TO BLEND IN OR STAND OUT?

Hospital Social Workers' Jurisdictional Work in Sweden and Germany

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Abstract

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This dissertation describes, analyses, and compares the means by which hospital social work associations in Sweden and Germany pursue their members' professionalization through 'jurisdictional work'. The time period covered by the research is 1989 through 2008. The analysis starts from the observation that jurisdictional work represents an ongoing effort by hospital social workers' professional bodies to establish and maintain formalized professional jurisdiction, both internally within the profession and externally vis-à-vis outside stakeholders. The research questions guiding the investigation focus on the kind of activities these professional bodies perform, and the way in which they are performed, to promote hospital social workers' professionalization in the two countries in question. The question will also be asked as to the reasons why hospital social work bodies perform the specific activities under consideration.

This dissertation is a cross-national comparative case study on jurisdictional work performed by a social work subgroup operating in organizational settings where social work represents a minority occupation subordinate to other professional fields. The research materials used for the study include, in the first place, various documents obtained from professional hospital social work bodies in Sweden and Germany. In addition, two focus group interviews with board members of two of the associations studied were conducted.

The theoretical framework used for the analysis and comparison of the empirical data draws on theories of the sociology of professions (Abbott 1988, 2005), complemented by theorizing on compliance in voluntary organizations (Etzioni 1961) and on social identity (Jenkins 2004). Additionally, argumentation analysis is drawn upon Karlsen (2012).

The results obtained show there to have been major differences between the jurisdictional work strategies resorted to by the Swedish and German social work bodies. The differences mainly involved the ways in which these organizations supported their members, related to their social work knowledge base, positioned themselves vis-à-vis their trade union, and concretely sought to advance formal protection. The findings point to both internal (i.e., associational, related to the organization's size and resources) and external (national context, specific healthcare setting, and degree of subordination to other occupational categories within the professional context and the specific healthcare setting) factors behind the differences in the studied social work bodies' use of jurisdictional work strategies.

Altogether, two different jurisdictional work strategies were found to be used by professional hospital social worker groups operating in subordination in Sweden and Germany. A *mimetic* strategy was used by the Swedish hospital social workers, to allow them, as a professional group, to better "blend in" with their hospital settings; in this case, similarities between the hospital social workers and their working environment, including other professions present in it, were emphasized, especially as concerns their knowledge base, professional identity, and disciplinary affiliation. In contrast, the German hospital social workers relied on an *aposematic* strategy stressing differences between the social workers' and their hospital co-workers' knowledge base, professional identity, and disciplinary affiliation, so as to make their subprofession "stand out" from its enveloping hospital settings.

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Manuela Sjöström
Gothenburg in October 2013

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Nätverk för forskande socionomer inom hälso- och sjukvård (NFS)

Abbreviations

BA	(*Berufsakademie*) University of cooperative education, Germany
BÄO	(*Bundesärzteordnung*) Law concerning the Order of the Medical Profession, Germany
BAR	(*Bundesarbeitsgemeinschaft Rehabilitation*) National Committee on Rehabilitation (health care funders, suppliers, interest organisations and public administration from all federated states are represented). This committee negotiates public regulations concerning rehabilitation obligatory for all parts, comparable with public regulations, Germany
BeitrEntlG	(*Beitragsentlastungsgesetz*) Law concerning the insurance fee relief, Germany
BGBl	(*Bundesgesetzblatt*) Official publication of changes in law, Germany
BPflV	(*Bundespflegesatzverordnung*) Public regulation on remuneration of hospital in-patient care as well as day-/and night Care, Germany
DAG	(*Deutscher Angestellten Gewerkschaftsbund*) Umbrella organisation for employee's trade union, Germany
DBSH	(*Deutscher Berufsverband für Soziale Arbeit e.V.*) Trade Union representing Social Workers, Social Pedagogues and Educational Therapists, Germany
DGS	(*Deutsche Gesellschaft für Soziale Arbeit e.V.*) German Society for Social Work
DVSK	(*Deutscher Verband für den Sozialdienst im Krankenhaus e.V.*) German Professional Association for Social Services in Hospitals (the DVSG's name before 2004),
DVSG	(*Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V.*) German Professional Association for Social Work in Health Care (name from 2004 onwards),
ErgThG	(*Ergotherapeutengesetz*) Law concerning Ergotherapists, Germany
FAMMI	(*Familjemedicinsk Institut*) Public Institute for the Development of Primary Care and Knowledge Development for Health Care Professionals in Primary Care, Sweden
FORTE	(former FAS, *Forskningsrådet för arbetsliv och socialvetenskap*) Scientific Committee for Work Life and Social Sciences, Sweden
FG	Focus group interview
FG DVSG	Focus group interview with members of the DVSG national board
FG SK	Focus group interview with members of the SK national board
FH	(*Fachhochschule*) University for applied sciences, specific university feature, Germany
G-BA	(*Gemeinsamer Bundesausschuß*) Federal Joint Committee – A statutory corporative committee concerned with implementing

	legislature by regulations and contracts between funders and suppliers of health care services, patients and public administration, Germany
GG	(*Grundgesetz*) Federal Constitution, Germany
GKV-WSG	(*Gesetzliche Krankenversicherung – Wettbewerbsstärkungsgesetz*) Law on Intensifying Competition in Statutory Health Care Insurance), Germany
GSG	(*Gesundheitsstrukturgesetz*) Health Care Structural Reform Act (aiming at competition between public insurance companies), Germany
GMG	(*Gesetz zur Modernisierung der gesetzlichen Krankenversicherung*) Statutory Health Insurance Modernisation Act, Germany
HBKG/HKaG	(*Heilberufekammergesetz*) Law concerning the statutory association of professions and occupations within health care, Germany
HebG	(*Hebammengestz*) Law concerning midwifes, Germany
HSL	(*Hälso- och sjukvårdslagen* (1982:763)) The Health and Medical Services Act: defines nationally delivered health care services, their expected quality measurements as well as organisation of health care, Sweden
HSW	Hospital social work
HSWs	Hospital social workers
HwO	(*Handwerksordnung*) Trades and Crafts Code, Germany
KrpflG	(*Krankenpflegegesetz*) Law concerning the nursing profession, Germany
LKHG	(*Länder-/Landeskrankenhausgesetz*) federated states Hospital Law, Germany
LogG	(*Logopädengesetz*) Law concerning speech pathologists, Germany
LYHS	(*Legitimation av yrkesverksamma inom hälso- och sjukvården* (1998:531)) Professional Activities in the Health and Medical Care Act, Sweden
M.A.	Master of Arts
MPhG	(*Massage- und Physiotherapeutengesetz*) Law concerning masseurs and physiotherapists, Germany
NFS	(*Nätverk för forskande socionomer i hälso- och sjukvård*) Network for health care social workers in research, Sweden
PjL	(*Patientjournallagen* (1985:562)) Law on Patient Documentation, Sweden
PodG	(*Podologengesetz*) Law concerning podologists, Germany
PsychPV	(*Psychiatrie Personalverordnung*) Public regulation concerning compulsory professions included in the psychiatric hospital staff, Germany

PsychThG (*Psychotherapeutengesetz*) Law concerning psychotherapy, Germany

SächsKHG (*Sächsisches Krankenhausgesetz*) Saxonian Hospital Law, Germany

SGB (*Sozialgesetzbuch*) Social Code: national law on social welfare distribution, including health care distribution (e.g. regulations concerning health care insurance), Germany

SGB II (*Sozialgesetzbuch 2, Grundsicherung für Arbeitssuchende*) Second Social Code: social security for the unemployed, Germany

SGB V (*Sozialgesetzbuch 5, Gesetzliche Krankenversicherung*) Fifth Social Code: law on statutory health care insurance, Germany

SGB IX (*Sozialgesetzbuch 9, Gesetz zur Rehabilitation und Teilhabe behinderter Menschen*) Ninth Social Code: law on rehabilitation and integration of the disabled, Germany

SGB XI (*Sozialgesetzbuch 11, Pflegeversicherungsgesetz*) Eleventh Social Code: law on compulsory care insurance, Germany

SGB XII (*Sozialgesetzbuch 12, Sozialhilfegesetz*) Twelfth Social Code: law on social welfare benefits, Germany

SK (*Svensk Kuratorsförening*) Swedish associations for social workers in health care

SKL (*Sveriges Kommuner och Landsting*) Swedish Association of Local Authorities and Regions, Sweden

SKTF (*Sveriges kommunaltjänstemannaförbund*) Trade union, representing a variety of different professions and occupations employed by municipalities, Sweden

SoL (*Socialtjänstlagen* (2001:453)) Social Welfare Legislation, Sweden

SPRI (*Sjukvårdens och socialvårdens planerings- och rationaliseringsinstitut*) Institute paid by national health care administration in order to support health care organisations in their development of quality management, health economy and care computerisation, Sweden

SSR (*Akademikerförbund Sveriges Socionomernas Riksförbund*) Trade union, representing a variety of different professionals as academics from economy, social sciences, Sweden

StGB (*Strafgesetzbuch*) German Criminal Code

TAM-archives (*Tjänstemanna- och akademikerorganisationernas arkiv*) Swedish archive where all trade unions for civil servants and academics store their documents

VKF (*Vuxenpsykiatrista Kuratorers Förening*) Association for hospital social workers in adult psychiatric care, Sweden

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1 Introduction

1.1 Professionalization and jurisdictional work

Just like the guilds in the Middle Ages, professional organizations of our own time are powerful actors in the labour market. In fact, over time we are becoming only more and more dependent on recognized professionals' skills and knowledge in carrying out the essential functions of our daily lives. The same way as in the mediaeval times when we relied on craftsmen's skills and professionalism, we today can but place our trust in the professionals' expertise and discretion in pursuing the fulfilment of our everyday needs. The state, for its part, has taken steps to ensure the professionals' trust-worthiness and reliability, by defining the context and conditions for the performance of the professionals' tasks as well as professions' monopolies over different domains of knowledge and competence. This process, unfolding in interaction between the state, the professions, and the professionals, is often likened to negotiation. In it are determined key aspects governing the development of professions. These include, on the one hand, authority over certain knowledge bases of work fields, monopolization of specific work tasks, and, in the case of welfare professionals in especial, the remuneration for professional services; and, on the other hand, the state and client interests concerning, for example, the reliability, objectivity, and quality of the professionals' skills and services (Abbott 1988, Macdonald 1999, Sarfatti Larson 1979, Wilensky 1964).

In the theory of professions (Abbott 1988, Freidson 1994, Hughes 1971, Macdonald 1999, Parsons 1951b, Sarfatti Larson 1979), it is, precisely, the efforts to establish professional authority and monopoly for specific professional groups that have been looked upon as a main driving force behind professionalization. Other important factors identified as contributing to the development of professionalization include the improvement of professional skills and the regulation of the relationship between professions and the state. The desire to formalize the acknowledgement of professions' autonomy and monopoly in the performance of specific work tasks, again, has been understood as an aspiration for formal jurisdiction (cf. Abbott 1988, Molander & Terum 2008). Such aspirations, however, have consequences for the relationship between the state, the clients, and the professions. They, furthermore, affect the relations between neighbouring professions and between professional subgroups (Abbott 1988). Similarly, also the role of the state in controlling the professions to bring them in line with the intentions of policies and policy makers has been given attention, predominantly in the case of traditional healthcare professions such as medicine and nursing (e.g., Kuhlmann & Saks 2008).

The striving for formal jurisdiction in this context has, for example, been taken up in terms of a professional project aimed at increasing a profession's labour market control and social status (Sarfatti Larson 1979). This project is sometimes described in terms of a battlefield, as a struggle for power and protection in which professions seek to extend, or at least maintain, their power over specific professional territories by demarcating their exact boundaries. Terminology such as territory, boundary, and demarcation is often used to describe the creation of distinct professional jurisdictions with their own professional knowledgebase, work field, and work tasks, along with, as in the case of modern welfare societies, the right of welfare professionals to receive publicly determined remuneration for the professional services they render (Abbott 1988, Gieryn 1983).

In this dissertation, the activities and strategies resorted to by professions and professional subgroups in their quest to establish or maintain a distinct professional jurisdiction in both legal, public-administrative, and workplace arenas are collectively addressed using the concept of 'jurisdictional work'. This work is processual and negotiative in nature, and it aims at securing a formal external acknowledgement of a certain professional domain for the profession pursuing it. This usually means the settlement of any jurisdictional disputes through legislation, public regulations, and written organizational job descriptions, as well as the attainment of a certain position within the social order of professions. Additionally, jurisdictional work can also be carried out to bring about a settlement of jurisdictional controversies among specific subgroups within a given profession.

More generally, the concept of jurisdictional work refers to a continuous process unfolding in different, interrelated key dimensions. One of these involves the demarcation and development of symbolic boundaries. Specific linguistic characteristics such as particular narratives or terms, for example, are filled with specific symbolic meaning associated with the profession. Such symbolic contents, in turn, are used to draw boundaries around the profession or professional subgroup, attributing special symbolic significance to certain defined characteristics. Another dimension in which jurisdictional work proceeds has to do with the development of a distinct professional identity. This takes place through the development of characteristic narratives and attributes, the determination of the profession's or subgroup's relation to neighbouring professions, and the establishment of effective mechanisms to ensure internal compliance, for the creation and maintenance of the group's professional identity. A third key dimension along which jurisdictional work in this context proceeds involves the engagement of the professional body in the establishment of a negotiated order in legal, public, and workplace arenas; the same occurs also in relation to the stakeholders defined as strategic by the professional body in question.

Following Becher (1999), the term 'professional bodies' as used in this thesis refers to different forms of professional organizations such as, for instance, professional institutions, professional associations, and interest groups. Finally, jurisdictional work can also be understood as a claims-making process where representatives of professions or professional sub-groups employ specific arguments in negotiating jurisdictional settlements in particular arenas.

Professional bodies have from the start been recognized as playing an important role in the promotion of professionalization (Abbott 1988, Carr-Saunders & Wilson 1933, Flexner 1915, Freidson 2001, Greenwood 1957, Millerson 1964, Sarfatti Larson 1979, Wilensky 1964). They perform jurisdictional work to establish and maintain professional jurisdiction internally as well as externally through claims-making. Towards this end, they develop structures within the profession itself and, externally, pursue common professional interests and goals. Professional bodies that are institutions or associations go on to represent such professional interests on a broader organizational and political level (Becher 1999).

Previous research has duly noted this role of professional bodies in professionalization, the development of a professional identity, and the internal stratification of a profession (e.g., Becher 1999, Burri 2008, Halpern 1992). Studies focusing on efforts by professional bodies of minor professional subgroups working in subordinate positions to establish a professional jurisdiction, however, have remained scarce if not altogether non-existent (none could be located for the purposes of this dissertation). Cross-national comparisons of professionalization or jurisdictional work strategies have been similarly rare as well.

To address this research gap, this dissertation attempts a cross-national comparison of jurisdictional work strategies, understood as ongoing processes incorporating internal and external strategies to develop boundaries, create and establish a professional identity, and effect jurisdiction through claims-making. This research focus also includes comparison of the efforts professional bodies engage in when aiming at the advancement of formal jurisdiction in legal, public, and workplace arenas.

1.2 Hospital social workers: A professional subgroup in subordination

Research on professionalization and jurisdictional work has tackled a variety of arenas. Of all the existing studies in the area, the ones most directly relevant for this dissertation research are those involving the healthcare setting. These studies have predominantly considered the professional performance of those working in dominant or subordinate professions in a few core work fields, such as physicians and nurses (e.g., Allen 2001, Burri 2008,

Halpern 1992, Samson 1995, Timmons & Tanner 2004). They have concerned themselves, for instance, with the implications of healthcare policy for healthcare professionals and the implications of their domination and subordination in multi-professional teamwork (Collin et al. 2011, Kuhlmann 2006, Lingard et al. 2012, Paloniemi & Collin 2012). The relationship between healthcare professions and the state has been considered as well; as have been the various ways jurisdictional disputes have been settled in arenas where these professionals predominantly act (e.g., Hughes 2010, Kuhlmann 2006, Kuhlmann & Saks 2008, McMurray 2010, Samson 1995).

Building on this research and complementing it, this dissertation instead looks at the profession of social work, previously of interest to research on professions mainly owing to its position at the interface between occupations and professions (see Flexner 1915, Etzioni 1969). More exactly, it considers the case of hospital social workers (HSWs), a professional subgroup that can be said to operate in a subordinate position. It is this very position that makes the group a particularly interesting object for analysis along the present lines. HSWs, first of all, constitute a professional subgroup within the broader category of social work, and, secondly, in the hospital setting hospital social work (HSW) remains subordinated to other professions present in it. As regards the former aspect of subordination, this dissertation uses the term 'primary profession/discipline' to describe the broader profession and discipline of social work in its relation to the professional subgroup of HSWs. As regards the latter aspect of subordination, hospitals, in contrast to social welfare agencies where social workers more ordinarily work, function for HSWs as 'hosting organizational settings' that in the first place concentrate on the provision of health care while the HSWs hosted in these settings focus on the performance of social work.

The main challenges arising from membership in a professional subgroup that operates in this kind of subordinated position can, from the point of view of practitioners, be summarized as follows:

> [I]t is important for hospital social workers to strengthen their professional identity as a group by sharpening their professional tools. Among other things, hospital social workers need to improve their ability to specify and point out the results of the treatments they offer, by further refining the treatment categories and treatment goals they draw upon in their work. The same applies to their ability to conduct psychosocial diagnoses. (Schmidt 2013: 39)[1]

Hospital social workers' jurisdictional struggle can, accordingly, be said to proceed on multiple fronts: it takes place vis-à-vis the broader society, other

[1] All translations from Swedish and German are by the author

professions within the hosting healthcare setting, the primary profession, as well as the academic knowledgebase and education related to that profession. As regards in particular the hospital context focused on in this dissertation, terms such as professional identity, categorization of treatment, and psychosocial diagnosis as in the above quotation indicate the perceived professional challenges faced by HSWs in their hosting organizational settings. Some of these terms are otherwise only seldom used within the broader profession and discipline of social work.

1.3 Research aims and research questions

This dissertation describes, analyses, and compares the ways in which professional bodies of Swedish and German hospital social workers promote their professionalization through jurisdictional work. The time period covered by the research is 1989 through 2008. The investigation is guided by five research questions as outlined below. The first three of the questions concern what the professional bodies in the two countries do to promote the professionalization project of HSWs and how they in fact go about doing this, with the second and third question focusing on the professional bodies' external strategies to develop and maintain formal jurisdiction. The fourth and fifth research question concern factors that influence the choice of jurisdictional work strategies. The five research questions are as follows:

- Through which means, during the twenty-year period in question, have professional bodies of hospital social workers in Sweden and Germany sought to advance the creation and maintenance of a collective professional identity for hospital social workers in their home societies?
- Through which means have these professional bodies of Swedish and German hospital social workers sought to promote the establishment and maintenance of a formal professional jurisdiction in their home countries?
- What kind of claims and arguments have been resorted to by these professional bodies in their efforts to make a case for a specific hospital social work field, and what differences, if any, might be there between Swedish and German hospital social workers' claims-making?
- What impact, if any, have the organizational characteristics of the professional bodies in question (size, structure, relationship with trade unions, etc.) had on their jurisdictional work strategies in the two countries?

- What impact, if any, have national context and national healthcare structure had on the choice of jurisdictional work strategies by HSWs' professional bodies in the two countries?

To answer these questions, a comparative case study was conducted based on empirical data collected from Swedish and German HSWs' professional bodies, including, primarily, various types of documents and focus group interviews (see Chapter Four). It merits emphasis that the aim of this research is to provide a comparative, not an evaluative, analysis. The purpose here is not to assess whether professional bodies have been more or less successful in their attempts to establish formal jurisdiction, or whether some particular strategy used to this end has proven itself more or less effective than others. To study these, it would have been necessary to obtain an entirely different set of empirical data and the research questions would have had to be formulated differently. Nevertheless, the results from this study should all the same lend themselves to further discussion on the feasibility of different strategies in the pursuit of specific formal-jurisdictional goals by professional bodies of hospital social workers and others.

The two professional bodies studied in this dissertation are *Die Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V.* (DVSG) in Germany and *Svensk Kuratorsförening* (SK) in Sweden. In the Swedish case, the collected data was subsequently complemented with additional information obtained from *Vuxenpsykiatriska Kuratorers Förening* (VKF) and from the nationwide research network *Nätverk för forskande socionomer i hälso- och sjukvård* (NFS). A common characteristic for all of these organizations is that they are not trade unions. The selection of the professional bodies for this research is discussed below in Chapter Four, while a closer description of them is given in Chapter Five.

It is important to keep in mind that this dissertation deals with *hospital* social workers – social workers working in hospital settings. These have to be distinguished from non-hospital social workers engaged in health care-related work tasks in other healthcare contexts such as, to name but one example relevant for this dissertation, primary outpatient care. Hospitals, in this dissertation, are in contrast healthcare organizations that span multiple health care-related professions working on patients' somatic and psychiatric health problems in in-patient care.

The choice to focus on the professional group of hospital social workers is not, however, self-evident. A variety of other, rather similar professional subgroups exist, too, that operate in subordination, as for example school social workers and social workers specialized in family law. The choice of HSWs was thus motivated by the following reasons and considerations. For one, the organizations HSWs work for, namely, hospitals, could be expected

to show organizational similarities across differing national contexts. HSWs, furthermore, appeared to offer an interesting case for a study of social work professionalization in settings in which empirical research so far has primarily concentrated on healthcare professions. Social work in healthcare settings occupies a very specific position, in relation to both social work proper and healthcare professions. To begin with, HSWs, and even social workers working in healthcare settings more in general, represent a sub-group of the broader social work profession (Dellgran & Höjer 2003). As such, they perform their work in organizational settings that differ from those of more traditional social work-dominated organizations set up and run by social welfare authorities. In healthcare settings, HSWs are thus a subordinate group, and not just in terms of their numbers as compared to the healthcare professionals around them, but also in terms of their educational background that is in social sciences instead of natural sciences.

Also the national contexts involved in the two cases studied were selected carefully and based on specific considerations (see Chapter Four). As Dent (2003), for example, has noted, the type of the welfare system adopted in the society may influence the course of professions' professionalization in it. Accordingly, the two country cases considered were selected based on their differing welfare regimes, to better detect the influence of any contextual factors and differences on professional bodies' jurisdictional work (cf. Flyvbjerg 2006). In Germany today, one finds in place what has been termed a conservative-corporate welfare regime, while Sweden has adopted a social-democratic one (Esping Andersen 1999). In consequence, even the healthcare systems in the two countries differ from each other, with the national healthcare system in Sweden contrasting with the insurance-based system in Germany. During the time period covered by this study, both countries came to face economic constraints affecting, among others, the healthcare sector as well as changes in the social welfare sector. Social policy reforms intended to handle these pressures (see, e.g., Sen 2003). As Kuhlman (2006) and Saks (2008) have noted, such developments can then in turn propel changes in professional jurisdiction, leading one to expect that empirical data from these kinds of periods will provide one with a rich source for analysing and interpreting jurisdictional work.

1.4 Significance of the study

Comparative cross-national studies on professionalization have remained relatively scarce to date, as have studies looking at the specific strategies professional subgroups in subordination – such as HSWs – use to advance their professionalization. Similarly, only very little research has been conducted on the collective activities of professional HSW bodies and their

inclusion in, or exclusion from, healthcare policy and decision-making structures at workplace and at the public and legislative levels.

The aim of this study is, in general, to contribute to research on professionalization more broadly and, in particular, to improve our knowledge about the strategies professional subgroups in subordination use in their efforts to establish formal jurisdiction. The comparative nature of this study will help move forward the theoretical discussion of whether or not concepts such as profession and professionalization are context-bound and what kind of contextual factors may play a role here. The study proceeds by describing, analysing, and comparing jurisdictional work as a key aspect of the professionalization pursued by primarily two hospital social workers' professional associations in Sweden and Germany over the twenty-year period 1989–2008.

The study will, moreover, help provide the theoretical discussion of professionalization with a *social work* perspective and, more specifically, with a *hospital social work* perspective. HSWs represent a professional subgroup situated in a hosting context in which the main focus lays on other professions. The particular relational position HSWs occupy vis-à-vis their primary profession as well as the organizational setting in which they operate is likely to be quite unique. This dissertation, accordingly, sets out to understand the specific challenges Swedish and German HSWs encounter in advancing their profession's formal jurisdiction in the broader healthcare environment, as well as the specific consequences that derive from their particular position as both a professional subgroup and a subordinate professional group situated in the hosting hospital settings.

The study has, furthermore, relevance for the social work discipline, shedding as it does new light on a professional subgroup that thus far has attracted only limited attention in social work research (see, e.g., Dellgran & Höjer 2011). It may, moreover, contribute to social work education by prompting it to reflect on whether or not there might be a need for contextualizing the training according to a broader diversity of social work fields that one needs to relate to. In terms of professional social work practice, the findings of this research will lend themselves to supporting HSWs and their professional bodies in their efforts to consciously reflect on the implications that social policy-making and their own choices of professionalization strategy potentially have for them as a professional subgroup.

Professions are powerful actors in society. From a societal perspective, it is thus important to understand how social policy-making impacts on the jurisdictional work of professional subgroups in multi-professional settings – and vice versa. It is also important to understand the way this interplay between social policy-making and professional groups impacts other professions operating in the same setting, welfare organizations, welfare service

production, and, last but not least, the consumers of welfare services. This study will thus, at least potentially, also be able to contribute to an increased awareness of the effects of policy making on minor subordinate professions in hosted settings, on the interrelations among different professions in the these settings, on the organization and production of welfare services, and on the addressees of these services.

1.5 Previous research on hospital social work and hospital social workers

Previous research on HSW and HSWs has for the most part concentrated on the study of specific client groups or specific intervention methods used in HSW. The studies relevant to the topic of this dissertation have predominantly focused on HSW at the workplace or regional level, involving a variety of national contexts. The topics investigated have touched upon issues such as HSW work tasks, the role of HSW in healthcare settings as perceived by HSWs and other professionals, the overlap between HSW and nursing, trends towards specialization and prioritization of specific case groups in HSW, and reported expansion of work fields in HSW. Occasionally, previous research has also tackled themes such as the professional identity of HSWs, the relation between professional identity, professional culture, and multi-professional teamwork, the exclusion of HSWs from access to power networks and information resources, and the relationship between the HSW profession and the state.

In the following, I discuss some of this research more in detail. First, I focus on previous research on HSW in multi-professional teams and on HSWs and professional power networks. After that, I look at the existing literature on the tasks and roles of HSW. Lastly, I review previous research addressing HSW specialization, socialization, and work field expansion in different national contexts.

Multi-professional teamwork and professional power networks

In previous research, some researchers have reported on the specific challenges HSWs encounter in their collaboration with healthcare professionals. The question, however, of whether the role of HSWs in multi-professional teams and professional power networks varies across national contexts still remains empirically unexamined. Nevertheless, several factors have been identified as impacting on teamwork between HSWs and other professionals. McAlynn and McLaughlin (2008), for example, have described a set of factors impeding HSW discharge management in Northern Ireland, including pressure from other professions and tensions in the collaboration around multidisciplinary assessments. Albrithen and Yalli (2012), for their part, have drawn the conclusion that inter-professional teamwork in Saudi Arabia

in this area is hampered by factors like professional culture, language barriers, job diversity, and unequal power relations between HSWs and physicians. Harrison, Hepworth, and de Chazal (2004), again, have examined the unequal distribution of access to IT and Internet services among British healthcare professionals, noting that it was primarily HSWs who lacked this access in the group they studied.

Changes in management structures concerning HSW have been analysed especially by researchers in the United States and Canada. Earlier on, HSWs in these countries were often organized into separate, independently operating HSW departments. In more recent years, however, there has been a tendency to integrate HSW into multidisciplinary management structures (e.g., Globerman & Bogo 1995, Judd & Sheffield 2010). At least in the case of Canada, this change in management structures has been described as challenging for HSWs' profession-specific identity (Globerman 1999).

In addition to difficulties HSWs perceive in multi-disciplinary teamwork, also limitations concerning HSWs' possibilities to influence hospital governance have been reported. Saudi Arabian HSWs, for instance, have been found to have limited possibilities to involve themselves in the development of their hospitals' internal policy, due to their inadequate communication channels and ineffective relationship with hospital management, both seen to result from HSWs' marginal position in the hospital hierarchy (Albrithen & Yalli 2012). Elsewhere, US and Canadian studies have examined ways to increase HSWs' power within hospital organizations. The means analysed have included strategies to enable de-centralized HSWs to gain more control and influence over their own practice, such as spelling out their contributions to the primary economic interests of the hospital, developing decision-making networks to improve the efficacy of patient discharge, and using social group work and radical democracy as a management tool (Berger 1991, Sulman, Savage, Vrooman & McGillivray 2005).

Research in the UK has also looked at efforts to transfer responsibilities from medicine to social services through legislation. The changes made, however, seem to have had only minor effect in practice. In the everyday operation of hospitals, medical decision-making still takes precedence over multi-disciplinary co-operation in discharge management (Phillips & Waterson 2002).

Work tasks and role

Research on HSW has frequently brought up a discrepancy between the profession's own understanding of its professional tasks and role in healthcare settings and other professions' view of these. In countries such as the Canada, Germany, Hong Kong, the United Kingdom, and the United States, HSW work tasks have been taken by HSWs to consist primarily of discharge

management including the mobilization of community services (Davies & Connolly 1995, Holliman, Dziegielewski, & Datta 2001, Phillips & Waterson 2002, Thierau 1998, Wong, Chan, & Tam 2000) as well as psychosocial assessment/treatment (Davidson 1990, Holliman, Dziegielewski, & Datta 2001). In the Swedish context, Olsson (1999) has found HSWs' work tasks to have changed considerably over time, expanding from mostly social case management to now also and primarily include psychosocial and other more therapeutic care provision. Non-HSW professionals such as nurses and physicians have reported differing notions about the tasks and role of HSW and HSWs in healthcare settings (see Kadushin & Kulys 1995, Thierau 1998). In the United Kingdom and, to some extent, also the United States, they have, however, articulated specific factors concerning HSW as important. They mainly expect HSWs discharge management to be quick and efficient rather than appropriate and of good quality (Davies & Connolly 1995, Kadushin & Kulys 1995, Phillips & Waterson 2002). At the same time, however, Wong, Chan, and Tam (2000) have found physicians and HSWs in Hong Kong to be basically in agreement about HSWs' tasks, considering these to consist of psychosocial counselling and organizing of community services. Nurses, on the other hand, expected HSWs to involve themselves in discharge management, organizing of community services, and psychosocial counselling to a lesser extent than what the HSWs themselves expected.

Studies conducted in Australia, Israel, and the United States have, furthermore, found HSWs to experience their role in healthcare settings to be something secondary to that of healthcare professionals, with HSWs reporting themselves to often lack recognition and support from other professionals in their work context; this then led to difficulties in collaboration and perceived lack of appreciation for one's work (Kadushin & Kulys 1995, McMichael 2002, Werner & Carmel 2001). HSWs have also reported themselves as experiencing inadequate supervisory support and difficulties in access to further training to develop their professional skills (Albrithen & Yalli 2013). At the same time, a desire has been expressed among other healthcare professionals that HSWs be clearer about their role in healthcare settings (in the UK, context, see Davies & Connolly 1995). In Germany, a major source of differences in the role expectations in this regard has been HSWs' more holistic, "life-world"-oriented focus on interventions that contrasts with the more isolated therapeutic orientation of healthcare professionals (Thierau 1998).

In addition, research has called attention to work task overlap between nursing and social work in health care. The earliest report on work task overlap in the HSW context comes from Motte in the United States (1911). The last two decades, however, have seen an increasing number of publications (especially in the US and Canada) address the issue, especially in

case/discharge management and psychosocial counselling (e.g., Globerman 1999, Neuman 2003).

In Sweden, jurisdiction overlap between HSWs, nurses, psychologists, and physicians is indicated by current research on HSW roles. Svärd (2013), for instance, has identified three different roles HSWs tend to take in multi-professional child risk assessment in hospitals, seeing these as dependent on the professional logic HSWs adopt for their work. In her study, HSWs who followed a "social work logic" in their work assumed more active roles in healthcare teams, applying rather traditional social work methods and reporting children at risk to social services. In contrast, the HSWs who followed a "therapeutic logic" tended to adopt more reflective roles in their healthcare teams, opting for predominantly therapeutic and motivational methods but still reporting children at risk when problems could not be solved in voluntary co-operation with the parents. HSWs following a "medical logic", again, took rather passive roles in their healthcare teams, relying more on medical expertise and for the most part reporting children at risk only when there was definite evidence of abuse.

Specialization, socialization, and work field expansion

Research in the United States has shown HSWs to tend to internally specialize around patient groups and medical departments, instead of particular HSW work tasks or social work practice models (Holliman, Dziegielewski, & Datta 2001). The expansion of HSW into health care-related work fields there has been linked to HSWs' work in perinatology. In Australia and Israel, it has taken place in tandem with HSWs' involvement in disaster and emergency teams (Pockett 2006, Walther 1991, Yanay & Benjamin 2005). In Germany, the expansion of HSW fields has primarily been linked to HSW's increasing engagement in geriatric settings (Thierau 1998).

Canadian HSWs in psychiatry have been reported to base their professional identity on factors like social status, respect, and autonomy (Marriott, Sexton, & Staley 1994). More precisely, research has found the differences in the professional socialization between physicians and social workers to involve aspects such as values and the importance accorded to patient rights and teamwork (Kadushin & Kulys 1995). In Australia, HSWs have expressed their need to be able to define their own professional priorities to better enable them to advocate for more resources and social policy change (Giles et al. 2007).

Gachoud and his co-workers (2012) have examined the ways in which "patient-centred practice" is understood among physicians, nurses, and healthcare social workers in Switzerland. The differences that they found in this regard reflected the professional cultural values of each group studied. All three professional groups stressed the importance of a holistic approach

and good communication in any patient-centred practices. Additionally, social workers defined patient-centred practices as also including empowerment and respect for patients' autonomy. In their understanding of the notion, however, the quality of medical procedures and nursing care aspects were assigned minor significance. Nurses, in contrast, emphasized rapport as the most important aspect of patient-centred care, considering empowerment as something less important. Physicians, for their part, included neither empowerment nor rapport in their definition of patient-centred practice. Professional cultural values, in other words, or cultural differences among the professional groups, entailed differences in orientation that could at least potentially bear upon the interaction between professions and professionals.

To sum up, previous research shows differences in both internal notions and understandings among HSWs regarding their professional work tasks and external expectations about what the role of HSW ought to be and what HSWs ought to do. Based on evidence from different countries as presented above, it seems also probable that the main social work methods as applied in HSW in different national contexts vary from one another. At the same time, the literature remains silent on the contribution and role of professional bodies in developing internally and externally recognized descriptions and definitions of HSW work tasks. Yet, there are indications in previous research of HSWs' lack of access to professional power, negatively impacting on HSWs' possibilities to influence healthcare policy making and decision making. Nevertheless, no studies on the inclusion and exclusion of professional HSW bodies in policy-making and decision-making processes in healthcare structures at work place and at public and legislative level seem to have been carried out thus far. Neither do there appear to be any studies yet that compare processes of, and strategies for, developing a professional group-specific identity for HSWs, or the impact of existing healthcare organization and social policy development structures on HSWs' possibility to influence their profession's future. The same applies to cross-national comparative studies concerning inter-professional differences in defining certain professional values and studies on collective action striving for formal jurisdiction for a profession.

1.6 Structure of the dissertation

This dissertation comprises nine chapters. Following this introductory chapter, Chapter Two will introduce the reader to the national specifics of healthcare structures and the healthcare organization in Sweden and Germany. Chapter Three presents the theoretical framework including an in-depth description of the concept of jurisdictional work, enabling the subsequent

investigation of the professionalization strategies used by HSWs in Sweden and Germany. The data and methods of this dissertation research are described and discussed in Chapter Four. Chapters Five to Eight then present the analysis and results, comparing professional HSW bodies' activities in promoting the professionalization of HSW in Sweden and Germany. Chapter Five first describes the landscape of professional HSW organizations in the two countries in question. After that, Chapters Six and Seven discuss the internal and external jurisdictional work as performed by the professional HSW bodies studied in this dissertation. Following it, Chapter Eight looks at these bodies' claims-making in connection with their efforts to advance the professional jurisdiction of HSW in each country case. Finally, Chapter Nine presents a concluding discussion, analysing the differences found in the strategies used by professional HSW bodies in Sweden and Germany. The chapter also discusses factors influencing the choice and outcomes of these strategies, as it does theoretical implications related to the findings from this study.

2 Hospital Social Work and Healthcare Systems

Wherever HSW is performed, it is always shaped by certain specific factors conditioning it. These factors include the education of HSWs as a professional group and other profession's stances towards hospital social work. The performance of HSW, however, is also preconditioned by the underlying healthcare organization and social welfare regime, given how social welfare regimes influence the pathways for evolving healthcare systems in certain national contexts. Awareness of these kinds of conditioning factors is therefore important for any understanding of the ways jurisdictional work is performed by HSWs in specific countries. It is also necessary for a proper understanding of the analysis and results to be presented later in this dissertation. For these reasons, this chapter considers HSW in the broader national context conditioning its practice, looking at the internal and external factors shaping it in the kind of organizational settings focused on in this dissertation. It looks at HSW and its position as a part of the broader social work profession, discusses healthcare systems and the way they are organized in Sweden and Germany, considers the role of the welfare system and the influence of the kind of welfare regimes in place in Sweden and Germany, and explores the possibilities for welfare professions to influence the development of welfare governance.

2.1 Hospital social work as a professional subgroup

In both Sweden and Germany HSW is perceived as a specialized subfield of social work. This view of is shared by both its primary profession and great many individual HSWs. At first glance, however, this relationship may seem more obvious in Germany than in Sweden, given that HSWs there call themselves *Krankenhaussozialarbeiter* ("*hospital social workers*") whereas in Sweden they are traditionally known as *kuratorer*, a term rooted in the Latin verb *curare* ("to cure"). Nevertheless, since the beginning of the 2000s Swedish HSWs have begun to more often openly thematize their disciplinary and professional relationship to social work, addressing themselves as "social workers in health care" (*socionomer i hälso- och sjukvården*; see section 6.3).

Today, HSWs in both Sweden and Germany receive their basic training in university social work departments. In Sweden, social work became an academic discipline taught at the university level in the 1970s; since then, research has been an integral part of the social work departments' mission. Some of the departments also offer doctoral degree programmes in social work (see, e.g., Hessle 2007). During the 1990s, the neighbouring academic

programmes in social care and social pedagogy became at most universities absorbed into their social work programmes, which today also offer special advanced-level courses or study programmes to social work practitioners working in health care (Högskoleverket 2003).

In Germany, social pedagogy is one of the traditional university disciplines, even if it is sometimes integrated into pedagogical or social science departments. In the country, it is predominantly these departments that conduct research and offer doctoral degree programmes in social pedagogy (Staub-Bernasconi 2007). Social work, on the other hand, has traditionally been taught at what in the German context are called "universities for applied sciences" (*Fachhochschulen*, FH) or at "universities of co-operative education" (*Berufsakademie*, BA; see, e.g., Baron, Brauns, & Kramer 1986). These universities have only recently started to offer doctoral degree programmes in social work. They do not, however, have any explicit state-delegated responsibility to conduct research. Nevertheless, some limited research funded through external sources is performed at these institutions of higher education as well. In the late 1990s, however, social work and social pedagogy were merged into a single discipline as, simply, social work. The professional title of the graduates from the new programmes nevertheless often remained the same – social pedagogue. In addition, since at least the 1980s the national healthcare social workers' association DVSG has been offering special further education for those working in this field, and HSWs in particular (see Chapter Five). At the same time, during the last 10 years, there has been a parallel new development resulting in special Master's programmes for social workers in health care at some universities (Pauls 2001, Reinicke 2001b).

2.2 Healthcare systems in Sweden and Germany

Health care provision in Sweden and Germany is organized differently, based on the different healthcare systems in place in the two countries. A common denominator for the two systems, however, is that in both cases, the role of the state (the federal government in Germany) is reduced to the mere provision of applicable legal frameworks. In Sweden it is the regional governments (county councils, or *landstingsfullmäktige*) and in Germany the federated states (*Länder*) that then have the responsibility to organize the provision of health care within these frameworks provided (Europäisches Parlament 1998, Ginsburg 1992). Despite this basic structural similarity, it is nevertheless the differences between the two healthcare systems that dominate the picture.

In Sweden, the responsibility for financing and managing the provision of health care, delivered through the national health service, lies, as already

said, with the country's 21 county councils. It is thus the county politicians who control the resources and supply of healthcare services. The Health and Medical Services Act of 1982 (*Hälso- och sjukvårdslagen*, HSL) is the basic law governing health care provision, delivery, and financing in the country. In Paragraph 2a, point 1 of this Act, it is pointed out that all health and medical care provided in Sweden should be of "good quality". In Paragraph 2e, it is, furthermore, required that "all personnel" needed to ensure provision of this good-quality care be made available for the purpose. From the point of view of the individual health-service recipient, in other words, the exact level of healthcare service to be provided is left rather vague in the law (Blank & Burau 2007).

The county councils are in principle free to organize the financing and provision of healthcare services the way they prefer. In general, the tendency since the 1980s has thus been an increasing de-centralization of health service delivery, organization, and finance, as the responsibility for these has been transferred from the central government to the county councils, which today have a complete control over both the financing and the provision of healthcare services (Blank & Burau 2007, Ginsburg 1992). Nevertheless, over the last few decades the autonomy of the county councils and hospitals in this respect has become somewhat curtailed, owing to the enactment of various action plans developed by the country's National Board of Health and Welfare (a government agency) that set forth nationwide priorities and quality standards.

In the case of Germany, the responsibility for healthcare financing and provision is divided differently, as health care in Germany can be characterised as being of a social insurance type. On the national level, in line with the subsidiary system (see section 2.3 in Chapter Two), the healthcare scheme is set forth by the country's Social Code (*Sozialgesetzbuch*, SGB). This legislation acts as the regulatory framework for social welfare and healthcare provision intended to guarantee the supply of the necessary services and their quality.[2] The Hospital Laws (*Landeskrankenhausgesetz*, LKHG) of the individual federated states must conform to this legislation (for more details, see, e.g., Blank & Burau 2007). Unlike in the Swedish case, where the exact level of service provision is left vague, these laws define federated-state residents' rights to defined health care including their related rights to special support such as social integration for disabled people (for further details, see, e.g., Borgetto & Kälble 2007). The federated-

[2] The Social Code is the umbrella for all legislation on welfare in Germany. It covers also the healthcare sector. Currently, it comprises twelve lawbooks. Five of these are of particular relevance to health care: SGB II includes regulations on healthcare provision for the unemployed, SGB V regulates statutory health care insurance, SGB IX spells out the rights concerning rehabilitation and the integration of the disabled in society, SGB XI regulates the statutory care insurance, and SGB XII includes regulations concerning health care for those lacking health care insurance.

states and national laws in Germany, however, represent framework legislation governing the organization, provision, and funding of health care. Self-governing and self-administrating institutions represented by public corporative bodies then negotiate the exact translation of these legal frameworks into implementation policies included in corporative contracts. The negotiations take place on both the national and the individual-state level, and the resulting corporative contracts specify the residents' legislated rights to particular insurance-funded healthcare services more in detail.

The ultimate controlling authority within the healthcare system in Germany is the Federal Ministry of Health, which can intervene in matters relating to it through legislative efforts. Ensuring the uniform interpretation of citizens' welfare rights in corporative contracts as well as their congruence with the intentions of the Federal Constitution, again, is the task of the Federal Constitutional Court, the country's highest court. On the national level, the efforts to impact on healthcare provision have, in the last two decades, had a two-fold orientation: on the one hand, they have focused on cost containment, and, on the other hand, on the activation of patient representatives in public corporative bodies in health care (Borgetto & Kälble 2007, Becker & Kingreen 2007, Fuchs 2008).

Organization of healthcare provision in Sweden and Germany

The way health care is provided to individuals differs considerably between Sweden and Germany. In Sweden, it is the country's 21 county councils that are responsible for healthcare provision in primary care as well as in in-patient and out-patient hospital care. Traditionally, a major way to offer specialized health care has been through in-patient and out-patient hospital care provided by publicly owned and operated providers. Especially during the last three decades, however, the provision of primary care has changed. Primary health care is now predominantly offered at primary-care centres employing doctors, nursed, midwives, physiotherapists, psychologists, and/or social workers as well as other healthcare professions, with sometimes also specialists such as psychiatrists and gynaecologists attached to these centres. The number of privately owned and operated primary-care centres has gradually increased, as has the variety of professions employed in these centres.

Research on the Swedish healthcare system has drawn attention to increasing difficulties in access to health care in the country and to growing co-operation problems between the healthcare and social welfare sectors (e.g., Anell 2007). The latter became a marked tendency especially from the first half of the 1990s onwards, affecting in particular the co-ordination of primary care and social services for the elderly, and later on also of primary psychiatric care and social services for psychiatric patients (Falk & Nilsson

1999). Both of the two developments have been claimed to have emerged as a result of legislative reforms (*Ädelreformen, Psykiatrireformen*) that delegated responsibility for these patient categories almost exclusively to the municipalities (*ibid*.). The intention behind the reforms had been to make health care more efficient by transferring the responsibility for what were called the "social problems in primary care" from health care to the municipal social services. Since the implementtation of these reforms re-shaping the division of responsibilities between the county councils and municipalities, debates have flared up frequently about whether co-operation between social services and health care can work in practice. Not only prestige thinking has been seen as hindering the co-operation; also territorial thinking has been diagnosed as a cause behind it, especially when it comes to questions of economic nature and questions with economic consequences (Falk & Nilsson 1999).

In Germany, the responsibility for healthcare provision lies solely with the 16 individual federated states of the republic. As already noted, the role of the national state itself is merely that of a provider of framework legislation. Until quite recently, hospitals have for the most part been publicly owned, by either the federated states or the municipalities, being only occasionally operated by non-profit organizations and certain for-profit organizations (see Anell 1999). Since 2007, however, privatization of hospitals has accelerated. Municipalities, local governments, and federated states, however, still remain the owners in the majority of cases, with politicians from all these administrative levels serving as members of the hospitals' supervisory boards. Through the 1990s and in the early 2000s, care provision was characterized by a strict traditional separation between in-patient health care at hospitals, rehabilitative care, and out-patient care by private general practitioners and medical specialists. Following subsequent legislative reforms, however, this organizational framework has begun to change in the course of the last decade or so. Health care is today also provided by privately practising physiotherapists, psychologists, and the like. Besides their inclusion in the general funding schemes in the country, health insurance coverage of these healthcare services also depends on a referral by a certified medical practitioner. Until recently, health care at hospitals was restricted to in-patient care, and a referral by an out-patient practitioner was required, except in the case of emergency care and privately paying patients.

There are two basic types of hospitals in Germany. General hospitals give predominantly basic somatic care at a local level, and specialized hospitals provide for example psychiatric and psychosomatic care, therapy for drug abusers, medical rehabilitation, rheumatology, geriatry, transplantation, as well as forensic and military hospital care. According to the country's Social Code, both types of hospitals are to offer necessary in-patient care as well as

obstetrics according to scientifically-based diagnostic and therapeutic methods. Medical doctors, nurses, and other healthcare personnel are expected to work in order to diagnose and cure disease, prevent deterioration, mitigate consequences, and provide obstetric care (Borgetto & Kälble 2007).

The strict separation between out-patient, in-patient, and rehabilitative care has been reported to cause problems at the intersection between health care and social welfare provision. The different steps of the treatment process, for example, have been seen as insufficiently integrated and harmonized, treatment and rehabilitation processes have been criticized as frequently delayed or interrupted, and patients have been referred to inappropriate care facilities. Insufficient co-operation and communication between out-patient specialists, between in-patient and out-patient care and rehabilitative care, and between different social welfare sectors have been criticized as well (Borgetto & Kälble 2007). Of the consequences of these problems, cost-ineffectiveness and "revolving door" effects (patients cycling in and out of hospital care) have been pointed out as perhaps the most salient (Borgetto & Kälble 2007).

As already mentioned, the financing of healthcare services is organized differently in Sweden and in Germany. In Sweden, the democratically elected county councils have the right to tax county residents in order to cover approximately 90 per cent of the public expenses of healthcare provision. Additional financing for the health care provided by the regional governments comes from patient fees and the income from medicine sales as well as from government subsidies (Lidström 2003). The available economic resources in a county are allocated by global budgets either to specified diseases or to specific healthcare organizations such as hospitals. Also contracts with private hospitals are possible, although these are often paid prospectively on a per-case basis with both quality as well as price ceiling defined beforehand. Some county councils split their healthcare administration into purchaser and provider organizations, allocating their economic resources to the purchaser side of the administration while the provider's services are paid for by purchaser. In these counties, the purchaser may not only pay public providers; they may also contract private providers/hospitals, again using advance payments with both the price and quality ceilings defined ahead of time (Blank & Burau 2007). Most of the healthcare services provided, however, are funded from public sources through the national health service system.

In Germany, in contrast, healthcare financing comes predominantly from public health insurance funds (*Gesetzliche Krankenkassen*). Since the beginning of the 2000s, however, the need for private payments has increased, mostly due to rising cost of health care. In the 1990s, there were

about 1,000 public (non-profit) public health insurance funds, with a number of additional private (for-profit) funds also in the market. Membership in one of the public health insurance funds is mandtory for all those below a certain income level. For those with earnings above the specified level, and for those who are self-employed, membership in a public health insurance fund is voluntary: they may choose between membership in a public and a private health insurance fund. Altogether, approximately 9 per cent of the country's population are today privately, not publicly, insured. In the case of the public health insurance funds, employers and employees jointly pay the accompanying fees, which, however, are fixed to a certain percentage of the employee's salary (the exact level depending on the health insurance fund in question). Public control of the various kinds of health-insurance funds and over healthcare expenditure has remained rather limited, as the federal government's role in this healthcare system continues to be limited to setting forth the legislative frames for the actual funders (Blank & Burau 2007). This control, however, has been increasing as of late: the Federal Ministry of Health, for instance, today participates in the negotiations around the definition of healthcare services to be funded by public health insurance funds.

Healthcare sector and legislation

Current healthcare legislation in both countries can be characterized as predominantly aimed for setting frames. It therefore first and foremost prescribes the basic conditions for healthcare provision. In Sweden, besides the above-mentioned 1982 Health and Medical Services Act that basically does little more than notes the county councils' responsibility in providing "good-quality" health care and that there is to be the necessary personnel available for this purpose, there is also a second law, the Professional Activities in the Health and Medical Care Field Act (*Lagen om yrkesverksamhet på hälso- och sjukvårdens område*, LYHS), that regulates the licensing of healthcare professionals and the use and protection of professional titles. The administrative responsibility for licensing professionals is assigned to the National Board of Health and Welfare. In Germany, it is primarily the above-discussed federal Social Code and Hospital Laws of the federated states that regulate the healthcare sector, or its organization (Blank & Burau 2007). In general, the licensing of professionals and the use and protection of professional titles are not specifically regulated for the healthcare field, although there are separate laws addressing licensure for specific professions and occupations. The responsibility for the administration of licensure is assigned to accredited federal schools and professional chambers operating at the national level (see below).

So far, neither in Germany nor in Sweden have social workers become a licensed profession (e.g., Weiss-Gal & Welbourne 2008), even though, in both countries, other healthcare professions have been able to establish their formal jurisdictions through diverse forms of legislation. For the establishment of a profession's jurisdiction, two things in particular are important: the protection of the professional title and some form of licensure for protecting specific work tasks. In Sweden, the title most commonly used for HSWs, *kurator*, is not a protected professional title under the current law.[3] In Germany, in contrast, academic professional titles such as social workers' are protected by the German Criminal Code (*Strafgesetzbuch*, StGB), thus providing a minimum degree of legal protection even for HSWs. Professional titles based on academic degrees such as, for instance, *Dipl. Sozialpädagoge (FH/Uni)* are generally protected as are all professional titles that include a form of state accreditation (*Staatliche Anerkennung*); only persons with a degree from one of the three state-accredited university types may use one these titles. The law does not, however, protect the frequently-used titles corresponding to "hospital social worker." In consequence, as long as Swedish employers look for *kuratorer* or the German ones *Krankenhaussozialarbeiter*, they can employ staff without academic training, as anyone can then claim to be a "hospital social worker". When employers in Germany instead look for *Sozialarbeiter (BA)* or *Sozialpädagogen (FH)*, applicants are expected to be holders of the protected professional title in question. In neither Sweden nor Germany, however, does the protection of the professional title automatically include the protection of specific work tasks for those holding the title.

The primary way to legally protect a profession's jurisdiction is through licensure. In Sweden, there exists, strictly speaking, only one form of professional certificate for occupations and professionals in the healthcare sector: *legitimation*. The awarding of *legtimation* is regulated by the Professional Activities in the Health and Medical Care Field Act, which provides a list of licensed academic and non-academic professions.[4] It further gives the protected professional titles and specifies professions' exclusive rights to certain work tasks.[5] In it are also defined the various duties of healthcare professionals, the procedure for licence withdrawal, and the national health and social welfare authorities' means of control over healthcare services.[6] Unlike most other professions in the healthcare sector, HSWs (just as social workers in general) are not licensed in Sweden.[7]

[3] See LYHS 1998, Section 3, Paragraphs 5–7.
[4] LYHS 1998, Section 3, Paragraph 2.
[5] These include physicians, midwifes, pharmacists, dentists, etc.; see LYHS 1998, Section 3, Paragraphs 4-7.
[6] LYHS 1998, Sections 2, 5, 6.
[7] See LYHS 1998, Section 3.

In Germany, licensure takes three different forms when it concerns healthcare professions. Firstly, there is the historically rooted Trades and Crafts Code (*Handwerksordnung*, HwO) that contains a list of protected trades. This list also covers several "trades" belonging to the healthcare sector.[8] It defines the length and level of education required for each particular trade at federally accredited schools and universities, along with the rules for trade licence withdrawal.[9] The licensing authority in these cases is the relevant Chamber of Trades and Crafts (*Handwerkskammer*).

A second form of licensure is for non-academic medical occupations, which are regulated through their own, separate occupation-specific laws.[10] These laws usually specify the pertinent work field and work tasks, the minimum necessary general education, and the required educational level at special, federally accredited occupational schools, providing also the protection of the occupational title.[11] Licensure for these occupations is automatic, taking place at the end of the successful completion of one's occupational education at state-accredited schools, and cannot be withdrawn.

Last but not least, the third and most elaborate form of licensure in the healthcare area in Germany is called *Approbation*. It regulates the admission to professional practice as a physician, psychological psychotherapist/children's psychotherapist, pharmacist, dentist, and veterinarian. Even it is regulated by special laws such as the Federal Medical Practitioners' Act in the case of physicians and dentists (*Bundesärzteordnung*, BÄO) and the Psychotherapy Act in the case of psychologists and social workers working in psychotherapy (*Psychotherapeutengesetz*, PsychThG). These laws protect professional titles, specify the relevant work fields and the required level of university education, and define the licence withdrawal procedures.[12] Members of the professions concerned are required to join their particular professional association (*Kammer*), regulated in turn by the Laws concerning the statutory association of professions and occupations in health care in all federated states *(Heilberufekammergesetz,* HBKG or HKaG). German social workers, however, including HSWs, are not regulated by any of the above three forms of licensure.

Other forms of formal inscriptions in legislation may, if not directly present, at least indirectly give reasons for calling for a certain type of competence from healthcare professionals. This kind of legislation is found espe-

[8] Such as opticians, hearing aid acousticians, orthopaedic technicians, orthopaedic shoemakers, and the like.
[9] Anlage A (HwO); Handelskarte according to HwO, Paragraphs 1, 7, 13.
[10] Such as *Krankenpflegegesetz* (KrpflG) for nurses, *Hebammengesetz* (HebG) for midwives, *Ergotherapeutengesetz* (ErgThG) for ergotherapists, *Logotherapeutengesetz* (LogG) for speech pathologists, *Masseur- und Physiotherapeutengesetz* (MPhG) for masseurs and physiotherapists, *Podologengesetz* (PodG) for podologists.
[11] E.g., KrpflG, Paragraphs 1, 3, 4, 4a, 5.
[12] See, e.g., PsychThG, Paragraphs 1, 1(3), 2, 3, 5, 6.

cially in Germany. On the national level, several paragraphs of the Social Code strengthen the argumentative base of HSWs claiming their necessity in healthcare provision as performers of specific work tasks as set forth by the law. Two examples:

1. According to the federal Social Code V (federal law on statutory health care insurance), social counselling and social care as well as direct transition from acute to rehabilitative care are to be provided in hospitals.[13] This prescription does not actually protect HSW services, but nevertheless can be said to help strengthen the arguments HSWs have advanced at the federated-state and federal-state level for the inclusion of more protective sections in legislature and in corporative contracts.

2. The Social Code IX (federal law on rehabilitation and integration of the disabled) contains a paragraph on specific interventions aimed at the inclusion into social life and workforce of persons threatened by disability or already disabled.[14] These interventions are characterized as "social work interventions", and they include support in coping with disease and disability, assistance aimed to activate self-help potential, information and counselling, crisis intervention, and other similar measures.

In any case, the particular competence necessary to perform the federally prescribed social service work tasks is not defined by the federal state but is left up to the federated states themselves. Consequently, whether national-level legislation strengthens the professional situation for HSWs differs from case to case. In some of the federated states (such as Saarland), the requirement to employ professional social workers is included in these states' federated states' Hospital Laws (LKHG). In these cases, hospital social services are expected to be staffed by social workers holding a university-level social work degree. In the majority of the federated states, however, the legal requirements on hospitals only prescribe the provision of "hospital social services" (as, for example, in Baden-Württemberg and North Rhine-Westphalia). In these cases, also personnel with professional qualifications other than those of a social work, for instance nurses or pedagogues can be employed.

Some federated states such as, for example, Bavaria, however, do not specify anything in this respect at all. In these states, federal law complemented by federal and federated state-level public regulations such as corporative contracts is then what regulates the staffing of hospital social services within their jurisdictions. In such cases, it is up to the corporative partners to agree, through corporative contracts, on the requirements regarding

[13] SGB V, Paragraph 112, Subparagraph 2, Nos. 4 & 5.
[14] SGB IX, Paragraph 26, Subparagraph 3, Nos. 1–7.

the professions and competences to be involved in the hospital services in the state, including the social work provision (Ansen, Gödecker-Geenen, & Nau 2004). An example of this is the federal corporative contract specifying the prescriptions of the SGB IX. In it, it is stated that nurses and social workers are required professions for the performance of the interventions to integrate disabled persons into social and work life in the Social Code.[15] Another example from the federated state-level is a corporative contract defining the staffing of psychiatric wards (*Psychiatriepersonalverordnung*, PsychPV), which calls for the staffing of hospitals with, for example, social workers. Social work itself, however, is not defined as a healthcare profession in SGB V, Paragraph 32.

Examples of public regulations specifying and concretizing broader law in a manner that helps strengthen HSWs practitioners' claims for professional jurisdiction can also be found in the Swedish context. The National Board of Health and Welfare, for example, in its guidelines for the treatment of certain diseases has noted the necessity to supplement medical care by integrating into it also psychosocial aspects (National Board 2007). No particular profession, however, is pointed out in this context as a candidate for bearing the responsibility for the performance of the work tasks related to these psychosocial aspects.

To be able to assess the possible influence of broader policy developments on HSWs' jurisdictional work during the period under consideration (1989–2008), important healthcare reforms in the two countries in question need to be looked at and briefly analysed. As regards Sweden, the healthcare reforms of the 1990s and the 2000s in the country can be seen as having had two general aims for themselves. On the one hand, these reforms were enacted to increase efficiency in the use of economic resources, through added incentives for privatization of health care; and on the other hand, they aimed at effecting a separation of responsibilities between health care and social welfare.

Already in the 1970s, a government report in the country had drawn attention to an overlap between health care and social welfare responsibilities in the case of certain client groups (SOU 1978:78). The report further pointed to a possibility to improve the efficiency of health care in general, and of primary care in especial, through transfer of responsibility for healthcare clients with mainly social problems to the social-welfare sector. According to the report, the elimination of the overlap between the two sectors would reduce the risk of medicalizing and psychiatrizing social problems (see Falk & Nilsson 1999). Also the economic crisis of the 1990s had brought into sharper focus the need for more efficient use of tax revenue and for reducing healthcare costs. One of the aims for reform was thus a more

[15] SGB IX; other examples can be found in SGB XI.

effective use of resources in the area, to be attained through improved co-operation and service co-ordination between social-welfare and healthcare agencies. A pioneering effort in this direction was then the so-called *Ädelreform,* implemented in 1992. With it, the responsibility for eldercare was now to be regulated by the Social Services Act (*Socialtjänstlagen*, SoL), while acute medical care and other medical care performed on the elderly by doctors still remained within the purview of the country's Health and Medical Services Act of 1982. What these changes amounted to was the de facto delegation of responsibility for eldercare to the municipal welfare services, while the responsibility for acute care and emergency medical services still remained with the county council-driven healthcare organizations (Thorslund 2007).

Similar concerns were also what motivated the country's psychiatric care reform (*Psykiatrireformen*) of the mid-1990s. Just like the eldercare reform above, it, too, can be said to have led to problems of co-ordination between the municipal welfare services and county healthcare services (Thorslund 2007). Neither the Health and Medical Services Act nor the Social Services Act regulates social work services provided at hospitals, or the municipalities' and regions' responsibility to provide HSW. Notwithstanding any such still-evolving counter-productive effects, however, the positive effects anticipated in the 1970s' government report above still keep being referred to in studies addressing themselves to the distribution of responsibilities between health care and social welfare (see Falk & Nilsson 1999).

Other important legislative reforms in Sweden, likewise taking place in the early 1990s, have related to the ongoing privatization of primary care in the country. Even if some of these initiatives have subsequently been withdrawn (only to be later resuscitated), the trend towards privatization in the health sector remained strong during the entire period under consideration in this dissertation (and after). The aim has been to introduce private for-profit health care, but also to develop internal markets in the counties to increase the internal market exposure of health care. Both of these two trends – privatization and the development of internal markets – later showed that it has been difficult for the county councils to maintain control over their healthcare expenditure, even where the other main aim of the reforms, increased efficiency, has been achieved (Blomqvist 2002). Even here, furthermore, it has remained unclear where the responsibility for providing social work services in primary health care lies. According to Falk & Nilsson (1999), moreover, privatization of primary care also contributed to the weakening of the co-operation between the municipalities and primary/psychiatric care in the 1990s.

Also in Germany there were a great many legislative reforms introduced in the 1990s and 2000s that affected the healthcare sector. Most of the efforts related to the area were driven by the desire for cost containment, with the result that the term “reform” is today often used simply to mean “decrease of welfare”. Especially healthcare insurance has been an area heavily affected by the initiatives to drive down costs (Schulin 2008). One of the most important reforms involving it, the Health Care Structural Reform Act (*Gesundheitsstrukturgesetz*, GSG) of 1993, did not, in fact, aim at improving resource allocation, but at increased efficiency and rationalization within the insurance sector (Becker & Kingreen 2008). In its wake, a federal ceiling for health insurance fund fees was thus implemented as well, in 1996 (*Beitragsentlastungsgesetz*, BeitrEntlG). Even other legal initiatives were taken to lower costs, among them reforms concerning compulsory care insurance (1997), the implementation of disease management programmes in health care (2002), and the development of primary care centres and quality measurements pursuant to the federal Social Code (since 2004) (see Borgetto & Kälble 2007). Another new law, the Statutory Health Insurance Modernization Act (*Gesetz zur Modernisierung der Gesetzlichen Krankenversicherung*, GMG) of 2003, was enacted to better control the established corporative partners’ (especially the medical profession) influence within the corporative system, by giving more influence to other actors such as patient representatives (see Borgetto & Kälble 2007).

Beside these efforts driven by the desire to better control healthcare expenditure, there was also another important series of legal developments impacting the social welfare state more in general. These developments came about through the initiative of federal policy makers who wanted to formally integrate all legislation concerning the welfare sector – social welfare as well as health care – within one legislative framework, the federal Social Code. Historically, legislative developments concerning the welfare state had created a fairly splintered legal landscape in the country, with separate laws for just about each specific part of the welfare system. There was, for instance, a law on child care, a law on statutory health insurance, a law on compulsory care insurance, and yet another law on social welfare benefits. Accordingly, also the German welfare state had developed an organization characterized by a plurality of health insurance companies, care insurance companies, employment agencies, social welfare agencies, and so forth. To systematize this framework, the efforts to integrate all different laws into one single federal state-wide Social Code had already begun before 1989. Finally, in 2008, the Social Code included all the most important laws related to the social welfare sector and the healthcare sector. While the prior legislation had, logically speaking, differentiated between social insurance, social distribution, and social security, the logic of the

current legislation is geared towards differentiating between welfare services related to social prevention, social compensation, and social support and integration, under which the different areas of health care as well as of social welfare are now all subsumed as the constituent elements of the social welfare system (see Schulin 2008).

This integration of social welfare and health care can be discerned particularly well in, for example, the Social Code IX (SGB IX), which today explicitly defines medical rehabilitation as including also psychological and pedagogical interventions.[16] Apart from covering strictly medical rehabilitative treatment, this definition also specifies the responsibility of rehabilitation providers to offer social services such as counselling and support by qualified personnel concerning social rights, integration, and interventions. The purpose of these services, according to SGB, is to promote coping with the consequences of disease and disability,[17] to help activate the self-help potential of individuals, to facilitate counselling with relatives, employers, and colleagues, to support and help develop social competences in crisis situations, and to perform motivational work (Fuchs 2008).[18] HSWs claim their specific competences in order to perform these specific interventions.

2.3 The impact of welfare regimes on healthcare organization

The type of welfare regime in Sweden and Germany preconditions the structure of the healthcare system in place in each country. It, furthermore, influences the relation between the state and professional groups in health care in the two countries (Burau, Henriksson, & Wrede 2004). Welfare state regimes describe specific ways of:

> … government action in the fields of personal and family income, health care, housing, education and training, and personal 'care' services. 'Government action' embraces not only direct provision of benefits and services, but also the regulation and subsidy (including fiscal reliefs) of the various private forms of welfare. These latter include occupational welfare provided by employers, welfare provided by for-profit, charitable, trade union, community, religious and other voluntary organizations, as well as that provided informally family members, friends and neighbours. (Ginsburg 1992: 1)

Background knowledge on the particular type of welfare regime in place in Sweden and Germany, respectively, is thus important for understanding not

[16] SGB IX, Paragraph 26, Subparagraph 3.
[17] SGB IX, Paragraph 22.
[18] SGB IX, Paragraph 26, Subparagraph 3, Nos. 1–7.

just the way health care is organized in the two countries, but also the possibilities professions have for influencing healthcare governance. According to Esping-Andersen (1990), modern Sweden represents a typical case of "the social-democratic welfare regime" and Germany of "the corporatist" one.

The main goal of the Swedish social-democratic welfare state model has been to promote de-stratification in society through distribution of welfare benefits. In other words, its purpose is to equalize class and status differences using, among others, health care distribution as a tool. State benefits deriving from taxation are used to help ensure equal rights for citizens and possibilities for everyone to access welfare services. Towards this purpose, welfare services, including health care, are thus made universally accessible to all residents, even those who might not have previously contributed to the funding of these services. Welfare and healthcare services are meant to be distributed equally to everyone, regardless of class, race, and the client's/patient's possibility to pay for them. In the social-democratic welfare model, women are encouraged to join the labour market, and, in line with this objective, the provision of social and health services for each family member is made independently from the other family members (Esping-Andersen 1990). Since the 1990s, however, there have been tendencies in the country pointing, for example, towards decreasing universality of access to healthcare services, even bringing about the factual exclusion of some groups from the scope of healthcare services (such as, e.g., illegal immigrants; see Salonen 2001).

The underlying vision of the Swedish welfare system has traditionally involved the idea of *folkhemmet*, "the people's home". In this vision, the welfare state and its tasks are seen as analogous to the family and its tasks: the state should provide a safe and good place for all citizens to live, with, just as in a small family, qualities such as inclusion, equality, helpfulness, co-operation, consideration, and affiliation forming the core of the notion. As a result, the country has seen the implementation of a strongly collective model of political and public policy decision-making, reaching down even to its social-welfare organization and the distribution of social and health-related services. In Sweden, access to healthcare services is, consequently, perceived less as an individual right to a set of particular services, and more as a collective right to more vaguely defined "healthcare services of good quality". Swedish citizens' individual rights to specific healthcare services are therefore much weaker than in countries where this notion of rights is associated with the fulfilment of particular duties or obligations. Indeed, the notion of social rights accompanied by a notion of social obligations remains quite strange in the Swedish perspective (cf. Andersson 2007).

The German corporatist welfare state, on the other hand, specifically guarantees social rights to its citizens, by offering them (state-supported)

welfare benefits. Even here, however, certain de-commodification has been the consequence due to welfare benefits (Esping-Andersen 1990). Nevertheless, access to most of these benefits is based on obligatory membership in public social and health insurance funds (Kohl 2000), often organized according to occupational groups, thus preserving the existing order of status groups and social classes (Esping-Andersen 1999). In contrast to Sweden, benefits deriving from, especially, the public health insurance funds can be received by all family members, not just the insured person alone. The contributions, moreover – though not the level of healthcare services provided – are income-related (Kohl 1994). In this manner, the redistributive effects of the health insurance funds are generally high, cutting across multiple factors such as income, sex, status, age, as well as the high-risk vs. low-risk nature of patients (Offermann 1996, Blank & Burau 2007). The country's existing health insurance funds cover 99 per cent of the population, which makes the healthcare system nearly universal and in this respect comparable to the Swedish one (Freeman 1998).

Just as the Swedish welfare system, also the model of the German welfare state has been influenced by certain highly powerful ideas. One of these is *Sozialstaat*, the traditional German notion of the welfare state. The classic triad of freedom, equality, and solidarity has remained fundamental to all social policy in the country. Equality, however, is in Germany measured by opportunity, not, as in Sweden, by outcome (Hoefer 1996).[19] Moreover, the German idea of solidarity is based on the principle of subsidiarity, and thus it does not, as in Sweden, directly extend to cover the whole of society (Hoefer 1996, Brumlik 2001). This principle, while rooted in Catholic ideology, continues to influence legislation (and state action in general) still today, informing the way health care is organized, funded, and provided. In accordance with it, the state intervenes when citizen themselves, their family, community, or occupational group, and the market are unable to solve the problem on their own. It thus points to the central role of the family, tending to preserve traditional family structures and family responsibilities, among which it includes, among other things, also caring activities (Clasen 2005).

The way in which healthcare governance is arranged in Sweden and Germany is directly influenced by the two countries' respective welfare state regimes. As will be shown below in this chapter, furthermore, the particular form of healthcare governance in turn impacts on professions' possibilities to influence policy making in the healthcare sector. In Sweden, it is democratically elected politicians in county councils who answer for healthcare governance within their jurisdiction (see also Blomqvist 2007). There are altogether 21 county councils in the country, each with the responsibility to

[19] *Grundgesetz* (GG), Article 2.3.

finance and organize mainly their own healthcare provision but also other services. Healthcare provision and care for disabled people represent the two main activities in this regard, taking up 85 per cent of the councils' total expenditure (Lidström 2003). The role of the state remains very much restricted. The most important law in the healthcare area is the previously named Health and Medical Services Act of 1982. Aside from national legislation, health care provision in the country is also governed by national guidelines for care and treatment as published by the National Board of Health and Welfare. This government agency is also tasked with supervising, monitoring, and evaluating the healthcare services provided by the county councils, as regards, for example, their quality (Blomqvist 2007).

Important initiatives for legislative reforms and changes in healthcare organization are in Sweden always preceded by publically commissioned investigations. Ideas, suggestions, and considerations are accepted from political parties, authorities, interest associations and organizations, professional associations, and the government itself. The purpose of the investigations is to subsequently serve as a basis for decision making on the proposed changes, and they are conducted by a special state investigation committee based on the written government instructions received. A responsible civil servant will decide on the composition of the committee, which can comprise either a single investigator or a group of investigators. Outside experts can be attached to the investigation committee, although they may not interfere with the decision-making. Preliminary investigation results are submitted to all concerned parties for consideration and comments before the government makes its decision on the matter (Falk & Nilsson 1999).

The main aspects of the healthcare performance are nevertheless governed through informal structures between the national and regional levels. Informal meetings, negotiations, contacts, and discussions between representatives of these two levels are resorted to in order to arrive at an agreement on, for instance, how national subsidies to health care should be used. The national-level negotiation partners may include either the Ministry of Health and Social Affairs or the National Board of Health and Welfare. The county councils are represented by the Swedish Association of Local Authorities and Regions (*Sveriges Kommuner och Landsting*, SKL), which handles the councils' contacts with national-level actors. The association is comprised of county politicians, and its task is to not just represent county interests at the national level, but also transmit information from the national level down to the counties. Some reforms, like the recent *Vårdvalsreform (*Free Choice Reform) enabling patients to choose between different healthcare providers and the *Vårdgaranti* (Maximum Waiting Time Guarantee) that set a maximum time for waiting to see a general practitioner, to get a

visit to a specialist, or to get a treatment/operation, were implemented via informal structures and not by legislation (Blomqvist 2007).

In Germany, political governance of health care remains very limited. In contrast to Sweden, though, it is not limited through decentralization of responsibilities but because of the corporative nature of the country's welfare regime, bringing about the delegation of governance to statutory self-governing and self-administered federal and federated-state institutions (Borgetto & Kälble 2007, Ginsburg 1992). Formal governance is handled through legislation. The laws most relevant to the purposes of this dissertation are the federal Social Code in its various Books along with the Hospital Laws of the federated states, even if also some other legislation concerning cost containment in health care remains pertinent as well. As noted by Ginsburg (1992), this legislation often transfers the responsibility and competences related to the healthcare organization as well as the administration of the system to the federated-state or even district level. Core governance tasks are also handed over from the federal state and the federated-state governments to statutory self-governing institutions. Direct political influence on healthcare services remains thus always much more limited than in Sweden, for example.

Unlike in Sweden, in Germany the important negotiations and decisions take place in formal arenas of self-governance, such as the Federal Joint Committee (*Gemeinsamer Bundesausschuß*, G-BA), the relevant committees of the upper and lower house of the German parliament, or regional/local roundtables for health care and nursing where corporative partners or interest groups meet under more formal circumstances. Of these different arenas, the Federal Joint Committee is the most important one. In it, representatives of public corporative bodies as funders, hospitals, doctors, dentists, patient organizations, and so-called "impartial participants" engage in negotiations and adopt mandatory guidelines for healthcare provision and financing. The contents of such negotiations and the decisions resulting from them constitute then guidelines for medical treatment in out-patient and in-patient care, for the adoption of new treatment or investigation methods, for the financing of new medical aids and drugs, for the quality requirements of health care. Self-governance is, however, very often also practiced through more informal contacts between public corporative bodies as funders, providers, and, increasingly, patient interest groups, although frequently involving also trade unions, employers, lobby groups for the pharmaceutical and medical-technical industry, and many others. In these negotiations, however, less important decisions are made (Borgetto & Kälble 2007).

Implications for professional involvement in healthcare policy development

Different professions have different possibilities to impact health care governance in both Sweden and Germany. The way in which healthcare governance in the two countries either facilitates or hinders HSW provision and HSWs' efforts to achieve for themselves a protected jurisdiction has not been empirically investigated in either case. Most research on the two countries' healthcare systems has thus far concentrated on describing mostly physicians' influence on healthcare policy making, with the influence of other professions such as HSWs' or nurses' in this regard remaining for the most part unexamined.

In Sweden, of all the health and medical care professions, it is mainly physicians who are depicted as exerting influence on healthcare policy making. Historically, this perceived influence of theirs is attributed to their ability to make medical diagnoses and their knowledge about patients' need for treatment. Today, physicians still occupy the most important position in healthcare provision when it comes to making the decisions on where the resources should be allocated (Blank & Burau 2007). They also hold important positions in the National Board of Health and Welfare. Even if it is politicians who ultimately control the financial resources for health care, and not the doctors, they thus remain intimately intertwined with the state in deciding on the prerequisites of their professional performance. While, for outsiders, priority setting in health care may often seem like a highly bureaucratic task handled by the higher administration, it is thus in reality done in partnership with physicians on the ground (Ginsburg 1992).

The doctors employed within the Swedish national health service are duty-bound to treat all patients entitled to healthcare services. Therefore, one of the key challenges for Swedish physicians is to be able to maintain control over public policy making (Blank & Burau 2007). Since the 1970s, however, nearly all of the physicians in the country have become salaried employees in the public healthcare provision (Ginsburg 1992), and their influence on policy-making in health care matters has markedly weakened. Working for the national health service, they are today more and more dependent on politically controlled healthcare governance (Blank & Burau 2007). The state's desire to gain control over physicians is made visible in a variety of contexts, as for instance in controversies around budgeting, status, and clinical autonomy (Ginsburg 1992), the discussions about inclusion or exclusion of certain types of treatment (Blank & Burau 2007), or the government's attempts to prevent major strikes by physicians through the use of emergency laws (Ginsburg 1992). The erosion of physicians' influence seems to continue even today: with the rise of the "New Public Management" thinking, the physicians' ability to influence decisions at the organizational

level is weakened, with this ability transferred to managers and consultants instead who are not nearly always physicians by background, and external control in the form of inter-professionally developed quality management in hospital organizations is replacing intra-professional control by physicians (Blank & Burau 2007). The fact that struggles around political, social, and ethical questions within the Swedish healthcare system have tended to be relatively minor, if not altogether non-existent, could be one result of these very developments over the last four decades (Ginsburg 1992). Seen from this perspective, the medical profession in Sweden indeed appears relatively weak in its influence on policy-making, and dominated by the administrative and managerial-bureaucratic decision-making apparatuses. This circumstance can then create space to other forces to enter into the game of influencing healthcare policy making, such as, for instance, other professions in the healthcare sector.

In this situation, however, the fact remains that national legislative frameworks, regulations, action plans, and guidelines touching upon aspects as HSW performance, financing, and required competences continue to be vague or even non-existent. Additionally, policymakers' interest, as noted above, seems to be towards exclusion of social services from healthcare provision. In a rather de-centralized national health system such as the Swedish one, this means that county councils and hospital organizations are left with substantial freedom to decide whether or not they see hospital social services as contributing to the provision of "good-quality health care", and, if indeed they do think so, which profession they choose to staff these services with. Given the county councils tendency to de-centralize budgetary responsibility to hospital administrations, moreover, these decisions may then ultimately lie with the hospital organizations, falling, in practice, within their competence to decide on how much of their budget they want to invest in, for example, just hospital social services.

In a corporative welfare regime such as the German one, direct political influence on health care provision remains limited mainly to the legislative level (Blank & Burau 2007). The translation of healthcare legislation into implementation policies for healthcare provision, however, is achieved through self-administered and self-governing negotiations between the public corporative bodies. It is therefore these bodies that hold the most power within the healthcare system. This power they have partly thanks to their privileged access to the policy-making process and partly thanks to their right to self-govern the translation of legislation into implementation policies at both the federal and the federated state level. The role of these bodies is institutionalized and circumscribed by the structure of the healthcare system. At the national level, these self-administered entities have been given the right to negotiate contracts, including the right to sign contracts

with other corporatist organizations and organize financing. At the local level, they independently negotiate contracts for healthcare provision, including service descriptions, prices, and financing (Blank & Burau 2007). Traditionally, the following public corporative bodies are part of the self-administrating system: public health insurance funds (*GKV-Spitzenverband Bund*, *Deutsche Rentenversicherung*, representing employees and employer interests), providers (the *Bundersärztekammer* and *Deutsche Krankenhausgesellschaft*) and, ever since the most recent changes in legislation, user organization representatives.[20]

As a result of this system, German physicians participate in the definition and specification of the healthcare to be provided, based on the national and federated state-level legislative frameworks such as the national Social Code (esp. SGB V) and the Hospital Laws of the individual federated states. In other words, the medical profession is directly involved in the specification of the exact nature of the healthcare services to be covered by public health insurance funds. Even the evaluation of the medical and economic efficiency of the various types of treatment offered has today been delegated to the self-administrative system. Moreover, when it comes to the range of healthcare services offered at hospitals and making any changes to it, there is a separate sub-committee set up by the self-administrative system for the purpose in which physicians are included as negotiation partners for the representatives of the German Hospital Federation and public health insurance funds (Blank & Burau 2007).

Other healthcare professions in the country, such as nurses, lack the necessary legal recognition and have thus far remained excluded from these public bodies for the self-administration and self-governance of health care. It is, moreover, not clear, either, how these other professions could influence the healthcare policy making in these contexts to begin with, given its nature as a self-governing, self-administered system in which so far only seemingly prestigious professions promote their interests. Other professions' interests or perspectives are thus at risk of being neglected in it (Kuhlmann 2008). As a result, one can expect the interests not formally represented in these self-governing institutions to have only little chance of becoming expressed, heard, and incorporated in negotiations and in the making of framework agreements and contracts. Securing financing for HSW services, for example, will then, in these contexts, be unlikely to be seen as a priority of any kind in corporative negotiations. If professions outside the system of self-governance and self-administration want to succeed in making their voice heard, informal ways to express their professional interests will have to include

[20] *GKV-Spitzenverband Bund* (National Association of Statutory Health Insurance Funds), *Deutsche Rentenversicherung* (German Statutory Pension Insurance Scheme), *Bundesärztekammer* (German Medical Association) and *Deutsche Krankenhausgesellschaft* (German Hospital Federation)

participation in many different forums and arenas involving many different public corporative bodies as negotiation partners.

However, even if it is difficult to see how other professions in Germany could formally impact policy making, some steps towards the inclusion of HSWs' jurisdictional interests have been taken in the country's legislation during the last two decades. Certain specific HSW tasks (but not necessarily competences), for example, are now included in the newest Social Code (see previous section).

To sum up, HSWs in both Sweden and Germany are university-trained professionals representing a sub-speciality of social work with a possibility to specific further education. Neither of the two countries currently has a licensing procedure for social workers in general and HSWs in particular. While HSWs in Germany are accredited by the federal state and hold a protected professional title, the same is not true of Sweden. In Germany, HSWs also enjoy some degree of formal jurisdiction, owing predominantly to specific healthcare-related HSW tasks mentioned in federal and federated-state legislation (SGB, LKHG) and to certain corporative contracts negotiated in corporative self-governing institutions. Any definition of specific professional social work competences, however, remains mostly lacking. In Sweden, again, any kind of social work perspectives are only seldom brought up in healthcare legislation (such as, e.g., the child perspective) or in the public guidelines issue by the National Board of Health and Welfare (e.g., a psychosocial perspective).

