Work Package 1:

Literature review on innovation in social services in Europe

(sectors of Health, Education and Welfare Services)

Report

May 2012

TABLE OF CONTENTS

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INTRODUCTORY REMARKS

Innovation in Social Service in Europe: A literature Review

About the study

This is the final report of a literature review on innovation in social services in Europe both on innovation in the field of health, education and welfare and across the boundaries of these sectors ('blurring boundaries') within the InnoServ - Innovative Social Services platform Project under contract to the 7th Framework Programme for Research, Funding scheme 'Coordination and support action' (EU).

The report was prepared and lead by IRS as Lead Partner of Project Work Package 1 on the basis of its own research activities and the input coming from project partners.

Objectives and tasks

What does innovation in social services in Europe mean? Trying to answer this research question constitutes the main aim in view of which the literature review has been undertaken.

Based upon empirical evidence and theoretical information available - the status quo of research and the input from practitioners - the literature review is aimed at detecting current trends and directions. The information has these objectives to identify:

1. concepts and definition (dimension and sub-dimension) of innovation and innovative approaches in the field of social services on one hand, and on the other hand research fields and themes to investigate innovation for social services provision. The distinction between product, process and content innovation was one of the analytical instruments for searching and retrieving the appropriate literature, analysing and synthesizing the findings;

2. factors driving innovation, types of innovation prevalent in each sector, new forms of social services, innovative practices and fields, new targets, demands and social needs as determined by the current demographic, economic and political situation in Europe;

3. practical cooperation and networking of actors across different service fields and governance level but also the role of competition in the social services sector; the emergence of hybrid organizations which combine features of NPOs/NGOs, profit-organizations, and volunteer associations; the role and collaboration of different actors (users and beneficiaries, volunteers, paid staff and professionals, policy shapers and managers, social and organizational representatives controlling social services organizations, financiers and directors investing in and controlling commercial enterprises);

4. key issues and challenges in researching and analysing innovation in social services considering a methodological level (i.e. indicators to evaluate innovation and the role of

performance indicators; the use of social network methods), a practical level (the role of professional practitioners and users in designing the governance of social services, the role of information technologies) and a political level (the effects of reform; the effects of different logics).

Taking as the key point of reference the concept of social services of general interest proposed by the European Commission (2006)[1], a first working definition of innovation in social services has been proposed in the project such that innovations are those social services that meet individuals' needs in the areas of health, education and care in living in wider society through:

a) the promotion of social interaction for mutual support;

b) the delivery of organizational arrangements for the provision of directed support to individuals or groups.

The term social and health services of general interest refers to 'social (and health) services that are entrusted by a competent public authority with a general interest mission of a social or health nature and that are supported or subsidised by a public authority. They are designed to ensure certain objectives such as high levels of social protection, employment and equality'[2] (2006, p. 376). We decided not to include the first pillar mentioned there, obligatory social insurance schemes, but only the second pillar, personal social services and including health services that are not been covered under SSGI at EU level.

Methodology

The review has been conducted in 13 European languages starting with an analysis of the literature available in English, French and German, the majority of publications within the EU. Innovation in social services, distinguishing itself among the main sectors, is the review topic. In order to gather appropriate literature a combination of primary and secondary source reviews (i.e. books, journals, articles, papers, documents, providers organization materials) has been conducted, initially mainly based on the following keyword searches: innovation in social services, service innovation, social innovation, service science.

To ensure that the most relevant texts from each of the selected languages were taken into account and to give the reader some insight into the breadth of the literature sourced, IRS has

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[1] The Communication on Social Services of General Interest of 26 April 2006 distinguishes three broad categories: (i) 'health services', (ii) 'statutory and complementary social security schemes' and (iii) 'other essential services provided directly to the person'. See also Council of Europe (2007) Study on Integrated Social Services; European Commission (2010) Second Biennial Report on Social Services of General Interest; European Commission (2008) First Biennial Report of the European Commission on Social Services of General Interest; European Commission (2007) Communication of the Commission on SGI and SSGI, including the frequently asked questions (FAQ) documents on EU rules and SGI/SSGI; European Commission (2006/2007) Study on Social and Health Services of General Interest in the European Union; Social Protection Committee (2010) A Voluntary European Quality Framework for Social Services; Social Protection Committee (SPC) (2008) Report of the Social Protection Committee on the application of Community Rules to SSGI, December 2008. For a graphical representation of the Conceptual framework including SGI, SGEI, SSGI, SHSGI see the 'Study on Social and Health Services of General Interest in the European Union (2006, p. 70).

[2] Source: Communication from the Commission 'Implementing the Community Lisbon programme: Social services of general interest in the European Union', 26.04.2006 COM(2006)177 final.

designed a template for identifying and analysing the literature utilized by the consortium members to gather and organize information. The template (see Annex 1) is structured along three sections: A) Concept and the state of art; B) Contents (and impacts) of Innovation in Social Services for each field of social services (Health Services, Education Services, Innovation in the field of Welfare Services) including practical examples of significant innovative forms in the social service; C) Trends and Demand for further research. The aim was not to gain a complete overview, but to get an idea of key innovative aspects and identify main trends for social service provision, their logic, problematic aspects, in particular related to mechanism for the provision and delivery of social services, socio-economic impact of these innovations, new capacity of these services to be more inclusive, and gaps within our scientific knowledge.

The follow list of key words, clustered into 3 groups, was suggested in the template:

Themes. Innovation, Social Innovation, Innovation in Social Services, Socio-Institutional and Governance Factors supporting the innovation in SS (i.e. institutional framework, model of financing SS, governance, partnership and networking), New/emerging social problems and challenges (i.e. disability and increasing life expectancy), New Approach to an old Social Problem, New Social Services, Mixing Different Fields of Services, Knowledge Creation Process and Experience Knowledge, Methods of Service Delivery with or without a technological component, The introduction of Informatics and New Technologies (i.e. devices, teleassistence) in social work, Process Innovation and Territorial-Local Development, Social Reforms introduced, Evaluating Innovation in Social Services, Performance Indicators, Social Benefits, Failures in Supporting, Researching and Evaluating Innovation in SS, New perspectives in the concept of wellbeing.

Actors. Innovators: main actors in the innovation process; The new role of patients and users (as expert users/patients directly involved in care activities); The new role of the family and relatives in care.

Fields (Social Services): Innovation and Health, Education and Welfare Services, Innovation in terms of integration between policy fields and approaches (i.e. integrated care, cooperation between health and social care, intergenerational project), Social Innovation and Education, Innovation in Parenting Support and child policies, Innovation in the reconciliation between Family and Working Life, Innovation in the support to mental health, Innovation in old age policies and challenges(i.e. new technologies, new forms of housing for the elderly), Innovation in Disability policies and challenges (i.e. new technologies, new forms of housing, community care), Innovation in Migration policies and challenges and Access to Social Rights, Innovation in Poverty and Social Exclusion policies and challenges.

The first findings of the literature review in the 13 languages and a first set of criteria of innovation in social services have been discussed during a meeting of the consortium in conjunction with advisory board.

Finally, a bibliography was compiled using a variety of methods including, also, an online database. Two Group Libraries in fact have been created in Zotero to collect and to collaboratively manage bibliographic data (research sources and materials in different languages) referring respectively to the bibliography in general and to sector bibliographies. The InnoServWP1 Groups Libraries evolved and changed during the literature review process gathering new sources and eliminating those that appear less useful.

The Structure of the Report

This Final Report presents the main findings from the review dividing the literature into themes or categories. In detail, in this report definition, concepts of innovation and the state of the literature - with its strengths and limitations (cap. 1) - are first considered. The aim is to clarify the terminology used and to analyse links, overlaps between the topic reviewed and other ones such as social innovation, service innovation and social change. What the literature tells us about innovation both in each field and cross sectoral services are contained in the cap 2 before concluding with a final part about criteria (and key words) to identify innovation in social services, in Europe, as arises from the literature (cap 3).

1 CONCEPT AND THE STATE OF ART (LITERATURE REVIEW ON INNOVATION IN SOCIAL SERVICES)

1.1 Concept and issues concerning innovation in social services in a European context

In order to address the issue of innovation in social services in Europe, three research questions, closely linked, provide the context for the literature analysis, namely:

1. What does innovation in social services mean? What is distinctive?

2. Which are the origins of innovation in social services?

3. Which are the main criteria to identify innovation in social services?

The chapters one and two of the report are aimed to give answers to the first two questions (see the final chapter for the third question). We use both an inductive and deductive approach to uncover relevant dimensions and criteria of innovation in social services. In the next section our literature review findings about the context of social service innovation are outlined. Different definitions, links and, overlaps exist between innovation in social services and other topics in particular concerning social innovation, service innovation and social change. Specifically economic, social and cultural perspectives can be distinguished. More in detail, literature concerns business and new public management studies, social services and social innovation literature from the following perspectives of technological issues, access to market, changes in process and product, client interaction/client delivery and the participation of end users, evolution of the demand and social needs and that of introduction of new relationships with stakeholders and territories. In such a context, a clarification of some concepts we find in the growing literature from diverse perspectives converging around the issues of innovation in social services appears to be necessary.

1.1.1 Theoretical and analytical background: a dialogue between service innovation, innovation in social services and social innovation

Distinctive aspects and determinants of innovation in social services in Europe emerged on analysing academics contributions, European documents and practical knowledge of praxis social service organizations. These contributions can be grouped mainly into three different fields: service innovation literature, social service literature and social innovation literature. What brings us to review this kind of literature is its utility for understanding some conceptual key issues concerning social service innovation in the European context. So the following section discusses some concepts and definitions arisen from the literature with the aim to contribute in providing a framework for identifying and analysing innovation in the social service sector.

Innovation and Service Innovation

Innovation and service science literature have expanded considerably (Cooke, Schwartz, 2007; Hage, Meeus, 2006; Fagerberg, Mowery, Nelson, 2005) in recent years, mainly focusing on service systems (principally on supply-driven characteristics), service design and innovation related to profit-seeking organizations. Innovation in the profit sector is defined as a process to better align products and services to the requirements of the client. Following the European Commission's 'Green Paper on Innovation', innovation consists of 'the successful production, assimilation and exploitation of novelty in the economic and social spheres' (1995, p. 1). It deals with organizational innovation as well as with market or presentation innovation, (Van Geyes, Vandenbrande, 2005). At the same time, the definition of service innovation is mostly placed in the profit sector. The definition elaborated by van Ark et al. (2003 in UNECE, 2011)[3] focuses, for example, on *services innovative functions*: innovation in services in fact includes 'new or considerably changed service concept, client interaction channel, service delivery system or technological concept that individually, but most likely in combination, leads to one or more (re)new(ed) service functions that are new to the firm and do change the services/goods offered on the market and do require structurally-new technological, human or organizational capabilities of the service organization' (p. 6). Other relevant analytical suggestions have been offered by the authors: firstly, besides technological innovation, there are three main types of *non-technological innovation*, namely new services conceptions, new interfaces with clients and new systems of service delivery (p. 7); secondly, innovation varies by *who guides it*: the supplier, the client, the company itself, the use of services and paradigmatic changes (ibidem).

As noted - besides position innovation, paradigm innovation[4], incremental and radical innovations in services (Bessant and Davies, 2007, p. 68) - dominant categories through the literature on service innovation are product and process innovation. As reconstructed in Promoting Innovation in Service Sector (UNECE, 2011), 'the categorization to product, process and organizational innovation first emerged from Schumpeter's work (1934). Specifically for services, Miles and Howells distinguish between product innovation (goods or services), process innovation, organizational innovation and innovation in client interaction as a specific type' (p. 7). As reported by Phills, Deiglmeier and Miller (2008), *product innovation* refers to 'innovation as an outcome that manifests itself in new products, product features, and production methods. This branch of research examines the sources and economic consequences of innovation' (available on line)[5]. *Process innovation*, instead, concerns 'the organizational and social processes that produce innovation, such as individual creativity, organizational structure, environmental context, and social and economic factors' (ibidem). Nevertheless, while this

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[3] See table I.1.1. Business services innovative functions in UNECE, 2011, p. 6.

