus promoting autonomy and independency) through its approach that view others as equal (for example, the person being cared for), the significance of the concept of ‘democracy of the emotion’ is reflected in the necessity to forge new social pacts, especially in the area of private boundary that involves family units and their members. The social pacts have to be forged across class, generations and sexes. For example, in terms of generational social pacts, the gap between generations is created by the pace of social and technological change, which detaches the experience of children from that of their parents; and by the resentments which
children, who have more formal rights than they used to, may come to feel about inadequate parental care. The advance in children’s rights is a significant contribution on the potential for emotional democracy. A pact between the sexes is in many ways the key to the retrieval of other forms of solidarity. What happens to family life, for obvious reasons, serves either to connect or disconnect the generations; and what happens to gender divisions is deeply consequential for transformation in the world of work, paid and unpaid. In this situation, we can say that conservative welfare systems or even social and community systems which continue to depend, implicitly or explicitly, on a model of patriarchy are likely in the end to come apart.

All the above are factors that will contribute to the positive or negative formation of individual’s inner self perception or inner self-value that will determine his or her attitude towards the strive in attaining one’s own self-betterment and level of resiliency in effort to achieve one’s own well-being. On the other part it also determines his or her attitude towards the exercise of reciprocity (interdependency) and the process of solidarity. Tackling the issues from both macro and micro perspective, and in a seamless manner, is the preconditioned for the success implementation of any collective action,
including integrated care. The final aim of welfare should be directed to enable
individual to make an autonomous psychological justification that will facilitate
his or her well-being. In this situation, there’s a need to create a ‘fit’ between:
individuals’ inner perception and personal talents (resiliency); environmental
facilitation that promotes the nurturance of such talents (through care in both
formal and informal settings); (re)acknowledgment on the importance of the
concept of integration and individuals’ totality (rather than segregation or
segmentation); and early engagement in facilitation process that is later
categorized by continuation in attempt to support their independent effort to
attain self-betterment in a way that respect their concern and preferences.
Respecting individuals’ independency and diverse ways of living would mean
helping, facilitating and granting them the freedom to decide how they should
go about with their life decisions while supplementing such efforts with a
comprehensive (needs) support system that is founded on collaborative and
integrative social actions. A true integrative social action is a process that is
bonded not merely through or in its physical appearance, but from the inner
sanction that originates from our within.
Summary

Greater awareness on the existence of specific and particular needs of diverse individuals in contemporary community and the criticality of acknowledging the facts is highlighted by recent researches and studies in welfare. At the same time, the incapacity of a single body to satisfy a service providing condition that is characteristically comprehensive and yet focused on various individuals’ particularity of needs are revealed. It is the attempt to fulfill these service provisioning conditions that necessitate the formation of collaborative and integrative efforts in welfare areas, involving efforts from the most micro level to the most macro level possible. Different types of integrations that are initiated at different levels of implementation are observable from the contemporary flow of argument relating to welfare studies and its practice. On the policy level, despite of the denial expressed by some scholars towards the possible existence of policy convergence among welfare states; the same trend of awareness on the necessity to identify (and to regulate) the new social risks that are posing challenges to the intractability of the states, and the need to shift towards a new mode of welfare with new political settlement which fits the current condition of respective societies are observable.
At practice level, it is noted that the method of intervention in social work has been undergoing a constant tension between the believe that assistance should be rendered focusing to each individual in case-by-case manner in order to guarantee the efficiency and the professionality of such act, and the believe that such intervention should thoroughly incorporate consideration relating to environmental factors surrounding the targeted individual in order to deliver a holistic and humanistic service that will truly help. In many aspects, implicit and explicit, this is still a continuous debate in the spectrum of social work. Yet, if we were to trace back the history of social work’s development, in terms of its emergence as a profession and changes of intervention, the truth is revealing the existence of some particular trends that illustrate the integration of these supposedly contradicting practice methods. What we could observe from the trend of changes in social work intervention methods is the constant tension that exist between, for example, individualistic approach as against environmental perspective approach; favoritism towards scientific approach as against humanistic approach; and between therapeutic approach as against collaborative or empowering approach in effort to create the most efficient method for intervention at certain point of time and in certain need situation.
From the trace of history, we could identify that the trend does not progress in a linear pattern of changes, but rather in a ‘recycling’ or ‘repetitive’ mode where trend of intervention that was taught to be appropriate and applied to practice at an earlier stage vanishes and reappears (reapplied) again as time progress. The attempt to select or create a suitable method of intervention necessarily revolve around the question of ‘where and which part of the identified need should be defined and understood as deficient’. Who will conduct and what is the base of knowledge to be utilized in the process will strongly influenced and determine the type of intervention to be applied. In other words, those who have socially valued knowledge (scientific knowledge) and / or authority have the power to make decision. In the context where an intervention approach that involves all stakeholders in the community is considered as necessary (i.e. integrative model of intervention), the implementation of such practice inevitably calls upon the re-argument and consideration about power-relation (power-balance in terms of authority and knowledge) that is structured and established in the society or social system. Without the analysis of power-relations and understanding towards their possible influence in reinforcing the status quo of certain situation (of needs) it would be difficult to
recognize object for alteration.

The development of knowledge in practice, along with the necessity to face complex needs has all along became the motivating factor for social work method to continuously improving and adapting. Practice has moved from pre-generic to generic practice, and the fact that integration rather than choosing a particular method is needed to respond to complex problems situations was (is) acknowledged. Such integration process must be derived from a collective of multi-perspective knowledge and expertise. It was the blending of Diagnostic Approaches and Functional Approaches method in social work that among first triggered the practitioners’ interest towards searching for an integrated ground of practice under a unified profession. Later, this attempt was further extended by the use of social system theory and communication theory in social work practice. The usage of such theories has led to the important formulation of concepts that were universal to all category of social work (the generic perspective). Approaches in generic perspectives all contain a means of assessment, concern about relationship, a process, and a focus on the clients-in-a-situation. This trend continues to current context where emphasis on collaborative integration, client competence, individuals
and environmental change, solutions, and a mutually engaging relationship between clients and professionals are valued.

The development of integrated care is actually one of the clearest reflections or actualization of the above mentioned integrative trend. Integrated care is a concept of providing care services in which the single units act in a coordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care. Means to this end include the reduction of inefficiency within the systems, the enhancement of continuity, tailoring services within the process of care provision and the empowerment of service users. The fundamental aim of integrated care is to create a seamless care provisioning that empowers service users and at the same time capable of guaranteeing service users’ participation in the society. Such implementation of integrated care necessarily needs a networking process that will link parts within a single level of care and a networking process that will mutually connect different levels of care. What is necessary in the process is the creation of a shared vision through coordination, cooperation and networking between health and social care services with the aim of improving services and quality of life from a user’s perspective. There
need to be a joint conduct of assessment and planning by interdisciplinary and multidimensional team is the complex relationships. And, in addition, the role of families and informal carers in supplementing the network of professional carers must be acknowledged in care setting that is not merely curative, but also preventive.