In the time period 1989–2008, however, both countries witnessed a series of healthcare reforms that at least potentially have significant repercussions for HSW and its position in the two, otherwise fairly dissimilar contexts. In Sweden, these reforms mostly involved privatization of health care and the explicit separation of the overall service provision into regional-level healthcare services and municipality-level social welfare services components, with implications for social work in health care in general and for HSW in particular. In Germany, the reforms were primarily aimed at increasing the competition between public healthcare insurance funds, limiting the power of traditional corporative partners, and integrating separate healthcare and social welfare laws under one general legislative framework, the national Social Code. These reforms, too, have significant implications for HSW services as performed in the country. HSWs' possibilities to influence healthcare policy making so as to be able to better represent their professional interests are, however, a topic not previously explored in the literature. What has been established in previous research is, nevertheless, the major influence that the medical profession is capable of exerting on policy making in both of the two countries studied, much based on its ability to effectively represent its own professional interests.

3 Professionalization and Jurisdictional Work

The professionalization of HSWs takes place in the context of organizational healthcare settings in which HSWs practice their profession as a subordinate professional group. This chapter presents the theoretical framework and terminology employed to analyse this process. Particular attention is paid to the theory of professions and professionalization in this chapter.

One of the starting points of this research is that the processes of professionalization of professional subgroups operating in subordinate organizational settings are conditioned by a number of contextual factors. A large body of previous research suggests, for instance, that the relationship between the profession, the state, and the organizational setting where the profession operates impacts on that profession's professionalization prospects (Abbott 1988, Alaszewski 1995, Allsop 1995, Burrage 1990, Dent 2003, Doherty 2009, Erichsen 1995, Evans & Honold 2007, Immergut 1992, Johnson 1995, Kocka 1990, Kuhlmann 2006, Kuhlmann, Allsop, & Saks 2009, Littek, Heisig, & Lane 2005, Macdonald 1999, Siegrist 1988). The literature further suggests that the professionalization possibilities of professional subgroups depend on these groups' relationship with more dominant subgroups of the profession, and on the extent to which the professional bodies representing these groups succeed in advancing their interests by promoting the protection of specific work tasks claimed as part of their purview (Allen 2001, Becher 1999, Burri 2008, Halpern 1992, Macdonald 1999).

Another starting point of this research is the assumption that professional subgroups' jurisdictional work aims at relating these groups to their professional, organizational, and broader societal context, by internally supporting the development of a specific professional identity for them. In addition, external jurisdictional work can be expected to be undertaken to facilitate the formalization of a professional subgroup's jurisdiction, using various strategies.

In the first section of this chapter (3.1), I will outline a theoretical framework for the investigation of HSW professionalization in two different country contexts. Previous research on professionalization and the role of professional bodies in professions' quest for professionalization is reviewed. In the second section (3.2), internal and external jurisdictional work is then analysed as a central task of professional associations.

3.1 Professions and professionalization

Theorizing and research on professions has for the most part proceeded along two main directions. First of all, it has concentrated on the develop-

ment of a general *definition of professions* as specific occupations, including the categorization of professions. Secondly, it has focused on the *process of professionalization*, understood as either a transition from being an occupation into being a profession, the monopolization of specific work fields, or the improvement of professional/occupational practice in general.

Professions

Anglo-Saxon research on professions has a long tradition, with Talcott Parsons (1970) often seen as one of the central researchers for the theorizing in the area. According to Parsons, professions represent one of the subsystems of society. Initially, several ideal-typical professions were developed. Characteristically, the resulting typologies were built around sets of features that distinguished professions from occupations (Greenwood 1957, Hughes 1971, Millerson 1964, Wilensky 1964). Abstract scientific knowledge, trained skills, organization into professional associations, and the performance of professional duties in a spirit of service to a societal good were often included among these features (Abbott 1988, Sullivan 2005). Occupations, in contrast, were assumed to lack these characteristics. At the same time, however, researchers found that this categorization into either occupations or professions was far too rigid in light of the available empirical evidence (Mann 1996). In consequence, Etzioni (1969) formulated a third category in between the two extremes of occupations and professions: the semi-professions. These lacked professional discretion, authority, and autonomy, but were otherwise closer in nature to professions than occupations. According to these typologies, social work and its subgroup HSW would have had to be defined as semi-professions. All these approaches to, and definitions of, professions, however, have been subsequently criticized from a variety of perspectives, partly for being naïve, insensitive for gender aspects, and too dependent on time and context (e.g., Freidson 1973, 1994, Torstendahl 1990, Witz 1992).

Drawing from another tradition, Kocka (1990) as well as Siegrist (1988, 1996) have described the key theoretical term 'profession' as difficult to understand from the perspective of non-Anglo-American contexts. For them, other terms such as 'liberal occupations', 'academic occupations', 'civil servants' or 'bourgeoisie', and 'the educated middle class' seemed more relevant in the efforts to understand and define the various aspects of the concept of 'profession'. As Kocka concluded, it was difficult to investigate continental professions departing from the Anglo-American traditions and using the latter's definitions as one's conceptual arsenal. More recently, Siegrist (2001) has categorized professions into civil servants, members of state-appointed professions, "free" or self-employed practitioners, and free trades. Also Stichweh (1996, 1997) has pointed to such differences between the two basic views on professions: from the German perspective, occupations de-

fined as professions are not seen as related to the society as sub-systems of some one primary functional system à la Parsons (1970); instead, they are seen as directly related to sub-systems of society such as health care, justice, religion, education, and social welfare. Social work, from this perspective, could thus in several different ways be defined as a profession: it could be either an academic occupation, part of the educated middle class, or a category of state-appointed or self-employed practitioners. In Germany, social workers mainly work within the social welfare system, but are also found in health care and within the educational system. In other words, the Germanic and the Anglo-Saxon contexts differ in the way social work's relation to the society as the primary functional system and its sub-systems is understood and formally arranged.

In the Scandinavian countries, Anglo-American research, definitions, and concepts related to professions have not been subjected to critical scrutiny to the same extent. Some researchers have gone on to classify professions in a manner more responsive to the Scandinavian context, with the resulting categorizations, as with Stichweh (1996, 1997), rather more related to the subsystems of society than the society in general. Others have looked at professions from the perspective of their relationship with the state or of the legal protection of professional work tasks. In any case, the fiduciary relationship between the professions and the state has, characteristically, been more stressed than in Germany (Grimen 2008).

In the Scandinavian context, three different ways to categorize professions have been developed. Castro (1992) divides professions into four different types: market professionals, welfare professionals, subordinated professionals, and partisan professionals. This categorization lays emphasis on market and welfare professionals as interacting in complex and heterogenic interaction fields, with focus on (multi-) professional interaction within these fields. Brante (2011), on the other hand, has proposed a new time and context-independent definition for professions as occupations obtaining a specific status based on the currently dominating truth regime, such as for instance accumulated scientific knowledge. To help identify types of professions specific for a certain time period, he has put forth a categorization based on specific types of professional knowledge, yielding structure-oriented, technologically/experimentally oriented, and context-oriented professions.

Based on Castro's (1992) typology, the vast majority social workers would be classified as either welfare professionals (when working for social services) or subordinate professionals (when working in healthcare settings). In terms of Brante's (2011) typology, again, social work and nursing would be defined as context-oriented professions, while physicians/medi-

cine would fall within the technologically and experimentally oriented professions.

Elsewhere, Hellberg (1999) has coined the term 'life professions'. These deal with humans' legal rights and health by delegation of the state, and they can be said to be altruistic and knowledge-based. These professionals work in work fields protected by legislation, most commonly in the public sector or in state-subsidized private sectors. Social work could be defined as a life profession, albeit, in the case of Sweden, without the characteristic legislative protection.

To sum up, from an international perspective there is no one straightforward way to define social work as a profession the same way as one can define, for instance, medicine. Whether social work and its subgroups could be categorized as a profession or not depends on the importance researchers attach to the observed degree of professional freedom of social work, the functional system to which social work is related, and the status of social work in society. These difficulties in categorizing occupations context-independently as professions, semi-professions, and so forth apply to social work as well, as they do to a large number of other occupations.

Professionalization

Research on professions such as social work has also focused on the processes of professionalization. In these investigations, a variety of aspects have been brought into focus. Professionalization has been understood as a sequence of developmental stages, as a collective striving for labour market closure, and as a quest for improved professional status. Very often, it is collective professional actors such as, for example, professional associations that engage in such professionalization efforts vis-à-vis the state. Research since the 1990s has paid attention to the specific and changing state–profession relationships as a factor influencing professions' prospects for professionalization. The professions' internal efforts for professionalization, however, are, as a rule, noted only in passing. The main focus in professionalization research has, moreover, predominantly been on medicine and other healthcare-related professions operating in healthcare settings, with the efforts of social work for professionalization for the most part not looked at at all in the investigations.

Early studies on professionalization explored it as process consisting of a sequence of stages, which had to be passed in order to advance from being occupation to being a profession (e.g., Wilensky 1964). Later on, professionalization became defined as the collective effort to improve one's professional group's social-class affiliation and effect a change in its status position, as the striving for professional power by a knowledge-based monopoly, and as the collective striving of an occupation for market closure (Hughes

1971, Sarfatti Larson 1979, Abbott 1988, Freidson 1994, Macdonald 1999, Collins, 1990). According to Brante (1988), however, the approaches to professions drawing upon this perspective can nevertheless be described as "cynical", given that they place the professions' self-interests at the centre stage of the analysis. These analyses have also been claimed to be closely interwoven with the Anglo-American context, inhibiting understanding of professionalization in other parts of the world, especially in Germanic countries (e.g., Evans & Honold 2007, Gispen 1988, Littek, Heisig, & Lane 2005, Mann 1996, Macdonald 1999, McClelland 1990, Sarfatti Larson 1979).

In more abstract terms, knowledge-based monopolies and collective strivings to close the market for specific work tasks and fields involve the protection of the link between the profession and its work (Abbott 1988: 20), also called *jurisdiction*. More specifically, for example Molander and Terum (2008) have defined a profession's jurisdiction as the combination of autonomy and monopoly belonging to a certain profession in the performance of specific work tasks, which sometimes becomes formalized in the legal arena. In the case of "classical" professions such as medicine, for example, this is usually a matter of the state formalizing and institutionalizing a certain jurisdiction through legislation or public regulations. In other cases, professional jurisdiction might be formalized in job descriptions in the workplace arena. Professional jurisdiction is not, however, formalized in all arenas; as Abbott (1988) has pointed out, informal jurisdiction is what is more commonly achieved in the public arena and also in the workplace, where professions' jurisdictions might be subject to constant renegotiations. Professional jurisdiction draws and builds on symbolically significant elements such as diagnosis, treatment, professional inference, and a close relation to the academic discipline from which the profession's scientific knowledge derives (Abbott 1988).

Professions advance their jurisdictional claims in different arenas, including the legal, public, and workplace ones. In legal arenas, jurisdictional claims are made in order to induce the state to protect the profession's work; in public arenas, jurisdictional claims are raised in order to secure the public's support for the claims advanced in the legal arena; and in the workplace arena the claims for general professional jurisdiction are given their organizationally adapted versions serving organizational needs. Professionalization thus describes claims-making processes as they develop in formal and informal structures of daily work, processes whose aim is to monopolize a certain knowledgebase as well as certain work tasks and work fields. These claims can be advanced at a variety of levels to convince all the relevant actors involved. In consequence, jurisdictional claims-making tends to take place at the workplace level, at the level of professional associations, and at the public and the state level (Abbott 1988).

Jurisdictional settlements can attain different forms involving different arenas. What is common to all of the efforts involved, however, is the perception by the professions that the clearer the definitions put forward, the better they protect against intrusion from other professions (Abbott 1988). *Full jurisdiction*, first of all, is achieved when the relevant work tasks become protected through legislation and public regulations, including licensure rules. *Jurisdictional subordination*, on the other hand, describes an at least partial failure to establish one's occupation as a new profession or to separate a subgroup from a primary profession (Abbott 1988). *Intellectual jurisdiction*, again, describes the settlement of a process of jurisdictional negotiation where one profession is able to maintain its control over a specific knowledgebase while nevertheless allowing an intruding profession to conduct its work tasks. *Advisory jurisdiction*, for its part, entails a profession's legitimate right to interpret, buffer, and modify certain actions by other professions. Last but not least, *jurisdictional settlements at the workplace level* are attempts to solve problems arising in practice from contradictions between officially accepted jurisdictions of a number of professions. One possible solution in such cases is to allocate specific client categories to each profession.

Both Freidson (2001) and Abbott (1988) define professionalization as a negotiation process between state and professions whereby the state classifies certain work tasks and knowledge as particularly important and certain professions as trustworthy and competent enough to gain exclusive rights to the performance of these tasks. As a result of such processes, the professions involved in them may be given full jurisdiction, becoming regulated by licensure. The latter represents the most complete form of legal protection of a profession. It ensures that only as a member of that profession is one authorized to use its particular knowledgebase, special skills, and professional discretion to, as for example in the case of the healthcare professions, diagnose and treat specifically defined societal or health problems (Abbott 1988).

Full jurisdiction can include the delegation of licensing competence to professional bodies by the state to enable these to license members of a profession. To that way be given licensing competence could then be one goal for a profession's professionalization project (cf. Freidson 1994). The outcome in this case, however, is a situation where legal and public jurisdictions become interlaced (cf. Abbott 1988, Macdonald 1999). In any case, formal jurisdiction can also be pursued at the workplace level, for example through formalized written job descriptions or employment of instruments for standardizing specific work procedures, preceded by professions' negotiations in the workplace.

The dominant thinking around professionalization has been criticized in the German context by, for instance, Gispen (1988), who has pointed out how the term professionalization in that country rather describes efforts to advance professional status and occupations' general striving to improve their technical skills. Given this, it is then only understandable that German theorizing has been more centred on professionalization as the improvement of professions' capability to employ discretion (e.g., Oevermann 1996, 2008). From Oevermann's (2008) perspective, only human-service professions such as, for instance, physicians, psychologists, social workers, and pedagogues are defined as performing any discretion at all: only they possess the ability to interpret clients' crisis situation from a hermeneutic perspective, supported by standardized theoretical knowledge. In doing so, they strive to sustain and protect their clients' legal, educational, and informational interests as well as their biological, psychological, and social integrity with consideration to the clients' historical contexts and present situation. Also the research carried out on social work professionalization in Germanic countries has thus far been more focused on understanding the performance of inference by social workers (e.g., Dewe & Otto 2005), leaving the state–profession relationship of social work and its attendant phenomena such as the protection of labour market sectors to the sidelines.

In Germany, Anglo-Saxon research on professionalization was initially criticized for treating the state and professions as equal negotiation partners mutually reacting and adjusting to each other, or as mere cultural factors in the development of professionalization projects (Freidson 2001, Light 1995, Macdonald 1999). Indeed, professionalization in Central European countries had been shown by many to be a state-led process (e.g., Burrage, Jarausch, & Siegrist 1990, Kocka 1990, McClelland 1990, Siegrist 1988, 1990, 1996). There was even a suggestion that an essential distinction be made between professionalization in European and Anglo-American contexts (Brante 2003, Dent 2003, Gispen 1988, Torstendahl 1990). More recently, however, researchers like Evetts (2012) have argued there to be a process of convergence going on between the different theoretical systems in existence, with the theory of professions becoming more generally applicable across different national contexts.

Nevertheless, the processes of professionalization can undoubtedly be very much impacted by the professions' relationship to the state, given the capacity of states to act as important promoters or inhibitors of professions' professionalization projects. A number of authors have discussed professionalization in, for example, Germany and the United Kingdom as something characteristically performed "from above", with legal protection of the labour market for certain professions coming about as a product of political goals and state policy (e.g., Alaszewski 1995, Doherty 2009, Johnson 1995,

Kuhlmann 2006, Kuhlmann, Allsop, & Saks 2009, McClelland 1990, Siegrist 1990, Starr & Immergut 1987). In other countries such as the Scandinavian ones, the processes of professionalization have been located as taking place somewhere in between the two extremes of profession-led and state-led professionalization (Erichsen 1995). It has, furthermore, been pointed out that the state–profession relationship is not the same for all profession within a state (Dent 2003, Kuhlman 2006, Kuhlmann, Allsop, & Saks 2009). Some professions are assisted in their efforts to gain legal protection of labour market segments for them by either their status or their degree of integration with policy-making and corporative institutions. Other professions are hindered due to their de facto exclusion from the state apparatus despite the official state-policy claims to the contrary.

According to Wingfors (2004), for example, for the last 50 years the Swedish state has refused to officially sanction social work through legislation establishing labour market closure for it. In Germany, again, during the Weimar Republic social work education was controlled from above by political and welfare agency interests, despite social work associations' repeated attempts to influence governmental and welfare institutions in order to limit entrance to education by a numerus clausus (Hong 1990). Such state control over education and access to education has been characteristic of "professionalization from above". In general, however, at least in Germany the state's influence on professionalization, exerted through granting occupations and professions an exclusive right to sections of the labour market, has only rarely been investigated more thoroughly in the literature (cf. Stock & Wernet 2005).

Nevertheless, research has depicted specific healthcare professions in Scandinavia, Germanic countries, and the United Kingdom as being integrated into political institutions and, in consequence, also policy making (Dent 2003, Kuhlmann, Allsop, & Saks 2009, Larkin 1995). Maggetti (2009) and Erichsen (1995), for instance, have discussed such incorporation of the medical profession into the state system in Sweden and Germany. In Sweden, medicine has become integrated into the political administration, while in Germany state power requisites have been delegated to some specific professional and occupational associations by legally defining them as public corporative bodies.

This state incorporation promotes the dominance of healthcare professions and medicine above all, as it enables especially the latter to control other professions' access to power networks and use this ability of its to subject other professions (cf. Abbott 1988, Macdonald 1999). At the same time, however, the dominance of medicine extends also to the workplace level where supervision and standardizing guidelines for multi-professional work procedures such as strategies to maintain boundaries between domin-

ant and subordinate professions have become a tool for it (Halpern 1992). As noted by Timmermans (2002), however, this dominance can only continue for so long as the professional practice remains congruent with the profession's legal prerogatives. According to him, especially standardization produces only a rather unstable professional boundary, as it necessitates the monitoring and validation by other audiences. During the last two decades, this dominance of the medical profession has also been declining, with the empowerment of other healthcare professions more and more becoming integrated into healthcare policy making (Alaszewski 1995, Dent 2003, Immergut 1992, Samson 1995). As a result, the subordinate professions' possibilities of professionalization have become larger.

Existing research has identified a variety of strategies professions use in their striving for professionalization vis-à-vis the state. Immergut (1992), for instance, has examined ways to influence policy making by lobbying politicians and civil servants and through the authoring of official statements and parliamentary bills; of these, especially the latter two have shown themselves to be effective strategies in Sweden. Other popular strategies, especially among subordinate professions, include describing specific competences and contributions to political actors as well as displaying the specific role of the profession in a certain setting in practice (Kuhlman 2006, Pfadenhauer 2003).

In sum, professions and their subgroups such as social workers and HSWs strive to obtain protection for specific sections of the labour market. This they do in different arenas, pursuing different types of jurisdiction. The outcomes of their efforts, however, depend on their relationship to the state, on the prevailing political interests, and on the presence and influence of other, possibly dominant professions.

Professional bodies and their role in professionalization

Professional bodies are important collective actors operating in the labour market system (Parsons 1951a). Their role in professionalization is often noted in the literature on professions, especially in connection with their participation in the processes of allocation of role contents, or, the division of labour. In this role, they create work task descriptions and boundaries in interaction with other actors. They also develop, negotiate, and advance professions' collective claims and interests concerning the protection of specific segments of the labour market, both internally as well as externally vis-à-vis the state.

Professional bodies also strive for improving the status of the professions they represent; they are, moreover, promoters of professional change in order to help their associated professionals to better adapt to changes in society, they pass on professional values and knowledge, and they control

professionals both formally and informally (Abbott 1988, Becher 1999, Freidson 2001, Macdonald 1999). In Sweden, professional bodies are important stakeholders with representatives in the public administration through whom they can influence public policy (Evertsson 2002). Additionally, professional bodies promote the feeling of solidarity and collective identity among the professionals they represent, develop collective claims and professional norms and values, support academic work with the intent of developing a profession-specific language charged with a specific meaning, and define the range and scope of their associated professions' work tasks and work areas (cf. Goode 1957, Hughes 1971, Macdonald 1999, Siegrist 1990).

In spite of the occasionally expressed doubts concerning how representative professional bodies actually are of the professions and professionals they claim to represent, professional bodies are still seen as representatives of their associated professions vis-à-vis the state and its policy-making bureaucracy. They are also viewed as performers of cultural work promoting the application of acquired knowledge in daily practice and the legitimation of cultural values (Abbott 1988, Freidson 2001, Sarfatti Larson 1979). In other words, professional bodies such as, for example, professional HSW bodies have the ability to promote and directly contribute to professionalization, both internally within the professional group and externally vis-à-vis the state and the public and in the context of the workplace.

Trade unions' impact on the external professionalization of social work and HSW in Sweden has been examined by Wingfors (2004). What her study describes is the ambivalence of a major professional body towards promoting professional social work licensure for a professional subgroup in the country. The study also looks at the reasons why the professionalization projects of Swedish social workers in the second half of the 20th century always failed, identifying divergences of interest between the professionals and their trade union as well as ambivalence in the trade union's stance toward licensure for a relatively minor and narrow subgroup of social work. These diverging interests and ambivalences had to do with the interests of other segments of the union's membership base, composed mostly of the neighbouring professions of social care professionals who were merged into the social work profession and of human relations professionals during this time. The demarcation of a narrow and specific knowledgebase for social workers in health care conflicted with the trade union's mission to promote general social work professionalization rather than the interests of some specific professional subgroups and to provide union support equally to all its associated professions. In examining HSWs' professionalization in Sweden and Germany, it thus seems necessary to focus on the activities and stra-

tegies of professional bodies in these countries, as demonstrated by the above example.

According to Becher (1999), professional bodies can be categorized, among other things, into professional interest groups, professional institutions, and professional associations. It is predominantly professional institutions and professional associations that perform the function of interest representation on behalf of their constituencies. *Professional institutions* control entrance into the profession and apply obligatory membership; they often employ administrative staff and might operate as a trade union. They, furthermore, often also strive to control professional conduct and provide their constituencies with extensive services and resources. *Professional associations*, on the other hand, more typically have voluntary membership, have no paid administrative staff, and lack legitimation by the state. Even these, however, provide their members with specific services such as conferences, journals, and periodicals. *Interest groups* are even less formalized than professional associations, and often focus on activities that are rather more social in nature than cognitive, although they, too, promote the ability of their members to improve their skills and competences by providing advice and various kinds of support services.

In the literature on professions, compulsory membership in professional bodies is habitually assumed and is often addressed in relation to professional self-regulation (Freidson 1994). Nevertheless, organizational membership in professions such as social work and its subgroups tends more often to be voluntary. Professional bodies with compulsory membership promote the professionalization of professional subgroups internally and externally by developing standards, regulations, and definitions that the members of these subgroups then must comply with. When membership is voluntary, however, this compliance has to be achieved through means other than direct application of power. The most obvious way to induce individuals to be more compliance-ready is to make them sign up as members of a professional body. As Etzioni (1961) has noted, people are motivated to become members in organizations with voluntary membership when these organizations either address their specific needs or appeal to moral obligations. However, in order to induce, for example, HSWs in general, not only members, to comply with the standards, regulations, and definitions created by the professional body, it seems not enough to get them to join in as members; other factors are likely to be important as well.

According to Etzioni (1961), essential in developing voluntary compliance among members is to offer them possibilities for becoming involved in the development of the organization, including its values and norms as well as the exercise of its symbolic and normative power over organizational members. This symbolic power over voluntary members, as Sarfatti Larson

(1979) has noted, can be exercised by those members of the profession who produce the profession's knowledgebase through their involvement in the profession's education as representatives of professional bodies. Considering the point of Etzioni above, it seems then that professionals are more likely to comply with the professional standards, regulations, and definitions they take to be integral attributes of their profession with an underlying symbolic meaning if they become involved in the very development of these attributes. Articles in associational journals and other documents, for example, may be used to display specific symbolic meanings attached to professional attributes as represented by the collectively agreed-upon standards and definitions of the profession. Last but not least, also social control is used to secure voluntary compliance to professional norms, values, and attributes. According to Etzioni (1961), such social control in organizations with voluntary membership can be achieved through internalization of knowledge, norms, and values in ritualized activities such as congresses and further education.

Accordingly, professional bodies with voluntary membership such as the professional bodies for HSWs need to try to involve their members in the development of common professional norms, values, and attributes, if they are to improve their members' compliance to these. This can be accomplished through the formalization of professional attributes (by defining and describing professional work tasks), standardization of practice procedures, norms, and values, and the formalization of the rules for professional conduct. Even downward and horizontal communication can be an effective tool for achieving compliance (Etzioni 1961). Voluntary professional bodies such as those of HSWs, however, also have to exercise symbolic power and social control, by involving those with high symbolic capital, like the profession's knowledge elite, in ritualized further educational activities and in representing the professional body. It can further be assumed that compliance to professional attributes, norms, and values is especially critical for the development of a professional subgroup-specific identity when only a minority of those constituting the subgroup in fact affiliate themselves with the professional body. In these cases, it is plausible that measures need be taken to be able to embrace the entire professional subgroup, not just members of the association per se. Following Siegrist (1990), the strength and power of a professional body is not based solely on the amount of influence it has on state policy making; also its ability to develop and maintain a profession-specific or a professional subgroup-specific collective identity needs to be taken into account.

The extent to which professional bodies can influence the external and internal perception of the profession or the professional subgroup through the definitions they put forward in terms of professional attributes such as

work tasks, norms, values, and regulations, is difficult to immediately discern. In keeping with Etzioni (1961), however, the external impact of professional bodies concerns especially the pervasiveness and scope of the professional body. High pervasiveness, according to Etzioni (1961), is indicated by the organization's ability to set norms in a great number of contexts and activities both within and outside the organization. Consequently, pervasive professional bodies have a potential to impact policy making at the macro level as well as work task allocation for certain professional groups at the micro level. The scope of a professional body, in turn, describes its ability to reach more than only members with the definitions, standards, norms, and values it sets forth.

Yet, there are also other signs that tell of a professional body's external strength and power to pursue the interests of the profession. Such signs include for instance the professional body's ability to win media support for its projects and the public recognition of the body as the representative of the profession (see Abbott 1988, Macdonald 1999, Sarfatti Larson 1979). At the workplace level, a sign of the strength and power of a professional body is, for example, that local organizations adapt work tasks based on its recommendations. The professional bodies less interested in, or capable of, articulating a profession's cognitive base may be interpreted as leaving it to the professionals themselves to adapt their work tasks to local organizational needs (Abbott 1988).

Multi-professional teamwork in hospital settings

Several factors come into play when different dominant and subordinate professions come together to work side by side in multi-professional teams. Hall (2005), to begin with, has drawn attention to the challenges of multi-professional teamwork that derive from different professional cultures, having to do with differing professional attributes, customs, beliefs, and values. The above-noted differences that Gachoud and his co-workers (Gachoud et al. 2012; see Chapter One) found in the way the concept of patient-centred practices was understood by Swiss physicians, nurses, and healthcare social workers provide one example of these. In both of these studies, study participants reported themselves as perceiving professional cultures to constitute barriers to effective multi-professional teamwork.

Also hierarchies and differences in professional status between the involved professions are perceived as barriers in work task allocation and problem solving in multi-professional teams. Especially the relation between physicians and hospital managers has often been described as ambiguous at best. Hospital management members have reported it to be difficult to control physicians' discretionary freedom in multi-disciplinary teams with the help of common managerial methods (von Knorring, de Rijk, &

Alexanderson 2010). Collin and her colleagues (Collin et al. 2011), on the other hand, have reported on how work task allocation in multi-professional teams is negotiated amongst team members using different forms of power. Although the professionals' performance of specific work tasks in hospital settings is conditioned and regulated by law and hierarchical relationships, the authors describe how physicians' formal power is contested and how specific individuals in certain situations, employing strategies such as manipulation and resistance both verbally and non-verbally, transgress their designated boundaries.

Paloniemi and Collin (2012) have described power relations in healthcare teams as necessitating practical and collective creativity. Team members need to be able to develop practical solutions for how to reconcile the different professional views in the team. In this situation, subordinate professionals use collective creativity and discursive power to solve practical problems. What is needed for this, however, is support from the group and from the powerful individuals who make the first move. This precondition is of particular importance, since the superordinate positions/statuses and highly ritualized interaction as found in hospital settings can also be instrumentalized in order to silence subordinate team colleagues (Salomon & Ziegler 2007).

Bolin (2011), for her part, has discussed how professionals in multi-professional teams switch between a shared professional team identity and their own professional group specific identity. Reese and Sontag (2001) as well as Kvarnström (2008), again, have examined how lack of knowledge about team members' different knowledgebases and expertise, differences in professional values, and role blurring cause difficulties in inter-professional team performance. Mitchel, Parker, and Giles (2011), somewhat along the lines of Bolin (2011) above, have drawn attention to how professional identity influences inter-professional interaction, with team-related identity moderating the effects evolving from the interaction between diverse professions in healthcare teams; professionals threatening the professional identity of other team members in the multi-professional teams were, however, likely to provoke only hostility in this study.

Previous research, in other words, has tackled many different aspects of multi-professional teamwork and its obstacles. One major conclusion to be derived from the findings of the existing studies, however, is that professionals with weaker professional bodies may more easily develop shared professional identities in multi-professional organizations, compared to those with stronger professional bodies. The ability of a professional body to develop and impart a professional identity for its constituency is thus likely to impact on the effectiveness of the work performed in multi-professional teams, in healthcare settings just as elsewhere.

3.2 Jurisdictional work

As already noted, professional jurisdiction is something that remains subject to constant renegotiation, especially in the case of professional subgroups like HSWs that operate in a subordinate organizational position. These groups' jurisdiction is likely to be more unstable than the jurisdictions of dominant professions. In their case, the negotiations about professional jurisdiction are more likely to focus as much on the autonomy aspect as on the monopoly aspects of the jurisdiction, compared to the more established professions in the organization. Accordingly, the concept of jurisdiction as used in this dissertation includes both of these aspects in equal degree, covering both formalized professional monopoly and professional autonomy. Formalized professional monopoly as an aspect of jurisdiction is expressed in legislation, public administrative regulations, and job descriptions. Professional autonomy within a certain jurisdiction, again, is reflected in aspects of the profession's identity, including the right to define relevant work tasks, the relevant knowledgebase and work methods, and the relation between the professional subgroup and its primary profession, or the profession of which the group defines itself to be a subgroup.

Jurisdictional work in this dissertation refers to an interaction that has a processual and negotiative character. On the one hand, this interaction occurs internally between members of the same profession or professional subgroup; on the other hand, it occurs externally with different actors at the national, inter-professional, and organizational levels. Its goal is to stabilize a profession's relation internally to its members and externally to society, by continuously re-negotiating the social order of professions in given contexts, which in the present case are health care and social welfare.

This way, jurisdictional work aims at the formal settlement of jurisdictional disputes both inside the profession and outside it, in the legal, public, and workplace arenas where it operates. Jurisdictional work can be performed by professions or by specific subgroups of a profession, and it can be analysed from different, although often overlapping perspectives. It can, for instance, be studied by looking at aspects such as boundary work, identity development, negotiation of social order, and claims-making. The sections that follow describe and discuss these different perspectives on the jurisdictional work of professions and their subgroups more closely.

Boundary work

Boundary work is a term originally used for investigating the relation between science and non-science (Gieryn 1983) and the relation between scientific disciplines (Becher & Trowler 2001). Nevertheless, it can be, and

is, used to investigate jurisdictional work by professions as well. The term describes the attempt to create social boundaries around specific professions in order to distinguish these from one another, or to differentiate different subgroups within one profession from one another. This is done mainly by selecting specific characteristics and defining them as attributes of a profession. The characteristics that come into question are to demarcate a professional knowledgebase in the profession's field of interest, and they include the definition of specific work tasks earmarked for it (Fournier 2000, Gieryn 1983). The process of selecting and attributing these specific characteristics can be seen as the profession's quest for defining itself by characteristic attributes. These attributes are charged with symbolic significance and defined as either typical or atypical, and they serve to demarcate the profession from other professions or distinguish a subgroup from its primary profession. In the course of this definition work, boundaries are erected around the symbolic attributes, often circumscribing particular tasks and procedures as the profession's "own" in relation to research, legitimation, and education. In this fashion, for example, social work in Sweden has developed for itself a trade union-administered licensure (see Wingfors 2004). This licensure can then be understood as precisely the kind of symbolic attribute of the profession that aims to demarcate social workers from other social science-based professionals.

However, also culturally entrenched professional values and norms can be used as attributes defining a certain profession, such as ethical codes. Becher & Trowler (2001) have shown the demarcating boundaries to be constantly changing, seeing in the degree of their permeability an indication of, in their case, the discipline's coherence, stability, or fragmentation. The authors also discuss the breakdown of boundaries when disciplines merge and the erection of new boundaries when they specialize, causing fragmentation within disciplines. In any case, boundary work must be constantly performed to enforce and maintain social boundaries by symbolic means, which can be actual or desired attributes, norms, and values (Lamont & Molnár 2002).

Already Talcott Parsons (Parsons et al. 1951a) analysed professional bodies as collective actors within the labour market system. These bodies, according to him, influence the allocation of specific work tasks to specific professions, itself descriptive of boundary work. Professional bodies, however, also engage in continuing professional education and training (Becher 1999), and professional practice itself very often presupposes initial university education and practical training (Oevermann 1996). This training and education, too, can be understood in terms of professional boundary work, answering as it does for the mediation and development of the internal notion of professional boundaries.

Several studies have addressed themselves to boundary work in social welfare and healthcare settings, looking at both the development of internal boundaries between subgroups of a profession and the enforcement and maintenance of inter-professional boundaries in multi-professional contexts. Research focusing on boundaries between professions and subgroups of professions often uses terms and concepts plucked from academic political science as analytical tools adjusted for its purposes. These include metaphors such as territories, controversies, conflicts, territorial demarcation, rivalry, rural and densely populated areas, and the like.

Allen (2001) has described how discursive strategies such as the use of atrocity stories are employed as a tool to internally demarcate subgroups of a specific profession from one another. Drawing on horror stories derived from daily practice, competing professional subgroups put forward narratives illustrating why competences of other subgroups are less suitable than their own for coping with certain situations. Liljegren (2008), in another context, has examined the way different arguments are used in order to position professional subgroups in relation to one another. Arguments following the professional domain's logic were employed to establish higher-status subgroups, while subgroups resorting to arguments following the organizational domain's logic were relegated to a lower status position within the profession. Internal professional boundary work, however, also entails, according to Halpern (1992), the need for emerging subgroups to announce their interests in a way that presents them as compatible with those of the older and more prestigious subgroups. As Halpern (1992) and Burri (2008) have shown, it is nevertheless also essential to claim a knowledgebase or at least a technical expertise that can be perceived as substantially different from that of other subgroups.

Research on boundary work among professions in multi-professional settings such as hospital settings shows professions to use different strategies to enforce and maintain their professional boundaries, depending on their status position and the degree of spatial and temporal proximity of their co-operation. While closely co-operating professions tend to use negotiation as a strategy to establish professional boundaries, more loosely or remotely co-operating professions are more likely to use conflict strategies (Sanders & Harrison 2008). As in intra-professional boundary work, atrocity stories are described as tool to demarcate inter-professional boundaries (Timmons & Tanner 2004).

Different kinds of claims can be used to argue for a specific jurisdictional setting of inter-professional boundaries. Overall, jurisdictional claims follow one or several of the three basic types of domain logics: a professional, an organizational, and a political logic. The latter, quite often, draws upon ideas and notions with almost a paradigmatic impetus such as, for example, a

"patient-centred" or a "holistic" perspective. Predominantly professions with high status positions within the team or a well-established status within the society tend to exclusively use arguments following the professional logic, centring them on, most commonly, specific expertise or technical skills (Sanders & Harrison 2008). Newly established professions, in contrast, are likely to combine arguments following the professional logic with arguments following the organizational or political logic, centring these on economic efficiency or patient-centredness (McMurray 2011, Sanders & Harrison 2008, Timmons & Tanner 2004, Welsh et al. 2004,). In rare cases, it seems also possible for individual subordinate professionals to seek support from well-established dominant professionals, to be able to announce their specific claims (McMurray 2011).

Identity development

Professional boundary work and the development of a collective profession-specific identity are overlapping concepts. A profession-specific group identity is often developed to erect boundaries towards other professions. The literature on both professions and social identities commonly refers to boundary work (Jenkins 2004, Liljegren 2008).

On a general level, identity development involves the establishment of two aspects: similarity and difference (Jenkins 2004). The identification of "A" means that it shares some key attributes with all other "As". These attributes in turn distinguish the thereby identified entity or person from all "Bs" and "Cs". After that, one associates either oneself or others in relation to these two aspects, practicing identification and classification. This identity, however, always remains fluid (as do boundaries) and identification a continuous process.

Like individuals, also social groups may develop a collective social identity (Jenkins 2004). In the same fashion, furthermore, also jurisdictional work by HSWs can be understood as the identity development of a professional subgroup. Internal collective identification yields an image of a plurality of similarities between the group members, in terms of, for instance, their behaviour, context, and/or situation. Those sharing the similarities, however, have to first agree on the fact – that they indeed share similarities. This does not, however, mean that they actually have to behave uniformly or that no local variations in the interpretation of similarities may occur; it is more important for the development of a social group that its members *believe* themselves to be sharing certain similarities.

Those sharing similarities in a particular social group, however, also have to agree on how much difference they can tolerate while still being able to affirm belongingness to the one and the same group. Nevertheless, the membership of the social group at the same time continues to evolve as the

group's boundaries keep developing. The resulting social boundaries are cumulative in nature and develop in interaction between members of one group and members of another group. In this interaction, relevant group attributes are developed, examined, and negotiated, and specific attributes are constructed as symbolically significant common or distinguishing attributes. A collective identity, moreover, also encompasses specific descriptions of how the group in question relates to other groups. Collective identities, in other words, are established as qualitative descriptions resulting from negotiations and agreements (Straub 2002). Consequently, the jurisdictional work of HSWs entails two things: that HSWs engage in internal efforts to define themselves as a social group, and that they define their "external" relation to social work and other professions around them. Specific arguments as well as attributes, values, norms, and goals can be used as suitable significant symbols for a common professional identity (Heggen 2008).

Collective identity work can be performed by organizations, and collective identity can be develop when social groups acquire, claim, and allocate power in relation to their contextual setting. The formalization of commonly-agreed shared attributes, values, norms, and organizational goals is important in order to enable their internalization by members of the organization (Etzioni 1961). Consequently, this formalization of common attributes may also help members of professional bodies to better internalize their shared professional identity including attributes, norms, values, and goals. As a result, professional bodies may develop into significant actors in the creation of a collective profession-specific or subgroup-specific professional identity.

Professional bodies with compulsory membership may then assume the role of professional identity developers and controllers of entrance and exclusion in regard to the professional community (Sarfatti Larson 1979). Especially they, but also other bodies, keep for this reason developing ethical codes, with some of them even controlling compliance claiming a right to dismiss members for misconduct (Jonnergård & Erlingsdottír 2008). The professional bodies with voluntary membership, however, lack tools to supervise entrance into, and exclusion from, the profession, and may therefore put more emphasis on the development of a professional group identity. Any formalization of professional control systems by professional bodies may threaten the development of this collective professional identity, given that their end result is the inclusion of certain professionals and the exclusion of others (Freidson 2001). The professional group might then be divided into those sharing the collectively agreed attributes, norms, and values and those who stand outside this collectivity. According to Freidson (1994, 2001) and Lamont & Molnár (2002), shared professional rituals are therefore more suitable for the development of a profession-specific iden-

tity. These may include recurring conferences, further education activities, peer supervision, collective discussions about professional attributes, norms, values, and claims, as well as recurring occasions for discussing internal specialization within the profession.

To perform jurisdictional work, understood as the development of a profession-specific or subgroup-specific professional identity, professional bodies can resort to a variety of tools. Lamont and Molnár (2002) have pointed to the particular importance that, for example, the creation of an interrelated web of symbols has for them, in contributing to their members' feeling of belongingness to the group. Language, too, is an arena for symbolic interaction to enhance collective identification (Jenkins 2004). The use of professional terms in HSW is one example of a situation enabling only members to participate in the conversation, with all the others excluded from it. The language employed is, in part, passed on in professional (further) education, when the knowledgebase involved is abstract enough (Sarfatti Larson 1979). The specific languages in question may, however, also be developed within the professional bodies themselves, for example by creating new classification systems or through adaptation of general professional knowledge to the specific context of the work field represented.

One way to use language in the development of a group-specific collective professional identity is employing it for the creation of narratives with a uniting symbolic significance for the professional group or subgroup involved. Telling and re-telling shared, specific narratives contributes to a perceived proximity between the members of the group or subgroup, while also, in the case of subgroups, helping to distinguish one's own group from all other groups within the profession. As Ricoeur (1992) has shown, narratives can be used to develop a narrated identity, an understanding of oneself gained through the narration of one's own life-story. In professional groups, narratives are used to contextualize and generate meaning (Torsvik 2008). They can thus be said to represent a profession's institutionalized self-perception (Heggen 2008). Collectively shared narratives are nevertheless not uniform but can vary depending on the individual telling the story. The discourse, however, or, rather, the essence of the story, remains constant. Narratives can also be used to set the professional group in relation to its history, so as to be able to describe the profession's perceived present as well as its perceived jurisdictional problems. These narratives can then be understood as describing the characteristics constructed for the profession or the professional subgroup as its symbolically significant markers. They are meant for the group's internal consumption but simultaneously also serve to distinguish the professional group from, or connect it to, the primary profession and other professions.

Even the process of defining professional characteristics in collective action can be understood as a way to produce symbolically significant professional attributes to be shared by the specific professional group or subgroup. It can thus contribute to the development of a professional group-specific identity. In general, however, the professional characteristics so defined tend to relate to specific work tasks (e.g., diagnosis, inference and treatment, as well as professional discretion in general), specific classification systems (e.g., for diagnosis and treatment), specific skills, or specific standardizing instruments for work procedures.

To be able to refer to, and fall back on, a unique knowledgebase is typically considered as an essential requirement for fields to become professions (e.g., Abbott 1988, Etzioni 1969, Grimmen 2008, Macdonald 1999, Oevermann 2008). Following Jenkins (2004), association with a specific academic discipline could therefore be understood as a further professional attribute with symbolic significance for the specific professional group or subgroup, linking it to a distinct knowledgebase. Here the amount of theoretical input received from the associated primary discipline – social work in the case of HSW – can be of particular importance as a uniting or distinguishing attribute that professional subgroups can then use when defining their relation to the primary profession, affecting as it does the degree of perceived proximity or distance between the professional subgroup, its primary profession, and the neighbouring professions.

As Dellgran and Höjer (2011) have noted about social work, knowledge development in the periphery as for instance social work in health care is marginal. Nevertheless, the presence of professional specialists engaged in research and theorizing is vital even for professional subgroups, to be able to ensure the transmission and availability of latest knowledge (Freidson 1994). If, however, the primary discipline fails to produce sufficient knowledge for the use of its professional subgroup, this subgroup may perceive the discipline instead as incapable of delivering the needed knowledge. This, in turn, may contribute to the professional subgroup's turning to other disciplines for their knowledge. In such a case, the subgroup may begin to see the knowledgebase associated with its primary profession as more distant and less relevant for their practice, leading to a situation where there are not enough attributes with symbolic significance to link the sub-profession more closely to its primary profession. Where this is so, the perceived degree of proximity with the primary profession begins to differ from the formally proclaimed one, and the professional subgroup may begin drawing upon attributes shared with other professions instead.

Negotiations

As already noted above, the development of collective professional identity calls for negotiation amongst members of the profession or professional subgroup. There is, however, also a need for professional groups and bodies to engage in negotiation, as a collectivity and in the name of the collectivity. In this subsection, jurisdictional work is thus discussed in terms of professional bodies negotiating the role of the profession or the professional subgroup in relation to society.

Negotiations about jurisdiction can be understood as an attempt to integrate professions or their subgroups into the broader social order, in dialogue with other actors in society. Following Abbott (1988), these negotiations can be said to represent an attempt to arrive at agreements on division of labour, allocation of specific attributes to individual professions, and the place and position the professions occupy in the social order in relation to other professions and stakeholders in state, public, and worksite arenas. As Jenkins (2004) has stressed, identities are negotiated at their boarders, where the external categorizations meet the internal identification. Especially professional subgroups in subordination have a twofold need to negotiate their specific professional attributes, norms, and values with external actors and lobby for labour market closure.

In these negotiations, bargaining is used as a strategy to reach an agreement which is mutually acceptable to the parties involved, whether these be individual or collective actors. Whether these negotiations follow a specific pattern is an issue still unsettled in the literature, but the consensus appears to be that they tend to result in the establishment of particular orders (Fine 1984, Goldman & Rojot 2003, Strauss 1993, 1978). According to Fine (1984), smaller-scale negotiations occur between individuals as an adjustment strategy intended to make one's action conform to policies, traditions, and structure, while larger-scale negotiations take place between representatives of collective actors aiming to impact structures, policies, and traditions.

Strauss (1993) has argued that all actions and interactions, of which negotiations are one example, have a certain trajectory encompassing aspects such as phasing, projection, scheme, arc of action, and management. Goldman & Rojot (2003), on the other hand, see negotiations as more flexible and depending in the evolution of their course more on factors and circumstances such as participants' recognition of one another's worth and dignity, their respect for mutual interests and needs, the skills and behaviour of the negotiating individuals, and the strategies and tactics employed. Structural factors influencing a negotiation's course, to follow Fine (1984), include the number of the negotiators, their experience, the instance or person(s) they represent, the structure of the negotiation process (sequence

and frequency of the interactions), the power balance between the parties, the number of issues negotiated on, the complexity and interrelation of these issues, and the interests represented. Other conditions influencing it include temporal aspects, the fact whether negotiations are held hidden from the public or not, and whether there are alternatives to negotiation or not.

Several strategies used in the negotiation of professional jurisdiction have been identified in the literature. In contexts where it is dominant and subordinate professions that are the parties to the negotiation, the strategies used are aimed at, respectively, establishing/maintaining domination and subordination, or counteracting domination by other professions and one's own subordination. Hughes (2010), again, has looked at the use of gendered strategies such as belittling and silencing by a dominant (male-dominated) profession pursuing its political interests vis-à-vis a subordinate (female-dominated) profession in policy-making bodies. Salhani and Coulter (2009), for their part, have analysed strategies used to maintain professional dominance at the workplace, such as the exercise of power through majority decisions, strategic collaboration, marginalization, direct coercion, supervision, and use of ideology.

Some strategies are especially well-suited for presenting the contributions of one's profession in a specific setting; others lend themselves more to the strengthening of one's power position in co-operation with others. Professions may, for example, strategically use certain forums at the worksite and state levels to perform their proclaimed professional role and demonstrate their particular competence and contributions (Jonnergård & Erlingsdóttir 2008, Pfadenhauer 2003). This strategy is targeted at actors in the legal and executive branches of the polity and meant to convince these of the validity of the professional and jurisdictional claims advanced. It, nevertheless, tends to be the dominant professions that more often win the ear of the target audiences when it comes to questions like the interpretation of policy issues or gaining support for one's interests from, for example, the media and the public bodies (see, e.g., Abbott 1988, Macdonald 1999, Sarfatti Larson 1979). The professional bodies of subgroups and subordinate professions may therefore have to find new communication channels for communicating their claims to the public.

Building open cartels with other stakeholders is yet another strategy used in jurisdictional work. In open cartels, professional organizations co-operate with other organizations that share their interests in order to be able to more effectively pursue their claims (Åmark 1990). These organizations could be lobby groups, political pressure groups, clients' and consumer organizations, health insurance funds, or, in some cases, the state and municipalities. Parallel to this, as Maggetti (2009) and Abbott (1988) have

pointed out, subordinate professions are denied access to policy-making, legal, and executive arenas. In these situations, co-operation in local, state, legal, and executive arenas can then be resorted to to that way establish new de facto forums where subordinate professions can directly relay their issues.

Selander (1990), for his part, has discussed how networking between professional associations and university institutions may be used to gain control over a legal jurisdiction. By networking, the two can co-operate around the development of educational systems to that way gain control over a specific knowledgebase. Even trade unions may become part of these networks. In them, the parties can join their efforts to strengthen their arguments, based on common interests. As Salhani and Coulter (2009) have shown, by harnessing the collaborative power of networks, subordinate professions can then put themselves in a better position to pursue their jurisdictional claims vis-à-vis dominating professions. Acting in consort, subordinate professions may accumulate enough power to make claims on the intellectual jurisdiction of a dominant profession, in the best case resulting in new formal jurisdictional settlements (Abbott 1988).

Jurisdictional settlements may be formalized through legislation in the legal arena, by public regulations in the public arena, and in job descriptions at the workplace level. The job descriptions produced, however, often merely transfer professional jurisdiction from the superordinate levels to the workplace level. Yet, workplace jurisdiction is often cross-cut by, and adapted to, organizational interests. Especially when working output is valued more than credential input, professionals can be obliged to compromise with other professions on a workplace jurisdiction that differs from the jurisdiction in the other arenas (Abbott, 1988: 64). Professional jurisdiction at the workplace level is also likely to lead to assimilation of work tasks between different professions, and to facilitate teamwork in multi-professional organizations.

Claims-making

Last but not least, jurisdictional work can also be understood as claims-making. In these cases, language is used as a tactical tool for putting forward claims about professional interests (concerning things like jurisdiction and identity), enabling actors to strategically bargain with external actors. Claims-making can concern the profession's knowledgebase, the classification systems used in diagnosis and intervention, discretion, or professional norms and values (Abbott 1988, Etzioni 1969, Grimen 2008, Macdonald 1999, Oevermann 2008,). Claims-making employed to establish, maintain, or extend a profession's formal jurisdiction in legal, public, and workplace arenas is one of the major tasks of professional bodies (Abbott 1988).

Political claims-making is usually normative in nature, and it is practiced to persuade other actors to act in a certain way (see, e.g., Karlsen 2012). The same tends do apply to the claims-making resorted to by the professional bodies of HSWs in connection with their jurisdictional work. Its goal is to influence the actions and behaviour of policy makers, organizations, and professions in the healthcare sector and in healthcare policy making. In claims-making, certain specific claims are raised. These claims must be proven legitimate using specific arguments that can persuade others. In normative claims-making, also alternative claims can be employed to describe the consequences of acting in contradiction to the raised claim. Arguments supporting a claim can thus be either descriptive or normative, just like the claim itself; when relating to facts, they are descriptive. Indeed, claims can be supported by an indefinite number of arguments. Together, the claim and its supporting arguments create a way of sound reasoning on behalf of the point of view raised, substantiating the claim as well as possible.

As Karlsen (2012) has pointed out, the claims put forward have to be sufficiently precise to ensure their intelligibility in the context. For this reason, they typically need to be articulated clearly and explicitly. In addition, all those involved in the claims-making process need to be in possession of in-depth knowledge of the particular context in which the claims are raised, and understand the language to be used in this context. They must all be able to participate in the language community of the context and be able to use the terminology of the context if they are to be able to formulate sufficiently precise claims and judge whether the claims they raise indeed are sufficiently precise or not. In other words, they need to become members of a community where they use the language and the specific terminology of the context. At the same time, they need to keep in mind that claims seen as sufficiently precise by the members of a community sharing the same language may still as perceived as imprecise by those outside it (Karlsen 2012).

Indeed, when jurisdictional claims-making by professions is directed towards the public and other external contexts, the senders (professions) and the receivers (policy makers, other professions, organizations, others) of the message are not nearly always members of the same language community. They may operate in entirely different arenas (legal, public, or workplace) or represent entirely different professions or academic disciplines, to name but two possible scenarios. Professional bodies, therefore, must resort to context-specific language when arguing for a particular settlement of professional jurisdiction. This is especially true of the strategies used by professional subgroups in their claims-making in multi-discipli-

nary and policy-making contexts where they operate in a subordinate position compared to other professions and stakeholders.

In multi-professional organizations, subordinate professions may use linguistic symbols of the dominant profession strategically in order to increase the effectiveness of their claims-making activities. Following Karlsen (2012), paramount arguments and claims that are put forward in claims-making using clearly defined terminology are more likely to be perceived as precise, sustainable, and relevant by those they are intended for. Especially in situations where claims-making targets audiences in other contexts, explicit arguments and precision are of vital importance to ensure the intelligibility of the claims put forward.

To be able to evaluate arguments and their persuasiveness in claims-making, those in the target audience must first examine the sustainability and relevance of the reasoning behind the arguments (Karlsen 2012). The sustainability of arguments can be examined by separating the argument from its place in the overall line of the reasoning and then assessing its acceptability independently of the role it has in the latter. The relevance of an argument, on the other hand, is judged by asking whether it, the argument, if it is accepted, will make a difference in the overall line of reasoning (Karlsen 2012). Sustainability arguments and relevance arguments can both present themselves as pro or contra the claim put forward. Pro-type arguments strengthen the sustainability or relevance while contra-type arguments weaken these. Consistency in argumentation improves its persuasiveness. One major alternative for the use of supportive normative arguments is the employment of descriptive further arguments, which present possible alternatives for action or future situations. Argumentation relying on these implicitly compares possible consequences and, at least to some extent, hides its own normative origins from sight. The sustainability of such arguments is, again, judged by assessing the argument's acceptability based on how realistic the consequences described in fact are (Karlsen 2012).

In claims-making where the claims-makers, such as HSWs, attempt to reach audiences in other contexts (e.g., policy makers, other professions), the sustainability and relevance of the arguments used may be judged differently by the senders and the intended receivers of the message. The claims-makers may therefore attempt to adapt their arguments for their audience's context to make them appear as sustainable, relevant, and thus persuasive in that environment, too (whether it be, as in the present case, policy making or a multidisciplinary care setting). An argument put forward is more likely to be perceived as relevant and sustainable when terminology familiar to the target audience (terminology from the audience's own context) is used to advance it. In other words, good knowledge of the relevant symbolic ter-

minology and language use is of vital importance when claims-making is addressed to actors belonging to other contexts.

Grape (2006) has analysed different organizational fields as having partly diverging interests and means in the provision of welfare services. Healthcare service area provides one example of this. Following Grape, health care could be viewed as an organizational field, with healthcare service provision representing a specific domain of activity. In this organizational field, numerous actors from a variety of arenas contribute to the provision of healthcare services, each following its own specific logic. Actors from the legal arena, for example, would be likely to focus on the creation of a reliable, egalitarian, and high-quality healthcare service provision system via legislative acts, follow a social-policy logic. Actors from the executive public arena, on the other hand, would rather focus on the interpretation and implementation of social policy, largely regulated by legislation and through sub-legislative regulations to be complied with, but nevertheless following a public-administrative logic.

Local healthcare service providers such as hospitals could then be examples of the latter. The professionals working for them focus on the provision of high-quality healthcare services within given economic frames; they could be assumed to follow an organizational logic. Their professional bodies, on the other hand, focus on financing, organizing, and delivering healthcare services through autonomously operating professionals, with the intention of ensuring best possible practice; they, for their part, could then be said to follow a professional logic. In claims-making in a specific activity domain, actors from the same organizational field raise arguments intended to strengthen their own interests. As Grape (2006) and Evetts (2004) have shown, however, claims emanating from the legal and public arenas tend to override professional interests. For this reason, professions, even while pursuing their own professional interests, might use arguments that follow the logic of the legal, the public, or the workplace arena. As Abbott (2005) has argued, effective claims-making concerning professional jurisdiction is dependent on a profession's ability to establish argumentative links to other arenas and their logics.

Abbott (2005) identifies two possible ways to create such links between different arenas and their logics in claims-making: through "hinges" and "avatars". Hinges, for him, are issues and strategies that work in both contexts, while avatars are attempts to institutionalize copies or colonies of actors in other contexts. Hinges, in other words, can be arguments used to represent professional interests by playing on legislative, public, or workplace interests, and avatars attempts to inscribe aspects from one arena into regulations of another arena or to entirely transfer a specific organization from one arena to another.

The use of hinges may serve several ends. To begin with, a profession might aim at sustainable argumentation. In order to be able to argue for its being a part of a specific context, it could then use the terminology of the particular arena or logic in question. In doing so, it at the same time makes it possible for actors from that other context to use their own terminology to evaluate the arguments put forward. In this process, symbols, which here would consist of that context-specific terminology, are thus used to establish relations with other professions and actors in other arenas. When these other actors are policy makers, the use of this terminology might then make it possible for the arguments put forward about, say, professional jurisdiction to be perceived as attractive enough for them to end up being used in the other party's policy-making context as well. In such cases, however, the professions will expect this use of their arguments in the new context to serve not just the interests of the policy makers employing them but, to an equal measure, also the interests of their own (cf. Abbott 2005).

Secondly, hinges can be used to signal whether the profession employing them intends to integrate into or differentiate itself from its hosting context. Professional bodies sometimes use terms reflecting state or other organizational interests as hinges to link their professions' claims-making and profession-specific interests to the interests of these other arenas and their logics. Following Jenkins (2004), HSWs might use symbolically relevant terminology in their jurisdictional claims-making in the healthcare sector in two different ways. On the one hand, symbols are likely to be used to underpin claims made for being part of a specific social group, as in the case of HSWs claiming to logically belong to the healthcare sector and have a natural place in it; on the other hand, they are also used to demarcate the identity of one's own professional group from that of other groups, as in the case of HSWs' attempts to demarcate themselves as a specific group within the healthcare context. Symbolically charged terms derived from other logics can thus be seen as a uniting device enabling one to cross boundaries between different arenas and interests, with profession-specific terms serving to demarcate boundaries between the logics engaged in the argumentation (cf. Gieryn 1983, Lamont & Molnár 2002).

Thirdly, a professional body might use hinges to argue for the relevance of certain of its claims. For minor professional subgroups in multi-professional teams, such as HSWs, it may well be necessary to use terminology (specific linguistic symbols) belonging to other logics to be able to persuade policy makers, other professions, and organizations of the relevance of their jurisdictional claims. They may, however, also need to be able to transfer profession-specific terms of symbolic character across contexts, for example by giving them new significance in the healthcare context as in the case of HSWs, to that way be able to more readily and effectively reason with actors

from the target sector about the arguments and claims they have put forward.

A second way to link professions to other arenas is to use what Abbot (2005) has termed avatars. These, for Abbott, are copies or colonies of actors institutionalized in other arenas or contexts. An example of the use of avatars would be the attempt to expand the work field of a profession or a professional subgroup to cover at least parts of work fields belonging to other contexts within the hosting organization in which that profession or the professional subgroup has not previously been represented.

In jurisdictional claims-making, claims aiming at colonization through the use of avatars are likely to concern one of two different aspects of symbolic significance to the profession: professional practices or organizational structures. The colonization of professional practices could, for example, be attempted through the application of symbolically significant terminology and practices in another profession's context.[21] Colonization of organizational structures, on the other hand, could be attempted through the integration of a profession's symbolic practices into the organizational and institutional structures of the hosting arena.[22] The adoption of symbolically charged professional terms or practices belonging to another profession in the hosting context and its reverse-direction counterpart, the invasion of another profession in the hosting context with one's own terms or practices, can thus be seen as two strategies to cross or demarcate professional boundaries through claims-making. The former, implying the accommodation of other arenas' avatars in one's own context, tells of a profession's ambition to integrate itself into the hosting arenas' structures, while the invasion of other arenas through the use of avatars is a sign of the profession's ability to impact other arenas and demarcate its own practices and structures. Following Jenkins (2004) and Lamont and Molnár (2002), claims-making geared toward accepting the language and structures of other professions and organizations thus indicates the willingness of a professional body to integrate the identity of the professional (sub-)group into its surrounding context, while the invasion of the hosting context with avatars from one's own profession indicates a desire to demarcate one's identity from the surrounding context.

In the context of this dissertation, hinges are understood in terms of professions using in their argumentation specific symbolically charged terms and logic belonging to other arenas, with the intent of enabling actors from these other arenas to better understand the reasoning behind one's claims. This is something the professions may also do in collaboration with

[21] An example of this is the use of medical terminology such as 'diagnosis' also in the professional language of social work.
[22] In the case of social work, this might be done by including the profession's own symbolical terms such as 'clinical social work' in corporative contracts.

other actors. Hinges operate in two directions. Accepting a hinge, first of all, means that symbolically charged terms from other arenas and professions are adopted for use in the profession's own context. Invading through the use of hinges, on the other hand, can take place in two different ways: either by filling symbolically important terms from another arena or profession with significance specific to one's own profession and then using them in argumentation, or by using symbolically important terms from one's own profession and filling it with meaning that actors in other contexts are able to understand and perceive as relevant to their context.

Avatars are in this dissertation understood as a device for institutionalizing copies or colonies of a profession and its activities in other arenas. Avatars, too, work in two directions. Accepting avatars implies a profession's willingness to accept structures, methods, and the like from other arenas or professions and incorporate them into its own practice. Invasion of other arenas through avatars inserted into them implies that a profession's practice is being integrated into the structure of other arenas, such as the administrative structures of the workplace arena or the policy-making, legislative and public-administrative structures of the political arena.

This chapter of the dissertation has, in its first part, presented its theoretical background drawing from the theory of professions, discussing relevant characteristics of professional bodies and aspects of multi-professional teamwork. In the second part of the chapter, jurisdictional work was discussed in terms of professional bodies' strategies of boundary work, professional group identity development, negotiation of their position in a specific social order, and claims-making. Against this theoretical background, the chapter that follows will present the methods and data used in this research, making the argument that investigation of documents produced by professional bodies offers a useful avenue for pursuing the research questions of this dissertation as presented above in Chapter 1.3 in more detail.

4 Data and Methods

This dissertation investigates the jurisdictional work and claims-making activities that HSW associations in Sweden and Germany have in recent years resorted to promote hospital social workers professionalization in the two countries. The present chapter provides an overview of the empirical data used in this research. It also discusses the data selection and the function of the specific data sets and the way they relate to one another. Methodological information and considerations concerning the analytical process and the translation of materials across languages in a comparative country study are presented, as are ethical considerations related to the research. Reflections on the representativeness and generalizability of the data are found interspersed throughout the chapter.

4.1 Object of study and data selection

The selection of empirical data for this study was preceded by the definition of its object, the kinds of data required for its investigation, and the way the different types of data to be collected would relate to one another and the object of the study.

Object of study

This dissertation investigates the jurisdictional work of a subordinated profession as carried out by professional associations. The focus is on hospital social work (HSW) and the professional associations of hospital social workers (HSWs). This definition of the object of study then informed the choice of the national and welfare contexts to be considered, the selection of the associations to be studied, as well as the period of study. Two country cases were selected: Germany and Sweden. The main associations considered are, on the German side, the *Deutsche Vereinigung für Sozialarbeit im Gesundheitswesen e. V.* (DVSG) and, on the Swedish side, the *Svensk Kuratorsförening* (SK), the *Vuxenpsykiatriska Kuratorers Förening* (VKF), as well as the *Nätverk för forskande socionomer i hälso- och sjukvård* (NFS). The research covers a 20-year period lasting from 1989 through 2008.

Strategically important methodological aspects were taken into consideration in the selection of the two national contexts. As pointed out in Chapter Two above, Germany and Sweden have different welfare and healthcare systems. The two countries are often seen as representing a "prototype" of, respectively, a corporative and a social-democratic welfare state model. Following Flyvbjerg (2006), they can thus be looked upon as "critical cases". These two countries and their healthcare contexts can,

accordingly, be assumed to be of particular interest for anyone studying phenomena closely related to the welfare state context, such as, for instance, the jurisdictional work of health and welfare professions. It can, moreover, be assumed that comparison between these two particular country contexts will yield richer findings of greater strategic importance than, say, a comparison between two Nordic or two Germanic countries would, as far as the impact of contextual factors on jurisdictional work is concerned. Lastly, also personal reasons guided the choice of the national contexts here, given that the author has personal experience from social work practice in both of the two countries and speaks fluently both languages.

Professional jurisdictional work can be studied looking at any number of professions. In this dissertation, however, the focus is laid on HSW, which is not a profession per se but rather a specific and fairly minor subgroup within the broader social work profession. The choice of just this particular group for study, however, is also a strategic one, as HSW could be defined as an a-typical case in two senses (cf. Flyvbjerg 2006): both in the context of professions in general and when it comes to its role as part of the broader social work profession more in particular. Social work, overall, has been considered an interesting case for study, as has been repeatedly noted (e.g., Etzioni 1969, Abbott 1988, May & Buck 2000). Another very particular consideration here, however, is that HSWs work in organizations dominated by healthcare professionals. What this means is that, in their work, they need to be able to communicate with professionals coming mostly from natural science background, as opposed to their own social science background. As Flyvbjerg (2006) has noted, researching such atypical cases may well produce richer results than what research focusing typical cases might normally be able to. The selection of this particular object of study for this dissertation research should thus be understood as reflecting a conscious strategic choice.

From the methodological perspective, the choice of the two countries of Germany and Sweden, however, also necessitates careful consideration regarding the comparability of the cases selected. How similar or dissimilar, and in which aspects, exactly, can the social work professions operating in the healthcare sector be said to be in these two countries, both in terms of the organization of social work within the health care contexts and the education of social workers, and what do these mutual similarities and/or dissimilarities mean from the point of view of the research undertaking itself and the findings from it? The selection of the two cases was, consequently, also preceded by a careful initial comparison of the social work organizations in these two healthcare and welfare settings, as it was by a preliminary comparison of how social work education is organized and carried out in the two countries. To ensure comparability between the two cases,

the definition of the object of study was narrowed down to only cover social workers with an academic social work degree who work in hospital settings. Yet, certain important differences, described in more detail in Chapter Five, remained between the two cases. For one, Swedish social workers in health care also work in out-patient care and in primary care settings, while, until fairly recently, their German colleagues have almost exclusively worked in in-patient hospital care only (some rare exceptions notwithstanding). Secondly, it could be argued that social work education differs slightly between the two countries, even if the differences are not significant enough to undermine comparability. This is also attested to by the fact that the Swedish National Agency for Higher Education considers the German social work/social pedagogic degree as an equivalent of the Swedish social work degree. Comparability is, furthermore, suggested by the fact that only minor curricular changes have been made to social work education in either country following the implementation of the Bologna Process.[23] Any differences that might thus be there should then not be expected to compromise the comparability of the two cases of professional jurisdictional work by HSWs considered in this dissertation.

The delimitation of the study object also concerns the specific definition of the time period covered by the research. The reason for selecting the twenty-year period 1989 through 2008 was that it, to begin with, was long enough to allow for examination of any fundamental changes in HSWs' jurisdictional work over time. Moreover, this period, in both countries, was characterized by important societal changes bringing, among other things, cutbacks and structural changes in the welfare system, which in turn can be assumed to have influenced HSWs' motivation to more aggressively (and thus visibly) engage in jurisdictional work. The years between 1989 and 2008, however, also saw other significant changes taking place in the two societies, even if these were rather dissimilar in kind. As commonly known, in Germany this period was characterized by the country's re-unification, with its economic and social consequences making their presence felt in the 1990s and, together with the general economic situation prevailing at the time, bringing a need for cost-containment in the health care sector especially in the 2000s. Circumstances such as these may be expected to pose significant challenges to the capability of the social work profession in the country, for instance in the integration of former Eastern German welfare workers and in terms of the profession's ability to describe its specific contribution to health care in the country to that way protect its professional jurisdiction there.

[23] This process, founded on the so-called Bologna declaration of 1999 (European Ministers of Education 1999), represents a concerted European effort to harmonize the higher education systems in place in the EU member countries, to ensure comparability in the quality and standards of these systems.

In Sweden, the period was characterized by the economic crisis of the 1990s and, as regards the country's health care structure, a transition to a system of county-based integrated health care delivery system, which meant a partial re-allocation of health and social welfare responsibilities from the beginning of the 1990s to the end of the same decade. Both of these developments can be assumed to have increased the need for the social work profession to be able to argue for its contribution to health service production and delivery in the country. Major changes and challenges such as these were then an important factor to consider in the determination of the period to be covered by this study. Undoubtedly, however, also other periods of major societal change could have suggested themselves for this purpose as providing an interesting perspective from which to pursue the research questions of this dissertation. Yet, one major benefit from the chosen time period is that during it, the challenges to HSW from cost containment emerged and were responded to at about the same time in both countries. It is obvious, however, that this choice may have also influenced the specific results obtained in this study, as regards, in particular, its findings concerning the jurisdictional strategies, claims, and arguments proving themselves to be the most effective in producing their desired outcomes.

Similar considerations influenced the choice of the professional associations to be studied as well. The aim here was to choose only such professional associations that genuinely worked for HSW interests. In the German case, the choice was rather simple, given that the DVSG is the country's only professional association meant specifically for social workers in health care. As described in Chapter Five below, this association represents German HSWs in a variety of hospital care areas while also trying to promote research in HSW in general. In the Swedish case, the SK, for its part, was chosen because of its similarity to DVSG as a professional association, working as it, too, does exclusively to promote HSWs' professional interests. In Flyvbjerg's (2006) terms, these two organizations can be considered as "critical cases", as they presumably represent the greatest variety of HSWs in the two countries considered.

The SK was, however, also selected because, just like the DVSG, it organizes a variety of different branches of HSW. Two other Swedish organizations were included in order to be able to cover as similar areas for the investigation of HSWs' jurisdictional work as possible. First, the VKF was added. This decision seemed justified in light of the fact that a significantly many of the members of the VKF turned towards the SK and became its members in the late 2000s while the VKF gradually wound down its activities. After that, also the more network-like NFS was included, owing to its mentioned contacts with the SK and the fact that the professional sub-

group's research interests seemed to be primarily represented and discussed within this network, not the SK.

It should be emphasized that this study does not intend to be evaluative, offering instead an analysis that is simply comparative in nature. It, therefore, needs to be kept in mind when interpreting the data that the size of the associations included in it differs, as does the number of active members in diverse local subgroups and their boards. Such differences in size then in turn influence the amount of possible associational activities.

The exclusion of other associations from this study could be questioned, especially the exclusion of social workers' trade unions in the Swedish case. However, the aim of this dissertation is to investigate "genuinely professional" strategies, claims, and arguments resorted to in efforts to circumscribe a professional terrain for HSW in two different country contexts. In Sweden and Germany, social workers' trade unions such as the *Akademikerförbundet SSR* in the former and the *Deutscher Berufsverband für Sozialarbeit, Sozialpädagogik und Heilpädagogik* (DBSH) in the latter also represent the interests of a variety of other professions such as psychotherapists, sociologists, and other social science professionals in the Swedish case and remedial teachers and pedagogues in the German one. It could thus be assumed that these two trade union organizations might then invest only little effort in representing the highly specific jurisdictional interests of social workers in work fields such as HSW where, among others, various social science professionals and pedagogues compete with them for jurisdiction over a specific terrain. As this study is interested in the specific jurisdictional strategies, claims, and arguments of HSWs instead, these two unions can thus be excluded from its scope. Other professional associations excluded from this research include the associations for HSWs in paediatric and palliative care that one finds in Sweden, in the interest of maximum convergence between the HSW fields studied in the two countries.

Data selection

As a next step, the selection of specific empirical data sets was decided on to enable investigation of how specific jurisdictional strategies, claims, and arguments are used by HSWs and their associations. Different methods of data collection were used in tandem. To enable investigation of jurisdictional work on the associational level, a decision was made to use document analysis and focus group interviews. The former, focusing on the document material collected from different HSW associations, served as the main source of the empirical data analysed, with the latter complementing the picture where needed. The different sets of data here were meant to respond to different types of research questions. It is primarily this data on

which the analysis and findings presented in Chapters Six through Eight of this dissertation are based.

A brief comment on the practical and methodological arguments for the inclusion of these different types of data in this research is in order. From a methodological perspective, the approach where data is collected using a variety of methods is referred to as 'method triangulation', and it is predominantly used to enable examination of different aspects of the topic or phenomenon under investigation. The approach has also been termed "saturate data collection" (Denzin 2006, Glaser & Strauss 2006). Researchers have found method triangulation useful as a way to increase validity in qualitative case studies and as a way to saturate perceived information (Vidich & Shapiro 2006). The method can, however, also be seen as tool to avoid bias, enlisting as it does for its purposes the power several methods that enable one to look at the phenomenon under study from different perspectives. The method triangulation can thus be looked upon as a way to increase the validity of data, but also as an alternative to validation (Seale 1999, Silverman 2006). For this dissertation, the decision to use a variety of data collection methods was made in order to form as rich an information base as possible, to that way be able to examine several different aspects of the jurisdictional strategies, claims, and arguments used by the professional associations in question. At the same time, this manner of proceeding was also seen as a way to help avoid bias in the sample that otherwise would potentially arise from the particular nature and characteristics of the documents collected.

To enable exploration of the way jurisdictional issues are negotiated by professional associations using specific jurisdictional strategies, claims, and arguments, document analysis was used. Associational documents lend themselves well to the study of jurisdictional work as perceived and actually pursued by the associations, since they express the associations' own understanding and perception of the stakes, issues, tasks, available means, and expected outcomes pertaining to the situation at hand and of their own (possible) role in it. They can, furthermore, be assumed to reflect these associations' possible intentions to influence their readership's thoughts and acts.

The suitability of documents as research material for this kind of study has been suggested by a number researchers. Prior (2004), for instance, has pointed out that while the documents, through their substantive content, can indeed tell much about some specific matter, they may also be able to tell us something about the actors involved, and sometimes even about what these actors intended in acting in certain ways. Documents usually identify those who authored them, often also including information about other actors in the context. They describe events as the perceived reality of these authors. In other words, documents from and by HSW associations ought

thus to be useful for anyone wishing to investigate the way these associations perceive their actions. They can, however, also be productively used to explore what the associations themselves claim they do in performing jurisdictional work, what their underlying intentions are, and perhaps even how they perceive the reactions of their context. The precondition for achieving all this, however, is that the documents included in this research were indeed produced by members of the association studied, as only those kinds of documents can be claimed to yield relevant and valid information about these association's efforts and intentions.

As Smith (2008) has suggested, the texts contained in such documents may also yield descriptions of the intended organizational governance and information about the ways in which the associations behind the documents intend or aim to influence their readership. Moreover, according to Lundström (2008), through them one might be able to trace the (re)actions of other actors over time, and analyse the document authors' response to these (re)actions. In other words, the documents produced by the associations can help one to understand how these associations seek to influence their immediate audiences, consisting of both members of the association and outsiders. According to Prior (2004), the content of these kinds of documents may tell us something about the efforts pursued, about acts that have been performed in the past. In addition, as Silverman (2006) has suggested, studying a phenomenon over time through documents might have the advantage that, unlike with interviews, one can then expect the data source to provide information that is clearer thanks to its excluding more recent actions that otherwise might blur it.

The final decision was thus made to study documents produced and authored by HSWs' professional associations over a period of 20 years. Even if these documents cannot tell us whether the associations' actual actions conformed to the intentions and claims as described in them, they can still provide information about how the associations claim to have acted and reacted in the negotiation of their specific professional interests. These documents also reveal whom the investigated professional associations interacted with around their efforts to establish and institutionalize HSWs' jurisdiction, and, at least to some extent, allow one to trace the reactions of such other actors involved in the process.

However, as Prior (2004) has also pointed out, when using documents as a data source for qualitative analysis one needs to proceed with some caution, given that they might yield data containing some form of interest bias arising from the document authors' awareness that their products might be used as means to influence other actors in specific ways. The documents collected for this study may, thus, in fact even hide what really happened and only tell us about how their authors preferred to describe it for their

readers. The documents consisted of articles selected from the two main association's journals (including editorials, feature articles, open letters), meeting minutes, annual reports, official definitions, and position papers (most of these also published in the associational journals, others collected from different official and private archives), and book volumes. It should also be noted that the purpose of the associational journals was to provide information on the current and future activities of the publisher association as well as to publicize and, to varying extents, also debate its positions and views. Indeed, the documents from German and Swedish associations that were available and selected for this study varied from one to the other in this regard, reflecting the different interest of their authors in producing them (see section below). The documents obtained were, to varying extents, used by their authors to present and represent HSW externally (Germany) and internally (Sweden). In Sweden, where these kinds of documents are more often produced for internal consumption, arguments and reflections are expressed in them more implicitly. In Germany, where they are more often intended for both internal and external purposes, different arguments tend to be presented more explicitly. Owing to this difference, a second data collection method was thus also used, to complement the data collected from associational documents.

Focus group interviews with board members of DVSG and SK were arranged to provide new or complementary perspectives concerning the jurisdictional work of HSW associations in the two countries. There were two main motivations behind this choice. The first was to complement the data gleaned from the associational documents with more specific information about how the associations believed they could support jurisdictional work at the workplace level and what they thought they could accomplish in that regard. The second was to broaden the publicly available "official" information already collected with more *informal* information on the professional groups' claims and efforts. The majority of the documents available for this research can be considered as offering a medium for the associations to present their official positions and viewpoints to outsiders. The focus group interviews, in contrast, can be expected to provide a way to address perceptions, opinions, or values not taken up, discussed, or otherwise openly presented in documents (Esaiasson et al. 2004). As such, they offer a tool for investigating politically sensitive matters and themes (Bogner 2005), of which, in the case of HSWs and their associations, jurisdictional work is one.

Additionally, the focus group interviews were also resorted to to help *deepen* the understanding gained from the analysis of documents from both countries. Compared to the German documents drawn upon, the documents collected from the Swedish associations were more limited in regard to the

kind of information they offered. For the most part, the positions, points of view, opinions, and the like put forward in them were meant for internal uses only; materials communicating externally the official positions and points of view of the association were less readily available through them. Generally speaking, focus group interviews can then, in this kind of context, provide a means to access the more in-depth reflections of a group of people on the given theme (Esaiasson et al. 2004). They, moreover, when composed of people with a shared history as a group meeting and interacting also outside the research situation, allow one to reconstruct collective views held by the group either currently or in the past (Bogner 2005).

In retrospect, one can speculate on the extent to which the focus group interviews indeed succeeded in fulfilling this task expected of them in this research. Occasionally, focus group participants indeed presented more informal information in the discussions, especially during the later stages of the interview process. Such information could concern questions such as, as in the case of the focus group interviews with the German informants, whether DVSG could in fact claim to represent the country's social workers in health care in general, or whether the association's impact on the legislative process in a certain federated state could be said to have been the result of mere coincidence instead. The Swedish focus group interviews, for their part, sometimes yielded enlightening information about the official stance of the association in question, for instance as regarded its co-operation with the trade union around professional licensure. Nevertheless, one must keep in mind that the person conducting the interviews (this author) was a stranger to the interviewees, which fact must then have, at least to some degree, had an impact on their answers and responses in the interview situation. Moreover, at least one interviewed association board member clearly understood the comparative aspect of the research to mean that it (and by extension also the interview) was evaluative in nature, even though it was emphasized that this was not the intention with either the research or the focus group interviews. Conceiving the purpose of the undertaking that way must certainly have affected the answers given to the interview questions.

Associational documents

As Scott (1990) has proposed, the quality of the documents to be analysed is assessed using general criteria such as the document's authenticity, credibility (sincerity and accuracy), representativeness, and meaning. The selection criteria for documents to be drawn upon in this dissertation were developed accordingly. To be included in the research, the document had to:

- be authored by an official representative or board member of DVSG, SK, or VKF, or a member of the NFS;
- include official information distributed to at least members of the own organization;
- address or touch upon one of three themes related to jurisdictional work: claimed work tasks, work fields, and formal jurisdiction for HSWs.

The first criterion comprehends all documents authored by board members or official representatives of the four organizations studied: the DVSG and the SK and the VKF in Sweden. In the case of the Swedish NFS, which has no official representatives as such, documents authored by members of their official delegations were used.

Especially on the part documents from the DVSG's journal,[24] considerable efforts were invested in excluding materials presenting other than the association's official opinion. In this case, assessment of "authenticity" (cf. Scott 1990) was not always easy. It was not always clear, for instance, whether the debate articles by DVSG board members were authored in their role as "ordinary" members of the DVSG representing their personal opinions, or as official DVSG representatives representing the associations' official position. For this reason, the kind of texts of this type that resulted in responses or open letters published by other members of the board in subsequent issues of the journal were excluded, while articles that had no follow up in subsequent issues of the journal were interpreted as presenting the association's official position.

There was one case in particular where it was difficult to determine whether the document ought to be classified as authored by the professional association or by the trade union, in spite of its having an officially named author. The document, entitled "Policy för socionomer i hälso- och sjukvård. Modell för kompetens- och karriärutveckling", came from Sweden (Akademikerförbundet SSR 2010). In the end, it was nevertheless included, given that it had been drafted by representatives of professional HSW associations acting in a role of an expert group for the trade union, and because the document itself had been officially adopted by the SK and the VKF as a policy paper for their purposes (Akademikerförbundet SSR 2010: 2). The document, even though officially a publication of the trade union, discusses career pathways for social workers in health care.

The aim of the second criterion was to identify documents that were of interest at least to members of the document publisher's/authors' own organization and had therefore been distributed to (at least) them. These types of documents were either published on the pages of associational journals or

[24] The name of the journal changed a few of times during the period covered by this research.

sent to the associations' members separately by regular mail or e-mail. As regards documents published by the DVSG, however, only documents published in the DVSG journal and official written statements published on the association's homepage were included. Materials distributed via, or appearing in, the DVSG's e-mail newsletter were excluded. This decision was made, in part, for practical reasons, in order to limit the number of documents to be considered (DVSG publishes or distributes vast amounts of materials), and, in part, owing to the observation that the most important information coming from the association was always published either on the pages of its journal or on its website.

The third and last criterion was meant to, with the help of the three "themes" included in it, narrow down the materials to only those documents that yielded information related to HSW work tasks, work fields, and formal jurisdiction. Following Layder (1998: 101), the three themes here could be termed "orienting concepts". This criterion was deemed useful as it was not always obvious from the titles of the documents coming into question whether they contained interesting information or not. Consequently, all articles even superficially touching upon any of the three themes were included in the initial data collection. Nevertheless, no document was included in the final data set and data analysis unless it met all three of the selection criteria above.

These three selection criteria were used to ensure credibility, authenticity, and representativeness of materials and data. They were, however, also used to limit the size of the sample and make it more manageable. A vast number of documents were left out of consideration, and, still, many of the documents included in the research only contained small amounts of the kind of information sought. Table 1 below gives a summary of the materials included in the final data set and analysis, with a fuller description of the documents and articles involved given in Appendix 1 to this dissertation.