[4] The author provides the following definitions: 'position innovation [concerns] changes in the context in which the products/services are introduced', 'paradigm innovation [concerns] changes in the underlying mental models which frame what the organization does.

[5] Available at http://www.ssireview.org/articles/entry/rediscovering_social_innovation.

distinction is 'adequate for manufacturing, it is less helpful for services' (Leich, Gökduman, Baaken, 2009, p. 9; Camacho and Rodriguez, 2008).

The distinction between product and process innovation is partially overlapping the one between innovation in services and service innovation. If *innovation in services* concerns 'the innovative change within the service activity or sector itself' (ibidem), *service innovation* refers to 'the innovative change in those organizations or companies that use innovative services or those engendering innovation' (ibidem). Most typologies proposed in literature distinguish: 'reliance on external innovation ('supplier dominated' innovation), degree of interaction with consumer ('client-led' innovation), intensity of in-house innovation (innovation in services), extent to which service firms support other firms to innovate (innovation through services)' (2007, p. 7)[6]. Service innovation can occur at various levels, inside and outside the organization, both on a large or small scale. Literature points out that different patterns of service innovation emerge at different scales and that the scale at which innovation is carried out has a strong influence on the results.

Origins, aims, diffusion and adoption of innovations are different and vary from sector and context. At the same time 'implementation environments' of innovations, process and mechanisms of service innovation such as actors or organizations and levels involved are different (i.e. technological, organizational, strategic, commercial, operative as far as innovative business services; Rubalcaba, 1999). Nevertheless, traditionally innovation (and service innovation) have been considered as a means of stimulating growth[7] (Lévesque, La jeunesse-Crevier, CRISES, 2005, p. 38) following a cumulative and future-oriented process dealing with organizational innovation as well as with market or presentation innovation (Van Geyes, Vandenbrande, 2005). When looking for sources of economic growth, economists focused their efforts on technological and scientific innovations, especially since the 1980s. In line with this, criteria for defining innovation have been mainly linked to marketing or integrating new development (a component or a method) into production, and to technological product and process in the business enterprise sector (i.e. The Frascati Manual by the OECD and the Oslo Manual by Eurostat). As contemporary economies have been becoming more services-oriented (Gadrey, 2003), the question of innovation - and the role of technology for growth - has been seen in a different light by both economists and sociologists since the 1990s. According to the new theories of endogenous growth (Romer, 1986, 1990; Lucas, 1988), 'technological progress is fully integrated as an endogenous variable, which is explained, amongst others, by learning and knowledge-related elements. The value of intangibles, and therefore the related services, would

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[6] See Bessant and Davies (2007), table 3.4, p. 87 for a summary of the implications for management by the following models of innovation: Product Life Cycle (PLC) (Abernathy and Utterback, 1975), Sectoral Taxonomy (Pavitt, 1984), Product-Process Matrix (PPM) - (Hayes and Wheelwright, 1984), Disruptive Innovation (Christensen, 1997), Open Innovation (Chesbrough, 2003).

[7] Traditionally economists have identified three growth factors: work, capital and innovation. Firms introduce innovations through the services they offer, in the way they develop such services, in organizing the company and in their marketing approaches (Hermel and Louyat, 2008, p. 18).

form part of these elements' (Rubalcaba in UNECE, 2011, p. 3). Evolutionist theories, an alternative approach to the neoclassical theories, have become the growth model to be favoured by service innovation specialists. Specifically, it relies on a concept of growth and innovation based on: (a) the integration of economic and non-economic factors (culture, institutions and sciences) and (b) the idea that 'services have developed within innovative systems as another dimension linked with the wider economic system, especially by means of knowledge-intensive services' (ibid., p. 3). The evolutionist theory suggests a systemic approach.

An issue of debate is the role of technology in service and in innovation service. Technological innovation activities are considered those 'all of scientific, technological, organisational, financial and commercial steps, including investments in new knowledge, which actually, or are intended to, lead to the implementation of technologically new or improved products and processes' (OECD, 2002, p. 19). To systemize the different positions in researching innovation in services as far as the nexus between innovation and the technology component, Gallouj (2002) identifies the following three main approaches (in Gallouj and Savona, 2009):

(i) the '*technologist or assimilation approach* that equates or reduces innovation in services to the adoption and use of technology (for instance, information and communication technologies - ICTs)....[and] attempt to assimilate services within the consolidated framework used for manufacturing sectors and manufactured products' (p. 10). To be noted that in recent years some authors have stressed the unsuitability of the technologist approach also for manufacturing sector (Drejer, 2004);

(ii) the '*service-oriented or differentiation approach* that seeks to identify any possible particularities in the nature and organization of innovation in services. This stream of literature attempts to develop a specific framework for service innovation, while attempting to highlight all the specificities in service product and production processes (Gallouj and Savona, 2009, p. 10);

(iii) the '*integrative or synthesizing approach*, which, taking as a starting point the trend towards convergence between manufactured goods and services, attempts to develop a common conceptual framework, able to account for an enlarged view of innovation which is applicable to any tangible or intangible product' (ibid., p. 11), to planned and unplanned innovation.

In a similar way, Tether and Howells in reviewing how understanding of innovation in services has changed over time observe a shift from 'technological adoption to complex complementary changes to technologies, skills and organisation' (2007, p. 21). The authors indentify, since the 1980s, the following four perspectives on innovation in services: the 'Neglect' phase, the 'Assimilation' phase, the 'Distinction' phase and the 'Synthesis' approach; the latter based on 'the importance of both technological and non technological (and especially organisational) forms of innovation' (ibid., p. 22). In line with this, skills (management skills and workforce

skills), focus on demand, diffusion – with 'the joint adoption of technological and non-technological, organisational innovations' (ibid., p. 23) - and measurement issues have been considered main areas of innovation policy for services (ibid., p. 17)

However, even if there is considerable agreement that the technological factor is just one potential element of innovation, as stated, for example, in the Green Paper on Innovation (EC, 1995), the importance of technology is still fundamental in the literature on innovation. Technically sophisticated[8] are also defined as the so called *transformative services* that according to the Expert Panel on Service Innovation in the EU (2011) can be grouped into three types of service sectors, namely: (i)'networking, connecting and brokerage services which link consumers, firms and supply chains and improve the allocation and distribution of goods and information in society'; (ii) 'utilities and infrastructure services, such as telecoms, energy and waste disposal, that increasingly provide higher value-added services for their customers'; (iii) 'knowledge intensive business services (KIBS) that collaborate closely with their customers to help upgrade their technology, organisational processes, and business models as well as transfer knowledge and experience across sectors' (pp. 7-8).

The Europe 2020 Strategy aimed at a smart, sustainable and inclusive growth attributes a relevant role to the transformative services, and, more generally, to service innovations that are considered drivers of innovation. The transformative capacity of these services is found in the ability to 'disrupt traditional channels to market, business processes and models, to enhance significantly customer experience in a way which impacts upon the value chain as a whole... innovations in these service systems therefore have the *potential to profoundly change the innovative potential of other sectors* and catalyse the drive towards economic growth' (ibid., p.7).

Even if economic outcomes of innovation - that primarily originate from technology and in the business - have mainly attracted the interest of the academic communities and of the business sector, recently, two perspectives to conceptualize innovation, aiming to broadening the innovation paradigm, have gained more attention: the socio-cultural approach on one hand and the complexity approach on the other hand. Links and connections among them can be found.

From the socio-cultural perspective innovations are 'changes or novelties of rites, techniques, customs, manners and mores' (Kallen, 1949); framing innovation and service innovation as complex issues might could also mean considering social and cultural components of innovation. Complexity in the conceptualisation of service innovation, in part, comes from the complex and multi-faceted nature of innovation. As highlighted by Hochgerner (2011), besides economic and technological elements, innovation 'bear social components as well....Any innovation emerges from a certain background in society, and has impact on particular social entities [that is to say] that all innovations are socially relevant' (power point presentation at the

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[8] 'Rather than just pushing technology, they work back from users' needs and changing concerns about environmental or social impacts, and find solutions, that often draw on technology, to address them' (2011, pp. 7-8).

Capacity Building on Social Innovation Research and Management in South East Europe Conference, p. 2). So, in order to develop an extended paradigm of innovation, the author considers eight types of innovation (products, processes, marketing, organization, roles, relations, norms and values) across the four functional systems (economy, culture, politics and law) (ibidem).

With regard to service innovations and innovations in social services, various types of innovations exist and there is a different degree to which individuals or organizations (firms, third sectors organizations, public authorities, clients, users, stakeholders, groups) enabling innovations are entangled in a given social construction or network that might be: relational, structural, cognitive, cultural, political, territorial/spatial/geographical, temporal, institutional, moral or normative, emotional embedding including also social class and gender inequalities structures. Furthermore, in the process of generating and spreading innovation *the interaction dimension* - within a complex system (society as a whole) and between different systems, contexts or implementing environments - is fundamental. Jalonen and Juntunen (2011) argues that complexity thinking opens up potential for analyse innovation in the context of complex systems and, in particular, for investigate cooperative dynamics (forms of cooperation in networks, public-private partnerships, public management networks and governance modes). According to the authors 'all of this has two implications: firstly, attention should be paid to the interaction processes between different actors, and secondly, an "open systems" view (instead of "closed system") of the governance processes should be favoured' (p. 402).

So applying complexity lens and complexity-informed conceptual models appears to be a prominent field for researching and analysing not only innovations but also service innovation and innovations in social services. According to the complexity perspective, 'an innovation can be defined as 'context specific "novelty in action" [Altshuler and Zegans, 1997]. This includes the idea that *innovation* is *a specific form of change* [Drucker, 1985; Osborne and Brown, 2005]. Innovation is about change because it represents discontinuity or break with the past [Osborne and Brown, 2005]...*translating new ideas into new forms of action* and improved...services' (Jalonen, Juntunen, 2011, p. 402)[9].

According to Phills, Deiglmeier and Miller (2008), 'to be considered an innovation, a process or outcome must be either more effective or more efficient than preexisting alternatives. To this list of improvements we add more sustainable or more just.....sustainable are solutions that are environmentally as well as organizationally sustainable that can continue to work over a long period of time' (available on line). Furthermore, 'any innovation provides a base camp to form new, tiny or strong branches of future changes at any given time with particular social, economic or technological status' (Hochgerner, 2010, in Prefacy).

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[9] Note readapted.

Innovation in social services

Moving from service to the specific social services sector, the characteristics of novelty, improvement and sustainability - criteria for funding innovation highlighted above – have to apply not only to new products (new social services, new form of delivery services) and new ideas (new social work method, new governance, new organizations, new partnerships) but also involve the sphere of social practices and the underlying values of these. The social services sector is centred on people and service delivery.

In line with this, relating innovation to social services primarily needs to consider meanings of social attribute and implication of situating innovations into a social perspective. What is social?

Social denotes not only the social sector as a legal category but also social problems and social impact on one hand, social motivations or intentions on the other hand (The Open Book of Social Innovation, 2010, note2, p. 10). Furthermore, social denotes the aims of innovations in social services and the values (culture) created and spread by such a kind of innovations.

Two main features of social services underscore the specific nature of the innovation question. Firstly, a service *does not have an autonomous existence* as does a physical thing with technical specifications. It is a social construction (with its world of reference) which fits into time frames in different ways (time horizon) and into matter (degree of materiality) (Djellal and Gallouj, 2000, p. 11). Furthermore, *the relational dimension* plays a central role, as the relationship between the user/customer and the service provider is direct (Bandt and Gadrey, 1994; Gadrey, 2003; Laville, 2005).

Compared to other services, not only are the above mentioned features distinctive in social services (degree of intangibility, interaction between providers and target groups, information-intensity, the relational dimension and the service relationships) but also *aims*, *values* and *missions* that ideally inspired people involved in the process of designing and delivering social services. The underlying objective of social workers and volunteers is to firstly meet individuals' needs and contribute to create social value and social cohesion.