It is noted that there exist similarities about the struggles for improvement that are taking place in the area of integrated care, social work practice and social policy in general. The struggles are all conveying the same message about the need to reconstruct our understanding and framework of approach in social work in order to formulate an intervention method that is more comprehensive, practical, fair and yet sensitive towards the needs of both service provider and receiving individuals through integration. It is obvious that the trend of integration and networking, be it in terms of policy implementations or practice interventions, is required as a base to device a comprehensive yet sensitive framework of approach that will satisfy the conditions set by contemporary social environments. The trend of movements is identified in different level of practice, from the level of international policy to micro level of social work practice. CARMEN Project is one of the movements that clearly
reflect this general trend. The project was shaped with the purpose to study
and to focus on matters relating to policy issues associated with the effort to
reform health care and long-term care at national and European levels. In this
attempt, member states were urged to acknowledge the importance and the
need to stimulate clear and coordinated policy responsibilities across local,
regional and national levels, involving all stakeholders in the society. It was
suggested that dialogue between diverse groups of stakeholders should
formed the heart of project. And, in the attempt to assist the elderly, efforts must
includes perspectives on empowerment, prevention, social values such as
equity and solidarity, and the acknowledgement on the important role played by
informal carers. In this context, people should be seen as individuals, not a
uniform group.

However, there’s a point that needs to be highlighted in this part. There is a
noted ‘uneasiness’ between the effort to ‘comprehensively coordinate’ and the
aim to ‘respect the individuality of affected individuals’. ‘Comprehensiveness’
and ‘individuality’ are two inherently different concepts that have become a
constant focus of argument in social policy and social work areas. Various
suggestions have been forwarded in effort to reconcile these two concepts.
One of the most frequently cited is the suggestion to include or integrate lay peoples’ autonomous perspective in formulating policy and devising approaches that directly affect their well-being (in CARMEN’s case, such integration is assumed to be attainable by the conduct of ‘mutual dialogues’).

For an ‘individual perspective’ to be expressible, first of all, such perspective must exist in individuals. Perspectives do not simply appear in a vacuum. They are a kind of structured thinking framework that is shaped by the influence of many factors internal and external to the self of such individuals, either in a conscious or subconscious ways. Thus, before we could expect individual to mutually voice out their autonomous perspectives in effort to form some kind of mutually meaningful networking or integrating process, we have to be sure that individual possess such perspective and possess the capability to conduct such act. And, if ‘voicing out individual perspectives’ would really be a basis that will be able to reconcile the concepts of ‘comprehensiveness’ and ‘individuality’, understanding the element that mainly shape and triggers the forming of individual perspective, devising some kind of intervention that will facilitate the shaping of such perspective, and ensuring that such perspective will develop into a pattern that is autonomous but more favorable to the
process of networking and integration is crucial. What we need is to identify a single factor that is capable of connecting between the processes of meaningful integration, maintenance of respect towards individuality, and autonomous self-betterment attainment.

To identify the factor that should underpin the process of integrated care and to promote awareness towards the significance of such factor in the process is crucial. Such understanding is hoped to be able to lead to the reshaping of integration into a social bonding process that autonomously awakes from individuals’ within and to transcend the earlier mere physical connection (of integration). How do we comprehend the content of this ‘within’ and how do we facilitate the ‘awakening’ in order to create a more meaningful integration with all is the core question that must be looked into. There are at least eight identifiable principles that should underpin the practice of integrated care (need responsiveness, individualized chains of care, services continuity, seamlessness, fluent flow of information, multi-disciplinary action, cooperation between formal and informal network, and flexibility). Integrated care approach is intended to be a standardized point of reference for the implementation of a care management practice that is reflexive to needs through the
multi-professionalizing and networking of intervention. The adoption of such approach is accompanied with the desire to create ‘need responsiveness’ through the provisioning of ‘individually tailored care’ that is characterized by ‘services continuity’. ‘Need responsiveness’ is made possible by the existence of factors such as ‘seamlessness’, ‘fluent flow of information’, ‘multi-disciplinary approach’, ‘cooperation’ and ‘flexibility’. The significance of each factors (in brief) to the practice of integrated care are as follows:

**Need Responsiveness:** The needs assessment process is one of the most important part of optimizing need responsiveness in integrated care. A comprehensive needs assessment provides a structure for collecting the information from all parties involved, where this ‘global’ information is used for all as a basis for visualizing the needs for integration of services and shared responsibilities. It is carried out to control and develop quality of care later in the care process. It will be the basis for organizing and managing the chain of care to be delivered, and support service planners to ensure that service developments are matched to greatest need as far as possible, and to prioritize between different needs.

**Individualized Chain of Care:** Care providers and professionals should not
standardized service packages and stereotype older people’s needs. These preferences have to be communicated and the interaction should be the core of care. The need to carefully define and to properly conduct a comprehensive assessment to determine the level of risks that respective individuals are facing, and to subsequently design an appropriate series of intervention and care programs should be conducted through the formation of care planning base on ‘care pathways’ method. Such care planning must be structured in a way that properly engages older person and their carer in decisions about their care plan.

*Services Continuity:* Integration of services is necessary in effort to face the challenges post by the complexity of human needs web. Due to the fact that client’s needs change over time it is important to focus on dynamic approach of needs. Both the content and timing of services provided must have continuity. In this context, two dimensions of continuity are always at stake – the simultaneous and the sequential – and care pathways offer means of achieving both. Where decisions are unclear, rules should be established, so that policies are put in place for every eventuality. It is useful to distinguish between three types of continuity, that are: information continuity; management
continuity, and a relational continuity (between a patient and providers).

Integrated strategic planning is a larger scale of care pathways to sustain services continuity.

**Seamlessness:** In integrated care, one of the ways to sustain its seamless characteristic is by carefully absorbing and acting on the information that emanate from individuals who are the closests to origins of needs, be it frontline social workers, carers or service receivers themselves (regardless of their position in terms of knowledge and social status). The accuracy of information that can drive responsiveness to situation is the critical part in this context. Increasing challenges to the expertise of professionals and policy makers, coupled with a movement to make services more democratic and accountable, have led to calls for service users to be more involved in the way that services are run. Service user involvement, therefore, should be an aim of services and systems that subscribe to the values of democracy and consumerism.

**Fluent Flow of Information:** A mutual and good communication is essential for working in an integrated way. For such reason information management system is probably the most important supportive process to modern care. Using an information management system opens up greater possibilities that
can contribute to integrated working – for example, better planning, improve
coordination, and better cooperation in assessing, treating and routing patients.
A good information management system can benefit organizations in many
ways. Compared to paper systems, ICT is more reliable, accurate, accessible,
modifiable and manageable, and can be more easily protected.

*Multi-Disciplinary Action:* Care providers use the comprehensive needs
assessment to obtain a better picture of the client, and such information can be
used to tailor a more professional care plan, alongside the other members of
the care providing team. This can be more easily done if the assessment is
carried out organizedly by professionals and all who are involved in the actual
care delivery. Such comprehensive assessment provides the client with a
better view of the types of preventative measures that care provider can offer.
Evidence shows that multi-disciplinary groups that is formed through
integration are preferable to single-discipline approaches in needs assessment
even if they are still uncommon. Many different models of integrated teams
have been developed in response to specific needs and areas. They share the
common characteristics and being composed by multi-disciplinary and
inter-organizational care professionals working together. The supporting
factors for the establishment of an integrated team of professional amongst many others are: a national or local policy commitment; backed by designated resources; a client-centered approach; and practical experience, knowledge and skills.

Cooperation: The majority of care is provided by informal carers, such as next of kin, neighbours, and volunteers. Family relations are a resource to care provisioning because their traditional values that predispose members to see carrying burdens of care as a matter of fate, love or solidarity. Helping carers by involving them in strategies to overcome their stress can, in the long run, be fundamental in providing better assistance for the older person who is being cared for. However, professional care providers do not always acknowledge the contribution of these groups, and they are seldom regarded as partners in the system. In this situation, often, discrepancy between client needs and preferences arises. This situation should also be dealt with in team discussions, to ensure a true balance between different interests. With a fuller picture of the client needs, it is possible to more easily make priorities and remodel different services. Forming cooperative network that is initially led by integrated organization, adopting cultural change to enable the sharing each other’s value
patterns, and pursuing the right quality of leadership that suits the demand of integrative approach will facilitate the cooperation between different members involved in integrated care provisioning.