Table 1 Documents collected for analysis

Name of association	Source	Type & number of documents
DVSG	• *Mitteilungsblatt der Deutschen Vereinigung für den Sozialdienst im Krankenhaus* (1990, 1991, 1992, 1993,1996,1997; 4–6 issues/year, 8 issues from 1994–1995 missing) • *Forum Krankenhaussozialarbeit* (1997–2004, 4 issues/year) • *Forum Sozialarbeit und Gesundheit* (2004–2008, 4 issues/year, issues no. 3 & 4 from 2008 missing) • Association homepage www.dvsg.org	• 177 journal articles • 5 open letters • 3 official definitions • 44 position papers • 9 annual reports • 172 board meeting minutes from local, federated-state & national level 410 documents in total
SK	• *Svensk Kuratorsförening* (1990–1997, 2 issues/year; total of 5 issues missing from 1990 (No. 1), 1991 (No. 1), 1991 (No. 2), 1994 (No. 2) and 1996 (No. 2) • Official membership information (1998–2004, 1–2 issues/year) • TAM archives • Privately archived meeting minutes (2004–2008, 4 mtg minutes missing) • Association homepage www.kurator.se	• 20 journal articles • 2 published letters • 7 official definitions • 20 position papers • 17 annual reports • 109 board meeting minutes from local & national level • 1 booklet 176 documents in total
VKF	• Association homepage www.vkf.nu (1999–2005)	• 6 annual reports • 15 board meeting minutes • 3 position papers 24 documents in total
NFS	• Various privately archived documents (1995–2008, 2 documents/year, total of 5 mtg minutes missing from 1996, 1997, 1998, 2001, 2002)	• 20 meeting minutes • 1 article published in *Svensk Kuratorsförening* (1995 No. 2) • 1 official definition (draft) 22 documents in total

As the table shows, the materials collected from the DVSG cover a large number of documents spanning the entire research period, with the exception of the years 1994 and 1995 (journal issues from these two years were no longer available). All this material was derived directly from the DVSG or its website. It includes documents of various type and character, ranging

from journal articles (e.g., editorials, debate articles, information on past and forthcoming associational activities, comments issued on government commission reports, draft law proposal, and public regulations) to open letters, official definitions, position papers, annual reports, and minutes from meetings at the local, federated-state, and national level. The meeting minutes from local and federated state-level working groups, federal board, and advisory board meetings are in the DVSG's case published as articles in their journal summarizing them in easily digestible form. All in all, a total of 410 documents were collected from DVSG that one way or another related to at least one of the three themes of work tasks, work fields, and formal jurisdiction.

On the Swedish side, a total of 222 documents from the SK, the VKF, and the NFS were included. Most of the materials were collected from the SK, with documents from and by the other two associations included to complement that main material. In the case of the SK, the documents collected included the associational journal, membership information mailings, various materials retrieved from the TAM archives,[25] privately archived board meeting minutes, and various materials made available through the association's web pages. The documents collected from, and on, this association fully cover the entire research period 1989–2008, with the exception of a few individual journal issues and meeting minutes. The journal articles collected were here, too, of different types, ranging from editorials and information from the association's different sections to comments issued on committee reports, official government investigation reports, draft law proposals, and draft regulations. Published letters, official definitions, position papers, annual reports, as well as minutes from board, sectional, and annual meetings as published in the association's journal were included as well. All in all, 176 documents were included. Unlike in the German case, the meeting minutes included were full copies of the originals (instead of mere summaries).

The documents concerning the VKF were obtained via the Internet, from the association's website that was maintained until around 2010; the association itself existed until around 2006. This material covers the period 1999–2006, with the exception of two position papers dating from 1996 and 1997. The documents collected, however, cannot be assumed to cover or even touch upon all jurisdictional activities by this particular association during 1989–2008. Nevertheless, they complement the materials collected from the SK. These VKF materials consisted mainly of meeting minutes (board and annual meetings) and annual reports, even though also three

[25] The TAM Archives (*Tjänstemännens och Akademikernas Arkiv*) is an organization offering, among other things, archival services to trade unions, interest organizations, and professional associations representing various white-collar and academic occupations and professions; see http://www.tam-arkiv.se/om-tam-arkiv_about-tam-archives.

position papers were included, giving a total of 24 individual documents collected. The meeting minutes here were for the most part available in an abbreviated, rather formulaic form only, although in some cases they included the content of held discussions as well.

Last but not least, documents were also collected from the NFS, so as to round out the data collection on the Swedish side. These documents were obtained from a number of individual network members, and they mostly consisted of rather more informal minutes from network meetings but also one official definition. A total of 22 documents were collected in all. This brought the total number of documents collected to 632, assembled in the original or as copies of the originals, and then archived and coded in NVivo.

In analysing these documents, some caution, however, needed to be exercised when comparing what the different associations stated or otherwise put forth in them as claims concerning HSW tasks, work fields, and formal jurisdiction. As Smith (2008) has reminded us, what can be written or stated in a public document is always necessarily restricted. Regarding the associations' positions and views related to HSWs' jurisdictional claims, the documents collected from them that were addressed to their own profession might then tell a different story than those that were addressed to outsiders. Such differences could be discerned in both the Swedish and the German materials collected.

As even a quick look at the variety of sources used for this research shows, professional associations in both Sweden and Germany address their different audiences (members, non-members) differently. To start with the German case, all the documents collected from the association in that country were available to both those the association officially represented (its members, members of the profession) *and* the wider public (social workers, other healthcare professionals, corporative organizations such as healthcare funders and providers, developers of social welfare and health care policies). In recent times, the association has, however, become more and more conscious of this dual audience of its, as can be seen comparing the documents from it that date from the beginning and the end of the 20-year period investigated: over time, the amount of unofficial "back stage" information put forth by it has decreased while more space is being given to open debate on social policy issues and the presentation of official associational views and positions. As a result, the representation of association's official points of view became more and more frequent in the materials collected for this research.

Unlike in Germany where the journal of the association studied has, even if with a changing name, been issued continuously up to the present day, in Sweden there was an associational journal in existence only for the first ten years of the investigated 20-year period. The association's journal there was,

furthermore, issued as an information source for its members only. Moreover, meeting minutes were not provided in an easy-to-read summary format on the pages of its journal as in the case of the DVSG, but were, instead, published and distributed unedited. Annual reports on the associations' activities and official position papers, on the other hand, were also published on the Internet. Unlike the board meeting minutes, however, they were aimed towards external audiences just as much as they are towards the internal one. The documents collected from the other two Swedish associations, the VKF and the NFS, were also only available to members, with the one exception that all the documents produced by the VKF (meeting minutes, annual reports, and official statements) were also published on the association's website. In the Swedish case, therefore, the likelihood of the profession's internal claims (regarding its work tasks, work fields, and formal jurisdiction) becoming expressed and thematized in the publications and documents put forth should thus be greater than in the German case. It can, moreover, be assumed that the documents circulating among the members of the association's own profession could rely on a certain shared understanding of commonly used terms and concepts of the profession, while documents read also by members of other professions could not; in the case of the latter, there would then to a greater extent have been a need to focus on the task of defining such terms and concepts. This is then something to be kept in mind by both the researcher analysing this data and the reader perusing the presentation that follows.

An additional consideration to be kept in mind is that, in this research, also meeting minutes presumably having a standard format and style could differ from association to association. The format in which they were published varied quite a lot, affecting not just the accessibility but also the content of the information provided in them. The DVSG provided them in a descriptive summary format, the SK made them available in a cursory format only with little more than the basic facts stated, the VKF issued them in a rather formulatic form but with a brief summary of the content of the discussions provided for certain topics. The minutes obtained from the NFS were rather informally kept notes with, however, more details given, including information on different positions and views taken during the discussions. The minutes obtained from the VKF and the NFS thus provided a better access to the issues discussed in their meetings than the minutes obtained from the DVSG and the SK, which were far more restricted in the type of information they offered. The utilization of the different forms and formats for giving out information here could very well have reflected a conscious strategy: especially the brief, blurb-like summaries provided by the DVSG might express a deliberate choice to select the issues for one's audi-

ence, to filter information to better produce the effects one intended to have on one's readers.

Focus group interviews

Two focus group interviews were conducted, one with board members of the German DVSG and one with board members of the Swedish SK. The aim of these interviews was to help complement and balance the data derived from the documents collected in the two countries. In Germany, this meant, first and foremost, obtaining additional information of more informal character on the professional groups' claims regarding work tasks, work fields, and formal jurisdiction, to bring to light identify hitherto unexpressed perceptions, opinions, and values concerning these. In Sweden the primary aim was to improve the understanding of the sometimes cursory, incomplete, or otherwise obscure information in the intra-group oriented meeting minutes collected, and to collect descriptions that could be said to represent a more official point of view. In both cases, however, also kind of complementary information was collected.

The focus group interviews were conducted in 2010 in connection with the associations' regular board meetings. This was necessary in order to be able to conduct focus group interviews at all, given that engagement in associational activity in both Germany and Sweden is voluntary at all levels of the association. Those invited to the focus groups could only join them in connection with their other associational business that enabled their physical availability for the purpose.

In 2010, the DVSG board consisted of twelve persons. As Esaiasson and his co-workers (2004) have suggested, restricting the number of those participating in focus groups to four to six is likely to be useful, ensuring all participants an equal possibility to be active during the interview. Participant selection for the German focus group was therefore mainly guided by the intention to keep the size of the focus group relatively small without compromising its representativeness. In co-operation with an official representative of the DVSG, five members of its board were then invited to participate, in addition to this official representative. All five of the invited focus group participants worked in somatic and psychiatric hospital settings.

In Sweden, the SK board had only five regularly participating members in 2010. To create a similar-size focus group as in the case of the German DVSG, all of them were invited to participate in the focus group. Of them, one did not work in hospital settings at the time of the interviews.

The interviews were conducted using a semi-structured interview guide (see, e.g., Andersen 1998). The guide included questions about claimed HSW work tasks and work fields, and another set of questions about how the participants perceived the relation between the professional body and the

workplace level, the impact of the professional body on social and healthcare policy, and the impact of the society on HSW jurisdiction. Since the interviews were to be held in German and in Swedish, respectively, the interview guide, just as all the information given to the interview participants, had to be designed and written in both languages. To guarantee the comparability and reliability of the interview questions used in the two groups, the questions included the interview guide were first discussed with HSWs in the two countries, soliciting their input. The same interview guide was then used in both countries, albeit in different language versions, with the questions, as already indicated, geared to collecting more informal and "official" views, opinions, positions, and data, as especially in the Swedish case the information gleaned from the associational documents needed to be complemented in several different ways. In the German case, however, one might nevertheless ask in retrospect whether it might have ultimately been more productive to design the interview questions somewhat differently, so as to obtain the desired kind of information from the association's board members. The interview questions were sent to the focus group participants in both countries in advance of the interviews, along with written information about the research project, the focus groups, and the interview situation. In Germany, this information package was distributed to the participants via the above-mentioned official representative of DVSG, and in Sweden via the chairman of the SK board.

In the accompanying letter to the focus group participants, the focus group participants were asked to plan for a two-hour interview session with the group. In the German case, apart from one participant who arrived at the session about 45 minutes late, the arrangement worked well for all participants. In the Swedish one, the actual duration of the interview session was rather closer to 1 ½ hours, as the majority of the participants had to leave a little earlier than expected to catch their transportation home. As a result, the discussion of the interview questions inquiring about how the association "officially" viewed its past and future impact on policy and the society's impact on HSW jurisdiction was thus cut a little short, leaving the possibility open that some useful information was perhaps not obtained. It also needs to be pointed out that, even though it was made clear to the participants that the intention with the interviews was to obtain from them more information about their association's internally discussed, unpublicized positions, concerns, opinions, and the like, it sometimes seemed difficult for them to discuss these in their capacity as board members of the association, especially in the Swedish case. There, questions were repeatedly answered from a personal point of view, instead of trying to formulate and articulate a more "official" or representative one. In these cases, where that which the focus group participants put forward was clearly their own personal views and

opinions, the data was omitted from the analysis of associational strategies and claims.

Two special cases were included among the focus group participants whose role and input is worth noting. On the German side, one of the group members was the officially assigned representative of his association, the DVSG. As such, it was only well suited for the purposes of the focus groups that this person could keep his role also during the interview, and thus perhaps more readily and capably serve as a conduit for information concerning the "official" positions, views, and opinions of his association. Moreover, the position this person held in the organization as a member of its paid staff was a central one, allowing him access to many forums where both informal and official positions, opinions, views, and statements were discussed within the association. During the subsequent analysis of the interview session transcripts, it became very clear that this person indeed had been able to steer the discussions more in the desired directions and help give them a more "formal" tone. Very often, this was achieved by directly reminding the other focus group participants of the fact that it was the associational views, positions, and opinions that were in focus, not personal ones.

As already noted above, furthermore, among the Swedish focus group participants there was one hospital social worker who did not work in hospital settings. This person was employed in primary care. The fact was expected to turn out to be somewhat problematic from the point of view of the interview aims, as, for instance, when the focus would be on HSW work tasks and work fields or formal jurisdiction for HSWs. This person's background was therefore discussed at the beginning of the focus group interview, with the other group members agreeing that she should participate, but only when what was discussed concerned matters of more general nature such as formal jurisdiction. In reality, however, it was not always easy to keep the different themes clearly separate. When this happened, this person's input in the group, consisting, for instance, of particular circumstances or specific views presented from the primary care perspective, was excluded from the analysis.

4.2 The analytical process

The analytical focus on the empirical data in this research underwent some changes over time. These changes involved aspects such as the analytical questions posed to the data, the different procedures used to code and interpret it, and the way the collected data were related and compared. Following these changes in focus, the analytical process came to comprehend three distinct phases.

The first phase of the analytical process focused on the associational documents collected, which were reviewed, coded, and analysed. The aim during this phase of the analysis could be characterized as orientative. Three analytical questions guided this initial analysis of the documentary material:

- What, is claimed to constitute HSW work tasks and work fields?
- What knowledgebase is claimed?
- Which regulative instruments for the establishment and protection of HSW's professional jurisdiction are identified?

Coding during this phase was highly influenced by theory, using concepts from the theory of professions to structure the material and proceeding deductively (see, e.g., Andersen 1998). The comparison work mainly focused on the ways in which the answers obtained to the above analytical questions perhaps differed between the Swedish and the German case. However, after a while this procedure proved to have some limitations to it as it failed to yield satisfactory answers to all research questions.

As also the focus group interviews had by now been completed, this could thus be defined as the starting point for the second phase of the data analysis. The theoretical apparatus was now set aside, and re-coding was commenced, beginning with a focus on negotiative activities by the professional HSW bodies and their addressees. Miles and Huberman (1994) have characterized this kind of approach as lying in between deductive and inductive approaches. Some new questions were posed to the documentary material and to the focus group interview transcripts. These were:

- What activities do the HSW associations engage in in order to negotiate their professional territory?
- Who are the parties involved in such associational negotiations?

An attempt was nevertheless made to develop a coding system capable of being applied to activities in both of the countries and revealing differences as well as similarities between them. This time, codes and relations between the codes were allowed to emerge from the data itself. Subsequently, relevant literature was consulted to make sense of the findings, involving mostly literature on organizational theory that tackled concepts such as compliance and social collective identity. During this phase, a comparative perspective was applied to examine similarities and difference between the two country cases on the national level. Findings related to the above-named questions

were investigated from a historical perspective as well, a procedure which, according to Rowlinson (2004), can be used in sociological research to analyse development or change over time. This was done by structuring the accounts obtained regarding certain activities/strategies into a year-by-year timeline format, inspired by Silverman (2006). This technique was employed to bring to light differences between the two cases in the use of certain strategies and activities as these evolved internally over time, but also in relation to important historical changes such as new national legislation.

During the third phase of the analytical process, the focus was laid on rhetorical aspects of identity development. Specific analytical questions were formulated towards this purpose. The questions related to the rhetorical aspects of identity development were as follows:

- What narratives do the HSW associations in question use to describe HSW's past, present, and future?
- How do these narratives describe the relation between the professional subgroup, the social work discipline, and other disciplines in the hosting health care setting?
- What (kind of) central discourses do these narratives contain?

The aim of these questions was to help one understand the ways in which HSW associations use narratives in order to form a subgroup-specific professional identity. According to Ricoeur (1992), narrating one's own life story provides a way for individuals to understand themselves and to develop a narrated identity. In a similar fashion, narratives gleaned from the empirical data on hand were understood as a way for professions to develop a collectively shared professional life-story and a narrated professional group identity. Such efforts describing commonly shared self-perceptions of one's own professional subgroup concerned, in the present case, past and contemporary history of HSW as well as its current situation. The examination of these narratives showed most of them to refer to three specific discourses recurrently surfacing in the material. These discourses could be compared to what Bruner (2004) has termed 'central discourses', or statements that contain the essential account of a narrative. The narratives may change over time, in relation to a perceived change in the contextual conditions of the professional subgroup.

Also new questions focusing on the argumentative structure of claims in claims-making were formulated and addressed to the research material. These included the following:

- What kind of claims do the HSW associations raise in their claims-making?
- What arguments do they employ to support these claims?
- What strategies do they use to make their claims persuasive and have them accepted across organizational and disciplinary boundaries?

According to Bergström and Boréus (2005), claims-making can be studied by investigating the arguments used to back up the raised claims. For this particular phase of the analytical process, relevant theoretical work was thus once more consulted and examined in order to develop suitable concepts. Both the theory of argumentation and the theory of professions were drawn upon.

The argumentation analysis here was, however, also inspired by Karlsen's (2012) work on arguments' persuasiveness, sustainability, and relevance. Argumentation, which is a central element in claims-making, is, according to Karlsen (2012), dependent on the context where it is performed, as the terms operationalized and relied on it may have even highly differing connotations and importance in different contexts. Consequently, an argumentation analysis of HSWs' claims-making would need to take into account whether claims-makers define the terminology they employ in a way that also outsiders can relate to and understand. The analysis of the claims-making strategies of HSW associations in this research focused on the terminology and concepts these associations used in advancing their claims and arguments so as to increase the persuasiveness of their claims-making in contexts where they had to cross contextual boundaries (in health care, policy-making, etc.).

4.3 Translation between languages

The ensuring of reliability of research in cross-national comparative studies also implies a need to reflect on how challenges caused by the use of more than one language are handled in research. This dissertation is written in English, but it is based on materials that are in Swedish and German as well as focus group interviews that were conducted in Swedish and German. In this section of the dissertation, I will briefly describe how these language-related challenges were met in this research.

As Ekpenyong (2010) has emphasized, translation is a process of transferring the meaning of a word, a phrase, and, finally, a paragraph from one language to another. As he points out, findings deriving from different contexts can often be better understood when certain specific aspects and characteristics of these contexts are described and explained. Here such aspects

are for example those relating to legislature, society, and the organization of welfare. Chapter Two, the list of abbreviations, and footnotes are used to describe and convey just such contextual specifics to the reader.

As Baker (1992) has pointed out, full equivalence on the word level cannot always be achieved in even the best translation, since some words lack their connotative equivalent in other languages. Idioms and fixed expressions cannot simply be translated word by word; even text structure and the way in which cohesion is produced may differ. This creates several different challenges to the translation process. One concerns the translation of spoken German/Swedish into written English, given how in spoken language there are always many references to specific contexts and meanings that are not verbalized explicitly. In this research, this sometimes implied the need to alter the sentence structures, content, and specific expressions put forth by the speakers when the translating these into English, especially when quoting from the focus group interview transcripts. The purpose here, however, was always to be as faithful as possible to the content and the meaning of the text passages quoted. Also terms and concepts used for context-specific societal phenomena may have different connotations in different languages, and may therefore be difficult to understand for speakers of other languages. Where available, authoritative dictionaries and official translations by public agencies were used as an aid when translating the names of public bodies and legislature or specific terms the social work discipline. Nevertheless, many of the connotational differences relating to the terms and concepts employed, it was felt, warranted a separate clarification, either in footnotes or in the text itself.

4.4 Ethics and the principle of public access to official records

Cross-national comparative research needs to be conducted respecting the customs and conventions in the host countries (MOST 2012). Moreover, even where the research topic itself can be assumed to pose no particular ethical issues, ethical issues relating to the cross-national perspective need to be addressed. This section attempts to briefly do just that. The data collection was carried out in two different countries with slightly differing ethical standards for research and with some differences in the way and extent to which they regulate public access to official reports. Because of this, it was simply necessary to accept that the meeting minutes obtained from the German association were not available in their full originals and could only be accessed in a summary format. In Sweden, on the other hand, this was not the case and the meeting minutes could be obtained in their full originals. To protect confidentiality, however, all names have been omitted when quoting from them. Journal articles as well as meeting minutes and documents avail-

able on websites are nevertheless considered public documents in Sweden. The names of their authors are therefore included in the list of references below.

The interviews with association board members were conducted according to the Swedish laws and regulation, as this research was carried out at a university in Sweden. Written information on the purpose of the research and its aims and the interview guide were sent to all participants in advance. Information concerning the degree of anonymity for research respondents, however, was given to the German participants in more detail, given the differences in privacy regulations between the two countries. All participants gave their informed consent. The regulations and guidelines applied to were the Public Access to Information and Secrecy Act (*Offentlighets- och sekretesslag,* OFS 2009), the Swedish Freedom of Press Act (*Tryckfrihetsförordningen*, TF 1949), Law on Ethical Review of Research Concerning Humans (*Etikprövningslag* 2003), and the ethical guidelines for academic research by the *Vetenskapsrådet* (2009).

5 Hospital Social Work Associations in Sweden and Germany

The aim of the present chapter is twofold. On the one hand, it presents the broader associational context in which professional bodies for social work and HSW operate in the two countries. On the other hand, it analyses the character of the two main professional bodies involved, the SK and the DVSG, and the ways in which they made their members and other HSWs comply with the standards and definitions they were developing. As a first step, HSW and its associational landscape in both countries will be presented, followed by a short overview of the SK's and the DVSG's history. As a second step, the professional bodies' expressly articulated aims and visions are discussed. Becher's (1999) term 'professional bodies' and Etzioni's (1961) theory of organizational compliance are used to analyse the self-ascribed roles as well as the organizational structures of the SK and the DVSG, along with their impact on the characteristic development of subgroup-specific professional identity in their cases. The chapter, however, also examines how the organizational structures of the two professional bodies impact on HSWs' compliance with regard to the various suggestions and recommendations made by them. The chapter concludes with a comparative summary.

In the theory of professions, professional bodies are often seen as important actors in the promotion of professions' jurisdiction. The particular characteristics of professional bodies concern their internal structures, the diverse interests their members pursue, and the means of power the professional bodies have available to themselves to, for instance, exert influence over their members and in relation to other actors in society (Becher 1999). The power of a professional body can also be measured by its ability to develop and maintain a subgroup-specific professional identity (Siegrist 1990). The internal organizational structures, aims, and vision of a professional body can be used to improve members' and other interested professionals' voluntary adoption of, and compliance to, the organizational definitions and standards being developed concerning the professional subgroup's specific identity.

Like other professional bodies, also the professional bodies organizing HSWs depend for their existence on professionals to organize. A quick overview of HSWs and their approximate numbers in the two countries compared is therefore helpful. Table 2 gives the number of professionally practising HSWs in Germany and Sweden. It should be noted here, however, that the figures available from SKL and Destatis are not fully comparable, as they include somewhat different HSW fields. In Sweden, the figures include all employed staff in regional healthcare social services, that is to say, both

those social workers working in primary care and those working in hospital care. In Germany, the figures only include social workers employed in hospitals; healthcare social workers employed in out-patient care settings such as primary care and social-psychiatric services and in other out-patient healthcare services are excluded from them.

Table 2 Number of professionally practising HSWs in Sweden and Germany (Source: SKL 2013, Destatis 2013)

Year	No. of hospital social workers in Germany	No. of healthcare social workers in Sweden
1994	4,600 (0.06 per 1,000 inhabitants)	3,400 (0.4 per 1,000 inhabitants)
2004	8,400 (0.1 per 1,000 inhabitants)	3,700 (0.4 per 1,000 inhabitants)
2008	6,900 (0.08 per 1,000 inhabitants)	4,800 (0.5 per 1,000 inhabitants)

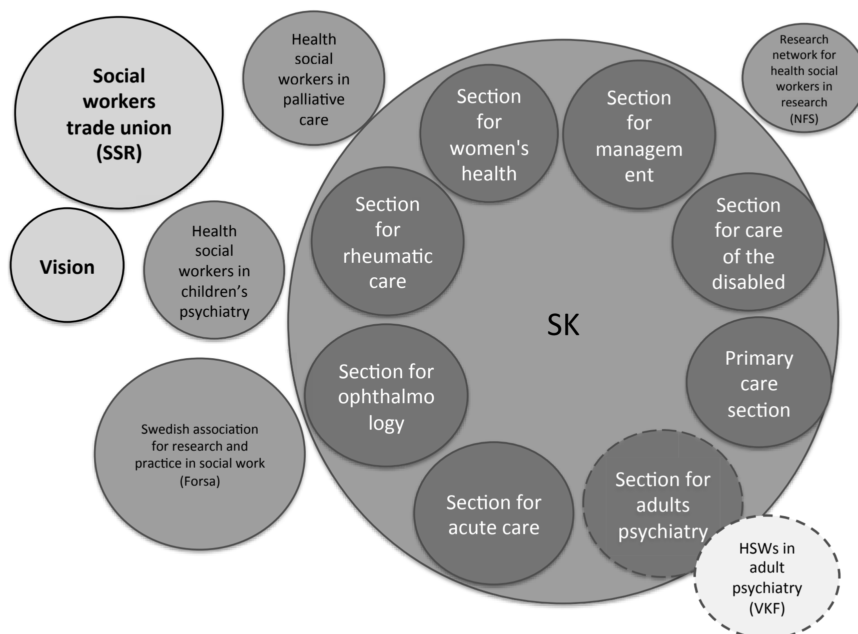
As shown in table 2, the number of social workers employed in Swedish healthcare social services has increased by approximately 30 per cent since the beginning of the 1990s. Approximately 3,400 HSWs were employed in county-organized health care in Sweden in 1994, compared to 4,600 social workers in hospital health care in Germany that same year.[26] Until 2004, the number of professionally practising social workers in health care increased somewhat in Sweden while increasing by more than 80 per cent in Germany. Between 2004 and 2008, the number of HSWs in Sweden continued to rise, while in Germany it went down. Even if the figures obtained from Destatis (2013) and SKL (2013) are then not fully comparable, however, it seems evident that considerably more HSWs are employed in Swedish than in German health care. These HSW practitioners are the main recruitment basis of the professional HSW bodies in the two countries.

5.1 Associational landscape in Sweden

From an Internet search on Swedish HSWs' professional bodies in 2008, an associational landscape as shown in Figure 1 emerges. (Circle size does not indicate the actual size of the professional body in question, in terms of its membership base, while overlap indicates the integration of members of one association into a section of another.)

[26] No figures were available for health social workers in Sweden for the years preceding 1994.

Figure 1 The associational landscape of HSW in Sweden (July 2009)



In the country, two trade unions, the *Vision* (formerly SKTF) and the *Akademikerförbundet SSR* (SSR), represent social workers' professional interests. The bigger one of the two, the SSR, represents social workers' and other academic professions' interests, while Vision mainly represents the interests of a variety of (non-academic) occupations within the social welfare sector and social workers employed in public service areas (Wingfors 2004). Approxymately 80 per cent of all the country's social workers are trade union members. Those represented by SSR are social workers from larger subgroups of the profession such as social workers working in welfare services, and minor groups such as social workers working in schools and in health care. From the perspective of the SSR, professional interests such as, for example, licensure are not pursued only as a specific interest of HSWs, but because these are perceived as conforming to the interests of social workers in general. The *Vision* has not demonstrated any interest in advancing licensure for social workers at all (cf. Wingfors 2004). The SSR is listed as an official referral organization for public investigations by the Swedish state.

In Sweden, the association for research and practice in social work (*Förbundet för forskning i socialt arbete,* Forsa) does not aim at pursuing the professional interests of social work in general. Instead, it aims at improving the relationship between social work practice and research. In the documents

obtained from the SK, early 1990s' connections between the SK and Forsa are brought up at times. HSWs seem not to be actively participating in this organization.

The NFS was set up towards the end of 1995, and during the time period covered by this research it was financed by a research fund.[27] The network's aim is to provide HSWs in research with a possibility to meet and exchange experiences and knowledge regarding social work research in hospital settings. It has no representative function towards the trade union. Like Forsa, it seems not to pursue the political interests of the professional subgroup. Nevertheless, it seems to function as a forum where HSWs engaged in research meet to discuss matters concerning HSW as a profession and HSW research in especial. The network's relationship to the other professional bodies for HSWs is difficult to determine based on the empirical data available. Both Forsa and the NFS can be characterized as politically independent non-trade union interest organizations.

When it comes to professional bodies aiming to represent genuine HSW interests in healthcare policy making, there exist a variety of different organizations in Sweden. There is, for instance, a professional body for health social workers in children's psychiatric care (*Föreningen Barnpsykiatriska kuratorer*) and another one for health social workers in palliative care (*Socionomer i palliativ vård,* SiP). A further professional body for HSWs in psychiatric care for adults (VKF) seems to be in decline, however, at least judging from the low level of activity traceable to it on the Internet. At the same time, the number of members in the section for adult psychiatry in the fourth professional body, the SK, has been on the increase. This organization represents a variety of the specialties found among HSWs and is organized into several sections. The different sections represent HSWs working in women's health, ophthalmology, emergency rooms, rheumatic care, primary care, and care for disabled children and adults, in addition to HSWs engaged in leadership and managerial position. Membership in SK, as in each of the other professional bodies above, is voluntary.

None of the professional bodies SK, VKF, health social workers in palliative care, or health social workers in children's psychiatry are referral partners for government investigations independently from the SSR in the country. Together with other HSWs in health care, they represent HSW interests towards the SSR via an advisory panel.[28] In professional policy matters, HSW interests become then represented through the SSR. Due to the size of the unions as well as their established role in policy making in Sweden, the SK is rather dependent on the trade union. The SK, the other associations for

[27] FORTE (former FAS, *Forskningsrådet för arbetsliv och socialvetenskap*).
[28] HSWs advisory panel (*Yrkesråd för kuratorer*)

social workers in health care, and the NFS therefore co-operate with one another where it concerns matters of common interest to them.

This existence of a great variety of professional bodies for HSWs can be understood as produced by a process of diversification. It could be interpreted as the assertion and display of internal boundaries within the subgroup, emphasizing differences in interests and needs between the specific subgroups of HSWs rather than their mutual similarities, especially when it comes to the relationship between somatic, psychiatric, child and palliative care. To be able to become member of any of these professional associations, a university degree in social work is required; membership is voluntary.

Table 3 SK in numbers (sources: Neergaard 2013, SKAR001)

Year	Number of members (approx.)	Membership fee
1991	560	SEK 160 (approx. € 16)
2008	250	SEK 200 (approx. € 20)

As Table 3 above shows, the number of SK members has decreased considerably over the past 20 years (by 45 per cent), from 560 in 1991 to 250 in 2008. Having represented approximately 16 per cent of all HSWs in 1991, it only represented 6 per cent of them in 2008. The membership fee in 2008 was approximately 20 euros. During the years 1989–2008, the board consisted of between 11 and 6 active members who involved in the development of the association and the pursuit of the aims of the association. During all the years, the board of the SK consisted of 100 per cent women. All active members in the association work for it on a voluntary basis.

Of all the professional bodies for HSWs in Sweden, especially the organizational structure of the SK speaks of an ambition to include HSWs from diverse work fields and represent HSW interests more generally. Drawing on Etzioni's (1961) term 'organizational scope', especially the SK may be interpreted as taking measures to embrace the interests of a wide range of HSWs working in different health care settings. However, membership in it is restricted to actively practicing HSWs only, thus excluding, for example, social work researchers and teachers with a focus on HSW who are not HSW practitioners. From an internal perspective, as Etzioni (1961) has noted, the inclusion of persons representing professional symbolic power can be used as a means to improve social control and improve the voluntary compliance of members. The exclusion of research and teaching professionals may thus

impact members' willingness to comply and submit themselves to the social control of the professional body.

SK: Aim and vision

As stated on its homepage, the SK wants to promote a holistic and psycho-social perspective on all levels of HSW (Svensk Kuratorsförening 2007). It wants to promote and develop academic education of HSWs at both basic and advanced levels, and support the development of social work methods. The SK aims to represent its members, support them in their professional role, and facilitate co-operation between its members. It also wants to facilitate co-operation between HSWs and other professional groups, promote discussion of health care-related and broader societal problems and issues, and promote international co-operation. Yet another of its aims is to inform decision makers about the role of the SK (Svensk Kuratorsförening 2007). The association's board works on a voluntary basis and the organization employs no administrative staff. According to Becher (1999), professional bodies such as the SK that aim at representing professional interests but lack licensure, provide services like conferences and journals to its members, have a voluntary membership, and are run vocationally without paid administrative staff, can be termed professional associations. The SK's aims and visions can be understood as describing it as precisely such a professional association, albeit one with a possible tendency towards becoming a professional interest organization, given that the services offered or provided by the association are focussed on social activities with any more ambitious collective-level services limited to organizing an annual congress (ever since the cessation of the association's journal).

SK: History

According to Fredlund (1997), the founding of an association for HSWs was delayed in Sweden by ongoing disagreements concerning HSWs' formal training requirements. Many HSWs in the 1920s and the 1930s were nurses. Ultimately, the disagreements were nevertheless settled, and the SK was founded in 1944. The new association's formal membership criteria were tied to social work training (*socialinstitut*). Soon, the SK claimed itself the role of the public voice of HSWs, providing an important source of information for HSWs and a forum were social workers could together develop their competences as well as develop common positions and views on matters of public importance. The association also became a referral organ for public investigations around issues of relevance to HSWs. Social work competence was one of the first major issues the association started tackling in

its early years, with one of its first undertakings being the organization of seminars for HSWs.

The SK, furthermore, created the first nation-wide questionnaire inquiring HSWs' formal competences and working conditions in the middle of the 1950s (see Fredlund 1997). The results of this survey then provided the argumentative base for an official proposal that HSWs' annual caseload be limited to no more than 400–450 cases. The association also played an active role in state investigations, for example by drafting guidelines regarding future demand of HSWs in mental health care.

The association became even more active in the 1960s when the issue of specific HSW units within hospital organizations increasingly moved into focus (see Fredlund 1997). There were disagreements between the National Board of Health and Welfare and the SK concerning organization of the HSW work force, however. While the state administration proposed submitting HSW units to the hospitals' social medicine departments, the SK argued that HSW units should be placed directly under the hospitals' top management. In the late 1960s, the National Board for Health and Welfare also created and distributed guidelines concerning, among other things, HSWs' main work tasks (*Normalinstruktionen*), developed in collaboration with the SK and subsequently adopted by *Landstingsförbundet*, the association of Swedish county administrations. The guidelines thus came to constitute the official frame for HSWs work in health care. The SK also actively asserted HSWs' need for local introduction and continuing education within hospital organizations, and apparently also itself offered further education courses for regular and top-level HSW personnel (Fredlund 1997).

In the 1970s, the SK could then claimed success by developing statistical report systems that pointed to current and future demand for HSW. Towards the end of the 1970s, the association also proposed integrating social workers into primary care organizations. During the early 1980s, the association collected statistical evidence for its case, leading to a re-evaluation of the former guidelines of the National Board of Health and Welfare. During the 1980s, the SK also sought the collaboration of the trade union in the area (SSR) to put forward its claim for HSWs' licensure (Fredlund 1997).

From the early 1950s until the 1960s, all Nordic HSW associations jointly published one common journal which mostly provided descriptive information derived all national associations. Seminar session minutes, course records, information on international conferences, debate articles, book tips, and articles about practice in HSW, and official statements and comments on draft law proposals and government investigation committee reports were among the kinds of items published (Fredlund 1997). When the Nordic collaboration ended, the SK at first attempted to continue the journal project bringing out a Swedish version of it. However, in the late 1990s, the

publication of also this journal ceased. Today, the SK mails out to all its members various kinds of membership information once or twice a year, including, first and foremost, invitations to seminars and minutes from the association's board meetings.

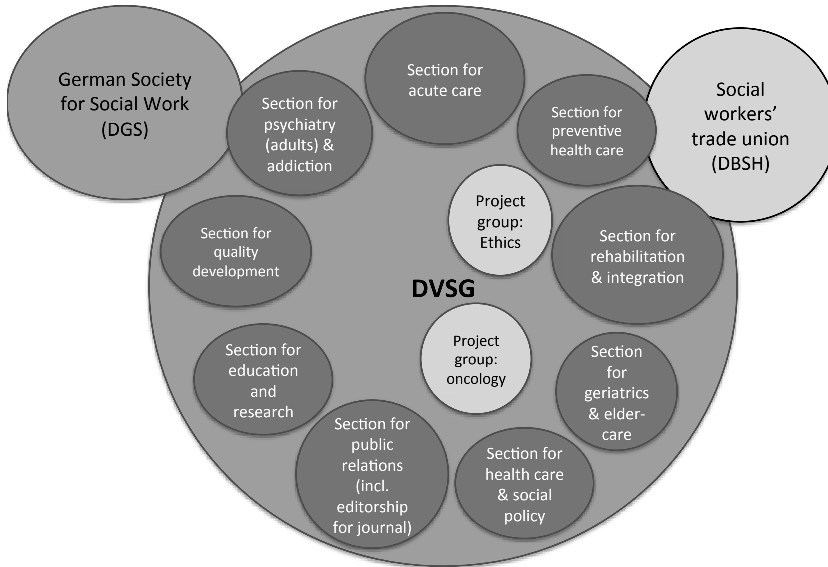
Even this brief glance at the history of SK shows that even though the association has to rely on voluntary membership, its scope can be described as having been narrow from the very beginning, excluding hospital social services practitioners with other educational background in fields than social work. It also indicates, however, that the association seems to have been recognized as an official representative for the professional subgroup at least from the 1960s on, with influence on the macro level (e.g., its claims concerning caseload), and on the developments bringing the extension of social work to other healthcare areas such as psychiatry and primary care.

To sum up, the associational landscape in Sweden has tended toward diversification where differences within the professional subgroup of HSW are stressed more than the similarities. Parts of the symbolic elite, such as researchers of HSW, are excluded from membership in the SK, affecting the association's internal sources for symbolic power that could be used to control members' compliance. Also the scope for the association is focused on HSWs with formal training in social work. Historically, it seems evident that the SK has come to be seen as representing HSWs, having today an ability to influence policy making on specific issues.

5.2 Associational landscape in Germany

In Germany, the associational landscape looks rather different compared to Sweden, as shown in Figure 2. (Circle size does not indicate the actual size of the professional body in question, in terms of its membership base, while overlap indicates mutual membership.) The picture presented here, too, derives from available Internet information collected in 2008.

Figure 2 The associational landscape of HSW in Germany (July 2009)



In Germany, there are three professional bodies related to HSW interests. On the one hand, there is the trade union, the *Deutscher Berufsverband für Soziale Arbeit e.V.* (DBSH). As in Sweden, the trade union represents the interests of a variety of academic professions within the social science field, of which social work is but one. While it, predominantly, represents employee interests, it also represents social policy and professional interests for the social work profession in general. In this capacity, it represents approximately three per cent of all social workers in the country (Engelke 2004). The German Society for Social Work (*Deutsche Gesellschaft für Soziale Arbeit e.V.*, DGS), on the other hand, is a politically independent voluntary organization uniting the interests of, mostly, members of social work and social pedagogy faculties at universities of applied sciences and other universities (Staub-Bernasconi 2007).

Today, the professional body DVSG represents the interests of all social workers in a wide range of healthcare settings, including specific HSW interests. Historically, however, it is an association representing the interests of social workers working in hospitals. Its scope covers some permanent subgroups. HSWs from "speciality" fields such as psychiatric care and addiction, in-patient somatic hospital care including emergency room care, rehabilitation and integration, as well as geriatrics and eldercare are represented through their own sections, as are HSWs working in preventive

health care. Other sections relate to common interests of all association members, handling matters like public relations, the association's journal, healthcare and social policy, quality development, education, and research. Tasks and interests judged to be of temporally limited nature are dealt with in project groups such as those for ethics and oncology.

The DVSG and the trade union DBSH have mutual membership in each other's organizations. Both of them are independent professional bodies, equal in size and political power. Also the DVSG and the DGS have mutual membership in each other's organizations.

The associational landscape of HSW in Germany can be characterized as dense, given that association in this case is concentrated on just a few professional bodies. The representation of specific HSW interests by one professional body can be perceived as underlining the similarity of interests between social workers from different healthcare fields.

Table 4 DVSG in numbers (sources: Müller-Baron 2013, GAR001)

Year	Number of members (approx.)	Membership fee
1991	800 (incl. 190 organizations)	DEM 90 (approx. € 45) on average
2008	1,400 (incl. 400 organizations)	In East € 60, in West € 80 (HSW practitioners) or € 100 and up (organizations)

As Table 4 above shows, the number of DVSG members has increased by 75 per cent since the early 1990s. The DVSG may therefore represent up to approximately 16 per cent of all employees in hospital social services today. The organization also allows individuals with social work degrees and other educational backgrounds as well as social work researchers and educators to sign up, as it does healthcare organizations. The only strict requirement is to commit to supporting the interests and development of HSW. Membership fees in 2008 ranged from 60 euros to over 100 euros, being different for organizations and individual practitioners as well as depending on the size of the organization and whether the practitioner was employed in the former East or West Germany. In consequence, also other professionals and even hospital firms, health insurance funds, and other corporative organizations can become members, to promote the development of social work in health care. Counting members and representatives in the DVSG board, advisory board, sections and regional work groups in the federated states, the DVSG has more than twenty active members in 1989 and nearly 40 active members in 2008. Board and work group representatives on the national and federated states level of the DVSG were together comprised of 35 per cent men and 65 per cent women, compared with 67 per cent men and 33

per cent women in 1990. Even if most members work voluntarily for the DVSG, there were also 1.5 full-time employees working in the association's offices: one person working half time with administrative tasks and another person working full time on mainly public relations, representing the DVSG externally vis-à-vis the press but also in other official connections.

Drawing on Etzioni's (1961) term 'organizational scope', the DVSG can be characterized as aiming at a broad scope, since it aims at including within it interests of HSWs working in increasingly diverse segments of the healthcare environment. Membership criteria are much less rigid than in Sweden and relate mostly to just willingness to pursue shared interests. As a result, even teachers and researchers of HSW can sign up. According to Etzioni (1961), this influences other members' willingness to comply with the definition of their professional attributes, standards, and regulations by the DVSG, impacting the organization's ability to exert social control.

DVSG: Aim and vision

The tasks and aims of the DVSG are presented on the DVSG homepage (DVSG 2009). The association aims at promoting the exchange of information between research, education, and clinical work, and fostering possibilities to exchange experiences and engage in co-operation, both internally within social work and externally with other professions and disciplines. The DVSG also promotes further development of quality aspects in HSW by either itself conducting or collaborating around research, by developing standards, and by issuing professional regulations for members concerning clinical social work. In addition, it promotes the development of structural concepts for social work and its content in healthcare settings.

The DVSG aims at furthering the inclusion of social aspects in medical intervention and rehabilitation. Towards this end, it publishes its official positions on healthcare and social-policy matters and comments on public policy documents like official reports and policy proposals. The DVSG informs and counsels politicians, administrations, and the professional public about HSW matters, and co-operates with decision-making bodies in health care and social welfare.

The association further offers advisory and informational services. It edits and publishes a professional journal for social work in health care (combined with an academically oriented supplement in clinical social work). It also organizes professional meetings, conferences, seminars, and further education opportunities for its members, and handles public relations tasks vis-à-vis the wider society (DVSG 2009).

According to Becher's (1999) categorization of professional bodies, the DVSG can be termed a professional association. Nevertheless, that it employs paid staff and provides rather extensive services to its members could

also be seen as indications of its being in the process of gradually transforming into a professional institution. On the other hand, the fact that members of other professions and diverse organizations may take up a membership in it rather suggests proximity to interest organizations instead. Following Etzioni's (1961) characterization of voluntary organizations in general, the DVSG could be said to be exercising social control by promoting the internalization of specific associationally approved knowledge and collectively defined professional attributes characterizing HSWs through ritualized associational activities such as continuing education, seminars, and conferences.

DVSG: History

As described by Reinicke (2001a), the DVSG was founded by two HSWs in 1926 in Berlin.[29] The organization was intended as an arena for HSWs to publicly discuss problems they experienced in their work. Another aim given for it was to raise issues relevant to HSW also at the level of corporative bodies such as, for example, the German Hospital Federation. In his opening speech to the DVSG, the director of the German Hospital Federation acknowledged the importance of HSW as the third pillar in health care besides medicine and nursery, pointing out that physicians as well as administrators could learn much about HSW through the newly founded DVSG. The DVSG management and board were composed by HSWs from the very beginning. The aim of the DVSG has always been to collect national and international experiences regarding HSW, to adapt knowledge from abroad to the German context, and to disseminate research findings among the association's membership, for example through continuing education offered to HSWs. Due to its corporative character and the structure of the welfare state, the DVSG has had both social workers and public corporative bodies (German Statutory Pension Insurance Scheme, the German Hospital Federation, National Association of Statutory Health Insurance Funds, etc.) as its members.

Even here, though, there were disagreements from the very beginnings. Reinicke (2001a) has described how, motivated by their differing interests, various welfare organizations viewed the DVSG with suspicion, believing it to be aiming at a position where it could influence the basic education of HSWs that had hitherto been the turf of these organizations. Discussions around this issue continued until 1933. The two founders of the DVSG, however, representing as they did HSW interests, held on to their idea that integrating as many interests as possible would also serve HSW interests best. In consequence, the DVSG board had unusually many members from early on, with the intent of that way representing the interests of a maximum

[29] Hedwig Landsberg and Anni Tüllmann.

number of different healthcare service actors. Nevertheless, the leading positions in the association were always held by HSWs, even if its chairmen of the board came from other professions in the early stages of its existence.

Seminars and conferences for professionals were one of the most important instruments the DVSG resorted to in order to discuss and disseminate experiences and knowledge. The topics discussed in the association's early days remain debated still today, such as the high workload of HSWs and the organizational structure of HSWs within hospital organizations.

From 1933 to 1945, the DVSG and HSW more in general voluntarily joined the Nazi Party's public healthcare agenda (*Volksgesundheitspflege*), for example by dismissing now undesired board members (for example Hedwig Landsberg), by helping to implement the Party's racial hygiene programme, by organizing social care for war victims and the return of impaired slave labourers to their home countries. Following the end of the war, the DVSG was liquidated, only to be re-founded in 1947, now with the earlier dismissed founder of the association once more as its director.

Since 1979, also the association's chairmen of the board have been social workers (Reinicke 2001a). Following the German reunification, some of the DVSG's most pressing tasks were the integration of East German hospital welfare workers and dissemination of information about the importance of participating in corporative negotiations in the new federated states. Its other major tasks had to do with the formal integration of HSW into the legal framework of the federated states, HSWs' statutory professional secrecy, and the creation of guidelines concerning work tasks, quality management, the integration of HSW into disease management programmes, the integration of HSW into corporative contracts and quality programmes, as well as the organization of training courses for HSWs and research co-operation. In response to changes in the country's healthcare sector in the 2000s, the DVSG amended its statutes in 2003, opening up the association for social workers in all healthcare sectors (DVSG 2006). Today, the DVSG is included in the Federal parliament's official list of referee organizations for parliamentary hearings around healthcare issues.

As the history of the DVSG shows, the corporative healthcare organization and changes to the healthcare sector in Germany have impacted on how professional HSW interests are perceived to be represented most effectively. A broad scope, including the representation of interests also other than HSWs', was implemented from the beginning. However, a successive retreat of many of these competing interests can be witnessed as taking place throughout the 20th century in the association, especially on the part of the key positions in it. More recent membership data show the majority of the members to today be individual HSWs, with a significantly smaller (but growing) participation of HSW employers. As also the historical record indicates, the as-

sociation has throughout its existence (with the exception of the National Socialist era) been perceived as the official representative of HSWs, and it seems capable of influencing macro level healthcare policy making on issues such as HSWs' caseload, HSWs' work task descriptions, and the extension of social work to other healthcare areas besides hospital care.

In summary, the landscape of the professional bodies concerned with HSW interests in Germany can be characterized as dense, with just one association representing all HSWs. Externally, this way of organizing the professional interests of HSWs can be said to be highlighting similarities between HSW fields rather than their differences. Also the internal structure of the association supports this impression, given that, even though the association's different sections each deal with a different HSW work field, they at the same time focus on the common interests of all HSWs. The mutual membership between trade union, the German society for Social Work (DGS), and the DVSG can similarly be understood as underlining similarities between the interests of these professional bodies, thereby pronouncing the affiliation of HSW to social work. The broad scope of the DVSG allows membership of both individual HSWs and HSW employers. The inclusion of symbolic elite drawn from research and education in the association can be assumed to affect the association's ability to motivate its members' compliance and exert social control. The DVSG is seen as an official representative of HSWs and has the ability to impact policy making on health care issues.

5.3 Comparative summary

As described above, the associational landscapes for HSWs in Sweden and Germany are quite different. In addition, as shown in Chapter Two, the legal conditions of HSW in the two countries differ as well. Table 5 below gives the main differences in the two countries' associational landscape and associational activity.

Table 5 Sweden and Germany: main differences in associational landscape and activity

Differing aspect	Sweden	Germany
Type of professional body	Association tending toward interest group	Association tending toward professional institution
Associational landscape	Diversified	Dense
Representation of HSW interests	Rather narrow representation of specialties' interests; assertion of differences between HSW fields and vis-à-vis social work	Rather generalized representation of social work; assertion of similarities between HSW fields and vis-à-vis social work
Membership requirements (SK and DVSG)	Individual membership for HSWs with a university degree in social work; only including social work researchers who at the same time continue working as HSW practitioners	Individual, organizational, and mutual membership for all with an interest in promoting HSW interests; including professionals with symbolic power (SW teachers and researchers)
Publicizing of HSW interests	Internal membership information; dissemination of information mostly to members	Professional journal of social work in health care, including an academic supplement on clinical social work; dissemination of information to broader public
Membership services (SK and DVSG)	Professional exchanges, conferences	Professional exchanges, seminars, conferences, further education

Both the SK and the DVSG could be roughly defined as a professional association. Nevertheless, there are some significant differences between them. While the German HSW association DVSK could be described as increasing assuming the characteristics of a professional institution, the Swedish HSW association SK rather tends towards becoming a professional interest group. The SK represents HSWs mainly via the trade union, while the DVSG represents HSW interests independently.

Considerable differences between the associational strength of the SK and the DVSG also exist as regards their size and their economic and other organizational resources. The DVSG has more than five-and-a-half times larger membership base than the SK. The differences in economic resources, however, are even larger, with even the average membership fee of the German association nearly four times higher than that of the Swedish one. It can, moreover, be presumed that the German association also has additional in-

come sources, deriving from the sale of its professional journal and other publications and from its role as an offerer of education opportunities. These resources enable the DVSG to employ paid staff in its administration and other strategic tasks, while the SK has to entirely rely on voluntary work by its members. Over time, the German association's strength can thus be characterised as increasing, both in membership numbers, economic and human resources. In contrast, the strength of the Swedish association can be described as weakening due to decreasing membership numbers. These increasing differences between the two associations in strength are magnified by the fact that fees for a regular DVSG-membership are five times higher.

Differences between the two cases are also obvious even when it comes to the associational landscape in the two countries. In Germany, the landscape can be defined as dense, with one professional association representing all HSWs. Here the professional association, the research association, and the trade union have mutual membership, implying collaboration in an organizationally structured way around important questions. In the German case, the above characteristics can be defined as asserting similarities in interests amongst HSWs and in relation to the social work profession in general. In Sweden, on the other hand, the associational landscape can be defined as diversified. HSWs are organized into different professional associations representing different specialties of HSW and their specific points of view. In relation to the trade union, the SK has the role of a referee. In the Swedish case, however, they can be seen as underlining internal differences between the interests of HSWs and those of diverse healthcare fields, as well as differences in interests between the trade union and the HSW association.

Membership requirements, too, differ between the German and the Swedish association. The professional association in Germany has opened its membership to all individual and organizational actors who are willing to promote HSW interests, including researchers and university teachers. The Swedish association, on the other hand, accepts only HSWs with university education in social work who actually work in hospital social services.[30] Especially in voluntary organizations, the fact whether professionals with symbolic power are included or excluded may have implications for members' motivation to comply with the organization's official positions and the organizations' ability to exert social control over their members in the application of collectively approved professional definitions and attributes.

One indicator of a more public representation of HSWs' interests is the possible publication of an official professional journal for social workers in health care. This is done by the German association, whose publication is even available to the interested public. In contrast, the Swedish association's

[30] At the same time, both the DVSG and the SK stress social work competences as a prerequisite for practising HSW.

publication forum is limited to internal membership information. Etzioni (1961) has described how compliance in voluntary organizations is facilitated by downward information supply and how voluntary organizations attempt to extend their scope by reaching out with information to non-members. The use of professional journals available to a public larger than just the strict membership base of the association can then be interpreted as an effort to broaden the scope of the association. This was the case in Germany but not in Sweden.

Additionally, the SK enables its members to exchange experiences with one another and invites them to conferences; however, the association itself does not provide further education. In Germany, in contrast, the association arranges a variety of further education training courses for HSWs, in addition to its other membership services as already noted. As Sarfatti Larson (1979) has observed, professional bodies can utilize education in order to exert social control through the internalization of certain associationally approved knowledge. Ritualized activities such as conferences, seminars, and, in especial, further education and exchange of experiences within the association itself, can thus be perceived as enabling social control by the association: all these can be used to promote internalization of specific knowledge. In this context, encouraging members to exchange experiences and support one another, as in the Swedish case, can be understood as a way to exert an individualized form of social control in which the association is less able to control the content. Further education in associationally arranged courses, on the other hand, can, as in the German case, be understood as offering a means for the association to exert social control in a structured way that allows the content of the course to remain tightly controlled.

6 Developing and Controlling a Collective Identity

In this chapter, hospital social workers' internal jurisdictional work efforts in Sweden and Germany are described, analysed, and compared. The jurisdictional work here represents intra-professional strategies for establishing and controlling a specific professional group identity. More in particular, the chapter investigates the concrete means by which HSW associations in the two countries have used to establish and maintain a collective professional identity for HSWs.

The term 'jurisdictional work' offers a way to describe the process of developing and maintaining professional boundaries and shared professional goals in negotiation with other members of the profession (cf. Abbott 1988, Gieryn 1999, Macdonald 1999). The claims-making connected with this work usually concerns the profession's distinct professional attributes such as a particular knowledgebase, classification systems, work tasks, methods for diagnostic inference, and approaches to treatment including treatment skills. These are often described as defining symbolic commonalities within and between professions (Abbott 1988, Etzioni 1969, Grimen 2008, Macdonald 1999, Oeverman 2008). At the same time, however, when it comes to organizations with voluntary membership, the development and control of such distinguishing professional attributes and goals as well as their symbolic implications can be understood in terms of group identity development and compliance (Etzioni 1961, Jenkins 2004).

As the empirical data shows, the jurisdictional work of HSWs' professional associations in Sweden and Germany aims at the development and maintenance of a collectively agreed professional group identity for HSWs. This process has several distinct dimensions to it. It, first of all, involves negotiation efforts by the associations that are aimed at bringing about an agreement on a specific collective professional identity, including the definition of specific attributes as characteristic of, and symbolic for, the professional subgroup (HSW). Such professional attributes involve the subgroup's professional work tasks, skills, and intervention methods as well as the development of standardizing instruments for its professional practice. Through internal negotiations, symbolic meanings and learned profession-specific behavioural patterns are attached to these attributes, defined subsequently as characteristic of this particular professional group. Together, the symbolic meanings and learned behavioural patterns then constitute the professional culture of the professional subgroup.

At the same time, however, the same data show associational efforts to develop a group-specific professional identity to also include collective life stories of the history and present situation of the professional subgroup. These life stories draw upon historical narratives and facts as well as

narratives and facts concerning present jurisdictional threats posed by other professions or by changes taking place in society. Even the perceived and declared association of the professional subgroup with a certain academic discipline and its relevant knowledgebase and education for professional practice play an essential role in the development of a subgroup-specific professional identity.

The development of this group-specific identity, as in the case of the professional subgroup of HSW, also implies the development of professional boundaries. These are used to demarcate the professional subgroup from the rest of the broader profession and from other professions, which is done through the adoption of specific symbolic meanings and learned behavioural patterns designated as the group's professional attributes, and through the assertion of the professional group's history, its narratives, and its perceived affinity to one or another profession. However, the development and, even more, maintenance of a collective subgroup identity also presupposes voluntary compliance with the attributes describing this identity, by both members of the association and most non-affiliated representatives of the subprofession (HSWs in this case).

6.1 Developing collective professional life stories

The associational documents obtained from both countries provided ample material for studying the development of narratives of the present situation of the professional subgroup in its context. In addition, the SK and the DVSG also promoted the development of narratives of HSW's past. Three specific kinds of narratives could be discerned here: narratives of the profession's self-perception, narratives about its relationship to other professions, and narratives about the impact of healthcare policy.

Narratives of professional self-perception

Both the Swedish and the German HSW associations studied used documents to communicate their professional self-perception of HSW through narratives of the history and present situation of the subgroup. In the Swedish case, *historical narratives* of HSW, its work tasks, function, and identity, were rare. Two publications were available regarding this. One of these described the history of the SK: the beginnings of HSW as a profession and its changes over time. The publication in question, a booklet, was produced to commemorate the association's 70th anniversary.[31] The other one, a doctoral dissertation, describes the changing role of the professional group in the

[31] Fredlund 1997; cf. SKA031, SKP001, SKP045, SKP049, SKP050, SKP051, SKP075, SKP092.

hospital setting over time.[32] Neither work was published by a regular publishing house but could be obtained either directly from the authors or from the SK. In them, HSW history is described, but it is not tackled as means to describe or explain the present situation of the profession.

In Germany, historical research tends to be more common and its function from the point of view of HSW has been pointed out repeatedly. In an annual report of the DVSG, for example, it is stated that "Memory of HSW's past is a precondition for its having a constructive impact on its future; the future needs its origins."[33] The research here has focused especially on historical key figures and the history of HSW in general and the DVSG in particular. The available publications include book volumes published by regular publishing houses, booklets issued by the DVSG, and articles appearing in the DVSG journal.[34] In narrations concerned with the situation of HSW, the association frequently describes the current jurisdictional problems of HSW as related to historical factors and circumstances, such as, for example, the relative youth of the social work profession or the history of social work in general.[35] Overall, narratives of HSW history were more often used to contextualize current descriptions of HSW in Germany than in Sweden.

Narratives of HSWs' current situation were common. In connection with them, also the need to produce evidence on which to base the shared narratives regarding HSWs' situation was repeatedly addressed. In the Swedish case, this need was stressed especially in the documents dating from the early 1990s. At the same time, however, the Swedish association also considered itself to lack the resources to carry out the kind of work needed for this task, to that way be able to better analyse and describe the present situation of social work:

> A decision was made to shelve a proposal by primary-care hospital social workers from Sörmland to have the SK collect data on hospital social workers' responsibilities in primary care. According to the Board, it would be practically impossible for the association to do so as it lacks the necessary capacity to register and store materials and keep the collected material up to date.[36]

The work to develop such intended descriptions in Sweden was, instead, often initiated and carried out by specific healthcare organizations or specific county councils, or undertaken upon the initiative of the association but

[32] Olsson 1999.
[33] GAR007: 5.
[34] E.g., Reinicke 2001a, DVSG e.V. (2006).
[35] GPO017, GA117, FG DVSG.
[36] SKP002: 24.

financed by a multi-professional state authority, such as the SPRI.[37] The results from these investigations tended to be used to argue for specific professional interests.[38] In Germany, too, in the 1990s, the DVSG often addressed the need for such descriptions of HSW's situation, assumed to enhance the future development of work task and work field descriptions and the acknowledgment of HSW's contributions to health.[39] Accordingly, the association itself in several cases initiated and developed such narratives of the current HSW situation.[40]

Indeed, the SK and the DVSG put forward a similar key discourse concerning the situation of HSW. In both cases, the key discourse on the association's self-perception of HSW can be summarized as follows: *For other professions encountered at workplaces locally, HSW is a fuzzy and unfamiliar profession*. The "fuzziness" here refers to other professions' vague notions of HSWs' work tasks that often fail to correspond to HSWs' own understanding of these. In a hospital context, one could therefore also speak of the fuzzy professional identity that HSWs have in the eyes of their co-workers from other professions. This becomes evident for example from the following quote, taken from a statement by the DVSG:

> New HSWs working in rehabilitation find their work situations fuzzy. In a work field dominated by medicine, this is experienced as a situation that can evoke feelings of powerlessness and uncertainty, especially as professional social workers often are the sole representatives for their profession [at their workplace].[41]

The professional group's self-perception of its present situation was discussed in the documents obtained from DVSG as well.[42] These narratives, too, described HSW work tasks as being differently understood by HSWs and other actors, resulting in unclear and contradictory expectations set on HSWs by other professionals. Unlike their Swedish colleagues, however, German HSWs did not appear to perceive this fuzzy professional identity of theirs as something setting them apart from the rest of the social work profession. On the contrary, it was even claimed to be a unifying characteristic of all social workers in general. As one of the DVSG representatives put it:

[37] SPRI (*Sjukvårdens och socialvårdens planerings- och rationaliseringsinstitut*), SKP059, SKP078, SKP008, SKP020, SKP031, SKAR001, SKWS006.
[38] SKWS006.
[39] GPO003, GPO010, GPO011e, GPO013a/c, GPO014, GPO017, GPO025b/c, GPO028b, GPO029d, GA039, GA048, GA063, GA074a-c, GA097c, GA112, GA125c/d, GA104a/e, GPA013e, GPC005a, GPC006a/b, GPB050, GAR001: 5, 9, 12ff, GAR002b, GAR006, FG DVSG.
[40] GA016a, GPO002, GPO006.
[41] GA016a: 41.
[42] GA039, GAR002: 16f, GAR005: 6, GPO010, GPO011f, GPO012, GPO014a, GPO031d.

> This is very much related to the overall professional identity of social workers. Social work, quite simply, has not developed a uniform professional identity.[43]

In Sweden, on the other hand, narratives of the current situation of HSW tended to portray this perceived uncertainty of identity in relation to other healthcare professions as a particular characteristic of HSWs and not of the social work profession overall. These narratives were common especially in the materials dating from the end of the 2000s. However, in these cases, the causes behind this uncertainty were not only ascribed to the unclear and contradictory expectations by other professions in health care; unclear expectations were also imputed to social work education as well as to the actions of actors such as employers and, not least, welfare authorities.[44] The refusal by the Swedish National Board on Health and Welfare to implement licensure for HSWs was in these narratives described as evidence of the authority's lack of awareness concerning the specific situation of HSW in the context of the social work profession more in general.[45] In the following quote, some of the consequences of HSWs' fuzzy professional identity are described in terms of being a stranger within health care, in this case from a researcher's point of view:

> Often, HSWs interested in research are the only ones from their profession [in their work environment] and/or do not have access to any research groups, whether in social work departments or medical departments.[46]

Nevertheless, narratives describing HSWs' contemporary situation in Germany also described changes in both the internal and external perceptions about the HSW profession. Articles published by representatives of the association in its journal spoke of a heightened self-consciousness amongst HSWs.[47] German focus group members, for their part, estimated it to be more commonly known today that social workers and social pedagogues provided social services.[48] The reasons behind this change were considered to be multiple, although the association's own role in assisting HSW practitioners to deal with this fuzziness was deemed critical.[49]

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[43] FG DVSG.
[44] SVKFP014.
[45] SKA020, SKP053.
[46] NFSP018: 5.
[47] GPA011, GA026, GPB053, GA045.
[48] FG DVSG.
[49] GPO011e, GPO013c, GPO016, GPO017, GPO024b, GPA009e, GA016a, GA031, GA044c, GA046c, GA055, GA059d/e/f, GA070, GA143c GAR005, GPB035b, GPB038, GWS028, GWS038, GWS041, GA039, GAR002: 16f, GAR005: 6, GPO010, GPO011f, GPO012, GPO014a, GPO031d.

The production of narratives of HSW history and current situation can be understood as a cultural activity aimed to create specific professional attributes and their associated symbolic meanings that then can define the subgroup-specific identity of HSWs. Among the professional attributes presented in historical narratives are, for example, the profession's young age and its historical relationship to social work. The German association has subsequently used these attributes to better understand the present situation of HSW and create new narratives, this time of the present situation of HSW.

These latter narratives, focused on the present situation of HSW, tended, on the one hand, to stress the need to investigate the present situation of HSW to begin with and, on the other hand, to put forward key discourses describing the present situation of HSW as characterized by its being an unfamiliar profession that was a stranger in the healthcare setting, a profession in whose case external expectations concerning HSWs' professional responsibilities and duties diverged from those of the HSW practitioners themselves, expressing their fuzzy professional identity.

In Sweden, these attributes were described to be something that contrasted with the attributes of the social work profession in general. There, they were thus referred to in narratives to draw a boundary line between the subgroup and its primary profession social work, to be able to present HSW as a professional subgroup. This was unlike in Germany, where these attributes were described as shared by both HSW and social work. In this case, they were associated with symbolic meanings subsuming the professional group of HSWs under the broader social work profession.

Depending on associational resources, the narratives of the present situation were sometimes built on factual evidence and data obtained through the association's own empirical investigations. Where such investigations and, by extension, also the development of narratives of the present situation of HSW were, instead, delegated to other actors as in the Swedish case, this could also be understood as an implicit delegation of the power to develop aspects of the profession-specific group identity to these actors. This might then have been one reason why knowledge of HSW as produced by other actors was only rarely referred to in the documents investigated, whereas associationally developed narratives were frequently brought up or otherwise referred to.

Narratives describing lack of professional control

A recurring key discourse in the narratives concerned the HSW profession's role in healthcare settings. This key discourse could, in a nutshell, be articulated as follows: *HSW lacks control over its jurisdiction; therefore other professions think they can do our job*. In Germany, this lack of control was fre-

quently described and emphasized in the documents studied and in the focus group interview. In Sweden, in contrast, it was mostly not addressed by the associations. Two documents, however, stood out as exceptions, even if the professional group's lack of control over a certain professional territory in this case was only implicitly referred to, rather than explicitly addressed.[50] At the same time, the Swedish focus group participants, however, did expressly note and speak about this lack of professional control of HSWs in their interview.

Narratives of lack of professional control related to several different areas of HSWs' professional activity. There was, for example, the assertion made that HSWs often lacked control over diagnosis and inference, and that other professions interfered in HSW treatment, often bringing about a premature termination of HSW treatment.[51] Narratives of lack of professional control also referred to experiences such as denied access to patients as well as lack of say in work task prioritising.[52] As one of the focus group participants from the SK elaborated on this:

> We have colleagues who come back from medical rounds and they are very frustrated and worn out. They say that there's no point in giving your professional opinion as a hospital social worker when you are out there on these rounds, because there's no one there who wants to listen to you because the others already decided to discharge the patient … taking the risk that the patient will then later on be brought back to us again, just because those other professions didn't want to address all the issues now.[53]

This excerpt from one narrative on the perceived lack of control describes a situation where the needed HSW treatment is not given importance on part with treatment provided by other professions and where HSWs' professional opinion is not listened to by other professionals, due to insufficient resources or the like. Another focus group participant from the DVSG estimated that social work was still seen by everyone else as a "layman's work":

> I think they know who's doing this job, but there are still quite a lot of those out there who think they could do it themselves as well … They don't see that you also need certain discretionary skills to be able to do this job, sometimes. And this is what our problem is all about.[54]

[50] SKP017, SKP050.
[51] FG SK, GPO001, GPO003, GAR001, GAR002, GPO002B, GA059b.
[52] FG SK.
[53] Participant in FG SK.
[54] Participant in FG DVSG.

This particular narrative described a disagreement between other professions and HSW concerning the allocation of professional activities such as work task execution, inference skills, and diagnosis setting. What is important here is that autonomy over these activities is described as an essential characteristic of professions (Abbott 1989, Etzioni 1969, Grimen 2008, Macdonald 1999, Oeverman 2008). In using the key discourse of lack of professional control, HSW associations described their threatened professional autonomy and their threatened professional practices of social work in hospital settings as their professional attributes. Using Jenkins' (2004) terms 'category' and 'group identity', these professional activities, however, can also be understood as a focal point in the continual negotiation of HSW tasks between HSWs and other professionals in healthcare settings: the narrative here would then address the perceived discrepancy between, on the one hand, the HSW category as understood by other professions and, on the other hand, HSWs' group identity as expressed by the members of the professional group itself.

According to Jenkins (2004), the ascription of attributes to a specific group also reflects the power relations between the group and its settings. The HSW associations described the power over HSW performance to, for the most part, be in the hands of other professions. In both countries studied, the professional groups stressed the importance of giving HSWs more power in hospital settings in terms of access to patients, diagnosis setting, use of inference skills, and patient treatment, if the desired outcome of patient treatment was to be ensured.

However, as the documents collected show, the German association also engaged in efforts to replace old narratives with new ones. Instead for describing HSWs as lacking power, they thus sometimes preferred to speak of HSW as a self-confident profession:[55]

> An eagle or a chicken in the backyard?... In hospital social services we are "golden eagles", rising to astonishing heights, putting our independent professionalism on full display. We have our competence that speaks for itself, whether it be in our dealings with patients or when we work in inter-disciplinary teams, participate in diverse forums, and, not least, act within our professional association itself.[56]

Attempts to change or modify a key discourse in this fashion can be interpreted in several ways. First, they could be understood as an internal attempt by the associations to alter the self-perception of their professional subgroups in a more positive direction, by changing the professional at-

[55] GA139.
[56] GA026.

tributes put forward in the discourse; second, they could also be understood as an ongoing negotiation between an externally imposed category and an internally adopted group identity, in line with Jenkins (2004). The attempt to change the professional attributes put forward in narratives on HSW can be understood as an associational effort to constantly relate and re-relate external categories of HSW to internal HSW group identity and vice versa, so to as to be able to influence the external perception of the professional group by infusing it with more positive connotations. In Etzioni's (1961) terms, these efforts could, however, also be understood as an attempt to increase the attractiveness of the association both internally and externally, partly by addressing the interests of prospective members and partly by increasing the scope and pervasiveness of the association.

Narratives describing the impact of healthcare policy

In addition to the above-named types of narratives, the HSW associations in this study, characteristically, also used another type of narrative to identify and describe their professional subgroup. In this case, the narratives concerned the way in which healthcare policy developments affected HSW practice. These narratives evolved from the analytical activities promoted and performed by the professional associations and could be summarized as yielding a key discourse on how *the impact of healthcare policy development on HSW practice is ignored*. References to such analytic activity were found in documents collected in both countries, dating from all the years covered by this study (1989–2008). However, the Swedish narratives of the healthcare policy impact on HSW practice that drew on analyses of healthcare policy development in the country were much fewer than their counterparts in Germany.

In the German documents, the DVSG often expressed its view that it was important and indeed necessary to deliberately promote internal reflections on the kind of problems that healthcare policy development meant for HSW practice. According to it, reflection was needed to solve such emerging problems collectively at the structural level, whether nationally or locally.[57] However, a second aim of the analytic activities carried out by the association was to describe and predict the consequences of changing welfare structures and legislative reforms from the point of view of the development of HSW jurisdiction.[58]

[57] GPA005, GAR002b, GAR002/b, GAR003, GPO024a, GPO026, GPO027, GA097a/b/d/e, GA138, GA083, GA099b/d, GA113e, GA125a, GA104c/e, GA132a/b, GA021, GPA013e, GA064b, GA054b/c, GA078, GAR005, GPO031a/c, GPO014, GPO032a/b, GA082c, GPB027.

[58] GPO001, GPO016, GPO020, GPO031a/c/e, GA006, GA022, GA036, GA044d, GA057a/d, GA073, GA083.

GA97e, GA099d, GA122, GA125a, GA129, GA130, GA136, GA143a, GAR003, GAR005, GAR006, GAR007, FG DVSG.

On the part of the documents collected in Sweden, on the other hand, the descriptions of jurisdictional problems deriving from healthcare policy development appeared to have no further aim. At the same time, the documents by the Swedish associations nevertheless showed there to be internal discussions going on from time to time concerning such consequences of policy development. These discussions took place mainly in board meetings, although they could, on rare occasions, take place in further education seminars.[59] The official narratives emerging from the discussions in board meetings, however, were for the most part only presented in other contexts as well when they concerned the topic of licensure or a circumstance such as a certain regulation or law being seen as neglecting the importance of non-licensed professions in health care.[60]

In Germany, in contrast, the discussions on, and the definition of, the consequences of healthcare policy development, just as with the demarcation of HSW work tasks vis-à-vis other professions in and outside the hospital context, appeared to unfold as a collective process embracing all levels of associational activity, from local work groups to the national boards.[61] In seminars and in further education, the task of transferring knowledge was combined with discussions regarding the consequences of the changing legal framework. These consequences were often narrowed down to the predicted, still-evolving economic and jurisdictional consequences that (ongoing or already enacted) changes in legislation were seen as bringing for HSW.[62] When this happened, the associations often used a strategy to involve as many as possible of their local work group members in the analysis of what the healthcare policy developments in question meant for HSW practice. Sometimes outside experts were invited to help in this process, as in the meeting of one regional work group of the association where "NN, an attorney specialized in social law, explained the ongoing changes resulting from the integration of social benefits legislation into the Social Code."[63] During the ensuing discussions, narratives concerning the presumed consequences for HSW practice were then developed further and presented to even more members of the profession by circulating them through the association's journal.

While discussions to identify jurisdictional problems from healthcare policy development took place within the associations in both Sweden and Germany, there were nevertheless differences between the two country cases in terms of the extent to which this happened. In both countries, how-

[59] SKA016, SKP096.
[60] SKP047, SKP102, SKP112, SKP117, SKA016, SKAR011, SKAR013.
[61] GAR002b, GAR003: 18, 24, 26f, GAR004, GAR007, GA020b, GPO001, GPO014a/b, GPO016, GPO017, GPO023, GPO029b.
[62] GPO003, GPO013a/b, GPO029c, GA054a, GA122, GA132b, GAR007: 11f.
[63] GA100a.

ever, these discussions lead to the development of narratives concerning the impact that policy developments involving the healthcare sector had on HSW practice. Using Etzioni's (1961) terms, the analytical activity preceding the development of these narratives could be described as the performance of cultural work inside the association to develop professional attributes and their associated symbolic meanings that would be specific to the professional subgroup in general. This cultural work then also enabled the development of visions concerning the subprofession's future professional jurisdiction. However, such attempts to derive professional goals from narratives about the impact of healthcare policy on HSW practice seemed to be more frequent in Germany, where the association also made a point of identifying a far greater variety of ways in which of this impact was or could be felt than the association in Sweden. In the latter, it was predominantly narratives concerning the impact of licensure that were worked out or circulated over the long term, implying that the primary collective goal in the efforts to promote the development of professional jurisdiction for HSWs in Sweden was indeed that: licensure.

According to Etzioni (1961), members of a professional association stand a better chance of successfully pursuing organizational and professional goals when the association's expressive elite – its board, in the present case – publicize them and they are communicated both downwards and horizontally within the organization. By extension, it could thus also be assumed that professionals more likely engage in professional action capable of supporting the establishment of formal jurisdiction for their profession when members of the associational elite and peers employ narratives that describe the profession's professional goals and the kind of professional action called for to attain those goals. In Sweden, the SK board, during the period of this research, was primarily engaged in developing and disseminating narratives that addressed themselves to the lack of licensure and to professional goals responding to this lack; narratives addressing themselves to the lack of explicit recognition of HSW interventions in national healthcare guidelines and other public healthcare regulations were developed to a minor extent only. The DVSG, on the other hand, during the same time period produced and promoted a variety of narratives concerning the impact of developing healthcare policy on HSW practice. Some of the consequences it identified were HSW's lack of legal jurisdiction in several federated states and at the national level, as well as the exclusion of HSW aspects from public regulations and healthcare programmes. These narratives were developed and then disseminated and promoted at several levels of the association, both horizontally and vertically. The inclusion of non-members in the ensuing discussions, through publications in the associational journal and seminars

held in Germany, broadened the scope and the pervasiveness of the association and its goals to non-members.

6.2 Developing standardizing instruments and definitions of tasks and skills

The development in both Sweden and Germany of standardizing instruments and collective definitions of HSW work tasks and competences can be understood as the development and maintenance of professional attributes as elements of collective professional identity for HSWs. According to Abbott (1988), commonly shared definitions of work tasks and technical skills, and the classification systems developed to structure practice, are important elements for describing professions. By developing collectively shared definitions of these elements, the latter are turned into profession-specific attributes. The standardization of HSW practice in this context can then be understood as a way to develop classification systems structuring both daily work and knowledge.

The HSW associations engaged in jurisdictional work to define work tasks and technical skills and develop standardizing instruments for HSW practice. Through internal negotiation of these, a shared sense was reached regarding the way in which these aspects were to be understood by HSWs in especial. Through the activities they engaged in to develop their collective definitions, the parties involved also negotiated the specific symbolic meanings and behavioural codes to be linked to these professional attributes. As Gachoud et al. (2012) have shown, different professions attach different symbolic meaning to seemingly shared professional attributes. The HSWs' efforts in this study to define the underlying symbolic meaning of the tasks, skills, and standardizing instruments of social work can thus also be understood as an attempt to articulate exactly how these aspects were seen to differentiate the professional group from other professional groups and reduce ambiguity in one's professional identity.

Work tasks

The different work task and workplace descriptions put forth by the associations studied were aimed to help individual HSWs to demarcate their line of work from that of other professions' at the workplace level.[64] Both the SK and the DVSG engaged in developing and publishing official work task descriptions, intending these for both internal and external purposes. In both cases, the published descriptions were revised and updated from time

[64] FG DVSG.

to time.[65] In Sweden, updates were made to the original work tasks description, dating from 1989, in 1990, in 2004, and in 2008. In Germany, work tasks descriptions were processed at different levels of the associations and then passed over three periods, in 1990–1993, 2002–2006, and 2002–2007. In both countries, the descriptions were distributed to members of the profession, to members of other professions, as well as to healthcare policy makers, with the intention that they would be used by members at the workplace level and also draw upon at the organizational and legislative levels. [66]

Some of the work tasks enumerated in these descriptions were roughly the same for both the German and the Swedish HSW association. These included social and psychosocial counselling, co-operation with other professionals both inside and outside health care, and co-ordination of services. [67] At the same time, there were also differences in the way the HSW associations in Germany and Sweden officially presented HSW tasks and developed work task descriptions over time. Official work task descriptions by the SK remained basically unchanged throughout the two decades covered by the study period, with only minor adjustments made to the logic of the presentation. The importance the work task definitions assigned to structural social work gradually diminished while the importance assigned to psychosocial research and development grew over time.[68] In Germany, in contrast, the descriptions became more and more refined over time, with amendments made to the descriptions intended to adapt official work task descriptions to certain new purposes. The work task descriptions were developed to display social work's contributions to health care, to define its function in somatic, rehabilitative, and geriatric hospital contexts, and, last but not least, to facilitate the inclusion of specific standardized social work treatment procedures in the healthcare funders' benefits catalogues.[69]

There were, however, also differences in the way German and Swedish associations defined work tasks. The board members of the Swedish association stated themselves having difficulty summarizing general HSW tasks, perceiving HSWs' work tasks to vary considerably from one individual practitioner to another.[70] It was mostly treatment aspects of work tasks that were therefore taken up, although also diagnosis and professional inference

[65] SKD001, SKD005, SKD007, SKD006, GA005, GA070, GA092, GPA001, GPA002, GPA003, GPA006, GPB034: 22, GAR001, GAR002, GD001: 107f, GD003, GWS040.
[66] SKP002, SKP003, SKP016, SKP030, SKP078, SKP143, FG SK, GD001, GD003, GWS040, FG DVSG.
[67] SKD001, SKD005, SKD007, SKD006, GA005, GA070, GA092, GPA001, GPA002, GPA003, GPA006,
GPB034a: 22, GAR001, GAR002, GD001: 107f, GD003, GWS040.
[68] SKD001, SKD005, SKD007, SKD006.
[69] GA070, GA092, GPA001, GPA002, GPA003, GPA006, GAR001, GAR002, GD001, GD003, GWS040.
[70] FG SK.

were named in some cases.[71] In Germany, on the other hand, a research project aimed at the describing "an ordinary HSW case" was launched to come up with a first draft towards officially defined "ordinary HSW work tasks".[72] In the following quotation from an associationally approved job description for HSWs in somatic and emergency care, social work diagnosis involving professional discretion and social work treatment is, effectively, put forth for the first time in public as an independent work task concept calling for HSW inclusion. In that document, it was proposed that the professional duties of HSWs include, among other things, the following:

> – Initiation of social anamnesis, social diagnostics, and treatment using social work/social pedagogic methods;
> – Clarification of the needed services.[73]

Subsequently, these work tasks descriptions have become only further refined. HSWs' work tasks are today described as including several steps, from social anamnesis, "decision making tasks", and "counselling and information tasks" to "co-operative tasks", and "co-ordinative and administrative tasks".[74]

Besides now containing a definition of such general steps in the overall HSW task, the amended descriptions have gradually also come to address HSW treatment itself in a more structured and specific fashion. The standardized work tasks are today arranged into five logically separate but, in individual cases, often overlapping intervention areas: psychosocial, social, and economic interventions; out-patient (home) care; in-patient interventions; medical-rehabilitative interventions; and, last but not least, interventions aimed at work–life integration.[75]

The associations in this study repeatedly saw a need to update the definitions they had put forth of the work tasks to be performed. Occasionally, such changes and developments coincided with legislative or regulatory developments. Moreover, it appeared to be difficult for HSWs in Sweden to agree on a shared definition of work tasks, as becomes obvious from the following quotation:

> *Interviewer*: What are the most essential work tasks for HSWs?
> *NN*: That very much depends on the specific work field in question.[76]

[71] SKD002a, SKWS017.
[72] GPA001, GPA002, GPA003, GPA006, GAR001, GAR002, GD001.
[73] GPB034a: 22.
[74] GD001: 107f, GA005, GA070, GA092, GPB034a/b, GWS040.
[75] GD003.
[76] Participant in FG SK.