Placing the analysis on the European level, it is acknowledged social services potentially constitute 'pillars' of the European society and economy contributing 'to several essential values and objectives of the [European] Community, such as achieving a high level of employment and social protection, a high level of human health protection, equality between men and women, and economic, social and territorial cohesion' (EC, 2006, p. 4). Specifically social services might gain a crucial role to implement the normative project and the European Social Model (at a societal level) on one hand, and to improve, on the other hand, the quality of life of the European citizens and, primarily, their inclusion into society (at individual level). European aims and objectives interact with aims of innovation in social services that have been defined at a Member State level by the relevant social groups, by the political, cultural, institutional contexts and by the regulative framework.

Innovation in social service is a dynamically evolving phenomenon stimulated both by the growing pressures from social challenges and by cultural and institutional changes involving the welfare state, the social, security and care categories. According to Hochgerner, 'innovations, addressing primarily social objectives, include: *roles* (of individuals, CSOs, corporate business, and public institutions); *relations* (in professional and private environments, networks, collectives); *norms* (on different levels, legal requirements) and *values* (custom, manners, mores, ethic/unethical behaviour)' (2011, p. 4, power point presentation).

How change happens such as the connection between innovation (in service, in social services, in society) and social change are themes widely discussed in literature. The main given answer is that 'in some circumstances each of the four barriers to change [namely: *efficiency*. People resist even the most appealing reforms because in the short-run they threaten to worsen performance. Second... *peoples' interests*... The third barrier is *minds*. Any social system comes to be solidified within peoples' minds in the form of assumptions, values and norms...The fourth barrier is relationships. The *personal relationships* between the movers and shakers in the system create an additional stabilising factor in the form of social capital and mutual commitment...these networks...are likely to seriously impede any radical change] switches' (Mulgan, Tucker, Ali, Sanders, 2007, p. 18). It follows that innovations that are social can 'occur in all sectors of society (private, public, civil society). Their prime outcome is changing social practices, yet besides there may be economic implications as well' (Hochgerner, 2011, p. 2, power point presentation). Innovation in social service is supposed to change a social practice in order to reach aims and objectives of innovation (the normative dimension of innovation) that, as pointed out, are contextual and 'local' negotiated.

Distinctive of social service innovation are also (a) the processual dimension - *the process of innovating* and *the diffusion or adoption of the innovation* - and (b) the role attributed to the technological dimension. Although in many cases the introduction of information and communication technology (ICT) plays an important role in the innovation process, innovation in social services results in new forms of service delivery and/or new target groups (Hermans, Vranken, 2010) or in new mechanisms or social practices introduced in pre-existing social services. It most likely also means tearing down walls between sectors (e.g. between family carers and professional care, between preventive and curative care) and collaboration or networking (i.e. flexible relationships between independent partners) inside or outside the social services sector (ibidem). But, who does innovation in social services?

Institutions, organisations, movements and individuals, are the innovators in the field of the social sector. In recent literature, particular attention has been paid on users' movements highlighting how 'discontent' and awareness of a gap between what people need and what they are offered by governments, private firms and NGOs (Mulgan, Tucker, Ali, Sanders, 2007, p. 9) gain a crucial role in promoting innovation. Service users are social service innovators driving culture change as well exemplified by the global disability movement (Schalock, 2004) and by

the independent living philosophy (Shaping Our Lives, National Centre for Independent Living and University of Leeds Centre for Disability Studies, 2007). In this case measuring innovation firstly means measuring the contribution of innovation in social services for social-cultural changes.

In any case, researchers agree that, unlike the linear process of innovation in the technological sector, *innovation* in social services is *interactive* based on utilising connectivity and interdependencies (Jalonen, Juntunen, 2011), cooperation, sharing information, creating trust and so on. The margin for innovation in services would appear to be more complex, requiring more negotiation and more room for cooperation between the various actors (Callon in Klein, Harrisson, 2007, p. 25). Several studies have in fact emphasised that innovation in the services sector can arise (among other possibilities) in the *transactional space* where the service offering encounters the customer (Hermel, Louyat, 2008, p. 3). It also requires essential *transformations among spheres and actors* at both production and consumption levels, born from observation of the specific kinds of service activities and the social relationships involved. In particular the relational dimension implies that at different deployment stages, the customer can participate in producing the innovation (collaboration). The customer/user can therefore be one of the actors of the innovation, the success of which depends on the quality of this interaction (Djellal and Gallouj, 2000, p. 14). Some authors have emphasised that in the process of innovation, one must take into account not only how this interaction takes place, but also the time and images associated with the nature of the service (Klein, Harrisson, 2007, pp. 4-5). This in turn implies synergies and tensions stemming from the confrontation between subsisting older models and new productive requirements engendered by innovation (Laville, 2005, p. 31), from old paradigms and organizational cultures and new ones.

As far as the diffusion, dissemination and implementation of innovations a useful conceptual model pointing out the interactional dimension has been proposed by Greenhalgh et al. (2004) with reference to health service organizations. The author defines social service innovations (in the area of health care-related services) 'as a *novel set of behaviors, routines,* and *ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness or user's experience* and that are *implemented by planned and coordinated action*' (ibid., 2004, p. 1). According to the model, the innovation process is placed in the interaction between 'the resource system, knowledge purveyors and change agency on one hand, and the user system on the other hand. The user system is, during the design and implementation stages of the innovation, linked to the resource system and the change agency by e.g. shared meanings and mission, effective knowledge transfer, user involvement in specification, communication and information, user orientation, product augmentation and project management support' (Keller, Gare, Edenius, Lindblad, 2010, p. 1). A representation of the proposed model is shown in the figure below (Figure 1). Is this model also suitable for other service sectors? Is this model suitable for social service providers belonging to the social economy or third sector (non-governmental organization, non profit organization, foundations,

social cooperatives, social enterprises, volunteer association, family/neighbourhood)? Are all determinants included? To what extent is the cultural component of innovation taken into account? These issues lead to a more general question concerning the existence of different criteria (or variants) and pattern of innovation by social service sector (health, education, welfare services and cross-sectoral) and by actor or network promoting innovation. In line with this, with regard to voluntary organizations, Osborne (1998) developed a typology of innovation in the social sphere distinguishing between: the traditional activity of VCOs *in providing specialist services* (situated within the 'traditional organizations'...; the developmental activity of VCOs involved in the *incremental change of their services* (situated within the 'developmental organizations'...; the innovative activity of VCOs that *changed the paradigm of their services and/or their skills base* (situated within the 'innovative organizations' (Osborne, Chew, McLaughlin, 2008). Interesting theoretical and empirical insights derive from some contributions on innovation in the third sector organizations (i.e. social cooperatives in Italy; Fazzi, 2011) and from the new public governance literature (Pestoff, Brandsen, 2009 in Osborne).

Figure 1. Conceptual model for considering the determinants of diffusion, dissemination, and implementation of innovations in health service delivery and organization, based on a systematic review of empirical research studies
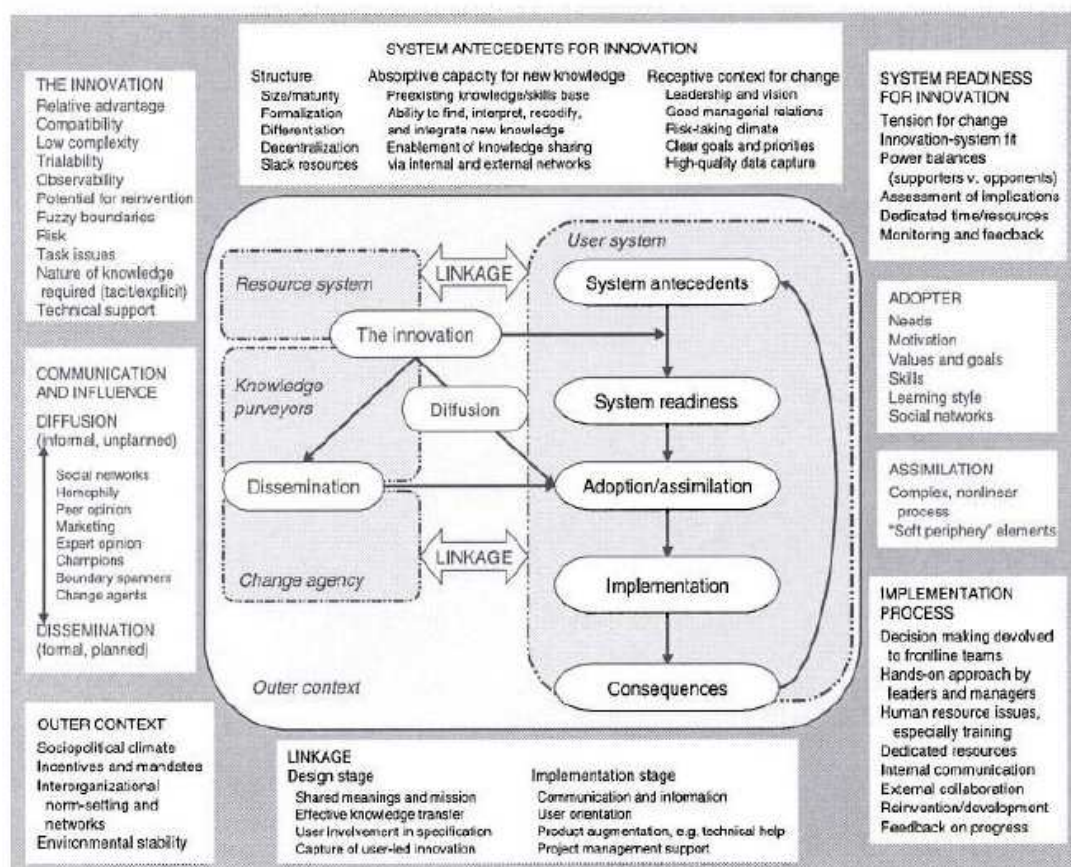
Source: Greenhalgh et al., 2004 in Keller, Gare, Edenius, Lindblad, 2010, p. 3

It might be useful to extend this model (developed from the point of view of the provider organization) including, at an organizational level, aspects related to the social service system (the welfare system model, the various types of service providers) and to include in the societal (macro) dimension both those 'institutional processes (legal acts, regulatory rules) designed to explicitly influence environment for innovation' (Pro Inno Europe, 2008, p. 13) and 'the scope and effectiveness of existing frameworks and tools defining, measuring and assessing the quality of …social services' (EC, 2011, p. 8). Furthermore, as pointed out in the Study on Social and Health Services of General Interest in the European Union (EC, 2006), 'social services cannot be implemented in a standard manner as most of them need to be adapted to individual situations and needs' (p. 21).

Focusing on the *regulatory system* means, for example, considering 'the regulatory framework governing service provision, financing of these services and their evolution' (ibid., p. 8). This includes forms, regulatory rules and governance of third sector partnership for public service

delivery (Rees, Mullins and Bovaird, 2012), *EU rules on public-private partnerships*[10] (PPP), *public procurement and concessions*, *socially responsible public contracts and social clauses*[11], *outsourcing mechanisms, quality assurance and accreditation mechanisms, tools for monitoring and evaluating social services, social accountability system*. The social sector is in fact embedded in the logic of the care state with government interventions in financing, price setting, quality control and regulation. In this way, government creates the conditions for innovation (Leys, 2009). Social services organizations are confronted with the continuous tension between the institutional logic of legislation and regulation, the logic of provision of the service delivery and the logic of demand of needs and requirements of clients (i.e. quality and trust are often difficult to formalise). They also have to take into account the often contradictory objectives of stakeholders: clients and advocacy groups, professional service providers and unions, politicians, managers and federations and umbrellas. Furthermore, the responsible people and the caregivers are not the same persons. The responsible people are rarely confronted with the impact of care and the caretaker is not able to confront them with what is good or bad.