**Flexibility:** Flexibility is assumed to be attainable through continuous improvement and re-evaluation of process. Other than the need to set up a joint system and the need for legislation backup; experience, devising suitable tool and method for training, ensuring continuity of education, performing research and survey and so forth are important for re-evaluation of services and monitoring. These are all pointing to the need to develop and support the human capital part in the organization and in the process. It is important to have the right number of staff with the appropriate knowledge, skills and motivation to deliver services with expertise, empathy and efficiency. New or different professional roles, competencies, values and attitudes may have to replace the more traditional ones, as they do not necessarily fit the requirements for integrated care service provisioning. Integration of services often implies that boundaries between provider organizations will become increasingly blurred. For this reason, sharing workforce-support mechanisms – including training – across organizations may be not only appropriate but also
could be instrumental.

Targetting to address the specific need of the elderly is an attempt that has long been observed even before the implementation of integrated care practice. One of the most frequently debated is the idea of ‘successful ageing’. The perception of ageing has changed throughout history. With industrial revolution, older workers were increasingly viewed as redundant and expandable. Thus, emerged the concept if ‘Ageism’. Ageism is elaboration about pessimistic old age that connotes poverty, isolation, and illness. Nevertheless, the concept of successful ageing seeks to replace this paradigm. It focuses on renewed attention on health promotion and the prevention of disease and injury as a means of improving the quality, and not merely the quantity, of the later years. Viewed more critically, however, the successful ageing model may be seen as contributing to and reinforcing a new form of ageism. The main critic of successful ageing is that it tends to blame those who do not measure up to high standards of ageing. In this context, the norms embedded in the notion of successful ageing are understood as problematic in the following two senses. First, in their tendency to assume the existence of a commonly recognized and accepted end point that makes one person’s aging a success and another’s
usual or a failure. And second, even if there were agreement on a desirable and discreet end point people clearly differs in the abilities and resources available to them for attaining such a goal. How people live is heavily affected by socio structural factors beyond their control, and success is more difficult for some to achieve than for others. The trend of pursuing this standardized criterion of well-being is exemplified by ICF. The significant of ICF contribution in various perspectives are undeniable. Yet, the temptation to devise a method to enable internationally consistent data comparison lead to the adoption of the principle of standardizing. This approach is insensitive to the fact that human function is more complex and possessed in it a huge ‘potential power’ that science can’t understand.

There are similarities and differences between successful ageing and integrated care practice. Both are committed to improve elderly citizens’ well-being and in such aims emphasize the importance of networking and person-environment relation. However, both practices tend to focus on different perspective of intervention methods. While integrated care tends to focus more on macro extrinsic factor (system and policy approaches), successful ageing highlights the importance of micro intrinsic factors (individuals’ efforts and
struggles). While efforts to assist individuals from the perspective of ‘others’ through integrated care practice is driven by the characteristics of empathy; the individual efforts originates innately from one’s survival instincts. These two driving force (empathy and instincts) and their combination in forming the proper social bond are the unifying factor between the two perspectives of efforts. If we are to stand from the service providing side point of view, reconciling or synchronizing individually initiated efforts to the networking or integrated method of intervention must be done through acknowledging the importance of such individuals’ instinct (as an inner driving force or motivation) of which the existence is reflected in their autonomous effort to attain self-betterment. It is the instinct that gives them ‘reason’ to move forward. Thus, understanding the characteristics of human instinct is necessarily essential in this matter.

Human development and behavior are the outcome of 1) genetic traits and characteristics (the innate instinct), 2) the environment (external stimuli), and 3) the learning that produces new and synthesized behavior (acquired behavior). This is a process where all three forces contribute to who we are and what we do. Behaviors that have specific instinctual characteristics can be modified.
Learning increase the frequency of occurrence of a behavior influenced by instinct, and as a result the behavior will increase in accuracy. Although instinct may drive a process, learning gives it a new form and a different look. Instinct is the inner driving force or motivational factors that give reasons to individuals' pattern of behaviors. Instinct is necessarily related to the emotional part of individuals. Thinking and intervention methods that are based on conventional science and medicine have concentrated on the physical aspects of life style, for example, encouraging people to eat healthy foods, to exercise regularly and not to smoke. While these things are important, they do not provide the total answer. We need to investigate the profound effects emotions and the social environment may have on a person's health and well being in later life. Understanding a person's mental attitude, though complex and difficult, is important in this context.

The factors that facilitate the development of individuals' instinct; the connection of such process to the formation of individuals' identity and their characteristics of social bond; the influence from the formed identity to individuals' capability and interest in social participation; and existing social system's characteristics strongly affect the implementation of integrated care
as a process that is based on mutual concern and solidarity. The concept of attachment and social bond are crucial in this context. The phenomenon of population ageing is one of the most common reasons representing the concerns towards the necessity to integrate policy and approaches (thus, services). The problem of population ageing does not exist in solitary. It is interrelated with many other social phenomena and they confront individuals and societies simultaneously rather than individually and one at a time. For such reason approaches intended to assist should be organized in a holistic environment and through comprehensive way that transcend the traditional method and approaches. New approaches that are integrative and capable of producing a series of seamless services are necessary.

The eight principles of integration as discussed earlier require mutual consent and fair reciprocity from involving parties for their actualization. Both, mutual consent and fair reciprocity exist in a sphere where there is awareness towards the importance of social solidarity. For such reason, integrated care itself is actually, or must be, a process of social solidarity. The actualization of the concept of fair reciprocity in this context could imply two meaning, that is: the requirement for individual members to contribute their concern and to
participate in the collective action; and the fair and mutual acknowledgement of involving individuals’ inner perspective in relation to such processes in order to ensure that participation is meaningful to them. Participation necessarily needs competency on the part of participating individuals and the performance release of such competency is in many ways associated with or influenced by the frame of reference that individuals possess in them (the inner perspective). As such, knowing about this inner perspective in terms of where it originates from and how its existence will influence the practice of integrated care is important. And, as it was discussed in earlier chapters, such perspective originates from individuals’ instinct; or to be more precise, their welfare instinct.

Welfare instinct is the natural inclination or tendency to attain self-betterment that every individual innately possess in them. Such inclination involves a series of multi level and mutually interconnected biological action and psychological reasoning ranging from the most basic of self-maintaining bodily process, to the development of intellectual faculties that was made possible due to the success of earlier self-maintaining process, and finally, this wills for the preservation of the individual self accompanied by the development of intellectual faculties tends to pass into a will of self-maximization through a
higher and more complex functioning, such as the creation of social bond. Though welfare instinct may be characterized by a low degree of consciousness in its initial stage, environmental adjustment that can facilitate learning strategy along the process is hoped to be able to transform such instinctual impulse into a positive acquired habit that can equip individuals to coop with the demanding pressure from his or her immediate environment in effort to attain self-betterment. The understanding and acknowledgement towards the importance of instinct is useful in effort to device an intervention approach and ideological framework that is universal, non-coercive, and capable of maintaining the respect towards individuals’ diversity. Instinct is an element that is universal due to its existence in every living animal; non-coercive due to its natural existence in respective individuals (rather than externally imposed or established); and capable of respecting individuals’ diversity through the freedom and motivation that it guarantees in the process of decision-making. It would be most ideal to the contemporary social situation if we are able to precisely identify the characteristics of instincts that exist in respective individuals and utilize such knowledge to reconcile individually initiated efforts for attainment of self-betterment to the collectively initiated effort
(of intervention) in our attempt to create an intervention method that can comprehensively look into the unique needs of individuals, while at the same time fostering social solidarity. It would also be ideal if we could utilize such knowledge to create services that are free from standardized framework of intervention in order to justly address the totality of individuals (including their valued internal perceptions). The society should work to acknowledge the significance of instinct that exists in respective individual in effort to actualize the advocated meaningful relationship that is said to be attainable through the process of integrated care. However, the reality is showing a trend that is far from this ideal expectation.