Jenkins (2004) has described it as necessary for the development of a social group identity that the group first defines and then reaches an agreement on the commonly shared attributes, so as to be able to define its members and outsiders. Accordingly, the difficulty that HSWs in Sweden have had in coming to an agreement about their commonly shared and collectively defined work tasks can be understood as a difficulty to agree on a collective profession-specific group identity. To the extent it may be difficult to reach agreement on the kinds of work tasks HSWs are supposed to engage in, it can also then, similarly, be difficult to also be able to collectively define what the professional group is not supposed to be doing. Where the group members have trouble defining the symbolically charged attributes of their profession, it can be even more difficult for them to also define the symbols representing the boundaries between their profession and other professions. Nevertheless, official work tasks descriptions especially in Germany (in rare cases also in Sweden) often contained elements defined as characteristic of one's professional practice (cf. Abbott 1988). These elements included diagnostic work tasks, inference and treatment, and the use of a classification system for social work interventions in health care. In Sweden, it was predominantly just treatment that was put forth as the characteristic defining element of HSWs' professional practice.

Skills and interventions
Like work tasks, also internal agreements on required work methods or techniques can be used by the professional association of a subgroup to limit fuzziness in the professional identity and increase control over the claimed work field. The Swedish and German HSW associations in this study developed and publicized definitions of skills and interventions to that way help their professional subgroup develop for itself a collective profession-specific group identity. What these efforts were mostly concerned with were requirements concerning the skills needed for specific social work methods.

The associations in Sweden and Germany described such required *social work techniques* to a varying degree of detail. In both countries, specific techniques were named, as, for example, in the case of counselling techniques and techniques in networking. In Sweden, however, detailed descriptions of the social work techniques used or to be used were often missing. Specific requirements, too, were often only named implicitly, by calling HSWs "social experts", for example, even in official statements addressed to non-social workers.[77] Instead of detailed descriptions of required competences, official statements often contained a reference to a knowledgebase of a neighbouring discipline, or to patient needs.[78] However, by far the most often-named

[77] GD001: 121, FG DVSG, SKP024: 33, SKD004, SKWS017, FG SK, NFSD1: 19.
[78] SKWS002, SKWS004, SKWS017, SVKFWS003.

competence requirement for HSWs in Sweden was psychosocial competence. The way in which HSW professionals' psychosocial competence differed from that of their colleagues representing other professions in terms of usage of different techniques, however, was most often not specified. The following quotation provides a characteristic example of how the Swedish association described work tasks in a multi-professional team:

> The team focuses on psychosocial factors that promote rehabilitation. The team is composed of two psychologists, one work therapist, a speech and language therapist working 75 per cent of full-time hours, a hospital social worker working 60 per cent of full-time hours, and a physiotherapist working 50 per cent of full-time hours. The team performs qualified neuropsychological investigations, crisis interventions, family therapy, network therapy ... individual cognitive training to train compensating mechanisms in patients,... group treatments to develop social competences and enhance life quality, and support work through education of relatives. In addition, groups for relatives are planned. Sometimes individual psychotherapy is provided.[79]

The specific techniques or interventions listed in this quotation are not linked to the competences of any particular profession. As a consequence, based on this description it is not possible to tell with which specific techniques or interventions the hospital social worker included in this team was presumed to contribute to its work.[80]

In Germany, on the other hand, many of the official descriptions gleaned from the associational documents included more detailed information on the recommended specific competences of HSWs' and on the social work techniques expected to be used. Very often, what was mentioned in this connection was social case management, often with a reference to ecologic or systems theory. Sometimes, also empowerment techniques and networking techniques were specified.[81] Inference skills were repeatedly mentioned and even described in greater detail.[82] Official statements as well as focus group interviewees outlined the ways in which HSW professionals' use of the above-mentioned methods distinguished HSW from other professions.[83] One example of this concerned the specification of how case management was to be used by HSWs at a structural level: "Case Management at the system level includes optimizing the supply structures in health care."[84]

[79] SKP024: 33.
[80] SKWS001, SKA012, SKA029, SKA031, SKA035, SKP052, SKP062, SKP071.
[81] GD001: 112–123, FG DVSG.
[82] GPB034a/b, GA070, GWS040.
[83] GWS023, GWS024, GWS029, GWS039, FG DVSG.
[84] GWS039.

Similarly to the professions described by Abbott (1988), the HSW associations in Sweden and Germany claimed specific academic knowledge and professional techniques to circumscribe the specifics of their professional group, even if to differing degrees. To borrow Jenkins's (2004) terms, social case management in Germany and psychosocial work in Sweden can be understood as commonly agreed-upon and shared attributes of HSW.

At the same time, however, the DVSG also used HSW skills and techniques to reduce fuzziness in the professional identity of HSW and the overlap of its jurisdictional field with the jurisdictional fields of other professions. In defining HSW skills and techniques in detail, it also identified them as the professional attributes that in the first place distinguished the profession from other, competing professions in health care. The occasional references to law in these connections could be understood as an attempt to stress the transdisciplinary character of social work that thereby then differed from other professions in health care in Germany. In Sweden, on the other hand, the association made regular references to a variety of disciplines, which, in turn, can thus be understood as rather contributing to ambiguity concerning HSWs' group-specific identity. The strategy used by the SK stressed the similarity of the techniques used by the HSW profession and its neighbouring professions, instead of their mutual differences. Such assertion of similarity of competences vis-à-vis other professions, however, has, from the perspective of group identity development, to be understood as a pursuit of a shared professional identity across disciplinary boundaries, as described by, for instance, Bolin (2012) for multi-professional teams in schools.

Standardizing instruments for hospital social work practice

During the period of this research, both the DVSG and the SK were, at least periodically, concerned with developing instruments for standardizing work procedures for HSW tasks and documentation as well as for statistical representation of HSW's contributions to health care. In Germany, special software for HSW documentation and statistics have been under development since the mid-1990s; in Sweden, the standardizing project, dating from the beginning of the 1990s, has thus over time evolved more into drafts and recommendations put forward. In both countries, the efforts to standardize work procedures intensified in late 1990s and the early of 2000s.[85]

In addition, the German association engaged in developing instruments to standardize and classify specific HSW case groups and interventions, as well as, more recently, social diagnoses.[86] Methods to standardize work task pro-

[85] SKAR001, SKAR002, SKA010, SKP007, SKP008, SKP17, SKP018, SKP030, SKD001, SKD002a/b, GA054a/b/c, GA065a, GAR003.

[86] GPO025b, GA118d, GPA013c/e, GD002.

cedures were been applied to the work of the association itself, with the intent of enhancing the efficacy of the outcomes from associational efforts in developing and implementing instruments to standardize work procedures for HSW practice. This was attempted by disseminating information on these developments in the association's own journal, in seminars, in further education, and in social work education in general.[87] In Sweden, the efforts to reach agreement on specific standardized work procedures were extended to cover quality management methods and career pathways for HSWs, which happened in the beginning of the 2000s. The standardized instruments in question were developed in co-operation with the other professional associations for social workers in health care as well as the trade union.[88]

The professional associations in Sweden and Germany, however, did not develop any ethical codes themselves. Instead, they referred to ethical codes supplied by the trade unions in the two countries.[89] Nevertheless, specific shared values of HSWs in Sweden were pointed out in the document *Kvalitetspolicy för socionomer/kuratorer i hälso- och sjukvård* (National Policy for Quality in HSW) issued by the SK in 2000.[90]

Both the SK and the DVSG declared their aim with the development of these instruments to be to serve individual HSWs by providing them with an argumentative base that could help them position and circumscribe HSW within its organizational and social context.[91] Standardization of work procedures was, according to the DVSG, used to promote more uniform application of HSW techniques within the professional community, to enable arguments for a more specific remuneration system for social work, and to demarcate HSW from other professions, as expressed, for instance, in the following quotation:[92]

> As a consequence of an increasingly economic focus and the structural changes affecting health care, the demands for standardized psychosocial diagnosis in social work are increasing in order to professionalize practice, to mark off other professions, and to lead to greater transparency.[93]

The HSW associations in Sweden and Germany engaged in cultural work aimed at ritualizing work tasks, treatment, the use of statistical and quality

[87] GAR005, GPB013b, GPB038, GPC006c.
[88] SKP048, SKP059, SKP064, SKP071, SKP075, SKP078, SKP080, SKP105, SKP109, SKP118, SKAR009, SKD004, SKA039, SSR 2010.
[89] DBSH in Germany, SSR in Sweden.
[90] SKD004.
[91] SKD001, SKP048, GA054b: 26.
[92] See also GAR007, GD002.
[93] GA118d.

management methods, and the like. The creation and development of these particular symbols, however, did not imply that all group members automatically subjected themselves to them and perceived themselves as sharing a collective group identity (cf. Lamont & Molnár 2002). For this reason, these standardizing instruments can be understood as collective goals for the professional group, simultaneously with their function as collectively shared attributes. The effectiveness, the scope, and the pervasiveness of these goals' reach depend, among other things, on who communicates them inside the association (Etzioni 1961). The DVSG and SK boards both used their role within the association to communicate about what they saw as important developments supporting HSW practice. In terms of compliance as defined by Etzioni (1961), this can be looked upon as an effective way to transmit professional goals to the members of voluntary organizations. The differences between the German and the Swedish association in this respect had to do with the aspired-for pervasiveness and scope of the developed work-standardizing instruments meant to foster the development of a group-specific identity for HSWs. Both the pervasiveness and the scope of the German association's goals can be defined as broad: the DVSG forwarded to its members and non-members alike information on all developments related to the standardization of work tasks, treatment, and so on, using a variety of channels (the association's own journal, homepage, and newsletter, published official guidelines, seminars, and further education). A specific focus in the development of standards was laid on fundamental aspects of HSW such as work tasks like treatment, documentation, data processing, and case groups. As underlined by the association's board itself, the standardization of HSW tasks and caseloads was understood as a tool helping to strengthen HSWs' pervasiveness in multi-disciplinary context of health care, by supplying standards for practice as developed by HSWs themselves.

The goals of the SK in this work were more limited. The association, as a rule, provided information to its members only, using for this purpose the association's own journal, e-mail, and, since the 2000s, website. This was so particularly when it came to developments concerning fundamental aspects of HSW such as work tasks, documentation, and statistics. Calling these instruments drafts or recommendations further reduced the pervasive power of the associational efforts, as it undermined the chances of practitioners' adopting the standardized documentation and statistics without alterations. Moreover, in only two cases – quality management and career pathways – were the scope and pervasiveness of the association's goals and standardising instruments widened to include non-members as well, using a broader platform for development and communication by involving other HSW associations and the trade union in the task as well.

6.3 Social work or health care?

The collectively developed narratives and collectively defined work tasks, skills, and standardizing instruments that define the relationship between the professional subgroup, social work, and healthcare professions can be understood as the development of professional attributes shared by all HSWs. These attributes can also be used to distinguish the professional group from, or associate it with, healthcare professions and social work respectively and thereby define a collectively shared or separate professional identity. In the same way, the active attempt to link the professional group to a certain academic discipline such as social work or a healthcare discipline can be understood as means to refine this collectively shared professional identity.

The professional associations in both countries engaged in attempts to link HSW to an academic discipline they perceived as primary for it. However, the Swedish HSWs appeared to have doubts about their "natural" disciplinary link in this regard. Attempts by the associations to link their professions to specific academic disciplines involve three different dimensions, thematizing either the proximity or distance of the disciplinary affiliation, the connection of the professional group's work to specific scientific theories, or the ability to include aspects of HSW in the education offered in the discipline.

Disciplinary affiliation

The HSW associations addressed their linkage to a particular academic discipline and its knowledgebase as a means to develop the collective identity of the professional subgroup of HSWs. On the one hand, they perceived the disciplinary linkage as an agreement on certain formal requirements seen as necessary for the performance of professional HSW. On the other hand, disciplinary linkage was discussed and described as the perceived proximity of the relationship between the professional subgroup and a discipline as social work or another healthcare discipline.

The Swedish and German associations resorted to different strategies to refer to formal competence requirements in HSW. The Swedish associations only seldom mentioned an academic social work degree as a requirement for professional SW practice.[94] The need to have the degree was mainly brought up in documents dating from the 2000s. At the same time, two of the four official brochures that the SK had given out on HSW did not in any way touch upon the issue of the required educational background for social workers.[95] This could indicate two things: either this requirement was seen

[94] SKP105, SKP116, SKWS017, SKP118, SKP136, SKP138, SKD001, SKD007, SKWS014.
[95] SKD005, SKD006.

as all too obvious for everyone to merit a separate mention, or it was perceived as being of marginal relevance only.[96]

In Germany, on the other hand, the DVSG regularly put forth claims to the effect that an academic degree in social work/social pedagogy was necessary as a formal requirement for professional HSW practice. This claim recurred repeatedly in the documentary material obtained, becoming slightly modified for its present context every time, and it usually made its way to official documents as well, among others the *Rahmenempfehlungen der DVSK zur Einrichtung von Stellen im Krankenhaussozialdienst in Akutkrankenhäusern* ("Workplace Recommendations for Somatic Care").[97] These were associationally approved and recommended general job description for HSWs in somatic care. In two more recent documents, specific competence requirements were named as well, even if now more implicitly and subtly. This was by classifying social work treatment in the title of the *Produkt- und Leistungsbeschreibung der Klinischen Sozialarbeit* ("Product and Service Description of Clinical Social Work", a standardized and detailed definition of HSW treatment offered at hospitals) as "clinical social work", or by using spelling conventions to distinguish academic social work from other forms of lay or occupational social work: in the description of HSW case groups, academic discipline names such as *Sozialarbeit* or *Soziale Arbeit* were used instead of the "lay" term *soziale Arbeit*.[98]

In the Swedish case, such subordination of HSW to the social work discipline was not equally self-evident. There there seemed to be more doubts concerning the relationship between HSW and social work, as evident from the following quotation:

> [For our next annual meeting,] we could investigate how social work departments view HSWs work tasks: what they think these are and what social workers can learn through social work education that may be of benefit to the healthcare sector.[99]

According to focus group participants from the SK, Swedish HSWs' have much hesitation calling themselves *socionomer* or, even more so, "social workers", as these titles are perceived among them as exclusively reserved for their colleagues in social welfare services, who are seen by them to have different interests.[100] Even though there were discussions between the SK and the trade union SSR around the mid-1990s about a more inclusive terminology, the process of incorporating the professional title *socionom* in-

[96] http://www.kurator.se/bli-medlem/
[97] GD001: 110, GA011a, GA070, GPB034a/b, GWS040: 1.
[98] GAR007, GD002.
[99] SVKFP014.
[100] FG SK.

stead of *kurator* proceeded slowly in both the SK and the VKF. Even today, the SK continues to use the symbol "Q" (for *kurator*) in its logo.[101] The ambivalence about HSWs' identity as social workers, however, was also reflected in the relationship between the professional association and the trade union in the 1990s, when the association felt the trade union to lack interest for, or even entirely disregard, HSW matters.[102] At the same time, the HSW associations saw in the trade union their only possible co-operation partner, and went on to intensively co-operate with it following the foundation of the HSW advisory board.[103]

In Germany, the disciplinary linkage to social work was more and more emphatically addressed over time. In the early 1990s, discussions began to take place on whether work tasks in health care should be called "hospital social services" or "hospital social work". The outcome of these discussions was that many years later, in 1997, the title of the association's journal was changed to *Forum Krankenhaussozialarbeit* ("Hospital Social Work Forum") and, in 2003, the name of the association itself was changed to *Deutsche Vereinigung für Sozialarbeit im Gesundheitswesen* ("The German Association for Social Work in Health Care").[104]

In Sweden, career advancement possibilities were perceived as a topic that distinguished social work from HSW. There was also the perception that HSWs had fewer possibilities to publish articles in the country's sole popular-scientific social work journal, *Socionomen*, compared to other social workers.[105] This was in contrast to the German association, which published its own journal and thus never had reason to complain about similar problems in reaching out with HSW work themes. Moreover, in some cases, the German association was also asked to contribute to special issues other social work journals put out on topics connecting social work aspects and disease themes.[106] Since 2005 the association's own journal has come out with a clinical social work research supplement for each issue, published in co-operation with a university social work department (*Zentralstelle für klinische Sozialarbeit*, ZKS) and the German Society for Social Work (*Deutsche Gesellschaft für Soziale Arbeit e. V.*, DGS).

HSWs in Sweden expressed a desire for a disciplinary connection that HSW would share with other healthcare professions. This becomes evident for example from the following quotation:

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[101] SKP063, SVKFP008, SVKFP012, SVKFP015, SVKFP016, SVKFP018, www.kurator.se.
[102] SKP090, FG SK.
[103] SKA025, SKP003, SKP045, SKP046, SKP059, SKP063, SKP118, SKP143, NFSP001, NFSP002.
[104] GD001: 110, GA011a, GA070, GPB034a/b.
[105] SKP020, SKP049, SKP054, SKP103, SKAR004, SVKFP022, SVKFP021, NFSP001, NFSP017, NFSP016.
[106] GPA006: 7.

> NN reported on a present work task of hers at the Karolinska Institutet [university hospital]. There she works together with NN2 to design a joint Master's-level course for social workers in health care, in co-operation with Karolinska Institutet and Stockholm University …. An interesting question was raised about the disciplinary placement of the Master's degree.[107]

The discussion of the "disciplinary placement" of the Master's degree suggests that it was not self-evident for the discussants that this Master's-level course for HSWs would lead to a Master's degree in social work; it could also be in medicine or in nursing. This display of uncertainty can be understood as rooted in the history of HSW in the country. The profession's disciplinary linkage to either social work or nursing had become a topic in the debates already in the 1920s, with social work ultimately winning the day.[108] In Germany, on the other hand, a closer disciplinary relationship with other healthcare professions was never really discussed, and HSW's status as a subgroup of social work remained uncontested.[109] What the DVSG did instead was to explicitly define the mission of social work in health care as being to bridge the boundary between social welfare and health care within the overall welfare state context, breaking ground for the inclusion of social aspects in the biomedical paradigm of health care:[110]

> The goal of the association is to describe the contribution of social work to health care, to ground it scientifically, as well as to take clear positions and partake in important decisions in the healthcare sector. Social work must remain a self-evident part of the overall healthcare system and enhance its ability to impact on the latter.[111]

Instead of integration of the profession into healthcare professions, the DVSG thus proposed the development of strategies for overcoming issues emerging at the interface between health care and social welfare.[112]

Formally, the SK and the DVSG both defined social work as the discipline to which HSW most closely related. The social work discipline was stated to supply the knowledgebase used in HSW diagnoses, inference, and treatment. Filling these aspects with shared symbolic meaning then turned them into symbolically charged attributes that could be used for the development of a collective profession-specific group identity. However, this formally pronounced affiliation to the social work discipline was also questioned, given

[107] NFSP007: 2. *Karolinska Institutet* is the most prominent university hospital in Sweden.
[108] Fredlund 1997.
[109] GA008, GA055, GPA008a, GPB011, GAR001, GAR003, GAR007, FG DVSG.
[110] GPB050.
[111] GAR006: 4.
[112] GPO027, GA024, GWS027, GAR006.

that references to theory were not all to the social work discipline, but also, and especially often in Sweden, to other disciplines (psychology, sociology, law, economics, and political science).[113] On the one hand, this can be understood as reflecting the transdisciplinarity or interdisciplinarity nature of social work in these countries, and therefore a genuine attribute social work shared with HSW (cf. Büchner 2012, Dellgran & Höjer 2000). At the same time, however, it could also be understood as an expression for opening the professional boundaries, rather than closing them. Moreover, at least in Sweden, there seemed to be a difference between having a formal affiliation to social work and whether this formal affiliation could actually be perceived through attributes shared with other social workers. The VKF, for example, questioned whether the social work discipline in fact contributed to HSW with useful knowledge. Additionally, the SK noted there to be a lack of (research) interest in HSW topics as well as a lack of possibilities to reach out with HSW interests through publications in social work journals. Social work tasks were perceived as differing between social welfare and health care. Moreover, the need for knowledge from medicine and nursing was rather defined as something linking HSW with healthcare disciplines, instead of social work. Accordingly, then, professional HSW associations in Sweden could be understood as questioning the relevance of the formally claimed affiliation to the social work discipline, implicitly suggesting medicine or nursing instead as a better alternative.

In Germany, in contrast, the DVSG never expressed any doubts concerning HSW's disciplinary affiliation to social work. Problems arising from HSW's status as a subgroup of social work were understood as caused not so much by the problems in the relation between HSW and social work as the fact that HSW was being performed in the domain of medicine, with which it did not share any attributes.

Connecting to theories

As already noted, the development of a collective profession-specific identity presupposes a shared agreement on definitions concerning work tasks, skills, and the development of standards. However, it also entails agreement on the knowledgebase providing the most useful answers to problems and issues encountered in daily practice. Agreement on a knowledgebase can be expressed through the proclamation of a disciplinary affiliation, but also through a proclamation of affinity to certain scientific theories. A clear reference to a specific scientific theory or theories can strengthen the profession's disciplinary affiliation, and thereby also its collective profession-specific group identity.

[113] SKA017, SKWS014, SKWS016, SKWS017, SKWS020, FG SK, NFSP016, NFSD1, FG DVSG.

The differences found between the references made to academic theories by the HSW associations in Sweden and Germany were significant. While the documents collected in Germany referred to several theories as representing genuine social work theory, the documents collected in Sweden referred to only one social work theory, with all the other theories referred to being "non-social work" theories belonging to other disciplines. Specific theories and scholars behind them were named by the DVSG, while in Sweden any references to individual authors were uncommon.

The theory almost exclusively referred to by the Swedish association as a specific social work theory was to the psychosocial work theory of Bernler and Johnsson (1988).[114] However, this inherent connection the association seemed to propose was in the end not quite as clear as it first seemed. Psychosocial work theory was mostly referred to in the form of "psychosocial work", "psychosocial content", and "psychosocial practice", without providing any concrete definition for these terms. A draft document on "Psychosocial Practice and Research" by members of the NFS from the 2000s was then meant to develop a more genuine definition of social work in health care. As this document shows, the term psychosocial work, originating from Bernler and Johnsson's (1988) theory, was used rather as an umbrella term subsuming under itself psychosocial theory and a variety of other theoretical concepts derived from a variety of other disciplines. This much becomes evident, for instance, from the following passage, quoted from the draft document in which members of the NFS described the theoretical implications of the concept of psychosocial work from the network's point of view:

> Theoretical starting points for psychosocial work in health care:
>
> 1) Social-psychological communication theory models
> 2) Systems theory, network theory
> 3) Crisis theory
> 4) Stress-vulnerability model
> 5) Change theory and motivation
> 6) Exstential psychology and salutogenesis
> 7) Empowerment
> 8) Psychodynamic theory
> 9) Cognitive, behaviouristic theories[115]

This presentation exemplifies the very eclectic way the theory originally developed by Bernler and Johnsson (1988) was received in HSW in Sweden. This eclecticism may then be seen as one reason for the perceived difficulty of describing HSW tasks and HSW's theoretical anchoring, as reported by

[114] NFSD1, SKA031, SKWS017.
[115] NFSDI: 7f.

members of the SK board (see section 6.3) and as evidenced by the 10 years it took to finalize the above draft document. Besides psychosocial work theory, the theoretical perspectives included in the above quote could also be located in psychology (psychodynamic and behavioural theory, existential theory, crisis theory), in social psychology (communication theory, coping theory), in medical sociology (salutogenesis theory), in sociology (systems theory, network theory), in psychiatry (stress-vulnerability model), and in empowerment theory, whose origins themselves could, in turn, lie in feminism, politics, or social work/social pedagogy.[116] In other words, the disciplinary roots of the theories referred to mostly all lied outside social work. Nevertheless, the HSW associations and HSW researchers studied in this dissertation made attempts to include them all under the umbrella term psychosocial work, even when it was a question of work or concepts not originally part of the psychosocial work theory as put forth by Bernler and Johnsson (1988).

In the 1990s and 2000s, the German association made explicit references to four different social work theories. In addition, in its more recent publications it has referred to a general concept of social work. The most frequent reference it has made is to Wendt's (1982, 2010) social case management theory, in a form adapted to the 21st century German context. Initially, however, also case management theorists from the North American context were cited, as were, on occasion, Thiersch's 'life-world oriented social work' (Thiersch 2006), Germain and Glitterman's (2008) 'life model of social work' and Lüssi's (1992) 'systemic social work'.[117] In publications dating from the 2000s, the concept of clinical social work was added to the list, albeit without any reference to a specific theory or particular authors.[118] Characteristically, the association also brought up specific theories pointing to their implications for daily HSW practice, as for instance in the following passage:

> In practice, the term 'case' does not refer to a human being, but to "her problematic situation, which needs to be handled in general as well as in detail. This problematic situation is the 'case' and the subject of goal-oriented professional problem-solving action". Case management at the system level implies systems management (i.e., improvement of supply structures). Wendt regards it as a central advancement to understand and use case management as the "control of human service production" (such as supply management) and as the control of the very process in relation to the

[116] NFSD001, SKD007, SKA031, SKWS017, SVKFWS003.
[117] GA008, GA016a, GD001, GWS039.
[118] GA033.

single case (such as methodological case management by single professionals).[119]

In defining usable theories for HSW practice in their own country context, the two associations studied can thus be looked upon as having engaged in attempts to enhance the ability of the professional subgroup to develop a certain group-specific identity. In Sweden, the main such theory from social work was psychosocial work and in Germany social case management. In Germany, the association referred to social work theories as developed by specific social work researchers. A more in-depth analysis of references made by the Swedish association, however, shows that the psychosocial work theory evoked by it could rather be described as an umbrella term under which a variety of theories rooted in other disciplines, including theories not originally part of Bernler and Johnsson's (1988) theory, were subsumed. Accordingly, the definitions of 'psychosocial work' (where such are found) varied depending on the context in which they were offered. The German association's references to theories can thus be understood as enabling the attachment of a shared symbolic meaning to these theories, identified as professional attributes. In Sweden, in contrast, the use of the theory of psychosocial work as no more than an umbrella term can be understood as action opening up the possibility of attaching a variety of symbolic meanings to it.

Including hospital social work aspects in education

In addition to the question of formal disciplinary affiliation and relevant connection to a discipline's theories, the professional groups' felt association with one or another discipline was also influenced by whether the professional subgroup in question perceived the academic education of the discipline to provide its members with relevant knowledge and skills. The documents collected from the associations in both countries provide evidence of the ways and the extent to which the two main associations perceived university programmes in social work to include specific HSW perspectives in their teaching. They also reflect the associations' perceived possibilities to influence social work education and outline the conclusions they drew concerning their relation to social work education.

Both the DVSG and the SK complained about what they saw as the absence of HSW aspects from basic social work education. In Sweden, this critique was expressed in rather general terms, involving both theoretical aspects as well as practical skills. As the SK board members admitted, however, the lack of education in practical HSW skills was partly caused by the fact that HSW practitioners only seldom engaged themselves in this educa-

[119] GWS039: 2f.

tion as supervisors for social work field studies.[120] In the following quotation, this lack of HSWs' own interest in social work education is addressed from HSW researchers' perspective. In it, social work education is seen (by the NFS) as handling its critical task of transferring knowledge to future HSWs inadequately when it came to social medicine and quantitative research methods:

> Psychosocial Work in the Healthcare Sector: Dilemmas for Research
> 1. The basic [HSW] education is outside the medical faculty.
> 2. The knowledge transfer on the part of medical knowledge in basic [social work] education is insufficient....
> 3. Different faculties have different approaches as far as research methods are concerned.[121]

In Germany, this complaint was mainly raised during the years around 2000 and concerned particular areas such as clinical social work as well as specific legal and methodological competences. Additionally, education and research were claimed to inadequately handle their tasks of developing and adapting methods for the needs of the changing healthcare sector. They were, however, also claimed not to adequately address any specifics about the subordinate function of social work within health care, as, for instance, in the following quote reporting from a national meeting with social work educators in Germany where the DVSG, too, was in attendance:[122]

> All participants agreed that changes to social work education are necessary, as its quality is highly variable. Education [in this field] does not adequately focus on clinical social work; neither does it focus on the fact that especially social work in health care often evolves in response to changes in social welfare and healthcare systems, with interests that differ from those of other professions, and in response to economic changes.[123]

The HSW associations in Sweden and Germany had a fairly similar understanding when it came to their perceptions of the lack of focus in social work education on social work in healthcare settings. The Swedish associations mostly saw there to be a problem with knowledge transfer when it came to the teaching of social medicine and natural science research methods. The German association brought up more specific social work techniques in this connection, but also knowledge of the impact of the healthcare context on

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[120] SKAR010, SKP130, FG SK.
[121] NFSD1: 18.
[122] GA021, GPA010, GPB015, GPB038, GPC006c.
[123] GPB038: 18.

social work practice. The objections of Swedish HSW associations and researchers here must, however, be understood against the background of the history of social work education. In the past, basic social work education in Sweden had been more specialized, focusing on specific fields of social work and education for social work in the healthcare field, and only later came to exclude HSW specific social-medical and nursing knowledge.[124]

Based on the SK's impression that HSW perspectives and the specific needs of HSW were neglected in social work education, attempts were then made to address these problems from above, partly by the association itself, partly by the trade union, and partly also by the NFS.[125] The discussions in the area also concerned the possibility of setting up a new university programme specifically for social workers in health care.[126]

6.4 Promoting implementation and compliance

In their efforts to develop and maintain a collective group-specific identity for HSWs, the associations in Sweden and Germany used different means to promote their members' willingness to comply with common agreements regarding the shared attributes of the professional group. Such attributes included narratives of the history and presence of HSW, definitions of work tasks, skills, and standardizing instruments for practice, as well as definitions describing the proximity of HSW to social work or healthcare professions. To induce professionals to voluntarily comply with the symbolic implications of such specific professional attributes, professional associations must employ specific means like, for instance, information and involvement strategies (Etzioni 1961).

Informing

At a basic level, the internalization of symbolic meanings attached to professional attributes and of the particular professional goals of the profession presupposes that the association informs at least its own members or more in general hospital social workers about jointly developed and agreed-upon professional attributes, professional goals, and their associated symbolic meanings. Following Etzioni (1961), voluntary organizations in general must therefore engage in communication both downwards and horizontally if they are to be able to induce conformity to organizational values. In the same fashion, HSW associations must use a variety of information channels to communicate their commonly defined attributes and goals as well as the

[124] Fredlund 1997.
[125] SKP112, SKP116, SKAR004, SKP092.
[126] SKP105.

symbolic meanings inherently attached to these, in order be able to include HSWs' compliance with them.

The particular communication and information channels used by the associations in this study changed over time. In both the Swedish and the German case, the association's board was interested in setting up new communication channels to better enable information flow within the association and between different parts of the association such as sections, boards, and local, federated-state, and national work groups.

These communication channels included face-to-face interaction, telephone, the Internet, and the print media. In the case of the Swedish association, the decision, moreover, was made that all the sections of the association send a representative to its national board.[127] In Germany, the information flow between associational organs was discussed occasionally, with new work routines and guidelines issued to define the face-to-face channels to be used and to co-ordinate information flow both vertically and horizontally at and between all levels of the organization.[128]

The SK and the DVSG also used various media to transmit the information they wanted. Up until 1997, the SK published its own biannual journal, *Svensk Kuratorsförening*. Later on, up until 2004, it mailed out a specific membership information letter to its members once or twice a year. The association also informed its members via e-mail. Since the beginning of the 2000s, the association has used its own webpages to provide information to all interested parties. The DVSG, on the other hand, published its own journal of HSW during the entire study period. Since the beginning of 2000, it has, furthermore, distributed information via the association's website and, finally, since 2005, through its monthly newsletter distributed via e-mail.[129] The SK and the DVSG have thus pursued somewhat different strategies over time in their use of different media as information channels: the Swedish association has rather switched from one media to another while the DVSG has concentrated on complementing its existing information channels by establishing new ones.

The two associations have to a differing extent used these text-based information channels to inform HSWs in general. The SK has used its journal issues, membership information letters, and e-mails exclusively to inform the members of the association. The German DVSG's journal and monthly newsletter, on the other hand, were distributed to all HSWs and organizations in the country with an interest in the developments in health care and social work in health care in general and in the association's stances and activities in particular. Since the beginning of the 2000s, both of the two as-

[127] SKP078, SKP136: 3, SKP143.
[128] GA014, GA019, GA027, GA052a/b, GA078b, GPA009b, GPA012a, GPB012, GPC005a, GPC006c, GPO011a/b, GAR001, GAR005.
[129] GA057e, GAR006: 30, GAR007.

sociations have also used their homepage to make information on their activities and stances available to a wider public.[130] For both associations, the information channels used were employed with the aim of reaching a wider readership, even if, as already noted, this was done to differing extents.

The content of the two associations' journals, however, differed to a degree. While in both cases the associational journal contained editorials, information on and from seminars, sections, and sectional meetings, annual reports, calls for action, official written statements, and occasionally reprinted newspaper articles, only the DVSG journal published articles, reports, and debate articles on specifically HSW topics. Since 1997, the content of the SK membership information letter and of the e-mails the association sent out to its members has been further pared down. Usually, the membership information letter included a message from the board, board meeting minutes, information on and invitations to the association's annual conference, as well as membership lists, but no articles, official written statements, or information from sectional meetings any more than the journal did before. The association journal's editorials and the messages from the board contained in the membership information letters were used to provide additional background for the otherwise abbreviated and/or formulatic information on the association's key activities and stances. Since the beginning of the 2000s, key written documents such as annual reports, recent official statements, and official definitions have, moreover, in both Sweden and in Germany been available via the association's website.

The members of the SK were informed about the association's events, initiatives, and activities such as, for example, setting up of new sections, changes made to board membership, work towards the development of standards, co-operation with the trade union, and contacts had with state officials.[131] Especially during the 1990s, the association's journal also informed members about ongoing and recently concluded healthcare policy developments, (forthcoming) changes in legislation, relevant actions of state authorities, ongoing state investigations, and activities engaged by other associations, the trade union, and the NFS.[132]

The information provided by the SK tended to be rather cursory. Specific investigations, law proposals, healthcare policy developments, and the like were merely noted in the board meeting minutes obtained, along with the fact that these were discussed in the meetings. Any description of the content and outcomes of these discussions, such as shared positions taken, was,

[130] GA057e, GAR006: 30, GAR007.

[131] SKA032, SKP017, SKP018, SKP019, SKP020, SKP032, SKP059, SKP071, SKP091, SKP093b, SKP110, SKP111, SKP118, SKP121, SKP122, SKP137, SKAR001, SKAR002, SKA005.

[132] SKP008, SKP020, SKP030, SKP031, SKP047, SKP049, SKP054, SKP57, SKP062, SKP076, SKP080, SKP102, SKP112, SKP117, SKAR011, SKAR013, SKA016, SKA022.

however, usually omitted.[133] Occasionally, meeting minutes nevertheless reflected the fact that strategic deliberations were taking place in board meetings, as the following quotation shows:

> Recently, NN's one-man government investigation on "Social Workers' Competence Requirements for Application to Psychotherapy Education Programme" was revised and submitted. The [government's] proposal was discussed [in the board meeting].[134]

Common associational stances on particular topics seemed to only rarely be discussed, judging from what was stated in meeting minutes and other journal articles. An exception here was nevertheless a discussion on the definition of the term "workability", involving social work's ability to assert its importance in the healthcare sector, as was a discussion of an official statement of the association concerning guidelines in palliative care.[135]

During the period under investigation, the DVSG also provided information on diverse kinds of associational meetings and seminars, including information on ongoing discussions from all levels of the association (local to national). Articles were, furthermore, published on the development of standardizing instruments and social work methods as well as on other projects run or planned by the association. Like the SK, also the DVSG disseminated information on legislative changes, other healthcare policy developments, associational views and positions, and official written statements.[136] Members of the German association were frequently provided with news about changes in corporate contracts and legislation, accompanied by comments and analysis regarding the impact of such changes on HSW practice. This became increasingly common beginning in the 2000s.[137] Ongoing healthcare policy developments, professional developments, co-operation and conflicts with other professions, and the like were common topics addressed in debate articles.[138] The association also used its journal articles to show how its visions, positions taken, and policies developed were rooted in the activities of all associational organs.[139] The following quotation serves expresses this desire:

> The annual meeting in Berlin voted to initiate the expansion of our association.... It is our task in the coming weeks to inform our

[133] E.g., SKA020: 3, SKP112: 3.
[134] SKP008: 12.
[135] SKA005, SKAR001, SKP063, SKP0087, SKP096.
[136] GA013b, GA023, GA052a/b, GA057b/e, GA059e/f, GA064b, GA072, GA118f, GA137, GPA007a, GPA009b, GPA010, GPB004, GPB012, GPB031, GPB035a, GPB043, GPO012, GPO025b/c, GPO029a, GPO029b, GAR001, GAR005.
[137] GAR001, GAR002b, GAR005, GAR006, GA100a/b, GA118b, GA127b.
[138] GPA010, GA098, GA101, GA126, GA129, GA144, GA073.
[139] GA103, GA074a/b/c, GA023.

> members at all levels of the organization about the tasks and goals of this project. This is to ensure everyone's engagement, necessary for a successful change.[140]

As already noted, the association board in both country cases was involved in activities aimed at informing on the symbolically charged professional attributes and cultural goals that the association wanted to pursue and have their members comply with. In Sweden, the documentary studied for this dissertation shows that the information was mostly disseminated in a top-down fashion, from the board to sections and individual members. Horizontal information channels were formalized by sending lists of affiliated members with contact information to all members. Information across sectional boundaries was mainly spread through the association's journal up until 1997, and via its website after 2000.

In the case of the German DVSG, on the other hand, the information was disseminated both vertically and horizontally, with communication channels developed between different sections, work groups, and levels of the organization. All these information activities can be understood as an active striving by the associations to communicate their symbolically charged professional attributes and cultural goals to their members and achieve a certain convergence concerning the collective interpretation of these values. In the German case, the horizontal communication channels can be understood as information networks supporting the dissemination of information from above.

The way in which information transmission was used as a strategy to reach non-members differed between the SK and the DVSG. While the SK targeted its information activities to also non-members, especially when is used its homepage and, in some cases, the trade union to disseminate information about the development of standards and the various kinds of discussions held within it, the HSWs without a social work degree were still excluded from associational activities, as were social work researchers working on HSW, insofar as these were not engaged in HSW practice.

In Germany, most of the information with strategic relevance to jurisdictional claims-making was made publicly available and shared with both members and non-members. Only information likely to attract outsiders to sign up as members was withheld from the public, to recruit new members. There were no restrictive requirements for membership, either, apart from the fact that members were expected to promote HSW interests. In terms of organizational compliance (cf. Etzioni, 1961) this can then be understood to mean that the DVSG pursued a broader scope and a higher pervasiveness than the SK in its attempts to use information about associationally de-

[140] GA053.

veloped common professional attributes and professional goals as a means to achieve compliance.

Involving

The HSW associations in Sweden and Germany involved their members and other HSWs in the development and negotiation of professional attributes, professional goals, and their associated symbolic meanings. To borrow Etzioni's (1961) terms, HSW associations can be understood as normative organizations with voluntary membership. The efforts to involve members in the development of professional goals and address their self-interests can then be described as attempts aimed at enhancing the commitment level of the voluntary members of the association and of HSWs who are not members of the association.

During the period studied, the SK and the DVSG tried to involve their members in the development of the programmes of their seminars and national annual meetings and in daily routines. Especially in Germany the association intensified its efforts to *engage members in associational activities* from the late 1990s onward; in Sweden, such efforts peaked mainly during the late 1990s.[141] In Sweden, the involvement of members in the authoring of official statements and comparable was most often attempted via the sections; in Germany, it was pursued both via work groups and sections and directly through centrally-led investigations of members' needs.[142] In both countries, members were asked to indicate their needs and interests,[143] with associational structures consequently adapted to make them better suited for involving the membership and engaging members' interests, be they, for example, in networking and HSW matters more generally (development of work task descriptions) or in more specific professional topics (e.g., somatic care, psychiatric care).[144] However, decisions concerning matters such as which new work groups and sections would be set up in Germany (e.g., on ethics in health care) were made based on strategic interests as defined by the association itself.[145] Also economic and symbolic rewards were used as incentives to increase members' involvement in associational activities. These rewards could include economic assistance for sectional activities, as in Sweden, and rewards of a more symbolic character as used in competi-

[141] GPA013e, GPC007, GPB031, GPB012, GA013b, GA023, GA122, GA125b, GA115c, FG SK.
[142] GA031, GPO023, GPB026, SKA005, SKA008, SKA016, SKA025, SKA031, SKA032, SKP136, SKAR001, SKP063, SKP064, SKP053, SKP047, SKP078, SKP049, SKP019.
[143] SKP078, SKP098, SKP136, SKA016, SKA031, SKAR001, GA031, GA033, GA083, GAR005.
[144] GPB012, GA013b, GAR005, GA052a, GPO013d, SKA005, SKP010, SKAR001, SKP018, SKA014, SKA016, SKP031, SKA019, SKP047, SKP048, SKA027, SKP072, SKP079, SKA037, SKP097, SKA040, SKP111, SKP112, SKP118, SKP122, SKP136.
[145] GA023, GA048.

tions to, for example, find a new name for the association's journal in Germany.[146]

In both countries, *networking* with other HSWs from the same specific work field was pointed out by the associations as a major motivation for joining them. The SK and the DVSG therefore offered organized possibilities for their members to contact and meet one another. Indeed, in Sweden the association perceived this to be its primary task.[147] There the association was organized in sections according to specific medical specialities (see Chapter Five). In them, members could exchange experiences and discuss their specific professional issues and questions.[148] In some cases, this specific interest of members in networking with other HSWs from the same work field came before their interest in the SK in general. Consequently, members of the SK board often faced a need to clarify the role of the association. This primary interest in associating with members from very narrow work fields occasionally led to the setting up of new associations related to the particular HSW fields in question.[149] In Germany, networking interests were especially pronounced during the period 2000–2003, but also in 1997–1998 and in 2007. The DVSG therefore organized regional and federated state-level work groups and promoted the expansion of these networks so as to include even Eastern Germany after the reunification.[150] In these work groups the focus then lied on networking both regionally and across federated states, on the exchange of experiences, on knowledge/information transfer, on discussing healthcare policy, and on professional identity issues.[151]

In both associations, *discussions* were held on specific issues of relevance to HSW, such as changes in healthcare policy and welfare structure or the association's position in jurisdictional matters. These discussions were sometimes held within the association, while on other occasions they could take place with the involvement of other associations and organizations.[152] Yet, there were differences between the SK and the DVSG in the way in which members were invited to participate in these discussions. In the case of the SK, the discussions predominantly involved board members. Invitations to ordinary members to participate in discussions became fewer after 1997 and the discussions were often held following the annual meetings.[153]

[146] SKP111, SKP136, GA069b.
[147] SKP137, SKP093b, SKP030, SKP098, SKP123, SKP138, SKA019.
[148] SKP048, SKP118, SKP123, SKA021, SKAR003, SKA019, SKP064, SKP118, SKP019, SKA006.
[149] See Chapter 5.1 above, SKP019, SKP028, SKP050, SKP071, SKP105, SKAR009.
[150] GPA010, GPB012.
[151] GPA009a/b/c/d/e/f, GPA011, GA104c/e, GA131, GPO010, GPO011a/b/c/d/e, GPO014, GPO026, GPO025a/b/c, GPO027, GPO028a, GPO032a/b/c/d.
[152] SKAR001, SKA005, SKP048, SKP019, SKP053, SVKFP018, GAR005, GPB035a, GA043, GA052a, GA027, GA097a/b/c.
[153] SVKFWS003, SKD001, SKA003, SKA005, SKAR004, SKP071.

More and more often, especially during the 2000s, members became only informed of the fact that discussions had taken place, were planned, or were going on, but not about their content.[154] The communication could now be very cursory and take the form of a brief factual note only, as in the following case: "The trade union advisory board for HSWs met on 22 February 2007 in Stockholm. Amongst others, licensure was discussed."[155]

The DVSG, on the other hand, often involved all levels of the association in discussions when it concerned more important topics.[156] These discussions were used to prepare members for coming changes in healthcare policy and/or welfare structures, and to deliberate on collective actions to be taken in response to emerging jurisdictional problems.[157] Since the 2000s, DVSG members were increasingly more often encouraged to express their opinions in public to provoke discussion on the pages of the association's journal, and since 2003 the association has maintained a members' discussion forum on the Internet for the same purpose.[158] Even annual meetings were opened for broader discussion on the association's official stances and positions and on important questions related to the future development of the association. Drafts of major position papers, standardizing instruments, and the like were circulated among the association's membership in advance of their publication.[159]

Association members in both countries were also *involved in the development* of standards, definitions, and the like, although even here in different ways and to differing extents. In Sweden, in the late 1990s SK members were, for example, encouraged to provide their own input in matters relating to the development of common quality standards and measurement tools and participate more in work of their sections.[160] Additionally, since the mid-1990s, the development work towards new HSW standards and definitions was more and more frequently delegated to external co-operative panels like the trade union's advisory board. There are some indications in the documents studied that members were also involved in the internal discussions and preparatory work around the issues raised in these panels.[161]

[154] SKA031, SKAR002, SKAR003, SKP061, SKP078, SKP092, SKP094, SKP098, SKP104, SKP123, SKP130, SKP137.
[155] SKP136: 4.
[156] E.g., GA053.
[157] GA054a.
[158] GAR002, GA011a, GA011b, GA015, GA019, GA021, GA023, GA024, GA025a/b, GA044b/c/d, GA052a, GA056, GA065a/b, GA063, GA073, GA074a/c, GA098, GWS036, GPC006a/c.
[159] GPA001, GPA005, GPA011, GPB003, GPB005, GPB008, GPB010, GPB011, GPB012, GPB014, GPB020, GPB026, GPB031, GPB054, GPC001, GPC004, GPC005d, GPC006a, GPC007, GA004, GA069a/b, GA088, GA102.
[160] SKA025, SKA031, SKA032.
[161] SKA031, SKP071, SKP078, SKP098, SKP105, SKP112, SKP123, SKP130, SKP136, SKP137, SKP138, SKP143.

In Germany, DVSG members were consistently involved in the developmental work of the association, although to a particularly notable degree in the years 2001–2005. Mostly between the mid-1990s and the early 2000s, associational seminars, furthermore, were used to jointly plan collective counter-action and counter-strategies in response to challenges posed by hospital organizations or other professions. During this time period, jurisdictional problems were addressed and analysed drawing on diverse methodological tools and perspectives.[162] Also the development of guidelines and definitions was perceived to provide structured support for efforts to claim a certain jurisdiction and develop arguments for members at all levels of the association, from worksites to the federated state and national levels.[163] This was seen as important in order to avoid the possibility that the arguments used might be perceived as good at the local level but still bring negative effects for the broader collective.[164] Multiple levels of the association, including local work groups, federated state-level groups, and, where suitable, different sections and the advisory board, were thus typically involved in the planning and co-ordination of collective actions.[165]

Another example of such work involving input from multiple levels of the association was the process of developing new standardizing instruments for the profession that resulted in the document *Produkt- und Leistungsbeschreibung der Klinischen Sozialarbeit* ("Product and Service Description of Clinical Social Work").[166] In 2001, the need to develop a standards manual for HSW services was repeatedly brought up in the association's journal, with the information given out to its readers that the DVSK had begun the development work towards associationally created service descriptions, handled mostly by its sections on quality management and somatic care. The journal's readers were thereby encouraged to send in for analysis their already existing manuals, to that way contribute to the further development of the draft version.[167] The following year, a quality management manual was then presented and discussed in a regional seminar organized by the association, with the statistics section of the manual reportedly integrated into the association's documentation software pre-tested in 26 hospitals.[168] Subsequently, in 2004, the standards manual was then presented for discussion in the association's regional work groups as well as its annual meeting, with the official publication of the finalized version of the manual announced to take place right in time for the following DVSK Conference in

[162] GPO001, GPO003, GAR001, GAR002, GPO002B, GA059e/f.
[163] GD001B, GA057a/d/e, GA065a/b, GA069a/b, GA097c, GA117, GA142, GAR001, GAR003, GAR006, GPC005a GPO002B, GPO014, GPO010, GWS038, GWS040.
[164] FG DVSG.
[165] GPB006: 10.
[166] GD003.
[167] GA044d, GA047a, GPO021.
[168] GA054a/c.

2005.[169] Following this, during the period 2005–2007 the standards manual was revised, with the new, revised version published and presented in the association's 2007 annual meeting.[170]

Disseminating

Apart from informing members on, and involving them in, the development of common professional attributes, goals, and their associated symbolic meanings, the SK and the DVSG also disseminated knowledge and information to other HSW practitioners when including them into associational activities. Both the SK and the DVSG engaged in further education activities to that way disseminate to HSWs what they saw as relevant formal knowledge. The associations in both countries organized national conferences, regional and national seminars, occasional peer supervision, and, in the case of the DVSG, also introductory courses for HSWs.[171] In both countries, the focus in the knowledge transfer lied on relevant social work methods and theories, on knowledge related to specific patient groups, and on medical diagnosis. Additionally, the two associations supported exchange of experiences among their members. In Sweden, further topics such as staff supervision, evidence-based practice, and official directives concerning rules and ethical dimensions of HSW were addressed. Topics specific to the German context included legislative reforms, social work, economy, and methods for healthcare policy involvement. Information on the content and results of such further education initiatives was reported on in the two associations' journals, although in Sweden only during the 1990s.[172]

However, as the documents obtained from the SK show, the Swedish HSWs' preferred context for knowledge transfer was section-specific seminars addressing specialist topics relevant to HSWs in neurology, diabetes care, psychiatry, and comparable. This was partly claimed to have to do with

[169] GA083, GPC006b.
[170] GAR007, GA131.
[171] GA001, GA007, GA008, GA019, GA025a, GA033, GA035, GA046b, GA059b/e/f, GA083: 34, GA095, GA097a/c, GPA001, GPB012, GPC004, GPC005a, GPC006b, GPO001, GPO012, GPO013b, GPO024a, GPO026, GPO032a, GAR001: 11, 13–16, 18ff, GAR002/b, GAR003: 18ff, 21f, 23f, GAR004, GAR005, GAR006, GWS006, SKA015, SKA004, SKA005, SKA016, SKA019, SKA020, SKA022, SKA031, SKA035, SKA036, SKA037, SKA038, SKA040, SKA041, SKA042, SKA043, SKA011, SKAR001, SKAR004, SKAR005, SKAR006, SKAR009, SKAR011, SKAR013, SKAR018, SKP001, SKP002, SKP003, SKP019, SKP009, SKP015, SKP016, SKP017, SKP020, SKP028, SKP030, SKP031, SKP032, SKP045, SKP047, SKP050, SKP052, SKP059, SKP061, SKP064, SKP072, SKP078, SKP085, SKP0087, SKP089, SKP092, SKP093a, SKP093b, SKP094, SKP095, SKP096, SKP097, SKP101, SKP102, SKP104, SKP105, SKP110, SKP112, SKP116, SKP118, SKP121, SKP122, SKP122, SKP123, SKP129, SKP130, SKP136, SKP137, SKP138, SKP139, SKP140, SKP142, SKP143, SKP144, SKP145, SKP146.
[172] SKP053, SKP023, SKA014, SKA021, SKA028, SKA029.

employers' unwillingness to pay for employee participation in further education when the courses offered had, in their view, too general a focus.[173]

When it came to the use of further educational activities to disseminate among the broader professional group collectively developed attributes central to the development of a group identity, there were major differences between the SK and the DVSG. The SK appears not to have deliberately promoted the dissemination of collectively defined associational positions and statements through seminars and conferences. However, even if there never were any explicit intentions to do so, in 1993–1997 it nonetheless engaged in activities that had the effect of furthering the dissemination of common positions. These activities included common conferences for all HSWs, seminars by the sections of the association sometimes co-organized with the national conference, and mentoring of new HSWs. As one member of the SK explained some of the motivations for these activities:

> Our superiors who are nurses or physicians don't know how to develop our work. They aren't able to support us.... That's why we've organized a mentorship system for ourselves all on our own, to help newly recruited HSWs find their way in their new job.[174]

These efforts can be understood as an attempt by the SK to unite an otherwise heterogeneous professional group whose members often tended to orient themselves towards medical specialties rather than their own professional group.[175] At the same time, the SK kept advertising other organizations' (patient organizations, hospital organizations) conferences and seminars, that way offering those organizations opportunities for developing common descriptions and definitions for HSW. This could be understood as a special service provided for one's own members. At the same time, it could also be viewed as something jeopardizing one's attempts to gain control over the processes in which central HSW attributes were defined.[176]

The DVSG, on the other hand, used its conferences, seminars, and introductory courses with the express purpose of disseminating knowledge on collectively developed official positions and statements, definitions, and standards.[177] Moreover, as non-members and external guests, too, were wel-

[173] SKA014, SKA016, SKP019, SKP015, SKP029, SKP030, SKP032, SKP048, SKP049, SKP050, SKP052, SKP053, SKP054, SKP071, SKP063, SKP101, SKP096, SKP097, SKP098, SKP121, SKP122, SKP122, SKP124, SKP129, SKAR003, SKAR004, SKAR005, SKAR006, SKAR008.
[174] Participant in FG SK.
[175] SKP032, SKP052, SKP054, SKP061, SKP066, SKP072, SKA017, FG SK.
[176] SKP047, SKP052, SKP0087, SKP102, SKP117, SKP118, SKP120, SKP143, SKP146, SKAR014, SKAR018.
[177] GPC005a, GPC005b, GPC007, GWS002, GWS006.

comed by the association, this dissemination was likely to have a scope going beyond the association's own boundaries:[178]

> Many qualified further educational activities are organized all over the country, under the umbrella of the DVSK. Our development work [standardizing instruments, definitions, and social work techniques] in the sections and in the project and work groups forms part of the content of these activities.[179]

Both associations' board members collaborated with other actors (primarily trade unions and patient organizations in Sweden and professional associations and hospital organizations in Germany) to be able to better represent HSW concerns and interests vis-à-vis these actors.[180] In the case of both the SK and the DVSG, the associations used such opportunities to disseminate beyond their own boundaries what they perceived as commonly accepted attributes of HSW.

6.5 Expanding into new territories

As noted in Chapter Five, only a minority of HSWs in Sweden and Germany are members of their professional associations. A professional group-specific identity, however, can only function as such if it is shared by the majority of HSWs. In the same vein, specific professional attributes can only be claimed to be common to all HSWs if a majority of HSWs agree to them. The associational documents collected from Sweden and Germany show the HSW associations studied to have engaged in efforts to extend their territories in several ways. On the one hand, they made efforts to expand their membership base to engage as many social workers in health care as possible. On the other hand, they sought to expand HSW practices into new, neighbouring work fields.

Some of these attempts at expansion related to particular major healthcare policy developments affecting the structure of the welfare state. Among these were, in the Swedish case, the introduction of the *Ädelreformen* in 1992, the implementation of the *Psykiatrireformen* in 1995, and the onset of the financial crisis of 1990–1994. In the German case, these included the country's re-unification in 1990 as well as the fundamental reforms in the German social welfare and healthcare legislation in 1993–2003 and 2007.

One very basic way to *broaden the membership base* of a professional association is to change its membership requirements, as demonstrated by the

[178] GAR001, GAR002, GPO015b.
[179] GPC006b.
[180] SKP053, SKP047, SKP078, SKP137, GPO011d, GPO013a, GPO014a/b, GAR001.

DVSG in the German case. As described in Chapter Five and in the focus group interviews with DVSG board members, membership in the DVSG was open to all individuals and organizations either working with social work tasks in health care or otherwise interested in supporting HSWs' professional interests.[181] The association also engaged in co-operation and collaboration with other organizations (e.g., DGS and the trade union DBSH), including mutual membership, as a strategy to increase the number of social workers it could officially be said to represent.[182] In Sweden, on the other hand, membership in the SK was only open to social workers with a university degree who were employed in county-based health care.[183]

Nevertheless, both the SK and the DVSG were interested in recruiting as many HSWs as possible in order to increase their representativeness and solve their respective problems with free-riding HSWs.[184] Different strategies, however, were applied by the two associations in their efforts to make their free-riders into fee-paying members. The SK closed all its seminar activities to non-members.[185] The DVSG, on the other hand, only restricted access to certain strategic documents of particular value to HSWs' work in organizations, and to its internal associational meetings.[186] The majority of the association's documents, local and regional seminars, local co-operative meetings, national conferences, and further education opportunities were kept open to both members and non-members.[187] The following reflections by two representatives of the DVSG illustrate the use of strategic documents to induce non-members to sign up, while also showing the association's intent to influence HSW practice more in general through the dissemination of the association's positions, statements, and values:[188]

> NN1: Restricting the availability of documents is a problem. The more you do that, the less publicity you get and the less people talk about these documents.
> NN2: We try to find the golden mean: documents that support and facilitate professional work are made available to members only, while certain strategic papers that need to be disseminated as widely as possible are made available to everyone. I think this is a good way of doing it; it's proven itself to be a good strategy. I can tell that from the reaction of all those who call us up and say that

[181] FG DVSG.
[182] GAR007.
[183] Fredlund 1997, SKP105, SKP138.
[184] GPO032a/b, FG DVSG.
[185] SKP010, SKP071, SKP0072, SKP091.
[186] GAR001, GAR005, FG DVSG.
[187] GPA005, FG DVSG.
[188] GAR001.

> they absolutely need these papers. Well, then you have to become a member...[189]

Other strategies to extend the associations' influence on HSWs could, however, also be observed. These were all specific to the context and the circumstances to which they were responding. In the mid-1990s, for example, the SK made a failed attempt to merge, or at least extend its co-operation, with the VKF.[190] Later on, however, the number of SK members working in psychiatric care went up simultaneously as the activities of the VKF winded down, indicating an unintended fusion between the VKF and the SK.[191] More recently still, there was also an attempt to integrate the NFS into the SK, even if this project, too, ultimately failed.[192] In Germany, again, the early 1990s saw a massive increase in recruitment activity owing to the inclusion of the former East German regions.[193] New local and federated state-level networks were developed, and support was offered in representing professional interests during the initial phase of legislative and structural reforms in the country.[194]

During the period under study, the SK and the DVSG also attempted to expand the range of the work fields they represented within health care. In Sweden, the SK argued for HSWs' inclusion in the newly emerging work fields (e.g., contagious diseases, primary care), sometimes in collaboration with the trade union.[195] Also in Germany, the DVSG argued for the expansion of HSWs' work fields in health care. In 2003, the association was then also formally opened to all social workers employed in the healthcare sector, including fields such as in-patient and out-patient care in organizations, occupational health care, eldercare/geriatrics, oncology, hospice/palliative care, psychiatry, disability, workplace and medical rehabilitation, public health administration, and self-employment based social work in health care.[196]

With the onset of reform activity affecting their respective countries' welfare state structures, the HSW associations in both Sweden and Germany saw new opportunities for social workers to claim new work fields in health care. The associations' attempts to extend the scope of social work to new work fields outside traditional health care were, however, more prominent in the case of the DVSG. Prompted by large-scale welfare state reforms, the

[189] FG DVSG.
[190] SKP066, SKP049.
[191] SKP130, SKP143.
[192] SKP135.
[193] GPB001, GPB002, GPB008, GAR001, GAR002, GAR003.
[194] GPB002, GPB003, GPB004, GAR002/b.
[195] SKP032, SKWS005.
[196] GA036, GA045, GA053, GA056, GA063, GA070, GA076, GA088, GA094, GA097a, GA142, GAR006, GAR007, GPA011, GPA012a, GPB035a, GPB043, GPB050, GPC005b, GPC006a/b, GPO025a, FG DVSG.

association engaged in efforts to redefine social work in health care. It argued for staffing certain functions (e.g., rehabilitation counselling) in healthcare and retirement insurance funds with social workers and for the integration of social work in the newly emerging organizational contexts located at the intersection between social welfare and health care (e.g., psychosocial services in geriatric care, integration counselling for disabled persons).[197] In Sweden, the legislative changes also resulted in the transfer of certain county healthcare functions to the municipal healthcare organizations and in the establishment of new social work fields in municipally organized health care (e.g., *personliga ombud* or municipal case managers).[198] In contrast to their German counterpart, however, the Swedish HSW associations, while discussing it, finally turned down a proposal to include in their membership also social workers from healthcare services other than the county-based ones.[199] As the following quote shows, the SK was more willing to reject the possibility of developing new functions for social work in health care than include them into its scope:

> The [government investigation] committee outlines a proposal to implement a system of municipal case managers. The proposal in question is utterly out of proportion and unrealistic. The investigators stress the need for co-ordinating interventions for psychiatric patients, as if such co-ordination of interventions did not already exist.... HSWs' role in this regard forms already today an essential, indeed indispensable part of team work in psychiatry.[200]

In other words, when, in HSW, it comes to voluntary professional organizations' effective development of compliance to a group-specific professional identity, it seems desirable that as many HSWs as possible accept this identity. The evidence collected from the SK and the DVSG shows the latter to have applied a broader scope than the former. In the German case this attempt to use a broad scope is indicated by the number of activities in which members of the association engaged together. It is further indicated by the association's efforts to involve also HSWs who were not its members. Looking at free-riders as potential multipliers helping to disseminate further the developed terms, definitions, and standardizing instruments, as the board of the German association did, provides further evidence still of the broad-scope approach the DVSG resorted to in its activities. The SK, on the other hand, could be described as a case exemplifying a narrower scope, both in

[197] GA087, GPB022, GPO011c, GPO012, GAR006.
[198] SKWS008.
[199] SVKFP009.
[200] SKWS008: 44.

terms of the association's amount of activities and in terms of its degree of inclusion of HSWs not affiliated with it.

6.6 Summary

In this chapter, the various means used by professional HSW associations in Sweden and Germany to internally develop, establish, and maintain a collective professional identity for HSWs has been discussed. The associations studied used collectively developed narratives to reproduce discourses on the importance of the profession's history, on the self-perception of the profession as currently having a fuzzy identity, on the profession's lack of control over its work tasks, and on the impact of the healthcare policy on HSW practice. The two associations' internal jurisdictional work was aimed at developing narratives describing and reproducing a picture of the professional subgroup as perceived by its members. Through shared attributes and goals, affinity with other members of the professional subgroup, and to some degree with other social workers or healthcare workers, was thematized and affirmed.

These shared attributes and goals were, however, somewhat different in the case of the Swedish and German associations. The Swedish association SK primarily aimed at licensure for HSWs, while the German association DVSG pursued a greater variety of goals. Among these were, for example, bringing HSW as an external category more in line with HSWs' own understanding of their professional identity, the integration of social work into new healthcare arenas, and the integration of social work in healthcare legislation and corporative contracts. The SK and the DVSG were also engaged in developing for HSWs a shared professional identity, by asserting certain professional attributes as profession-specific characteristics of HSW. These attributes related to HSWs' work tasks, covering aspects such as diagnostic tasks, treatment skills, the development of a classification system for HSW interventions, and the perceived and claimed affinity to a certain academic discipline. The attributes were symbolically charged, and they were used to either differentiate the professional subgroup from, or relate it to, social work and other professions.

The DVSG asserted HSW's linkage to the knowledgebase of social work, with references to other than social work theories being sparse. This indicates the social work knowledgebase to have been seen as a shared professional attribute of HSW. The almost exclusive referencing to social work theories proclaimed the transdisciplinary nature of social work, which in turn was used to erect symbolic professional boundaries towards healthcare professions. Social case management was pointed out as the foremost social work method and, thereby, as a relevant symbolically charged collective

HSW attribute. Moreover, associational structures for membership involvement in the DVSG's case supported the development of a uniform professional identity for all HSWs in health care. The work task and work field descriptions as well as the classifications of HSW treatments as developed by the German association were generalized to a degree enabling their application in a diversity of healthcare settings.

Also the Swedish associations supported the development of shared symbolically charged attributes for social workers in health care, although in this case the development of a collective professional identity was led into a different direction. In general, the Swedish HSW associations in this study were all in agreement that the formal affiliation of HSW was to social work and the performance of psychosocial work. Nevertheless, it proved difficult to reach a similar agreement on collective work task descriptions for HSW, apart from the general characterization that HSW tasks differed from other social work tasks. In addition, psychosocial work was used as an umbrella term for a variety of methods and theories derived predominantly from neighbouring disciplines; the usability of social work knowledge in HSW was from time to time claimed to only insufficiently describe work tasks as shared social work attributes creating and maintaining symbolical boundaries vis-à-vis other professions. The documents collected from the association thus contained frequent references to other disciplines and their knowledgebases. Medicine and nursing were sometimes pointed out as providing HSW with an equally important knowledgebase. Thereby, but also through organizational structures, the affinity to other healthcare professions was asserted. In Sweden, work task and work field descriptions were developed rather as drafts, necessitating their adaptation to specific work sites and different healthcare contexts. While, as such, they thus lent themselves well for circulation among the membership and therefore also to use as a means for group identity building, at the same time they then could not have the same multiplying effect that they might have had as fully developed, jointly agreed-upon final documents.

Differences could, furthermore, be observed between the Swedish and the German associations studied when it came to their attempts to evoke HSW practitioners' compliance with the proposed subgroup-specific professional identity. Here the SK and the DVSG, moreover, followed different strategies. The SK for the most part aimed at promoting its members' compliance, while the DVSG rather sought the compliance of the largest possible number of social workers operating in healthcare settings.

7 Promoting Formalization of Jurisdiction

This chapter of the dissertation describes, analyses, and compares the strategies and means used by HSWs' associations in Sweden and Germany to promote the formalization of their subgroup's professional jurisdiction. As noted, for example, by Abbott (1988), legal jurisdiction protects the relation between a profession's knowledgebase and its work tasks through legislation. External jurisdictional work promotes jurisdiction in more general terms, aiming to accomplish what in this dissertation is termed 'formal jurisdiction'. It pursues protection of professional knowledgebase and work tasks by legislation (e.g., licensure laws), by public regulations, and by official job descriptions. In some contexts, public regulations are seen as having a quasi-legislative status, which may then strengthen the jurisdictional protection granted by these regulations.

Section 7.1 below first describes the strategies Swedish and German HSW associations used to translate their internally developed jurisdictional claims into effective formal jurisdiction in three different arenas: legislature, public regulations, and the hospital setting. After that, section 7.2 looks at the strategies these HSW associations used vis-à-vis stakeholders deemed as critical for their success in advancing HSWs' formal jurisdiction. These stakeholders included the trade union, universities and research institutions, other professions, patient organizations, and local external organizations. Finally, section 7.3 focuses on the importance that HSW associations attach to the publicization of professional issues through the media. It also describes some of the main difficulties the two associations studied encountered in their efforts to present HSW and its jurisdictional claims to the broader public by using different media.

7.1 Claiming formal jurisdiction in legal and executive arenas

The documents collected from the associations in Sweden and Germany show them to have used similar strategies to promote the translation of their jurisdictional claims into formalized jurisdiction. The extent to which these strategies were actually made use of by the associations in the two countries, however, varied, as did their scope. While HSW associations in Sweden for the most part concentrated on the question of licensure in their jurisdiction work, the DVSG pushed for the inscription of HSWs' professional title and work tasks in various kinds of welfare legislation and public regulations while also addressing the need to develop, at the workplace level, official job descriptions for HSW in different work fields.

Maggetti (2009) and Erichsen (1995) have described the medical profession as one that is today incorporated into the state system in both Sweden and Germany. Abbott (1988) has, furthermore, suggested that medicine also controls its subordinate professions' access to the networks in which the allocation of particular work tasks to certain professions is negotiated. The HSW associations in this study used a variety of strategies to deal with problems arising from their exclusion from key bodies in the legal and executive arena. Such strategies for promoting HSWs' professional interests, however, often overlapped with one another. They can be described as negotiation strategies, covering a whole range of activities from attempts to merely establish a physical presence at certain forums to the writing of official statements and commenting on draft law proposals and government investigation committee reports. In between these extremes lied strategies such as informing, bargaining, and lobbying in matters involving legislation and public regulations. In the hospital settings, the strategies the associations studied used included motivating members to use the same strategies in their respective hospital organizations and the development of supportive documents for that purpose.

Advancing protection through legislation

Several different strategies were employed by the German and Swedish associations to achieve protection of professional HSW work tasks by legislation. This was so during the entire time period under study, but particularly in the period after 1999. The documents collected show the associations in Sweden and Germany to have engaged (often through lobbying) with politicians in Sweden and Germany, while doing the same advancing parties and authorities/administrations at the national and federated-state/county level.[201]

Concentrated and systematic efforts at detecting, identifying, and monitoring developments in health care and healthcare policy and the impact of these developments on HSW practices, and at informing and lobbying around these issues, were reported by the HSW associations in both Sweden and Germany to make up an important part of their activities. The SK and the DVSG, however, both cited difficulties in accessing information about forthcoming legislative reforms and law reform plans. Especially in the 1990s, the SK stressed the importance of its being kept informed about

[201] In Sweden, these included, among others, the Minister and Ministry of Health and Social Affairs, the Swedish National Board on Health and Welfare, the *Socialförsäkringsutskott* (parliamentary committee on social insurance), and various government investigation committees. In Germany, they included, among others, the Federal Ministry of Health and the federal advisory council on the assessment of developments in the health care system (*Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen*). See SKP046, SKP078, SKP090, SKP118, SKA005, SKAR013, GA006, GA122, GA131, GPA013, GPO032, GD001, GAR007, GWS029.

forthcoming proposals for healthcare legislation and the official investigations related to them. The main sources of information for the two associations in this respect were the trade union and various state agencies.[202] In Germany, co-operation between the association's national board and its work groups in the different federated states was attempted, so as to be able to better support one another in the task of detecting and monitoring HSWs' professional interests when confronted with changes planned to healthcare legislation at the federated-states and national level.[203] The following quote illustrates some of the dilemmas involved in this task:

> It is extremely difficult to find any information at all about forthcoming law reforms, as all negotiations [about amendments to federated states' hospital laws] are held at the federated-state level. And in the meetings of the national board, we don't always know who knows what at the federated state level…. In other words, we have to a) make sure we get information ahead of time, b) take a stance [on the proposed changes], and c) get ourselves in a position where we know who the people are who do the preparatory work for the law reforms and who are the ones sitting at the negotiation table. Otherwise you aren't able to get your voice heard.[204]

The quote describes some of the difficulties HSW association in Germany had in obtaining advance information about forthcoming changes in legislation, given their typical lack of access to the networks through which such information could be obtained and the planned reforms influenced. According to them, only by securing access to relevant bodies could the kind of information be obtained that enabled the associations to in turn inform their own audiences and stakeholders about all the important facts involved and produce official statements. The quote, however, also speaks indirectly of the experience of the professional group that it was nevertheless often heard and that its objections were taken seriously.[205]

Another important activity of the associations studied in this regard was to physically represent, and disseminate information on, HSW at forums where legislative changes are prepared. In both countries, gaining physical access to policy forums was perceived as essential for one's ability to promote legal HSW jurisdiction. In Sweden, the SK advocated for the physical presence of HSW in state administrative organs and in government investigation committees to be set up. The negotiations around this issue also concerned, for example, the inclusion of a HSW representative in the multi-

[202] SKP008, SKP020, SKP059, SKP087, SKP138, SKAR002.
[203] GPB002, GPB003, GPB004, GAR002/b.
[204] Participant in FG DVSG.
[205] FG DVSG.

professional advisory boards charged with the task of reforming healthcare licensure, especially in the 1990s.[206] This was seen as important for the SK "in order [for it] to be able to follow the process closely."[207]

Also the DVSG intensified its attempts towards the end of the 1990s to physically come into contact with actors from the legal arena, such as political parties, ministers, and politicians at both the federated-state and the national level.[208] These actors were, moreover, also invited to take part in plenary discussions and conferences organized by the association and in annual meetings in 2003–2007. Indeed, the association could report on having had "numerous conversations with representatives from political system".[209]

When a physical presence in the targeted administrative organs and committees was achieved, the SK often used this newly acquired position of its to disseminate information on HSW and its work tasks in health care. This information was provided to relevant state authorities, state administrators, politicians, ministers, and other representatives of the state. However, when informing on specific social work tasks in health care, the SK also made a point of bringing up the importance of social work competences in certain types of healthcare settings, along with HSWs' particular educational needs in health care.[210] Additionally, in the 2000s, the association also used the contacts it had established to gain specific information on what was needed for HSW to be able to win licensure and protect their professional title.[211] In Germany, on the other hand, the kind of information that the association there disseminated rather concerned the contributions of HSW to health care, the current situation of HSW in different federated states, and the possible consequences of specific laws and legislative changes for patients' need of social services or for HSW skills and competences needed to deliver those services.[212]

Lobbying was a further strategy resorted to by HSW associations in both Sweden and Germany. It was used by them to impact on the work of forums otherwise closed to it. In Germany, the association's federated-state level work groups and national board co-operated in their efforts to influence legislation in individual federated states and at the national level.[213] In both Sweden and Germany, these activities were meant to help sensitize politicians, ministers, and other state representatives. They were, however, also resorted to point out the contributions of HSW to health care, publicize the

[206] SKA022, SKP048, SKP050, SKP096.
[207] SKA022: 5.
[208] GPO013, GPO015, GAR005.
[209] GA037, GPC008, GAR006, GAR007.
[210] SKA020, SKA043, SKP046, SKP118, SKP143.
[211] SKP078, SKP090, SKP092, SKP110, SKP118, SKP136, SKP143, SKP146, SKAR013.
[212] GA007, GD001, GPC005, GPC006, GPO013, GPO015, GPO032, GAR001, GAR004.
[213] FG DVSG.

consequences that legislative reforms in the healthcare sector would predictably have for HSW, and to talk about what the consequences of not having legal jurisdictional protection were for HSW. Lobbying was further used to point to the need for inscribing the necessary functions of HSW in law and defining the competences required to perform HSW.[214] The following quote offers an example of how such lobbying could look like in practice in the Swedish case:

> NN met with the chair of the Socialförsäkringsutskott [Committee on Social Insurance], MM, discussing the necessity to pay sick benefits also to patients who are only attended to by hospital social workers. MM stated that the recent legislative draft indeed did not include this possibility, but that a revision to it was underway…. NN also informed MM about the association itself.[215]

Over time, especially licensure for HSWs became an object of intensive lobbying activities in Sweden. The following examples illustrate how several strategies were drawn upon by the Swedish association in its attempts to promote legal jurisdiction for HSW in the country. In the beginning of the 1990s, the SK decided to try to influence members of the Ministry of Health and Social Affairs so as to induce them to raise the question on HSW licensure in the Swedish national parliament.[216] The association closely followed the work of setting up the planned governmental investigation committee to ensure that the professional interests of HSWs would be represented in it.[217] When the law on licensure was then reformed in 1995, members of the association were asked to contact national-level politicians from their county or members of the now formed governmental investigation committee on licensure.[218] During the period 2000–2008, when further revisions were made to the law, additional contacts were sought, often in co-operation with the trade union, with the Ministry of Health and Social Affairs, former members of the government's investigation committee, and state secretaries, in order to be able to discuss with them licensure and distribute to them information on HSW and the need for licensure for it (see 7.2).[219]

Moreover, the HSW associations in both Germany and Sweden issued official statements and comments on legislative and policy drafts as well as draft regulations developments in health care, usually pointing out the importance of social work services in healthcare settings and outlining its posi-

[214] SKA005, SKP046, SKP092, SKP110, SKP136, SKP143, SKP146, GD001, GPO032, FG DVSG.
[215] SKP046: 23.
[216] SKA005.
[217] SKA002.
[218] SKP053: 21.
[219] SKP092, SKP110, SKP136, SKP143, SKP146.

tion on relevant healthcare-related questions.[220] The importance to take into account the HSW viewpoint was repeatedly brought up in the German association's comments and official statements put forward, as for instance in the following case:

> Therefore, the association demands regulations that require hospitals and rehabilitation hospitals to deliver hospital social services by professional hospital social workers and to clarify the latter's responsibilities in discharge management…. From the perspective of [the DVSG], the re-orientation of the healthcare system can be successfully implemented only if social work is systematically and consistently incorporated in intervention and supply concepts.[221]

In Sweden, however, written statements were often only indirectly addressed to legislative bodies. Most commonly, they were passed on via the trade union (see 7.2). Occasionally, however, no agreement with other HSW associations or the trade union could be reached concerning on a common position or a perspective. In these cases, separate comments or official statements were thus presented.[222]

In other words, when striving for legal jurisdiction, the HSW associations in both Sweden and Germany seemed to be succeeding in overcoming the obstacles caused them by their exclusion from strategic public bodies. In both countries, the associations sought to influence healthcare legislation at both the national, the federated states and regional/local level in order to incorporate in it HSW tasks and restrict the performance of these tasks to only those holding an academic social work degree. In Sweden, the SK focused its efforts in this respect primarily on the issue of licensure, and in Germany, owing to the country's insurance-financed healthcare system, the DVSG mostly sought to integrate HSW services into the remuneration system for health care. In line with what Abbott (1988) and Freidson (2001) have noted on the part of other professions, HSWs' efforts to establish legal jurisdiction followed different paths in the two countries, and were aimed not only at winning licensure. In any case, the prospects of being able to secure protection for HSW's jurisdiction through inclusion of specific work tasks and competence requirements in healthcare-related legislation remain uncertain. It cannot be foreseen, for example, whether the professional claims put forth by the associations will be heard or how other professions'

[220] SKA016, SKA022, SKP032, SKP045, SKP053, SKP054, SKP064, SKP089, SKAR001, SKAR003, SKWS006, SKWS008, SKWS010, SKWS013, SKWS014, SKWS017, GA122, GA131, GA137, GPA013, GPB006, GPB050, GPC007, GWS029, GWS031, GWS035, GAR007.
[221] GWS031: 1–7.
[222] SKP054, SKWS014, SKWS017, SVKFWS002.

interests will influence the final jurisdictional settlements, as the German example shows.

The jurisdictional work strategies applied by the HSW associations in the two countries suggest that these associations lack direct access to the kind of networks where information on the legislative reforms being prepared and other changes underway in regulatory frameworks is made available. The associations also lacked regular access to networks where the content of future healthcare legislation was being negotiated. Instead, it was medicine that as the dominant profession in the field controlled access to these forums. The strategies these associations resorted to in order to win legal jurisdiction for HSW thus reflected their need to gain access to, and draw upon, the existing co-operation networks established between medicine/healthcare professions and the state; it was only through them that they could legitimize their claims among their target audiences and ensure that their voices would be heard. Access to legislative bodies in Sweden is often only indirect, going via written statements to the trade union, although sometimes also direct; in Germany, written statements are passed on via multi-professional advisory boards, public corporative bodies, or representatives sitting in committees; occasionally here, too, however, the legislative bodies can be approached directly. In any case, these written statements usually have different addressees in Sweden and Germany. The difference here is due to the fact that Sweden relies on a centralized state system whereas in Germany one finds a federal state system. While the association in Germany, to advance its jurisdictional work, thus had to access information and negotiation networks at both the federated-state and the national level, the Swedish SK could concentrate on the national level only. Especially accessing these networks in the 16 federated states of Germany was frequently pointed out as challenging by the association there.

Advancing protection through public regulations

Apart from protection through legislation, the HSW associations also sought to protect HSW's professional jurisdiction through public regulations. In Germany, some of the country's corporative contracts in health care are considered to have a quasi-legislative status. In Sweden, the association's efforts to influence public regulations were, as evident from the documents collected, more or less constant and typically intensive. In Germany, especially the documents dating from 1996 and after show a much increased activity aimed to protect HSW through its inclusion in regulations and contracts.

During the period under investigation, the SK attempted to shape public regulations concerning the standardization and computerization of HSW documentation and language in health care, quality management (the development of criteria for quality development), and measures for quality

evaluation.[223] The public regulations it focused on also included national guidelines for the treatment of specific diseases and for work rehabilitation, while it also concerned itself with the interpretation of specific legal terms such as 'death' and 'good health care'.[224] In Germany, the DVSG sought to influence the development of corporative contracts concerning the discharge from hospital care to nursery care, social counselling in hospitals, domestic nursery care, supply management, and the remuneration of healthcare services, into which it wanted to integrate aspects of HSW.[225] The association's attempts to shape public regulations, however, also extended to compulsory recommendations such as the recommendations concerning the implementation of the Social Code IX in the co-operation between HSW and rehabilitation funders.[226]

In the documents collected, both the Swedish and the German association pointed out the insufficiency of their communication channels, which, in their view, did not allow them to influence public bodies' policy making in the healthcare sector. It was, moreover, difficult for them to approach the kind of contexts where information on upcoming law reforms and regulatory changes in the making was available and where new regulations were negotiated.[227] In Sweden, representation of HSW interests and the integration of these interests into public regulations were seen as sometimes successfully accomplished, sometimes not, depending on the ability of HSWs to get involved directly, as noted, for example, in the following quote:[228]

> There [in FAMMI] we had a possibility to discuss and point out HSW tasks. Our ability to do that effectively varied over the years, but it was in these contexts that we were able to come into contact with others and show our contributions [to health care]. We need to come into contact with others if we want to be able to spread information. But what we do is still only a drop in the ocean.[229]

The DVSG attempted to create communication channels to public corporative bodies already at the end of the 1990s, although it was able to do this most successfully in the following decade. In 2008, the healthcare funders compiled information on forthcoming changes in contracts and signed con-

[223] SKAR004, SKA022, SKA031, SKA026, SKP019, SKP020, SKP052, SKP053, SKP054, SKP059, SKP064, SKP071, SKAR001, SKAR002, SKAR005.
[224] SKP003, SKP085, SKP089, SKP094, SKP096, SKP098, SKP101, SKP102, SKP104, SKP110, SKP111, SKP112, SKP117, SKP118, SKP131, SKP143, SKAR008, SKAR011, SKAR012, SKAR013.
[225] SGB V paragraph 12, subparagraph 2, no. 5, paragraph 112, subparagraphs 4 & 5, paragraph 37; GKV-WSG paragraph 11; *Bundespflegesatzverordnung,* BPflV.
[226] GPC006, GA099, GAR007.
[227] SKA026, SKP061, SKP096, SKP052.
[228] See SKP061, SKP005.
[229] Participant in FG SK, FAMMI is the *Familjemedicinsk Institut*

tracts that they made available via links and notices on their web pages.[230] The DVSG also approached public corporative bodies in connection with their conferences at the federated-state and national level in order to inform members of these bodies of HSW tasks and interests.[231]

During the period 1989–2008, the professional associations in Sweden and Germany approached several different public and public corporative bodies in order to win protection for their professional jurisdiction through public regulations. In Sweden, these included different public administrations and their advisory panels on the national and county level.[232] Formal or legislative restrictions concerning participation and representation in advisory panels do not exist. In Germany, the DVSG approached a variety of public corporative bodies as it lacked a legally prescribed right to directly participate in negotiations among and by public corporative bodies in corporative self-government, for instance the *G-BA*.[233] According to law, only members of specifically defined public corporative bodies were authorized to negotiate and amend public regulations and contracts in the country and be present in the negotiations involved in the process.[234] Therefore, the DVSG's ability to influence corporative self-government directly was limited. Instead, to be able to point out HSWs' specific needs and interests at the federated-state and national levels, the association needed to address these levels indirectly by going through one of the legally defined public corporative bodies represented in self-government.[235]

Different actors in Germany and Sweden were thus informed about HSW tasks, competences, and contributions (as well as, in the German case, of the legal constitution of HSW tasks through national and federated-state legislation). The SK used for this its presence in meetings of advisory panels linked to public administration.[236] However, occasions for the DVSG to directly

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[230] GPB036, GPO003, GA115, GA132.