Problem of definition service efficiency are especially great from the public sector that, often, suffers from 'innovation deficit' and show difficulties in combining different goals, values, organizational cultures, inclinations to change characterizing the different actors involved in public-private partnerships. The effects of the implementation of New Public Management reforms in enhancing the efficiency of the public sector and in developing the quality of social services are other issues (as we will see in chapter 2) discussed within the debate on the nexus of innovation in social services, the welfare state and the public sector.

In order to investigate the different logics and dynamics involved in providing and innovating social services, as already mentioned, interesting suggestions derive from the application of complexity theories and a systemic approach to social service innovations. Features of complexity in the welfare service system 'refers to the feature of the system…arises from the nature of the issues in the welfare domain… [and are connected with] complexity of objectives and values in public sector' (Jalonen and Juntunen, 2011, p. 407). Along these lines, 'innovations are more often developed within a complex set of relations between actors with various different backgrounds [as an emergent phenomenon]. Given the potentiality of collective actions in reducing the inherent uncertainty in innovation…the mystery of innovation

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[10] See European Commission: 'Guide to the application of the European Union rules on state aid, public procurement and the internal market to services of general economic interest, and in particular to social services of general interest', 2010; European Commission 'Report on the public consultation on the green paper on public-private partnerships and community law on public contracts and concessions', 2005 (SEC(2005)629). See also European Commission: 'Mobilizing private and public investment for recovery and long term structural change: developing Public Private Partnerships', 2009 (COM/2009/615 final); European Commission: 'Communication on public-private partnerships and community law on public contracts and concessions', 2005 (COM/2005/0569 final) and European Commission: 'Green paper on public-private partnerships and community law on public contracts and concessions', 2004 (COM/2004/327 final).

[11] See European Commission: 'Buying Social - A Guide to Taking Account of Social Considerations in Public Procurement', 2010.

hides in complex intra and inter organizational interaction processes. It is these complex interaction processes that are fundamental for creating innovations that are based on the not yet known... [the] *unknown potential*...can be translated into a resource for improving innovation performance in welfare services' (ibid., p. 405 and 401).

On the whole, such kinds of considerations have implications in terms of measuring and evaluating innovation and innovation in social services. Measuring innovation in social services and measuring the contribution of innovation to social innovation and social change are critical aspects that have emerged from the literature review. To fully assess the value of social innovation in services, it is therefore difficult to apply strictly economic criteria and indicators, as they can hardly reveal the cognitive and relational content of the gains generated by innovative services (Bouchard, 2006, p. 11). For example, 'the quality of the relation and trust are important factors that are very difficult to express within the terms of a contract (EC, 2006, p. 21). It would also appear difficult to assess the extent of political 'transformation' (changes in social and power relations) and the impact in terms of social usefulness. Alternative indicators for measuring the wealth and well-being produced such as the social added value of are under study at this time.

With regard to evaluating innovation in social services, once the innovative process has not been considering linear but usually generating from 'partnerships and joint activities and within a much wider social and economic context... [consequently] a simple input-output or cause-and-effect model of evaluation is not appropriate.....such as [not appropriate are] performance measurement...increasingly being used as a means of evaluation of RTD...[the] use se of mean scores to assess impact and [others] traditional approaches to the evaluation of innovation...[failure] to recognise the reactive nature of evaluation' (Perrin, 2001, Evaluation, The International Journal of Theory, Research and Practice). A *learning approach* to the evaluation of innovation in social services, following a systems approach, would appear appropriate when looking simultaneously at societal, organizational and individual levels.

In order to overcome the risk that many traditional evaluation methods have to inhibit innovation, a good evaluation strategy suggested is to 'identify the minority of situations where real impact has occurred and the reasons for this...the extent to which there has been any attempt to learn from 'failures' (as well as from 'successes')...to identify implications for the future... and the extent to which action has been taken based upon what has been learned' (ibidem).

Another interesting evaluation strategy is *developmental evaluation* that in conjunction with the system thinking and the complexity theory lead to design a 'framework for engaging in sense making' (Patton, 2011, p. 13). According to Patton 'traditional evaluation aims to control and

predict, to bring order to chaos...[while developmental evaluation[12]] involves exploring the parameters of an innovation and, as it takes shape, changing the intervention as needed (and if needed), adapting it to changed circumstances, and altering tactics based on emergent conditions' (p. 5 and p. 39). Among the key conditions there is the presence of 'social innovator with a strong vision and commitment to making a difference' (p. 46).

Innovation in social services and social innovation

The literature review conducted in different languages reveals how innovation in social services is strictly connected with (and often encompassed within) the *social innovation* literature and the social economy literature. Even if with some exceptions – in a few European countries such as in Croatia, literature on social innovation is lees developed and literature on innovative social services or innovation in the field of social services does not exist - innovation in social services and innovation related to public/no-profit partnerships are becoming fundamental issues for contemporary social science, innovation research and policy developments. At the same time a strong interest on social economy, social enterprise (Euricse and Ciriec publications[13]; Spear, 2012, 2011, 2010; Cornforth, Spear, 2010; Leadbeater, 2007; Moulaert et. al, 2005; Borzaga, Santuari, 2001) and social innovations has grown. Models of social entrepreneurship and service provider from the social economy approach have been established. Social entrepreneurs share characteristics and techniques with traditional business entrepreneurs, such as utilizing time-tested business theories and practices, and their focus on innovation. However their goals are social: participation, user involvement and community benefit. Social entrepreneurs create innovative solutions to immediate social problems and mobilizes the ideas, capacities, resources, and social arrangements required for sustainable social transformations (Harvard University Website) and social innovation. Moving from a sectoral perspective to a functional perspective, we can observe that social innovation often deal with innovation in service (provider organization) or service innovation. From a conceptual point of view, social innovation is a broader concept containing both that of innovation driven by social economy (and third sector) organizations and innovation in social services (Djellal and Gallouj, 2009, p. 62).

So, further insights into the discussion on social service innovation were brought about by the debate on social innovation (and social economy literature). The study of social innovation poses the question of how a 'social innovation' should be defined. From a conceptual standpoint there are a variety of definitions used by different actors (researchers, practioners, policy makers). Among the many definitions of social innovation, the following presented below have been selected:

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[12] The author intend to distinguish developmental evaluation from more formal model-focused evaluation. Two niches for developmental evaluation have been identified: 'to support exploration and innovation before there is a program model to improve and summative test...the second niche is for those dynamics situations, like the one...where [for example]program staff and funders expect to keep developing and adapting the program, so they never intend to conduct a final summative evaluation of a standardized and hypothesized best practice model' (p. 17).

[13] Available at http://euricse.eu/it/pubblicazioni and at http://www.ciriec.ulg.ac.be/en/pages/6_0publications.htm.

'A social innovation is a new configuration of *social practices* in certain areas of action or social contexts prompted by certain actors or constellation of actors in an international, targeted manner with the goal of better satisfying or answering needs and problems than is possible on the basis of established practices' (Howaldt and Schwarz, 2010, p. 20). From a socio-cultural perspective, social innovations are 'new practices, intuitions, rites, techniques, customs, manners and mores' introduced (Hochgerner, 2010; Leo, 2001).

Social innovation refers to 'a *novel solution to a social problem that is more effective, efficient, sustainable*, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals. A social innovation can be a product, production process, or technology (much like innovation in general), but it can also be a *principle*, an *idea*, a *piece of legislation*, a *social movement*, an *intervention*, or *some combination of them*' (Phills, Deiglmeier and Miller, 2008 in The Open Book of Social Innovation, 2010, note2, p. 10). Social innovation also applies to public institutions because of the societal and political pressure to align their way of working and products to the requirements of citizens and companies (see the Social Economical Council of the Netherlands; Advice SER 2006).

In 'The Open Book of Social Innovation' (Murray, Caulier-Grice, Mulgan, 2010), social innovation is described as 'new ideas (products, services and models) that simultaneously meet social needs and create new social relationship or collaboration' (p. 3). Social innovator are those bringing together ideas, resources, tools and case studies for finding practical solutions to social problems (Social Innovator, Social Innovation and Exchange; http://socialinnovator.info). *Social innovation processes* develop in a different ways from business innovation (Mulgan, Tucker, Ali and Sanders, 2007, p. 44) as regards '*motives*, which may include material incentives but will almost certainly go far wider, to include motives of recognition, compassion, identity, autonomy and care'; the critical resources are likely to be different'; 'the critical resources...social innovations usually seek out a different *mix of resources* including political recognition and support, voluntary labour and philanthropic commitment; '*social organisations tend to have different patterns of growth*: as a rule they don't grow as fast as private ones, but they also tend to be more resilient' and, finally, '*judging success* is also bound to be very different for a social innovation... in some of the most radical social innovations participants' lives are dramatically improved by the act of collaboration (e.g. the reorganisation of social care as self-directed support)'. Even if less developed than in other sectors, 'funds, agencies, brokers, incubators and intermediaries...[represents] key institutions which help to make innovation happen' (Murray, Caulier-Grice, Mulgan, 2010, p. 9). *Enabling conditions* for innovation (structures, laws, cultures and values) can be traced in the market, state and civil society such as by crossing the boundaries of these sectors. The following six stages are involved in the social innovation process: (1) prompts, inspirations and diagnosis; (2) proposal and ideas; (3) prototyping and ideals; (3) sustaining; (4) scaling and diffusion; (5)

systemic change (ibidem). Targets of social innovation are the individuals, the environment or territory, the firm or organisation (Djellal and Gallouj, 19-21 September 2011[14]).

In the context of the Europe 2020 strategy, social innovation is defined as indicating '*new responses to pressing social demands*, by means which affect the process of social interactions. Social innovations are characterized by the production of a *social return* and the *creation of new social relationships or partnerships* which involve the end users and thereby make *policies more effective*' (EC, 2010)[15]. Within such framework social services are considered *drivers* of *social innovation*. According to BEPA - 'Empowering people, driving change. Social Innovation in the European Union (2011) - social innovation relates to '*new responses to pressing social demands by means which affect the process of social interactions*'. It is aimed at improving *well being*. It covers wide fields which range from *new models of childcare to web-based social networks, from the provision of domestic healthcare to new ways of encouraging people to exchange cars for bicycles in cities, and the development of global fair-trade chains*. In its recent usage, the social innovation approach is understood to mean not only a *new governance mode working across traditional fields of responsibilities with an active involvement of citizens*, which is effective in addressing the challenges of climate mitigation, social justice, ageing, etc., but also *the culture of trust and risk-taking* which is needed to promote scientific and technological innovations' (p. 7).

At academic level, contributions stress how although it can be said that all processes of innovation have a social dimension, in that it is characterised at each stage by social rapports (Alter, 2005; Callon dans Klein, Harrisson, 2007), it is nonetheless true that all innovations are not exclusively social. Referring to the standardising aspect of innovation, certain authors maintain that only when the purpose of innovation is linked to solidarity can we really speak of social innovation (Nussbaumer and Moulaert in Klein, Harrisson, 2007).

For other researchers, the definition of social innovation is linked rather to its source, the nature of its 'milieu of origin': 'social innovation emerges most frequently from citizen-led initiatives and, both upstream and downstream, from the results of research in social and human sciences, even arts and letters' (Dandurand, 2005, p. 382). Other research emphasises the role of social actors who are stimulated to 'move to confront what they consider to be rising inequality in a market-dominated society' (Degavre, Nyssens, 2008, p. 82). Thus, social innovation is connected to social transformation, marked by its 'capacity to envision options other than reproduction, and to contribute to the transformation of organisations and institutions' (Bouchard, 2006, p. 1). These different theoretical contributions can be broken down into two conceptions of social innovation, one rather *functionalist* and the other *transformationalist*

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[14] Power point presentation.

[15] For an overview of social innovation in the Member States see http://www.socialinnovationeurope.eu/. Information on finance, context, governance, health and wellbeing, design and technology, education and youth, local development and communities, environment and climate change and methods and tools are collected.

(ibid., p. 3) or, according to the definition of Laville (2011), weak innovation or strong innovation. The first approach puts more emphasis on innovation's contribution in terms of answers to social problems. The transformationalist approach, on the other hand, considers that the resolution of social problems brought by these services is part of a broader perspective of transforming institutions.