Different kinds of instincts simultaneously exist in individuals and are competing for supremacy. Due to the superiority of certain instinct – in this context, segregative instinct – against the other, the tendency to categorize or segregate rather than initiating to address the totality of individual is more common in our social system and social setting. Such practices further aggravate the social divide situation rather than promoting integration and solidarity. Segregationist behaviors in our culture and social organization have often taken the form of discrimination against humans who are different
sexually, racially, ethnically, or religiously. The practice of segregating or categorizing reflects the existence of a certain spectrum of power balance between different social actors in our social structure. The existence of these structures of power balance influences our social system and our life in many ways. They are characterized and determined by factors such as social position, knowledge, gender, age, and so forth, and could be the ultimate determinant factors that decide the final shape of any intervention and collaborative effort. From a perspective closer to welfare areas, the practice that mirrors the concept of social segregation or social categorization is more commonly associated with the term or aim of ‘intervention efficiency’. Such practice is manifested in many different forms; from the macro to the most micro practice of interventions. Some of the examples are the categorizations that are observable between people of different nationalities and race; between different boundary of services and expertise in welfare areas; between service providers and service receivers; and between different levels of policy intervention. The kind of categorization or segregation that typically works to segregate the elderly as an exclusive group from the main stream community is negative age stratification or ageism.
The rationality to categorize is a point that requires careful consideration. Are we implementing the right type of categorization that our contemporary environment requires? The comprehension and knowledge on which the current social institutions and social policy are derived do not usually result from a consideration for the instinctual needs or instinctual drive that influences human development and behavior. We have not explained very much about human behavior regarding causal mechanisms that influence human instincts. The absent of this component in most theories on human behavior renders them anthropocentric, if not culturally isolated. A contextual approach is obviously inadequate and can only explain short-run and culturally bound behavior. Such approach that is grounded in current events has unacceptable limitations. Segregation is an instinct that in certain situation must be sublimated or redirected. Knowledge and logic are the tools most commonly employed to supersede such instinctual tendency and learned habits. Segregation is an instinct that can be easily manipulated using education and social pressure. From the above, it is arguable that we have the tendency to, first, segregate, and then, (purposely or inadvertently) paternalized approach by standardizing intervention procedures in our efforts to create a social system
that we thought might be comprehensive, inclusive and fair to all. The created social system to a certain extent has fail to grasp the dynamic of individuals instinctive inner-drives or instinctive urges (concerns) that determine the way they value and cherish their respective way of living. These are the innate strengths that individuals are endowed with within themselves and by denying these strengths the system actually kills the motivational root and limits the resiliency and creativity of individuals in effort to independently improve their own well-being. Base on such reasons, there is the need to reform the segmented system and to acknowledge the importance of instinct due to its potentiality to act as a factor that can promote solidarity, a factor that can reconcile individuals’ and collective effort, and a factor that can be an inner-driving force to stimulate individuals’ capacity in attaining their well-being in a non-coercive manner. The amelioration of our understanding towards the importance of the concept of instinct in relation to individuals’ totality is important.

To a large extent, efforts to assist individuals that are extended through our social support system are focusing and emphasizing on facilitating the external factors for self-betterment that is forwarded from the external point of view.
What is equally important is to ensure if there exist a match or fit between the externally provided opportunities and the (self-determining) internal perception that inherently lies within each individual. In this context, once again the understanding towards the concept of instinct is crucial. The instinct or the internal perception that individual possesses acts as an important switch or the starting point that determines his or her characteristics of later engagement in utilizing and benefiting from the opportunities provided to them by others. Such engagement is presumed to be able to assist in stimulating and improving the growth of individual's capacity, to name one among many, his or her resiliency in dealing with the challenges faced in the effort to fulfill their needs and to attain their well-being. Resiliency in this context involve actions that is not merely physical or psychological, but a complex combination of both so that the coordination or the matrix that is created from both can satisfy the totality of the individual. Attempt that aims to assist the development of this resiliency must acknowledge the importance of both sides of perspective to individual capacity. As such, the attempt must be based on intervention that can address the totality of individual and founded on a series of seamless services. This is also where the necessity to integrate services and the necessity to reconsider the
needed intervention approaches and skills emerged from.

The attempts to ameliorate the segmented methods of intervention that are observable in our social system are conducted though many efforts. Some of them are carried out, for example, through the promotion of the concept of common citizenship that is respectful of diverse individuals’ particularity; by adding some flexibilities to the rigid boundaries that surround different categories of welfare services and professionals; by practices that try to tear down the gap of social hierarchy between service providers and service receivers, and by integrating policies that is conducted at different levels of approaches. From the micro level, the amelioration is done through the exercise of a care process that is characteristically continuous and based on the understanding towards the significance of the concept of social bond to individuals’ life. Other than hoping that it would act as a countermeasure that will assist in blocking the development of unwanted quality of instinct that adversely effect individuals’ inner perception regarding others and his or her environment, the importance of comprehending and carrying out the process of care in a continuous manner rather than as a segmented focus lies in the acknowledged necessity to create proper bond that will yield resilient individual
with a proper social quality. How care is delivered and whether the continuity of the process is sustainable, is strongly influence by the kind of environment where such care is situated. Upon identifying the flaws in the social system that originated from the unnecessary categorizing, and upon initiating efforts to rectify such flaws, our focus should be continued by identifying the factors that will facilitate the creation of environment that will sustain care continuity.

From the perspective of formal care, such effort can be materialized thorough the formation of suitable care team-work (through team approach that based on a high degree of functional-expertise) that is multidisciplinary and resilient in structure and capability. Information sharing is crucial in this formation. Other than that, reforming the social worker’s competency profile, in other words, preparing the suitable kind of manpower that will sustain the efficiency of future social work practice, is also deem necessary. And, from the informal care perspective, as stated earlier, focus is directed to the understanding on the importance of the concept of attachment and social bond. Attachment is the result from primal human instinctual need for physical contact with another. Such need is then developed and shaped into what can be termed as ‘social bond’. This bond is the mature response of the neonate’s
need for physical contact. It influences behavior throughout life. Therefore, it is considered a force that has an effect on both individual and group behavior. First, it is shaped by the mother-child bonding process and by interactions with the environment. Second, it is shaped by the family, friends, and community, and by increased interactions with the environment. Finally, to some degree, behaviors are consciously or unconsciously selected that result in either strengthening or weakening one’s attachment with subgroups in his or her primary environment.

Researches have suggested that maternal love was as important for the mental development of children as were proteins and vitamins for their physical development. Being deprived or separated from the mother was usually as damaging for the child’s mental health as were contagious diseases for ‘physical’ health. The absence of a durable attachment relationship in the first year of life would have irreversible consequence for what is called ‘mental health’ or ‘adaptability’. It would result in an unfortunate form of maladjustment to its surroundings and a lack of confidence in itself and its fellow human beings in times of need. Attachment behavior in adult life is a straightforward continuation of attachment behavior in childhood. For example, the function of
mother or mothering figure as a secure base is strongly recalled or reflected in situation where sickness or calamity strike such individual. In this situation adults often become demanding of others; in condition of sudden danger or disaster a person will almost certainly seek proximity to another known and trusted person.