[231] GPB011, GPB012, GAR001, GAR002, GAR003, GAR007, GPC006.

[232] E.g., the National Board on Health and Welfare, *Sjukvårdens och socialvårdens planerings och rationaliseringsinstitut* (SPRI), *Familjemedicinsk Institut* (FAMMI), Nationellt Försäkringsmedicinsk Forum.

[233] E.g., the *Bundesarbeitsgemeinschaft Rehabilitation*, BAR (National Committee on Rehabilitation), the *Bundesarbeitsgemeinschaft Kinder und Krankenhaus* (National Committee on Children in Hospitals), and the *Gemeinsamer Bundesausschuß*, G-BA (federal corporative body of self-government the Federal Joint Committee); see GAR001, GPA010, GAR002.

[234] The legally mandated members of the G-BA include the *GKV-Spitzenverband Bund* (National Association of Statutory Health Insurance Funds), the *Deutsche Krankenhausgesellschaft* (German Hospital Federation), patient representatives, and three non-affiliated members.

[235] GA006, GPB009, GPB011, GPB012, GPC006, GPO001, GPO015, GAR001, GAR002, GAR003, GAR007. Such legally mandated members included healthcare funders (*GKV-Spitzenverband Bund*, *Deutsche Rentenversicherung* and *Deutsche Gesetzliche Unfallversicherung*, *DGUV-Spitzenverband e.V.*(the German Social Accident Insurance)), the *Bundesärztekammer* (German Medical Association) and the *Deutsche Krankenhausgesellschaft* (German Hospital Federation). All these are public corporative bodies.

[236] SKP052, SKP129.

address public organs of the self-governance system such as the Federal Joint Committee were rare.[237] Instead, information on HSW was spread by it on different occasions, although first and foremost in connection with the annual conferences and meetings of public corporative bodies.[238]

However, just like the associations' possibilities to inform on HSW interests in Sweden and Germany, also the arenas available for lobbying for the inclusion of HSW issues in public regulations were restricted to a varying degree in the two countries. At the same time, the opportunities to directly negotiate and co-operate with public administration and its associated advisory panels around the inclusion of HSW tasks and aspects in public regulations were often less restricted in Sweden than in Germany.[239] There HSWs were more often able to find ways to become involved in the implementation of HSW aspects in guidelines and standards.[240] As recounted by the SK in its 1994 annual report:

> We follow the developments in quality management in health care and especially in HSW. Our utmost wish is to co-operate with SPRI [*Sjukvårdens och socialvårdens planerings och rationaliseringsinstitut*] so as to be able to develop common criteria for quality measurements in HSW. The same applies to computerized patient documentation. To achieve this goal, it is necessary to make use of [our profession's] experiences and competences.[241]

In Germany, direct involvement in co-operation and negotiation around public regulations and contracts was more unusual. One example of such, however, was the representation of HSW in multi-professional committees where the aim was to develop common statutory recommendations and public corporative contracts between funders and suppliers in health care.[242] In these committees, the DVSG presented drafts and negotiated on the integration of social services in the healthcare funders' service and benefits catalogues for somatic and rehabilitative care and on specific contract contents concerning statutory services. Often, the DVSG also pointed out

[237] Federal Joint Committee (G-BA)
[238] GPA006, GPC005, GAR001, GAR002, GAR003, GAR004.
[239] SKA019, SKP028, SKP046, SKP049, SKP050, SKP080, SKP085, SKP090, SKP097, SKP117, SKP118, SKP131, SKAR004, SKAR006.
[240] SKA022, SKA031, SKA026, SKP003, SKP019, SKP020, SKP052, SKP053, SKP054, SKP059, SKP064, SKP071, SKP085, SKP089, SKP094, SKP096, SKP098, SKP101, SKP102, SKP104, SKP110, SKP111, SKP112, SKP143, SKAR001, SKAR002, SKAR005, SKAR008, SKAR011, SKAR012, SKAR013.
[241] SKAR004: 34.
[242] GAR001, GPA010, GAR002. One such committee is the *Bundesarbeitsgemeinschaft Rehabilitation*, BAR (National Committee on Rehabilitation).

problems arising for practice from contracts in whose preparation HSW representatives were not involved.[243]

Otherwise, the DVSG had to rely on indirect involvement, lobbying public corporative bodies in health care and other actors with access to self-administrative and self-governing institutions and their advisory panels at federated-state and national level. At conferences organized by health insurance funders, the DVSG, for example, presented its own perspective on quality measurements in HSW and provided information on HSW tasks, competences, and responsibilities in health care. In roundtable discussions with *GKV-Spitzenverband Bund* or the *Deutsche Krankenhausgesellschaft*, a variety of themes were addressed, such as the insurers' interference with HSW discretion and other work tasks, as were the staffing of newly established statutory services with social workers as well as the DVSG's recommendations regarding, and feedback on, corporative contracts.[244] Such corporative contracts were signed between hospital boards and funders concerning the specific interpretation and implementation of certain statutorily provided healthcare services and the remuneration of these services. A focus group participant from the DVSG board described the implications that HSWs' inability to directly access and partake in the medical remuneration system meant for them as follows:

> Services by physicians are always according to the specific section of the remuneration contract in question; they get paid for their services. The law lists the obligatory social services, such as supply management. But it doesn't say that this supply management needs to be of high quality in terms of how well it is done, or based on certain competences, which would of course entail certain costs. That is a problem. We [HSWs] don't have anything similar that would correspond to this medical remuneration system.[245]

In consequence, negotiations by the HSW association concerning the inclusion of remuneration for HSW services in contracts with funders were intensified after 2000. Additionally, communication channels to private insurance companies were established and negotiations with accident insurers were held with the aim of including social services for their patients into HSW responsibilities.[246]

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[243] GA006, GA035, GA057, GA078, GPB055, GA092, GPA013, GPB009, GPO01, GPO011a-c, GPO015a/b, GPO021, GPO023, GAR001, GWS033.

[244] GA037, GA115, GA132, GPA010, GPB008, GPB011, GPB012, GPB046, GPB056, GPB58, GPC005, GPC006, GPC007, GAR002, GAR004, GAR006, GAR007. *Deutsche Krankenhausgesellschaft* (German Hospital Federation).

[245] Participant in FG DVSG.

[246] GPB010, GA025, GPB036, GPB043, GPB056, GA087, GAR006.

Besides funders, the DVSG also lobbied and co-operated with an important representative body of healthcare suppliers, the *Deutsche Krankenhausgesellschaft*, at both the national and the federated-state level. Through these contacts, the content of existing and new corporative contracts and regulations were discussed in order to enable supplier bodies to negotiate with healthcare funders on issues such as remuneration for HSW services and statutory services. Also in these cases the DVSG, in the documents obtained from the association, noted problems arising from the exclusion of the associations from the process.[247]

The lobbying efforts focused on public administrative multi-professional committees in which some or all of the corporative organs were represented to work on specific issues. The DVSG was able to establish a presence in some of those committees.[248] These committees and their events offered another opportunity for members of the association to present on various HSW themes.[249]

The Swedish associations and the DVSG also used different kinds of position papers, official statements, and comments on public investigation committee reports and draft legislation/regulations as a strategy for expressing their opinion in public and influencing discussions around particular issues. In Germany, official statements were written proactively, prompted by the association's desire to draw attention to particular professional issues. Comments were issued on official government investigation reports, commission reports, draft legislation, and other policy instruments, presenting the association's stance on certain proposals put forth by the authorities. In Sweden, such statements and comments were addressed to the administrative organs of the state and its advisory panels and committees in charge of conducting investigations on particular issues. In Germany, official statements were in principle addressed to all relevant corporative bodies as well as politicians and the public administration; in certain individual cases the statements were addressed to only one of these. There were, however, differences in how the associations in the two countries used their position papers for their purposes. In both cases, position papers were used in order to influence particular issues, such as the development of specific national guidelines or healthcare programmes in Sweden or the development of corporative contracts and the inclusion of HSW in common statutory recommendations concerning health care for specific diseases in

[247] GA006, GPB009, GAR001, GPO01, GPO015.
[248] Such committees were for example, the *Konferenz der Fachberufe im Gesundheitswesen der Ärztekammer* (an advisory panel for healthcare professions associated to the German Medical Association), the *Deutsche Gesellschaft für Public Health* (association on public health), and the *Deutscher Verein für öffentliche und private Fürsorge* (an association for public and private institutions delivering social work and social care). GAR001, GAR002, GAR005, GAR06.
[249] GAR003, GPB012, GPB022.

Germany.[250] More general HSW issues, such as professional jurisdictional frictions between nursing and HSW about discharge management, the remuneration of HSW services, and HSW tasks, competences, and responsibilities, and problems in the co-operation between the HSW association and a corporative body were only addressed through official written statements by the DVSG.[251]

Protection of HSW tasks in both countries was attempted through legislation, but also through public regulations or healthcare programmes, which in certain cases have quasi-legislative character in Germany. At this public regulatory level, the differences between the two HSW associations in terms of their ability to access negotiation networks were more pronounced. Even if HSWs in both countries were rather excluded from direct negotiation on public regulations, healthcare guidelines, treatment programmes, and corporative contracts, direct access to policymaking forums as state or public administration was in general more easily accomplished by the Swedish associations than the German one. While the Swedish associations in this study were able to lobby government investigation committees in different ways either in individual meetings or through their participation in advisory panels (either independently or as representatives for their trade union), the German association had to rely on lobbying other stakeholders in these negotiations, who then represented their own and only additionally also HSWs' interests. In consequence, the German HSW association had to divide its efforts to be able to influence multiple actors, while the Swedish associations could concentrate on a few actors. In rare cases, the German HSW association was allowed to directly sit at the negotiating table. In contrast to HSW, medicine is represented in policymaking forums either via integration of medicine in administrative structures or through legislation (Maggetti 2009, Erichsen 1995). HSW's exclusion from the same forums had consequences for their ability to stay informed about upcoming negotiations on guidelines, programmes, and contracts, and, as a result, for their ability to impact on the development of these, according to the two associations studied. The associations' efforts to establish a presence, to inform, and to lobby were targeted at this level as well, especially in Germany. There the DVSG even attempted to negotiate with representatives of corporative bodies on jurisdictional issues like internally defined symbolically charged attributes such as HSW tasks, competences, and responsibilities and on service remuneration, to that way try to influence these bodies' categorization of the HSW profession.

[250] SKWS002, SKWS003, SKAR013, SVKFWS003, SVKFP002, GA095, GA099, GAR003, GAR005, GAR006, GWS006, GWS010, GWS022, GWS030, GPB010, GPB012.
[251] GA065, GA070, GWS005, GWS007, GWS008, GWS010, GPB012, GPB047, GPO015.

Pursuing protection in the hospital setting

Support to members through pursuit of protection for HSW jurisdiction at the workplace level was named in documents by the associations studied in both countries. There were differences between them, however, in terms of the time periods when such support was said to have taken place. In Sweden, support by the association in the form of protection of workplace jurisdiction was recurrently brought up throughout the 1990s, while the German documents, for the most part, speak about efforts in this direction from 1996 onward.

There were major differences also in the extent to which the HSW associations saw themselves as responsible for the protection of workplace jurisdiction. The Swedish associations indicated that they saw the responsibility for workplace jurisdiction to lie predominantly with individual HSWs. In Germany, in contrast, the association expressed it as its responsibility to support its members also by protecting workplace jurisdiction.

> The association does boundary work. We define the work tasks and we developed the Product and Service Description catalogue [of Clinical Social Work]. In it, we describe what social workers in health care do…. Therefore, HSWs can rely on our definitions, instead of creating their own. It is easier for the association to define the work task boundaries than it is for individual practitioners…. When local HSWs do boundary work on their own, it all results in individual solutions: solutions where overlapping work tasks might be perceived as natural and logical. The association, however, sees inherent problems in overlaps.[252]

Support in protecting professional workplace jurisdiction was performed in different ways by the two associations. While, in general, in the Swedish case the support in protecting workplace jurisdiction may be generally described as individual support, in the German case it may be described as structural support.

The SK and the DVSG alike created documents such as guidelines and position papers to support their members in jurisdictional work at the workplace level. In Sweden, however, projects to develop such documents were rare and date for the most part from the beginning of the 1990s. In Germany, in contrast, such activities become more and more relevant and frequent beginning in the mid-1990s.[253] The supportive documents were predominantly aimed at the associations' members in Sweden and in Germany.[254] In Germany, however, also hospital organizations could join the

[252] Participant in FG DVSG.
[253] SKD001, SKD002a, SKD007, GA019, GPB023, GPB031, GPB039, GPO001, GPO003, GPO011, GAR001, FG DVSG.
[254] SKD001, SKD002a, SKD007, GA019, GA064, GPB031, GPB039, GPO004, GAR007.

DVSG, for which reason not just HSW practitioners but also hospital organizations could turn to the association for assistance. In Sweden, on the other hand, the SK supported its members more through individual face-to-face discussions on specific topics and through occasional protest letters sent to hospital managements than through supportive documentation.[255]

In Sweden and Germany, strategic supportive documents consisted of HSW tasks and workplace descriptions as well as of recommendations on annual statistics to make them more able to describe HSW's contributions to health care. Additionally, the DVSG developed associational recommendations regarding HSWs' caseload in certain hospital settings and a special statistical software enabling HSWs to display their contributions to health care in their hospital environment.[256] A member of the DVSG board explained the use of associational recommendations by their members as follows:

> I know members who use these papers to make their argument vis-à-vis their hospital owners. They allow them to show what social work in health care is, what its competences are, and what we want to do. Or they use them simply to answer questions like how many HSWs are needed in certain healthcare settings.... Our recommendations concerning the required number of HSWs in specific work fields really are very authoritative. It always impresses the listeners when people can present associationally recommended figures. Then no one asks how representative the association is.[257]

Generally speaking, the efforts by the Swedish associations to get involved at the workplace level were limited. They coincided primarily with periods of local economic restraints, or when, for example, a large number of HSW jobs were threatened at hospitals, with members perhaps turning to their associations for assistance in deciding how to act. In very rare cases, the associations also wrote protest letters to hospital managements to point out the necessity of HSW in healthcare settings.[258]

The DVSG, on the other hand, pursued a motivation strategy to induce its members to represent the profession in their daily work at the organizational level, even if this was only rarely mentioned in public.[259]The association pointed at the importance of having HSWs present in all intra-organizational contexts such as internal team meetings, meetings with the company directory/hospital management, seminars, and other professions' educa-

[255] SKP018, SKP025, SKAR001, SKAR002.
[256] SKD001, SKD002a, SKD007, GA019, GPB023, GPB031, GPB039, GPO001, GPO003, GPO011, GAR001, FG DVSG.
[257] Participant in FG DVSG.
[258] SKP018, SKAR001.
[259] GPO004, GPO010.

tional activities. Every HSW was called on to use these contexts for self-marketing purposes, to assume personal responsibility for guarding HSW interests, and to make an effort to impact decision-making from the perspective of the HSW profession in intra-organizational contexts.[260] Members were also encouraged to address the ethical dimensions surrounding the emphasis given on economization and effectiveness when discussing with hospital managements and directories.[261] As one member of the DVSG board described his efforts to be invited as representative for HSW for different occasions:

> We have to be present at all possible occasions in order to present our work…at morning conferences, in the warden's team meetings, and so on…. HSW has a thick catalogue of statutory obligations which no other profession has, not nursing or anyone else…. Here is one example from my own practice. When our hospital changed ownership, an external service supplier tried to take over HSW tasks. I wrote protest letters to different people for two years, bothering them just to show that HSW existed and was competent. At some point the new company owners began to understand that HSW is economically effective…. Today there are only very few occasions when I'm not invited to the rostrum.[262]

The HSW associations in Sweden and Germany supported their members in settling HSW jurisdiction at the workplace level. In Sweden, this support was predominantly given in an individualized form in situations when, for example, HSW positions were generally threatened at hospitals. In rare cases, recommendations concerning work tasks were developed or HSW contributions to health care highlighted through statistical data. In Germany, on the other hand, support to members in the protection of HSW workplace jurisdiction was given in a more formalized fashion. The creation of supportive documents, recommendations, and descriptions regarding specific workplace jurisdiction-related topics is one example of the strategy used. In both countries, the recommendations and descriptions issued contained more or less collectively agreed symbolically charged attributes, which the association saw as common and specific to HSW (see Chapter Six). Where the associations employed such documents, the support given was more formalized and the negotiations between HSWs and other professions or the hospital organization were more likely to concern collectively agreed symbolically charged attributes of the profession.

In consequence, jurisdictional workplace settlements were then more likely to be in line with associational definitions and with the commonly

[260] GAR001, GPB012, GPB023, GPO001, GPO003, GPO011.
[261] GA064, GAR007, GPO004.
[262] Participant in FG DVSG.

agreed-upon group identity of the professional group. Just as in the legal and public arena, here, too, HSW did not seem to have any self-evident access to power networks within the hospital organization. Consequently, it had no access to forums where work task, responsibility allocation, and job descriptions were negotiated. In Germany, the access to these seemed to be controlled by other professions, namely medicine and economy. The association's emphasis there on individual HSWs' obligation to represent the profession in intra-organizational contexts can thus be understood from this perspective. Accessing intra-organizational networks can be understood as a way to increase one's power in the demarcation of a professional territory and in the formation of internal professional-group identity vis-à-vis external categorization. Referral networks by professional associations as well as their recommendations and definitions are then used to strengthen the argumentation power of the individual HSWs.

7.2 Promoting formal jurisdiction through negotiations with other stakeholders

Given the limited opportunities for the HSW profession to directly impact healthcare legislation and public regulations in health care, the HSW associations in this study negotiated with other stakeholders seen as strategic for the success of their project of promoting their claims concerning formal jurisdiction. These stakeholders usually had their own, sometimes rivalling, agendas and interests that they pursued in legal, executive, or public arenas. Nevertheless, they were perceived as potential supporters of HSW interests. Additionally, some of them, namely professions and patient organizations, had direct access to legal and executive public bodies.

Abbott (1988) has discussed the ways in which way professions pursue their public jurisdiction, and Pfadenhauer (2003) has drawn attention to how professions display their work in order to influence the public impressions regarding them. The professions' aim in both cases, according to the authors, is to pave the way for an eventual establishment of formal jurisdiction for them. The HSW associations used strategies intended to help them to reach their goals in the negotiation of that jurisdiction. They sought to form alliances with, or at least secure some support from, trade unions, universities, and interest groups. Additionally, they bargained about work tasks boundaries with other professions and co-operated with local actors with the aim of influencing the public impression of the profession they represented. The negotiation strategies they used vis-à-vis these different stakeholders can be described as mutually overlapping, embracing a broad range of objectives from the establishment of mere physical presence to more systematic co-operation with other actors. In between these two

extremes were strategies focused on information dissemination either verbally or through action, on lobbying, and on bargaining. The difference between lobbying and bargaining strategies was not always clear-cut. Lobbying actions were interactions in which one of the two actors involved was more interested in addressing a certain issue and more actively engaged in presenting its stance or position to its interaction partner than the other one. Bargaining, instead, involved interactions in which both of the parties were actively engaged in the negotiation of an issue in a far more concrete sense, even where one of the actors involved might have been more active and more interested in this bargaining than the other.

Co-operating with trade unions

The HSW associations in both Sweden and Germany co-operated with social work trade unions in order to protect the jurisdiction of HSW. The trade unions in question, however, had diverging interests which then impacted on the relationship between them and the HSW associations. This was so especially in Sweden, but also in Germany.[263]

The SK, judging from the documents collected, started co-operating with the trade union in 1991, with, however, less activity in this regard in the years 1997, 2002, and 2003. In Germany, activities involving co-operation with the trade union were reported on from 1996 onward. Based on the sheer number of references made to such co-operation in the documents obtained, however, co-operation of this kind was less intensive or at least frequent there than in Sweden. Co-operation between the SK/DVSG and the trade union was, for the most part, a topic touched upon in the associations' meeting minutes and annual reports, although it was occasionally brought up also in official statements and articles.

The SK, the VKF, and the DVSG all co-operated with the trade union. In Sweden, the increasing number of jointly authored official statements and the decreasing number of separately authored (by either the association or the trade union) official statements, just like the decreasing frequency of any mention of co-operation failures in the document materials obtained, can be understood as indicative of increasing co-operation between the associations and the trade union in the course of the 20-year period studied.[264] In Germany, communication with the trade union intensified from 1996 onward.[265] One reason for this, according to the DVSG, was that difficult times demanded joint representation of shared social work interests.[266] However, also the SK appeared to be dependent on its co-operation with the trade

[263] in Sweden the SSR, in Germany the DBSH.
[264] SKA005, SKA010, SKA037, SKP019, SKP045, SKP096, SKP109, SKP116, SKP129, SKWS019, SVKFS003.
[265] GPB010, GPB011.
[266] GPB012.

union, and not only when it came to securing resources such as economic and labour power, but also in terms of the access the latter offer for it to formalized channels for disseminating information, as for instance in connection with official government investigations and law proposals involving the areas of health care and social welfare. The trade union was seen as the foremost representative of HSW, with formalized access to inter-professional information on health care and social welfare.[267] In Germany, the association's access to information and negotiation networks was described as highly restricted when it came to legislation and public administration in the healthcare area. For a long time, the role of the formal representative of HSW interests in the country was more or less reserved for members of the *Konferenz der Fachberufe im Gesundheitswesen der Ärztekammer* only.[268] The DVSG itself was represented in this panel, being therefore not as dependent on the trade union as the SK was.[269]

Nevertheless, even this co-operation with the trade union became, in both countries, more and more formalized over the years. This was mostly due to the developing official contacts between the organizations and the development of permanent work groups with specified tasks. In Sweden, a permanent advisory panel was established in co-operation between the HSW associations and the trade union in the late 1990s, offering an arena for the HSW associations to jointly represent their shared professional interests. In subsequent years, the SK was also, in various hearings and advisory panels, given the role of a spokesman for associational and trade union interests towards the public administration.[270] In Germany, too, official agreements began to be made in the second half of the 1990s concerning co-operation between the association and the trade union at the national level. Gradually, the union and the DVSG even appointed joint representatives for them to work on specific social welfare and healthcare policy issues and started issuing joint official statements.[271]

The differences in the issues and areas covered by the co-operation in Sweden and Germany reflect the different character that the relationship between the trade union and the HSW associations had in the two countries. In Sweden, the co-operation was often related to specific issues such as li-

[267] SKA020, SKA025, SKA036, SKP008, SKP015, SKP020, SKP028, SKP030, SKP046, SKP049, SKP059, SKP078, SKP085, SKP120, SKAR001, SKAR002, SKAR004, SKAR009, SKAR010, SKAR013.

[268] An advisory panel for healthcare professions at the German Medical Association, an association affiliated with the umbrella organization of the German trade union (DAG).

[269] GAR001, GAR004.

[270] SKA035, SKA036, SKA037, SKA043, SKAR009, SKAR010, SKAR011, SKAR012, SKAR013, SKAR015, SKAR017, SKAR018, SKP010, SKP061, SKP063, SKP065, SKP072, SKP075, SKP078, SKP079, SKP085, SKP090, SKP097, SKP115, SKP123, SKP124, SKP128, SKP140, SKP141, SKP146, SVKFP012.

[271] GA123, GA128, GA131, GA142, GAR005, GAR007, GPA007, GPA013, GPB0131, GPB014, GPB026, GPC005, GPC006, GWS029, GWS038.

censure, self-licensure, other legislative issues, quality development, and contacts with university departments of social work. Written statements and other documents were often authored in trade union advisory boards and then put forward by the union.[272]The trade union also aided in the lobbying of politicians and public administration, by supporting the association's claims and offering help in practical issues such as obtaining financial assistance for publications, providing a location for the storage and archival of associational documents, and finding a space for the association's board meetings.[273] In Germany, on the other hand, the areas for co-operation included information exchange between the organizations, the crafting of common stances and positions on specific social welfare and healthcare issues, the development of joint further education activities and seminars at both local and national level, publication of articles in each other's journals, as well as self-licensure by the trade union and its availability for DVSG members.[274] The support the trade union gave to the DVSG was very much limited to mutual co-operation in the external representation of overlapping interests such as HSWs' employee interests and the more general political interests of the social work profession.[275]

In Sweden, the trade union's need to balance between supporting specific HSW interests and promoting the general interests of its own membership was perceived as a problem by the SK. Numerous meeting minutes offer evidence of a continual dialogue between the association and the trade union in which the association repeatedly points out how it expected the trade union to represent HSW interests.[276] A focus group member described the representation of SK interest by trade union as follows:

> We have a good co-operation with the SSR; we don't encounter any resistance directly. But we have different perspectives. The association only recruits social workers. The trade union, on the other hand, wants to enlist as many members as possible, and therefore it invites members from other educational backgrounds. So the trade union has to represent the interests of these members as well. This is a problem for us who are only a minor subgroup within the trade union. And sometimes it feels like fighting against windmills.[277]

[272] SKA022, SKAR011, SKAR013, SKP047, SKP102, SKP112, SKP117, SKWS011.
[273] SKA005, SKA010, SKA016, SKAR018, SKAR003, SKP029, SKP031, SKP032, SKP045, SKP046, SKP049, SKP059, SKP064, SKP085.
[274] GA083, GA141, GA143, GAR001, GAR007, GPA007, GPA010, GPA013, GPB057, GPC003, GPC006, GPO014, GPO031.
[275] GAR007, GPA013.
[276] SKA016, SKAR004, SKAR016, SKP016, KP028, SKP052, SKP054, SKP063, SKP065, SKP080, SKP085, SKP088, SKP090, SKP118, SKP124, SKP125, SKP128, SKP129, SKP130, SKP132, SKWS016.
[277] Participant in FG SK.

Especially in the 1990s, the association felt there to be difficulties in its co-operation with the trade union. Essential information such as the requests for referrals in connection with official government investigations were not forwarded to the association, and even circulation routines previously established with the trade union seemed no longer to work as expected.[278] As a result, the association began to feel more uncertain about the trade union's will to support specific HSW interests.[279] A number of new efforts, however, were undertaken to improve the co-operation, especially during the five-year period 1991–1996.[280]

Co-operating with social work education and research

The HSW associations in Sweden and Germany also wanted to co-operate with social work education and researcher to further the jurisdictional claims they had put forth in legal and executive arenas concerning the specific knowledgebase of HSW and its contributions to health care. There was, however, hardly any documentation available of such attempts in the case of the SK: the issue is only addressed in two meeting minutes dating from 2005.[281] It was, however, brought up in the focus group interview with the association's board members. In Germany, there was more material available to speak of the HSW association's desire to co-operate with social work research, with the issue touched upon on a regular basis and almost every year in the documents collected, peaking in 1997–2000 and in 2004–2005.

The SK and the DVSG both strove for mutual co-operation with social work education. The ultimate goal they had in mind was to be able to harness additional support for their jurisdictional claims, by adjusting academic education to suit the specific needs of HSW. As regards the SK, the association's efforts to impact university education in social work to that way strengthen its argument for the protection of HSW's jurisdictional territory, however, met difficulties. A member of the SK board described the collaboration between the SK and social work departments as follows:

> There are several university departments of social work in this country and all of them operate independently from one another. The social work education they offer is thus not identical across the different departments…. We tried to take this concern of ours up with the social work departments, hoping to be able to sit down together with their people in one of their meetings, to that way maybe have some influence on them. But we didn't get a

[278] SKP008, SKP020, SKP046, SKP059, SKP120, SKAR001, SKAR002.
[279] SKAR010, SKAR013, SKAR013, SKP030, SKP028, SKP049, SKA020, SKA025, SKAR009, SKP015, SKP078, SKP085.
[280] SKA020, SKA036, SKAR004, SKAR010.
[281] One set by the SK, the other one by the NFS.

> chance to meet them, and there is no way to influence them. It seems that we have to get licensure first and only then try and adapt education to make it better fit in with our healthcare system.[282]

As this remark shows, the SK saw it as difficult to co-operate with social work departments. What the quote also shows, however, is that the SK thought it more possible to change the licensure regulations for healthcare professions than to adapt social work education to the needs of HSW.

Even in the German case the association strove for increased co-operation with university departments of social work. Here, however, the efforts also concerned the development of scientifically grounded arguments to support the jurisdictional claims put forth. What the DVSG aimed for was, among other things, to promote education and research in clinical social work in general, develop healthcare-oriented social work methods, and extend teaching to also cover topics such as social work ethics in health care and quality management in HSW.

Specific attempts to impact social work education were reported in both countries from the end of the 1990s onward, in Sweden especially by the NFS but also by the SK, and in Germany by the DVSG in co-operation with social work researchers from the DGS.[283] In both cases, these attempts consisted of associations and researchers addressing the national committes for for social work education. Only in Germany, however, a document concerning basic and advanced social work education in the healthcare sector was ratified by the DVSG and discussed between it, the DGS, and the *Hochschullehrerkonferenz für Soziale Arbeit*, with the dialogue between these actors still ongoing today.[284] In Sweden, on the other hand, the SK attempted to contribute to social work education by publishing a booklet on the history of HSW.[285]

The outcome of both of these efforts was the development of new, advanced-level courses in social work in Sweden an in Germany. In Sweden, courses for HSWs in habilitation services, social work in health care, and psychosocial work in health care have been offered in Sweden since the end of the 1990s; in Germany, the outcome from the early 2000s' negotiations was the development of a new MA programme in clinical social work.[286] While the Swedish association cited difficulties in approaching chairs of social work departments and in impacting the content of social work educa-

[282] Participant in FG SK.

[283] NFSP001, NFSP004, GA009a, GA021, GPC006b.

[284] GPB038. The *Hochschullehrerkonferenz für Soziale Arbeit,* a national organization of university teachers in social work.

[285] SKA031.

[286] SKP078, SKP085, SKP089, SKP096, SKP094, SKP121, SKP122, NFSP004, SKAR012, GPB052.

tion, the experiences of the DVSG had, apparently, been far more positive in these respects.[287]

In the case of the SK, however, direct contacts with social work researchers were rare and mostly initiated by researchers wanting to come into closer contact with HSW practitioners.[288] Also members of the NFS referred to difficulties in gaining access to research networks, whether in social work or in health care.[289] In Germany, however, it was the association itself that initiated the contacts between it and the researchers, at least from 1996 onward. This was managed to do by going through the DGS (*Deutsche Gesellschaft für Soziale Arbeit e.V.*), a society that worked to bring together the interests of social workers and social work researchers in the country.[290] The association expressed a particular interest in research capable of producing scientific evidence of HSW's contributions to health care and of the effects of social work in health care.[291] It, furthermore, tried to address the problem of not having enough researchers willing to supervise HSW practitioners in empirical research.[292] Its negotiations with some university departments resulted in co-operation with researchers around several research projects of strategic importance to HSW.[293]

Nevertheless, the German association, too, reported multiple problems in its co-operation with social work researchers. First of all, it was seen as methodologically problematic to show HSW's independent contributions to health care as a profession separate from other healthcare professions. A second problem was the conflict between the ontological paradigms of natural science and social science, which was difficult to handle for HSW. Thirdly, there was a lack of public and private interest in funding research in HSW. Lastly, there was a problem with what were perceived as vested interests of social work researchers involved in the collaboration. As two members of the DVSG board summed up their experiences of this co-operation:

> NN1: You could also do research together with university departments. Unfortunately, though, I have the impression that university departments are not too interested in supporting our interests. So I can't really say that we're constantly engaged in two or three research projects or even have any success with our projects with German universities.

[287] GPB038, GA143c.
[288] SKP122.
[289] NFSP011, see Chapter 6.3 above.
[290] GPB010, GPB011.
[291] GA009a, GA027, GAR002, GPC006, GPB012, GPB013, FG DVSG.
[292] GA105, GAR006, GPO024.
[293] GAR003, GAR004, GA105, GA127, GPB010, GPB011, GPB012.

> NN2: My impression is that university departments rather take advantage of our know-how than invest money in research with or about us. We've got experiences of departments and researchers who mostly just follow their own research interests, copy our know-how, and then sell it further.[294]

Nevertheless, the German association could nevertheless boast at least three cases of successful co-operation around research projects with strategic significance to its attempts to ground jurisdictional claims. One of these concerned the definition of 'a typical client in clinical social work', another HSW's contributions to health care and the effects of HSW involvement on patient satisfaction, and the third practitioners' need for supportive data from research.[295]

As discussed in Chapter 6.3, the HSW associations in Sweden and Germany to a varying degree perceived there to be symbolic boundaries separating social work education/research from HSW. This was also reflected in the attempts of the HSW associations in question to build coalitions with social work departments and researchers to that way obtain additional support for the jurisdictional claims of the professional group. The associations in both countries saw it as essential for their jurisdictional claims-making in the legal, public-regulative, and workplace arenas that they be able to underpin their claims with a reference to a relevant academic knowledgebase or data on the contributions of social work to health care, if they were to be able to compete with medicine for the intellectual jurisdiction of HSW. Some such efforts by associations to build coalition networks with university departments and researchers have been described earlier by Selander (1990), and they can be understood as a reflecting a strategy by the associations to strengthen their arguments put forward in their jurisdictional negotiations with dominant actors in the healthcare sector. Nevertheless, the SK addressed the need to bulwark its arguments through the use of scientific evidence of HSW's contributions to health care less often than its German counterpart. This might be understood as sign of the SK's de facto acceptance of the priority of the medical knowledgebase as platform for the interpretation of psychosocial problems in HSW practice as well. The German DVSG's strategy, on the other hand, could be understood as sign of the association's rejection of the dominance of the medical knowledgebase and, consequently, of the dominance of medicine's intellectual jurisdiction. At the same time, however, difficulties in the relationship between HSW practice and social work research were reported by in both countries, especially when it came to the associations' hope for non-self-interested support from researchers for their jurisdictional interests.

[294] Participants in FG DVSG.
[295] GAR002, GPB002, GA017, GA028, GA083, GPC005, GPC006, GA099.

Forming coalitions with interest organizations

In order to better pursue their professional interests, the HSW associations in Sweden and Germany also co-operated and even built coalitions with interest organisations such as patient and consumer organisations. Co-operation between the HSW associations studied and patient organisations, to be sure, took place only rarely, but references to it were made in documents obtained from both Sweden and Germany.[296] Co-operation with patient organisations was reported by the Swedish association in its documents dating mostly from the 1990s and by the German association in its documents dating from the period 1996–2005.

In both countries, the HSW associations acknowledged the strategic importance of alliances with patient organisations for their work. These were deemed critical for any success they might have with their efforts to lobby for the inclusion of HSW competence in health care, especially during periods when draft legislation and public regulations were being prepared.[297] Coalitions with patient organizations in Germany were particularly important for the DVSG, however, as they gave it access to forums otherwise closed to it where legislative drafts and public regulations were discussed. At the same time, the German association also noted the mutual dependency of the partners in any such co-operation. Also patient organisations were claimed to be interested in these alliances, given that the DVSG represented also their specific interests when contributing its professional expert opinion to the work on legislative drafts and health care reforms, by using its risk and consequence analysis expertise to the benefit of also these groups.[298] Commenting on a meeting between the DVSG and the *Sozialverband VdK* (an interest organisation for welfare users), a DVSG board member described the expected benefits from such collaboration as follows:

> The consequences of these measures will hit those the hardest who are in greatest need of help and support. A coalition with interest organizations for the disabled can underpin our claims for the withdrawal of the planned cutbacks for these groups.[299]

However, the coalitions the HSW association built with patient organisations were not limited to mere lobbying activities. Coalitions were also formed to facilitate the development of policy documents on counselling and healthcare guidelines for specific patient groups.[300] One example of the kind of

[296] SKA008, SKP045, SKP002, SKP016, SKP078, FG SK, GA071, GPC005, GAR003, GAR006, GPB010, GPB036b/c, GPB044, GPB053.
[297] SKA008, SKP078, FG SK.
[298] GAR006, GPB036b/c, GPB044
[299] GPB044.
[300] GPC005, GAR003, GPB010, GPB036, GPB053.

coalitions the DVSG formed with patient organisations in Germany was the designation of a member of the association's board as an expert representative for patient organisations serving in an advisory panel set up for the development of a disease management programme on breast cancer.[301] In Sweden instead, this kind of co-operation between patient organisations and the HSW association included occasional sponsoring of seminars and developmental projects of HSW by patient organisations.[302]

Nevertheless, patient organisations were, at least in Germany, at the same time also perceived as non-professional rivals in the provision of certain types of social services in health care. Self-help groups and patient organisations, for instance, claimed to perform tasks such as the provision of perspectives on life with certain disabilities, medical aid counselling, informing patients about their social rights, and rehabilitation.[303] In 2006, the national umbrella organisation for German patient and self-help groups nevertheless at least partly alleviated such fears, by publicly announcing the organisations' lack of capacity, ambition, and ability to provide anything capable of substituting professionally performed psychosocial or social rights counselling.[304]

Jenkins (2004) has described social group identity in terms of continuing negotiations between the internal identification of a social group and the external categorization of it by other actors. Along the same lines, the HSW associations in this study also used their co-operation with interest organizations to negotiate their social group identity. The DVSG, for example, negotiated on the description of HSWs' specific professional role in healthcare guidelines for certain diseases such as breast cancer. Through these negotiations the DVSG simultaneously negotiated the relationship between, on the one hand, its internally developed professional attributes and their associated symbolic meanings and, on the other hand, the external conceptualizations of HSW by the interest organisations it negotiated with. As reported by the SK, again, even joint healthcare development projects at the workplace level could be understood as offering a way to negotiate the allocation of specific work tasks vis-à-vis patient representatives. The public declaration by German patient organizations that they lacked the capability to replace professionally performed psychosocial and social rights counselling can be seen as indicating a final settlement of a jurisdictional dispute between patient organisations and HSW, in this case to HSW's advantage.

Additionally, in line with what Åmark (1990) has observed in other contexts, the creation of coalitions between HSW and patient representatives can also be viewed as a strategy used by HSW associations

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[301] GA071.
[302] SKP045, SKL002, SKP016.
[303] GWS003.
[304] GA112.

to build open cartels. The associations in this study used this strategy to increase their potential to impact jurisdictional settlements in legislative drafts and public-administrative regulations. Especially in Germany this strategy often provided the associations' representatives with direct access to otherwise hard-to-reach policy-making forums where medicine ruled as the dominant profession in the negotiations. Such co-operation between HSW associations and patient organizations was based on a shared interest in strengthening the impact of their arguments vis-à-vis representatives of other, more powerful actors such as medicine. Both of these strategies – negotiating one's professional group identity with external actors and building cartels with patient organisations – were means by which the associations could thus pave the way for jurisdictional settlements in the legal, public-administrative, and workplace arenas.

Bargaining with other professions

The documents collected from the Swedish and German HSW associations provide evidence of these associations' efforts to bargain directly with other professions over the allocation of contested work tasks. Such bargaining took place either directly between the HSW association and other specific professional associations, or in multi-professional forums. It was often preceded by the arrival of HSW representatives to other profession's conferences and dissemination of information on HSW work tasks at these conferences. In Sweden, bargaining with other professions took place much more rarely than in Germany, and seems to have been more intensive in the 1990s than in the 2000s. The bargaining in Sweden, moreover, more often had the character of more abstract negotiations. Documents often put forth examples of work task boundaries more in detail, and in most cases the rivalries with particular professions were noted although not described in any greater depth. In Germany, on the other hand, contacts and bargaining with other professions became more frequent during 1996, remaining at approximately the same level up even today.

In bargaining, suggestions on work boundaries were specified to a varying degree by the DVSG and the SK. In Germany, also the definition and protection of HSW work tasks and work fields in legislative and administrative forums were prepared for by bargaining with other professions and especially their associations about what the HSW associations had internally agreed were HSW work tasks and work fields. The aim in this bargaining was the settlement of these jurisdictional boundaries.

Contested jurisdictional boundaries vis-à-vis other professions were mainly an issue HSWs had with psychologists, physicians/psychiatrists, and nurses. In Sweden, nurses were perceived as the foremost rivals, followed

by psychologists, physicians, and midwifes.[305] As in Sweden, nurses were also perceived as the main rivals in Germany, especially since the mid-1990s.[306] Subsequently, even administrative personnel from insurance funds were seen there as potential rivals, given that these were often described as neglecting HSW tasks and expertise while at the same time colonizing parts of HSW tasks. Also physicians and psychologists were viewed as potential rivals in Germany; in the German context, they in fact were perceived as more threatening than in Sweden, since they had full jurisdiction over parts HSW work tasks and controlled access to legal and public administrative forums where professional jurisdictions were negotiated.[307]

The associations in both countries reported controversies concerning the allocation of work tasks between HSW and other professions, especially when it came to psychosocial counselling. Additional disputes concerned the performance of psychotherapy (Sweden), discharge management, case management, and counselling on social rights (Germany). In Sweden, the differences between psychosocial conversations, psychosocial care by nurses and psychosocial counselling, psychosocial therapy, and family treatment by HSWs seemed, at least in part, to be difficult to distinguish.[308] Also in the disputes with physicians and psychiatrists the question was about the performance of psychosocial interventions, specific forms of counselling (in the case of contagious diseases), and the division of responsibility for certain patient groups between HSW and medicine.[309] When it came to psychologists, on the other hand, the controversies were rather about the performance of psychotherapy.[310]

Since 1996, the main battlefield for HSW in Germany has concerned a variety of aspects of discharge and case management, with HSW most often pitted against insurance administrators and nurses. The disputes here have involved the areas of care management, care discharge management, and supply management, which all were defined as aspects of case or discharge management. Attempts by nurses and insurance administrators to take over care discharge management in out-patient care were reported on in the documents collected from the German association. Even in supply management, work task jurisdictions between nursing, insurance administration,

[305] SKA016, SKP007, SKP020, SKP045, SKP047, SKP059, SKWS005, SVKFWS002, FG SK.
[306] GA038, GA056, GA057, GA058, GA060, GA061, GA065, GA066, GA082, GA097, GA101, GA103, GA104, GA106, GA125, GPA013, GPO001, GPO 012, GPO014, GPO021, GPO023, GPO031, GWS004, GWS018, GWS019, GWS024, GWS030, GWS041, GAR003, GAR004, GAR006, GAR007, FG DVSG.
[307] GA038, GA056, GA057, GA058, GA060, GA061, GA065, GA066, GA073, GA078, GA081, GA082, GA086, GA097, GA101, GA103, GA104, GA106, GA110, GA125, GAR003, GAR004, GAR006, GAR007, GPA013, GPO001, GPO012, GPO014, GPO021, GPO023, GPO031, GD001, GWS002, GWS004, GWS009, GWS018, GWS019, GWS024, GWS030, GWS041, FG DVSG.
[308] SKP020, SKP045, SKWS005, SVKFWS002.
[309] SKA016, SKP007, SKWS005.
[310] SKA016, SKP059, SKP047, SVKFWS002.

and HSW overlapped. Additional efforts to control counselling on the use of medical aids (a part of discharge management) were reported to have come from nurses, while efforts to colonize counselling on social rights were reportedly made by insurance administrators.[311] Occasionally, even physicians were reported to intrude in case management tasks in primary care. Psychosocial counselling, however, was an area of contestation for HSW on the one side and psychologists, physicians, and psychiatrists on the other side. Legally defined aspects of psychosocial counselling (i.e., psycho-oncologic counselling) constituted the main contested area between HSW and psychology, while the contestation between medicine/psychiatry and HSW rather concerned the right to perform psychosocial diagnostics and psychosocial counselling in general.[312]

During the two decades under investigation, formal jurisdictional settlements in the above issues were reached in Germany. These concerned the performance of discharge management and counselling on the use medical aids, and involved the *Deutscher Berufsverband für Pflegeberufe* (DBfK) and the HSWs' association.[313] As a result, nurses may today perform both aspects, but only under surveillance of HSWs.[314] The legal jurisdictional settlement was not in favour of HSW, however, when it came to supply management. In this case nurses, insurance administrators, and HSWs were all found eligible to perform the tasks in question.[315]

The SK and the DVSG attempted to send their representatives to conferences organized by the associations of competing professions. In Sweden, these included, for example, the annual conference of physicians and the conference for paediatric nurses. In Germany, they included different medicine, psychology, and care management conferences organized by the professional bodies for physicians, psychologists and care managers.[316] These included the conferences for healthcare professionals, the congress of the German association for gerontology, the German congress in social medicine, the congress in rehabilitation and nursing, and the national rehabilitation fair).[317] At least in Germany, the HSW presence at these events was used

[311] GA015, GA020, GA037, GA038, GA056, GA057, GA058, GA060, GA061, GA064, GA065, GA066, GA082, GA097, GA099, GA101, GA103, GA104, GA106, GA125, GA137, GAR003, GAR004, GAR005, GAR006, GAR007, GPA013, GPB027, GPO001, GPO011, GPO012, GPO014, GPO015, GPO021, GPO023, GPO031, GWS004, GWS005, GWS018, GWS019, GWS024, GWS030, GWS041, FG DVSG.

[312] GA073, GA078, GA081, GA086, GA110, GD001, GPO014, GPO031, GWS002, GWS009, FG DVSG.

[313] *Deutscher Berufsverband für Pflegeberufe* (DBfK) is the federal association of nurses in Germany.

[314] GA106, GWS023, GWS029.

[315] GAR007, GWS041, FG DVSG.

[316] *Bundesärztekammer* (German Medical Association); *Bundespsychotherapeutenkammer* (BPtK, the psychological association); and *Deutsche Gesellschaft für Care und Case Management e.V.* (DGCC, the association for care management).

[317] SKAR013, SKAR015, SKP001, SKP015, SKP016, SKP021, GA068, GA132, GAR002, GAR004, GAR005, GAR006, GPO008, GWS023.

to actively inform about HSW work tasks and HSW's contributions to health care. The DVSG also publicized HSW interests in journals published by, and for, other professions, such as, for example, the journals of the country's medical association.[318]

When it came to bargaining directly with other professions about jurisdictional boundaries, the strategies used in Sweden and Germany were different. In Sweden, direct bargaining between the HSW association and the associations of other professions was rare. What the documents collected talked about was information (rather than bargaining) campaigns with the trade union, in the connection of which written statements about HSW were sent to other professional associations. Another example was the invitations the HSW association in co-operation with the trade union sent to other professional associations to discuss the work situation of HSWs in health care.[319] In Germany, the association, primarily in the 2000s, adopted a more active bargaining strategy. The participation of HSW representatives in other professions' conferences was there used to initiate inter-professional bargaining at the associational level regarding contested work tasks. One DVSG representative, reporting on a conference, described the use of this strategy as follows:

> NN participated, giving a presentation at the conference on care management at hospitals in Baden-Württemberg. She was sent there to talk about case management from a social work perspective. She also used the occasion to present the DVSG's point of view concerning care discharge management.[320]

Also roundtable discussions with certain professions like nursery/care management, primary care physicians, and psychologists were held to be able to present and discuss competing stances on work task boundaries.[321]These discussions were then continued in inter-professional work groups where bargaining on joint agreements on professional boundaries would then commence between different associations.[322]

The SK and the DVSG also looked after and represented HSWs' professional interests in multi-professional forums. Through these networks, such as the *Svensk Reumaforum* in Sweden and the *Konferenz der Fachberufe im Gesundheitswesen* in Germany, both associations then engaged in co-opera-

[318] GPC005.
[319] SKP031, SKP032, SKP098, SKAR003, SKAR006.
[320] GA068.
[321] GA065, GA106, GA110, GA125, GA132, GA141, GAR005, GAR007, GPC005, GWS023, GWS029.
[322] GA106, GWS023, GWS029.

tion and negotiations.[323] In them, professions shared professional knowledge and experiences with one another, developing common interests and views concerning, among other things, their respective work tasks and the possible changes taking place in social and healthcare policy.[324] As reported in an annual report of the DVSG, the association, among other things, participated in the work of a advisory panel for health care professions associated to German Medical Association with the aim of:

> … discussing the implications of healthcare reforms for the healthcare sector, its patients, and the professions involved. The shared deliberations aim at information exchange, at consensus building around shared professional interests, and at agreeing on a common position towards healthcare funders and current healthcare policy.[325]

In Sweden, the SK occasionally tried to use its contacts with professional associations of other professions to obtain advice on successful strategies for its licensure project, and to facilitate HSW researchers' co-operation with researchers from other disciplines to that way promote and advance research in HSW.[326]

The professions that the HSW associations in the two countries engaged in their negotiations about the professional attributes of HSW were mostly nursing, medicine, psychology, and, in the German case, also insurance administration. In these negotiations, the associations of the these professions mediated between their internally established group identities and their externally ascribed professional attributes, with the aim of reaching a shared understanding of what HSW was all about. However, even if, based on the documents collected, this kind of mediation can be observed to have taken place in the case of both associations, the character of the activities it involved differed between the SK and the DVSG. In Sweden, the HSW association avoided directly challenging the jurisdiction of other professions, both on its own and when co-operating with the trade union. Compared to the DVSG, the SK seemed, indeed, rather to urge jurisdiction than claim it. In the German case, in contrast, negotiations were held both individually with other professions and in collaboration with other professions. The DVSG directly challenged the legal jurisdiction of dominant professions such as medicine and psychology in the case of psychosocial diagnosing and counselling. The bargaining about the overlaps between professional jurisdic-

[323] *Svensk Reumaforum* (a multi-professional organisation for professionals in rheumatic care); *Konferenz der Fachberufe im Gesundheitswesen* (an advisory panel for healthcare professions associated to the German Medical Association)
[324] SKA007, SKP048, SKP079, SKP080, SKAR016, SKAR017, GPO011a-c, GPO015a/b, GPO023.
[325] GAR006: 32.
[326] SKP137, NFSP001.

tions here took place between representatives of all the relevant professional associations. However, both of the above two dominant professions ultimately succeeded in using their demarcation powers to maintain their jurisdiction and clinical autonomy. The use of such strategies by medicine has been previously discussed, for instance, by Allsop (1995) and Macdonald (1999).

In its formal bargaining with the professional association of nurses, the DVSG succeeded in maintaining its claim to jurisdictional dominance in case and discharge management. The conflict was settled by a public announcement declaring the subordination of nursing to HSW concerning these work tasks. The performance of certain aspects of discharge management such as out-patient care management and medical aid counselling by nurses was subjected to supervision by HSWs in hospitals (cf. Abbott 1988, Salhani & Coulter 2009).

Through the engagement of their associations, nursing and HSW, however, also developed new networking strategies that enabled them to collaborate and that way more effectively challenge medicine in their efforts to re-allocate more power and work tasks to themselves (cf. Castro 1992, Salhani & Coulter 2009). This collaborative strategy uniting nursing and HSW vis-à-vis their dominant professions and public-administrative actors such as insurance funders nevertheless also had unexpected consequences that affected the settlement of these jurisdictional disputes through legislation. Medicine and insurance funders were ultimately able to use their controlling power to force nursery and HSW to collectively share jurisdiction for supply management with insurance administrators. In settling the jurisdictional conflict this way, medicine thus divided the power over these work tasks among three professions.

Co-operating with other local actors

The co-operation between local or federated state-level work groups of the DVSG and local actors in Germany involved a number of different entities and organizations. Among these were welfare organizations offering diverse services such as in-patient/out-patient care and eldercare, counselling bureaus with focus on specific social and health problems, interest organizations, rehabilitation hospitals, social welfare authorities, childcare authorities, politicians, employment agencies, healthcare and German Statutory Pension Insurance Scheme, and local courts. Documents providing evidence of such co-operation date mostly from 1996 and after in the German case, while reports on the Swedish association's engagement with local actors were rare.

In Sweden, HSWs were reported to co-operate with local communities, occupational health service providers, social insurance authorities, munici-

pal employment offices, and other health care providers in the counties. However, the descriptions the collected documents put forward of this co-operation solely focus on social work at the individual level, not at a structural level.[327] Furthermore, no accounts could be found about how this co-operation between HSWs and local actors was related to the work done by HSW associations. In Germany, on the other hand, the co-operation between local DVSG work groups and local actors could include local social service and healthcare suppliers, schools, solicitors, employers, representatives of local law courts, local healthcare and social welfare authorities, local healthcare funders, and, occasionally, also regional hospital managements in the case of certain federated states.[328]

The need for HSW associations to co-operate with local external actors was perceived differently by the SK, the VKF, and the DVSG. The presence of HSW in local external arenas and co-operation between HSW and local actors outside health care was pointed out as an important aspect in the pursuit of formal jurisdiction for HSW. In the Swedish case, however, even though a good relationship between local HSWs and local external actors was described as essential for HSW performance, this aspect was nevertheless only rarely brought up.[329] The responsibility to engage in local co-operation was left to local HSW practitioners. Neither the SK nor the VKF seemed to use co-operation in local arenas as an argument for associational interests in the formalizing of HSW jurisdiction.[330] In Germany, in contrast, the DVSG viewed local co-operation as providing an opportunity to inform local actors about HSW, to represent HSW in local contexts, and to co-operate on diverse concrete issues. This point of view was put forth in an annual report of the DVSG as follows:

> It is important to reliably organize the professional dialogue throughout the regions. In them, work group directors and work group teams are very important as local addressees for associational members, co-operation partners, and potential new members.[331]

Moreover, the association also engaged in efforts to develop relations first to welfare workers in healthcare settings, and then, after the country's re-unification in 1990–1993, to healthcare administrators, local hospital managements, and the German Hospital Federation in the new federated states.[332]

[327] SKWS003, SKWS021.
[328] GA020, GA082, GA127, GD003, GPB001, GPB002, GPB008, GPO011, GPO012, GPO015, GAR001, GAR001, GAR002, GAR003, GAR006, GAR007, GWS002, GWS025, GWS031, GWS042.
[329] SKWS003, SKWS021.
[330] SVKFP011, SVKFP010.
[331] GAR007: 11.
[332] GPB001, GPB002, GPB008, GAR001, GAR002, GAR003.

The co-operation between the DVSG and external local actors was often formalized through recurrent meetings between local and federated state-level work groups and their specific, local co-operation partners.[333]It could also be arranged through regional inter-organizational workshops and seminars organized by the DVSG for healthcare and social welfare services, or for HSWs, healthcare administrators, hospital managements, and the German Hospital Federation.[334]

In these co-operative contexts, different themes were addressed. The discussions in them could concern legislative reforms and the interpretation and implementation of new laws, or they could concern the limits of co-operation as exemplified by the following quote from a debate article by a DVSG board member:[335]

> We should refuse to function as information delivery service for healthcare funds. For this reason, funds with genuine medical questions should be referred to physicians…. What we want is to co-operate, not be taken advantage of.[336]

The DVSG had also many other motives for its co-operation with actors at the local level. One was to inform them about HSW, another to publicize practical evidence on HSW's contributions in bridging the gap between the healthcare sector and the social welfare sector. This evidence could be about HSW's ability to facilitate co-operation between hospitals and external healthcare and social welfare actors, develop regional structural co-operation networks and routines for actors in health care and social welfare, provide structural descriptions of patient needs and services in relation to gaps in service supply, ensure the attainment of healthcare treatment effects, and ensure the protection of individual social rights on a structural level.[337] Where deemed necessary, structured information on patient needs was delivered to political parties and regional welfare organizations using written statements. Occasionally, members of local or regional work groups were also called on as experts for hearings with local and federated state parliaments.[338] In other words, co-operation was used to better be able to better advertise the professional competences of HSW. It could, accordingly, be understood as a form of impression management technique used by the professional group for its purposes, along the lines of Pfadenhauer (2003).[339]

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[333] GAR001, GAR002, GAR003, GAR006, GAR007, GA020, GA127, GD003, GPO012, GPO015, GWS031.
[334] GPB001, GPB002, GPB008, GPO031, GAR001, GAR002, GAR003.
[335] GA015, GA20, GPO011, GAR001, GAR002, GWS004.
[336] GA029.
[337] GA082, GA127, GPO011, GPO012, GPO015, GAR001, GAR002, GAR003, GAR006, GAR007, GWS029, GWS031.
[338] GAR001.
[339] GWS002, GWS025, GWS042, FG DVSG.

To sum up, only the DVSG described its use of the co-operation between HSW and local actors as a deliberate strategy for publicizing the ways in which HSW contributed to health care by providing a connection between the social welfare and healthcare sectors at a structural level. This strategy can be understood as having contributed to the development of the professional group's formal jurisdiction in several ways. On the one hand, co-operation with local actors was used to locally establish a presence on de facto forums for negotiation on HSW tasks. The negotiations between professional groups and external actors can also be understood as attempts to reconcile the group's internal identity and external categorizations of the group, along the lines of Jenkins (2004). The strategy can, however, be further understood as a way of actively developing forums with the local, regional, and federated state-level public administration on which HSW, as profession, can then become involved in the local interpretation of laws and the development of local service structures. Finally, it can also be understood as the virtual display of the specific professional role and competence of HSW.

7.3 Using media for presenting hospital social work

The SK and the DVSG both saw it as important to present their professional perspective on healthcare issues through the media. Towards this end, both associations approached different types of traditional media outlets such as local, regional, and national newspapers, intra-organizational and healthcare-related journals and magazines, and TV, as well as some newer media such as the Internet. The purpose with this was to be able to more effectively inform the public about themes relevant to HSW practice, such as, for example, the consequences of social policy developments from the professional point of view of HSW, or the professional needs and interests of HSW.[340] The DVGS engaged in such efforts to attain publicity for HSW themes through the media nearly every year from 1997 onward.[341] In Sweden, similar efforts by the SK were less systematic and more occasional.[342]

The HSW associations publicly commented on diverse subjects. These could relate to dysfunctional parts of the healthcare system, HSW work tasks, HSW competences and interests, and positions taken on social policy developments.[343] Nevertheless, the efforts of the SK and the DVSG to gain

[340] SKA010, SKA018, SKA038, SKAR016, SKP002, SKP030, SKP105, SKP122, SKP141, FG SK, GA082a, GPB011, GPB019, GPC005, GPC006, GAR001, GAR002, GAR005, GAR007, FG DVSG.
[341] It, however, also did so twice in the early 1990s.
[342] Mention of such efforts on the part of the SK can be found for 1990, 1993–1994, 2000, 2002, 2005–2006, and 2008.
[343] SKP030, SKAR016, FG SK, GA082a, GPB011, GPB019, GPC005, GPC006, GAR001, GAR002, GAR005, GAR006, GAR007, FG DVSG.

publicity for these topics and HSW more generally were mostly met with disinterest in the media.[344] A member of the DVSG board described the relationship between HSW and the latter as follows:

> The television channels are not interested in our topics, which makes it difficult for us to publicize our work and our function through traditional media. Social work only becomes interesting when there are scandals: when grandma starves to death in her flat, social work is presented as a profession in disarray. Recently, the *Stern* magazine published an article about patients with bad experiences from discharge management. In that article, 40 per cent of physicians and nurses were claimed to have experienced problems caused by poor discharge planning. Social work was not even mentioned. In other words, it's others who garner media interest with our issues. Not social work… We need to react to this article and offer the *Stern* an interview to explain our profession's contributions in discharge management.[345]

Even if it was difficult to have news on HSW and its interests publicized through traditional media, occasional success was also reported. Since the early 1990s, the DVSG had held internal discussions about how to better attract media attention, resulting, among other things, in occasional press conferences and meetings for the press. In some cases, local and regional media reporting then also paid attention to or noted the association's activities or certain relevant policy developments.[346] Even general-audience healthcare magazines could publish an occasional article on HSW.[347] Some years later, the association could even start making the specific claim that it was:

> … experienced as an organization that needs to be consulted in healthcare matters. Currently, journalists regularly contact us when researching healthcare themes, and they receive the information they want. Board members are frequently interviewed as experts, and we also arrange for those interested in them further contacts with other experts in health care and social welfare.[348]

Nevertheless, since gaining publicity for one's professional issues through the traditional media was all the same perceived to be relatively difficult, both the SK and the DVSG began to use the Internet to disseminate information on HSW, the association itself, and the profession's official stance and positions on certain issues and developments. Since 1997 (DVSG) and 2002 (SK), information on HSW has thus mostly been made available on

[344] SKP002, SKP129, SKA010, SKA018, SKA038, FG SK.
[345] Participant in FG DVSG.
[346] GAR001, GAR002, GAR005.
[347] GPC005, GPC006.
[348] GAR006: 30.

the associations' web pages. In Germany, this was done first via pages on a university website, and later on, as in Sweden, using the association's own website.[349] In both cases, the association's homepages have been used to inform members about internal associational matters, but also to inform and network with external actors such as public authorities and others in the health care system about HSW and pertinent matters.[350] On them, also collective stances and positions taken by the profession on current social policy developments are publicized.[351] Nevertheless, as a member of the board of the SK pointed out, information on HSW was spread much more effectively when websites of multi-professional public administrative bodies were used for the purpose, since more professionals visited these than the association's own dedicated site.[352]

According to Abbott (1988), jurisdictional claims are raised in public in order to gain public support for claims concerning a profession's labour market control over a certain set of work tasks. The HSW associations in this study reported difficulties in their ability to publicly address relevant jurisdictional issues through traditional media. The SK and the DVSG both described the possibility for HSW to initiate discussions on relevant social welfare and healthcare issues in public forums such as the print media and TV as being limited. For medicine or even patients, on the other hand, it was no problem to launch discussions on the very same topics. In other words, it was more difficult for HSW associations to negotiate on their professional identity with the public than it was for, for instance, medicine to do so (cf. Jenkins 2004). Likewise, it was more difficult for HSW than medicine to put forth professional jurisdictional claims and publicly comment on healthcare topics when using traditional media (cf. Abbott 1988). However, the DVSG's efforts to gain publicity for HSWs' professional issues in the media were more successful when it merely responded to opportunities offered by an already ongoing media debate initiated by other professions or patients to join it. The SK and the DVSG also used the Internet as a vehicle for informing the public on HSW, taking advantage of the medium's near-universal status as something accessible to most everyone. Nevertheless, the SK had found it more effective for its purposes to use the websites of multi-professional public administrative bodies as a medium to publicize its issues and topics. On these sites even medicine was present, and also the general public and other professions were much more likely to frequent them than the association's own, more narrowly focused homepage.

[349] GPB011, SKAR016.
[350] GA106, GPB019, GPC006, GPO024, SKP105, SKP122, SKP141, FG SK.
[351] GA082a, GPB019, GPC006, GAR007, SKP105, SKP122, SKP141, FG SK.
[352] Participant in FG SK, FAMMI (*Familjemedicinsk Institut*)

7.4 Summary

The Swedish and German HSW associations pursued their project of formal jurisdiction in three different arenas: through legislation, through public regulations, and – especially in Germany – at the workplace. However, unlike medicine, HSW generally speaking lacked access to the policy-making bodies operating in these arenas. Because of this, the associations in both countries invested efforts in gaining access to, and being present on, forums where they could obtain information on forthcoming changes in public policy. Occasions when the Swedish and German HSW associations were allowed direct access to represent the profession in policy making were rare, however, although somewhat more numerous in Sweden than in Germany. Nevertheless, even in the German case these occasions became more frequent when the association engaged in direct negotiations with legal, public, and local actors or with other stakeholders and the media.

The associations applied a variety of strategies to deal with their lack of access to policy-making bodies. Several differences could be observed in this regard, however. In Sweden, given the country's centralized state system, access to policy making was mainly mediated by the trade union, and it was to a small number of government bodies or public administrations only. In the federally organized Germany, the association had to distribute its lobbying efforts between public bodies and stakeholders representing a wide range of activities, concerns, and power in both the 16 individual federated states and at the national level.

Differences between the German and the Swedish case could also be seen in the type of legal protection sought through negotiations. While the Swedish associations pursued mostly just one issue, licensure, what the DVSG sought was protection of specific work tasks, competences, responsibilities, and remuneration, and this was pursued through a variety of healthcare and social welfare-related laws and regulations.

Through collaboration with the trade union and patient organizations, the SK and the DVSG attempted to influence the development of draft legislation and public regulations. Especially in Germany, the HSW association used the de facto establishment of new negotiation platforms with local actors as a way to impact social policy development. On these forums, the DVSG actively engaged in negotiations on the local interpretation of laws, public regulations, and service structures to advance professional HSWs' interests. The DVSG and the SK also negotiated with professional bodies of other healthcare professions. The SK tended to do this (either alone or in co-operation with the trade union) to win recognition for HSW at a more abstract level, while the DVSG rather engaged in more concrete bargaining to secure HSW's entitlement to certain work tasks such as psychosocial diagnosing and specific forms of counselling.

These strategies often involved co-operating with trade unions, university social work departments, and researchers. The HSW associations' co-operation with these actors was aimed at strengthening and underpinning the jurisdictional claims and arguments they put forth in their negotiations with dominant actors in the healthcare sector. The Swedish HSW associations, however, occasionally experienced this co-operation as cumbersome.

8 Jurisdictional Work: Claims and Arguments

In the preceding two chapters of this dissertation, jurisdictional work was described in terms of HSWs' activities and strategies aimed at developing a collective profession-specific identity. Additionally, strategies and activities resorted to in order to translate this identity into a public and formal professional jurisdiction were looked at. In this chapter, the focus moves onto jurisdictional work in terms of claims-making and argumentation aimed at creating a formal jurisdiction for the HSW profession.

In line with what Abbott (1988) has observed for other professions and professional groups, a central component of also the German and the Swedish HSWs' jurisdictional work was claims-making, as evidenced by the documents and interviews analysed. According to Karlsen (2012), claims-making is a form of strategic action in the public sphere whereby language is used rhetorically to persuade someone of something in a given context. The arguments used in this activity become persuasive when they are articulated using that someone's own terminology. Abbott (2005) has described how professions, to be more successful in their claims-making, attempt to create argumentative hinges that link professions, policy makers, and universities by using the terminology of their audience's context.

Another strategy enabling organizational actors to argue more persuasively is, to continue using Abbott's (2005) terms, the use of avatars to institutionalize symbolic linguistic or structural colonies in the policy making, organizational, or one's own professional domain. One example of such institutionalization of a professional avatar in social policy making could be the successful introduction of social work (i.e., clinical social work) terminology into law and corporative contracts; another one might be the incorporation of the (originally non-social work) term 'social diagnostic classification system' into the language of social work, indicating the integration of medical perceptions into social work practice. When jurisdictional claims-making results in the inclusion of such symbolically charged aspects in the audience organization, one might say the phenomenon in question to be about an *embodied avatar*. An embodied avatar could then be achieved, for example, through the inclusion of social work representatives in policy-making structures.

This chapter describes and analyses Swedish and German HSWs' claims-making as a key component of their jurisdictional work. First, in section 8.1, these HSWs' general claim concerning the necessity of including social work in the healthcare setting will be examined as to its precision and persuasiveness in both country contexts. Next, in section 8.2, the claim that HSW bridges the gap between the healthcare and social welfare sectors is explored. Section 8.3 then focuses on the claim made by the HSWs in the two

countries that social work's advocacy mission was needed in health care as well. In these first three sections, the arguments made in support of the HSWs' claims all more or less focus on patient needs and problems. The claims examined in the next two sections instead focus on the organizational and political level. Section 8.4 takes up the argument by HSWs that more gap-bridging and advocacy work was needed at the organizational level of healthcare organizations such as the hospital, with this argument then analysed more in detail. It also considers their argument that also healthcare policy lacked a sufficient focus on both patient needs and problems arising from legislative gaps between the healthcare and social welfare sectors. Finally, section 8.5 discusses the claim put forward by the HSWs that overcoming these problems at the level of patients, organizations, and policy required specific competences and that it was HSWs who represented these competences. Differences in claims-making between the two countries are addressed, as are changes in the arguments and argumentation style used by the respective HSW groups over time, allowing examination of the possible impact that any differences in the hospital and welfare contexts might have on HSWs' claims-making in Sweden and Germany.

8.1 Necessity of social work in health care

> If health care is to meet future challenges, psychosocial services need to be ensured a place beside medical, nursing, and therapeutic interventions.[353]

Along the lines of the above quote from the report of the DVSG's national congress in 2006, the professional associations in both Sweden and Germany put forth a core claim that it was necessary to integrate social workers into healthcare settings. From a jurisdictional work perspective, this could be defined as the core claim made to advance the formal jurisdiction of HSW tasks: a normative claim postulating the vital importance of HSW in healthcare settings and healthcare policy development. This claim was made by both Swedish and German HSWs throughout the entire period under investigation, as shown by the documents collected in the two countries. As the documents further indicate, the HSWs in both countries, differently from healthcare professions proper whose contribution to health care has always been more obvious, felt an urgent need to make this claim for including professional HSWs in the healthcare sector. The Swedish and German professional associations studied saw the HSW profession as being threatened by employers and authorities approaching HSW with different expectations

[353] GA110.

concerning its tasks and responsibilities.[354] As shown by the documents, a particular challenge for the social work profession was therefore to convince healthcare professions, the public, and policy makers alike of the fact that patients' illness or impairment could cause social and psychosocial problems in both patients themselves and their relatives, which in turn could lead to delayed or even thwarted recovery and medical rehabilitation. Accordingly, the HSW associations' argument went, it was important that these problems be treated simultaneously with the disease/impairment itself.

According to Karlsen (2012), a claim as general as this could be perceived as very broad and imprecise, as it neither explains the exact content of the social and psychosocial services referred to nor suggests the societal level at which they should be performed. Be that as it may, claims of this kind, as in the present case, then tend to be given more precision in further, more detailed subsidiary claims, as shown in the following sections. In the Swedish case, for instance, the above claim was often succeeded by the claim that HSW ought to be involved in what is called the individual level of social work.[355]

The SK repeatedly stressed the importance of HSW in patient-related work, along with the fact that HSW interventions, in its view, were given an undeservedly low status in health care in general. Even though the content of the documents collected from the association was mostly about social work at the individual level, the documents otherwise testified of HSWs' activity at the structural level: in them, we can read how HSWs try to involve themselves in policy development, by issuing professional statements on legislative drafts and on healthcare policy developments in general. Nevertheless, this was not explicitly defined as an aspect of their claim for the inclusion of social work in health care. Following Karlsen (2012), one might then indeed get the impression that the jurisdictional claim put forth by the SK was somewhat imprecise.

Only occasionally did the SK define its claim as originating from patient interests. Instead, the claims made were more often defined from the point of view of one's self-interest or the interest of one's organization, at the following example shows:[356]

> The *Svensk Kuratorsförening* claims it is the HSWs who recognize the psychosocial aspects and represent social competence. The professionals providing medical and psychological treatments (physicians, nurses, and psychologists) all have licensure. From an

[354] GA16a, GA014, SVKFP014, FG SK.
[355] SKWS021.
[356] See FG SK, SKA00.

> equality and patient-security perspective, also those representing the psychosocial and social perspective should then be licensed.[357]

The claim appealing to inter-professional equality here could, in this particular case, be interpreted as a linguistic symbol representing an argument rooted in self-oriented status interest, while the one referring to patient security could be interpreted as a linguistic symbol for a claim rooted in either institutionalized organizational interest or patient interest. Nevertheless, the patients themselves, in describing their interests, could well be expected to prefer the use of symbols other than patient security. Therefore, this claim could rather be defined as being rooted in organizational rather than patient interests. In consequence, the addressees of this claim might get the impression of a claim rooted in self-oriented professional and organizational interests, rather than patient interests. This argumentative strategy, in turn, could thus induce Swedish policy makers to assume that HSW is more interested in self-oriented than altruistic goals when performing its jurisdictional work. As will be shown in section 8.5 below, this impression that the jurisdictional claims of Swedish HSWs might be rooted in mere self-interests of the professional group is, furthermore, only strengthened by the decreasing frequency with which Swedish HSWs, over time, put forth explicit arguments for the societal advocacy mission of HSW.

In Germany, on the other hand, the core claim made for HSW involvement in health care was defined in more detailed manner. There, several explicit and implicit sub-claims, too, were immediately presented, embracing both the structural level and the individual level of social work to a same extent.[358] The sub-claims put forth could here be interpreted as, indeed, giving the closer definition of the more general main claim concerning HSW's involvement in health care. Moreover, the claims the German association put forth were often couched in terms of the patients' perspective, as for example in the follow quote taken from the DVSG's 2005 annual report:[359]

> These structural changes call for [the integration of] social work competence to ensure provision of reliable psychosocial support and support in social matters for sick people in crisis.[360]

This way of arguing indeed contributes to making the main claim more precise. It also produces the impression that the profession putting for the argument is interested in representing patient interests and in drawing upon its competences to effectively manage just that. The use of terminology as

[357] SKWS017: 49
[358] GAR007.
[359] See GWS007, FG DVSG.
[360] GAR006: 10.

"structural changes call for" demonstrates competence; the use of expressions derived from laymen's linguistic praxis as "reliable psychosocial support and support in social matters for sick people" suggests the representation of patient interests. The impression is further reinforced by evidence gathered from a variety of other documents collected, such as associational reports describing patients' problems with access to HSW services in the former East German states, or problems with healthcare service supply on the part of certain patient needs that were caused by the fundamental reformation of the German social welfare state in the 1990s.[361] Only occasionally, in the early 1990s for the most part, were more clearly self-oriented professional interests put forth to further the claims presented, usually invoking arguments for increased professional recognition and status.[362] Overall, the argumentative strategy used by the German HSWs was thus more likely to produce a general impression among their addressees that the claims-making by the profession was rooted in genuine public and patient interests rather than professional interests per se.

To refer back to Karlsen's (2012) theses about argumentative precision and persuasiveness, the general picture emerging here is then that the German HSWs' claim for HSW's involvement in health care was more precisely spelled out and explicated, giving a more obvious impression of its being rooted in a genuine advocacy interest, while the claim put forth by the Swedish HSWs implied the same only indirectly or in a peripheral fashion, containing, moreover, contradictory information that probably only left the claim's addressees in some state uncertainty as regards its exact content and the nature of the interests behind it. Consequently, the German HSWs' claim might at first glance be assumed to have been more persuasive than the Swedish HSWs'. Yet, the persuasiveness of a claim cannot be judged based solely on an examination of the content of that claim itself; one also needs to take into account the arguments accompanying it. It is these arguments that then, either on their own or in reference to the claim made, cause the case made to be seen as either more or less persuasive in the eyes of its target audience (cf. Karlsen 2012).

[361] GAR002b, GAR003, GPA012a, GA022, GA044d, GA096a, GA097c, GA100a, GA136, GPB044, GPO001, GPO020, GPO024b, GPO031a, GA040b, FG DVSG.
[362] GA003, GA004, GA005, GA019.

8.2 Bridging gaps between welfare sectors

> Going against all scientific knowledge, the primary-care reform draft proposal in question lays out a primary care model that is focused exclusively on the provision of medical care, with all the care functions concentrated in the hands of the primary care doctor…. In this kind of a model that restricts itself to the provision of medical care only, people will interpret their social problems as being medical ones instead, and will thus seek merely medical care in their efforts to overcome them.[363]

In this quote, taken from a written statement by the SK on a draft law proposal, the association puts forward its claim for a greater role of social work in primary care. This and other similar claims were used by both the DVSG and the SK to further elaborate on what was only implicitly stated in their previously presented core claims. With that, the focus was shifted to the need to bridge structural gaps between the social welfare and healthcare sectors.

This claim, to be sure, was clearly related to the HSWs' core claim that social work services needed to be integrated into health care. Both the SK and the VKF claimed that HSW played an indispensable role at the interface between health care and the social welfare sector.[364] Consequently, the argumentation as presented in this section can be described as relying on a variety of further arguments supporting the relevance of the claim that welfare structure deficiencies between social welfare and health care had to be overcome (through HSW involvement).

In Germany, the centrality of this claim seemed to become greater over time. From being used only occasionally during the 1990s, it began to be the subject of intense discussions beginning in 2000. In Sweden, in contrast, this claim was used by the HSW association only until the mid1990s, becoming gradually abandoned ever since. The difference in this respect between Sweden and Germany might have been caused by changes in legislation. In Sweden, these led to a more pronounced separation of responsibilities between social welfare and health care, while in Germany the new legislation was aimed at more and more integrating the two sectors within one single legal framework to govern the entire welfare sector (see Chapter Two). In a context where legislation establishes health care and social welfare as separate sectors each with their own, separate tasks and responsibilities, an argument for overcoming the gaps between the two may then be perceived as less attractive. Such a context can also be assumed to be less receptive to the establishment of argumentative hinges and avatars linking health care and

[363] SKWS007: 2.
[364] SKWS008, SKWS013, SKWS003, SVKFP010, SVKFP011.

social welfare. In other words, legislation creating a division between social welfare and health care is likely to make it more difficult to develop linking arguments declaring the relevance and sustainability of HSW's claims, as far as policy makers' and other professions' perceptions are concerned. It seems also to complicate the establishment of social work colonies in the health-care sector and contribute to the elimination of existing social work colonies from health care (e.g., the reduction in the number of social work units in Swedish hospital organizations from the 1990 onward). Reversely, it seems to have made it easier for the medical profession to create avatars in social work, supporting for example an exclusive focus on the individual level of social work intervention in claims-making.

In Germany, on the other hand, legislative policy developments indicate an at least implicit intention to integrate the social welfare and healthcare sectors. This then suggests that the use of arguments calling for the bridging of gaps between those sectors might there be more successful as a strategy than in Sweden. In the German environment, even the establishment of argumentative hinges and avatars appeared to be easier. Accordingly, the HSW association in the country seemed to have less difficulty in finding arguments asserting the linkage of HSW claims to the healthcare sector and in establishing linguistic and structural colonies of social work in health care.

The associations in both countries claimed HSW services to form a vital part of health care provision. In the German case, even though the individual level, too, was brought up, especially the structural social work level was repeatedly pointed out as the goal of social work interventions, to overcome the gap between the healthcare and social welfare sectors.[365] Nevertheless, one of the problems in this respect, noted by the HSW associations in both Sweden and Germany, was that the co-operation between the healthcare sector and the social welfare sector was not satisfactory and had to be improved.[366] As the SK emphasized in its written statement on a government investigation committee report it had been asked to comment on:

> The municipalities and counties should have a common strategy for medical and social care and for support interventions. The aim is not to leave clients stranded in the middle between the municipalities' and the counties' respective areas of responsibility.[367]

Explicit claims regarding the unique competences of HSWs with which to bridge such gaps between social-welfare and healthcare interventions were, to be sure, more often put forth in Germany than in Sweden. In both cases, nevertheless, several further arguments were resorted to in order to stress

[365] GWS035.
[366] SKWS003, SKWS006, SKWS008, SKWS013, SKWS021, GWS031, GWS035.
[367] SKWS021: 2.

the sustainability of the claim that these gaps indeed needed to be bridged. These arguments, however, differed between the Swedish and the German case. In Sweden, the claim for the need of HSWs' involvement at the interface between health care and social welfare was, for the most part, put forth in associational documents dating from 1997 or before, although there were rare exceptions to this pattern dating from the 2000s. The claims presented by the SK predominantly concerned the individual social work level and interventions at the individual level;[368] structural social work was more or less excluded as a possible work task to be claimed by HSW. This fact could then be interpreted as an attempt to draw a parallel between the individual-centred approach of medical care and the psychosocial interventions of social work, which latter, too, are characterized by an individual-client focus. To borrow Abbott's (2005) terms, what was going on in Sweden could thus be described as a case of successful insertion of a medical avatar into HSW's professional field, as evident from the arguments Swedish HSWs used when confronting policy makers and healthcare professions.

The Swedish associations in this study described situations where other professions simply ignored HSWs' objections to medical treatment plans in daily practice, or where employers' and policy makers' expectations regarding HSW were unclear or were based on the fear that HSW would take over tasks that social welfare service provision was supposed handle, thus diminishing the latter's role (see also Chapter Seven).[369] In a written statement issued on a circulated state investigation, the SK puts this perceived implicit fear into words:

> One can sense a certain anxiety behind the present investigation report: a fear that the healthcare sector could become responsible for tasks belonging to other sectors in society. In reality, however, there is no sector in society that can boast the same knowledge, education, experience, and cultural competence that social workers in healthcare have.[370]

Descriptions of this kind were used as further arguments to underpin the association's claims for either maintaining the status quo or extending HSW resources in health care. Connected to these claims were often also demands that HSWs be more clearly recognized as medical staff, given that, as the argument went, HSWs represented unique competences that neither social workers nor other hospital staff had.[371] Here, however, certain contradictions become obvious in the claim that the competences of social work are

[368] SKA031, SKWS017.
[369] See SKP087, SKWS014, SVKFP016.
[370] SKWS013.
[371] SKWS006, SKWS008, SKWS017, SVKFWS002.

unique and help to bridge the gap between health care and social welfare: on the one hand, the associations claimed that social work competences were a requirement for HSW work, while, on the other hand, they claimed HSW competences to be separate and distinct from those of social work. This argumentative contradiction, to follow Karlsen (2012), very likely weakened the persuasiveness of the general argument concerning the uniqueness and necessity of HSW competences in the country, given that it presented this argumentation as inconsistent. Nevertheless, both history and competence based arguments were considered to be useful by the SK as hinges linking social work to policy makers or healthcare professions. Competence and tradition were raised as arguments when HSW jurisdiction conflicted with that of other healthcare professions.[372]

In Germany, the further arguments used by the association were quite different. Here their purpose was to help make more sustainable the claim that HSW had unique competences that could bridge the gaps between health care and social welfare. In one of its documents, the DVSG made this argument in the following way:[373]

> In analysing process problems, hospital social work contributes to the ability to detect and identify service gaps in healthcare supply. It, moreover, also contributes to the development of solutions. Furthermore, the consequences that social welfare and healthcare legislation reforms (e.g., SGB II, SGB V, SGB XI, SGB XII) have on healthcare distribution and the life-world of patients become particularly visible to social work. This is because of its location at the interface between these two societal sectors. Its experiences can thus be useful when new reforms are planned and prepared, in helping to prevent negative and undesirable side effects.[374]

The kind of argument put forth in this quote addresses several things simultaneously. It addresses both unique competences at the structural level (and not at the individual level as in the Swedish case) and the location of social work at the interface between two different support systems. It, however, also provides examples of legislative reform cases in connection of which HSW has already shown the value of its competences, in detecting and identifying gaps in healthcare service supply.[375] It also goes on to claim that social work can anticipate such problems ahead of time as well. This further argument was used by the German association to help underpin the relevance of its normative claim that precisely social work ought to be used

[372] SKWS006, SKWS008, SKWS013, SKWS017, SVKFWS002.
[373] GAR001, GAR004, GA007, GPC005, GPC006.
[374] GWS029: 2.
[375] GA082, GAR006, GPO011, GWS031, GA127, GAR002, GAR003, GAR006, GAR007, GPO011, GPO012, GPO015, GWS029.

to bridge gaps between health care and social welfare – or, as in the context of the above quotation, be put in charge of controlling human service production at the interface between the two, with social workers staffing the newly developed services there (see Chapter 6.5).[376] Claiming HSWs to have the ability to detect and even anticipate service supply gaps and see better than others the consequences of legislative changes can then be interpreted as representing an effort by HSW to create a hinge in the social policy domain, one that would then facilitate the integration of HSW into the policy making process. Unlike the Swedish case where it was medicine that provided the hinge for linking HSW to it through HSW's focus on treatment aspects of social work, in the German case it was the HSW association that took upon itself to create a social work hinge to link it to policy making, by proposing the continued integration of HSW in policy-making and policy implementation.