From the *functionalist* viewpoint, social innovations create social services that meet demands to which neither the State nor the market has responded. This requires new tools (governance, work organisation, hybridisation of resources, etc.) and a renewal of the relationships between service providers and the intended beneficiaries of the initiative. Following this perspective, social innovation could be connected with the social economy literature and studies on third sector provider organizations. Across European countries, the 'tendency for a growing number of welfare services to be provided by co-operation between the public and private sectors' (Jalonen and Juntunen, 2011, p. 402), mainly by the third sector organizations, is observed. Among academics, practioners and politics a wide consensus on developing 'innovative working methods and practices' as a way to face effectiveness of welfare services and service system responsiveness (ibidem) exists. This strand of the literature would appear particularly appropriate when looking at: the territorial dimension of innovations, the contributions of clusters with social objectives (partnership between local authorities and social economy organisations) in providing innovative local social services (i.e. local social services to the reconciliation of work, family and public life; Reves, 2007) and, finally, territory based social services that contribute to the creation of training and job opportunities for disadvantaged people and community services. Existing research on social innovation is often associated with experiments in social and sustainable economics (Richez-Battesti, Vallade 2009, p. 43) and, more recently, with social entrepreneurship (Barthélemy, Slitine, 2011). Services developed in these areas give rise to socio-economic experiments at the production level, as well as in consumption and ways of living. For example, they can take the form of neighbourhood services, fair trade, solidarity tourism, organic farming, critical consumption and short-circuit retailing, renewable energies, recycling and waste recovery, maintaining heritage, microfinance, alternative currencies and integration through economic activities. Depending on the nature and field of the developed social service, the resulting social innovations emphasise formalised equality among members at the internal level. Furthermore, they presuppose an awareness of the importance of the end goals (be they ecological, cultural or otherwise) and the necessity of direct participation (Lipietz, 2001). The political aspect of certain innovations is expressed in the intention of the stakeholders introducing the innovation to bring about 'social change' (Bouchard, 2005, p. 142). The key criteria for understanding social innovation and its effects are therefore its impact on institutional frameworks (standards, legitimacy-promoting values) as well as on organisation (tools, activity management methods) (Klein, Harrisson, 2007, p. 6). Social innovations in services trigger an indispensable interconnection when they touch upon a

base of common grounds that concern multiple players, participative or cooperative organisation, and socially relevant objectives.

More emphasis on the institutional dimension is placed by the *transformationalist* approach[16]. From this perspective social innovation is more a 'process of provoking institutionalisation, contributing to institutionalising of new practises, standards and rules founded on values inherent to solidarity' and intended to work towards social and political transformation (Bouchard, 2006, p. 6). As one of the aims of innovations is transformation, they can indeed go beyond seeking improvements or new answers to inspiring aspirations to other models of society. Thus, we can speak of *joint construction of a space for public action* (Laborier et al., 2003), in which social actors and public authorities are stakeholders in a process of *redefining public governance bodies and methods*. To go in this direction, it is also necessary for public authorities to assume a role of facilitators of innovation to rely systematically on social innovations in territories; secondly, the political role of social innovations would appear crucial to understanding the determining factors for local policies" (Loncle, 2005, p. 401). Where this is not the case, the process of remodelling institutions, albeit ineluctable, can be very slow: 'The opposition between innovative practices and prolonged insistence on a model that corresponds less and less to reality—which reflects the intransigence of those who would defend it—ultimately crumbles, even if the coherent model remains to be found, as well as its application' (Racine, 2000 quoted by Mendell, 2006, p. 5).

Which conceptual framework helps to explain the relationship between social innovation and innovation in social services?

A first step consists in *situating innovation in social services within a social innovation framework*. On the basis of what has been discussed earlier, to conclude this section, a first working definition of innovation in social service is proposed. Innovation in social services can be defined as a type of social innovation process. Innovation of social services is delivering services in another way as an answer to current and future challenges in society. It mainly concerns:

(i) designing and implementing new social services to face new needs or unmet needs (i.e. types of services offered to face autism, migrants with an irregular status, violence against women);

(ii) introducing new social services (or new mechanisms or practices), new interfaces with clients or new practices in social work in pre-existing social services.

Novelty, improvements (effectiveness and efficiency), and sustainability are only first set of criteria to identify innovation in social services. Values and the socio-cultural foundations of innovations in the social sphere should be considered.

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[16] Cfr. Bouchard, 2006 (p. 3).

Firstly, in dealing with social services:

1. respond 'to pressing social demands which are not addressed by the market and are directed to vulnerable groups in society';

2. address societal challenges at a level in which the boundary between social and economic blurs and societal challenges are directed towards society as a whole;

3. generate systemic changes in changing attitudes and values, strategies and policies, organisational structures and processes, delivery systems and services (EC, Europe 2020 strategy, Executive Summary).

Social services innovations can be considered *ways to enhance processes and the outcome of social innovation.*

Secondly, situating social services within a social innovation framework means to focus on ways, processes and mechanisms activated by social services that are able: (a) to cope with more pressing social needs, (b) to stimulate new solutions mobilizing people's creativity and connecting people, ideas and resources to a context of limited resources and rising costs; (c) to be able to see social challenges also as opportunities (EC, 2010; Murray, Caulier-Grice, Mulgan, 2010).

To summarizes, the table 1 reports some of the definitions arising from the literature search.

Table 1: Sources, Concepts and Definitions

Sources	Concepts	Definitions
	Service Innovation	
van Ark et al. (2003)	Innovation in services	'A new or considerably changed service concept, client interaction channel, service delivery system or technological concept that individually, but most likely in combination, leads to one or more (re)new(ed) service functions that are new to the firm and do change the services/goods offered on the market and do require structurally-new technological, human or organizational capabilities of the service organization' (in UNECE, 2011, Promoting Innovation in the Service Sector, p.6)
OECD (2005)	Innovation in services	'Innovation activity in services tends to be a continuous process, consisting of a series of incremental changes in products and processes. This may occasionally complicate the identification of innovations in services in terms of single events, i.e. as the implementation of a significant change in products, processes or other methods' (available at http://ec.europa.eu/enterprise/policies/innovation/glossary/index_en.htm)
Greenhalgh et al. (2004)	Service innovations in the area of health care-related services	'a novel set of behaviours, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness or user's experience and that are implemented by planned and coordinated action' (p. 1)
Expert Panel on Service Innovation in the EU (2011)	Transformative service innovations	'Services are transformative when they disrupt traditional channels to market, business processes and models, to enhance significantly customer experience in a way which impacts upon the value chain as a whole' (p. 7)
	Social innovation	
The OECD's Forum on Social Innovations (2000)	Social innovation	'Conceptual, process or product change, organisational change and changes in financing, and can deal with new relationships with stakeholders and territories. 'Social innovation' seeks new answers to social problems by: • identifying and delivering new services that improve the quality of life of individuals and communities; • identifying and implementing new labour market integration processes, new competencies, new jobs, and new forms of participation, as diverse

Sources	Concepts	Definitions
		elements that each contribute to improving the position of individuals in the workforce' (available at www.oecd.org/cfe/leed/socialinnovation)
Moulaert et al. 2005	Social innovation	'Social innovation is path-dependent and contextual. It refers to those changes in agendas, agency and institutions that lead to a better inclusion of excluded groups and individuals in various spheres of society at various spatial scales'; 'Social innovation is very strongly a matter of process innovation – i.e. changes in the dynamics of social relations, including power relations'; 'As social innovation is very much about social inclusion, it is also about countering or overcoming conservative forces that are eager to strengthen or preserve social exclusion situations'; 'Social innovation therefore explicitly refers to an ethical position of justice. The latter is of course subject to a variety of interpretations and will in practice often be the outcome of social construction' (Moulaert et al. 2005)
Phills, Deiglmeier and Miller (2008) **What is social?**	Social innovation	'A novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals. A social innovation can be a product, production process, or technology (much like innovation in general), but it can also be a principle, an idea, a piece of legislation, a social movement, an intervention, or some combination of them' (in The Open Book of Social Innovation, 2010, note2, p. 10) Social indicates different things: social motivations or intentions, the social sector as a legal category, social problems, and social impacts (cf. Ibid.)
Hochgerner (2009, 2010, 2011)	Social innovation	'Social innovations are new concepts and measures that are accepted by impacted social groups and are applied to overcome social challenges. This may concern a new solution for a previously identified problem, a recognized solution that has not yet been applied in a certain spatial social context or a solution responding to problems arising in the wake of social change' (cf. Ibid., and www.zsi.at; in Social Innovation: Concepts, research fields and international trends, p. 28); 'social innovations are new practices, intuitions, rites, techniques, customs, manners and mores' introduced (Hochgerner, 2010; Leo, 2001); 'innovations, addressing primarily social objectives, include: roles (of individuals, CSOs, corporate business, and public institutions); relations (in professional and private environments, networks, collectives); norms (on different levels, legal requirements) and values (custom, manners, mores, ethic/unethical behaviour)' (2011, p. 4, power point presentation)
Howaldt and Schwarz (2010)	Social innovation	'A social innovation is a new configuration of social practices in certain areas of action or social contexts prompted by certain actors or constellation of actors in an international, targeted manner with the goal of better satisfying or answering needs and problems than is possible on the basis of established practices' (p. 20)
Phills, Deiglmeier and Miller (2010)	Social innovation	'Our interest is in innovations that are social both in their ends and in their means. Specifically, we define social innovations as new ideas (products, services and models) that simultaneously meet social needs and create new social relationships or collaborations. In other words, they are innovations that are both good for society and enhance society's capacity to act' (p. 3)
EC (2010)	Social innovation	'New responses to pressing social demands, by means which affect the process of social interactions. Social innovations are characterized by the production of a social return and the creation of new social relationships or partnerships which involve the end users and thereby make policies more effective' (See also BEPA societal brief on Social innovation, October 2009); 'A mean to empower citizens to be actively engaged in an innovative and learning society and to recognize the value of social capital. It is also an excellent entry point for a social dynamics behind technological innovations' (note 1, p.1)
BEPA (2011)	Social innovation	'new responses to pressing social demands by means which affect the process of social interactions. It is aimed at improving well being. It covers wide fields which range from new models of childcare to web-based social networks, from the provision of domestic healthcare to new ways of encouraging people to exchange cars for bicycles in cities, and the development of global fair-trade chains. In its recent usage, the social innovation approach is understood to mean not only a new governance mode working across traditional fields of responsibilities with an active involvement of citizens, which is effective in addressing the challenges of climate mitigation, social justice, ageing, etc., but also the culture of trust and risk-taking which is needed to promote scientific and technological innovations' (p. 7)

2 CONTENTS: INNOVATION IN SOCIAL SERVICES

2.1 Why innovation? The context of innovation in social service in Europe

The nexus of innovation in social services and the welfare state…

Organizations and individuals enabling innovations in social services (third sector organizations, social workers, institutional social sector workers, policy maker innovators) are embedded into society such as the processes of innovation in social services are grounded into different welfare system models and public policies traditions. The literature review shows that context influence is partially reflected in definitions of innovation and social service innovations proposed by country, context, sector (public, private, third sector) and main implementation environment of innovation (European, national, local).

Since the impact of a set of reforms in the 1980s the landscape of public management and social services in Europe has been completely reconfigured. These reforms sprung from both neo-liberal ideas concerned with cost containment and another complexity of ideas concerned with best practices, social innovation, participation of the third/voluntary sector and partnership in the policy fields of health, education and welfare services at local, regional and national level. Several critical issues of quality, accessibility, inequality (concerning gender, class and ethnicity), participation, consumer protection as well as the effects of the liberalization of some social services have continuously been raised.

The reforms that had been put into place over the last decade are reframing:

a) the different fields of service sectors (health, education and welfare) their logics and the social services providers.