Care provisioning is based on the same principle of attachment. People best grow, heal, and learn in the context of meaningful relationships. Such relationships are a primary determinant of how well needs for support, knowledge, healing and growth are met. It is at the point of contact between caregivers and care seekers that the latter experience themselves as meaningfully taken in and cared for. Growth, healing, and learning often involves risk and vulnerability for people. For many of them to move ahead on the face of their anxieties requires, often enough, a safe-enough relationship with others they experience as caring. Without a sense of safety, it is difficult for people to move toward engaging their own growth and development. The possibilities of careseekers to venture forth to engage their journeys toward health, growth, and learning depends on relationships with caregivers who offer careseekers a sense of security, a place to which they can return should they
become momentarily overwhelmed (secure base function). The search for a secure base occurs throughout the life cycle, especially in emergencies.

The instinctual characteristics found in the individual’s behavior result in group behaviors and species behaviors that are almost always beneficial to the survival of the group and the species. First, instinct influences behaviors in such a way as to promote individual survival. Then the individual instincts influence behavior in such a way as to promote the survival of a primary group. Finally, instincts influence behavior in such a way as to promote the survival of the species. This is the base for social bonding process. Social bond theory is an expansion of logical elaboration of Bowlby’s concept of the attachment instinct in the newborn. Social bond is an expression of a human instinct that first appears as attachment to the mothering figure and continues to develop in concert with social experiences in the family, with friends, at school, at work, and in the community at large. Social bonds are the enduring ties that ‘unite members of a species in couples, in groups, and in complex social organizations. Group existence is a major adaptive mechanism in primates, and bonds to the group are promoted in several ways. The first social relationship is that attachment between the infant and its mother and this
relation will eventually involve other family members in its later stage to form family bond. In the next stage of its development that is accompanied by increasing social experience, social bond moves beyond that particular relationship of family bond and establishes a bigger role and wider connection with other group members that are outside the circle of family unit. Such development will lead to the formation of social networking. Research findings suggest that social uncertainties can create confusion, anxiety, and self-destructive behavior within the individual. The fear of weakened or broken bonds creates a sense of confusion and anxiety. Deviant behavior occurs when an individual’s bond to society weakens or is broken. This broken bond is what frees the individual to violate the norms of society.

Understanding and acknowledgement towards the importance of the concept of instinct and social bond in our life can be significant in many ways. Such importance is manifested through the capability of both concepts to assist in: first, putting in sequence and connecting between our split understanding towards the concept of physical well-being and psychological well-being that has been long placed in a contradicting position; second, acting as an inner motivation that continuously generates the consciousness of self which will
eventually lead to the striving (in efforts) of individuals to attain autonomous self-betterment; third, reconciling between the principle of impartiality (exercised based on collective effort) and individuality (exercised based on individual effort) in social work intervention; fourth, providing a complementary view of argument against the mainstream framework of intervention that merely focus on extrinsic environmental factors for promotion of self-betterment; and fifth, maintaining social cohesion for the possible formation of solidarity and practice of fair reciprocity that should found the practice of integrated care.

Instincts that exist in individual can be influenced and shaped into (positive) acquired behaviors through learning processes and environmental facilitation, and instincts are the initial and crucial determinant factors that influence decisions relating to individuals' engagement in certain behavioral patterns as against their external world. Instinct is an energy that is assumed to be capable of driving individuals' inner motivation to autonomously seek and attain self-betterment due to its position that is free from any external coercion. It is also both universal and at the same time exclusive in nature due to its existence in every individual. The understanding towards the concept of instinct is important in any collective action due to its capability to act as a factor that
can consolidate both individually and collectively initiated efforts, and promotes solidarity and reciprocal interdependency. Instinct development in individuals has to be promoted through a process that takes account the totality of a person and such process has to be conducted through a comprehensive and continuous, rather than segmented approach in both formal and informal setting. What follows from this logic is the need to ameliorate the currently segmented social systems and their framework of approaches and interventions. Sensitivity towards the significance of instinct is hoped to be able to assist the development of the instinct itself. The development in such perspective is expected to contribute to the heightening of individuals’ overall capabilities development, and ensure the existence of fits between delivered opportunities and individuals efforts to attain self-betterment. What is really needed in creating this fits is to integrate from the within of individuals.

In sum, instinct is an inner-drive that constantly exists in individual throughout his or her stretch of live influencing many significant aspects of such individual’s psychological and physical dimension of action. Thus, a continuous and constant focus, and understanding towards the far-reaching influence that it can exert to individual’s behavior and pattern of action is necessary.
Moreover, the continuous and constant focus is necessary due to the fact that the quality necessary for individual to enable himself or herself to participate in collective action such as integrated care – through solidarity and reciprocity – is not a quality that can be shaped instantly. The comprehension on the concept of instinct and social bond is important to understand the psychological characteristics of individual members in the society in effort to secure the stability of social structure so that solidarity can be sustained and fair reciprocity can be performed for collective action to be implemented.

There is different understanding towards the meaning that is given to the concept of collaborative actions. Many different words (for example, work together, joined-up thinking, joined-up working, partnership, and integrated approach) are used to explain the nature of such relations. All these words are used as a quick way to describe a way of working which are base on multi-agency working, interdependent of action and shared vision. Upon understanding the factors and the concepts that should sustain the structure of integrated care, it would be important to look into existing models of integrated care to observe how the practices are actually conducted in order to know the advantages and disadvantages of each model. Integrated care in Finland,
Britain and Japan were looked into for this purpose. The existence of these models of collaborative action clarify the universal characteristic of contemporary social policy's tendency in promoting and pursuing integrated care as an effective countermeasures in dealing with many arising challenges.

Though all three models of collaborative actions posses their own distinctive method of operation, all are fundamentally based on the same principal; the 'integrated care'.

The practice of integrated care in Finland is mainly characterized and driven by the effective function of its 'health center'. It is a functional unit that provides primary curative, preventive and public health services to its population. It is not necessarily a single building or a single location where care is provided. Health center activities are often organized at several places and the size of a health center varies, depending on the number of people it serves. The personnel consists of general practitioners, sometimes medical specialists, nurses, public health nurses, midwives, social workers, dentists, physiotherapists, psychologists, administrative personnel, and so on. Health centers offer a wide variety of services such as outpatient medical care, inpatient care, preventive services, dental care, maternity care, child health
care, school health care, care for the elderly, family planning, physiotherapy and occupational health care. Health centers are usually well equipped and the inpatient department of a health center works in much the same way as a hospital department. All primary and public health care, which until then had been provided in a fragmented way, were brought together under the administration of health centers. The other characteristic for the implementation of integrated care is the adoption of a system that is termed as ‘population responsibility’. It is a model whereby a team of doctors and nurses is responsible for the health care of geographically specified populations. Most health centers are now moving towards the principle of population responsibility.

The practice in Britain has long been characterized by the concept of community care that mostly starts from the grass root level. This ideology is then further actualized and develops through the practice of Local Strategic Partnership (LSP). An LSP is a single body that brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors so that different initiatives and services support each other and work together. Generally, the aims of Local Strategic
Partnership are: to represent the wider interests and needs of the area, both within the region and nationality in order to secure the well-being of the area; to promote and facilitate multi-agency working by helping to overcome the barriers between organizations; to work towards the more integrated provision of mainstream services in partnership with the community; to address social inclusion, regeneration and development; to coordinate contributions of individual partnerships to the community strategy and other priorities; to share information on key policy and budget issues that will have major implications for partners; to develop shared approaches to consulting and engaging the local community; and to develop responses to major issues that is beyond the scope of any existing single partnership. The performance and achievement of local authorities in delivering such services through the implementation of Local Strategic Partnership needs to be evaluated from time to time. In this context, the method of Best Value was adopted for such purposes, and this is the other factor that characterized (s) the practice of integrated care in Britain.