Additionally, in the German case, also a second further argument was raised, this time a more descriptive one whose purpose was to support the sustainability of the claim that HSW bridged structural gaps. While the first further argument concerned the structural level, this second one was made to engage the individual level. The association now argued that HSWs could develop the structural and co-operative routines needed to improve service supply for specific clients. The profession was also said to have the ability to detect and describe individual patient service supply needs at the structural level:

> The DVSG has made the point that chronically ill and old people will be the losers of the healthcare sector reform if networking structures are not developed. This is of particular concern especially in conurbations, where a great number of individual households lack neighbourhood and family networks. A comprehensive needs assessment is therefore required for discharge management to be effective. Somatic and rehabilitative care hospitals have a responsibility for successful patient discharge: either the patients return home or move on to other care institutions. Therefore, social case management needs to be able to transcend boundaries. Social work represents the knowledge, the professional attitude, and the competences required to fulfil this role in co-operation with physicians and nurses.[377]

In arguing this way, the DVSG shows its ability to aggregate problems from the individual level to the structural level, and to describe a specific perceived supply problem and propose necessary measures to solve that problem. In addition, HSW tasks and competences at the individual level are

[376] E.g., GA087, GAR006, GPB022, GPO011, GPO012, GPO014b, GWS041, GWS042.
[377] GAR006: 12.

pointed out as capable of bridging interface gaps between health care and social welfare.[378] The use of terms such as "supply problem" indicates the appropriation of issues originating from social policy making and using these as hinges by investing them with social work-specific meaning. By presenting its argument this way, the association aimed at increasing the credibility of its claims concerning the professional jurisdiction of HSW. Additionally, it also attempted to use embodied avatars at the workplace level: the claims it put forward propose that the new services intended to bridge welfare sectors be staffed with HSWs. Similar attempts to create and insert avatars were also made around issues such as the staffing of the newly set up patient counselling centres and the staffing of existing services of health insurance funds.

Comparing the further arguments put forth concerning HSW's ability to bridge interface gaps, the SK can be seen as using arguments originating from other domains such as medicine and social policy, suggesting that it had adopted issues from another context to function as a hinge for its own argumentation, to that way link it to that other context. One effect of this strategy in Sweden was probably then the fact that the claims of the HSW association in the country were oriented towards either maintaining or decreasing the range of its professional jurisdiction (for example by calling for either the maintenance of status quo or an increase in the number of HSWs in their already established professional roles, while at the same time scaling back its claim for involvement at the structural level) and towards reducing its range of tasks to focus more on the individual level. In the German case, the claims the association put forth could, again, be interpreted as indicating an attempt to insert one's own issues and arguments into other domains so as to function there as hinges and avatars. This interpretation is suggested by the efforts the DVSG made towards extending HSWs' professional jurisdiction: it, for example, called for an increase in the use of social work competences in the newly developed or still developing work roles of the healthcare system, and claimed that there was a need to involve HSW at both the individual and the structural level.

8.3 Societal advocacy mission

A second claim that helped to define the core claim as presented above in section 8.1 articulated yet another aspect of it: the societal advocacy mission understood to characterize social work. Documents obtained mostly from the DVSG, but in some rare cases also from the SK, put forth the explicitly

[378] GA082, GA127, GAR002, GAR003, GAR006, GAR007, GPO011, GPO012, GPO015, GWS029, GWS031.

argument that HSW was also necessary in an advocacy function. This was achieved by supporting patients and safeguarding their interests at the individual but also the structural level.

This claim gave more precise definition to the core claim already put forward, but it was also aimed at enhancing the sustainability of the HSW's jurisdictional claim about the necessity of including the profession in the healthcare setting. Claims-making concerning this advocacy mission of HSW in healthcare settings was, however, only rarely apparent in the Swedish case. The kind of arguments that the German association put forward in its documents were almost non-existent in Sweden. Nevertheless, some individual documents and statements given in the focus group interviews with HSWs in the country indicate that also there the need for advocacy on behalf of healthcare patients and their rights in both health care and social welfare was understood as important.[379]

At the same time, as a document obtained from the SK indicates, there was also the perception that this advocacy mission might not be easy to fulfil:

> Recurrent questioning and undermining of our competence in organizations has immense negative effects for patients, bringing the risk that they get caught in the middle with ultimately no one to take care of them. From our point of view, licensure, with the responsibility for patient safety in health care that it implies, is necessary. Licensure would also help to counteract the current neglect of the profession. The status of social work needs to be acknowledged and recognized on the same level as medicine and psychology.[380]

What this quote illustrates is, to begin with, how the association typically brought up patients' interests only implicitly ("patients will get caught in the middle with no one to take care of them" instead of "patients' rights" or "patients' interests"). This sort of argument was regularly resorted to by the SK when complaining about HSW's being ignored by other professions. At the same time however, the claim also includes a descriptive explanation of why it is relevant in the present context: the profession is ignored because of the lacking licensure. Licensure, it is stated, would win more respect for the profession among other healthcare professionals and would thus improve patient safety. According to Karlsen (2012), this then represents a normative argument used by the SK to explain why HSW should obtain licensure.

[379] SKWS002.
[380] SKWS014.

Other kinds of claims and arguments potentially capable of linking the advocacy argument to the main claim, such as an argument for a societal mandate for HSW to act as a representative for those who cannot represent themselves, are not put forth by the Swedish association, although such might be perceived as being implicitly there in the materials, at least by those with knowledge of social work. The mostly implicit use of this kind of argumentation and claim-making may, to follow Karlsen (2012), then be seen as something undermining the overall claims-making effort, as the association, from time to time, also claimed the other professions to lack knowledge of social work, which could then be presumed to also include knowledge of social work's advocacy function. An explicit use of the advocacy mandate claim and further arguments in relation to it could, reversely, be expected to have strengthened the association's jurisdictional claims. The use of symbolically charged terminology such as "patient safety" could also be perceived as an associational effort to create a hinge linking HSWs to social policy developers. The term was something the latter could very well relate to, putting them in a better position to evaluate the claims raised by HSWs. There is, however, nothing to suggest that the claim to represent patient interests in Sweden should be seen as implying an attempt to create a hinge or another kind of linkage to patient organizations, as the documents obtained from the association do not give any indication of its ever having been put to use in direct contact with those organizations.

In Germany, the advocacy claim was regularly made and argued for by the association ever since 1996. The claim the DVSG put forth was about more direct representation of patient interests, also at a structural level:

> The central mission of the social work profession is to safeguard patients' right to self-determination. The main goal here is to protect patients' right to participate in society and the co-ordination of service supply systems in health care. Consequently, social work understands itself as an interface manager between rehabilitation, the individuals' life-world, and service supply systems. Social case management enables social workers to steer patients through the service supply system, standing by each individual's side.[381]

In this quote, the main claim put forward is underpinned by a number of further arguments that define the content of the claim while simultaneously arguing for the claim's sustainability. First and foremost, the association explicitly points at the profession's perceived client advocacy mandate in the healthcare setting. Additional claims are then raised to the effect that HSW

[381] GA141c: 45.

already serves as a representative of patients in local but also national professional, organizational, and policy-making networks.[382]

The following quote reports on a meeting between the DVGS and one of the major funders of medical rehabilitation care, giving an example of HSWs' jurisdictional claims-making vis-à-vis these healthcare actors:

> We addressed the service quality of rehabilitation hospitals. The *Deutsche Rentenversicherung* [German Statutory Pension Insurance Scheme] sees the availability of professional HSW services at their contracted hospitals as a quality measurement. However, the funders' views in this respect differ, resulting in more limited availability of treatment for those whose rehabilitation is paid for by other insurers. From the association's point of view, this situation of inequality among patients can only be eradicated through enactment of quality standards to which all funders commonly agree.[383]

Through further argumentation like this, the DVSG attempted to give more precision to its overall argument. At the same time, the argument put forth here could also be seen as resulting from an attempt to create hinges and, by extension, also avatars, that could link HSW especially to patient organizations and social policy makers, which in this particular quote are represented by funders in their role as corporative policy makers. The association attempts to create hinges by using terminology (linguistic symbols) that is attractive to other actors such as social policy developers ("quality standards") and patient organizations ("patient's rights", "patient's self-determination"). This way, the association hoped, its arguments could be made more persuasive to these actors. This effort by the DVSG to produce avatars could be sensed to be there in its sometimes explicitly articulated ambition to be assigned the role of a formal representative of patient interests in certain policy development forums, which could then be interpreted as speaking of a goal to colonize these forums with social work representatives.

The German association elaborated on these arguments it had put forward by underpinning them with further arguments. These were mainly descriptive, although sometimes they could also be normative in nature. A specific cluster of descriptive arguments could be observed that were meant to help improve the sustainability of the overall argument through the use of "atrocity stories" about the way healthcare professinals handle patient interests. These arguments presented HSWs using their competences to impact on patient treatment guidelines, having first seen patients' rights as being

[382] GA025, GA037, GA087, GA115, GA132a, GAR006, GAR007, GPB004, GPB010, GPB036, GPB043, GPB046, GPB056, GPB58, GPC005, GPC006, GPC007.
[383] GA132a.

under threat, ethical concerns in health care set aside, and problems arising from new trends and policy developments in health care. The DVSG could, for example, point at problems with hospital organizations not adapting themselves to patient needs, funders jeopardizing patient rights by delimiting HSW discretion, HSWs being taken advantage of to obtain sensitive internal hospital information, and, last but not least, funders and others service suppliers intruding in and colonizing HSW tasks and violating patients' rights through the provision of counselling biased by the funders' interests:[384]

> A prerequisite for professional and patient-oriented social work is absolute neutrality and independency. This condition, however, can no longer be said to be met when HSW services are paid for by external out-patient care service suppliers or by rehabilitation hospitals.[385]

In arguing in this way, the association attempted to underpin the sustainability and relevance of its arguments by claiming professional social work to be fundamentally patient-oriented, neutral, and independent. Arguments raised by using atrocity stories could be interpreted as indicative of an effort to establish hinges linking the profession to a variety of actors. Especially the use of the term "patient orientation" could be seen as speaking for this, given that it is an all-round term that is viable and understandable not only from a patient perspective but also in public policy making and in organizational domains. The usage of this particular term also relies on a definition of it specific for social work in this context, meaning that actors from all these domains and patients alike can use it to evaluate the persuasiveness of the claim raised.

When discussing patients' rights, the association tended to rely on normative arguments, or ones based on legislation. According to Karlsen (2012), these types of arguments are used to prove the indiscussable persuasiveness of the argument and the claim. At the same time, however, the DVSG could nevertheless still claim that HSW's contribution to health care in terms of its defending and safeguarding patient interests still continued to be underappreciated.[386]

Claiming patient interests to be underrepresented in health care development (and inadequately provided for more in general) and presenting the social work profession as the natural and proper representative of patient interests with all the needed competences for the task, was something that

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[384] See GD001: 107f, GA015, GA020, GA029, GA037, GA064, GA095, GA099, GA137, GAR003, GAR004, GAR005, GAR006, GPB010, GPB012, GPB027, GPO011, GPO014, GPO015, GWS005, GWS006, GWS010, GWS022, GWS030.
[385] GWS030: 3.
[386] FG DVSG.

basically only the DVSG did to support its claims-making, and even it did this mostly from 1996 onwards only. The Swedish association resorted to this line of argumentation only very seldom. In Sweden, in general, the major arguments used to strengthen the argumentation, such as the professional mission to represent client interests, tended to remain implicit. The argumentation by the German association predominantly relied on descriptive arguments, although also some normative further arguments were employed in order to underpin the sustainability and the relevance of the claims made. Many of these claims were also used to establish hinges and, when possible, avatars, to create a linkage mostly to social policy making and patient organizations, but also to hospital organizations and other professional associations. This attempt to produce hinges and avatars was made evident by the association's use of terminology (linguistic symbols) that could be assumed to be attractive to its intended audience. This was the case with "quality standards/measures" in relation to hospital organizations and social policy makers, "patients' rights/interests/self-determination" in relation to patient organizations, and "patient orientation" in relation to not just several different patient contexts, but also policy, professional, and organizational domains.

8.4 Failure of professionals, politicians and legislation

Thus far, this chapter has concentrated on describing HSW associations' different claims and arguments concerning societal and individual patients' needs. The first of these claims took its point of departure from the fact that disease and impairment often had social consequences as well; the second from the perception that there were gaps between the healthcare sector and the social welfare sector which needed to be bridged before one could help patients to overcome such social consequences; the third from the understanding that patients needed advocates capable of representing their specific interests at all levels in health care. This section considers the means the associations used to argue for the sustainability and relevance of their thus far outlined claims. It takes up the claim put forward by HSW that other professions, politicians, and legislature have all failed to adequately respond to the needs identified in, and addressed by, the above-mentioned claims. The first part of this section outlines the arguments put forth by HSWs about the failure of other professions to do so at the workplace level, while the second part looks at the arguments advanced about the failure of legislation and policy makers in that same task.

Failure at the organizational level

The DVSG claimed that none of the traditional healthcare professions could be said to have engaged in advocacy of patient's interests. Moreover, the claim went, the emerging social and psychosocial problems caused by disease and impairment were all more or less ignored by healthcare professionals. While the SK, in its claims-making activity, was for the most part concentrated on efforts to influence actors at the state level, the German association focused on both levels: the workplace level as well as the state level. The way these associations argued for other actors' failure in the necessary advocacy tasks, however, differed.

On the part of both associations studied, the claims-making activities addressing the failure of professionals in healthcare organizations to observe and respond to social and psychosocial problems mostly took place in the 1990s. In Sweden, judging from the documents collected, they nevertheless largely died out in the 2000s. In Germany, evidence of this kind of claims-making was to some extent found in documents dating from the early 1990s, but increasingly in documents dating from 1996 and after.

The DVSG often put forward arguments of the following kind, here taken from a debate article:

> It has been known for a long time that health and social matters are intertwined. On the one hand, social factors can influence disease, and, on the other hand, disease can bring changes to life situations and, for example, cause premature and long-lasting dependency on support and care.[387]

In Sweden, this relation between the social context and health/disease was more often only implicitly noted and less drawn upon in argumentation than in Germany. The argument made for it was basically descriptive in nature, being based on the use of research findings and evidence to underpin the core claim for the necessity of HSW services in the healthcare sector. This highly specific use was well suited for hiding the normativity of the core claim; it could thus also be used to present the raised claim as truth. The purpose of this type of argument was to show the relevance of the core claim to an audience from outside the language community. Consequently, its explicit use as in the German case could be expected to make it easier for the target audience of the claims-making activity to understand and accept the relevance of that claim.

Specific examples from daily work were given to prove the relevance of the arguments raised in both the SK's and the DVSG's jurisdictional claims-making. Such examples were also supplied to support the claim that medical

[387] GPB037: 14.

professionals tended to forget or even neglect the psychosocial consequences of disease and impairment.[388] It was, furthermore, claimed that this neglect had repercussions for patients' rights, as in by the following quote from an article published by the SK:

> However, according to the authority's own clarificatory regulations, only conversational therapy by psychiatrists, licensed psychologists, and licensed psychotherapists is eligible for additional sick benefits. Conversational treatment by HSWs is not.[389]

This and other similar problems were something that HSWs encountered in their daily practice, and they were used in both countries to support the argument that healthcare professionals neglected social problems. In Sweden, however, such supporting evidence was predominantly supplied only by the board members participating in the focus group interviews, while in Germany it was frequently encountered in the associational documents as well. One Swedish focus group participant, for instance, reported on cases where HSWs had been expected to remain loyal to other professions' treatment instead for performing their own duty. For example, objections by social workers who had not yet completed their work with a patient turned down in favour for other professions' interest in quickly discharging the patient.[390] Examples of this kind then supplied descriptive arguments to support the sustainability of the preceding argument that healthcare professionals had forgotten, ignored, and even neglected the relevance of patients' social problems for their recovery and their adaption to the new health situation.

The associations in both countries underscored the need to publicize more on HSWs' contributions to health care. They claimed that it was indeed necessary to do so, since state representatives, other professions, and healthcare organizations still seemed to lack information about HSW contributions in the field.[391] The responsibility and methods for spreading such information, however, was located and described differently in Sweden compared to Germany. The SK mostly claimed that information campaigns on all levels of society would solve the problem with the lack of information.[392] The DVSG, on the other hand, claimed it to be a general duty of the entire society to recognize and pay attention to the social aspects of disease in

[388] GWS007, GD001 p107f, SKA016, SKA020, SKAR001, SKAR003, SKP032, SKP045, SKP046, SKP053, SKP061, SKP089, SKP118, SKWS006, SKWS008, SKWS010, SKWS013.
[389] SKA016.
[390] FG SK.
[391] GA007, GAR001, GAR003, GAR004, GAR005, GAR006, GAR007, GD001, GD003, GPC005, GPC006, GPO013, SKA020, SKA043, SKD001, SKD002a, SKD007, SKP003, SKP046, SKP078, SKP118, SKP143, FG SK.
[392] SKA020, SKA043, SKP046, SKP118, SKP143.

health care. As the DVSG itself put it in a document defining HSW and its role in the hospital context:

> All hospital care that excludes the social dimension (i.e., fails to include social pathology as well as social consequences deriving from biography and impacting individuals' health-promoting resources or the individual's context) can be said to be suffering from quality deficiencies and promoting revolving-door medicine. It is, moreover, not cost efficient at all. From the perspective of the current social-medical knowledgebase, the hospitals that deny their patients the initial help they need to cope with the consequences of their disease and treatment may be characterized as inadequate and unethical.[393]

In this quote, the association claimed the inclusion of the social dimension of disease and impairment not to be the task of any specific profession but in the general interest of the wider public, including hospitals. Especially the use of symbolically charged terminology like "cost efficiency", "quality", and "ethical" transforms its claims from being profession-specific and particular to HSWs to appearing as something putatively raised by the public, other professions, and policy makers alike. This in turn could be interpreted as signifying the creation of hinges to link HSW to other arenas such as the public, policy makers, and healthcare organizations. Their production here is enabled by using terminology familiar from workplaces, public discourses, and policy making circles, and indicates appropriation of language originating from these actors and domains, which is then used as a hinge paving the way for these actors to better understand HSW claims. The development of evidence on HSW's contributions to health care and its dissemination to hospital organizations and policy makers could be interpreted as a way to develop arguments claiming the necessity of HSWs as a social work avatar in the healthcare sector. Other actors may then make use of, or "borrow", these arguments to, for their part, argue for the avatar HSW in health care in their domains.

In both the Swedish and the German association's external claims-making, the production of evidence on HSW contributions to health care and the highlighting of the need to also consider social problems in health care was combined with internal requests to HSW practitioners to produce statistical data on the effects and contributions of HSW to health care. The German association engaged in such additional efforts to facilitate its production of hinges to link it to other actors such as hospital organizations and policy

[393] GD001: 96f.

makers in order to better be able to integrate its own claims-making with that of other actors.[394]

The HSW associations in both Sweden and Germany claimed healthcare organizations and healthcare professionals to have failed in observing and upholding patients' rights, just as much as they had failed in bridging gaps between health care and social welfare despite having been aware of the correlation between social factors and medical treatment on the one hand and recovery and rehabilitation on the other hand. This "atrocity story" was then used as a descriptive argument to affirm the relevance between the previously presented claims and arguments. Probably due to the specific legislative developments in each of the two countries, evidence of argumentation concerning the mutual impact of disease and social factors became less frequent in the documents of the Swedish association over time, while in Germany it became only more and more frequent. Nevertheless, the associations in both countries claimed the involvement of HSWs in the healthcare setting to be able to alleviate the problems arising from this causal relation between the social context and disease/health. In both countries, argumentation with external audiences was mainly descriptive in nature, drawing upon evidence from research. Also evidence from daily work was used where possible, to prove the "truth" value of the associations' claim. Symbolically charged information and terms such as "scientific evidence", "effect", "sustainability", "economic advantages", "quality", and "ethics" were also used to facilitate the production of hinges linking HSW to hospital organizations, the public, and policy makers. By this way relating to their specific interests, the associations' formal jurisdictional claims could be further advanced. In addition, the German association accused health care of neglecting patients' rights to social services and of thereby providing to them services that were de facto incomplete, ineffective, and, unethical in nature.

Failure at the policy-making level

Apart from the need to include HSW in healthcare distribution, the SK and the DVSG also argued for the relevance of including HSW in healthcare policy development at the national, federated-state/county, and local levels, citing policy makers' failure to integrate social and psychosocial aspects into health care. In the documents studied here, the HSW associations claimed to

[394] GA009a, GA009b, GA017, GA027, GA028, GA048, GA054a/b, GA058, GA065a, GA068, GA083, GA099, GA112, GA132, GAR001: 6, GAR001: 9, GAR001: 12f, GAR002, GAR003, GAR004, GAR005, GAR006, GD001, GPB002, GPB012, GPB013, GPC005, GPC006, GPO002, GPO008, GPO010, GPO011e, GPO013a, GPO017, GPO025a/b/c, GPO027, GPO028b, GWS002, GWS023, GWS027, FG DVSG, SKA007, SKA035, SKAR003, SKAR006, SKAR009, SKAR010, SKAR011, SKD002a, SKP031, SKP032, SKP048, SKP061, SKP063, SKP065, SKP072, SKP075, SKP078, SKP079, SKP080, SKP085, SKP090, SKP098.

have also reminded actors at the policy-making, level of the fact that disease and impairment caused social and psychosocial problems, which needed to be treated.

The documents obtained from the SK and the DVSG indicate that the associations saw it as their foremost duty to externally represent the professional group. In Sweden, the documents collected from the SK contained implicit claims about the HSW involvement at a structural level throughout the entire period of study, with perhaps an increased level of activity in 1994–2005. Although HSW involvement at a structural level was thus something the association clearly attempted in practice, the claims it officially or expressly put forth were only about the necessity of including HSW in health care at the individual patient level. Consequently, its argumentation as to why HSWs' claims for involvement in healthcare policy-making at the national level should be seen as relevant became less persuasive, or in any case less persuasive than the comparable arguments put forth in the German context (cf. Karlsen 2012). This was so especially when it came to target audiences of claims-making who were not participants of HSW's disciplinary language community, meaning most of the non-HSW personnel employed in healthcare provision and policy making in the country. In Germany, the claim for HSW involvement at a structural level was regularly raised throughout the entire period under investigation, although mostly, and more explicitly, in the years following 1996.

The main claim here was that policy makers tended to ignore in their policy development work the relation between, on the one hand, social and psychosocial aspects and, on the other hand, disease and impairment, just as much healthcare professionals ignored it in their healthcare service distribution work. To convince their audiences of the relevance of this claim, the associations in both countries resorted to mostly descriptive arguments that were used sometimes more explicitly, sometimes more implicitly. The following quote from a written statement by the DVSG serves as an example:

> Already existing institutional psychosocial service distribution still needs to be integrated into legislation. Thus far, only information and counselling services by self-help organizations have been included in its scope. All other psychosocial service distributers apart from social insurances have been left outside.[395]

The DVSG often brought up the issue of the exclusion of certain particular social services from the scope of healthcare legislation, noting the problems caused by this, what was perceived as ignorance at the policy development

[395] GPB028: 46.

level about the professional social and psychosocial services that HSWs provided. This was done to empirically support the sustainability of the argument that policy makers tended to ignore social aspects in healthcare policy development. Also the SK often brought up this omission of social and psychosocial aspects in national policy making. These sustainability arguments were then often followed by other, more descriptive arguments. In Germany, this was done to provide further support for the claim the association there made for HSW's integration into legislative processes and into legislation itself. Sometimes, these arguments were also combined with normative arguments proposing how to solve a specific legislative/regulative problem, as exemplified by the quote below. As already mentioned, in Sweden these descriptions were used for the exclusive purpose of depicting individual-level insufficiencies in law and regulation proposals. The effort to this way involve HSW either explicitly or implicitly in legislative processes could be interpreted as indicating a desire to create hinges capable of linking HSW to the policy making domain through the use of language and terms such as "client interests", a standard term in healthcare policy making. The formal establishment of avatars, again, was attempted through the integration of the already existing psychosocial services (as performed by social workers in health care) into legislation.

In Germany, the claims the DVSG made were for the inclusion of HSW in healthcare policy development. This was to take place in diverse policy making arenas at the national level:[396]

> During these deliberations we will point out the necessity of including HSW in all policy development processes that directly concern HSW and its clients' interests. We will also discuss our local colleagues' competences so that they can be involved in future federated state-level policy developments right from the start.[397]

It was, in other words, argued that HSW needed to be engaged in healthcare policy development wherever HSW's or its clients' interests were involved. In making this argument, the association specified and limited its claim for participation in policy making to concern only those cases where client interests or social and psychosocial aspects were involved. Besides the fact that it was aimed to underpin the relevance of its claim for HSW's involvement in policy making, this argument could also be seen as indicating an attempt to insert embodied HSW avatars into policymaking forums, by calling for the integration of HSW representatives into the policymaking bodies in

[396] See GPA010, GA129, GA144, GA073, GA057a, GA071. The same argument was also made by the SK, although implicitly only.
[397] GPO023.

question. The same could be said also about the way the German association attempted to prove its usefulness to policy makers by engaging in associational activities specifically aimed at public corporative bodies in the former East Germany during their integration into the broader polity framework of the German Federal Republic. Through these activities, the DVSG could be said to have attempted to offer evidence about its associational competence and the practical benefits of involving social work in healthcare policy and legislative development.[398]

Engaging HSW in healthcare policy development was argued to represent an investment by policy makers in the development of egalitarian health care distribution and in the inclusion of the disadvantaged segments in German society. Here the specific competences of social work, especially in health care, were stressed.[399] The association, furthermore, made efforts to highlight the various kinds of problems arising from the transfer of West German legislation to the East German context, which were stated to in particular necessitate the involvement of HSW in social policy development in the eastern parts of the country.[400] Descriptive arguments of this type were used to prove the sustainability of all arguments the DVSG made in this regard. Expressions such as "egalitarian distribution" and "elimination of disadvantages" could be interpreted as intended to provide argumentative hinges linking HSW to policy makers and patient organizations.[401] The expectation was that by using them, these actors would more likely be receptive to the message put forth through the particular claims raised by the association in its claims-making.

Additionally, the DVSG also made the expressed argument that the HSW profession could, earlier than other professions, anticipate problems arising from healthcare/social-welfare policy changes for health care.[402] Concrete evidence of such special sensitivity to detecting emerging problems from legislation and regulation was put forth by both associations, although somewhat more implicitly by the SK.[403] Both the DVSG and the SK claimed that the involvement of HSW representatives in healthcare and social welfare development would help in avoiding and counteracting these problems.[404] In this, the German association used mainly descriptive arguments for its purposes, while in Sweden the SK predominantly put forth normative arguments. According to Karlsen (2012), underpinning normative arguments and claims with descriptive arguments often contributes to the im-

[398] GPB001, GPB002, GPB008, GAR001, GAR002, GAR003.
[399] GA144.
[400] GAR005, GPA009e.
[401] GA144.
[402] GA007, GA057a, GAR001, GAR002, GAR004, GAR007, GD001, GPC005, GPC006, GPO032.
[403] SKP063.
[404] SKA007, SKA019, SKAR004, SKAR006, SKP005, SKP028, SKP046, SKP048, SKP049, SKP050, SKP061, SKP079, SKP080, SKP090, SKP097, FG SK, GAR003, GAR004, GWS007, GWS027.

pression that the argument or claim in question is sustainable. The same would not then apply to the use of normative arguments for the same purposes, as in the case of the Swedish association.

Mostly the DVSG claimed HSW funding to depend on healthcare organizations' goodwill. At least in Germany, this was claimed to impact patients' possibilities to access psychosocial services to which they were entitled according to law.[405] Both associations claimed that the resulting gaps in healthcare service supply were frequently due to the legislators' unwillingness to embrace HSW treatment in Germany or licensure for HSWs in Sweden. Both associations perceived this as resulting in insecurities concerning the willingness of hospitals to fund HSW services. The associations argued that an explicit inclusion of HSW in the law-making processes in the relevant areas would help solve some of these problems.[406] In Germany, there were direct discussions about this with healthcare funders, in which the necessity of developing direct communication channels with funders and inscribing HSW services and their funding in laws and regulations was brought up.[407]

In Sweden, the focus was instead laid on the inclusion of HSWs in legislative processes only where these concerned the issue of licensure; funding problems were not mentioned at all. Generally speaking, in both countries, one of the main associational objections concerning policy makers' failure to integrate social aspects and social work professionals into healthcare policy development derived from the fact that HSW was often not mentioned at all in healthcare legislation and the subordinate public regulations.[408] By the SK this concern was addressed, for instance, as follows:

> According to these regulations, only licensed healthcare professionals are required to participate in their unit's quality management.... Accordingly, it seems that the National Board of Health and Welfare intends to exclude HSWs from participation in their units' quality management processes.[409]

Here the association presents a descriptive argument aimed to support the sustainability of its previous argument that HSW was often ignored by policy makers and ought therefore to be included in the policy-making process.

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[405] SKA008, GA006, GAR001, GAR005, GD002, GPA007a/b, GPA009b/c/d/e/f, GPB012, GPB031a, GPB035b, GPB043, FG DVSG.
[406] SKAR011, SKAR016, SKP046, SKP098, SKP104, SKP122, SKP124, GA006, GAR002b, GPB026, GPO002, GPO012, GPO013, GPO033, FG DVSG.
[407] GA035, GA057, GA078, GA092, GPA013, GPB055, GPO021, GWS033, GA006, GA037, GA115, GA132, GAR001, GAR006, GAR007, GPB009, GPB036, GPB046, GPB056, GPB58, GPC005, GPC006, GPC007, GPO014, GPO015.
[408] SKAR011, SKAR016, SKP046, SKP098, SKP104, SKP122, SKP124, GA006, GAR002b, GPO002, GPO012, GPO013, GPO033, GPB026, FG DVSG.
[409] SKA016.

Moreover, in the associational documents collected from the associations in both countries, the claim was often put forward that healthcare legislation typically failed to explicitly incorporate into it HSW tasks and required competences in Germany and the role of non-licensed professions in Sweden. Where the legislation nevertheless did do that, as in the case of several particular laws and regulations in Germany, it was often tasks, not the required competences, that were named in it. Consequently, in both countries, also professionals other than social workers could perform genuine HSW tasks. Especially in Sweden, the regulations and legislature often explicitly stated "licensed professions" to have the responsibility for certain work tasks, which by definition meant the exclusion of HSW, as a non-licensed occupation, from the performance of these tasks.[410]

As already noted above, the HSW associations in Sweden and Germany used different strategies in their claims-making concerning the integration of HSW into legislative processes. In Sweden, the association's claims were very much focussed on the idea that licensure would solve most of the problems HSW perceived to be there in health care.[411] In Germany, on the other hand, licensure was not given the same attention in claims-making as a global solution for experienced problems in HSW. Instead, the claims the association put forth concerned jurisdictional problems seen to emerge from failures of legislation. The argument here was for the explicit integration of jurisdictional aspects in diverse laws concerning healthcare organization, healthcare funding, and healthcare delivery. The understanding in Sweden that licensure was what would solve HSW problems in health care can be interpreted as signifying the appropriation of an issue originating from health care and using it as a symbolic hinge that was ultimately aimed at facilitating the integration of HSW as a healthcare avatar ("healthcare profession") into legislation on healthcare professions' licensure. In Germany, again, the claim concerning the necessity of integrating terms such as "social case management", "social services", and the like into the country's legislation can be understood as implying an attempt to appropriate symbolic social work terms and use them as hinges providing a linkage to legislation. Once this was accomplished, they could then function as a legislative argument to establish social work colonies in healthcare.

In other words, one of the claims put forward by the German and Swedish associations in connection with their professional jurisdiction project was for the involvement of HSW in policy-making processes. This they saw as necessary owing to the policy makers' and public corporative bodies' failure to anticipate and overcome gaps between healthcare policy and social welfare policy and to adequately address patient interests. The objections

[410] SKP078, SKA016.
[411] SKA020.

concerning these were put forth in the form of relevant and supportive descriptive arguments. In Sweden, however, such claims were raised only implicitly, through associational action rather than explicit claims-making, and mostly during the period lasting from the mid-1990s to the mid-2000s. In Germany, in contrast, these claims were put forward by the association there in a very explicit manner, especially from the mid-1990s onwards. The periods of increased activity in this regard tended to coincide with periods of increased reform activity bringing changes to the healthcare (Germany) and licensure (Sweden) legislation in the two countries. In addition, the kind of arguments used to advance a certain kind of professional jurisdiction tended in both countries to depend on the intention with legislative reforms and their aims. When the reforms were aimed at creating a sharper demarcation between health care and social welfare sector, jurisdictional claims centred more on psychosocial treatment, and when a closer integration between these sectors was sought for, jurisdictional claims on social case management interventions became more frequent.

The associations in both countries predominantly used descriptive arguments to support the perception that their jurisdictional claims concerning the involvement of HSW in healthcare policy making were relevant and sustainable. Sometimes these arguments could also be accompanied by claims concerning possible solutions to the problems identified. Additionally, these descriptive arguments were often also used for the association's attempts to create hinges and avatars linking the profession to policy development and patient organizations, with the ultimate goal of inserting avatars into legislation and public regulations under the guise of formal jurisdiction. In Germany, association made use of explicit descriptive arguments in order to be able to better support the claims it put forward in its claims-making, while in the Swedish case these descriptive arguments were only more implicitly drawn upon in the claims-making. Combined with the somewhat implicitly presented main claim for the involvement of HSW in healthcare policy-making structures, the additional, also rather implicitly presented supportive descriptive arguments resulted in a less persuasive overall argumentation compared to the German case.

8.5 Necessary competences at the interface

In the HSW associations' project to establish and protect a specific jurisdiction for HSW in the two countries, the by far most frequently used claim in both Sweden and Germany was that HSW represented a profession that was particularly well suited and therefore necessary for the task of bridging gaps between the healthcare and social welfare sectors. The same applied to its

role in fulfilling an advocacy function in healthcare settings. In the German case, the DVSG, for example, argued that:

> Social work is the only profession that works at the interface between the different segments of the healthcare system, but also at the interface between social welfare and health care.[412]

Besides the SK, also the VKF and the NFS raised this claim in Sweden. The frequency with which it was put to use by the associations in the country remained basically unchanged throughout the entire period of study. The DVSG, too, kept stressing the importance of HSW expertise throughout the entire period of study. Nevertheless, the frequency with which it resorted to this particular claim began to increase in 1997, to go up again in 2002.

Required hospital social work competences

Similar, predominantly descriptive, further arguments were used in both Sweden and Germany to demonstrate the sustainability of the main claim. In both cases, it was argued, for instance, that state authorities and other professions underappreciated HSW skills and competences. In addition, there was also one normative argument that was used in the associations' external claims-making to protect HSWs' professional interests; this concerned their demand for labour market closure and the introduction of legal requirements for social work competences.

At the policy-making level, both the SK and the DVSG claimed that there was a need for labour market closure to guarantee the employment of professionals with social work competences as well as their involvement in the bridging of gaps between health care and social welfare and in the representation of patient interests. In both countries, a proposal was frequently put forward that the HSW labour market be narrowed to only those holding a social work degree (Dipl./BA/MA).[413] It was also pointed out that additional further education might be useful and recommended, although this broad suggestion was never specified any further.[414] Nevertheless, there were fewer documents in Sweden than in Germany, especially official written statements but also internal associational documents, that could be said to have put forth any official associational claims concerning the required competences here. Where such claims could nonetheless be detected, they were, typically, highly unspecific.[415] One reason for this was that compiling

[412] GA123a.
[413] SKD001, SKD007, SKP105, SKP116, SKP118, SKP136, SKWS017, SKWS014, FG SK, GA069b, GAR007, GD001: 110, GD002, GPB034a, GPB034b, GWS040.
[414] SKD007, GA069b, GD001: 110, GPB034a, GPB034b, GPB038.
[415] SKA017, SKA031, SKD004, SKP059, SKP062, SKWS002, SKWS004, SKWS014, SKWS017, SKWS020, SVKFWS003, NFSD1, NFSP016, FG SK.

together a large variety of HSW tasks was perceived to be a difficult task.[416] In Karlsen's (2012) terms, the SK, even though it represented one of its main claims, thus put forward this claim in an implicit form only, which very likely must have then affected its persuasiveness in the eyes of the intended audiences of the association's claims-making. This circumstance was probably further aggravated by the fact that those targeted by HSWs' claims also often lacked knowledge of the profession.

The DVSG, on the other hand, regularly put forth explicit claims concerning the labour market closure, to reserve the hospital social services market to only those with a social work/social pedagogue diploma. At the same time, the association often also claimed that HSWs represented unique and specialized competences which should be legally required for employment in hospital social services.[417] The explicit claim for labour market closure was combined with a supporting argument describing required skills and competences. To follow Karlsen (2012), this way of arguing had the effect of increasing the likelihood that the raised claim would be perceived as sustainable by its audiences, which can be presumed to have been of special importance in cases where these audiences of the association's claims-making came from other contexts outside the language and disciplinary community of HSW. Raising one's claims explicitly and using descriptive arguments to support the sustainability of one's argument were thus something that probably helped to strengthen the persuasiveness of the claims made (cf. Karlsen 2012). At the same time, these also helped to give the impression that the whole professional subgroup agreed to, and supported, the descriptions put forward.

The association in Germany also negotiated with other professional associations about the boundaries of professional jurisdiction before going on to push the issue in other public administrational bodies.[418] In these negotiations, research-based arguments were raised concerning the claimed jurisdictional boarders.[419] The DVSG saw this to provide an important way to promote its claims-making project, given that most of these other professions were represented in various policy-making bodies and their preparatory organs and forums. The agreements concluded with these professions then increased the chances of the association's having its HSW-related claims accepted in policy-making bodies later on.

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[416] FG SK.
[417] GWS002, GWS003, GWS006, GWS007, GWS009, GWS013, GWS018a, GWS018b, GWS019, GWS022, GWS023, GWS024, GWS025, GWS026, GWS027, GWS028, GWS029, GWS030, GWS031, GWS033, GWS034, GWS035, GWS036, GWS038, GWS039, GWS040, GWS041, GWS042.
[418] GA065, GA068, GA106, GA110, GA125, GA132, GA141, GAR005, GAR007, GPC005, GWS023, GWS029. These professional associations included those for nurses and psychologists.
[419] GWS027.

Required social work skills

As already noted, the associations in both countries argued more or less explicitly that, in the healthcare setting, only HSW could provide the unique set of competences needed to tackle the effects that social aspects of the patient's context had on disease development and recovery, and vice versa. These competences included a specific skills set. In Sweden, these skills were predominantly related to conversational and therapeutic techniques. In Germany, they were about mostly other kinds of genuine social work skills, such as, for example, clinical skills and social case management at the individual and structural levels.

Claiming the unique preparedness of HSW to handle certain specific tasks was not enough in itself, however. Occasionally, the associations pointed out that the underappreciation of HSW skills that they noted in both Sweden and Germany made claims-making concerning a specific jurisdiction necessary.[420] In an article explaining the association's interpretation of a newly signed corporative contract between healthcare funders and suppliers, the DVSG expressed this need as follows:

> This means that case management-oriented counselling of patients and their relatives must be performed using special skills that only diploma-holding HSWs possess. These skills include social rights counselling as well as psychosocial counselling. From our point of view, care discharge managers with a background in nursing only are not qualified to perform these tasks.[421]

Underappreciation of HSW skills was something that was only implicitly thematized in the associations' arguments. In the above quote, for example, the claim to this effect is put forward only indirectly, by stating that nursing skills were not enough in case management. Especially the nurses' counselling skills are questioned. In other cases, it could also be their scientific knowledgebase or their specific techniques that was questioned. These were, in turn, pointed out as the strength of HSW. Another further argument addressed the question of the underappreciation of HSW skills through the fact that legislation occasionally required further education for certain work tasks even when the techniques involved were already taught as part of regular social work training (e.g., conversation techniques).[422]

The argument that social work skills and competences were underappreciated was underpinned by additional descriptive further arguments, to demonstrate the sustainability of the main argument. These arguments could, for example, claim that superiors lacked knowledge of the specifics of

[420] SKP053, FG SK; FG DVSG.
[421] GPO023: 11.
[422] GPA013c.

HSW competences, and assigned irrelevant tasks to HSWs.[423] In Germany, this was repeatedly described as giving rise to unnecessary conflicts with other professionals. Such conflicts, in turn, were described as having negative consequences for patients' ability to cope with their health problems, resulting in further social or psychosocial consequences.[424] Occasionally, the DVSG specified this line of argumentation by suggesting that especially inference and diagnostic competences were often disregarded, with one of the reasons for this being the lack of a social diagnosis system of the kind found in health care.[425] With this kind of arguments, HSWs tried to show the sustainability of their arguments. Additionally, these arguments also indirectly stressed the importance of this symbolically charged terminology ("diagnosis system") derived from the healthcare context, suggesting the effects of the absence of similar symbolic terminology in HSW for professional HSW practice as one possible reason for the underappreciation of HSWs' professional work. The development of a diagnostic tool kit could thus provide a potential hinge for linking HSW language and theorizing to the dominant language and knowledgebase of medicine in health care. The creation of hinges to link HSW to the welfare policy level, on the other hand, was attempted by using terminology originating from the policy-making arena. By using statements like "inter-professional conflicts have negative consequences for patients", for example, individual experiences of HSWs were aggregated from the workplace level to a structural level.

Another descriptive further argument was raised to demonstrate the sustainability of the argument that HSW was underappreciated as a knowledge-based profession. This argument pointed out the domination of scientific methods and evidence-based practice methods as used in natural science and in health care, along with the expectation that ultimately even social work would begin applying these methods. Meanwhile, these methods were not always applicable to research in HSW.[426] As with the usage of medical terms above, the underappreciation of HSW's scientific knowledgebase could be argued to be caused by the absence from it of symbolically charged terminology compatible with the dominant language use in health care, rather than by any objective lack of a specific knowledgebase. Since social work was unable to present any adequate track record in research carried out using only these types of proven "scientific" methods, the creation of hinges that could provide for it a terminological linkage to healthcare professions utilizing these particular symbols was difficult. This, in turn, was argued to result in additional difficulties in funding HSW research and in

[423] FG SK, SVKFP016, GA011a.
[424] GA098, GA101, GA126.
[425] GPO025c, GA113b, GPA013e, FG DVSG.
[426] SKP063, FG SK, NFSP007, NFSP008, NFSP011, NFSP013, NFSP016, FG DVSG.

joining research networks in health care.[427] HSW researchers in Sweden thus increasingly began to use quantitative methods, in contrast to social work in general in the country (see Dellgran & Höjer 2003). They were also more likely to adapt their way of working with evidence-based methods to better conform it to the model provided by natural science. These efforts could be interpreted as indicating the adoption of a strategy of allowing HSW to become colonized through medical avatars (e.g., through HSWs' extensive use of quantitative methods) in order to facilitate the closer linkage of HSW to health care and medicine.

Social and psychosocial counselling

Psychosocial[428] and social[429] counselling could be described as an intervention used with the symbolically charged intent of circumscribing a cluster of professional skills and competences perceived as unique to HSW.[430] These interventions comprise conversational techniques for crisis intervention, conflict solving techniques, adaption-centred counselling, skills required for supply/needs assessments, and knowledge of social resources.[431] Group work techniques and advocacy techniques are often claimed to be included as well.[432] The DVSG described these skills in the following way:

> As prescribed by law, social work in medical rehabilitation delivers services concerning the individual, social, and job-related integration, supporting individual human beings in their efforts to recover their autonomy. To achieve these goals, social work provides the following services:
> - Motivation, support, and guidance during the rehabilitation process;
> - Support in developing adaptation strategies;
> - Development of solutions for individual health, work, and social rights-related problem situations;
> - Measures for enabling transparency and compliance;

[427] FG DVSG, NFSP013.
[428] A term mostly used by HSWs in Sweden, which often, even if implicitly only, more or less excludes pure social problems.
[429] A term mostly used by HSWs in Germany, which often includes both social and psychosocial aspects.
[430] SKP020, SKP045, SKWS005, SVKFWS002, FG SK, GA057a/e, GA073, GA081, GA086, GD001, GPO031, GWS002, FG DVSG.
[431] NFSD001, SKA 004, SKA007, SKA014, SKA021, SKA031, SKA035, SKA042, SKD 001, SKD002, SKD003, SKP003, SKD006, SKP020, SKP045, SKP049, SKP059, SKP063, SKP146, SKP143, SKWS003, SKWS005, SKWS009, SKWS010, SKWS017, SKWS020, SVKFWS001, SVKFWS001, SVKFWS002, SVKFWS003, GA003, GA046d, GA056, GA057a, GA057e, GA070, GAR001, GAR002, GAR006, GD001: 107, 112–123, GD003, GPB034a, GPB034b, GPC007, GWS006, GWS009, GWS018, GWS019, GWS023, GWS024, GWS025, GWS033, GWS038, GWS040, GWS042, FG DVSG.
[432] SKA016, SKP007, SKWS005, GA057e, GPB034a, GWS040, FG DVSG.

- Strengthening of the patient's self-determination and, where necessary, advocacy.[433]

The quote provides a good example of how psychosocial work skills were typically described in Germany. Initially, in this quote, it is argued that these tasks are prescribed by legislation. Then, the necessary competences are enumerated more in depth by the association itself. Typically of the German HSWs, no health care-related terminology originating from health care professions is adopted here. Instead, they defined their own specific competences and described them explicitly as located at the margins of health care, at the interface between it and social welfare, using the inscription of social services in legislation as an argument to institutionalize a social work-specific colony in healthcare practice. Within this colony, social work then performed its tasks as enumerated above.

In Sweden, the focus on psychosocial counselling was slightly different. Firstly, psychosocial counselling skills were often only implicitly referred to by the SK; explications of these skills often pointed at conversational and therapeutic techniques. However, as the interviewed members of the SK board explained, psychosocial interventions were not always performed by HSWs themselves. Often, HSWs were rather described to merely supervise other professionals in health or municipal care who provided the psychosocial treatment.[434] This claim by the Swedish HSWs that they often rather supervised other professions performing psychosocial treatment instead of providing it directly themselves can be understood as indicative of an effort on their part to retain control over genuine HSW tasks and knowledge, while allowing other professions to perform "non-HSW" work tasks. Following Abbott (1988), this effort could be characterized as aiming somewhere between intellectual and advisory jurisdiction. According to him, both forms of jurisdiction are extremely unstable, given that the "other" professions cannot be controlled by the original profession concerning their development of a relevant knowledgebase for the tasks already being performed, and advisory control could thus become impossible, especially when the controlling profession has a lower status than the controlled profession and when the controlled profession's knowledgebase develops faster than the superordinate profession's knowledgebase.

Such differences in the claims put forward in Sweden and Germany concerning the work tasks could performed be interpreted as indicating an effort by the two associations to establish different symbolic boundaries around HSW. The Swedish HSWs built hinges to health care by adopting into their vocabulary core symbolic terms from the health care context, such as

[433] GWS38: 1.
[434] FG SK.

"therapy" and "treatment". The DVSG, on the other hand, rather attempted to merely maintain the social work colony it had already succeeded in institutionalizing in health care.

Social case management

Social case management could be defined as a social work method that relies on a cluster of claimed social work skills and competences and is applied at both the individual and the structural level of social work. The HSW associations in this study used the term 'social case management' as a symbol helping to underline the professional group's "otherness" next to other healthcare professions. It demarcated HSW competences clearly from the competences of other healthcare professions. Of the HSW associations studied, social case management skills and competences were mainly addressed and explicated by the DVSG. In doing so, the association always referred to both the structural and the individual level of social work intervention.

Where, if at all, the SK mentioned social case management competences in its documents, this was by referring to case management at the individual case level. This difference between the claims-making of the German and the Swedish association confirms the impression that Swedish HSWs attempted to symbolically assimilate to medicine by emphasizing work at the individual level, while the DVSG, in contrast, attempted to prove it "otherness" through the use of social work terms and its assertion of skills at the structural level.

The DVSG claimed that only HSWs possessed the specific social work skills required in social case management, including, for example, ecological or systemic techniques, supply management, and empowerment and advocacy techniques. HSW was also claimed to have expertise in inter-professional/inter-organizational networking techniques and in administrative and quality management techniques required to match patient needs with legal requirements and services needed and then co-ordinate between all these. From the German perspective, this kind of social case management was often considered to also comprise psychosocial counselling skills.[435] In a more general characterization provided by the DVSG, social case management was defined the following way:

> Case management in social work and in healthcare settings is a method used for individuals with multi-faceted restrictions, where solutions and coping can only be achieved through the

[435] GA009a, GA027, GA038, GA056, GA057a, GA058, GA060, GA061, GA065, GA066, GA069b, GA082, GA097, GA101, GA103, GA104, GA106, GA125, GAR002, GAR003, GAR004, GAR006, GAR007, GD001: 107f, 112–123, GPA013, GPB012, GPB013, GPB034a, GPB034b, GPC006, GPO001, GPO012, GPO014, GPO021, GPO023, GPO031, GWS004, GWS007, GWS018, GWS019, GWS024, GWS029, GWS030, GWS031, GWS039, GWS040, GWS041, GWS042, FG DVSG.

> involvement of multiple (inter-disciplinary) services. Case management is understood as support management, designing and giving access to optimal, individually adapted support services involving service suppliers from a variety of different sectors. Case management is also understood as a case-related efficient and effective systematic management process by one person or a team.[436]

As in this quote, the German association often claimed that HSWs' specific competences were used in order to integrate social aspects and patient interests in discharge management, in the organization of after-care services, and in rehabilitation planning.[437] Unlike their Swedish colleagues, the German HSWs used symbolic terminology derived from social work, rather than health care. Consequently, terms such as "social case management" and "multi-faceted restrictions" were preferred over "patient management" and "multiple health-related problems", for example. As stated above, the use of these terms had the effect of underlining the "otherness" of the professional HSW group next to the more traditional health care professions. These terms, however, were also used as a way to develop hinges to link HSW to health care. With them, one could demarcate the claimed professional jurisdiction of HSW. In using its above-listed competences, the German association claimed, the profession had also developed a unique capacity to detect structural problems brought by healthcare/social-welfare policy reforms at both the federated state and national level, showing, moreover, an ability to solve such problems at the intersection between the individual and the structural level.[438] In the following quote, the DVSG attempts to describe specific HSW tasks in supply management, which is defined as a specific part of social case management at the structural level:

> The implementation of successful supply management must fulfil the following requirements... at the organizational level:
>
> - Development of standardized methods including methods for crossing sectoral boundaries;
> - Delegation of responsibilities for each part of the process;
> - Identification of possible medical, care, and social risk factors;
> - Development of screening procedures;
> - Development of routines for standard deviations;
> - Development of checklists;
> - Development of evaluation instruments;
> - Identification of gaps and further development opportunities;

[436] GWS039: 1.
[437] GWS031.
[438] GA007, GA057a, GAR001, GAR004, GD001, GPC005, GPC006, GPO032, GWS039.

- Reliable agreements with co-operation and supply partners.[439]

In this quote, the German association could instead be interpreted as trying to establish hinges linking HSW to procedural aspects of medical health care, given its use of expressions such as "screening procedures", "identification of risk factors", and "checklists", all of which are typical of healthcare settings. This could then be interpreted as indicative of an effort to enable members of other, dominant professions to understand that, even though their social work skills and competences are different, HSWs can be integrated in hospital settings where they are can then help to develop and improve healthcare services.

Clinical social work

A third complex of skills and competences around which the jurisdictional claims-making of HSWs concentrated consisted of specific competences termed as clinical social work competences. It was predominantly the German HSWs, however, who used this term explicitly and tried to define it more in detail. In Sweden the term was used only very occasionally and even then in daily talk only, often emulating medical talk in which clinical work was used as a way to describe medical practice. However, the term itself was never defined or even mentioned in any of the documents obtained from the Swedish HSW associations for this study. In the German documents, clinical social work could be said to comprise techniques/skills in conducting social anamnesis, social diagnostics, as well as specific inference competences used to assess and conduct suitable interventions or treatments.[440]

Such discretionary competences were, in the German documents, claimed to consist of professional HSW skills to balance between patient interests, the patient's legal rights, bio-psychosocial perspectives in health care, available health care and social resources, as well as the economic and ethical aspects pertaining to each individual case.[441] By more or less explicitly claiming these competences which Abbott [1988] calls diagnosis, inference, and treatment, the HSWs in Sweden and Germany underlined the nature of their work as a professional enterprise. Abbott (1988) has drawn attention to inference as an important aspect of the professions' jurisdiction. According to him, the more the professionals perform routine work and the less they exercise inference, the weaker the profession's jurisdiction becomes. It is from this perspective that the DVSG's explicit descriptions of inference competences vis-à-vis other healthcare professions, organizations, and

[439] GWS039: 3.
[440] GAR002, GA057e, GA059d/f, GA065b, GA070, GPC006b, GWS040, FG DVSG.
[441] GA057a, GA069b, GA070, GA093, GPB034a, GPB034b, GWS002, GWS031, GWS040, GWS040a, FG DVSG, FG SK.

policy makers have to be understood. The DVSG described HSWs' inference competences as follows:

> The specific output of clinical social work, the way in which a social worker sets the client's individual life situation, her/his subjective experience of the disease, existing medical factors, physical dysfunction, and social restrictions in relation to the service supply in rehabilitation and care.[442]

Specific inference competences were also claimed to be necessary to facilitate the integration of patient interests into health care and social welfare development at a structural level. No explanations were given, however, as to how this could perhaps be achieved.

In claiming specific competences to be something belonging to HSW's own jurisdictional field, the association's argumentation could be interpreted as meant to demonstrate the sustainability of its claims. What it also shows, however, is how the association attempted to adopt for social work symbolically charged terminology such a "diagnosis", "treatment", and "clinical" social work that all originated from health care, to use these terms as a hinge to that way link it to the latter. In turn, the re-introduction of these terms into health care, through the incorporation of the term 'clinical social work' into healthcare funders' benefit catalogues, can be interpreted as the establishment of a social work avatar in the domain of public regulations.[443] In addition, the claiming of explicit discretionary competences had importance for the association's attempts to demarcate HSW's own distinct professional jurisdiction.

To sum up, an analysis of the claims-making activities of the SK and the DVSG shows several differences between the two cases. First of all, the claims-making by the SK tended to be more often based on implicit argumentation, while the German DVSG's claims-making was predominantly based on explicit arguments put forth. Additionally, the DVSG more often used descriptive arguments to demonstrate the sustainability of its normative claims and arguments, while the SK more often used normative arguments. According to Karlsen (2012), the use of descriptive arguments tends to strengthen the claims' persuasiveness in the eyes of their addressees more than the use of primarily normative claims. Likewise, the use of explicit arguments tends to strengthen the persuasiveness of the argumentation more than the use normative arguments. Accordingly, the claims put forward by the HSW association in Germany were more likely to be found persuasive by their audiences there, compared to the claims put forward by the HSW associations in Sweden for its own audiences in that country.

[442] GPO003: 14.
[443] See for example GA035e.

Moreover, also when it came to their use of hinges and avatars, the SK and the DVSG showed themselves to be resorting to different strategies. The SK predominantly used hinges as a way to demonstrated that the HSWs in the country accepted arguments and perspectives drawn upon in Swedish health care more generally. The association tended, for example, to employ terms such as "patient safety", "licensure", "comprehensive overall view", and "therapy"/"treatment" to describe HSW practice and claims. These terms were all part and parcel of the linguistic practices of social policy makers and healthcare professions. The SK can be said to have resorted to these terms in its claims-making in order to be able to relate its arguments to the domain logic of social policy and the professional logic of healthcare professions. Apart from the term "comprehensive overall view", the SK did not, however, fill these terms with any HSW-specific meaning. One could therefore see the use of these terms as indicating the acceptance of hinges originally derived from the healthcare context, to that way facilitate the argumentation for the necessity of HSW in health care.

The SK also strove to describe HSW in terms of its being a "healthcare profession". Towards this end, it described the profession as one that used research methods and evidence-based practice methods from the healthcare context, along with individualized treatment methods. HSW practice, as such, could then be claimed to lie somewhere in the heartland of the broader medical care field: it was described as mirroring practice in other health care professions. By transferring these professions' concepts to HSW practice and downplaying the importance of other aspects of HSW practice, the SK could thus be understood as having consented to HSW's becoming colonized by the logic of the healthcare domain.

The DVSG, in contrast, primarily employed the strategy of using specific social work terms such as "multiple constraints", "social case management", "supply management", "clinical social work", and "structural social work" in order to be able to claim the necessity of HSW in medicine. These terms were then argued to be important within the health care context in turn, by using terms that social policy, healthcare professions, and healthcare management could more easily relate to. Such terms included, for example, "effectiveness", "quality standards", "patients' self-determination", "neutrality", "independence", "cost-efficiency", "ethical", "egalitarian distribution of services", "elimination of disadvantages", "screening", "risk factor assessment", and "checklists", all of which were used to demonstrate their relation to health care. When terms such as "patient orientation" and "diagnostic system" were adopted from the healthcare context, they were often turned into concepts with a specific HSW meaning, thus transferring social work meaning to the healthcare context.

The DVSG proposed the incorporation of social services and social work methods such as social case management and clinical social work into legislation and public regulations. The association also proposed that social work professionals be employed in certain new and already established roles in health care insurance, hospitals, and counselling centres. It further proposed that social work be represented in policy-making structures in the role, for example, of a formal representative of patient interests. The DVSG, moreover, supported the development of arguments that other stakeholders could then themselves use in their own argumentation. HSW was described as an important area of service located at the interface between two welfare sectors, not at the centre of medical care. This strategy could be characterized as one aimed at distinguishing HSW and its practice from that of other healthcare professionals. This employment of a strategy to integrate social work perspectives at both the legislative and public-regulative levels as well as at the workplace level could then be described as a project of colonizing the margins of health care with HSW and social work aspects.

9 A Professional Subgroup in Subordination

This concluding chapter provides first a summary and then a discussion of the findings, answering the research questions as presented in Chapter One. The presentation here focuses on the differences found between HSWs' jurisdictional work in Sweden and Germany. Particular consideration is given to the impact particular associational characteristics, the national context, and the overall healthcare organization have on the way the HSWs pursued their jurisdictional work and the strategies they used.

At the same time, certain similarities between the Swedish and the German case also propose themselves for consideration, concerning the general kind of claims and strategies resorted to by HSWs in their jurisdictional work. Both of the two main associations studied claimed HSW to be a fuzzy profession. Members of other professions were perceived as having difficulties in clearly identifying and understanding HSW work tasks and competences. Both associations, furthermore, claimed HSW to lack control over its jurisdiction. Moreover, in both cases, HSW was seen as having an important role to play in health care, in helping to bridge the gap between health care and social welfare. The HSW associations in both countries also, at least implicitly, shared the understanding that politicians, professionals, and legislation had all failed to adequately take into account the social aspects of health care at the organizational and policymaking level, and that HSW therefore had a societally mandated advocacy mission on behalf of patients in health care. In addition, the associations studied also claimed HSW to offer special competences needed to bridge critical gaps between health care and social welfare.

The internal jurisdictional work of the professional associations in the two countries relied on strategies involving the development of collective narratives and standardizing instruments, the definition of professional tasks and skills, and the formal description of HSW as a subgroup of social work. Externally, the associations' jurisdictional work comprised, in both countries, at least attempts to establish formal jurisdiction through legislature, through public regulations, and in workplace settings. This external jurisdictional work also included co-operation, coalition building, and bargaining with a variety of stakeholders as well as an attempt to utilize media in order to be better able to address HSW issues in public.

9.1 Major differences in jurisdictional work strategies

Although, in general, there were certain broad similarities between the jurisdictional work strategies of the HSW associations studied, differences between them were also clear. Generally speaking, the jurisdictional work strategies resorted to by the DVSG can be characterized as offensive in nature, while those employed by the SK could be termed as defensive and adaptive. Associational activities used by a HSW association that aimed at the independent and proactive development of standardizing instruments and written statements, at the inclusion of work task definitions and competence definitions in legislation and other regulations, and at the assertion of proximity in relation to the subgroup's primary profession and discipline are interpreted as indicating the use of an offensive strategy in this dissertation. A HSW association that produced written statements and standardizing instruments reactively, that did not strive for the inclusion of work tasks and competence definitions in legislation and other regulations, and that instead made attempts to assert proximity to professions other than their primary profession, is instead interpreted as using defensive and adaptive strategies.

The table below outlines the differences between the German and the Swedish HSW associations in this study as regards their main goals and the internal and external jurisdictional work strategies they resorted to in order to reach these goals.

Table 6 Major differences in jurisdictional work strategies

Internal and external jurisdictional work strategies	**Germany**	**Sweden**
Supporting members – developing collective narratives	Pronouncing proximity to social work as discipline and profession	Pronouncing distance to social work as discipline and profession
Supporting members – developing standardised instruments and written statements	Proactively Fitting all organizational contexts	Reactively Drafts and recommendations to be adapted to organizational contexts
Supporting members – achieving compliance	Formalised, supportive	Individualised, supportive
Relating to a profession and academic discipline	Social work	Neighbouring professions/disciplines and social work
Affiliating to the social work discipline	Increases over time	Decreases over time

Internal and external jurisdictional work strategies	Germany	Sweden
Cooperating with education and research	Yes	No
Relating to the trade union	As an independent organization	As a dependent organization
Advancing formal protection of professional jurisdiction	Defining HSW tasks & competence in legislations, regulations & job descriptions; Challenges other professions' jurisdiction	HSW licensure; Avoids challenging other professions' jurisdiction
Claims-making – necessity of formal jurisdiction	From a professional logic and patient interests	From an organizational logic and self-interests
Claims-making – specific work tasks and methods	Social case management Clinical social work Advocacy of patient rights	Psychosocial work

Starting from this table, the following sections will describe the different jurisdictional work strategies used by German and Swedish HSW associations in more detail.

Supporting members

The DVSG and the SK are professional associations that can be distinguished by the ways they support their members. There were differences in how the associations dealt with the claimed fuzzy role of the profession in the health care setting. Amongst others, social work education was blamed as causing this fuzziness in Sweden. In Germany on the other hand, fuzziness was instead perceived to be a historically rooted attribute shared by all social workers. It was predominantly the German association that attempted to develop alternative narratives, where HSW was described as strong and prosperous. Differences were also apparent in the way the associations addressed the lack of jurisdictional control of the professional group. Narratives on this claim were frequently expressed in written documents in Germany, while in general they were expressed verbally in Sweden.

The claims that HSW is a fuzzy profession that lacks jurisdictional control were dealt with in different ways. This can be understood to be an effect of major differences between the associations in *developing* and using *collective narratives* of HSW. For example, narratives concerning the history of HSW were referred to and occurred more frequently in German documents

than in Swedish documents. In Germany, these narratives were used to put HSW into a context and to understand problems of the contemporary situation of the professional subgroup as related to the history of social work and HSW. The empirical data used in this study indicates that HSW history was less frequently used to contextualise contemporary HSW in Sweden compared to Germany. Regarding the collective narratives about the contemporary situation of the profession, the German association sometimes used internal investigations of their members' daily experiences in order to corroborate central aspects, such as the description of how insurance companies tried to influence HSWs' inference.

The DVSG and the SK also used different strategies *to support their members*. The SK supported its members face-to-face, in an individualised manner; the DVSG did so in a more formalised manner, in that they prepared documents with recommendations and guidelines for the most important and most recurrent issues. The DVSG also highlighted for its members the necessity for them to advance strategic decision-making forums at work sites predominantly staffed by physicians and economists. For this purpose, the DVSG developed standardising instruments and written statements in order to support their members' argumentation.

Differences between the associations' strategies in Sweden and Germany can be observed when it comes to *the development and use of standardising instruments* for HSW. The SK started to develop standardising instruments for some areas of professional work (e.g. for annual reports, development of statistics and a national policy for HSW quality) earlier than the DSVG did. However, most of these instruments were drafts and recommendations, that allowed members to decide if they wanted to accept these recommendations and whether it was necessary to adapt them for a specific organization or not. In Germany, work with standardising instruments began some five years later. The development of standardising instruments there included a software programme, case-group classifications and a Product- and Service Description of Clinical Social Work, that were all used in order to describe HSW tasks in detail. Standardising tools were developed to fit all sorts of organizations where HSW was performed.

Further differences can be perceived when it comes to the *character and content of written statements*. In Sweden, position-taking written statements were predominantly reactions to draft government investigation reports and specific proposals with specific addressees. In Germany, the use of written statements was comparably more proactive, pointing out specific professional interests, but without any specific addressee. The DVSG also addressed problems in cooperation with public corporative bodies, frictions between professions, remuneration and the allocation of specific work tasks

(e.g. discharge management) directly in official statements issued by the association.

Professional associations in both countries try to *achieve compliance* to associationally established narratives, standards and definitions, using different methods of membership involvement. Major differences concerned members' involvement in the development of professional attributes and their symbolic significance. In Sweden, members were less involved in the development of professional attributes and narratives than in Germany. Face-to-face communication channels within the German association were suited to transporting information up- and downwards as well as horizontally. They were also more defined and routinized than in the Swedish association. Work task descriptions in Germany were developed and revised over several years and members at all levels were involved. In Sweden on the contrary, work task descriptions were developed and refined by the association's board itself.

Even written channels, such as the DVSG journal in Germany, were adapted to transport information up-, downwards and sideward as well as to discuss specific issues. Written information in Sweden was predominantly used for downward dissemination of information on board activities and section activities; discussions on professional issues were not supported in the same way as they were by the DVSG. The information provided by the SK board was limited and, in general, common stances were not explained or discussed with the members. Information to non-members was even more limited, but improved since the launch of the homepage in the beginning of the 2000s. In contrast, the DVSG provided the same information for members and non-members alike, however reserving some strategic documents for members only. Non-members could also be involved in discussions in the association's journal.

The associations in both countries strived to *expand their membership base*. The DVSG did so by integrating former welfare workers from the Eastern German territory, as well as expanding the territory to include social workers from other fields related to health, for example, eldercare or counselling bureaus for drug addiction and disability; the SK instead focused on the expansion of HSW into fields of in- and outpatient health care.

Relating to a profession and an academic discipline

Diverging trends are present in the strength of the *linkage of HSW to the social work profession and discipline*. In general, this linkage between HSW and social work was highlighted more often in official documents in Germany than in Sweden. Moreover, the DVSG strengthened this relation over time: it described its aim as bridging the gaps between health care and social welfare systems. The DVSG explicitly acknowledged the relevance of social

work theory as a knowledgebase for HSW. The SK and the NFS instead expressed a desire to strengthen the tie to health care professions. The subordination of HSW to social work as the primary profession and discipline was not self-evident in the Swedish context; theories from neighbouring disciplines and social work alike were acknowledged as the basis for professional HSW. Terms from social work theory were predominantly used as umbrella terms, subsuming varying theories from other disciplines. Swedish HSWs were, however, reluctant to call themselves social workers. More often than in Germany, HSWs in Sweden struggled with a number of problems that they perceived to be reasons for their hesitation: the lack of journals to publish articles in, few shared professional attributes with other social workers and a lack of professional education that provides specific knowledge necessary for HSW practice.

Efforts to *cooperate with social work education and research* were described more regularly in Germany than in Sweden, and are characterised in different ways. In Germany, cooperation concerned the development of a Master programme in clinical social work and cooperation on specific research projects. In Sweden, difficulties were reported to occur in developing academic further education specific to HSW and contacts between associations and researchers were not often named. Nevertheless, the SK and the NFS in particular often expressed their doubts that social work can deliver a complete and relevant knowledgebase for HSW education. They also stated more often than their German colleagues that they were not satisfied with the existing advanced courses for HSWs.

Relation to trade union

Major differences are also apparent in the relation between the professional association and the trade union in both countries. In Germany, cooperation was perceived to be the exchange of mutual interests on equal terms. The DVSG and the trade union applied mutual membership, meaning that their members were partly eligible for benefits from the other organization. Cooperation occurred on national, federated-states and local level alike and included the arrangement of seminars, conferences and the common development of written statements on specific strategic issues. Associational statements were passed on via multi-professional advisory boards, public corporative bodies, and representatives in committees or, in very rare cases, were passed on directly. Therefore, the DVSG perceived its capacity to impact on policymaking to be limited. A dependency on the trade union was not described by the DVSG.

Cooperation between the SK and the trade union in Sweden, however, was more often described in terms of the dependency of the SK on the trade union. This concerned a variety of aspects including; the access of the trade

union to state administration and its role as an advisory panel for public and state administration, as well as its size and economic strength (resulting in greater resources in terms of employed staff and infrastructure). In particular during the 1990s, the SK described its relation to the SSR as strained, partly because formalised and recurring forums for communication, participation and representation of HSW issues were absent. Therefore, the SK also perceived its possibilities to impact on health care policymaking to be limited by trade union interests from time to time.

Advancing formal protection

Further differences can also be identified in the jurisdictional work strategies used to *advance formal protection* in legislation, public regulations, job descriptions etc. Different sorts of legislature were in focus for the integration of HSW in health care. HSW associations in Sweden predominantly strove for jurisdictional protection by licensure. Simultaneously, efforts were made to integrate HSWs treatment and responsibilities into other laws concerning health care side by side with licensed professions. No perceivable efforts however were made to achieve the inclusion of social work interventions in The Health and Medical Services Act.

In Germany on the contrary, licensure was not yet identified by the DVSG as a possible option. Instead, all efforts have focused on inscribing requirements for social services into general health care legislation on the federated-states level, for example, Hospital Laws at the federated-states level and the Social Code at the national level. Attempts to integrate social services into hospital legislation at the federated states level concerned two primary areas: the inscription of social services in general and more precise description of requirements concerning professional competences and caseloads. The existence of social services in health care was at least partially protected in some work fields, especially after 2002 on the national and federated-states level. However, legislation in most cases did not identify specific professional competence requirements needed to provide these services. In other cases they named nurses, social workers, an health insurance administrators or nurses, alike.

Differences are also apparent in the efforts spent by the associations to impact public regulations. Efforts by the SK have been constant since the beginning of the 1990s; in Germany associational efforts have increased since 1996. Since then, the DVSG also increased its efforts to establish communication and information channels with those public corporative bodies involved in the development of public regulations. However, the issues addressed by public regulations differ in Sweden and Germany.

The way that the two professional HSW associations bargain with other professions on work tasks and fields differs in terms of what is bargained on,

when bargaining occurs and whether the bargaining strategy can be perceived to be aggressive or defensive. In Sweden, such negotiations occurred predominantly during the 1990s, while in Germany they have been on-going since about 1996. In the long run, these bargains were performed in order to settle disagreements on specific jurisdiction. The main controversies have concerned social case management in Germany and psychosocial counselling in Sweden. However, the SK has avoided challenging other profession's jurisdiction. Claims made by the DVSG on the contrary are more aggressive and aim at the subordination of nurses concerning the performance of specific work tasks in case management.

Claims-making

The SK and the DVSG claimed that there were several reasons for the *necessity of formal jurisdiction* for the profession. The associations argue that social welfare and health care have mutual impact. However, examples of arguments by the SK concerning the mutual impact of social factors and health decreased throughout the investigated period, while they increased in number in Germany.

Politicians, health care professionals and legislation have been accused of failing to give consideration to the social aspects of health and disease in both countries. Associations in both countries have argued that failure to consider social aspects of health care affects health care production. The SK primarily argued that the inclusion of social aspects would increase both effectiveness of health care and the status of HSWs. The DVSG on the other hand identified specific consequences of this failure in health care: patient rights were neglected and the health care that was provided was incomplete, ineffective and unethical. These claims were often underpinned by 'facts and figures' based on evidence from HSW practice. The involvement of HSW-specific competence and HSW's advocacy mission are factors, which the DSVG highlighted as useful for addressing these problems.

Consequently, it has been claimed that it is necessary to include HSW perspectives in health care policymaking and to formally protect the profession's jurisdiction. Since the mid-1990s, the DVSG has claimed that it is necessary for them to be involved in health care policymaking, in particular in the preparation of new legislation for the health care area. Occurrences of this claim have increased over time and have coincided with legislative and public administrative activity, for example when it comes to remuneration laws and schemes as well as other legislation. The SK has claimed that there is a need for it to be included in advisory boards as well as in legislative reforms predominantly when it comes to licensure. These claims were raised in Sweden during the mid-1990s and increasingly during the 2000s.

In other words, Swedish arguments concerning the effectiveness of and the social status of the profession have primarily followed organizational logic and self-interests for the establishment of formal jurisdiction for the professional subgroup. Social work specific competences were predominantly raised implicitly. Arguments for claiming formal jurisdiction by the DVSG concerning specific competences and advocacy mission primarily followed professional logic and patient's interests. Arguments playing on subgroup specific interests in Germany were exclusively raised in the very beginning of the 1990s.

Both the DVSG and the SK argued that HSW is a suitable profession to bridge the gap between the health care and the social welfare sector by claiming the use of *specific social work tasks and methods*. While the importance of this claim rose over time in the German context, it seems to have declined since the mid-1990s in Sweden.

Opposite trends can be perceived when it comes to claiming specific HSW competences in Swedish and German HSW. While the importance of social case management in Swedish HSW diminished continually, it increased in Germany; the opposite applies to psychosocial work. Swedish work task descriptions tended to be focused on treatment, while descriptions by the DVSG more evenly addressed diagnostic and treatment tasks.

In Germany, social case management, clinical social work and psychosocial work were mainly described as applied methods. Arguing for social case management can be perceived as stressing the 'otherness' of social work competences compared to those competences of other health care professionals, as it focuses on individual and structural social work. The DVSG disputed specific social case management competences on a structural level for the integration of social work in legislative and public regulative processes, but also in newly developing service structures in the German health care setting. The profession's obligation to address dysfunctional legislative structures was even pointed out. In order to increase the sustainability and credibility of this argument, the DVSG displayed this competence in specific aspects of legislation by aggregating evidence from practice on specific individual patient problems on a structural level.

Clinical social work on the contrary can be understood as signalling the readiness of social work to integrate into the health care setting, focussing on predominantly individual social work. The DVSG also often claimed that advocacy is a necessary social work method in individual cases and at the structural level. Predominantly since 1996, it has claimed that social work has a professional mandate to represent patient interests. Reoccurring cooperation with diverse patient organizations in Germany can be understood as a possibility to claim the profession's skills in advocacy.

In Sweden on the contrary, the description of specific HSW techniques or methods, as well as argumentation were often posed in general terms by the SK, with HSWs being social experts, having a broad knowledgebase from a variety of disciplines. The SK also argued that it is necessary to overcome sectorial gaps. However, arguments touched exclusively on the individual level. Psychosocial treatment was the foremost competency that was claimed to be suitable to social work in health care, where focus lies on social work treatment at the individual level. The SK claimed advocacy, however, this claim was also restricted to the individual level.

This focus on individual health problems can be perceived as a useful strategy that aims to facilitate the assimilation of the professional subgroup to other health care professions, rather than demarcating HSW competence from that of health care professions. At the same time, focussing on the individual level in HSW can be interpreted as reducing the range of HSW tasks and decreasing the claimed range of professional jurisdiction. The association primarily drew on knowledgebase arguments; however, little efforts were made to underpin the sustainability of this claim of HSW's necessity in the health care sector with specific arguments from practice.

9.2 Mimetic and aposematic strategies in jurisdictional work

HSW in Sweden and Germany is an example of a professional subgroup in subordination, both in relation to the profession and within the multi-professional settings they work in. Based on the summary above, the jurisdictional work performed by HSW associations in Sweden and Germany can be interpreted as following two different strategies. These strategies can be described as resembling two typical cases of jurisdictional work strategies; the mimetic strategy and the aposematic strategy. In this dissertation these terms, which originate from zoology, are used to describe the contrasting ways that subordinate professional subgroups present themselves in relation to the profession's own disciplinary background and to the hosting organizational multi-professional setting.

Using a *mimetic strategy* in jurisdictional work means that a professional group tries to camouflage itself as an equivalent part of the hosting multi-professional setting. Much like turbots and other flatfishes, professional groups that use this strategy try to blend into their surroundings. Professional groups that choose this strategy make a variety of efforts in order to imitate the hosting organizational setting as much as possible. HSW in Sweden, one of the cases examined in this dissertation, is an example of a professional subgroup that pursues a mimetic strategy by assimilating to the professional groups of the hosting healthcare setting as much as possible. In

this case the surrounding hospital context is imitated in order to present the own professional group as pars inter pares.

In using an *aposematic strategy* in jurisdictional work, a professional group tries to stand out and demonstrate its otherness from the hosting multi-professional setting as much as possible. Like wasps, they try to contrast themselves from their surroundings in order to alert other professions within the multi-professional team and prevent them from intruding into their professional territory. The case of German HSW resembles this example of pursuing an aposematic strategy by pronouncing the profession's differences from the host setting. The following table shows the major characteristics of the mimetic and aposematic strategies applied to the jurisdictional work of professions.

Table 7 Mimetic and aposematic strategies

	Mimetic strategy	**Aposematic strategy**
Claimed proximity to knowledgebase	Disciplines in the host setting	Primary profession's discipline
Subgroup specific collective narratives	Developing relation to professions in the host setting	Upholding relation to the primary profession
Collective group identity pronounces	Team related group identity	Profession related group identity
Claims for formal jurisdiction follow	Organizational logic	Professional logic
Cooperation with education/research/trade union of the primary discipline are perceived as	Cumbering	Supportive

In pursuing a *mimetic strategy*, a professional subgroup pronounces the differences from the original disciplinary base and proximity to the knowledgebase of those disciplines dominating the organizational host setting. This concerns a variety of aspects of jurisdictional work. In internal jurisdictional work, this means that professional associations use strategies to develop a collective professional identity for the subgroup based on the hosting work field. Team-specific collective identity is pronounced instead of profession-specific collective identity. In order to achieve this, differences from the subgroup's original disciplinary background, its knowledgebase, theoretical background and skills are pronounced, and proximity to the host setting's

knowledgebase are highlighted. Narratives are developed in order to distinguish the professional subgroup from its own professional background and instead relate the subgroup's identity to the hosting work field. The subgroup's association furthers the claim and use of skills that help to develop a subgroup-specific professional identity, which facilitates this blending into the surrounding organizational setting. The importance of being a member of the multi-professional team may be more pronounced than the subgroup's ability to precisely define how HSW skills differ from those of other professions within the setting.

When it comes to external jurisdictional work strategies, a mimetic strategy implies that the professional subgroup strives to achieve legislative prerequisites that are equal to the other professions in the hosting setting, for example, licensure. Equal status is also attempted in public regulations. Therefore, efforts are made to integrate the professional subgroup into existing policymaking structures in the host setting. In order to achieve this, the subgroup claims the use of skills, which are perceived to be suitable for the host setting. Therefore, used arguments facilitate the blending of the professional subgroup into the surrounding organizational setting in that they follow the organizational logic of the host setting or those of professional self-interests. The subgroup is presented as an avatar of the host setting. Cooperation with the subgroup's primary discipline, its education and research may be perceived as difficult as they may not support the externally raised claims by the subgroup that were discussed earlier. The relation to the trade union may also be perceived as cumbering on the same grounds.

In pursuing an *aposematic* strategy, a professional subgroup pronounces similarities and proximity with its original disciplinary base and the many ways it distinguishes itself from the disciplines that dominate the host organizational setting. Using internal jurisdictional work, the professional association of the professional subgroup attempts to develop a collectively shared professional identity that pronounces the affiliation between the primary discipline and the professional subgroup. The appropriateness of the primary discipline's knowledgebase, its theories and methods are highlighted and narratives that uphold the relation to the profession's origins are developed. A precise definition of the features that distinguish the professional group's work tasks from other professions' work tasks in the host setting are encouraged and promoted. Members of the subgroup are also empowered to maintain this external position through the development of supportive argumentative tools and definitions.

External jurisdictional work following an aposematic strategy also strives for the equal inclusion of the own subgroup into the legislative framework and public regulations of the host setting, not necessarily by claiming licensure. Efforts may be made to include the subgroup in existing policymaking

structures and, where necessary, to develop new forums that are more appropriate for lobbying and impacting on policymaking. It is claimed that the professional subgroup is necessary in the host setting. These claims describe aspects of the subgroup's skills and tasks in detail for outsiders, highlighting specific distinguishing factors that are different to those of the other professions in the setting. Arguments that are used primarily follow the original logic of the social work professions, but the hinge of the argument lies in the professional logic of the health care setting. Efforts may have to use the primary discipline's education and research to promote arguments presented in external jurisdiction; cooperation with the trade union is more likely to be perceived as supportive rather than cumbering. The performance of work tasks in local host settings is perceived as a way to present the professional competences of HSW and to corroborate the claims that are raised.

However, it must be pointed out that external jurisdictional work is dependent on the national context of where it is performed. Targets and numbers of contacts that have to be made in order to impact on policymaking may differ widely, as well as the chosen legislative settlements. The decision to choose a specific legislative settlement as convenient and appropriate may also change from time to time and is not independent from the chosen strategy of jurisdictional work. The decision to attempt licensure for example is specific to neither the mimetic nor the aposematic strategy, but instead seems to be dependent on the contextual circumstances.

This can be exemplified by referring back to HSW in Germany and Sweden. Efforts to include HSW in relevant legislation have been on-going since 2008. Major changes are at hand both in Sweden and in Germany. In Sweden, lobbying policymakers for licensure has at last been successful. Swedish HSWs have been promised future licensure on the basis of an advanced social work programme focussing on social work in health care. If future negotiations are settled in this direction, a minor number of social workers will achieve licensure, while a majority will still lack licensure. This can be interpreted as the success of HSWs' efforts to assimilate to the hospital context in Sweden, it could also be interpreted as widening the gap between HSW and social work.

In Germany, changes are also forthcoming; changes will concern the association's strategy for achieving the legal protection of social work tasks in health care. Independent expertise was requested in order to help the association with its decision. Currently, members are invited to vote for either pursuing a strategy aiming at the accreditation of HSW as a health care profession or a strategy aiming at licensing social work. A decision in favour of accreditation as a health care profession could possibly stimulate the development of mimetic jurisdictional strategies in the future. In the long run, this might initiate the evolution of a gap between the general social work

discipline and social work in health care settings. A decision favouring licensure as a social work profession on the other hand is likely to strengthen the relation between social work in health care and social work in general.