A broadening of services offered comes through the diversification and specialization of social services provided by an increasing variety of different actors. The growing number of welfare professions creates an expansion of the definition of requirements, particularly in the field of education, social work, psychotherapy, medicine and nursing. Profit organizations are becoming interested in the (market) opportunities of the social services sector. Social services providers themselves try to keep existing clients and win new ones with innovative products and services and try to find new sources of revenue.

'The expansion of social services was accompanied by the introduction of new steering mechanisms (particularly in quasi markets), targeting and decentralisation processes as well as by shifting shares in the mixed welfare economy. Provider and other stakeholder organisations, including public authorities, in this area are increasingly perceived as hybrid organisations guided by a mix of competition, concepts of solidarity, and public interest' (Ec, 2006, p. 15).

Social economy organizations - in particular social enterprises and social cooperatives - might gain a crucial role in terms of provision of social services. At the same time, nowadays, might have difficulties to combine own identity and market strategies in particular given the recent liberalisation in certain social services sectors.

On the whole, recent structural changes in welfare-state arrangements are to be understood primarily in the context of issues relating to the affordability of the welfare state ('neo-liberal critique') in relation to social change in modern service economies. Based on the tension between the requirements of increasing social welfare services on the one hand and growing demands for cost saving on the other hand, a restructuring of the architecture and the logic of welfare distribution is in progress in almost all fields of state intervention. This process (also called commodification or economization in the current discourse) refers not only to institutional and legal frameworks, but is also evident by an increasing business orientation of organizations. This drives the introduction of economic instruments to control social service providers onto the background of limited available resources. The economization is accompanied by the paradigm of activation, which comes together with a redefinition of the welfare state's self-image;

b) processes and mechanism in delivering social services including the roles of different stakeholders - such as user groups, professionals, volunteers, policy makers - that are involved in the provision of social services.

...and social challenges in Europe

Current social challenges addressing the demand for health and social services have been identified in the 'Second Biennial Report on social services of general interest' (EC, 2010), namely:

(i) a growing demand for health and social services, whose main driver is the ageing of the European population and increasing of chronic diseases.

Relating to *healthcare systems*, the current challenges are mainly influenced by demographic change and by resulting need-related implications. Aside from an ageing population (and the associated rise in chronic illness and the cost this entails), healthcare systems also have to face: the growth of multi-morbidity that involves ageing and which will increase pressure on care, human and financial resources; better knowledge and access to information which has heightened public demand for better (and more expensive) care and treatment; reduced capacity of health systems because of financial constraints and smaller workforce; advances in technology-based cures which extend lives but drive up costs; spread of unhealthy lifestyles; legacy healthcare structures which are characterized by fragmentation in both financing and delivery of healthcare, and which remain focused on the provision of acute, instead of chronic, care (Economist Intelligence Unit 2011a; Economist Intelligence Unit 2011b). Product innovations (mainly associated with medical and technical innovations) are enhancing the

spreading of interventions in preventive, curative and rehabilitative areas, while process innovations observed are aiming to increase overall efficiency and effectiveness.

Current challenges in the *health care sector* are also influenced by the unequal distribution of health risks and diseases along socioeconomic indicators. The consequence of demographic change on the health care system lies not only in an additional demand for aged care facilities, but also for more professionals. Rising life expectancy raises questions about the implementation of long-term care models that ensure nursing as well as medical care. The special care needs that dementia seniors have, represent a unique challenge to the nursing staff as well as to the organization of nursing services.

Socio-cultural changes has an effect on raising demand for social services and often lie at the basis of innovations such as: pluralism and individualization trends, changes in gender roles and relations, difficult transitions to adulthood, increasing mobility requirements by changing labour markets and structural change in families with a demand for a greater density of care services for children and adolescents (child care) (Stöbe-Blossey, 2008), but also for older people (elderly care) (Naegele, 2008).

Further issues include the effect of interculturalisation, the disappearance of the natural safety net, the participation of end users in social services (and the researcher accountability to users), the interest of profit organizations in social services market opportunities, the ICT development, the introduction of management culture in the social sector.

Bringing together the *user movement perspective*, the *gender and diversity perspectives* and *a rights based approach* (i.e. The Global Conference on Rethinking Care, Oslo, 2001[17]), it is possible to highlight how a way to enhance innovation in social services come from (a) cultural changes as reflected in international human right conventions and from (b) the diffusion of concepts (approaches and social work methods) as active citizenship, person-centred approach (Barrett, Brennan, Brown, Burton, Gordons and Watkins from People First Lambeth, 2011)[18], self-determination, choice and independence, independent living and full participation. The value and principle of participation carries with it the involvement of service users and carers (Levin, 2004 by the Social Care Institute for Excellence, UK) in the design and delivery of social care and health services on one hand, and, on the other hand, the involvement of the civil society (family, friends, volunteers) in social service and provider organization governance;

(ii) the developments in expenditure on health and social services such as the correlation between social protection expenditure and the employment rate in health and social services (probably due to 'the relatively large weight of wages and salaries in spending on benefits in

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[17] See, in particular, Re-thinking care from a rights perspective by Hurst.

[18] See the Shaping Our Lives publications, in particular the work of Branfield. See also 'Benefit barriers to involvement. Finding solutions (2007) by the Commission for Social Care Inspection, UK.

kind'); the challenge to 'maintain an adequate supply and quality of health and social services under increasing budget constraints';

With regards to *health care innovations* (and challenges mainly due to demographic and epidemiological changes), for example, issues of taking into account how the orientation of healthcare has shifted from acute care to chronic care (which demands the integration of care); the tension between users' demand for better, more expensive care or treatment and strains on public finances; the urgency of promoting preventive health care or medicine to respond to health conditions arising from unhealthy lifestyles (obesity, etc.); the tension between modernizing how healthcare is financed and maintaining it as a public and social good (Economic Intelligence 2011a, 2011b) come to play. The financing of rising health care costs for public agencies, health insurance, but also for the patient, requires sustainable solutions and structural reforms;

(iii) the impact of the current economic and financial crisis on the provision of social services (cost rising and scarcity of public resources) which implies specific attention to the role of social issues in modern societies.

More particularly, collective services to populations (education, health and social services), defined as "non-economic services in the general interest", are by nature meant to be distributed and validated by institutions (Lévesque, 2005, pp. 20-21). Although situated at the very heart of economic processes, innovation in services is "embedded" in the social realm. (Fontan, 2008, p. 4). As a consequence, the consumerism approach to favouring the user/customer, i.e., keeping the customer satisfied by improving the service rendered (Laville, 2005, p. 71), as reflected by technological innovation in the commercial market, is overshadowed by a different preoccupation—more akin to social coherence or social usefulness.

The following analysis is intended to describe these dimensions of social innovation in the welfare services, which include considerations valid also for the policy areas of education and health; for these two areas more specific issues are presented in the following paragraphs.

2.2   Welfare services

2.2.1   Origins of innovation and factors driving innovation

The main dimensions that, according to the literature review, can be associated with the introduction of social innovation in social services can be summarized as follows:

- The emerging of new needs or the search for new solutions to old needs.

- The emerging of new paradigms.

- The need to tackle affordability of the welfare state.

- The raising attention on effectiveness.

- The management of discontent.

- Drivers for innovation in accessing countries.

Each of them is explored more in depth in the following pages.

The emerging of new needs or the search for new solutions to old needs

Innovation is enhanced both by the demand side and by the supply side.

On the <u>demand side</u>, it is mainly *socio-demographic change* that triggers a growing variety of needs for social services.

- The demographic change has induced a modification of the composition of households and the disappearance of the natural safety net due to the increase of single households, of couples without children or with only one child, and the increase of families with different generations presenting different needs at the same time, due to the increase of life expectancy.

- The population's ageing with the quantitative increase of some target groups, such as the very old age people, implies the increasing of several new needs connected with not self sufficiency, mobility, etc.

- Migration has brought with it interculturalisation with new and different needs (Van Kammen, 2002).

- In the current information society, more groups are vulnerable to exclusion: elderly people, youngsters at the edge of society, illiterate people. An inclusive community will endeavour to include them and offer them new social services.

These changes entail a wider societal change and pose further challenges to the need to modernise the social services and the social protection and social inclusion systems.

As social services are embedded in an evolving society they are challenged to search for new answers to changing target groups and needs (Hermans&Vranken, 2010). Current and future

challenges in society are driven by user participation, new knowledge transfer, networks inside and outside the sector (Vranken&Hermans, 2009).

Life has become an individual project as the "natural safety net" disappears (family, neighbourhood, parish). A growing uncertainty directs more people to (new) professional care. Without a natural safety net, care becomes the responsibility of all people: glocalisation is the innovative term to describe the concept (periodical welfare province of Antwerp 2011).

Socio-cultural change has also an effect on raising demand for such services: pluralization and individualization trends, changes in gender roles and relations, increasing mobility requirements by changing labor markets and structural change in families e.g. demand for a greater density of care services for children and adolescents (child care) (Stöbe-Blossey, 2008), but also for older people(elderly care) (Naegele, 2008).

According to literature there are also <u>supply side</u> factors to be considered, and they are mainly associated with technical innovations or by:

- the diversification and specialization of social services provided by an increasing variety of different actors;

- the growing number of welfare professions creating an expansion of the definition of requirements, particularly in the field of education, social work, psychotherapy, medicine and nursing;

- the 'activating role' of the welfare state, considered responsible for an extension of the supply side;

- the introduction of protocols and guidelines in professional care introduced by the wide spreading management culture: the 'enabling state' has to offer a broad range of highly complex, preventative and activating social services in order to increase the capacity for self-help and individual responsibility.

By introducing knowledge culture, the social services sector can be made more aware of its responsibilities, of what it is actually doing and what its impact is (Kolen, 2005; Vranken&Hermans, 2009).

The emerging of new paradigms

According to the Dutch literature changes in society often lie at the basis of innovations in social services, which is driven by changes in the underlying paradigms: examples include interculturalization, the new inclusion paradigm, the greater maturity and will of citizens to participate, the interest of profit organizations in social services market opportunities, ICT development, and introduction of management culture.

These influencing factors need drivers to result in innovation. They may come from the government establishing more flexible regulations, stimulating collaboration between sectors,

stepping outside a too rigorous nomenclature or taking initiatives tackling societal needs. The social services providers should in turn create an innovating culture through coaching management in an atmosphere of initiative and experiment. Innovation thrives best bottom-up.

- An example, related to the emerging of the new *inclusion paradigm*, refer in particular to disability[19]: the World Summit for Social Development (Copenhagen, 1995) established the concept of social integration to create "a society for all," as one of the key goals of social development[20]. Practice has shifted from the creation of clients dependent on services controlled by professionals, to working in partnerships with disabled people to secure their rights as equal citizens of the state[21]. The global disability movement has matured over the second half of last century, thus impacting in its' own right the changing context. "The most important change...has been linked to gradual strengthening of voices and views of persons with disabilities"[22]. The shift away from medical and towards a social model of disability "has identified the role of social barriers in limiting the choices and quality of life of persons with disability"[23]. The conference also recognized the cost of managing care institutions as a reason to turn to community based rehabilitation (CBR). Finally, CBR is seen as an instrument of empowerment for disabled people.

- Referring to the new attention to the participation and involvement of final users of services Collin Barnes identifies emerging dilemmas regarding research ethics: emancipatory disability research[24] can empower people with disability (PWDs) and contribute to their struggle for a more equitable and just society[25] but it raises new questions. Emancipatory research stresses the significance of transforming the interactions between researcher and research participant. "Prior to 1990s, social research on disability rarely involved disabled people in the research process". According to Finkelstein[26], researcher accountability to disabled participants raises the following questions about the nature of control and how it is implemented: Who controls what the research will be about and how it will be carried out? How far have we come in involving disabled people in the research process? What

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[19] To note the new paradigms on disability and the effects of the independent living movement on social services (see p. 41) are representative cases of a 'Blurring Approach' involving a change in values and practices overcoming the division between social and health in favour of an integration of this two fields. The importance of welfare services and cross-sectoral services for disabled people result from such kinds of considerations. Even if innovations carried out by new paradigms on disability and IL movement are mentioned, in the report, in the paragraphs on innovation in the health sector and in the education sector, they always represent an innovation at a conceptual level that entail a social and holistic approach to disabilities.