The provisioning of integrated care in Japan started seriously upon the implementation of Long Term Care Insurance system that was started in the year 2000. However, as time passes by, new needs and unexpected difficulties
were faced by the system and a revision to improve existing system became necessary. Such revision was conducted partially starting from the year 2005 and expected to be fully complete in April 2006. The main unit that is expected to contribute for the effective practice of integrated care after the revision is Locally Attached (Regional) Comprehensive Service Center or LCSC. LCSC is a service unit that is created based on earlier functioning Home Care Support Center (HCSC). HCSC were earlier mandated with the duties and functions to educate and support care managers. In the new system where it will be reborn as LCSC, the scope of functions and duties will be extended to include the practice of preventive care through a total management of locally provided cares (comprehensive local care). All centers are legally required to station the following three categories of staffs who are social worker, supervisory care manager, and public health worker.

The formation of skill and quality (attitude) that every individual must possess in order to be able to participate competently in any collaborative action (including integrated care) is a continuous and interlinking process from an individual’s early life cycle towards the end, and from individual’s most micro environment towards his or her most macro social environment. To maintain
the continuity of such process and to cope with all the needs that will emerge along the process could never be a simple task, but nevertheless, an important one. In their effort to fulfill this requirement, a comparison between the three models of integrated care revealed that similarities are most striking from the perspective of policy struggles that all are facing. The main efforts are devoted and concentrated in attempts to bring all players in the social system, be it groups or individuals, into an active and fair participation in the initiated collective and collaborative actions. The struggles are to balance the division of duties among all actors in a condition where everybody acknowledge their mutual duties while balancing the availability of various kinds of services that are necessary to cater various needs originating from diverse parties and individuals. Particularly important in such context is the fact that the whole process need to be done according to proper planning and everyone participating in the process know their mutual duties and understand that the completion of every single segments of the duties are interrelated with other parts and affect the structure of process as a whole. It is highlighted that matters relating to power relation is crucial because it affects different people’s capacity differently in their participation to collaborative action.
Common to all the three models; the effort to constantly device and initiate new methods of interventions from time to time become necessary due to the continuously evolving characteristics of needs at any particular point of time. This tendency is then further strengthen by the incapacity of individuals to cope along with the changing environments in their effort to fulfill their own needs. In the following stage, it is generally observable that initial attempt to ameliorate such situation from the policy perspective is conducted by partially decentralizing the earlier implemented centralized administrative system, and by encouraging public participation from grass root level. The success in this stage will then encourage the introduction of a larger scale of reformation in policy where common views, mutual responsibilities and social solidarity are promoted in a clearer manner for the possible implementation of more comprehensive collaborative and collective social actions that are guided by a proper policy structure. For example, situations in Finland and Britain had led to an increasing demand for services to be provided by sources other than the centrally managed public sector. In the case of Britain, a focus was directed to the possible function of informal care network to supplement the existing system as an alternative. However, due to the slow speed of development,
Britain had to seek alternative solutions from the private sectors. In Finland, such solution was sought from the cooperation that was conducted between the central state, local municipalities, private sectors and the community.

In Finland and Britain it is noted that reformations were actions that were not brought by changes in policy or legislation, but initiated from the grass root level. In both cases, interests were shown by local authorities and communities to autonomously initiate reforms in order to improve their coping ability against evolving needs. In both cases, meaningful two-way engagement between all community members, and involvement of community in bottom-up strategy were noted as the underlying factors that help to build confidence among community members and will increase their capacity for ongoing engagement in the process. The structure of medium adopted to actualize the intended reformation in Finland was the ‘health center’. It took a wider perspective on the provision of primary care by comprising preventive and public health care in its intervention (Japan’s effort to revise its Long-Term Care Insurance system by setting up the Locally Attached Comprehensive Support Center and by promoting the concept of prevention resemble this approach and trend to some extent). In Britain, such collaborative effort is materialized through the
formation of ‘partnership’ (local strategic partnership in the case of Milton Keynes). In this perspective, it is noted that as collaboration progress, members will gain more capabilities and authorities will become further deregulated. The introduction of a larger scale of reformation in policy with the implementation of a more comprehensive collaborative action that are guided by a proper policy structure become necessary as needs become more complex and diverse. At this stage, cooperation between different organizations is emphasized, to which both public and private providers equally contribute their know-how. Reorganizing the production of services, development of customer orientation, multiprofessional teamwork and networking are the central areas for concern along with issues relating to the improvement of cooperation between clients and professionals and clients’ possibilities to influence decision-making in service provisioning.

The above flow in terms of policy struggle relating to, first, evolving needs and devising ways to attend them, then, followed by initial attempts to conduct reformation through collaborative action, and finally, ended with the implementation of comprehensive reformations that are backed by legislation are also observable in the development and struggles of Japan’s social policy.
In its more recent stage of development, Japan has moved towards the socialization of care in modifying its tradition of family care for the elderly where each citizen are required to take more responsibility for finance and decision making. For this purpose Long-Term Care Insurance (LTCI) system is utilized as the base policy for services delivery and the scheme has formalized the care management techniques for the running of process. The implementation, however, was troubled by inconsistency and variation in standards and availability of services. Expenditures have also increased greater than government’s original projection. In an effort to improve situations, the government has made revisions on the LTCI system in 2005. Locally Attached (Regional) Comprehensive Support Center (LCSC) was established in localities as a unit that is mandated with the responsibility to facilitate the actualization of the above revision program through the total management of locally provided care, replacing the earlier function of Home Care Support Center (HCSC).

From the above it is noted that the same tendency of policy struggles and the same trend towards employing integrated care methods as policy base for delivery of efficient services is observable in Finland, Britain and Japan. It is
generally understood that ‘integrated care’ should be regarded as a ‘total service’ that is composed from various services that are systematically linked to each other in order to create a synergistic effect to individuals. The forming of common understanding through collaboration in terms of ‘clear aim setting’ and ‘organizational cooperation’ between all related parties are required to ensure the ‘totality’. The differences between the three are only exhibited in methods utilize to materialize such aims and in the different level of comprehensiveness shown in approaches in each country setting. Though the aims are the same, the chosen mechanisms for the means of implementation and the extent to which an implementation is conducted and pursued is different. It is assumable that such differences are strongly influenced by the attitude and quality of individuals who participate and control the process.

Methods relating to staff compensation are among the noted differences. Methods of staff compensation must be altered so that scale will suit their level of professionality and will become a motivating factor to boost their performance. A proper system that support and justified the effort of social workers in upgrading their knowledge and skills, and in performing their tasks is thus necessary. Japan is still a few steps behind in materializing this point.
though awareness towards the importance of its actualization no doubt exists.

In Finland, for example, the implementation of Personal Doctor System was accompanied by an altered method of payments for doctors in a way that it relates better to the workload, expertise and experience of the doctor and the population structure he or she is responsible for. The next part that is crucial in determining the existence of ample number of manpower with sufficient professionalism is manpower planning, particularly in terms of training. It seems quite general in the observed three countries that different bodies will be responsible for training process and recruitment exercise of manpower. There seems to be a lack of cooperation and coordination involving the bodies and both the process. There’s a noted problems in the same area in Finland and strengthening cooperation between all related parties is suggested as one of the solutions. In Japan, this context of argument necessarily touches the area of care managers’ manpower planning due to the highly expected function from them in assisting the running of LTCI system initiated by the government. However, the current situation seems not to be so promising. It is in a strong contrast to situation in Britain.