9.3 Significance of associational characteristics for jurisdictional work

Some characteristics of professional associations are likely to be significant for the choice of jurisdictional work strategies. Internal preconditions such as size and economic strength, as well as characteristics such as associational landscape and relation between the association and the trade union may impact on whether a professional association chooses a mimetic or aposematic strategy for its jurisdictional work.

As noted earlier, the associations in Sweden and Germany differ in terms of *size and economic strength*. In terms of total membership numbers, the DVSG is nearly five times as big as the SK. Counting members and representatives in board, advisory board, sections and regional work groups, the DVSG also had two times as many active members in the beginnings of the 1990s and more than five times as many in 2008. Associational income goes hand in hand with membership numbers, which impacts the economic strength for jurisdictional work.

Differences in associational size and economy can impact on an organization's ability to perform jurisdictional work in a variety of areas. Internally, big organizations are more likely to have greater capacity to provide a broader variety of services to their members than small organizations. This can include for example, publishing professional journals, providing formalised support on professional issues for members and the ability to collect and aggregate information from members at a central associational level. This requires, however, intensive information transfer on and between all levels of the organization with well-developed information channels and routines. Smaller organizations may have less capability to routinize and perform large numbers of lobbying activities or to hold meetings with a great number of stakeholders and multiple representatives in legal and executive arenas. The number of active members within an association effects the sophistication of associational argumentation where this is perceived to be a requirement of associational success. In combination, all of these aspects impact on a professional association's possibility to distinctively represent the interests of professional subgroups. It is plausible that these factors also influence the profession's resources for developing a sustainable collective professional identity for the subgroup, to the extent that this impacts the associations' ability to represent the subgroup externally. This may therefore also contribute to the use of opposite jurisdictional strategies by German and Swedish associations. It is likely that choosing an aposematic

rather than a mimetic strategy requires a higher amount of associational activity in order to communicate information concerning the distinguishing aspects of a professional group to the other professions within the hosting setting, as well as inside the professional group and the profession in general. It may therefore be easier for professional associations with a larger number of active members and employed staff, such as the DVSG, to pursue an aposematic strategy than an association without employed staff and with a small number of active members, such as the SK.

Associational landscapes and associational relations to the trade union differ in Sweden and Germany. In Sweden, the landscape of professional bodies for HSW can be characterised as dispersed. It is likely that the fragmented representation of very limited and specific HSW interests by a variety of small professional bodies limits broad jurisdictional work moves for the whole professional subgroup. Delegating the representation of more general HSW interests to an advisory board subordinate to a trade union with larger resources (in terms of number of members, economic resources and contacts in state administration) simultaneously implies on the one hand that the professional group gets access to the possibly stronger associational tools of the trade union. On the other hand, it implies the subjugation of the specific interests of the professional group to the more general interest of the whole profession and other interests of the trade union. In consequence, passing on written statements on government investigation committee reports via the trade union, as is usual in Sweden, may lead to difficulties for the professional group in raising professional interests that diverge from trade union interests. This in turn could impact the association's tendency to dissociate HSW from social work, claiming that they share only few professional attributes with other social workers. The fact that representation of HSW interest is dispersed and that the SK did not always perceive the trade union as taking the professional group's specific interests into consideration in choosing trade union strategies in jurisdictional work, could have impacted the SK's choice of a mimetic instead of an aposematic strategy for Swedish HSW. Additionally, even work routines for the SSR's advisory board could impact on the SK's possibilities to involve members in decision making when it comes to official statements and the development of definitions for the whole professional group. Therefore, the use of an aposematic strategy by the association could be more difficult to uphold within a professional group when resources for membership involvement are scarce. Perceived difficulties in contacts between social work researchers and scarcity of contacts to other organizations aiming at the improvement of the relation between social work theory and practice may have even contributed to the choice of the mimetic strategy.

In Germany on the contrary, the associational landscape can be defined as dense. There, the DVSG is the only professional association that represents HSW interests; including both specific and general HSW interests. Additionally, and in contrast to Sweden, interest representation is not delegated to the trade union. The relation between the trade union and the DVSG can instead be characterised as independent because, in comparison to the SK, the DVSG has resources at its disposal that are relatively equal to those of the trade union. As in Sweden, the German trade union also represents professional groups who are rivals to HSWs for jobs in health care social services. However, they do cooperate on specific issues and both organizations have agreed on mutual membership in each other's organizations. Meanwhile, independency from the trade union increases the possibilities for small professional subgroups such as HSW in Germany to announce their specific interests, needs and stances more freely in their contact with the state, public administration, rivalling professions and academia. A more dense and trade union independent professional associational landscape, in combination with more regular contacts with the professional subgroup's primary discipline, it's education and research as described for the German case, makes it easier for professional subgroups to choose an aposematic jurisdictional work strategy.

The associational characteristics named above explain only minor aspects of why HSW associations in Sweden and Germany use mimetic or aposematic strategies for their jurisdictional work. Other potentially impacting factors are presented below. The interrelation between the jurisdictional work strategy used and these aspects, though, remains to be clarified by future research.

First, the impact of historical aspects on the professionalization strategies that are used can be discerned from the historical facts presented in this study. Siegrist (1996) suggests that history is an important part of professionalization. During the years of the foundation of the SK and Swedish hospital social work, disputes had already arisen concerning the question of whether basic competence in social work or nursing was preferable for HSW. German research from the early years, however, did not make similar considerations. The occurrence of such disputes about required professional competence in the early history of a profession may be interrelated with the profession's choice of mimetic or aposematic strategies at a later point of time. However, the impact of historical factors could only be described by more extensive research, investigating the roots of HSW in the beginning of the 20th century.

Second, the present study raises the question of whether gender factors impact on choice of jurisdictional work strategies. The presentation of the associations in Chapter Five touched on the gender composition of the as-

sociational bodies. The SK was presented as consisting of women only. The gender composition of the DVSG changed from being male dominated in the beginning of the 1990s to being women dominated in the end of the 2000s. The question can be raised whether the gender composition of the associational bodies impacts on jurisdictional work in general and chosen strategies and achieved results in legal jurisdiction in especial. Research by Hughes (2010), mentioned earlier, on the existence of gendered professional strategies in legal and public policymaking forums in British health care might suggest such an interrelation. She states, for example, that organizational members in policymaking forums are eager to conform to gendered role expectations, such as men showing their competence and credibility by talking, with women doing so by achieving the right balance between talk and non-talk. Results from her research also indicate that gendered role expectations in these policymaking bodies tempt women in subordinate positions to use defensive strategies when speaking, while males in subordinate positions use challenging strategies.

Therefore, this raises the question of whether men in representative professional positions, such as the DVSG, are more likely to act in a proactive, offensive and challenging manner, while women are more likely to choose reactive and defensive behaviour? As a consequence, the use of more offensive behaviour by male professional representatives or reactive/defensive behaviour by female professional representatives may have some impact on the choice of jurisdictional work strategy for the professional group. The significance of gender in choosing and using specific jurisdictional work strategies still remains to be investigated.

9.4 Significance of contextual characteristics for jurisdictional work

Regardless of profession, external structural characteristics such as organizational setting, or national contexts for the whole profession, also impact on the choice of jurisdictional work strategies. It has often been discussed in literature that political interests determine various professions' destinies to different extents (see e.g.,Alaszewski 1995, Kuhlmann et al. 2009, McClelland 1990, Starr & Immergut 1987).

Research in the health care setting focuses to a large extent on doctors or nurses. In both cases, the professions are either dominant in terms of numbers or professional authority in comparison to HSW. For both professions, the health care setting is the main arena for professional performance. HSW, in contrast, is a minor subgroup of social work, it is also a subordinate profession and, as a social science profession, it is a stranger within the host health care setting. Therefore, the range of strategies and possibilities to perform jurisdictional work that are available to professional subgroups in

subordination, such as HSW, might differ from those of the majority of health care professions in the health care setting. Results from this study suggest that differences in jurisdictional work could plausibly be due to differences in health care organization and national contexts as well.

Sweden and Germany differ in terms of their state governments. Sweden has a centralised government, while Germany has a federal government and delegates detailed health care policymaking, health care organization and administration to the authority of the federated states. The organization of health care governance impacts on the choice of jurisdictional work strategy of HSWs as well. Fewer representatives are necessary to lobby and gain access to the centrally organized and governed health care in Sweden, than to the federally governed health care in Germany, were national and federated states' governments must be addressed separately. The number of actors that must to be lobbied and negotiated with also increases when direct access to policymaking bodies is lacking. Additional welfare state characteristics such as corporatism result in an increase in the amount of necessary contacts as well. Documents show that the DVSG lobbies and negotiates with a large number of different actors in varying self-governing bodies at the federated state-level and national level. The SK on the contrary concentrates on a few strategic actors in the centralised state. Together with the differences concerning strength, economic and human resources mentioned earlier, health care organizational and national contexts could explain an association's choice of strategy.

The impact of state government structures on professional subgroups' choice of jurisdictional work strategy is most likely increased when health care providers and funders are members of public self-governing legal bodies, with public administrative and governing tasks, as in Germany. This is also the case when both providers and funders staff these positions independently from state influence and predominantly with representatives from a professional background in medicine. It is feasible that professional action in German social policymaking in self-governing bodies is more independent from the national and federated state intentions than in Sweden. For the choice of jurisdictional work strategies by HSW in Germany, this in turn means that effectively pursuing an aposematic strategy implies that extensive human and economic resources are necessary. However, diminished political influence paired with continuing medical dominance in policymaking forums can partly explain why rather intensive jurisdictional work efforts have had little effect on the formal protection of HSW, or the numbers of social workers employed in hospital settings.

When representatives from diverse professions are integrated into state administration by their employment, as in Sweden, the majority are health care professionals. Their actions in turn could, to some degree, be perceived

to be more influenced by political intentions. Even in Sweden, social work representatives are scarce in government structures for health care. For the choice of jurisdictional work strategy by HSW in Sweden, this implies that pursuing a mimetic strategy can be perceived to be the least resource consuming option, given this specific context. Politicians' possibilities to influence the health care organization on the other hand might partially explain why the choice of jurisdictional work strategy by the SK shows considerable effects on HSW, as measured by the number of HSWs employed in hospitals.

Since the beginning of the 1990s, social policy development in both countries has focused on cost containment; however, social policy strategies have differed. Generally speaking, health care and social welfare legislature in Sweden can be understood to aim to clearly delegate responsibility for health care production to counties and social welfare production to municipalities. In Sweden, legislative reforms since 1992 have focused on refining the separation between social welfare and health care structures.

Hence, professionals working at the interface between these sectors may believe that it is necessary to prove their eligibility to other professions in the welfare sector that they are actually employed in. Proving this affiliation to the health care sector and health care professions may therefore be the foremost reason why some HSW associations choose a mimetic strategy. Using the mimetic strategy could support HSWs' argumentation for employment within the health care context. Arguments focussing on the individual social work level, paralleling individualised medical services, namely psychosocial work, could be perceived to be fruitful in order to strengthen the professional group's jurisdiction from a Swedish perspective. Simultaneously, claims concerning structural work have decreased continually, as they are perceived as less successful in upholding the integration of social work in the Swedish health care system. Inconsistencies concerning the relevance of the social work knowledgebase for HSW can be perceived to be related to whether it is argued that social workers in health care should to be subsumed as health care professionals or not.

The mimetic strategy could also aid understanding of why HSW associations in Sweden focus on expanding within county organized health care, as expansion into these areas underpins the definition of HSW as a health care profession from an external point of view. An advanced effort to instead expand into health care services governed by municipalities and the state could confirm the perceived 'otherness' of HSW as a social welfare profession by other health care professionals.

Legislation in Germany focussed on cost-containment and integrating social welfare and health care services for its citizens since the beginning of the 1990s, and diminishing the power of funders and providers in self-government since the beginning of the 2000s. The intention to integrate health

care and social welfare sectors in Germany may therefore be the most important reason why the DVSG has chosen to pursue an aposematic strategy in its jurisdictional work. For HSWs in Germany, it can be perceived that it is more plausible to present the profession as a professional group that can integrate social work and health care by representing the social work profession within health care. From a German perspective, claims on structural social work, namely social case management and clinical social work, are reasonable for the implementation of legal reforms within the welfare sector. Claims on psychosocial work have simultaneously decreased. Additionally, the intended integration of health care and the social welfare sector makes it feasible for the DVSG to expand health care social work beyond traditional health care fields such as eldercare, care for the disabled and private health social work.

Like associational characteristics, these characteristics of the welfare state and health care structures only explain the use of aposematic and mimetic jurisdictional work strategies to a minor extent. Thus, this study cannot explain a large part of the variation in jurisdictional work strategies. Other aspects that might be related to the different choices of jurisdictional work strategies could contribute to a deeper understanding.

It is thinkable that professional self-esteem and self-perception is based on the initial professional socialisation that happens during undergraduate education. Additionally, future employers' expectations concerning the competence and employability of recently examined social workers may impact on professional training and initial socialisation. Swedish public administrations as employers, for example, may have different expectations of future social workers in terms of their loyalty to policy decisions, compared with politically independent welfare organizations in Germany. Such differences in initial professional socialisation could in turn impact on whether a profession or professional group fosters a more defensive, rather than offensive, style of interaction with the employing organization. In the long run, initial professional socialisation may therefore impact on the use of particular jurisdictional work strategies by specific professions and professional subgroups. More research, however, is needed to understand the significance of professional education for the choice of jurisdictional work strategy.

A closer analysis of the relation between trade unions and professional associations, and their common relation to the state, should be the subject of further investigations as well. Such an analysis might illuminate more precisely the ways in which this interrelation impacts on the choice of jurisdictional work strategy. This study only presents initial indications of such possible effects.

9.5 Concluding reflections

Some conclusions for practice and knowledge development can be drawn from this study. These conclusions touch on three different areas in particular: the significance of using a comparative method, the importance of the context for professions and the importance of language. The importance of language is superordinate to the other areas, but will be touched on later, mainly for pedagogical reasons.

Do jurisdictional work strategies make a difference?

In Chapter One, it was pointed out that this study lacks evaluative intensions. Nevertheless, results from this study may be used to reflect on the suitability of mimetic and aposematic strategies for reaching specific formal jurisdictional goals. Results from this study can also be used to reflect on whether the use of one jurisdictional work strategy over the other makes a difference for the legal jurisdiction achieved in both countries.

In Germany, the DVSG had some success in integrating HSW tasks and the HSW professional title in a number of legislations on federal and federated states level and in public regulations concerning welfare in general and health care in specific. In Sweden, the SK and the VKF succeeded in integrating social work aspects in some health care legislation and public regulations as well. So far, none of the used strategies led to licensure or any more stable form of legal jurisdiction for HSW. Even if the German associations were able to define specific tasks and, in some cases, achieved inclusion of the professional title in legislation and public regulations by using an aposematic strategy, this can only be perceived as a partial and relatively unstable success. Other professions may still claim the performance of specifically defined work tasks and other professions' protected titles are named alongside social work in these specific legislations and regulations. However, using a mimetic strategy in Sweden, the SK and the VKF have so far achieved even weaker professional protection in legislation and public regulations. By working for the inscription of social aspects into legislation and regulation of the health care field, health care professions are free to define the performance of specific professional interventions, as well as the necessary professional competence required for the treatment of these social aspects. Neither mimetic nor aposematic strategies have led to licensure so far, however future developments may show the effects of using specific jurisdictional work strategies in specific contexts in the longer run.

Significance of comparison, context and language for the study of professions

During the course of this research it became more and more apparent that the cross-national comparative approach itself is of major relevance, both

from a methodological perspective as well as from a theoretical perspective. Cross-national comparison served as a necessary tool to discern differences in professionalization and the impact of the context. As a consequence of this, the comparative nature of this study has had an important influence on the development of new knowledge. Without a comparative approach, different jurisdictional work strategies would not have been identified as important aspects of the empirical data. Therefore, the cross-national comparative method can also be claimed to be important for the further development of theory on professions.

Secondly, this study shows that research must pay attention to the context in which professions perform their jurisdictional work. The context supplies a variety of possible explanations for performed jurisdictional work and finally achieved professionalization. In other words, the context has shown to be an important variable for practical professional work and for the development of knowledge on professionalization. This concerns the performance of particular professional work by a profession in a specific setting, as well as the knowledge on professionalization in general and jurisdictional work strategies in particular.

Finally, language proved to be of great importance while collecting and analysing the data, as well as when writing this thesis. The intimate interrelation between language and context becomes especially evident in conducting cross-national comparative studies. Of course, this intimate relation between context and language exists in all sorts of social science research, but it becomes especially evident during cross-national comparative studies. A profound understanding of the language used is essential in order to understand the importance of the context, as well as linguistic differences and similarities. It is not possible to describe newly developing knowledge and its contextualisation without using language. Describing newly emerging context-dependent knowledge in a context-independent way therefore seems to be the real challenge in cross-national comparative studies.

Experience from carrying out this cross-national study also indicates that a profound understanding of languages used in different national contexts is essential for perceiving differences in detail. This concerns more than the linguistic level of language use. Recognising and transferring the specific context-bound meanings that words and terms carry in the original languages of the empirical data, into the language in which research results are presented raises its own challenges. The language in which the results are presented also has context-bound connotations. Authors (in translating information) and readers (in interpreting the text) share a common responsibility to consider this context-bound linguistic challenge, which is immanent to the interpretation of research results.

Swedish summary – svensk sammanfattning

Syftet med avhandlingen är att beskriva, analysera och jämföra vilka strategier sjukhuskuratorers professionella organisationer använder i Tyskland och Sverige mellan 1989 och 2008 för att professionalisera yrkesgruppen i termer av jurisdiktionsarbete. I fokus för denna avhandling är huvudsakligen två yrkesorganisationer för sjukhuskuratorer: Deutscher Verband für Soziale Arbeit im Gesundheitswesen e.V. i Tyskland och Svensk Kuratorsförening i Sverige.

Jurisdiktionsarbetet beskrivs som en pågående process som drivs av professionella organisationer. Dessa strävar efter att etablera eller upprätthålla en formaliserad professionell jurisdiktion både internt (inom den professionella gruppen) och externt (gentemot stat, offentliga förvaltningar och enskilda sjukvårdsorganisationer). Forskningsfrågorna fokuserar på tre aspekter: för det första, *vilka strategier* använder de ovan nämnda yrkesorganisationerna för att främja gruppidentitet för sjukhuskuratorer och deras professionalisering; för det andra, med *vilka argument* gör de anspråk på kuratorers existens inom sjukhusen; och för det tredje, *vilken betydelse* har professionsinterna och kontextuella faktorer för valet av specifika professionaliseringsstrategier.

Sjukhuskuratorerna används som ett intressant case – en specialiserad professionell undergrupp som utför sina arbetsuppgifter i en kontext, där professionen statusmässigt och antalsmässigt är underordnad andra sjukvårdsprofessioner. Dokument från huvudsakligen ovan nämnda yrkesorganisationer från perioden 1989–2008 ligger till grund för undersökningen. Två kompletterande fokusgruppintervjuer med medlemmar från dessa två organisationer ingår i det empiriska materialet.

Avhandlingen använder sig av ett teoretiskt ramverk för att analysera och jämföra resultaten som inkluderar professionsteori (Abbott 1988, 2005), sociologisk identitetsteori (Jenkins 2004), argumentationsanalys (Karlsen 2012) samt compliance-begreppet från organisationsteorin (Etzioni 1961).

Resultaten visar att det finns betydande skillnader mellan de tyska och svenska professionella organisationerna när det gäller jurisdiktionsarbetet. Dessa skillnader omfattar aspekter som

- vilket stöd medlemmarna får i att hävda anspråk på professionell jurisdiktion lokalt
- relationen till det sociala arbetets kunskapsbas och till socionomernas fackliga organisation
- vilket skydd professionsgruppen strävar mot i lagstiftningen

Det finns indikationer att interna aspekter (t.ex. den professionella organisationens storlek och resurser) och externa aspekter (som nationell kontext, hälso- och sjukvårdens styrning och organisering och den underordnade positionen den professionella gruppen har gentemot socialt arbete och hälso- och sjukvårdsprofessioner) påverkar vilka strategier som väljs i jurisdiktionsarbetet.

Resultaten pekar mot att professioner i en sådan position som sjukhuskuratorerna kan välja mellan åtminstone två strategier i jurisdiktionsarbetet. Den *mimetiska* strategin som används av svenska sjukhuskuratorer för att professionen ska ”smälta in” i sjukhuset (värdorganisationen). Det görs genom att man hävdar den professionella gruppens närhet till värdkontexten, bl.a. när det gäller kunskapsbasen, den professionella identiteten och relationen till en akademisk disciplin. Relationen till moderprofessionen (i det här fallet socialt arbete), den akademiska utbildningen och den fackliga organisationen uppfattas däremot som hindrande.

Tyska sjukhuskuratorer använder snarare en *aposematisk* strategi, där man försöker urskilja den egna professionella gruppen så mycket som möjligt från sjukhuskontexten. Detta görs genom att man hävdar närheten till professionen socialt arbete när det gäller t.ex. kunskapsbas, professionell identitet och relationen till det akademiska ämnet. Relationen till socialt arbete, dess utbildning och till den fackliga organisationen beskrivs till övervägande del som positiv.

German Summary – Deutsche Zusammenfassung

Ziel der Dissertation ist die Beschreibung, Analyse und der Vergleich von Strategien, die die fachlichen Organisationen der Krankenhaussozialarbeit in Deutschland und Schweden zwischen 1989–2008 benützen, um die Professionalisierung oder genauer gesagt die Jurisdiktionsarbeit ihrer Berufsgruppe zu betreiben. Die hauptsächlich untersuchten Berufsverbände sind die Svensk Kuratorsförening in Schweden und der Deutsche Verband für Soziale Arbeit im Gesundheitswesen e.V. in Deutschland. Als Jurisdiktionsarbeit wird dabei der fortlaufender Prozess bezeichnet, mit dem berufsfachliche Organisationen die Entwicklung und den Erhalt einer professionellen Jurisdiktion intern und extern anstreben.

Die Forschungsfragen richten die Aufmerksamkeit auf drei Aspekte: Erstens, welche Mittel verwenden die genannten Organisationen in Deutschland und Schweden um eine gemeinsame Identität für Krankenhaussozialarbeiter und deren Professionalisierung zu fördern; zweitens, welche Argumente führen Krankenhaussozialarbeiter für die Notwendigkeit ihrer Existenz im Krankenhauswesen an; und drittens, welche Bedeutung haben professionsinterne und kontextuelle Faktoren für die Wahl von Professionalisierungsstrategien dieser Berufsverbände.

Die Fallstudie bedient sich eines internationalen Vergleichs, um die Jurisdiktionsarbeit von Krankenhaussozialarbeitern, zu untersuchen. Diese stellen sowohl innerhalb der Sozialarbeit, als auch innerhalb des organisationellen Kontexts im Krankenhaus eine Minderheit dar. Dokumente aus der Zeit zwischen 1989 und 2008 von den zwei oben genannten Berufsverbänden, sowie zwei Fokusgruppeninterviews mit Vertretern der Vereinsvorstände bilden die Grundlage.

Theoretische Basis für die spätere Analyse bilden Theorien der Professionssoziologie (Abbott, 1988, 2005), der Identitätssoziologie (Jenkins 2004), der freiwilligen Compliance zu Organisationen (Etzioni 1961) sowie der Argumentationsanalyse (Karlsen 2012).

Die Untersuchung zeigt, dass sich die Strategien der Jurisdiktionsarbeit von Krankenhaussozialarbeitern in Deutschland und Schweden markant unterscheiden. Dies betrifft zum einen die Unterstützung für Mitglieder in der eigenen lokalen Jurisdiktionsarbeit, das Verhältnis der Berufsgruppe zur theoretischen Basis der Sozialen Arbeit und zur Gewerkschaft, sowie die Art des gesetzlichen Schutzes, der von den Berufsverbänden angestrebt wird. Es kann als wahrscheinlich bezeichnet werden, dass verbandsimmanente Faktoren (z.B. Größe und Ressourcen), sowie externe Faktoren (z.B. nationaler Kontext, Unterschiede in der Organisation des Gesundheitswesens, die untergeordnete Stellung der Krankenhaussozialarbeit) relevant sind für diese Unterschiede.

Die Ergebnisse deuten auch darauf hin, dass Berufsgruppen die sich, ähnlich wie die Krankenhaussozialarbeit sowohl innerhalb der Profession als auch innerhalb ihrer Arbeitsorganisation eine Minorität darstellen zwischen mindestens zwei möglichen Strategien der Jurisdiktionsarbeit wählen können: nämlich zwischen einer *mimetische* Strategie und einer *aposematischen* Strategie.

In Schweden wird von den Krankenhaussozialarbeitern die mimetische Strategie verwendet, um die Berufsgruppe möglichst in seine Umgebung im Krankenhaus einzuschmelzen zu lassen. Dabei betont die Berufsgruppe besonders im Hinblick auf ihre theoretische Basis, mit ihrer professionellen Gruppenidentität und ihrer disziplinären Verankerung die Nähe zum organisatorischen Kontext. Das Verhältnis zur akademischen Ursprungsdisziplin Soziale Arbeit, zu seiner Ausbildung und zur Gewerkschaft der Sozialen Arbeit werden dabei eher als hinderlich erlebt.

Die deutschen Krankenhaussozialarbeiter wenden dagegen eher eine *aposematische* Strategie an, bei der die Unterschiede zwischen Sozialer Arbeit und den anderen Professionen im Gastmilieu Krankenhaus besonders betont werden. Dies wird erreicht, indem die Nähe der Berufsgruppe zur Ursprungsprofession Soziale Arbeit hinsichtlich der theoretischen Basis, der professionellen Identität und der disziplinären Verankerung betont wird. Das Verhältnis zu dieser Ursprungsprofession, ihrer Ausbildung und das Verhältnis zur Gewerkschaft werden dabei als unterstützend beschrieben.

References

Abbott, A. (1988) *The System of Professions – An Essay on the Division of Expert Labour*. Chicago: The University of Chicago Press.

Abbott, A. (2005) Linked Ecologies: States and Universities as Environments for Professions. In: *Sociological Theory*. Vol 23 (3): 245-274.

Alaszewski, A. (1995) Restructuring health and welfare professions in the United Kingdom: the impact of internal markets on the medical, nursing and social work professions. In: *Health professions and the state in Europe*. T. Johnson & G. Larkin et al. (eds) London: Routledge.

Albrithen, A. & N. Yalli (2012) The Perception of Organisational Issues of Social Work Practitioners in Saudi Hospitals. In: *Journal of Social Service Research.* Vol 38 (3): 273-291.

Albrithen, A. & N. Yalli (2013) A Discussion of Professional Issues of Hospital Social Workers in Saudi Arabia. In: *Social Work in Health Care.* Vol 51 (1): 20–42.

Allen, D. (2001) Narrating Nursing Jurisdiction: "Atrocity Stories" and "Boundary-Work". In: *Symbolic Interaction.* Vol 24 (1): 75-103.

Allsop, J. (1995) Shifting spheres of opportunity: the professional powers of general practitioners within the British National Health Service. In: *Health professions and the state in Europe*. T. Johnson & G. Larkin et al. (eds) London: Routledge.

Andersen, I. (1998) *Den uppenbara verkligheten: Val av samhällsvetenskaplig metod*. Lund: Studentlitteratur.

Anell, A. (1999) *Läkemedelsförskrivning och kostnadskontroll – Vad kan Sverige lära av England, Tyskland och Holland?* Lund: Institutet för hälso- och sjukvårdsekonomi.

Anell, A. (2007) Varför är det så svårt att styra sjukvården? Medicinsk specialisering och professionens interessen. In: *Vem styr vården? Organisationen och politisk styrning inom svensk sjukvård*. P. Blomquist (ed) Stockholm: SNS Förlag.

Andersson, J. (2007) Baklänges in i framtiden – folkhemsnostalgi och historiska framtidsvisioner. In: *Den självstyrande medborgaren? Ny historia om rättvisa, demokrati och välfärd*. C. Florin & E. Eglán et al. (eds) Stockholm: Institutet för framtidsstudier.

Ansen, G. & N. Gödecker-Geenen, H. Nau (2004) *Soziale Arbeit im Krankenhaus*. München: Reinhardt UTB.

Baker, M. (1992) *In other words: a coursebook on translation*. London: Routledge.

Baron, R. & H.-J. Brauns, D. Kramer (1986) Education of Social Workers and Social Pedagogues in the Federal Republic of Germany. In: S*ocial Work Education in Europe.* H.-J. Brauns & D. Kramer (eds) Stuttgart: Kohlhammer Verlag.

Becher, T. (1999) *Professional Practices: Commitment and Capability in a Changing Environment*. New Brunswick: Transaction Publishers.

Becher, T. & P. R. Trowler (2001) *Academic Tribes and Territories*. Buckingham: Open University Press.

Becker, U. & Kingreen, T. (2007) Einführung. In: *SGB V*. Verlag C.H. Beck oHG (ed) München: DTV.

Berger, C. (1991) Enhancing Social Work Influence in the Hospital. In: *Social Work in Health Care.* Vol 15 (2): 77-93.

Bergström, G. & K. Boréus (2005) Samhällsvetenskaplig text- och diskursanalys. In: *Textens mening och makt: Metodbok i samhällsvetenskaplig text- och diskursanalys.* G. Bergström & K. Boréus (eds) Hungary: Studentlitteratur.

Bernler, G. & L. Johnsson (1988) Teori för psykosocialt arbete. Stockholm: Natur och Kultur.

Blank, R. & V. Burau (2007) *Comparative Health Policy*. New York: Palgrave MacMillan.

Blomqvist, P. (2002) *Ideas and Policy Convergence: Health Care Reform in the Netherlands and Sweden in the 1990s*. Columbia: Columbia University. PhD.

Blomqvist, P. (2007) Sjukvårdens styrning och organisation. In: *Vem styr vården? – Organisation och politisk styrning inom svensk sjukvård*. P. Blomqvist (ed) Stockholm: SNS Förlag.

Bogner, A. & W. Menz (2005) Das theoriegenerierende Experteninterview – Erkenntnisinteresse, Wissensformen, Interaktion. In: *Das Experteninterview. Theorie, Methode, Anwendung*. A. Bogner, & B. Litting et al. (eds) Wiesbaden: VS Verlag für Sozialwissenschaften.

Bolin, A. (2011) *Shifting Subordination*: *Co-located interprofessional collaboration between teachers and social workers*. Gothenburg: Gothenburg University. PhD.

Borgetto, B. & K. Kälble (2007) *Medizinsoziologie – Sozialer Wandel, Krankheit, Gesundheit und das Gesundheitssystem*. Weinheim: Juventa Verlag.

Brante, T. (1988) Sociological Approaches to the Professions. In: *Acta Sociologica*. Vol 31 (2): 119-142.

Brante, T. (1990) Professional Types as a Strategy of Analysis. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Brante, T. (2003) Konsolidering av nya vetenskapliga fält – exemplet forskning i socialt arbete. In: *Socialt arbete. En nationell genomlysning av ämnet.* Högskoleverket (ed) Stockoholm: Högskoleverkets rapportserie 2003:16R.

Brante, T. (2011) Professions as Science-Based Occupations. In: *Professions & Professionalism.* Vol 1 (1): 4-20.

Brumlik, M. (2001) Solidarität. In: *Handbuch der Sozialarbeit/Sozialpädagogik*. H.-U. Otto & H. Thiersch (eds) Neuwied: Luchterhand.

Bruner, E. M. (2004) Ethnography as narrative. In: *Narrative theory: Critical concepts in literary and cultural studies.* M. Bal (ed) London: Routledge.

Büchner, S. (2012) *Soziale Arbeit als transdisziplinäre Wissenschaft. Zwischen Verknüpfung und Integration*. Wiesbaden: VS Verlag für Sozialwissenschaften.

Burau, V. & L. Henrikson, S. Wrede (2004) Comparing professional groups in health care: towards a context sensitive analysis. In: *Professionals: Continental European and Anglo-American approaches*. L. Svensson & J. Evetts (ed) Göteborg: Göteborgs universitet. Vol 2 (2).

Burrage, M. (1990) Introduction: The Professions in Sociology and History. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Burrage, M. & K. Jarausch, H. Siegrist (1990) An Actor-based Framework for the Study of the Professions. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Burri, R. V. (2008) Doing Distinctions: Boundary Work and Symbolic Capital in Radiology. In: *Social Studies of Science.* Vol 38 (1): 35-62.

Carr-Saunders, A. M. & P. A. Wilson (1933) *The Professions*. Oxford: Oxford University Press.

Castro, F. W. (1992) *Bortom den nya medelklassen – Durkheim och de moderna professionella yrkesgrupperna*. Stockholm: Symposion Graduale.

Clasen, J. (2005) *Reforming European Welfare States – Germany and the United Kingdom Compared*. Oxford: University Press.

Collin, K. & T. Sintonen, S. Paloniemi, T. Auvinen. (2011) Work, power and learning in a risk filled occupation. In: *Management learning.* Vol 42 (3): 301-318.

Collins, R. (1990) Market Closure and the Conflict Theory of the Professions. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Davidson, K. W. (1990) Role Blurring and the HSWer's Search for a Clear Domain. In: *Health & Social Work.* Vol 15 (3): 228-234.

Davies, M. & J. Connolly (1995) The social worker's role in the hospital: seen through the eyes of other health care professionals. In: *Health and Social Care in the Community.* Vol 3 (5): 301-309.

Dellgran, P. & S. Höjer (2000) *Kunskapsbildning, akademisering och professionalisering i socialt arbete.* Göteborg: Göteborgs universitet. PhD.

Dellgran, P. & S. Höjer (2003) Forskning i praktiken. Om den seniora forskningens innehåll och socionomers forskningsorientering. In: *Socialt arbete. En nationell genomlysning.* Högskoleverket (ed) Högskoleverkets Rapportserie 2003:16R, Stockholm: Högskoleverket.

Dellgran, P. & S. Höjer (2011) Nya trender och gamla mönster. Doktorsavhandlingarna i socialt arbete 1980-2009. In: *Socialvetenskaplig Tidskrift.* Vol 18 (2): 85-106.

Dent, M. (2003) *Remodelling Hospitals and Health Professions in Europe - Medicine, Nursing and the State*. Houndmills: Palgrave Macmillan.

Denzin, N. K. (2006) *Sociological Methods*. New Brunswick: Aldine Transaction.

Destatis (2013) *Krankenhausstatistik 1991–2012. S. i. K.- 2011*. Wiesbaden: Statistisches Bundesamt.

Dewe, B. & H.-U. Otto (2001) Profession. In: *Handbuch Sozialarbeit/Sozialpädagogik*. H.-U. Otto & H. Thiersch (eds) Neuwied: Luchterhand.

Dewe, B. & H.-U. Otto (2005) Refelxive Sozialpädagogik. Grundstrukturen eines neuen Typs dienstleistungsorientierten Professionshandelns. In: *Grundriss Soziale Arbeit.* W. Thole (ed) Wiesbaden: VS Verlag für Sozialwissenschaften.

DVSG, e.V. (ed) (2006) *Tradition hat Zukunft – Stationen zur Entwicklung der Sozialarbeit im Gesundheitswesen und der Deutschen Vereinigung für Sozialarbeit im Gesundheitswesen e.V. (DVSG)*. Kempten: AZ Druck und Datentechnik GmbH.

DVSG, e.V. (ed) (2009) *Ziele und Aufgaben*. www.dvsg.org. (access: 20090721)

Doherty, C. (2009) A qualitative study of health service reform on nurses' working lives: learning from the UK National Health Service (NHS). In: *International Journal of Nursing Studies*. Vol 46: 1134-1142.

Ekpenyong, E. (2010) Translating and interpretating: One object, different approaches. In: *Babel.* Vol 56 (4): 328-340.

Engelke, E. (2004) *Die Wissenschaft Soziale Arbeit – Werdegang und Grundlagen*. Freiburg i. Br.: Lambertus Verlag.
Erichsen, V. (1995) State traditions and medical professionalization in Scandinavia. In: *Health professions and the state in Europe*. T. Johnson & G. Larkin et al. (eds) London: Routledge.
Esaiasson, P. & M. Gilljam, H. Oscasson, L. Wängnerud (2004) *Metodpraktikan – Konsten att studera samhälle, individ och marknad*. Stockholm: Norstedts Juridik.
Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*. Cambridge: Polity Press.
Esping-Andersen, G. (1999) *Social Foundations of Postindustrial Economies*. Oxford: University Press.
Etzioni, A. (1961) *A Comparative Analysis of Complex Organisations – On Power, Involvement and their Correlates*. New York: The Free Press.
Etzioni, A. (1969) *The Semi-Professions and Their Organisation*. New York: The Free Press.
Europäisches Parlament (1998) Das Gesundheitswesen in der EU – Eine vergleichende Studie. *Reihe Volksgesundheit und Verbraucherschutz*.
European Ministers of Education (1999) *The Bologna Declaration of 19 June 1999*. http://www.bologna-bergen2005.no/Docs/00-Main_doc/990719BOLOGNA_DECLARATION.PDF (access 130208).
Evertsson, L. (2002) *Välfärdspolitik & kvinnoyrken – Organisation, välfärdsstat och professionaliseringens villkor*. Umeå: Umeå universitet. PhD.
Evans, L. & K. Honold (2007) The division of expert labour in the European audit market: The case of Germany. In: *Critical Perspectives on Accounting.* Vol 18: 61-88.
Evetts, J. (2004) From profession to professionalism: A discourse of occupational change. *CSP Conference in the Studies of Professions*. Oslo: Høgskolen i Oslo.
Evetts, J. (2009) New Professionalism and New Public Management: Changes, Continuities and Consequences. In: *Comparative Sociology.* Vol 8: 247-266.
Evetts, J. (2012) Similarities in contexts and theorizing: Professionalism and inequality. In: *Professions & Professionalism.* Vol 2 (2).
Falk, V. & K. Nilsson (1999) *Hälso- och sjukvårdens organisation i Sverige*. Lund: Studentlitteratur.
Fine, G. A. (1984) Negotiated Orders and Organizational Cultures. In: *Annual Review of Sociology*. Vol 10: 239-262.
Flexner, A. (1915) Is Social Work a Profession? In: *Research on Social Work Practice*. 2001 (11): 152-165.
Flyvbjerg, B. (2006) Five Missunderstandings About Case-Study Research. In: *Qualitative Inquiry.* Vol 12 (2): 219-245.
Fournier, V. (2000) Boundary work and the (un)making of the professions. In: *Professionalism, Boundaries and the Workplace*. M. Nigel (ed) New York: Routledge.
Fredlund, U. (1997) *Kuratorsverksamhet inom svensk sjukvård under 70 år – Glimtar och utvecklingstrender.* Stockholm: Svensk Kuratorsförening.
Freeman, R. (1998) The German Model: the State and the Market in Health Care Reform. In: *Markets and Health Care*. W. Ranade (ed) London: Addison Wesley Longman Limited.

Freidson, E. (1973) Professions and the Occupational Principle. In: *The Professions and their Prospects*. E. Freidson (ed) Beverly Hills: Sage Publications.
Freidson, E. (1994) *Professionalism Reborn. Theory, Prophecy and Policy*. Chicago: The University of Chicago Press.
Freidson, E. (2001) *Professionalism – The Third Logic*. Chicago: The University of Chicago Press.
Fuchs, H. (2008) Einführung. In: *SGB IX*. Verlag C.H. Beck oHG (ed) München: DTV.
Gachoud, D. & M. Albert, A. Kuper, L. Stroud, S. Reeves (2012) Meanings and perceptions of patient-Centeredness in social work, nursing and medicine: A comparative study. In: *Journal of Interprofessional Care.* Vol 26: 484-490.
Gieryn, T. F. (1983) Boundary Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists. In: *American Sociological Review.* Vol 60 (2): 781-795.
Giles, R. & S. Gould, C. Hart, J. Swancott (2007) Clinical Priorities: Strengthening Social Work Practice in Health. In: *Australian Social Work.* Vol 60 (2): 147-165.
Ginsburg, N. (1992) *Divisions of Welfare – a Critical Introduction to Comparative Social Policy*. London: Sage Publications Ltd.
Gispen, C. W. R. (1988) German Engineers and American Social Theory: Historical Perspectives on Professionalization. In: *Comparative Studies in Society and History.* Vol 30 (3): 550-578.
Gitterman, A. & C. B. Germain (2008) *The Life model of social work practice: advances in theory and practice.* New York: Columbia University Press.
Glaser, B. G. & A. L. Strauss (2006) Theoretical sampling. In: *Sociological Methods – A Sourcebook.* N. K. Denzin (ed) New Brunswik: Aldine Transaction.
Globerman, J. (1999) Hospital Restructuring. In: *Social Work & Health Care.* Vol 28 (4): 13-30.
Globerman, J. & M. Bogo (1995) Social Work and the New Integrative Hospital. In: *Social Work in Health Care.* Vol 21 (3): 1-21.
Goldman A. L. & J. Rojot (2003) *Negotiation – Theory and Practice*. The Haugue: Kluwer Law International.
Goode, W. J. (1957) Community Within a Community: The Professions. In: *American Sociological Review*. Vol 22 (2): 194-200.
Grape, O. (2006) Domänkonsensus eller domänkonflikt? – Integrerad samverkan mellan myndigheter? In: *Organisation och omvärld*. O. Grape & B. Blom et al. (eds) Lund: Studentlitteratur.
Greenwood, E. (1957) Attributes of a profession. In: *Social work.* Vol 2: 45-55.
Grimen, H. (2008) Profesjon og tillit. In: *Profesjonsstudier*. A. Molander & L. I. Terum (eds) Oslo: Universitetsforlaget.
Grunwald, K. & H. Thiersch (2009) The concept of the 'lifeworld orientation' for social work and social care. In: *Journal of Social* Work *Practice.* Vol 23 (2): 131-146.
Hall, P. (2005) Interprofessional teamwork: Professional cultures as barriers. In: *Journal of Interprofessional Care.* Supplement 1: 188-196.
Halpern, S. A. (1992) Dynamics of Professional Control: Internal Coalitions and Crossprofessional Boundaries. In: *American Journal of Sociology.* Vol 97 (4): 994-1021.

Harrison, J. & M. Hepworth, P. de Chazal (2004) A study of hospital based social workers in the UK: the importance of verbal communication in this community. In: *Human Perspectives in the Internet Society: Culture, Psychology and Gender.* K. Morgan & J. Sanchez, et al. (eds) Vol 4: 367-375.

Heggen, K. (2008) Profesjon og identitet. In: *Profesjonsstudier*. A. Molander & L. I. Terum (eds) Oslo: Universitetsforlaget.

Hellberg, I. (1999) Altruism and utility: Two logics of professional action. In: *Professional Identities in Transition: Cross-Cultural Dimentions.* I. Hellberg & M. Saks et al. (eds) Gothenburg: Gothenburg University.

Hessle, S. (2007) Sweden. In: *Social Work as a Profession: A Comparative Cross-national Perspective.* Birmingham: Venture Press.

Hoefer, R. (1996) A Conceptual Model for Studying Social Welfare Policy Comparatively. In: *Journal of Social Work Education*. Vol 32 (1): 101-113.

Högskoleverket (2003) *Socialt Arbete: En nationell genomlysning av ämnet*. Stockholm: Högskoleverkets rapportserie 2003:16R.

Holliman, D. & S. Dziegielewsk et al. (2001) Discharge Planning and Social Work Practice. In: *Social Work in Health Care.* Vol 32 (3): 1-19.

Hong, Y. S. (1990) Femininity as a Vocation: Gender and Class Conflict in the Professionalization of German Social Work. In: *German Professions 1800-1950*. G. Cocks & K. Jarausch (eds) New York: Oxford University Press.

Hughes, A. (2010) The challenge of contributing to policy making in primary care: the gendered experiences and strategies of nurses. In: *Sociology of Health & Illness*. Vol 32 (7): 977-992.

Hughes, E. C. (1971) *The Sociological Eye*. New Brunswick: Transaction Books.

Immergut, E. M. (1992) *Health Politics: Interests and Institutions in Western Europe*. Cambridge: University Press.

Jenkins, R. (2004) *Social Identity*. London: Routledge.

Johnson, T. (1995) Governmentality and the institutionalization of expertise. In: *Health professions and the state in Europe*. T. Johnson & G. Larkin, et al. (eds) London: Routledge.

Jonnergård, K. & G. Erlingsdottír (2008) Mellan autonomi och kontroll – om professionella strategier, legitimitet och identitet vid införandet av nya kontrollformer. In: *När den professionella autonomin blir ett problem*. K.Jonnergård & E. K. Funck et al. (eds) Växjo: Växjö University Press.

Jonnergård, K. & E. K. Funck, M. Wolmesjö (2008) Professionell autonomi som risk och möjlighet. In: *När den professionella autonomin blir ett problem*. K. Jonnergård & E. K. Funck et al. (eds) Växjo: Växjö University Press.

Judd, R. & Sh. Sheffield (2010) Hospital Social Work: Contemporary Roles and Professional Activities. In: *Social Work in Health Care.* Vol 49 (9): 856-871.

Kadushin, G. & R. Kulys (1995) Job Satisfaction among Social Work Discharge Planners. In: *Health & Social Work.* Vol 20 (3): 174-186.

Karlsen, G. (2012) *Språk, tolkning och argumentation*. Lund: Studentlitteratur.

von Knorring, M. & A. de Rijk, K. Alexanderson (2010) Managers' perceptions of the manager role in relation to physicians: a qualitative interview study on the top managers in Swedish health care. In: *BMC Health Service Research*. Vol 10: 271-283.

Kocka, J. (1990) "Bürgertum" and professions in the nineteenth century: two alternative approaches. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Kohl, J. (1994) Die öffentlichen Ausgaben, ihre Finanzierung und die Entwicklung des Staatssektors. In: *Die EU-Staaten im Vergleich. Strukturen, Prozesse, Politikinhalte*. O. W. Gabriel & F. Brettschneider (eds) Bonn: Bundeszentrale für politische Bildung.

Kohl, J. (2000) Die deutsche Version des Wohlfahrtsstaates – Überlegungen zu seiner typologischen Verortung. In: *Der Deutsche Sozialstaat: Bilanzen – Reformen – Perspektiven*. S. Leibfried & U. Wagschal (eds) Frankurt a. M.: Campus Verlag.

Kuhlmann, E. (2006) *Modernising health care – Reinventing professions, the state and the public*. Bristol: The Policy Press.

Kuhlmann, E. (2008) Governing beyond markets and managerialism: Professions as mediators. In: *Rethinking professional governance – International directions in health care*. E. Kuhlmann & M. Saks (eds) Bristol: The Policy Press.

Kuhlmann, E. & M. Saks (2008) Health policy and work force dynamics: the future. In: *Rethinking professional governance – International directions in health care*. E. Kuhlmann & M. Saks (eds) Bristol: The Policy Press.

Kuhlmann, E. & J. Allsop, M. Saks (2009) Professional Governance and Public Control: A Comparison of Health Care in the United Kingdom and Germany. In: *Current Sociology.* Vol 57 (4): 511-528.

Kvarnström, S. (2008) Difficulties in collaboration: A critical incident study of interprofessional health care teamwork. In: *Journal of Interprofessional Care.* Vol 22 (2): 191-203.

La Motte, E. (1911) The Nurse as a Social Worker. In: *Public Health Nursing*. Vol 29 (2): 185-187.

Lamont, M. & V. Molnár (2002) The Study of Boundaries in the Social Sciences. In: *Annual Review of Sociology.* Vol 28: 167-195.

Larkin, G. (1995) State control and the health professions in the United Kingdom: Historical perspectives. In: *Health Professions and the State in Europe*. T. Johnson & G. Larkin, et al. (eds) London: Routledge.

Layder, D. (1998) *Sociological Practice – Linking Theory and Social Research*. London: Sage.

Lidström, A. (2003) *Kommunsystem i Europa*. Malmö: Liber AB.

Light, D. (1995) Countervailing powers: a framework for professions in transition. In: *Health Professions and the State in Europe*. T. Johnson & G. Larkin, et al. (eds) London: Routledge.

Liljegren, A. (2008) *Professionellt gränsarbete – socionomexemplet*. Göteborg: Göteborgs universitet. PhD.

Lingard, L. & A. McDoughall, M. Lvstick, N. Chandock, M. Spafford, C. Schryer (2012) Representing complexity well: a story about teamwork, with implications for how to teach collaboration. In: *Medical Education.* Vol 46: 869-877.

Littek, W. & U. Heisering, C. Lane (2005) Die Organisation professioneller Arbeit in Deutschland. Ein Vergleich mit England. In: *Organisation und Profession*. T. Klatetzki & V. Tacke (eds) Wiesbaden: VS Verlag für Sozialwissenschaft.

Lüssi, P. (1992) *Systemische Sozialarbeit – Praktisches Lehrbuch der Sozialberatung*. Bern: Verlag Paul Haupt.

Lundström, T. (2008) Aktforskning. In: *Forskningsmetodik för socialvetare*. A. Meeuwisse & H. Swärd et al. (eds) Stockholm: Natur och Kultur.

Macdonald, K. (1999) *The sociology of the professions*. London: Sage Publications.

Maggetti, M. (2009) The role of independent regulatory agencies in policy-making: a comparative analysis. In: *Journal of European Public Policy.* Vol 16 (3): 450-470.
Mann, M. (1996) *The sources of social power – The rise of classes and nation-states.* Cambridge: Cambridge University Press.
Marriott, A. & L. Sexton, D. Stanley (1994) Components of Job Satisfaction in Psychiatric Social Workers. In: *Health & Social Work*. Vol 19 (3): 199-205.
May, T. & M. Buck (2000) Social work, professionalism and the rationality of organisational change. In: N. Malin (ed) *Professionalism, Boundaries and the Workplace.* London: Routledge.
McAlynn, M. & J. McLaughlin (2008) Key Factors impeding Discharge Planning in Hospital Social Work. In: *Social Work in Health Care.* Vol 46 (3): 1-27.
McClelland, C. E. (1990) Escape from Freedom? Reflection on German Professionalization, 1870-1933. In: R. Thorstendahl & M. Burrage (eds) *The Formation of Professions – Knowledge, State and Strategy.* London: Sage.
McMichael, A. (2000) Professional identity and continuing education: a study of social workers in hospital settings. In: *Social Work Education.* Vol 19 (2): 175-183.
Miles, M. B. & A. M. Huberman (1994) *Qualitative Data Analysis – An Expanded Sourcebook*. London: Sage Publications.
Millerson, G. (1964) *The Qualifying Associations: A study in Professionalization*. London: Routledge & Kegan Paul.
Mitchell, R. J. & V. Parker, M. Giles (2011) When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofessional effectiveness. In: *Human relations.* Vol 64 (19): 1321-1343.
Molander, A. & L. I. Terum (2008) Profesjonsstudier – en introduksjon. In: *Profesjonsstudier*. A. Molander & L. I. Terum (eds) Oslo: Universitetsforlaget.
MOST (2012) *Ethical Guidelines for International Comparative Social Science Research*. Unesco, http://www.unesco.org/most/ethical.htm (access: 20120427).
McMurray, R. (2011) The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. In: *Human Relations.* Vol 64 (6): 801-822.
Neuman, K. (2003) The Effect of Organizational Reengeneering on Job Satisfaction for Staff in Hospital Social Work Departments. In: *Social Work in Health Care*. Vol 36 (4): 19-33.
Oevermann, U. (1996) Theoretische Skizze einer revidierten Theorie professionalisierten Handelns. In: *Pädagogische Professionalität: Untersuchungen zum Typus pädagogischen Handelns*. Frankfurt a. M.: Suhrkamp.
Oevermann, U. (2008) Profession contra Organisation? Strukturtheoretische Perspektiven zum Verhältnis von Organisation und Profession in der Schule. In: *Pädagogische Professionalität in Organisationen*. W. Helsper & S. Busse, et al. (eds) Wiesbaden: VS Verlag für Sozialwissenschaft.
Offermann, V. (1996) Solidarität nur unter Starken? – Die Verteilungswirkung der Reformen in der Gesetzlichen Kranken- und der Arbeitslosenversicherung. In: *Sozialstaat wohin? Umbau, Abbau oder Ausbau der Sozialen Sicherung*. W. Schöning & R. L´Hoest (eds) Darmstadt: Wissenschaftliche Buchgesellschaft.

Olsson, S. (1999) Kuratorn förr och nu – Sjukhuskuratorns arbete i ett historisk perspektiv. Göteborg: Göteborgs universitet (PhD).

Paloniemi, S. & K. Collin (2012) Discursive Power and Creativity in Inter-Professional Work. In: *Vocations and Learning.* Vol 5: 23-40.

Parsons, T. (1970) Equality and Inequality in Modern Society, or Social Stratification Revisited. In: *Sociological Inquiry.* Vol (Spring): 13-72.

Parsons, T., E. A. Shils, G. Allport, C. Kluckhohn, R. Sears, R. Sheldon, S. Stouffer, E. Tolman (1951a, 2008) Some Fundamental Categories of the Theory of Action: A General Statement. In: *Towards a General Theory of Action. Theoretical Foundations for the Social Sciences*. T. Parsons & E. A. Shils. New Brunswick: Transaction Publishers.

Parsons, T. (1951b, 2012) *The Social System*. New Oreans: Quid Pro books.

Pauls, Helmut (2001) Ausbildung und Qualifizierung für Klinische Sozialarbeit. In: *Soziale Arbeit im Krankenhaus – Vergangenheit und Zukunft.* P. Reinicke (ed) Freiburg i. Br.: Lambertus.

Pfadenhauer, M. (2003) *Professionalität – Eine wissenschaftssoziologische Rekon-struktion institutionalistischer Kompetenzdarstellungskomptenz*. Opladen: Leske + Budrich.

Phillips, J. & J. Waterson (2002) Care management and *social* work: a case study of the role of *social* work in hospital discharge to residential or nursing home care. In: *European Journal of Social Work.* Vol 5 (2): 171-186.

Pockett, R. (2006) Learning from Each Other. In: *Social Work in Health Care.* Vol 43 (2-3): 131-149.

Prior, L. (2004) Documents. In: *Qualitative Research Practice*. C. Seale, G. Gobo, et al. London: Sage Publications.

Reese, D. & Sontag M.-A. (2001) Successful Interprofessional Collaboration on the Hospice Team. In: *Health & Social Work.* Vol 26 (3): 167-175.

Reinicke, P. (2001a) Rückblick auf die Entwicklung der Deutschen Vereinigung für den Sozialdienst im Krankenhaus (DVSK). In: *Soziale Arbeit im Krankenhaus – Vergangenheit und Zukunft.* P. Reinicke (ed) Freiburg i. Br.: Lambertus.

Reinicke, P. (2001b) Welche Bedeutung haben die Arbeitsfelder Sozialdienst im Krankenhaus und Sozialarbeit bei Krankenkassen in der Lehre an Fachhochschulen für Sozialarbeit/Sozialpädagogik? In: *Soziale Arbeit im Krankenhaus – Vergangenheit und Zukunft.* P. Reinicke (ed) Freiburg i. Br.: Lambertus.

Ricoeur, J. P. (1992) *Oneself as another* (Originally published in French under the title Soi-même comme un autre, 1990). London: Routledge.

Rowlinson, M. (2004) Historical analysis of Company Documents. In: *Essential Guide to Qualitative Methods in Organisational Research.* C. Cassell & G. Symon (eds) London: Sage Publications.

Saks, M. (2008) Policy dynamics: marginal groups in the healthcare division of labour in the UK. In: *Rethinking professional governance – International directions in health care.* E. Kuhlmann & M. Saks (eds) Bristol: The Policy Press.

Salhani, D. & I. Coulter (2009) The politics of interprofessional working and the struggle for professional autonomy in nursing. In: *Social Science & Medicine.* Vol 68: 1221-1228.

Salomon, F. & A. Ziegler (2007) Moral & Abhängigkeit – Ethische Entscheidungskonflikte im hierarchischen System Krankenhaus. In: *Ethik in der Medizin.* Vol 19 (3): 174-186.

Salonen, T. (2001) Sweden: Between Model and Reality. In: *International Social Policy – Welfare Regimes in the Developed World*. P. Alcock & G. Craig (eds) New York: Palgrave.

Samson, C. (1995) The fracturing of medical dominance in British psychiatry? In: *Sociology of Health & Illness.* Vol 17 (2): 245-268.

Sanders, T. & S. Harrison (2008) Professional legitimacy claims in the multidisciplinary workplace: the case of heart failure care. In: *Sociology of Health & Illness*. Vol 30 (2): 289-308.

Sarfatti Larson, M. (1979) *The Rise of Professionalism – a Sociological Analysis*. Berkley: University of California Press.

Schmidt, J. (2013) Kuratorer: Ta plats på scenen! In: *Socionomen.* 2013 (2): 38-40.

Schulin, B. (2008) Einführung von Prof. Dr. Bertram Schulin. In: *SGB*. Verlag C.H. Beck oHG (ed.) München: DTV.

Scott, J. (1990) *A Matter of Record. Documentary Sources in Social Research*. Cambridge: Polity Press.

Seale, C. (1999) Quality in Qualitative Research. In: *Qualitative Inquiry.* Vol 5 (4): 465-478.

Selander, S. (1990) Associative Strategies in the Process of Professionalization: Professional Strategies and Scientification of Occupations. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Sen, K. (2003) *Restructuring Health Services. Changing Contexts & Comparative Perspectives*. London: Zed Books.

Siegrist, H. (1988) Bürgerliche Berufe. Die Professionen und das Bürgertum. In: *Bürgerliche Berufe: Zur Sozialgeschichte der freien und akademischen Berufe im internationalen Vergleich*. H. Siegrist (ed) Göttingen: Vandenhoeck & Ruprecht.

Siegrist, H. (1990) Professionalization as a Process: Patterns, Progression and Discontinuity. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Siegrist, H. (1996) *Advokat, Bürger und Staat – Sozialgeschichte der Rechtsanwälte in Deutschland, Italien und der Schweiz (18.-20. Jh.)*. Frankfurt a. M.: Vittorio Klostermann.

Siegrist, H. (2001) Professionalization/Professions in History. In: *InternationalEncyclopedia of the Social and Behavioural Sciences*. Amsterdam: Elsevier Science.

Silverman, D. (2006) *Interpreting Qualitative Data – Methods for Analyzing Talk, Text and Interaction*. London: Sage Publications.

SKL (2013) *Landstingsanställd personal 2004, 2008*. Stockholm: Sveriges kommuner och landsting.

Smith, D. (2008) On documentary society. In: *Handbook of research in writing.* Ch. Bazerman (ed) New York: Lawrence Erlbaum Associates.

Socialstyrelsen (2007) *Nationella riktlinjer för bröst-, kolorektal- och prostatacancer: Beslutsstöd för prioriteringar*. Lindesberg: Lindesbergs Grafiska.

SSR (2010) *Policy för socionomer i hälso- och sjukvård: Modell för kompetens- och karrärutveckling.* Stockholm.

Starr, P. & E. Immergut (1987) Health care and the boundaries of politics. In: *Changing boundaries of the political – Essays on the evolving balance between the state and society, public and the private in Europe*. C. S. Maier, Cambridge: University Press.

Staub-Bernasconi, S. (2007) Germany. In: *Social Work as a Profession: A Comparative Cross-national Perspective.* Birmingham: Venture Press.

Stichweh, R. (1996) Professionen in einer funktional differenzierten Gesellschaft. In: *Pädagogische Professionalität: Untersuchungen zum Typus pädagogischen Handelns*. W. Helsper, S. Busse et al. (eds) Frankfurt a. M.: Suhrkamp.

Stichweh, R. (1997) Professions in Modern Society. In: *International Review of Sociology – Revue Internationale de Sociologie*. Vol 7 (1): 95-102.

Straub, J. (2002) Personal and Collective Identity – a Conceptual Analysis. In: *Identities: Time, Difference and Boundaries*. Friese, H. (ed) New York: Berghahn Books.

Strauss, A. (1978) *Negotiations: Varieties, Contexts, Processes and Social Order*. San Fransisco: Jossey-Bass Publishers.

Strauss, A. L. (1993) *Continual Permutation of Action*. New York: Aldine de Gruyter.

Stock, M. & A. Wernet (2005) Hochschulforschung und Theorie der Professionen. In: *die hochschule*. (1): 7-15.

Sullivan, W. M. (2005) *Work and Integrity – The Crisis and Promise of Professionalism in America*. San Fransisco: Jossey-Brass.

Sulman, J., D. Savage, P. Vrooman & M. McGillivray (2005) Social Group Work. In: *Social Work in Health Care*. Vol 39 (3-4): 287-307.

Svärd, V. (2013) Hospital social workers' assessment processes for children at risk: positions in and contributions to interprofessional teams. In: *European Journal of Social Work.* E-publication: June 11th 2013.

Svensk Kuratorsförening (2007) *Mål och vision*. http://www.kurator.se/mal-och-visioner/ (access 20090721).

Thierau, D. (1998) Sozialarbeit in geriatrischen Kliniken – zwischen Autonomie und Funktionalisierung. In: *Zeitschrift für Gerontologische Geriatrie*. Vol 31: 338-342.

Thiersch, H. (2006) *Die Erfahrung der Wirklichkeit – Perspektiven einer alltagsorientierten Sozialpädagogik*. Weinheim: Juventa Verlag.

Thorslund, M. (2007) Det nygamla gränssnittet: Äldrevården och dess omorganisationer. In: *Vem styr vården? Organisationen och politisk styrning inom svensk sjukvård*. P. Blomquist (ed) Stockholm: SNS Förlag.

Timmermans, S. (2002) The cause of death vs. the gift of life: boundary maintenance and the politics of expertise in death investigations. In: *Sociology of Health & Illness.* Vol 24 (5): 550-574.

Timmons, S. & J. Tanner (2004) A disputed occupational boundary: operating theatre nurses and Operating Department Practitioners. In: *Sociology of Health & Illness.* Vol 26 (5): 645-666.

Torstendahl, R. (1990) Essential Properties, Strategic Aims and Historical Development: Three Approaches to Theories of Professionalism. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Torsvik, G. (2008) Profesjonar i økonomisk-teoretisk perspektiv. In: *Profesjons-studier*. A. Molander & L. I. Terum (eds) Oslo: Universitetsforlaget.
Vetenskapsrådet (2009) *Forskningsetiska riktlinjer*. http://www.condex.uu.se/texts/HSFR.pdf (access 20120427).
Vidich, A. J. & G. Shapiro (2006) A Comparison of Participant Observation and Survey Data. In: *Sociological Methods – A Sourcebook*. N. K. Denzin (ed) New Brunswick: Aldine Transaction.
Walther, V. N. (1991) Emerging Roles of Social Work in Perinatal Services. In: *Social Work in Health Care.* Vol 15 (2): 35-48.
Weiss-Gal, I. & P. Welbourne (2008) The Professionalization of Social Work: a Cross-national Exploration. In: *International journal of social welfare*. Vol 17: 281-290.
Welsh, S. & M. Kelner, B. Wellman, H. Boon (2004) Moving forward? Complementary and alternative practitioners seeking self-regulation. In: *Sociology of Health & Illness.* Vol 26 (2): 216-241.
Wendt, W. R. (1982) *Ökologie und soziale Arbeit*. Stuttgart: Enke.
Wendt, W. R. (2010) *Case Management im Sozial- und Gesundheitswesen. Ein Einführung*. Freiburg i. Br.: Lambertus.
Werner, P. & S. Carmel (2001) End-of-Life Decision Making: Practices, Beliefs and Knowledge of Social Workers in Health Care Settings. In: *Educational Gerontology.* Vol 27: 387-398.
Wilensky, H. L. (1964) The Professionalization of everyone? In: *The American Journal of Sociology*. Vol 70 (2): 137-158.
Wingfors, S. (2004) *Socionomyrkets professionalisering*. Göteborg: Göteborgs universitet. PhD.
Witz, A. (1992) *Professions and Patriarchy*. London: Routledge.
Wong, Ch., B. Chan & V. Tam (2000) Medical social workers in Hong Kong hospitals: Expectation, authority structure and role ambiguity. In: *International Social Work.* Vol 43 (4): 495-516.
Yanay, U. & Sh. Benjamin (2005) The role of social workers in disasters: The Jerusalem experience. In: *International Social Work.* Vol 48 (3): 263-276.
Åmark, K. (1990) Open Cartels and Social Closures: Professional Strategies in Sweden, 1860-1950. In: *Professions in Theory and History*. M. Burrage & R. Torstendahl (eds) London: Sage Publications.

Legislation:
www.gesetze-im-internet.de/index.html
www.notisum.se/Page.aspx?pageid=239

Professional associations' homepages:
www.dvsg.org
www.kurator.se

Appendix 1: Empirical sources

Germany – Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen (DVSG)

GA – German articles

GA001 DVSK e.V. (1990) Einführungsseminar 'Sozialdienst im Krankenhaus'. In: *Sozialdienst im Krankenhaus.* 1990 (7-8): 45.

GA002 Metzger-Paratsch, Sibylle (1989) Die Rolle des Sozialdienstes. In: *Sozialdienst im Krankenhaus.* 1990 (5-6): 12.

GA003 DVSK e.V. (1991) Erläuterungen zu den Regelungen des neuen Bundesangestellten-Tarifvertrages (BAT) für den Sozial- und Erziehungsdienst. In: *Sozialdienst im Krankenhaus.* 1991 (11-12): 5 ff.

GA004 AG Tarifrecht (1992) Erläuterungen zu den Regelungen des neuen Bundesangestellten-Tarifvertrages (BAT) für den Sozial- und Erziehungsdienst. In : *Sozialdienst im Krankenhaus.* 1992 (5-6): 3 f.

GA005 DVSK e.V. Erläuterungen zu den Regelungen des neuen BAT. In: *Sozialdienst im Krankenhaus.* 1991 (11-12): 3 ff.

GA006 Edda Schneider-Klett (1993) GSG – Gesundheitsstrukturgesetz. In: *Sozialdienst im Krankenhaus.* 1993 (5-8): 11.

GA007 Martina Christmann (1996) Liebe Kolleginnen und Kollegen, liebe Leserinnen und Leser. In: *Sozialdienst im Krankenhaus.* 1996 (10-12): 3.

GA008 DVSK e.V. (1997) Nachwort. In: *Sozialdienst im Krankenhaus.* 1997 (Sonderdruck 1): 74 f.

GA009a DVSK e.V. (1997) Sehr geehrte Damen und Herren. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 17 f.

GA009b Leitungsteam der AG Baden-Nord (1997) Fortbildungsveranstaltung der Arbeitsgemeinschaft Baden-Nord am 20.02.1997 im neurologischen Reha-Zentrum Quellenhof, Bad Wildbad. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 34 f.

GA010 H. U. Senftleben (1992) Aufruf zur Mitarbeit am Forschungsvorhaben Klinische Sozialarbeit. In: *Sozialdienst im Krankenhaus.* 1992 (3-4): 13

GA011a Stuttgarter Sozialarbeiterinnen (1992) Aufruf. In : *Sozialdienst im Krankenhaus.* 1992 (5-6): 5.

GA011b Martin Weber (1998) Aktueller Bericht aus dem Fachbereich Qualitätssicherung. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 21.

GA012 Margret Mehs (1991) Spendenaufruf an unsere Mitglieder und Abonnenten. In: *Sozialdienst im Krankenhaus.* 1991 (11-12): 1 f.

GA013a Hans Nau (1997) Zur Diskussion. In: *Forum Krankenhaussozialarbeit.* 1997 (10-12): 4.

GA013b Markus Köyer (1998) Vorwort. In: *Forum Krankenhaussozialarbeit.* 1998 (2): 1.

GA014 Michael Wiegert (1998) Fachbereich Rehabilitation der DVSK konstituiert. In: *Forum Krankenhaussozialarbeit.* 1998 (2): 5.

GA015 Hans Nau (1998) Anschlussrehabilitation. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 31 f.

GA016a Siegbert Kiessler & Michael Wiegert (1998) Erstes Basisseminar für Sozialarbeit in der Rehabilitation mit Erfolg durchgeführt. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 40 f.

GA017 Hans Nau & Ilse Weis (1998) Case-Management in der Krankenhaussozialarbeit. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 34 ff.

GA018 Conny Klingel (1998) Der Forschungsbericht „Der typische Fall der Krankenhaussozialarbeit". In: *Forum Krankenhaussozialarbeit.* 1998 (4): 36 f.

GA019 Michael Wiegert (1998) Fachbereich Rehabilitation. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 41 f.

GA020a Klaus Kaiser (1999) Fallmanager der BEK. In: *Forum Krankenhaussozialarbeit.* 1999 (1): 11 .

GA021a Hans Nau (1999) Bericht aus der Vorstandssitzung vom 15. bis 16. Januar 1999 in der Geschäftsstelle in Mainz. In: *Forum Krankenhaussozialarbeit.* 1999 (1): 13.

GA021b Norbert Gödecker-Geenen & Ilse Weis (1999) Arbeitstreffen der DVSK mit Vertretern der Fachhochschulen/Fachbereich Sozialwesen. In: *Forum Krankenhaussozialarbeit.* 1999 (1): 14 f.

GA022 DVSK e.V. (1999) Sozialarbeit in Kinderkliniken. In: *Forum Krankenhaussozialarbeit.* 1999 (1): 11.

GA023 Jochen Herlt (2000) Der Vorstand bildet die Projektgruppe Ethik. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 18.

GA024 Petra Nievelstein (2000) Fachbereich Öffentlichkeitsarbeit. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 46.

GA025a Michael Wiegert (2000) Klausur am 2./3. Februar 2000 in Bonsbeuren/Eifel. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 48.

GA025b Heike Ulrich (2000) Qualitätsentwicklung als Fachbereich installiert. In: *Forum Krankenhaussozialarbeit* 2000 (2): 49.

GA026 Jochen Herlt (2000) Adler oder Küken im Hinterhof. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 3.

GA027 DVSK e.V. (2000) Richtlinien für Fachbereiche beschlossen. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 50.

GA028 Hans Nau (2000) Der Fachbereich Akutkrankenhaus informiert. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 51.

GA029 Hans Nau (2000) Anfragen von Krankenkassen. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 52.

GA031 Nina Klein (2000) Längst überfällig: Der Fachbereich Psychiatrie. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 55.

GA032 Donna Eisler, Guido Krause & Manfred Voepel (2000) Akquisition von Praktikumsplätzen für Patienten eines psychiatrischen Krankenhauses der Regelversorgung Klinikum Nord/Ochsenzoll. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 56 f.

GA033 Siegbert Kiessler & Michael Gossner (2000) Die DVSK profiliert sich in der „Fortbildungs-Landschaft". In: *Forum Krankenhaussozialarbeit.* 2000 (3): 63 ff.

GA035a Hans Nau (2000) Neues aus dem Fachbereich Akutkrankenhaus. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 52.

GA035b Anke Abraham, Jörn Wieking, Manfred Voepel (2000) Schuldnerberatung für psychisch kranke Menschen. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 54 f.

GA035c Heike Ulrich (2000) Bericht aus dem Fachbereich Qualitätsentwicklung. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 56.

GA035d Josef Eder (2000) Neues Koordinatorenteam im Fachbereich Rehabilitation. In: *Forum Krankenhaussozialarbeit.* 2000 (4): p 57.

GA035e Josef Eder (2000) Neue KTL-Auflage 2000. In: *Forum Krankenhaussozialarbeit.* 2000 (4): p 58 ff.

GA036 Hans Nau (2000) Soziale Beratung im Spannungsfeld der medizinischen Rehabilitation und Nachsorge. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 7 f.

GA037 Klaus Kaiser (2000) Brückenschlag zu Politik und Krankenhaus. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 11-17.

GA038 Klaus Kaiser & Edwin Sannwald (2000) Überleitungspflege. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 64 f.

GA039 Norbert Gödecker-Geenen (2000) Vorwort. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 1.

GA040 Ursula Seelhorst (2001) Gekämpft, gehofft und doch verloren... In: *Forum Krankenhaussozialarbeit.* 2001 (1): 35.

GA041 Klaus Kaiser & Edwin Sannwald (2001) Überleitungspflege als Ergänzung des Sozialdienstes. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 75 f.

GA042 Ursula Seelhorst (2001) Case-Management zur Suchterkrankung im Akut-Krankenhaus. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 60-63.

GA043 Edwin Sannwald (2001) Einführungsseminar 2000 – Ein Bericht. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 67.

GA044a Nina Klein (2001) Treffen am 7. Februar 2001 in Mainz. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 69.

GA044b Manfred Voepel (2001) Trainingsprogramm zur verbesserten Früherkennung für schizophren erkrankte Menschen. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 69.

GA044c Dolf Kleinschmidt (2001) Zehn Jahre Psychiatrie-Personalverordnung (PsychPV) In: *Forum Krankenhaussozialarbeit.* 2001 (1): 71 f.

GA044d Brigitte Persch (2001) Es geht weiter im Fachbereich Qualitätsentwicklung. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 72.

GA045 Hans Nau (2001) Vorwort. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 1.

GA046a DVSK e.V. Einführungsseminar „Sozialarbeit im Krankenhaus“. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 20.

GA046b Manfred Voepel (2001) Platane 19 – Berlin. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 20.

GA046c Dolf Kleinschmidt (2001) Neuer kommissarischer Koordinator im Fachbereich Psychiatrie. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 21.

GA046d Manfred Schönhof (2001) Zuverdienst-Arbeitsplätze für chronisch schizophrene Patienten im Rahmen der Übernahme von Dienstleistungsaufgaben für ein Universitätsklinikum. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 21.

GA047a Fachbereich Qualitätsentwicklung (2001) Aufruf an alle Mitglieder und Leser des Forums. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 23.

GA047b DVSK e.V. (2001) Empfehlungen zu Standards der Prozessqualität in der kardiologischen Rehabilitation. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 23 f.

GA048 Jochen Herlt (2001) Ethik im Gesundheitswesen – eine Herausforderung für die Sozialarbeit. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 25.

GA049a Hans Nau (2001) Gesetz zur Rehabilitation und Teilhabe behinderter Menschen (SGB IX) seit 1.7.2001 in Kraft. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 2 f.

GA049b DVSK e.V. (2001) Das Sozialgesetzbuch IX ist am 6.4.2001 vom Bundestag verabschiedet worden. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 3 f.

GA051 Uwe Hinze (2002) Berlin – DVSK – 75 Jahre – Tradition – Gegenwart – Zukunft. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 1.

GA052a Fachbereich Psychiatrie (2002) Start-up Veranstaltung in Berlin zur Gründung von Regionalgruppen. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 42.

GA052b Fachbereich Rehabilitation (2002) Vorankündigung – Basisseminar Sozialarbeit in der Rehabilitation. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 43.

GA053 Peter Prahl (2002) Nun lasst uns gemeinsam an die Arbeit gehen... In: *Forum Krankenhaussozialarbeit.* 2002 (2): 1.

GA054a Sabine Meurer (2002) Qualitätsstandards in der Kliniksozialarbeit – wie rüsten wir uns für die Einführung der DRGs? In: *Forum Krankenhaussozialarbeit.* 2002 (2): 26.

GA054b Ulrich Kurlemann (2002) Statistik – Notwendigkeit zur Dokumentation der täglichen Arbeit? In: *Forum Krankenhaussozialarbeit.* 2002 (2): 26 f.

GA054c Ulrich Kurlemann (2002) LEXsoft Sozialdienst II, Folge 32. In: *Forum Krankenhaussozialarbeit.* 2002 (2): 27 f.

GA055 Bettina Lauterbach (2002) Wird die Personalausstattung von Sozialarbeitern nach PsychPV in den psychiatrischen Kliniken erfüllt? In: *Forum Krankenhaussozialarbeit.* 2002 (2): 31.

GA056 Hans Nau (2002) Ein Verband in Bewegung – wir stellen uns Herausforderungen. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 1.

GA057a Ulrich Kurlemann & Hans Nau (2002) Aus dem Fachbereich Akutkrankenhaus. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 39.

GA057b Ulrich Kurlemann (2002) LEXsoft Sozialdienst II – das erste update ist Ende Juni 2002 erschienen. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 40.

GA057c Klaus Kaiser (2002) Fachbereich Öffentlichkeitsarbeit. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 42.

GA057d Gernot Hahn & Manfred Voepel (2002) Hindernisse und Umwege zur Etablierung von Soziotherapie – was kann der Sozialdienst in der Psychiatrie tun? In: *Forum Krankenhaussozialarbeit.* 2002 (3): 43 f.

GA057e Josef Eder (2002) Dokumentationsanleitung zur KTL in der Klinischen Sozialarbeit. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 44-47.

GA057f Hildegard Hegeler (2002) Projektgruppe Geriatrie sammelt Informationen. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 47.

GA058 Petra Nievelstein (2002) Aufeinander zugehen. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 1.

GA059a Hans Nau (2002) das DVSK-Modell der Leistungserfassung. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 33.

GA059b Fachbereich Fortbildung (2002) Bericht über das DVSK Spezialseminar vom 26. bis 28.6.2002 in Wiesbaden-Naurod. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 33-36.

GA059c Marina Höhn-Beste, Klaus Kaiser & Edwin Sannwald (2002) Medizinische und pflegerische Indikationen, die das Einschalten des Sozialdienstes notwendig machen. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 36.

GA059d Manfred Voepel (2002) Längst überfällig, der Fachbereich Psychiatrie... In: *Forum Krankenhaussozialarbeit.* 2002 (4): 37.

GA059e DVSK e.V. (2002) Seminar: Effizient handeln in der Klinischen Sozialarbeit. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 38.

GA059f DVSK e.V. (2002) Basisseminar „Sozialarbeit im Krankenhaus". In: *Forum Krankenhaussozialarbeit.* 2002 (4): 39.

GA060 Petra Nievelstein (2002) Konstruktives Miteinander zum Wohle des Patienten. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 5-7.

GA061 Hans Nau (2002) Privater Pflegedienst bietet Konzept zur Umgehung bürokratischer Hürden. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 14.

GA063 Ursula Seelhorst (2003) Nichts ist so stetig wie der Wandel... In: *Forum Krankenhaussozialarbeit.* 2003 (1): 1.

GA064a Hans Nau (2003) Ethik in Zeiten der Krise im Gesundheitswesen. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 3.

GA064b Norbert Gödecker-Geenen / Hans Nau (2003) Patientenwohl und Ökonomie – ein Spannungsfeld der Gegenwart. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 4-9.

GA065a Hans Nau (2003) Bericht aus dem Fachbereich Akutkrankenhaus. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 69.

GA065b Manfred Voepel (2003) Bericht aus dem Fachbereich Psychiatrie. In: *Forum Krankenhaussozialarbeit* 2003 (1): 69 f.

GA065c Hans Nau (2003) Veränderungen im Redaktionsteam. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 71.

GA066 Ursula Seelhorst (2003) Expertenstandardentwurf – „Entlassungsmanagement". In: *Forum Krankenhaussozialarbeit.* 2003 (1): 2.

GA067a Uschi Grieshaber (2003) Kommentar aus FORUM SOZIALSTATION Nr. 1 19/Dezember 2002. In: *Forum Krankenhaussozialarbeit* 2003 (1): 24.

GA067b P. Delkos, H. Dohr & H. Windolf (2003) Leserbrief. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 24.

GA068 Hans Nau (2003) Visionen können Wirklichkeit werden. In: *Forum Krankenhaussozialarbeit.* 2003 (2): 1.

GA069a DVSK e.V. (2003) Name gesucht! In: *Forum Krankenhaussozialarbeit.* 2003 (2): 42.

GA069b Hans Nau (2003) Anhaltszahlen für Sozialarbeit in Akutkliniken. In: *Forum Krankenhaussozialarbeit.* 2003 (2): 42 f.

GA070 DVSK e.V. (2003) Rahmenempfehlungen der DVSK zur Einrichtung von Stellen in Geriatrischen Einrichtungen. In: *Forum Krankenhaussozialarbeit.* 2003 (2): 43-46.

GA071 Hans Nau (2003) Ilse Weis – Berufung zur Expertin für Diseasemanagement-Programme. In: *Forum Krankenhaussozialarbeit.* 2003 (2): 3.

GA072 Hans Nau (2003) Vernetzung – die Herausforderung im Gesundheitswesen. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 1.

GA073 Ilse Weis (2003) Diseasemanagement-Programme für Brustkrebs betonen die Notwendigkeit der psychosozialen Betreuung der Patientinnen. In: *Forum Krankenhaussozialarbeit* 2003 (3): 22 ff.

GA074a Ulla Seelhorst (2003) Wir wollen auf einen Baum, der drei Meter hoch ist und haben nur eine Leiter, die 1.50 Meter hoch ist. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 60 f.

GA074b Sibylle Kraus (2003) Von der DVSK zur Deutschen Vereinigung für die Sozialarbeit im Gesundheitswesen (DVSG)? In: *Forum Krankenhaussozialarbeit.* 2003 (3): 62 f.

GA074c Andrea Apel (2003) Kennst du den Weg zur DVSG? In: *Forum Krankenhaussozialarbeit.* 2003 (3): 64 f

GA075 Ulla Seelhorst (2003) Entlassung nicht möglich – Versorgung ungeklärt! In: *Forum Krankenhaussozialarbeit.* 2003 (3): 38-42.

GA076 Norbert Gödecker-Geenen & Hans Nau (2003) In Zeiten des Umbruchs und des Wandels! In: *Forum Krankenhaussozialarbeit.* 2003 (4): 1.

GA077 Norbert Gödecker-Geenen & Hans Nau (2003) Der Kommentar. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 4.

GA078 Hans Nau (2003) Neuer OPS-Katalog – Eine Chance für die Sozialarbeit? In: *Forum Krankenhaussozialarbeit* 2003 (4): 33 f.

GA079 Ursula Seelhorst (2004) Aus Der DVSK wurde die DVSG... und was kommt jetzt? In: *Forum Krankenhaussozialarbeit.* 2004 (1): 1.

GA080 Ulla Seelhorst (2004) Viele Neue am Start. In: *Forum sozialarbeit + gesundheit.* 2004 (2): 3.

GA081 DVSG e.V. (2004) Neue Reform – neue Strukturen – neue Chancen? In: *Forum sozialarbeit + gesundheit.* 2004 (2): 10-13.

GA082a DVSG e.V. (2004) Positionen der DVSG. In: *Forum sozialarbeit + gesundheit.* 2004 (2): 13.

GA082b Heike Ulrich (2004) Projektgruppe „Öffnung" gebildet. In: *Forum sozialarbeit + gesundheit.* 2004 (2): 13.

GA082c Ulla Seelhorst (2004) Eine Ohrfeige für die Sozialarbeit? Ja und nein... In: *Forum sozialarbeit + gesundheit.* 2004 (2): 29.