[20] UNDESA, Report of the Expert Group Meeting on Practical Strategies to Promote Social Integration: Lessons learned from existing policies and practices Convened in preparation for the 48th session of the Commission for Social Development, 2009.

[21] Workshop Paper: Social Work and Disabled People: From crafting clients to sustaining citizens.

[22] Rethinking care from different perspectives, Collection of papers, Global Conference on Rethinking Care, Oslo, 2001.

[23] Ibid.

[24] Oliver, Mike: Using Emancipatory Methodologies in Disability Research, Emancipatory Research: A Vehicle for Social Transformation or Policy Development, 1 Annual Disability Research Seminar, Hosted by The National Disability Authority And The Centre for Disability Studies, University College Dublin, 2002.

[25] Barnes, Collin, An Ethical Agenda in Disability Research: Rhetoric or Reality?, Sage, 2008.

[26] Finkelstein, V.: Doing disability research. *Disability and Society*, 14 (6), 859-67, 1999.

opportunities exist for disabled people to criticize the research and influence future directions? Mercer[27] testifies to the feminist assertion that the validity of research methods can be judged effectively by the quality of researcher relations with research participants. Finally, Barnes, Oliver and Barton[28] claim that one of the most significant issues in emancipatory research is the degree to which presumption of objectivity and detachment remain common within the academy, whilst the assertions of emancipatory research are largely unknown or contested.

- A very recent paradigm brought forward by EU institutions refers to active ageing. The European Union faces significant population ageing. Ongoing demographic changes due to low fertility rates, continuous increase in life expectancy and the approaching retirement age of the baby-boom cohorts are expected to affect the European population size and age-structure dramatically. As is frequently recalled, ageing populations will raise significant budgetary, economic and social issues. The phenomenon increases pressure on pensions systems, public finances, social and care services for older people, heightening the risks of exclusion from the labour market, family and community life, and intergenerational conflicts. However, it is equally true that ageing brings potential opportunities. The elderly may significantly contribute to tackling the challenges of population ageing by remaining active and autonomous after retirement and delaying exit from the labour market. The historical increases in educational levels and substantial improvements in health conditions make elderly people a great potential for social and economic development. Thus, active ageing emerges as a key factor in the process of optimising opportunities for health, participation and security and as a way to enhance the quality of life as people age (Corsi et al., 2011).

> In the Czech Republic the third sector is more involved in providing ambulant forms of social services and enhances the integration of seniors into the society (Preliminary National Report on Health Care and Long-term Care, 2005). A recent project of the *Respect Institute* approached the issue of ageing society from the perspective of active ageing. The project was intended to raise awareness how can the society involve these people and utilize their wisdom. Particular emphasis was put on the participation of elderly citizens in volunteering (Bočková et al., 2011). In its approach the project of the foundation *Happy Seniors* is very similar. Their main activity is the so called 'Bourse of mutual help'. The project is intended to mobilize elderly people and generate intergenerational communication.

The need to tackle affordability of the welfare state

In French social research, social innovations are often associated with experiments in social and sustainable economics (Richez-Battesti and Vallade 2009, p. 43). Recent structural changes in

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[27] Mercer, G., Emancipatory Disability Research. In C. Barnes, M. Oliver and L. Barton (eds.) *Disability Studies Today*, London: Polity, pp. 228 – 249, 2002.

[28] Barnes, Olicver and Barton.

welfare-state arrangements are to be understood primarily in the context of issues relating to the affordability of the welfare state ('neo-liberal critique') in relation to social change in modern service economies. Based on the tension between the requirements of increasing social welfare services on the one hand and growing demands for cost saving on the other hand, a restructuring of the architecture and the logic of welfare distribution is in progress in almost all fields of state intervention. This process (also called commodification or economization in the current discourse) refers not only to institutional and legal frameworks, but is also reflected by an increasing business orientation of organizations. This drives the introduction of economic instruments to control social service providers on the background of limited available resources. The economization is accompanied by the paradigm of activation, which comes together with a redefinition of the welfare state's self-image. The enabling state supports and encourages a stronger interaction between public and private providers as well as a free and active civil society (Lamping, Schridde, Plaß&Blanke, 2002).

The raising attention on effectiveness

The increasing business orientation of organizationsinvolved in welfare policies and the emphasis on personal rights and desired personal outcomes contributed to the move towards citizenship/inclusion approach and to be associated with a new attention on the effectiveness of policies.

"The key features of effective approaches to these trends, as identified in the research are:

- A good system for allocation of individualized funding.

- Allocation to block funding for services, when implementing support.

- Local area coordination, so that local needs and preferences shape the local service system.

- Minimisation of bureaucracy.

- Implementation of alternative quality systems.

- Universal access and increased use of mainstream services.

- Use of best practice models.

- Utilising a blend of formal and informal supports"[29].

The management of discontent

Among the drivers of innovation, authors mention discontent paraphrasing Lord Macauley: 'There is constant improvement because there is constant discontent'[30]. The authors of the

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[29] Ibid.

[30] Mulgan, Geoff with Tucker, Simon, Ali, Rushnara and Sanders, Ben, Social Innovation: What it is, Why it Matters and How it Can be Accelerated, Oxford SAID Business School, Skoll Centre for Social Entrepreneurship, Working Paper, 8 p. 9.

Working paper further recognize awareness of a gap between what there is and what there ought to be, between what people need and what they are offered by governments, private firms and NGOs – a gap which is constantly widened by the emergence of new technologies and new scientific knowledge. They identify the following great opportunities for new creative solutions:

- (Rising life expectancy).

- Growing diversity of countries and cities.

- Stark inequalities.

- Rising incidence of long-term conditions.

- Behavioural problems of affluence.

- Difficult transitions to adulthood.

- Happiness.

Drivers for innovation in accessing countries

As all post-communist countries after 1989, Czechoslovakia – later the Czech Republic and Slovakia – faced the process of democratization and the challenge of transforming a wholly centralized system. Decentralization concerned all public spheres, among others the sphere of welfare, healthcare and education. These services were extended to private and non-governmental sectors as well. Besides the organizational issues and enabling other actors to get involved, the shift required complex changes in approaches both of the providers and recipients of such services.Discourse on innovations in social services gradually gathers ground in both the Czech and Slovak societies. A collection of studies called Social Innovation – Understanding and Functions edited by Gabriela Lubelcová was recently published, which mostly focuses on the potentials of innovative approaches regarding social inclusion and gender equality. Recently there are several attempts how to involve more people in innovations. Respekt Institute launched a website[31] especially dedicated to prompt people to think about and share their innovative ideas. They took up the role of mediator between those having an idea and those willing to make a change. They are organizing the internationally well-known Social Innovation Camp.

Moreover both in the Czech and Slovak Republic the involvement of international organizations shed light on the issue of gender equality. As a priority for the EU it became subject of discussions and various campaigns. In both states special departments were established to enhance gender equality.

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[31] http://www.inovaceprospolecnost.cz/clanky.

Innovation in transitional economies

According to Paul Stubbs some of the triggers of social innovation in Croatia and in other transitional economies of the accessing countries may lie in a multidimensional crisis that shook the insurance-based welfare to the core (demographic ageing; high dependency ratios; grey economy; low activity rates; out migration; minimum declared wages; nature of remittances)[32]. The drivers include:

- Multiples hocks: War/conflicts; Structural transition; De-industrialization; Erosion of social;

- Capital/solidarities;

- 'Captured' social policies Distortions caused by 'locked in' expenditures (tertiary health care; residential care) and new (informal) marketization;

- Legacy of category-based (not needs-based) social protection;

- Stigma, discrimination and over-professionalised approaches;

- Political will – Fiscal space – Technical capacities.

The requirement to adhere to EU standards

According to Croatian literature the concept of innovation penetrates from key EU documents: the Lisbon European Council Summit Conclusions in 2000 and Europe 2020 Flagship Initiative. In the Questionnaire of the European Commission in 2003 that served as a base for obtaining candidate status for EU accession in 2004, Croatia referred to establishment of a modern innovation system among its microeconomic and structural priorities. However, the Commission added that greater efforts had to be taken in the field of innovation policy to make the country competitive and efficient at the European level[33].

2.2.2   *Main types of innovation and new forms of social services*

In French social research, social innovations are closely associated with *social entrepreneurship* (Barthélemy et Slitine, 2011)[34]. Services developed in these areas give rise to *socio-economic experiments at the production level*, as well as in consumption and ways of living. For example,

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[32] Stubbs, Paul, Promoting Social Innovations for Inclusion in the Western Balkans: key challenges, The Institute of Economics, Zagreb, 2011.

[33] Opinion on Croatia's application for EU membership, Council of European Community, 2004.

[34] On this subject, see: the web site of the "Institute for innovation and social entrepreneurship"- ESSEC Business School Paris (http://www.iies.fr/); theme of the 3rd International Research Conference of the EMES European network, "Social innovation through social entrepreneurship in civil society" 4-7 July 2011 (http://www.emes.net/index.php?id=515); theme of the 6th Seminar of the Centre d'analyse stratégique et de la Direction générale de la Cohésion sociale (under the French Prime Minister) "Social entrepreneurship for innovation", 23 March 2011 (http://www.strategie.gouv.fr/content/seminaire-l%E2%80%99entrepreneuriat-social-au-service-de-l%E2%80%99innovation); the "Toolbox for social innovation" on the site for social entrepreneurs: entrepreneur-social.net (http://entrepreneur-social.net/innovation/); theme of the 2010 Entrepreneurs Convention 2010 : "Towards social innovation" (http://www.communication-solidaire.com/salon-des-entrepreneurs-2010-cap-sur-l%E2%80%99innovation-sociale).

they can take the form of neighbourhood services, fair trade, solidarity tourism, organic farming, critical consumption and short-circuit retailing, renewable energies, recycling and waste recovery, maintaining heritage, microfinance, alternative currencies and integration through economic activities.

Depending on the nature and field of the developed social service, the resulting social innovations emphasise *formalised equality among members at the internal level* with the development of the cooperative form. Furthermore, they presuppose an awareness of the importance of the *end goals* (be they ecological, cultural or otherwise) and the necessity of *direct participation* (Lipietz, 2001). The political aspect of certain innovations is expressed in the intention of the stakeholders introducing the innovation to bring about "*social change*" (Bouchard, 2005, p. 142). The key criteria for understanding social innovation and its effects are therefore their impact on institutional frameworks (standards, legitimacy-promoting values) as well as on organisation (tools, activity management methods) (Klein and Harrisson, 2007, p. 6).

Social innovations in services trigger an indispensable interconnection when they touch upon a base of common grounds that concern multiple players, participative or cooperative organisation, and socially relevant objectives.

Using the concepts developed above, we can now attempt to describe the *process* of social innovation in services from a *tranformationalist* viewpoint in terms of *institutional and organisational impact*. On the basis of this analysis we can distinguish, thematically speaking, between innovation *in* services from innovation *by* services (Djellal and Gallouj, 2009, p. 62):

- Modification of organisational systems (modes of governance, work organisation, number of involved stakeholders in governance…).

Innovation in organisational systems involves the search for possible "solutions" through the implementation of methods of management in multi-stakeholder activities which can translate new frameworks into action.

Changes in organisation often concern *changes in governance*, as a divergent way of interpreting of power relationships within the firm: as an example *cooperative and participative forms* of organisation imply a non-hierarchical concept of working relationships, with a more democratic impetus. The strong beliefs of the "innovators" (Gaglio, 2011, p. 58) come into conflict with an established institutional framework. Changing organisational systems therefore goes well beyond a simple adjustment of shifting human and material resources because it strikes at the heart of attributed social roles: "where there is reciprocal adjustment between organisational and institutional forms within the firm, local innovations are often in varying degrees of contradiction with the macro-social institutional systems" (Bélanger, Lapointe, et Lévesque, 1998, Introduction).