The method and approach of care management started to receive much
attention in Japan since LTCI was introduced and brought into practice. However, it is still hard to justify whether the current practice of care managers in the country is in line with the originally expected function. Such doubt arises from how the LTCI system is applied to practice. First, the importance of relation between training and qualification, even between qualification and competency of care managers was not positioned as sufficiently significant in day to day processes. Then, the implementation of LTCI comes along with the enforcement of care expenses payment limit. Due to this rigid regulation, care managers in Japan tend to overly concentrate on applying their effort to the part that mainly concern with cost management in their daily practice in order not to exceed the fixed allowed budget. This regulation and attitude consequently restrict their action to truly provide the necessary support. Due to the incapability of care professionals (in this context, care managers) to deliver a proper standard of service, the possibility for elderly to continue a living in one’s own home by utilizing the scheme from LTCI doesn’t seem to be totally promising. In addition, under the condition where LTCI Law prohibits the application of its service to other family members, the capacity of care manager to provide the type of care that connects and advantageously utilizes the
existing relationship between individual who needs care and informal care provider from family members, and the existing relationship between individual and his or her surrounding community network is doubtful.

Integrated care is services that must be directly and specifically managed through one-to-one management with no layers between. For such reason, the implementation of an effective practice of integrated care needs care managers who are professionally independent and equipped with enough authority to conduct a proper distribution of care and resources. In Japan, however, though care managers are expected to act as an agent of the recipient and select providers as neutral buyers, majority of care managers are at the same time employees of home care providers. They are obliged to serve the employer and without ample authority that will enable them to conduct a proper practice.

LCSC is the organization where majority of care managers in Japan will be attached to in the near future. The setting up of LCSC as an independent body or organization is hoped to be able to groom a new breed of care managers who are equipped with multifaceted approach which allows them to conduct practice on a micro- and macro-level simultaneously, and with professional authority and independency.
The next difference that is observable in the delivery processes of integrated care between Japan and the other two countries (Finland and Britain) is in terms of their range of interventions or comprehensiveness of approaches. Among the three, Japan is identified as the one with most limited range of interventions. This is clearly reflected through the category of staff required to be stationed at each unit of LCSC, and through the provided services that are restricted to the area of welfare for the elderly (despite of the widely argued intention to device and to conduct a cross-cutting intervention in welfare). In Finland, it is observable that the health center team are usually consists of a wide categories of professionals working together delivering wide categories of coordinated services. The possible implementation has to be supported by a condition where the health centers must be well equipped. For such reason, the health centers in Finland are generally well equipped and the inpatient department of a health center works in much the same way as a hospital department. The approaches in Milton Keynes (Britain) are conducted even from wider perspectives where social, economical and political aspects of the community as a whole are clearly considered, and where the needs of a community as a whole is carefully looked into in integrated ways.
Locally Attached Comprehensive Support Centers (LCSC) in Japan is established with mandated duties to implement the series of reformations that were proposed and decided in the revision of law conducted in 2005 involving the LTCI system, and such duties cover a rather wide perspectives of intervention involving matters such as: acting as an agent to represent elderly individuals in the process of eligibility authorization application, and acting as a center to provide: general consultation, preventive care management, and delivering comprehensive and continuous support. However, this scope of intervention is still limited if compares to what is happening in Finland and Britain in the fact that the minimum requirement (as stated in the amended policy) for the placement of staffs that determines the composition of professionals in each centers only involves three categories of professionals that are social worker, supervisory care manager, and public health worker.

The scope of intervention that is limited only in catering the exclusive needs of an elderly is another matter of concern. There are worries on the possibilities of outcome from the implemented policies that the good intention to treat the elderly in a special manner will unintentionally end up segregating them from the main stream society due to the failure of approach to consider all the
necessary perspectives in balance.

Comprehensive approach in the context of integrated care could mean comprehensiveness in terms of ‘range’ of approaches and in terms of ‘continuity and in-depth’ of approaches. Comprehensiveness as illustrated in CARMEN Project is reflecting a process where three different functions that are crucial to the needs of individuals – cure, care and rehabilitation – are closely linked in a seamless process. The process also emphasizes the importance of need responsiveness that should be attain through a continuous series of care conferences that fairly involve all related parties in the process of care provisioning. Other than that, the characteristics of CARMEN Project also reflect and expect interlink between the process of ‘Pre-Care’ (preventive care) and ‘Post-Care’ (physical care). The importance is understandable from the fact that physical and psychological condition of the elderly changes and fluctuates constantly, and for such reason, need monitoring and feed back that is conducted from both perspectives of care are frequently necessary in order to provide a care that is comprehensive and affective. These are the characteristics from which the practice of integrated care in Japan has much to learn. In Japan, despite of the wide acknowledgement regarding the
importance to connect and link between the process of care, cure and rehabilitation in service provisioning, in reality, there is not much effort that is concentrated in order to conduct the necessary seamless integration. In this context, Japan should ameliorate the situation by targeting to input seamless integration function within the day to day process of clients life. The practice of integrated care in Japan is also aware about the importance of need responsiveness in the process. In Japan, the attainment or the conduct of such responsiveness is expected to take place at the level of care management, and to be conducted by qualified care managers. This over expectation (towards the function of care managers) has consequently created a care coordinating / provisioning system that is personally managed or controlled by individual care managers. The most striking difference that can be observed in this perspective is that while the CARMEN Project has been advocating and acknowledging the importance of ‘care conference method’ in its needs attending strategies, Japan has been obsessed by individually controlled ‘care management’ technique. And finally, the point that needs reconsideration in Japan’s practice of integrated care is the part where the process in Japan (through the practice of Long-Term Care) is exhibiting a clear separation between prevention (pre-care) and
post-active-care (a characteristic that is opposite to what is practiced in CARMEN Project). The differences that exist between the two originate from the different understanding that is given to the concept of care in Japan as compares to European Union (EU) member states. Operating method as suggested by CARMEN Project is characterized by a feed-back system that is performed through a team-work; and based on a care plan that is never too rigid and flexibly altered from time to time according to the most contemporary situation of individual needs. This is another perspective that is contradicting to practice in Japan, thus, should be regarded as another point of reconsideration.

The possible development of individuals’ independency is conditioned by the extent of autonomy that one possesses and such autonomy is likely to originate from the existence of one’s instinctive freedom. The more such instinctive freedom is obtained the more it is likely for autonomy, thus, independency to be developed. The attainment of independency is crucial because it preconditions the conduct of reciprocity, one of the core factors that sustain the possible implementation of any collaborative and collective social action. For this reason, it is in this part that the most formidable challenge to the
practice of integrated care would lie – that is; to acknowledge individuals’ inner strength (their instinct) in the process of independency attainment that will become the base to sustain the possible exercise of reciprocity for the formation of solidarity. We need to look into what is the basic thinking that permit or should guide the development of independency in individuals, especially in the boundary of private life where it is quite far from the reach of formal policy intervention.