GA083a DVSG e.V. (2004) Arbeitsgemeinschaften. In: *Forum sozialarbeit + gesundheit.* 2004 (2): 34-37.

GA084 Hans Nau (2004) Ohne Richtlinien ist sinnvolle Schnittstellenarbeit unmöglich! In: *Forum sozialarbeit + gesundheit.* 2004 (2): 39.

GA085 Hans Nau (2004) Vorsorge hilft allen. In: *Forum sozialarbeit + gesundheit.* 2004 (3): 3.

GA086 Hans Nau (2004) DMP-Brustkrebs – Der Baden-Württembergische Vertrag räumt der psychosozialen Versorgung einen hohen Stellenwert ein. In: *Forum sozialarbeit + gesundheit.* 2004 (3): 33.

GA087 Hans Nau (2004) Kooperation mit Berufsgenossenschaften. In: *Forum sozialarbeit + gesundheit.* 2004 (3): 36.

GA088 DVSG e.V. (2004) Arbeitsgemeinschaften. In: *Forum sozialarbeit + gesundheit.* 2004 (3): 38.

GA089 Ulla Seelhorst (2004) Die Alten sind die Zukunft. In: *Forum sozialarbeit + gesundheit.* 2004 (4): 3.

GA091 DVSG e. V. (2004) Bericht vom DVSG-Vorstand – Erprobung von Fallgruppen. In: *Forum sozialarbeit + gesundheit.* 2004 (4): 34.

GA092 Hildegard Hegeler (2004) SCAG-Fachgruppe Altenhilfe: Sozialarbeiter sind Lotsen in der Geriatrie. In: *Forum sozialarbeit + gesundheit.* 2004 (4): 35 f.

GA093 DVSG e.V. (2004) Arbeitsgemeinschaften. In: *Forum sozialarbeit + gesundheit.* 2004 (4): 36 ff.

GA094 Ulrich Kurlemann (2005) Ein Jahr der Veränderung. In: Forum sozialarbeit + gesundheit 2005 (1): 3.

GA095 DVSG e.V. (2005) Einführungsseminar - „Sozialarbeit im Gesundheitswesen". In: *Forum sozialarbeit + gesundheit.* 2005 (1): 31.

GA096a Ingo Müller-Baron (2005) Gespräch mit der Bundesversicherungsanstalt für Angestellte – Verbesserten Informationsaustausch vereinbart. In: *Forum sozialarbeit + gesundheit.* 2005 (1): 33 f.

GA096b Hans Nau (2005) Kodierung im Operationen- und Prozedurenschlüssel (OPS). In: *Forum sozialarbeit + gesundheit.* 2005 (1): 34.

GA097a Tanja Schäfer (2005) Arbeitsgemeinschaften – LAG Nordrhein-Westfahlen. In: *Forum sozialarbeit + gesundheit.* 2005 (1): 35 f.

GA097b Christine Benda (2005) Arbeitsgemeinschaften – LAG Baden Württemberg. In: *Forum sozialarbeit + gesundheit.*2005 (1): 36 f.

GA097c Ingo Müller-Baron (2005) Arbeitsgemeinschaften – LAG Rheinland-Pfalz/Saarland. In: *Forum sozialarbeit + gesundheit.*2005 (1): 37 f.

GA097d Thomas Unger (2005) Arbeitsgemeinschaften – AG Bodensee. In: *Forum sozialarbeit + gesundheit.* 2005 (1): 38.

GA097e Ulla Seelhorst (2005) Sozialarbeit in Veränderung einbeziehen – DVSG im Gespräch mit dem Bundesministerium für Gesundheit und soziale Sicherung. In: *Forum sozialarbeit + gesundheit.*2005 (1): 39 f.

GA098 Ingo Müller-Baron (2005) Erfolgsstories. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 3.

GA099a Ingo Müller-Baron (2005) Sitzung des DVSG-Vorstandes – Sozialarbeit im Gesundheitswesen vielfältig positioniert. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 32.

GA099b DVSG e.V. (2005) Kooperation - Sozialarbeit im beruflichen Alltag: Forschungsprojekt der Alice-Salomon-FH Berlin und der DVSG. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 32.

GA099c DVSG e.V. (2005) Modellprojekt mit Unfallkassen – Sozialdienste in Betreuung unfallverletzter Patienten einbeziehen. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 32 f.

GA099d Ingo Müller-Baron (2005) DVSG-Bundeskongress 2005: Sozialarbeit im Gesundheitswesen – Kontinuität und Wandel. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 33.

GA100a Anemone Falkenroth & Beate Schneider (2005) Arbeitsgemeinschaften – AG Berlin. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 35.

GA100b Bettina Lauterbach (2005) Arbeitsgemeinschaften – AG Hamburg. In: *Forum sozialarbeit + gesundheit.* 2005 (2): 35.

GA101 Hans Nau (2005) Alles in Bewegung? In: *Forum sozialarbeit + gesundheit.* 2005 (3): 3.

GA102 Ingo Müller-Baron (2005) Sitzung in Berlin: DVSG und Bundesministerium für Senioren kooperieren künftig. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 37.

GA103 Ingo Müller-Baron (2005) Beiratssitzung mit intensiven Diskussionen – Sozialarbeit im Krankenhaus sichert Behandlungsqualität. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 38.

GA104a Ingo Müller-Baron (2005) Einrichtung von Stellen in Geriatrischen Einrichtungen: DVSG-Vorstand verabschiedet Rahmenempfehlungen. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 40.

GA104b Ingo Müller-Baron (2005) Zeitschrift für psychosoziale Praxis und Forschung – Wissenschaftliche Beilage im FORUM ab Oktober. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 40.

GA104c Anette Fessler (2005) Arbeitsgemeinschaften – AG Bodensee. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 41.

GA104d Sylvia Sandke (2005) Arbeitsgemeinschaften – AG Franken. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 41 f.

GA104e Uta Hillers (2005) Arbeitsgemeinschaften – AG Rheinland-Süd: DVSG-Fallgruppen und Neuwahlen. In: *Forum sozialarbeit + gesundheit.* 2005 (3): 42.

GA105 Kirsten Becker-Bikowski (2005) Forschung – Stiefkind der Sozialarbeit im Gesundheitswesen? In: *Forum sozialarbeit + gesundheit.*2005 (3): 45.

GA106a Hans Nau (2005) Klinische Sozialarbeit und Pflegeüberleitung. In: *Forum sozialarbeit + gesundheit.*2005 (3): 35.

GA106b DVSG e.V. (2005) Position einer Arbeitsgruppe aus Baden-Württemberg zur Zusammenarbeit von Klinischer Sozialarbeit und Pflegeüberleitung. In: *Forum sozialarbeit + gesundheit.*2005 (3): 35 f.

GA107 Ulrich Kurlemann (2005) Ambulante Vielfalt. In: *Forum sozialarbeit + gesundheit.* 2005 (4): 3.

GA109 Ingo Müller-Baron (2006) Kontinuität und Wandel. In: *Forum sozialarbeit + gesundheit.* 2006 (1): 3.

GA110 DVSG e.V. (2006) DVSG-Bundeskongress: Das Ende der Bescheidenheit – Psychosoziale Leistungen müssen integraler Bestandteil der gesundheitlichen Versorgung werden. In: *Forum sozialarbeit + gesundheit.* 2006 (1): 42 f.

GA111 Ulla Seelhorst (2006) Statistik ist unabdingbar, auch in der Sozialarbeit. In: *Forum sozialarbeit + gesundheit.* 2006 (1): 34.

GA112 Hans Nau (2006) Es fehlt ein klares Votum. In: *Forum sozialarbeit + gesundheit.* 2006 (2): 3.

GA113a Ingo Müller-Baron (2006) Informationsangebot an die Politik soll verstärkt werden – DVSG-Vorsitzender trifft gesundheitspolitischen Sprecher der FDP. In: *Forum sozialarbeit + gesundheit.* 2006 (2): 45.

GA113b Petra Wehrle (2006) AG Baden Süd: Psychosoziale Diagnosen – Konsequenzen für die Soziale Arbeit. In: *Forum sozialarbeit + gesundheit.* 2006 (2): 45.

GA113c AG Bayern Süd (2006) Onkologisches Seminar für Sozialarbeiter. In: *Forum sozialarbeit + gesundheit.* 2006 (2): 45.

GA113d Ingo Müller-Baron (2006) DVSG und Berufsförderungswerke entwickeln Informationsmodell – Berufliche Perspektiven frühzeitig im Blick. In: *Forum sozialarbeit + gesundheit.*2006 (2): 46 f.

GA113e AG Baden-Nord (2006) Auswirkungen von Harz IV auf die Sozialarbeit im Gesundheitswesen. In: *Forum sozialarbeit + gesundheit.* 2006 (2): 47.

GA114 Ulla Seelhorst-Köhler (2006) Na denn Prost!? In: *Forum sozialarbeit + gesundheit.* 2006 (3): 3.

GA115a Ingo Müller-Baron (2006) Neue Broschüre erschienen: DVSG-Fallgruppen für die Sozialarbeit im Gesundheitswesen. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 45.

GA115b Ingo Müller-Baron (2006) Fachlicher Austausch: DRV-Bund und DVSG trafen sich erneut in Berlin. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 45 f.

GA115c DVSG e.V. (2006) Beiratssitzung in Magdeburg: Ehrenamtliches Engagement im Fachverband. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 46.

GA115d Holger Hagemann (2006) AG Sachsen: Reger fachlicher Austausch und Information zum Fachverband. In: *Forum sozialarbeit + gesundheit* 2006 (3): 47.

GA115e AG Baden-Württemberg (2006) Ökonomie und Sozialarbeit – Tagung rund um berufliche Ethik. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 47.

GA115f Ingo Müller-Baron (2006) Niederländisch-Deutsche Kooperation: Vernetztes Arbeiten in der Praxis. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 48.

GA116 Ilse Weis (2006) Rehabilitationsträger regeln Kooperation mit Sozialdiensten. In: *Forum sozialarbeit + gesundheit.* 2006 (3): 41 ff.

GA117 Ingo Müller-Baron (2006) Gegensätze ziehen sich an. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 3.

GA118a Ingo Müller-Baron (2006) 80 Jahre und kein bißchen leise: DVSG wurde im Oktober 1926 gegründet. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 44.

GA118b Ulla Seelhorst-Köhler (2006) DVSG im Gespräch ... mit dem Bundesministerium für Gesundheit. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 44.

GA118c Jürgen Walther (2006) AG Baden Nord: „Ambulante Rehabilitation – Möglichkeiten – Grenzen – Perspektiven“ – eine Fachtagung. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 45.

GA118d Petra Wehrle (2006) AG Baden Süd: Psychosoziale Diagnosen – Konsequenzen für die Soziale Arbeit. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 46.

GA118e LAG Baden-Württemberg (2006) 21. November: Tagung Ökonomie und Sozialarbeit. In: *Forum sozialarbeit + gesundheit.*2006 (4): 46.

GA118f AG Thüringen (2006) Erfolgreiche Tagung in Wasserberg. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 47.

GA119 Ilse Weis (2006) Gut beraten, gut gesteuert. In: *Forum sozialarbeit + gesundheit.* 2006 (4): 36.

GA122 Ulrich Kurlemann (2007) Auf ein neues gesundes Jahr. In: *Forum sozialarbeit + gesundheit.* 2007 (1): 3.

GA123a Ingo Müller-Baron (2007) Der Nutzen muss erlebbar sein: Neue Aufgabenverteilung und Kooperationsformen zwischen Gesundheitsberufen. In: *Forum sozialarbeit + gesundheit.* 2007 (1): 35.

GA123b Ingo Müller-Baron (2007) DVSG nimmt Stellung zur Gesundheitsreform: Eckpunktepapier unzureichend berücksichtigt. In: *Forum sozialarbeit + gesundheit.* 2007 (1): 35.

GA124 Hans Nau (2007) Bündnisse für Kinder. In: *Forum sozialarbeit + gesundheit.* 2007 (2): 3.

GA125a Ingo Müller-Baron (2007) Der Vorstand tagte im Januar: DVSG zunehmend als Fachverband anerkannt. In: *Forum sozialarbeit + gesundheit.* 2007 (2): 36.

GA125b DVSG e.V. (2007) Vorstandswahlen 2007: Erste mögliche Kandidatin informierte sich. In: *Forum sozialarbeit + gesundheit.* 2007 (2): 36.

GA126 Anemone Falkenroth (2007) Ohne Gesundheit keine Integration. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 3.

GA127a DVSG e.V. (2007) Zum Ende der Amtszeit: Vorstandsarbeit hat sich gelohnt. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 45.

GA127b Anemone Falkenroth (2007) AG Berlin: Gespräch mit Reha-Koordinatorin der BARMER Berlin/Brandenburg. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 46.

GA127c Claudia Wehnelt (2007) AG Baden-Süd: Fortbildung: Auch Patienten haben Familie. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 47.

GA128 Sibylle Kraus (2007) Anmerkung zum Leserbrief: „Was lange währt, ...“ In: *Forum sozialarbeit + gesundheit.* 2007 (3): 38.

GA129 Sibylle Kraus (2007) Aktuelle Veränderungen im Gesundheitswesen. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 39 ff.

GA130 Hans Nau (2007) Mobile Rehabilitation – eine neue Form der Versorgung. In: *Forum sozialarbeit + gesundheit.* 2007 (3): 42 ff.

GA131 Ulrich Kurlemann (2007) Erfolgreich fortführen! In: *Forum sozialarbeit + gesundheit.* 2007 (4): 3.

GA132a DVSG e.V. (2007) Kooperationsgespräch: Fachlicher Austausch mit der DRV Bund. In: *Forum sozialarbeit + gesundheit.* 2007 (4): 44.

GA132b Ingo Müller-Baron (2007) Gemeinsame Fachtagung: Schnittstellen von Pflege und Sozialarbeit. In: *Forum sozialarbeit + gesundheit.* 2007 (4): 45.

GA132c Ingo Müller-Baron (2007) Kompetenz durch Kooperation und Vernetzung: Netzwerk für geriatrische Rehabilitation zieht Bilanz. In: *Forum sozialarbeit + gesundheit.* 2007 (4): 46.

GA133 Ingo Müller-Baron (2007) Gesundheitsminister beschließen elektronisches Gesundheitsberuferegister. In: *Forum sozialarbeit + gesundheit.* 2007 (4): 40.

GA135 Peter Reinicke (2008) *Sozialarbeit – eine Profession bahnt sich ihren Weg.* Bielefeld: Bethel-Verlag.

GA136 Ingo Müller-Baron (2008) Herausforderungen annehmen. In: *Forum sozialarbeit + gesundheit.* 2008 (1): 3.

GA137 Hildegard Hegeler, Sibylle Kraus & Heike Ulrich (2008) Chancen nutzen. In: *Forum sozialarbeit + gesundheit.* 2008 (1): 42 f.

GA138 Ingo Müller-Baron (2008) Bundeskongress 2007: Das Gesundheitswesen konsequent am Menschen ausrichten. In: *Forum sozialarbeit + gesundheit.* 2008 (1): 44 f.

GA139 Hans Nau (2008) Gesundheit geht alle an! In: *Forum sozialarbeit + gesundheit.* 2008 (2): 3.

GA140 DVSG e.V. (2008) Die DVSG bietet an: Fortbildungsseminare 2008. In: *Forum sozialarbeit + gesundheit.* 2008 (2): 43.

GA141a Ingo Müller-Baron (2008) LAG Nordrhein-Westfalen: Reform des Landeskrankenhausgesetzes. In: *Forum sozialarbeit + gesundheit.* 2008 (2): 44.

GA141b Ingo Müller-Baron (2008) Rehabilitation ist immer Teamleistung: Fachtagung thematisiert interdisziplinäre Zusammenarbeit von Pflege und Sozialer Arbeit. In: *Forum sozialarbeit + gesundheit.* 2008 (2): 44 f.

GA141c AG Berlin (2008) Entwicklungen im Gesundheitswesen. In: *Forum sozialarbeit + gesundheit.* 2008 (2): 45.

GA141d AG Hamburg (2008) Themen und Treffen. In: *Forum sozialarbeit + gesundheit.* 2008 (2): 45.

GA142 Ulla Seelhorst-Köhler (2008) Lebe deine Träume! In: *Forum sozialarbeit + gesundheit.* 2008 (3): 3.

GA143a Katharina Müller (2008) AG Berlin: Soziale Arbeit mischt sich kompetent ein. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 41.

GA143b DVSG e.V. (2008) Bitte vormerken: DVSG-Bundeskongress 2009. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 41.

GA143c AG Rheinland-Pfalz/Saarland (2008) Fachtagung thematisiert professionelles Handeln. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 42.

GA143d DVSG e.V. (2008) Angebot für DVSG-Mitglieder. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 42.

GA143e LAG Baden-Württemberg (2008) Soziale Arbeit & Palliative Care. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 42.

GA144 Sibylle Kraus (2008) Rechtzeitiges strategisches Handeln erforderlich. In: *Forum sozialarbeit + gesundheit.* 2008 (3): 36 f.

GAR – German annual reports

GAR001 Margret Mehs (1991) Geschäftsbericht für das Jahr 1990. In: *Sozialdienst im Krankenhaus.* 1991 (1-2): 1-22.

GAR002 Martina Christmann (1993) Geschäftsbericht für das Jahr 1992. In: *Sozialdienst im Krankenhaus.* 1993 (1-4): 3-21.

GAR002b Hannelore Schmid (1993) Nachtrag zum Geschäftsbericht 1992 aus der AG Schleswig-Holstein. In: *Sozialdienst im Krankenhaus.* 1993 (5-8): 12.

GAR003 Marina Christmann (1997) Geschäftsbericht für das Jahr 1996. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 13-29.

GAR004 Nina Klein (1997) Hauptamtliche Geschäftsführung – Tätigkeitsbericht 1996. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 33 f.

GAR005 DVSK e.V. (1999) Geschäftsbericht der DVSK. In: *Forum Krankenhaussozialarbeit.* 1999 (1): 3-10.

GAR006 DVSG e.V. (2005) *Geschäftsbericht 2003-2005: Netzwerke – Aktivitäten – Gremien*. Mainz.

http://dvsg.org/fileadmin/dateien/Veroeffentlichungen/Geschaeftsberichte/DVSG-Gesch%E4ftsbericht%202003-2005.pdf (access 20120322).

GAR007 DVSG e.V. (2007) *Geschäftsbericht 2005-2007: Netzwerke – Aktivitäten – Gremien*. Mainz .http://dvsg.org/fileadmin/dateien/Veroeffentlichungen/Geschaeftsberichte/DVSG-Gesch%E4ftsbericht%202005-2007.pdf (access 20120322).

GD – German definitions

GD001 DVSK e.V. (1993) Handlungskonzept Sozialarbeit im Krankenhaus. In: *Sozialdienst im Krankenhaus.* 1993 (Sonderdruck 1): 92-124.

GD002 DVSG e.V. (2006) *DVSG-Fallgruppen für die Sozialarbeit im Gesundheitswesen*. Kempten: AZ Druck und Datentechnik GmbH.

GD003 DVSG e.V. (2007) *Produkt- und Leistungsbeschreibung der Klinischen Sozialarbeit*. Kempten: AZ Druck und Datentechnik GmbH.

GPA – German protocols by the advisory board

GPA001 Margret Mehs (1990) Kurzbericht aus der Beiratssitzung vom 2. bis 4.3.1990 in Kronberg. In: *Sozialdienst im Krankenhaus.* 1990 (5-6): 28.

GPA002 Margret Mehs (1990) Kurzbericht aus der Beiratssitzung vom 22. – 24. Juni 1990 in Mainz. In: *Sozialdienst im Krankenhaus.* 1990 (7-8): 3.

GPA003 Margret Mehs (1991) Kurzbericht aus der Beiratssitzung vom 2./3. August in Mainz. In: *Sozialdienst im Krankenhaus.* 1991 (11-12): 4.

GPA004 Margret Mehs (1992) Kurzbericht aus der Beiratssitzung vom 11./12. September in Rothenburg o.d.T.. In: *Sozialdienst im Krankenhaus.* 1992 (11-12): 2 f.

GPA005 Martina Christmann (1993) Kurzbericht aus der Beiratssitzung am 29. und 30.1.1993 im Intercity-Restaurant, Mainz. In: *Sozialdienst im Krankenhaus.* 1993 (1-4): 24 f.

GPA006 Martina Christmann (1993) Kurzbericht aus der Beiratssitzung. In: *Sozialdienst im Krankenhaus.* 1993 (9-12): 6 f.

GPA007a Conny Klingel (1998) Information aus der Beiratssitzung am 6./7. Febr. 1998 in Bensberg/Köln. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 24 f.

GPA007b Klaus Kaiser (1998) Bericht über das Treffen mit dem Geschäftsführer der DBSH. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 23 f.

GPA008a Markus Köyer (1998) Bericht zur Vorstandssitzung der DVSK am 16. u. 17.10. in Mainz. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 6.

GPA008b Markus Köyer (1998) Bericht zur Beiratssitzung der DVSK am 6. u. 7.11. in Mainz. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 6.

GPA009a Petra Nievelstein (2000) Bericht aus der Beiratssitzung vom 7. und 8. April 2000. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 24.

GPA009b LAG Baden-Württemberg (2000) Beiratsvorstellung der LAG in Baden-Württemberg. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 24 f.

GPA009c Michael Schüssler (2000) Gemeinsame Veranstaltungen der drei Arbeitsgemeinschaften in Bayern. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 25.

GPA009d Sabine Prange (2000) Kurzfassung des Arbeitsgruppenergebnisses Bremen, Hamburg, Mecklenburg-Vorpommern. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 26.

GPA009e AG Sachsen/Thüringen (2000) Sozialpolitische Strategien in den Bundesländern und auf der Ebene der Arbeitsgemeinschaften. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 26 f.

GPA009f AG Niedersachsen/Sachsen-Anhalt (2000) Initiativen zur sozialpolitischen Einflussnahme in Niedersachsen. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 27.

GPA010 Helmut Fischer (2001) Fortbildung für den Beirat. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 7.

GPA011 Norbert Gödecker-Geenen (2002) Beiratssitzung am 23./24.11.2001 im Roncalli Haus Magdeburg. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 25 f.

GPA012a DVSK e.V. (2002) Aus dem Beirat. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 26.

GPA012b DVSK e.V. (2002) Politische Aktivitäten in Rheinland-Pfalz. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 26.

GPA013a Ingo Müller-Baron (2007) DBSH und DVSG im Dialog: Verbände vereinbaren verstärkte Kooperation. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 37.

GPA013b Ingo Müller-Baron (2007) DVSG-Beirat traf sich in Mainz: Interessenten an Vorstandsarbeit sind willkommen. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 37.

GPA013c Hans Nau (2007) LAG Baden-Württemberg: Das Land stellt sich dem Thema Ökonomie und Sozialarbeit. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 38.

GPA013d Stefanie Metzger (2007) AG Franken: Tagung: Gesundheits- und Selbstmanagement. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 39.

GPA013e Stephan Fromm (2007) Fachtagung der LAG Nordrhein-Westfalen: Sozialarbeiter als Lotsen im Gesundheitssystem. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 39.

GPA013f Ingo Müller-Baron (2007) LAG Rheinland-Pfalz/Saarland: Fachtagung: Rehabilitationspraxis in Rheinland-Pfalz. In: *Forum sozialarbeit + gesundheit*. 2007 (1): 40.

GPB – German protocols by the association's board

GPB001 Margret Mehs (1990) Kurzbericht aus der Sitzung des Vorstandes am 6. Juli 1990 in Mainz. In: *Sozialdienst im Krankenhaus.* 1990 (7-8): 2 f.

GPB002 Margret Mehs (1991) Kurzbericht aus der Vorstandssitzung vom 18. Oktober 1991 in Mainz. In: *Sozialdienst im Krankenhaus.* 1991 (11-12): 3 f.

GPB003 Margret Mehs (1992) Kurzbericht aus der Vorstandssitzung vom 31. Januar 1992 in Mainz. In: *Sozialdienst im Krankenhaus.* 1992 (3-4): 1 f.

GPB004 Margret Mehs (1992) Kurzbericht aus der Vorstandssitzung am 29. Mai 1992 in Mainz. In: *Sozialdienst im Krankenhaus.* 1992 (7-10): 1.

GPB005 Margret Mehs (1992) Kurzbericht aus der Vorstandssitzung am 9. Oktober 1992 in Mainz. In: *Sozialdienst im Krankenhaus.* 1992 (11-12): 2.

GPB006 Martina Christmann (1993) Kurzbericht aus der Vorstandssitzung am 5. Mai 1993 in Goslar. In: *Sozialdienst im Krankenhaus.* 1993 (5-8): 9 f.

GPB007 Martina Christmann (1993) Kurzbericht aus den Vorstandssitzungen vom 24.09.1993 und 22.10.1993. In: *Sozialdienst im Krankenhaus.* 1993 (9-12): 4 ff.

GPB008 Martina Christmann (1992) Vorstandssitzung 18.12.92 im Uni-Klinikum Mainz. In: *Sozialdienst im Krankenhaus.* 1993 (1-4): 23 f.

GPB009 Martina Christmann (1996) Kurzbericht aus der Vorstandssitzung vom 12.07.1996 in Frankfurt/Main. In: *Sozialdienst im Krankenhaus.* 1996 (7-9): 5 f.

GPB010 Martina Christmann (1996) Kurzbericht aus der Vorstandssitzung vom 1. und 2. November 1997 in Wiesbaden. In: *Sozialdienst im Krankenhaus.* 1996 (10-12): 6-9.

GPB011 Martina Christmann (1997) Bericht aus der Vorstandssitzung vom 21. und 22.03.1997 im Erbacher Hof in Mainz. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 30 ff.

GPB012 DVSK e.V. (1997) Bericht des Vorstandes. In: *Forum Krankenhaussozialarbeit.* 1997 (10-12): 12-15.

GPB013	Markus Köyer (1998) Bericht zur Sitzung des Vorstandes der DVSK im Wilhelm-Polligkeit-Institut. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 21 f.
GPB014	Petra Nievelstein (2000) Bericht aus der Vorstandssitzung vom 5. und 6. Mai 2000 in Mainz. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 2.
GPB015	Norbert Gödecker-Geenen & Hans Nau (2000) An die Fachhochschule Coburg, Fachbereich Sozialwesen. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 4 f.
GPB016	Norbert Gödecker-Geenen & Hans Nau (2000) Bericht über die Sozialarbeit in Akutkrankenhäusern. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 4 f
GPB017	DVSK e.V. (2000) Vorschlag der DVSK zur Verankerung der Sozialdienste in den Landeskrankenhausgesetzen. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 6.
GPB018	Norbert Gödecker-Geenen & Hans Nau (2000) Richtlinien des Bundesausschusses der Ärzte und Krankenkassen über die Verordnung häuslicher Krankenpflege nach § 92 SGB V, veröffentlicht im Bundesanzeiger Nr. 91 vom 13.5.2000. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 18 f.
GPB019	Norbert Gödecker-Geenen & Hans Nau (2000) Sehr geehrter Herr Minister! In: *Forum Krankenhaussozialarbeit.* 2000 (3): 20.
GPB020	Klaus Kaiser (2000) Bericht aus der Vorstandssitzung vom 20./21.10.00 in Berlin. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 18.
GPB022	Ilse Weis & Hans Nau (2000) Das neue SGB IX. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 19.
GPB023	Klaus Kaiser (2000) Treffen mit der Deutschen Krankenhausgesellschaft am 21.9.00 in Düsseldorf. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 20.
GPB024	Norbert Gödecker-Geenen & Hans Nau (2000) Sozialarbeit ist unverzichtbar. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 24 f.
GPB026	Hans Nau (2001) Bericht aus der Vorstandssitzung am 19./20.1.2001 in Mainz. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 36.
GPB027	Norbert Gödecker-Geenen & Hans Nau (2001) Stellungnahme der DVSK zum Fallmanagement der Krankenkassen. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 43.
GPB028	Norbert Gödecker-Geenen & Hans Nau (2001) Die DVSK nimmt zum aktuellen Gesetzentwurf des SGB IX Stellung. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 46 f.
GPB029	Ilse Weis (2001) Rehabilitation und Teilhabe behinderter Menschen. In: *Forum Krankenhaussozialarbeit.* 2001 (1): 48 f.
GPB030	Hans Nau (2002) Europäische Fachtagung der DVfR im Rahmen der Messe „REHACare“ in Düsseldorf. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 19.
GPB031a	Bericht aus der Vorstandssitzung am 30./31.3.2001 in Mainz. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 6.
GPB031b	Hans Nau (2001) Forum Kinderklinik. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 6.
GPB034a	DVSK e.V. (2002) Rahmenempfehlungen der DVSK zur Einrichtung von Stellen im Krankenhaussozialdienst in Akutkrankenhäusern. In: *Forum Krankenhaussozial-arbeit.* 2002 (1): 20 f.
GPB034b	DVSK e.V. (2002) Rahmenempfehlungen der DVSK zur Einrichtung von Stellen in Rehabilitationseinrichtungen. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 22 ff.
GPB035a	Peter Prahl (2002) Die Arbeit hat begonnen! In: *Forum Krankenhaussozialarbeit.* 2002 (3): 5.
GPB035b	DVSK e.V. (2002) Meldebogen der DVSK. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 6.

GPB036a DVSK e.V. (2002) Kooperation mit der BfA. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 12.

GPB036b DVSK e.V. (2002) Neu: Kooperation mit dem Sozialverband Deutschland. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 13.

GPB036c DVSK e.V. (2002) Kooperation mit der Deutschen Ilco. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 13.

GPB037 Hans Nau (2002) Auswirkungen der DRG auf die Sozialarbeit im Krankenhaus. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 14-18.

GPB038 Ulrich Kurlemann & Hans Nau (2002) Anforderungen an die Aus- und Weiter- und Fortbildung von Sozialarbeitern. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 18-21.

GPB039 Hans Nau (2002) Empfehlungen der DVSK zur Supervision. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 22.

GPB043 Hans Nau (2002) Bericht aus dem Vorstand. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 16.

GPB044 Hans Nau (2002) Die Befürchtungen bestätigen sich. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 17.

GPB045a Hans Nau (2002) Der VdK wird auf die Sozialarbeit aufmerksam. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 24.

GPB045b Norbert Gödecker-Geenen & Hans Nau (2002) Die Sozialen Dienste sind gefordert. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 24 f.

GPB046 DVSK e.V. (2002) Kooperation mit der BfA. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 28.

GPB047a DVSK e.V. (2002) Resolution zur Sicherstellung psychosozialer Versorgung in der Akutmedizin. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 29.

GPB047b Wolfgang Jost (2002) Initiativen zur Einrichtung eines bundesweiten Berufsregisters für Soziale Arbeit sind angelaufen. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 29.

GPB050 Norbert Gödecker-Geenen & Hans Nau (2003) Die DVSK im Wandel. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 43-46.

GPB051 Wolfgang Jost (2003) Berufsregister für Soziale Arbeit. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 49 f.

GPB052 Norbert Gödecker-Geenen & Ilse Weis (2003) Was ist das spezifisch „Klinische" an der klinischen Sozialarbeit? In: *Forum Krankenhaussozialarbeit.* 2003 (1): 52-55.

GPB053 Hans Nau (2003) Die DVSK und die Deutsch Ilco wollen künftig enger zusammenarbeiten. In: *Forum Krankenhaussozialarbeit.* 2003 (2): 36 f.

GPB054 Hans Nau (2003) Rehabilitation vor Pflege – Kostenträger entscheiden immer häufiger zu Ungunsten der Betroffenen. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 50.

GPB055 Hans Nau (2003) Leistungen der Sozialarbeit ab Juli 2003 kodierbar. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 53 ff.

GPB056a Hans Nau (2003) DVSK und Unfallkassen verhandeln über eine enge Kooperation. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 55 f.

GPB056b Hans Nau (2003) Weiteres Kooperationstreffen der DVSK mit der BfA. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 56.

GPB057 Ulrich Kurlemann (2003) Qualitätssiegel für Soziale Arbeit. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 26.

GPB058 Hans Nau (2003) Die DVSK im Gespräch mit der BfA – hier die Ergebnisse. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 31.

GPC – German protocol – annual meeting

GPC001	Martina Christmann (1993) Protokoll der Mitgliederversammlung am 07.05.1993 in Goslar. In: *Sozialdienst im Krankenhaus.* 1993 (5-8): 4-8.
GPC002	Martina Christmann (1996) Protokoll der ordentlichen Mitgliederversammlung und Neuwahl des Vorstandes anlässlich der Bundesfortbildungstagung 1995 vom 21.-23. 9.95 im Hotel SAS Radisson Rostock. In: *Sozialdienst im Krankenhaus.* 1996 (Sonderdruck 1): 66-73.
GPC003	Markus Köyer (1997) Informationen aus der Mitgliederversammlung Erfurt 1997. In: *Forum Krankenhaussozialarbeit.* 1997 (10-12): 7.
GPC004	Markus Köyer (1998) Gedächtnisprotokoll der Mitgliederversammlung der DVSK e.V. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 2 ff.
GPC005a	DVSK e.V. (2002) Berichtszeitraum Oktober 1999-2001. In: *Forum Krankenhaus-sozialarbeit.* 2002 (1): 2-6.
GPC005b	DVSK e.V. (2002) Zukunftskommission Beschluss Mitgliederversammlung. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 7.
GPC005c	Peter Reinicke (2002) Sozialarbeit in katholischen Krankenhäusern und die DVSK. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 9-15.
GPC006a	Ursula Seelhorst (2004) Öffnung beschlossen – neuer Vorstand gewählt. In: *Forum Krankenhaussozialarbeit.* 2004 (1): 3 f.
GPC006b	Sibylle Kraus (2004) Von der DVSK zur Deutschen Vereinigung für den Sozialdienst im Gesundheitswesen (DVSG)? In: *Forum Krankenhaussozialarbeit.* 2004 (1): 5.
GPC006c	DVSK e.V. (2004) Bericht des Bundesvorstandes. In: *Forum Krankenhaussozialarbeit.* 2004 (1): 7-11.
GPC007	Ingo Müller-Baron (2006) Mitgliederversammlung setzt neue Ziele: An der DVSG kommt künftig keiner vorbei. In: *Forum sozialarbeit + gesundheit*. 2006 (1): 41.
GPC008a	Ingo Müller-Baron (2008) Mitgliederversammlung 2007: DVSG-Vorstand wurde neu gewählt. In: *Forum sozialarbeit + gesundheit*. 2008 (1): 46.
GPC008b	Ingo Müller-Baron (2008) Gemeinsame Fachtagung: Soziale Auswirkungen stehen bei älteren Menschen im Vordergrund. In: *Forum sozialarbeit + gesundheit*. 2008 (1): 47.

GPO – other German protocols (local/federated states work groups)

GPO001	Uschi Braun & Klaus Kaiser (1997) Bericht über die Fachtagung Sozial- „Dienst" am Kunden am 09. Mai 1996 in der Fachklinik Rhein/Ruhr in Essen Kettwig. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 37-41.
GPO002	DVSK e.V. (1997) Qualitative Auswertung der Bundesfachtagung 1996. In: *Sozialdienst im Krankenhaus.* 1997 (Sonderdruck 1): 54-73.
GPO003	Klaus Kaiser (1997) Bericht über die Fortbildungstagung „Kundenorientierung und Selbstmarketing" am 3.+4. Juni 1997 in der Odeborn-Klinik in Bad Berleburg. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 28-31.
GPO004	Arbeitsgruppe Perspektiven 97 (1997) Handlungsspielräume und Grenzen des Sozialdienstes. In: *Sozialdienst im Krankenhaus.* 1998 (2): 11.
GPO007	Markus Köyer (1997) AG Reha Baden Württemberg tagt im Stephanuswerk in Isny/Allgäu. In: *Sozialdienst im Krankenhaus.* 1997 (10-12): 7.
GPO008a	Petra Nievelstein (1998) Qualitätssicherung – ein Weg zu mehr Professionalität und Kooperation. In: *Forum Krankenhaussozialarbeit.* 1998 (2): 1.
GPO008b	Markus Köyer (1998) Bundesfachtagung \`98. In: *Forum Krankenhaussozialarbeit.* 1998 (2): 11.

GPO009 Markus Köyer & Sibylle Metzger (1998) Bundesfachtagung Rehabilitation 19./20. März 1998 im Maternushaus in Köln – Presse-Erklärung. In: *Forum Krankenhaussozialarbeit.* 1998 (2): 29.

GPO010 Herbert Dietel (1998) Neunte LAG-Tagung Baden-Württemberg. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 26 f.

GPO011a Maria Masoud (2000) Tagung in der Frankenklinik Bad Neustadt am 02.03.2000. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 30 f.

GPO011b Stefanie Vorwald (2000) Verordnung und Kostenübernahme von Hilfsmitteln in der Pflege. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 33.

GPO011c Uta Hillers (2000) Vertrag über den nahtlosen Übergang von der Krankenhausbehandlung zur Pflege. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 34-37.

GPO011d Thomas Biewen (2000) Man kann nur einem Herren dienen! In: *Forum Krankenhaussozialarbeit.* 2000 (2): 39.

GPO011e Klaus Jäger (2000) AG Westfalen. In: *Forum Krankenhaussozialarbeit.* 2000 (2): 38.

GPO012 Marianne Hoffmann-Fritsch (2000) Fachtreffen der DVSK am 21. Juni im Klinikum Nürnberg Süd. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 38-41.

GPO013a Uta Hillers (3000) Wo steht der Krankenhaussozialdienst? In: *Forum Krankenhaussozialarbeit.* 2000 (3): 42.

GPO013b Petra Nievelstein (2000) Richtlinien stellen Probleme dar. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 43.

GPO013c Cornelia Beyer & Sandra Höll (2000) Sehr geehrter Herr Minister! In: *Forum Krankenhaussozialarbeit.* 2000 (3): 48.

GPO014a Sybille Kraus (2000) Ergebnisse der Arbeitsgruppe Berlin/AG Brandenburg zum Thema „sozialpolitische Strategien in den Bundesländern und auf der Ebene der Arbeitsgemeinschaften". In: *Forum Krankenhaussozialarbeit.* 2000 (3): 34.

GPO014b Beate Schneider (2000) Bericht aus der AG Berlin. In: *Forum Krankenhaussozialarbeit.* 2000 (3): 34 ff.

GPO015a Uta Hillers (2000) Gesprächsnotizen. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 45.

GPO015b ? (2000) Regionalgruppe Wiesbaden-Rheingau. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 46.

GPO016 Cornelia Beyer (2000) Situation der Krankenhaussozialarbeit. In: *Forum Krankenhaussozialarbeit.* 2000 (4): 50.

GPO017 Klaus Jäger (2000) Ökonomie und Menschlichkeit im Krankenhaus – Ein Widerspruch? In: *Forum Krankenhaussozialarbeit.* 2000 (4): 51.

GPO020 Sybille Kraus (2001) Die Einführung des neuen Abrechnungssystems Diagnosis Related Groups (DRGs) und die Auswirkungen auf die Arbeit der Sozialdienste. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 13 ff.

GPO021 Hans Nau (2001) Beschreibung sozialarbeiterischer Leistungen im Akutkrankenhaus. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 16 f.

GPO022 Christine Benda (2001) Durch Fitness zu Wellness? In: *Forum Krankenhaussozialarbeit.* 2001 (2): 8 ff.

GPO023 Klaus Jäger (2001) Vereinbarung nach § 3 Landespflegegesetz Nordrhein-Westfalen. In: *Forum Krankenhaussozialarbeit.* 2001 (2): 10 f.

GPO024a Otto Ziegler (2002) Fachtagung der beiden geriatrischen Kliniken im Landkreis Ravensburg für Sozialdienste. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 28.

GPO024b Rolf D. Gabler (2002) Klinische Sozialarbeit und Qualitätsmanagement. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 28 f.

GPO025a Jutta Bergmann & Mechthild Büter-Conen (2002) Mitgliederversammlung der AG Niedersachsen am 05.09.2001 in Vechta-Langförden. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 34.

GPO025b Mechthild Büter-Conen (2002) Möglichkeiten der Dokumentation nach wie vor ein Thema. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 35.

GPO025c Elfi A. Böhler & Andreas Vogel (2002) Dokumentationsbogen entwickelt. In: *Forum Krankenhaussozialarbeit.* 2002 (1): 38.

GPO026 Maria Massoud (2002) Treffen der AG Franken. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 34.

GPO027 Bettina Lauterbach (2002) Qualitätssicherung in der Krankenhaussozialarbeit. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 36 .

GPO028a Herbert Dietel (2002) Sozialpolitische Aktivitäten. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 27.

GPO028b Hildegard Hegeler & Klaus Jäger (2002) Soziale Arbeit in der Rehabilitation – Selbstbestimmung und Teilhabe statt Fürsorge. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 28-31.

GPO029a Landesarbeitsgemeinschaft Rehabilitation (2002) Sozialarbeit in der Rehabilitation – Selbstbestimmung und Teilhabe statt Fürsorge. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 31.

GPO029b Uta Hillers (2002) Tagung in Bad Soden-Salmünster. In: *Forum Krankenhaussozialarbeit.* 2002 (4): 32.

GPO031a Herbert Dietel (2003) Sozialarbeit als Erfolgsfaktor im Wettbewerb. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 61 f.

GPO031b Petra Nievelstein (2003) Sozialarbeit als Dreh- und Angelpunkt. In: *Forum Krankenhaussozialarbeit.* 2003 (1): 63.

GPO031c Sybille Kraus (2003) Neue gesundheitspolitische Programme – Chance für die Sozialarbeit? In: *Forum Krankenhaussozialarbeit.* 2003 (1): 64 ff.

GPO032a Ursula Seelhorst (2003) Bedeutung der sozialen Arbeit im Gesundheitswesen. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 66.

GPO032b Hans Nau (2003) Zur Lösung der Aufgaben an der Schnittstelle von stationärer und ambulanter Versorgung ist Sozialarbeit unverzichtbar. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 67.

GPO032c AG Hessen (2003) Was läuft im Arbeitskreis Mittelhessen? In: *Forum Krankenhaussozialarbeit.* 2003 (3): 68.

GPO032d AG Bodensee (2003) Tagung der AG Bodensee. In: *Forum Krankenhaussozialarbeit.* 2003 (3): 68.

GPO033a Katja Stocker (2003) Vernetzung statt Grabenkämpfe – neue Strategien der sozialen Arbeit im Gesundheitswesen. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 38 ff.

GPO033b Katja Stocker (2003) Neue Realitäten im Gesundheitswesen. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 40 f.

GPO033c Petra Wagner (2003) Treffen der AG Sachsen am 20. Mai 2003 im Diakonissenhaus Dresden. In: *Forum Krankenhaussozialarbeit.* 2003 (4): 42.

GWS – German written statements

GWS001 DVSK e.V. (1992) Rehabilitation vor Pflege… oder, wie bisher: Pflege statt Rehabilitation? In: *Sozialdienst im Krankenhaus.* 1992 (7-10): 3 ff.

GWS002 DVSK e.V. (1993) Thesenpapier – Gruppe 'Werkstatt 12'. In: *Sozialdienst im Krankenhaus.* 1999 (Sonderdruck 1): 125 f.

GWS003 Hans Nau (1996) Die Bedeutung der Selbsthilfegruppen in der Patientenberatung. In: *Sozialdienst im Krankenhaus.* 1996 (10-12): 29-31.

GWS004 DVSK e.V. (1997) Stellungnahme zur „Konzeption eines Ambulanten Servicezentrums im Krankenhaus“, vorgelegt von Humanitas, Ambulante Kranken- und Altenpflege- Verwaltungs- und Beteiligungsgesellschaft mbH, Hagelkreuzstr. 101, 461 49 Oberhausen. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 26 f.

GWS005 DVSK e.V. (1997) Änderungen im ABH-Verfahren. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 2-3.

GWS006 DVSK e.V. (1997) KTL (Klassifikation therapeutischer Leistungen in der stationären medizinischen Rehabilitation) der BfA – Stellungnahme unseres Fachverbandes. In: *Sozialdienst im Krankenhaus.* 1997 (1-3): 4-12.

GWS007 DVSK e.V. (1997) Grundsätze für die Rehabilitations-Beratung bei der BKK. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 5 f.

GWS008 DVSK e.V. (1997) Ihre Broschüre „IKK intern – Der Soziale Dienst der IKK“. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 9 f.

GWS009 DVSK e.V. (1997) Sehr geehrter Herr Dr. Dick. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 23 f.

GWS010 DVSK e.V. (1997) Stellungnahme zu den Vertragsverhandlungen nach § 112 Abs. 2 Nr. 5 SGB V. In: *Sozialdienst im Krankenhaus.* 1997 (4-6): 19 f.

GWS011 DVSK e.V. (1997) Sehr geehrter Herr Hartschuh. In: *Forum Krankenhaussozialarbeit.* 1997 (7-9): 3.

GWS012 DVSK e.V. (1997) Neuerungen in der Anwendung von § 37 SGB V. In: *Forum Krankenhaussozialarbeit.* 1997 (7-9): 5.

GWS013 DVSK e.V. (1997) Anschlussheilbehandlungen – Änderungen des Verfahrens. In: *Forum Krankenhaussozialarbeit.* 1997 (10-12): 8.

GWS014a DVSK e.V. (1998) Kostenerstattung § 29 ff SGB V Tumorpatienten. In: *Forum Krankenhaussozialarbeit.* 1998 (1): 28.

GWS015a DVSK e.V. (1998) Leserbrief zur WZ-Ausgabe 21.10.98. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 33.

GWS015b DVSK e.V. (1998) Pressemitteilung. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 33.

GWS016 DVSK e.V. (1998) Pressemitteilung. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 3.

GWS017 DVSK e.V. (1998) Stellungnahme zum Entwurf der Vereinbarung zu § 3 Landespflegegesetz NW. In: *Forum Krankenhaussozialarbeit.* 1998 (4): 39.

GWS018a DVSK e.V. (2002) Pflegeüberleitung – Ergänzung oder Konkurrenz zur klinischen Sozialarbeit? In: *Forum Krankenhaussozialarbeit.* 2002 (3): 2.

GWS018b DVSG e.V. (2008) *Soziale Arbeit und Rehabilitation*. Mainz.

GWS019 DVSK e.V. (2002) Positionspapier der DVSK zur Kooperation zwischen Sozialdienst und Pflegeüberleitung. In: *Forum Krankenhaussozialarbeit.* 2002 (3): 2 f.

GWS022 DVSG e.V. (2004) *Stellungnahme zum Entwurf der Gemeinsamen Empfehlungen gemäß § 13 Abs. 2 Nr. 1 SGB IX, dass Prävention entsprechend dem in § 3 SBG IX genannten Ziel erbracht wird* (Gemeinsame Empfehlungen „Prävention nach § 3 SGB IX“). Mainz. http://dvsg.org/uploads/media/StellungnahmeGEPraevention.pdf (access 20120322).

GWS023 DVSG e.V. (2004) *Entlassungsmanagement: Positionspapier der Deutschen Vereinigung für Sozialarbeit im Gesundheitswesen e.V. (DVSG)*. Mainz. http://dvsg.org/uploads/media/Entlassungsmanagement_01.pdf (access 20120322).

GWS024 DVSG e.V. (2004) *Positionspapier der DVSG zur Kooperation zwischen Sozialdienst und Pflegeüberleitung*. Mainz. http://dvsg.org/uploads/media/PflegeNeu.pdf (access 20120322).

GWS025 DVSG e.V. (2004) *Sozialarbeit in Disease-Management-Programmen bei Brustkrebs: Positionspapier der DVSG e.V*. Mainz.

GWS026 DVSG e.V. (2004) *Stellungnahme zum Entwurf der Gemeinsamen Empfehlungen gemäß § 13 Abs. 2 Nr. 2 SGB IX zur frühzeitigen Erkennung des Bedarfs an Leistungen zur Teilhabe* (Gemeinsame Empfehlungen „Frühzeitige Bedarfserkennung"). Mainz. http://dvsg.org/uploads/media/StellungnahmeGEFruehzeitigeBedarfserkennung.pdf (access 20120322).

GWS027 DVSG e.V.(2005) *Prozedurenklassifikationen im Operationen- und Prozeduren-schlüssel (OPS): Kodierung von Sozialarbeitsleistungen seit 2005 möglich.* Mainz.

GWS028 DVSG e.V. (2006) *Empfehlung der DVSG – Anhaltszahlen für Sozialarbeit in Akut-kliniken.* Mainz.

GWS029 DVSG e.V. (2006) *Stellungnahme zur Anhörung der Berufsverbände am 24.08.2006: Gutachten 2007 des Sachverständigenrates zur Begutachtung der Entwicklung im Gesundheitswesen Neue Aufgabenverteilung und Kooperationsformen zwischen Gesundheitsberufen.* Mainz. http://dvsg.org/uploads/media/StellungnahmeBerufsverbaende_01.pdf (access 20120322).

GWS030 DVSG e.V. (2006) *Stellungnahme "Fremdfinanzierung der Sozialarbeit im Kranken-haus".* Mainz. http://dvsg.org/uploads/media/StellungnahmeFremdfinanzierung_03.pdf (access 20120322).

GWS031 DVSG e.V. (2006) *Stellungnahme der DVSG zur Gesundheitsreform*. Mainz. http://dvsg.org/uploads/media/StellungnahmeGesundheitsreform_03.pdf (access 20120322).

GWS033 DVSG e.V. (2007) *Neu: OPS-Ziffern für die Sozialarbeit 2007*. Mainz.

GWS034 DVSG e.V. (2007) *Zusammenstellung von Personalbemessungszahlen der Rehabilita-tionsträger für stationäre und ambulante Rehabilitations-einrichtungen*. Mainz.

GWS035 DVSG e.V. (2007) *Stellungnahme der DVSG zur Reform der Pflegeversicherung 2007.* Mainz. http://dvsg.org/uploads/media/DVSG-Stellungnahme_Pflege-Reform_01.pdf (access 20120322).

GWS036 DVSG e.V. (2007) *Entwurf eines Gesetzes zur strukturellen Weiterentwicklung der Pflegeversicherung (Pflege-Weiterentwicklungsgesetz – PfWG).* Mainz. http://dvsg.org/uploads/media/StellungnahmezumReferentenentwurfPflege-Weiterentwicklungsgesetz.pdf (access 20120322).

GWS038 DVSG e.V. (2008) *Rehabilitation geht über*. Mainz.

GWS039 DVSG e.V. (2008) *Positionspapier: Case Management und Soziale Arbeit*. Mainz. http://dvsg.org/uploads/media/PositionspapierCaseManagementOktober2008.pdf (access 20120322).

GWS040 DVSG e.V. (2008) *Rahmenempfehlungen zur Einrichtung von Stellen im Kranken-haussozialdienst in Akutkrankenhäusern*. Mainz.

GWS041 DVSG e.V. (2008) *Stellungnahme an den Bundesrat: Gesetz zur strukturellen Weiterentwicklung der Pflegeversicherung* (Pflege-Weiterentwicklungsgesetz). Mainz. http://dvsg.org/uploads/media/StellungnahmePflege-Weiterenwicklungsgesetz.pdf (access 20120322).

GWS042 DVSG e.V. (2008) *Stellungnahme: Versorgungsmanagement gemäß § 11 Abs. 4 SGB V.* Mainz. http://dvsg.org/uploads/media/StellungnahmeVersorgungsmanagementStand19_August2008_02.pdf (access 20120322).

Sweden

Svensk Kuratorsförening (SK)

SKA – Swedish association's articles

SKA001 Svensk Kuratorsförening (1991) Kuratorer inom KAI. In: *Svensk Kuratorsförening*. 1991 (2): 44.

SKA002 Svensk Kuratorsförening (1990) Upprop till kollegor som arbetar inom cancervården. In: *Svensk Kuratorsförening.* 1990 (2): 44.

SKA003 Svensk Kuratorsförening (1990) Studiedagen i Stockholm 900406. In: *Svensk Kuratorsförening*. 1990 (2): 34 f.

SKA004 Iris Sundelin (1990) Kära kollega! In: *Svensk Kuratorsförening*. 1990 (2): 2-5.

SKA005 Iris Sundelin (1991c) Kära Kollega! In: *Svensk Kuratorsförening*. 1991 (3): 3 ff.

SKA006 Gunnel ? & Eva Lundberg (1991) Hej Reumakollegor! In: *Svensk Kuratorsförening*. 1991 (3): 14.

SKA007 Eva Lundberg (1991) Reumasektionen inom Svensk Kuratorsförening. In: *Svensk Kuratorsförening*. 1991 (2): 45.

SKA008 Iris Sundelin (1992) Kära Kollega! In: *Svensk Kuratorsförening*. 1992 (2): 3-7.

SKA010 Iris Sundelin (1993) Kära Kollega! In: *Svensk Kuratorsförening*. 1993 (1): 3 ff.

SKA011 Svensk Kuratorsförening (1993) Pressmeddelande. In: *Svensk Kuratorsförening*. 1993 (1): 49.

SKA012 Solveig Åsen & Inger Jonasson (1993) Projekt med "Krisgrupp" vid Akutmottagningen, Östersunds sjukhus. In: *Svensk Kuratorsförening*. 1993 (1): 53 f.

SKA013 Inger Jonasson (1993) Onkologisektionen. In: *Svensk Kuratorsförening.* 1993 (1): 50 ff.

SKA016 Iris Sundelin (1993) Kära Kollega! In: *Svensk Kuratorsförening*. 1993 (2): 3-7.

SKA020 Iris Sundelin (1995) Kära Kollega! In: *Svensk Kuratorsförening*. 1995 (1): 3-6.

SKA022 Iris Sundelin (1995) Kära Kollega! In: *Svensk Kuratorsförening*. 1995 (2): 3 ff.

SKA025 Iris Sundelin (1996) Kära Kollega! In: *Svensk Kuratorsförening*. 1996 (1): 3 f.

SKA031 Iris Sundelin (1997) Kära Kollega! In: *Svensk Kuratorsförening*. 1997 (-): 3-6.

SKA035 Christina Johansson (1999) Svensk Kuratorsförenings studiedagar 15-16 april 1999 In: *Svensk Kuratorsförening – Medlemsinformation.* 1998 (10/11).

SKA042 Svensk Kuratorsförening (2004) Lugnet i stormens öga – Kuratorns roll i krisarbete. Svensk Kuratorsförenings fortbildningsdagar 22-23 april 2004. In: *Svensk Kuratorsförening – Medlemsinformation.* 2004 (1).

SKA043 Föreningsbrev okt 2004: Iris Sundelin (2004) Hej Föreningsmedlemmar! In: *Svensk Kuratorsförening – Medlemsinformation.* 2004 (10).

SKAR – Swedish HSW association's annual reports

SKAR001 Iris Sundelin (1992) Verksamhetsberättelse för 1991. In: *Svensk Kuratorsförening*. 1992 (1): 23-27.

SKAR002 Svensk Kuratorsförening (1993) Verksamhetsberättelse för 1992. In: *Svensk Kuratorsförening*. 1993 (1): 27-31.

SKAR003 Iris Sundelin (1994) Verksamhetsberättelse för 1993. In: *Svensk Kuratorsförening*. 1994 (1): 34-39.
SKAR004 Iris Sundelin (1995) Verksamhetsberättelse för 1994. In: *Svensk Kuratorsförening*. 1995 (2): 32-36.
SKAR005 Iris Sundelin (1996) Verksamhetsberättelse för 1995. In: *Svensk Kuratorsförening*. 1996 (1): 30 ff.
SKAR006 Iris Sundelin (1997) Verksamhetsberättelse för 1996. In: *Svensk Kuratorsförening*. 1997 (-): 44 f.
SKAR007 Iris Sundelin (1998) *Verksamhetsberättelse för 1997*.
SKAR008 Iris Sundelin (1999) Verksamhetsberättelse för 1998. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).
SKAR009 Iris Sundelin (2000) *Verksamhetsberättelse för 1999*.
SKAR010 Iris Sundelin (2001) Verksamhetsberättelse för 2000. In: *Svensk Kuratorsförening – Medlemsinformation.* 2001 (12).
SKAR011 Iris Sundelin (2002) *Verksamhetsberättelse för 2001*.
SKAR012 Iris Sundelin (2003) *Verksamhetsberättelse för 2002*.
SKAR013 Iris Sundelin (2004) *Verksamhetsberättelse för 2003*.
SKAR014 Iris Sundelin (2005) *Verksamhetsberättelse för 2004*. http://www.kurator.se/new/asp/articlesDetail.asp?ID=60&ArticleID=12 (access 20091206).
SKAR015 Iris Sundelin (2006) *Verksamhetsberättelse för 2005*. http://www.kurator.se/new/asp/articlesDetail.asp?ID=60&ArticleID=20 (access 20091206).
SKAR016 Iris Sundelin (2007) *Verksamhetsberättelse för 2006*. http://www.kurator.se/new/asp/articlesDetail.asp?ID=60&ArticleID=23 (access 20091206).
SKAR018 Iris Sundelin (2008) *Verksamhetsberättelse för 2007*. http://www.kurator.se/new/asp/articles.asp?ID=60 (access 20091206).

(SKL – Swedish HSW association's letters)

SKL001 Margareta Ström, Kerstin Nilsson et al. (19911104).
SKL002 Ingegerd Norén (19930316).

SKD – Swedish HSW association's definitions

SKD001 Svensk Kuratorsförening (1989) *Underlag till befattningsbeskrivning för kuratorer inom hälso- och sjukvård.*
SKD002a Svensk Kuratorsförening (1992) Förslag till mall för Verksamhetsberättelse för Kuratorsverksamhet. In: *Svensk Kuratorsförening*. 1992 (1): 30.
SKD003 Svensk Kuratorsförening (1992) Statistikunderlag för kuratorsverksamhet. In: *Svensk Kuratorsförening*. 1992 (1): 31.
SKD004 Svensk Kuratorsförening (2000) *Kvalitetspolicy för socionomer/kuratorer i hälso- och sjukvård*. http://www.kurator.se/wp-content/files/kvalitetshandbok.pdf (access 20120402).
SKD005 Svensk Kuratorsförening (1990) *Kurator i hälso- och sjukvård* (Brochure).
SKD006 Svensk Kuratorsförening (2004?) *Kurator i hälso- och sjukvård* (Brochure).
SKD007 Svensk Kuratorsförening (2008) *Kurator i hälso- och sjukvård* (Brochure).

SKP – Swedish HSW association's protocols

SKP001 Barbro Olsson (19900127/28) Protokoll 1/90, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1990 (2): 18-21.

SKP002 Barbro Olsson (19900310) Protokoll 2/90, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1990 (2): 22-25.

SKP003 Barbro Olsson (19900407) Protokoll 3/90 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1990 (2): 29 ff.

SKP004 Ingrid Nilsén (19901126) *Rapport från kuratorer verksamma inom Rehabilitering.*

SKP005 Barbro Olsson (19900406) Protokoll fört vid årsmöte. In: *Svensk Kuratorsförening*. 1990 (2): 26 ff.

SKP007 Barbro Olsson (19910907/08) Protokoll 5/91, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm In: *Svensk Kuratorsförening*. 1991 (3): 6-9.

SKP008 Barbro Olsson (19911019/20) Protokoll 6/91, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1991 (3): 10 ff.

SKP009 Barbro Olsson (19911130) Protokoll 7/91, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (1): 7 ff.

SKP010 Inga-Maj Ericsson & Ingrid Nilsén (19911002) Rapport från Rehab. Kuratorernas studiedag i Sandviken. In: *Svensk Kuratorsförening*. 1992 (1): 7 ff.

SKP011 Ingrid Svenman (19910610) Från NHR:s seminarium i rehabilitering för personer med neurologiska skador och sjukdomar. In: *Svensk Kuratorsförening*. 1991 (2): 38 f.

SKP012 Eva Lundberg (19910603) Hej Iris! In: *Svensk Kuratorsförening*. 1991 (2): 45.

SKP015 Barbro Olsson (19920125/26) Protokoll 1/92, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (1): 10 ff.

SKP016 Barbro Olsson (19920328) Protokoll 2/92, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (1): 19-22.

SKP017 Barbro Olsson (19920509) Protokoll 3/92 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (2): 8 ff.

SKP018 Barbro Olsson (19920905/06) Protokoll 4/92, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (2): 13-17.

SKP019 Barbro Olsson (19921024) Protokoll 5/92, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1992 (2): 18 ff.

SKP020 Barbro Olsson (19921128) Protokoll 6/92, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (1): 6-9.

SKP022 Marian Gustafsson (19920916) Projektinformation. In: *Svensk Kuratorsförening*. 1992 (2): 36 f.

SKP023 Ingrid Gustafsson (19921005) Referat från rehabiliteringskuratorernas studiedag i Västerås 920916. In: *Svensk Kuratorsförening*. 1992 (2): 31 f.

SKP024 Inga-Maj Ericsson & Margareta Bergmark (1992) Psykosociala aspekter på hjärnskada. In: *Svensk Kuratorsförening*. 1992 (2): 33 f.

SKP025 Barbro Olsson (19920327) Protokoll fört vid årsmöte med medlemmarna i Svensk Kuratorsförening. In: *Svensk Kuratorsförening*. 1992 (1): 13 ff.

SKP028 Barbro Olsson (19930123) Protokoll 1/93, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (1): 10-13.

SKP029 Inger Jonasson (19930327) Protokoll 2/93, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (1): 20-24.

SKP030 Inger Jonasson (19930515/16) Protokoll 3/93, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (2): 8-14.

SKP031 Inger Jonasson (19930918/19) Protokoll 4/93, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (2): 15-23.

SKP032 Inger Jonasson (19931120/21) Protokoll 5/93, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1994 (1): 7-11.

SKP033 Barbro Olsson (19930325) Protokoll fört vid årsmöte med Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1993 (1): 14 ff.

SKP045 Inger Jonasson (19940205/06) Protokoll 1/94, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1994 (1): 12-18.

SKP046 Lena Wlodarczyk (19940416) Protokoll 2/94 fört vid konstituerande sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1994 (1): 22 f.

SKP047 Inger Jonasson (19940604/05) Protokoll 3/94, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1994 (1): 24-30.

SKP048 Inger Jonasson (19940903/04) Protokoll 4/94, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1995 (1): 7-13.

SKP049 Inger Jonasson (941008/09) Protokoll 5/94, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1995 (1): 14-21.

SKP050 Inger Jonasson (19941203/04) Protokoll 6/94, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1995 (1): 22-27.

SKP051 Lena Wlodarczyk (19940415) Protokoll fört vid årsmöte med Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1994 (1): 19 ff.

SKP052 Inger Jonasson (19950204/05) Protokoll 1/95, fört vid konstituerande sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1995 (2): 6-12.

SKP053 Inger Jonasson (19950429) Protokoll 2/95, fört vid konstituerande sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1995 (2): 17-21.

SKP054 Lena Wlodarczyk & Birgitta Tordenström (19951028/29) Protokoll 4/95 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 5-8.

SKP055 Görel Kihlberg-C:son & Eva Wehrnlund Processuellt samarbete vid Rehab-gruppen, Vårdcentralen Norslund. In: *Svensk Kuratorsförening*. 1995 (2): 29.

SKP056 Inger Jonasson (19950428) Protokoll fört vid Svensk Kuratorsförenings årsmöte, Stockholm. In: *Svensk Kuratorsförening*. 1995 (2): 13 ff.

SKP057 Inger Johansson (19950916/17) Protokoll 3/95, fört vid sammanträde med styrelsen för Svensk Kuratorsförening. Stockholm. In: *Svensk Kuratorsförening*. 1995 (2): 22-27.

SKP059 Inger Jonasson (19960210/11) Protokoll 1/96, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 9-15.

SKP060 Inger Jonasson (19960419) Protokoll 2/96, fört vid konstituerande sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 20-26.

SKP061 Inger Jonasson (19960420) Protokoll 3/96, fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 21-26.

SKP062 Inger Jonasson (19960615) Protokoll fört vid sammanträde med AU[1], Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 27 ff.

SKP063 Inger Jonasson (19960831/0901) Protokoll fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 7-14.

SKP064 Inger Jonasson (19961109/10) Protokoll fört vid sammanträde med styrelsen för Svensk Kuratorsförening. In: *Svensk Kuratorsförening*. 1997 (-): 15-19.

SKP065 Inger Jonasson (19961214) Protokoll fört vid sammanträde med AU i Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 20 f.

SKP066 Inger Jonasson (19960419) Protokoll fört vid Svensk Kuratorsförenings årsmöte, Stockholm. In: *Svensk Kuratorsförening*. 1996 (1): 16-19

SKP071 Inger Jonasson (19970524/25) Protokoll 3/97 fört vid Svensk Kuratorsförenings årsmöte, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 30-36.

SKP072 Inger Jonasson (19970906/07) Protokoll 4/97 fört vid Svensk Kuratorsförenings årsmöte, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 39-43.

SKP074 Eva Lundberg (1997) Rapport från Sektionen för kuratorer inom reumatikervården. In: *Svensk Kuratorsförening*. 1997 (-): 47.

SKP075 Catharina Gåfvels (19970418) Årsmöte Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 27 f.

SKP076 Inger Johansson (19970125/26) Protokoll 1/97 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening*. 1997 (-): 22-26.

SKP078 Birgitta Tordenström (19980509/10) Protokoll 3/98 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1998 (10/11).

SKP079 Birgitta Tordenström (19980829/30) Protokoll 4/98 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1998 (10/11).

SKP080 Birgitta Tordenström (19981024/25) Protokoll 5/98 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (12).

SKP085 Birgitta Tordenström (19990123/24) Protokoll 1/99 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).

SKP087 Birgitta Tordenström (19990529/30) Protokoll 2/99 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).

SKP089 Birgitta Tordenström (19990904/05) Protokoll 3/99 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).

[1] AU = Arbetsutskott (work group)

SKP090 Birgitta Tordenström (19991030/31) Protokoll 4/99 fört vid sammanträde med styrelsen för Svensk Kuratorsförening, Stockholm. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).

SKP091 Barbro Olsson (19990415) Protokoll fört vid årsmöte med Svensk Kuratorsförening, Karlstad. In: *Svensk Kuratorsförening – Medlemsinformation.* 1999 (10/11).

SKP092 Birgitta Tordenström (20000312/13) Protokoll 2/00 fört vid styrelsesammanträde för Svensk Kuratorsförening, Nice.

SKP093a Birgitta Tordenström (20000520) Protokoll fört vid telefonsammanträde kl. 10:00-11:00.

SKP093b Birgitta Tordenström (20000910) Protokoll 3/00 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stad?

SKP094 Birgitta Tordenström (20001028/29) Protokoll 4/00 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP095 Birgitta Tordenström (20010126/27) Protokoll 1/01 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP096 Birgitta Tordenström (20010504/05) Protokoll 2/01 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP097 Birgitta Tordenström (20010908/09) Protokoll 3/01 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP098 Birgitta Tordenström (20011119) Protokoll 4/01 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stad?

SKP101 Birgitta Tordenström (20020126/27) Protokoll 1/02 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP102 Birgitta Tordenström (20020419) Protokoll 2/02 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP103 Birgitta Tordenström (20020615/16) Protokoll 3/02 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP104 Anita Samuelsson (20020907/08) Protokoll 4/02 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stad?

SKP105 Birgitta Tordenström (20021109/10) Protokoll 5/02 fört vid Styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP106 Birgitta Tordenström (20020418) Protokoll fört vid årsmötet för Svensk Kuratorsförening, Stockholm.

SKP109 Birgitta Tordenström (20030110/10) Protokoll 1/03 fört vid Styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP110 Eva Gerger (20030524/25) Protokoll 2/03 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.

SKP111 Eva Gerger (20030829/30) Protokoll 3/03 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.

SKP112 Birgitta Tordenström (20031114) Protokoll 4/03 fört vid styrelsesammanträde för Svensk Kuratorsförening den 19 april, Stockholm.

SKP115 Birgitta Tordenström (20040124/25) Protokoll 1/04 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.

SKP116 Birgitta Tordenström (20040618) Protokoll 2/04 fört vid Svensk Kuratorsförenings styrelsesammanträde.,Malmö.

SKP117 Birgitta Tordenström & Britt-Marie Johansson (20040828/29) Protokoll 3/04 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.

SKP118 Britt-Marie Johansson (20041112/13) Protokoll 4/04 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.

SKP120 Birgitta Tordenström (20050201) Protokoll 1/05 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP121 Styrelsemöte 1 februari 2005, Stockholm.
SKP122 Britt-Marie Johansson (20050610/11) Protokoll 3/05 fört vid styrelsesammanträde för Svensk Kuratorsförening, Stockholm.
SKP123 Birgitta Tordenström (20051022/23) Protokoll 4/05 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP124 Protokoll styrelsemöte 10-11 juni 2005, Stad?
SKP125 Styrelsemöte 22-23 oktober 2005, Stad?
SKP128 Ingrid Petersson (20060208) Protokoll 1/06 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP129a Styrelsemöte 8 februari 2006, Stad?
SKP129b Birgitta Tordenström (20060830) Protokoll 2/06 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP130 Birgitta Tordenström (200601122) Protokoll 3/06 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP131 Styrelsesammanträde 30 augusti 2006, Stad?
SKP132 Styrelsesammanträde 22 november 2006, Stad?
SKP135 Birgitta Tordenström (20070109) Telefonsammanträde i Svensk Kuratorsförenings styrelse kl. 19:00.
SKP136 Birgitta Tordenström (20070315) Protokoll 3/07 fört vid styrelsesammanträde för Svensk Kuratorsförening, Casa il Rosario, Rom.
SKP137 Birgitta Tordenström (20070514) Protokoll 4/07 Telefonsammanträde Svensk Kuratorsförenings styrelse kl. 19:00-20:15.
SKP138 Birgitta Tordenström (070907) Protokoll 5/07 Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP139 Birgitta Tordenström (071113) Protokoll 8/07, Telefonsammanträde 2007-11-13 kl. 19.00 i Svensk Kuratorsförenings styrelse.
SKP140 Styrelsemöte 7 september 2007, Stad?
SKP141 Britt-Marie Johansson (20080216/17) Protokoll 1/08 fört vid Svensk Kuratorsförenings styrelsesammanträde, Stockholm.
SKP142 Birgitta Tordenström (20080403) Protokoll 2/08 Telefonsammanträde i Svensk Kuratorsförenings styrelse kl. 19:30.
SKP143 Birgitta Tordenström (20080927/28) Protokoll 3/08 Svensk Kuratorsförenings styrelsesammanträde, SSR-huset, Stockholm.
SKP144 Birgitta Tordenström (20081103) Protokoll 4/08 Telefonsammanträde kl. 19:00-20:30 i Svensk Kuratorsförenings styrelse.
SKP145 Birgitta Tordenström (20081124) Protokoll 5/08 Telefonsammanträde i Svensk Kuratorsförenings styrelse kl. 19:00.
SKP146 Birgitta Tordenström (080927/28) Styrelsemöte, Stockholm.

Fredlund, Ulla (1997) *Kuratorsverksamhet inom Svensk sjukvård under 70 år*. Stockholm: Svensk Kuratorsförening.

SKWS – Swedish HSW association's written statements

SKWS001 Svensk Kuratorsförening (1990) Yttrande över rapport om psykoterapiutbildning för socionomer. In: *Svensk Kuratorsförening*. 1990 (2): 43.
SKWS002 Anita Erkki (1990) Remissvar om samnordiska insatser för personer med epilepsi. In: *Svensk Kuratorsförening*. 1990 (2): 38 f.

SKWS003 Inger Jonasson (1990) Remissvar över ”Astma hos vuxna – underlag till vårdprogram. In: *Svensk Kuratorsförening*. 1990 (2): 36 f.

SKWS004 Gunnel Nordsjö & Barbro Silverstolpe (1990) Svensk Kuratorsförenings remissyttrande över Handikapp och välfärd? – en lägesrapport (SOU 1990:19). In: *Svensk Kuratorsförening*. 1990 (2): 40 ff.

SKWS005 Skoglösa (1991) Synpunkter från STD-kuratorer med anledning av utvärdering av smittskyddslagstiftningen. In: *Svensk Kuratorsförening*. 1991 (2): 40-43.

SKWS006 Iris Sundelin (1992) Beträffande Landstingsförbundets primärvårdsprogram, Stockholm. In: *Svensk Kuratorsförening*. 1992 (1): 49.

SKWS007 Iris Sundelin (1992) Yttrande över Socialdepartementets Rapport ”Husläkare – Kontinuitet och trygghet i vården” (DS 1992:41). In: *Svensk Kuratorsförening*. 1992 (2): 22-26.

SKWS008 Iris Sundelin (1993) Yttrande över psykiatriutredningens slutbetänkande ”Välfärd och valfrihet – service, stöd och vård för psykiskt störda” (SOU 1992:73). In: *Svensk Kuratorsförening*. 1993 (1): 39-47.

SKWS009 Svensk Kuratorsförening (1993) Uttalande av Kuratorer inom Hälso- och sjukvården. In: *Svensk Kuratorsförening*. 1993 (1): 48.

SKWS010 Görel Kihlberg-C:son (1994) Yttrande över Rapporten från utredningen om prioriteringar inom hälso- och sjukvården (SOU 1993:93). In: *Svensk Kuratorsförening*. 1994 (1): 42.

SKWS011 Svensk Kuratorsförening (1994) *Synpunkter och reflektioner angående prioriteringsutredningens rapport ”Vårdens svåra val”*.

SKWS013 Inger Jonasson & Görel Kihlberg-C:son (1995) Yttrande över SOU 1995:5 ”Vårdens svåra val”. Slutbetänkande av Prioriteringsutredningen. In: *Svensk Kuratorsförening*. 1995 (2): 42 ff.

SKWS014 Yttrande 11-95: Iris Sundelin (19951107) Statlig legitimation av socionomer. In: *Svensk Kuratorsförening.* 1995 (2): 49 ff.

SKWS016 Iris Sundelin & Inger Jonasson (1996) Ang. egen-auktorisation för kuratorer inom hälso- och sjukvård. In: *Svensk Kuratorsförening*. 1996 (1): 51 f.

SKWS017 Yttrande 3-97: Iris Sundelin, Birgitta Tordenström (1997-03-06) Remissvar över Betänkande av 1994 års behörighetskommitté (SOU 1996:138) Ny behörighetsreglering på hälso- och sjukvårdens område m.m. In: *Svensk Kuratorsförening*. 1997 (-): 48-51.

SKWS018 Svensk Kuratorsförening (2000) *Kvalitet för socionomer/kuratorer inom hälso- och sjukvård*. http://(www.kurator.se/new/asp/singles.asp?ID=300 (access 20091206).

SKWS019 Gerd de Neergaard & Christin Johansson (2007) *Synpunkter på Patientdatautredningens huvudbetänkande om en ny Patientdatalag (SOU 2006:82).* http://www.kurator.se/wp-content/files/2007-Patiendatalag-Svensk-kuratorsförening-Egen-synpunkter3.doc (access 20120403).

SKWS020 Iris Sundelin (2007) *Hearing – Socialstyrelsen 15/10-2007*. http://www.kurator.se/new/asp/articles.asp?ID=35 (access 20091206).

SKWS021 Svensk Kuratorsförening (2007) *Yttrande över Slutbetänkande av nationell psykiatrisamordning*.

Akademikerförbundet SSR (2010) *Policy för socionomer i hälso- och sjukvård: Modell för kompetens- och karriärutveckling*. Stockholm.

Vuxenpsykiatriska kuratorers förening (VKF)

SVKFP – Swedish VKF protocols

SVKFP001 Cecilia Haglund (19990918) Styrelsesammanträde med Vuxenpsykiatriska Kuratorers Förening, Lund.
SVKFP002 Cecilia Haglund (19991018) Telefonsammanträde med Styrelsen för Vuxenpsykiatriska Kuratorers Förening.
SVKFP003 Göran Lindberg (19990507) Protokoll fört vid årsmöte i Vuxenpsykiatriska Kuratorers Förening, Stockholm.
SVKFP004 Åsa Liljegren (20000129) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening, Eslöv.
SVKFP005 Åsa Liljegren (20000916) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening, Lund.
SVKFP006 Åsa Liljegren (20001025) Telefonsammanträde i styrelsen VKF.
SVKFP007 Åsa Liljegren (20001206) Telefonsammanträde med VKF:s styrelse.
SVKFP008 Åsa Liljegren (20000505) Årsmöte i VKF, Stockholm.
SVKFP009 Åsa Liljegren (20010120/21) Vuxenpsykiatriska Kuratorers Förenings styrelsemöte, Lund.
SVKFP010 Eva Sundström (20010908) Protokoll från styrelsemötet, Stad?
SVKFP011 Patricia Näslund (20011025) Telefonsammanträde i styrelsen för VKF.
SVKFP012 Åsa Liljegren (20010518) Protokoll fört vid årsmöte i Vuxenpsykiatriska Kuratorers Förening fredagen den 18 maj 2001 i Stockholm.
SVKFP013 Patricia Näslund (20020126) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening, Lund.
SVKFP014 Patricia Persdotter Näslund (020928) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening på Danderyds sjukhus, Stockholm.
SVKFP015 Ewa-Marie Sabel (020524) Protokoll fört vid årsmöte i Vuxenpsykiatriska Kuratorers Förening fredagen den 24 maj 2002 i Stockholm.
SVKFP016 Patricia Näslund (030125) Protokoll från styrelsemöte i VKF, Stad?
SVKFP017 Patricia Persdotter Näslund (030927) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening på Kukkolaforsens Konferenscenter, Kukkolaforsen.
SVKFP018 Ewa-Marie Sabel (030516) Årsmöte i Vuxenpsykiatriska Kuratorers Förening fredagen den 16 maj 2003 i Stockholm, Stockholm.
SVKFP019 Patricia Persdotter-Näslund (20041009) Styrelsemöte i VKF. Evedal, Växjö.
SVKFP020 Patricia Persdotter-Näslund (20050122) Styrelsemöte med Vuxenpsykiatriska Kuratorers Förening, Växjö.
SVKFP021 Patricia Persdotter-Näslund (061118) Protokoll fört vid Årsmöte i VS/KF, Stockholm.

SVKFWS – Swedish VKF written statements

SVKFWS001 Göran Lindberg (1996) Ang. Psykiatrins termer – SPRI-projekt 58301 – VKF:s syn på ”Terminologisk begreppssystem”.
SVKFWS002 Göran Lindberg (19970224) Remissyttrande över SOU 1996:138 ”Ny behörighetslagstiftning på hälso- och sjukvårdens område m.m.”
SVKFWS003 Iris Sundelin & Göran Lindberg (19991212) Ändrings- och tilläggsförslag från Svensk Kuratorsförening tillsammans med Vuxenpsykiatriska Kuratorers Förening, VKF med avseende på ”socialstyrelsens nationella riktlinjer för utredning, behandling och rehabilitation av patienter med psykos, speciellt schizofreni.

Nätverk för forskande socionomer i hälso- och sjukvård (NFS)

NFSA – Swedish Nätverk för forskande socionomer i hälso- och sjukvård – article

NFSA1 Marianne Olsson & Birgitta Sanden Eriksson (1995) Upprop – nätverk för forskare inom socialt arbete inom hälso- och sjukvård. In: *Svensk Kuratorsförening* 1995 (2): 16.

NFSD – Swedish Nätverk för forskande socionomer i hälso- och sjukvård – definition

NFSD1 Agneta Öjehagen (red) 2008 Nätverk för forskande socionomer i hälso- och sjukvård inom hälso- och sjukvården: Psykosocialt arbete inom hälso- och sjukvård – Definition och innehåll i praktik och forskning. http://ki.se/content/1/c6/04/76/66/psykosoc%20arbete%20-%20praktik%20och%20forskning.2008-04-29%20pdf.pdf (access 130109).

NFSP – Swedish Nätverk för forskande socionomer i hälso- och sjukvård – protocol

NFSP001 ? (19960520) Nätverk – forskare inom psykosocialt arbete i hälso- och sjukvård, minnesanteckningar från möte den 20 maj 1996, Stad?

NFSP002 Mariann Olsson (19971017) Anteckningar från nätverksträff i Stockholm, Stockholm.

NFSP003 Mariann Olsson & Eva Wikman (19981016) Minnesanteckningar från mötet med forskarnätverket i socialt arbete inom hälso- och sjukvård, Stockholm.

NFSP004 Ulla Melin Emilsson & Kerstin Granberg Lundin (19990416) Minnesanteckningar från Nationellt Nätverksmöte, Lund.

NFSP005 Gunilla Fahlström (19991203) Minnesanteckningar från nätverksmöte, Karolinska Sjukhuset Stockholm.

NFSP006 Kerstin Granberg Lundgren & Mikaela Starke (20000505) Minnesanteckningar från nätverksmöte, Göteborg.

NFSP007 Birgitta Sandén Eriksson (20001117) Minnesanteckningar från nätverksmöte den 17/11 2000 med forskande socionomer inom hälso- och sjukvård, Stockholm.

NFSP008 Kerstin Granberg Lundgren (2001) Nätverket för forskande socionomer inom Hälso- och sjukvård den 2001-05-11, minnesanteckningar, Umeå.

NFSP009 Mariann Olsson (20020102) Nätverket för socionomer som forskar inom Hälso- och Sjukvården, Stockholm.

NFSP010 ? (20030509) Minnesanteckningar från Forskande Socionomers Vårmöte, Stad?

NFSP011 Berit Björkman & Karin Säflund (20040504) Bilaga till Minnesanteckningar forskarnätverket, Stad?

NFSP012 Ulla Melin Emilsson (20041025) Minnesanteckningar från Nationellt Nätverksmöte för forskande socionomer inom hälso- och sjukvård, Lund.

NFSP013 Mariann Olsson & Karin Säflund (20050411/12) Minnesanteckningar från nätverks-möte för forskande socionomer i hälso- och sjukvård, Stockholm.

NFSP014 Ann Lalos, Berit Björkman & Anneli Kero (20051114) Nätverksmöte för forskande socionomer i hälso- och sjukvård, Umeå.

NFSP015 Mariann Olsson & Helena Kärrfelt (20060403) Minnesanteckningar från vårmöte med nätverket för socionomer som forskar inom socialt arbete i hälso- och sjuk-vården, Stockholm.

NFSP016 Ann-Christine Gullacksen & Ingrid Runesson (20061002/03) Minnesanteckningar från Nätverksmöte för forskande socionomer inom Hälso- och sjukvård, Malmö.

NFSP017 Kjerstin Larsson & Helena Kärrfelt (20070416) Minnesanteckningar från nätverksmöte med forskande socionomer, Uppsala.

NFSP018 Siv Olsson (20081128) Minnesanteckningar från forskarnätverkets höstmöte, Huddinge.

Two focus group interviews with members of the Svensk Kuratorsförening & DVSG in 2010

Germany: Bettina, Sven, Ulf, Jochen

Sweden: Ida, Marianne, Birgitta