Integration from the macro perspective, though not a simple task to be implemented, is attainable through policy interventions and policy reformation. What is more complicated to pursue is a reformation in individual’s private life boundary that involve family unit and the setting. In other words, it is the integration within this most micro level that is most difficult to be reformed. Yet, this is a part of the larger scale of integration pursued in the macro level and without which full integration process in the macro level will not be attainable. Due to the fact that the necessary quality for integration must exist in every individual, the issues of power balance that strongly influence the process has to be tackled from the very early process of individual’s identity formation. Such process necessarily starts from, and influenced by the quality of attachment
and social bond forming chances of individual in their family unit. A focus even
from this very early stage of development is crucial reasoning to the fact that
the necessary condition for individual’s participation in collective social action is
his or her certain quality that is formed through a continuous process in his or
her life cycle and such process necessarily starts from home. The crucial part
in this context is to develop a person with characteristics that is instinctively
adapted to the formation of a resilient individual, and adapted to the principle of
fair reciprocity and solidarity that are essential in the formation of an intact
community. The whole process takes the freedom of individual’s instinct
development that will later lead to the development of such individual’s
independency as a starting process. For such reason, the effort to develop and
sustain individual’s independency is one of the most crucial issues to be looked
into. The correct process will assure the possible nurturance of positive instinct
development, the shaping of resilient characteristics, and guarantees the
attainment of independency in individuals. In other words, it will create the right
quality necessary for later social practice and social integration. Only by this
mean that a true integration, integration based on the quality that exists in
individuals’ inner-self (integration from within), can be developed. At this point,
we are aware and acknowledged the fact that individual's instincts is important in shaping his or her individuality and characteristics that are needed for the survival of both the individual and the society where the individual belong. The next difficult question is how or in what way do we translate this knowledge and apply such knowledge to a practice in general – in a form that is understandable to lay people and their personal environment. And, what is the fundamental or concept of care that is suiting to the contemporary community's requirement.

In order to exercise an implementation of integrated care practice that is truly affective and sustainable, we need to first of all, promote the concept of integrity and solidarity in our social system by sublimating the adverse development of segregational instinct that we naturally posses in us. This effort should be accompanied by attempts to nurture community members to grow into an individual that is equipped with the required quality necessary for the formation of social solidarity and other collective social action. In such attempt, early and continuous engagement in the process (of care), and understanding the importance of the concept 'attachment' and 'social bond' to the process is crucial. Further, the process of promoting the practice of integrated care also
need to focus on the concept of independency upon understanding that it is the precondition to solidarity. In this context, providing the type of rational care that is capable of guaranteeing individual's independency, equipping individuals with the quality of resiliency, and preparing individuals to exercise social solidarity should be an ultimate concern.

It is most important to understand that all the above effort must be bolstered by a principle that will guide carers to provide the most suitable kind of care as required by contemporary situation. The main question that needs to be dealt with in this perspective is; what is the basic quality, or the fundamental principle that can guide the production of care that will promote the total development of individual and his or her awareness towards the importance of meaningfully participate in actions relating to social collectivity? The concept of ‘democracy of the emotion’ as argued by Giddens (1994) is useful in providing some valuable ideas and clues on this part. To grasp what is the principle that suits the contemporary social requirement in terms of care provisioning; we need to look at what are the changes that take place within our society and how do the changes affect us as one members of the society. Then, upon understanding such facts, we need to initiate changes within our personal or
internal approaches (in relation to care provisioning) so that they will fit into or
match with the conditions that emerged from the changes that are occurring in
our public or external social setting. The necessary changes that we need to
pursue include fostering a care that is different from the conventional authority
relationship of a traditional family because we are now living in a world where
every individual possesses a higher level of reflexivity or social awareness due to
the availability of information and a wider social exposure.

I identified four factors that are relevant in explaining the changes that involves (social) environment surrounding individuals. Such factors are the
nature, state, community and other individuals. The changing relationships
between community and individuals; and between individuals themselves are
the changes that are most closely related to the argument that I brought
forward in this thesis. The key words that explain about the changes of
relationships between individuals in a highly reflexive world are active trust,
pure relationship, the democracy of emotions, and the forging of new social
pacts between class, sexes and even generations. In a world of high reflexivity,
an individual must achieve a certain degree of autonomy of action as a
condition of being able to survive and forge a life, and autonomy in this
situation implies obligation, reciprocity and interdependence. Enhanced solidarity in a highly reflexive society depends on what might be termed as active trust, coupled with a renewal of personal and social responsibilities for others. Active trust is trust which has to be won, rather than coming from the tenure of traditionally pre-established social positions or gender roles, as it was practiced in the conservative community. Active trust has to be actively and continuously produced and negotiated. Active trust presumes autonomy rather than standing counter to it and is a powerful source of social solidarity, since compliance is freely given rather than enforced by traditional constraints. Pure relationship is a relationship that is entered into and sustained for its own sake (pursued for the rewards that association with another, or others, can bring). Forming pure relationships and ensuring their continuity draws in an inherent way on active trust. Pure relationship depends on the compatibility within the context of a mutually rewarding relationship. Dialogue, between individuals who approach one another as equals, is a transactional quality central to their mutuality.

The shortcomings of liberal democracy in a reflexive social order suggest the need to further more radical forms of democratization. It is in this context
that Giddens stresses the importance of dialogic democracy. Dialogic democracy is a situation where there is developed autonomy of communication, and where such communication forms a dialogue by means of which policies and activities are shaped. It is not necessarily oriented to the achieving of consensus. The intention is to let matter of interests to remain essentially contested. Dialogue should be understood as the capability to create active trust through an appreciation of the differences and integrity of the other. Outside the arena of the politics, dialogic democracy can be promoted in several main contexts, for example, in the area of personal life that involve parent-child relations, sexual relations, and friendship relations. Such relationships are ordered through dialogue rather than through embedded power. Giddens terms this as ‘democracy of the emotion’. Democracy of the emotions depends on the integrating of autonomy and solidarity. It presumes the development of personal relationships in which active trust is mobilized and sustained through discussion and the interchange of views, rather than by arbitrary power of one sort of another. To the extent to which it comes into being, a democracy of the emotions would have major implications for the furtherance of formal, public democracy. Individuals who have a good understanding of their own emotional
makeup, and who are able to communicate effectively with others on a personal basis, are likely to be well prepared for the wider tasks and responsibilities such as conducting meaningful participation in any organized collective action.

From this statement, it is understood that the formation of characteristics necessary to support the participation of individual in any collaborative or integrative efforts starts from home, through the conduct of care that takes the principle of ‘democracy of the emotion’ as its basis. Other than its capability to lead to the type of care that respects individuality (thus promoting autonomy and independency) through its approach that view others as equal (for example, the person being cared for), the significance of the concept of ‘democracy of the emotion’ is reflected in the necessity to forge new social pacts, especially in the area of private boundary that involves family units and their members. The social pacts have to be forged across class, generations and sexes. The advance in children’s rights is a significant contribution on the potential for emotional democracy and a pact between the sexes is in many ways the key to the retrieval of other forms of solidarity. All the above are factors that will contribute to the positive or negative formation of individual’s inner self
perception or inner self-value that will determine his or her attitude towards the
strive in attaining one’s own self-betterment and level of resiliency in effort to
achieve one’s own well-being. On the other part it also determines his or her
attitude towards the exercise of reciprocity and the process of solidarity.
Tackling the issues from both macro and micro perspective, and in a seamless
manner, is the preconditioned for the success implementation of any collective
action, including integrated care. A true integrative social action is a process
that is bonded not merely through or in its physical appearance, but from the
inner sanction that originates from our within.
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¹ The conceptual idea of ‘prevention’ as presented in this paper originated from my involvement in the research project entitled ‘A Research on Social and Organizational Condition for the Creation and Systematization of a New Welfare Services (A Second Term Research for Academic Frontier Promotion Project, 2004~2008) – B Group Research Project’ that is currently conducted by Kansei Based Welfare Research Center of Tohoku Fukushi University. I wish to officially request for the permission to cite some of the early findings from this research project (i.e. Ogasawara et al., 2005; Abe, 2005; Doi, 2005) to be presented in this paper.

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<th>Conducted Presentations</th>
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<td><strong>Title</strong></td>
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