Example 1: "HABITATS SOLIDAIRES" SCIC (Société coopérative d'intérêt collectif)—A cooperative society as social enterprise with user's involvement:

Habitats Solidaires develops extensively socially-oriented public housing operations by adding a participative dimension (with joint ownership mechanisms), either in sensitive neighbourhoods by leading self-construction projects for marginal families, or by partnering mixed-management participative housing projects. The "SCIC", which is made up of about 160 tenants and co-owners as members, manages the entire property ensemble. Most of those co-owners were indebted to their co-ownership body, which endangered the balance in the organisation and its very existence. To refinance those debts, Habitats Solidaires arranged portage operations for different co-owned units. They review financing solutions for their housing, more extensive in scope, using original tools such as a "mixed solidarity property company" (*foncière d'économie solidaire mixte*) combining "solidarity savings financing" (*financement d'épargne solidaire*) and public funding.

Example 2: ASAÏS Accueil, (Soutien et Accompagnement vers l'Insertion Sociale) "Support and Assistance for Social Integration":

On a cross-sectorial basis, Asais addresses a marginal population involved in both health and social issues, with the aim of supporting, promoting and assisting the integration of people with serious psycho-social difficulties. Among other benefits, the SCIC provides day care: LeBistrotassociatif - GEM—Groupe d'Entraide Mutuelle (a mutual self-help group), co-managed by employees and users, and a Theatre, a "non-standard" space for meetings and original creations for accompanied individuals as well as the professional companies invited. In this GEM, psychologically or cognitively impaired persons are encouraged to develop a sense of responsibility by taking an active part in designing and organising a project in which they participate: the GEM's mutual self-help project whose modes of operation they can decide on themselves.

A number of studies investigate how user driven innovative practices are based on the *collaboration between public and volunteer organisations* (NGOs) or between civil and local networks in collaboration with public organisations and social enterprises in order to create better social services or to do better social work. Such studies draw on the literature on user driven innovation, social innovation and network theory (Delica, 2011; Pedersen, 2012; Larsen 2009) or theory on social entrepreneurship and social enterprises (Hulgård, 2007).

Innovation concerns also the introduction of *a new architecture of the provision system*. The German literature evidences that:

- The social services in the local government areas are being reorganized since the 1990s with regard to structures and processes. The underlying aim has been a radical modernization of the administration (keyword: new public management, lean management, double-entry accounting, privatization of municipal services support) (Spatscheck, Arnegger, Kraus, Mattner& Schneider, 2008).

- The institutional architecture and control systems in the employment service administration and in labor market policies have been reshaped completely as part of the Hartz reforms of the recent years – these have triggered far-reaching changes in the consulting processes

provided by employment agencies as well as in the assistance for long-term unemployed and the economically needy (Hielscher& Ochs, 2009).

- The areas of nursing and health services have undergone structural reforms in recent years in order to both, buffer the cost development and to respond to new challenges with regard to the range and quality of services offered (e.g. for the elderly) (Blass, 2011; Pfau-Effinger, Eichler, Och, 2006).

- In the area of child and youth services market competition has found its way into the provider landscape. While youth services have experienced an infrastructural extension in terms of playing a partial role in preparing adolescents for participation in working life (public investment in early childhood education), other functional areas of the sector (such as educational aids) have suffered from legitimacy pressures in recent years due to their declining power of integration (Hensen, 2006).

Innovation also means tearing down *walls between sectors* (e.g. between family carers and professional care, between preventive and curative care) (www.steunpuntwvg.be) and *collaboration or networking* (i.e. flexible relationships between independent partners) inside or outside the social services sector (Hermans&Vranken, 2010).

- The innovation of product

Innovation of a product in social services may derive for example by opposite drivers: individualisation vs standardisation.

As far as individualisation is concerned an example of innovation resides in the introduction of the concept of individualised support as a key issue to promote the quality of life of end users.

> Examples of the shift to individualized services
>
> Emerging national policy in Ireland seeks to refocus current provision away from group-based services towards **individualised supports** that move people to, and keep them in, the community, living the lives of their choosing. The challenge of reconfiguring resources to modernise services, however, is significant. Genio Trust focuses on strategically assisting key stakeholders to meet this challenge by working with the people who use services and their families; service providers; advocacy groups; the Office for Disability and Mental Health, the Department of Health; the Health Service Executive; and the Atlantic Philanthropies. The Genio Trust is supporting over 400 people to live as independently as possible in the community. Grants have also been awarded by the Trust to increase the capability of those who use services to develop and implement plans that will make individualised, community integrated supports a reality for many more. Genio Trust supports people to move from an institution where they used to live with plans in place for the eventual closure of the institution[35].

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[35] Genio. Real, Positive and Lasting Social Change, www.genio.ie.

> According to John Evans[36] independent living is the ability to **decide and to choose what a person wants**, where to live and how, what to do, and how to set about doing it[37]. "Personal assistance is an integral part of what independent living is. Personal assistance is one of the means in which enables disabled people to achieve Independent Living. Personal assistance is the support and assistance that an individual needs in order to live equally in the world, hence overcoming the restrictions that one experiences through one's impairment" [38]. A survey on Personal Assistance (PA) in Norway illustrates that the most important benefit for those who have PA concerns great quality of life improvements as a result of PA. "PA is experiences as providing a quality of life that is clearly better than that derived through use of traditional services. PA also leads to social-economic benefits in the manner of increased participation in working life on the part of PWDs and their families, a point which up to now has received little attention. Many people who have PA also have less need for public services than would be the case if they were using an alternative offer of public services."

An opposite path has been the introduction of rigid budget standards (in the restructuring of assistance in care) that have lead to the restructuring of the main concept of care in itself: In German care insurance for example, the concept of care has become narrower as certain budget standards have been set, and new principles and targets have been introduced. This is the case for example of the concept 'ambulant before inpatient care': the introduction of this concept has affected the field of assistance in care which adapted to procedural rules and guidelines, levels of care as well as services offered by the insurance. Due to the close coupling of the welfare provision of assistance in care and the care insurance, legislative changes in the latter lead to adoptions in the former (Klinger & Kunkel, 1996).

> Example of a standardized service
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> Services of assistance in care can be provided in an ambulatory, outpatient and inpatient setting. The principle of 'ambulant before inpatient care' prioritizes the form of home care. It shall be provide by relatives of the affected person or by systems of mutual aid. In addition, in-kind aids are funded (e.g. technical equipment), without which a successful care would not be possible[39].

An new perspective in the delivery of social services that is common for several very different targets refers to the concept that '*at home is better*'. The concept of deinstitutionalisation and community care is widely described referring to mental health, but the same trend is present in the area of care to the elderly but also to abandoned children:

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[36] member of the Board of Directors of ENIL and the European Disability Forum (EDF).

[37] Evans, John: Independent Living and Direct Payments in Europe: Rethink Disability Annual Conference, Ipswich, November 2003.

[38] Ibid.

[39] Klinger & Kunkel, 1996.

In regard to the social protection of children, in the Czech and Slovak literature it is widely described the transformation of big institutionalized centres for children to smaller child centres or ensuring care in foster families. The process of finding professional foster families is highly enhanced by NGOs[40].

The innovation of the product involves also the concept of *accessibility* of the service implying the idea of how the access to services is organised, the costs of access for families and the type of access (voluntary vs compulsory).

- Referring to the organisation of access literature on innovation in social services evidences the distinction between services with a *'come-structure'* and with a *'go-structure'*: while in the first traditional case the parent comes to the service, in the innovative second case the worker goes to the family in its environment. 'Go-structure' approaches may help to reach vulnerable social groups that have difficulties to refer to services or to participate to activities and programmes in formal settings: this is for example the case of programmes addressing Roma families, with multitudes of projects developed in their settlements (Corsi et al., 2009; Crepaldi et al., 2011).

- Accessibility is also linked to the cost of the access: the access to social services is generally free of charge, being the low threshold inherent the real nature of service. Innovation regards more time-intensive programmes, such as prevention programmes, educational support or psychological treatment, which require a more formalised service structure: normally they are provided by public institutions or by the market (private professionals) but literature review for example in parenting support programmes evidences the diffusion of experiences of services offered by not for profit organisations and NGOs (European Network of National Observatories on Childhood, 2007).

- The type of access may be compulsory or voluntary: in services/programmes based on voluntary access, the participation/involvement is influenced by the users' motivation. In this area a great innovation is linked to the diffusion of awareness raising campaigns through TV and radio programmes as well as brochures, booklets, publications and websites. Compulsory programmes on the contrary are established for instance when users show antisocial behaviour and/or are found to be unwilling to accept help in fulfilling their individual/parental responsibilities where a clear need for support has been identified (Crepaldi et al., 2011). The innovation here is the new wide attention on anti stigma policies: according to OECD (2009) this kind of support to those in need should provided in a non-stigmatising way and be coupled with additional help for the most vulnerable.

- The access may be targeted or universal: after years of debate on the concept of universalism opposed to the provision of targeted services limited to those most in need an innovation that emerged is the concept of 'progressive universalism'. The so called 'progressive universalism'

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[40] http://www.navrat.sk/?lang=SK&cat=a5ec1d344ccb3dedec6354de61dafe01.

– support for all, with more support for those who need it most – seems to be the most suitable way of intervening (D'Addato, 2011): it implies the creation of low threshold facilities in which integrated forms of support are being offered, without the risk of stigmatisation: as an example in Germany, to improve access to parents, parental support services are linked to child care services in children's day care facilities in 'family centres' or 'parent-child centres'.

> An example referred to parenting support policies
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> There has been considerable policy debate within and between OECD countries about targeted versus universal provision. "Targeting allows scarce resources to be used more intensively to remedy a problem. This can be more equitable than universalism… At the same time, targeting inevitably misses children who might have benefited, but do not meet the imperfect targeting criteria" (OECD 2009). However, universality is costly; Boddy suggests "the need for a more nuanced distinction between 'universal' and 'targeted' provision (or between 'mainstream' and 'specialist' parenting support)". Mainstream services accessible to every family, while putting within these general services a special emphasis on less-privileged ones, may help to overcome stigmatisation.

- The effort of increasing accessibility in all respects represents an important factor of social and political participation: in addition to traditional measures to remove architectural barriers in public and private spaces, other activities are highly required to facilitate access to information and communication, particularly in the area of **e-government**.

The introduction of information and communication technology (ICT)

The role of ITC in innovation in the welfare systems in literature seems controversial.

- The social services sector is centered around people and service delivery, not technological products. According to some literature the positive contribution of ICT to the quality and the productivity of care has not yet been proven. To do so technology should be embedded in the service delivery model. Too often it is now seen as a substitution of care. On the other hand, technology players do not understand the market of welfare and care (Leys, 2009).

- The lack of business models within the social sector and of perspective on high volume markets make it difficult to invest in ICT in the sector (Leys, Zorgnet Vlaanderen, 2010).

The challenge seems to combine a social attitude with economical talents (Periodical ING Institutional, 2006).

A new attention of quality

EU funded projects have widely introduced across Europe the concept of quality and of assessment and then evaluation in social practices. The impact has been massive also in

consideration of the introduction of new concepts of dissemination and diffusion of good practices across the continent: an example is the European quality framework which entails[41]:

- Adopting common EU quality principles and an EU quality framework providing guidelines and recommendations to Member States on the methodology to set, monitor and evaluate quality standards through the Open Method of Coordination (OMC) on social protection and social inclusion.

- Promoting a regular exchange of experiences between Member States, enabling transfer of best practice and innovative responses to shared problems, through the OMC on social protection and social inclusion[42].

- Organising a yearly participative EU forum involving users, service providers, trade unions, local authorities and other community stakeholders including NGOs to enable active exchange and public assessment of the effectiveness of the processes to ensure quality.

2.2.3 New actors, new roles and new relationships between stakeholders and end users

Innovation implies also the modification of roles and relationships between the actors of the system: an evolution in social and political participation of the different actors of the system and in the access to socio-political areas has occurred in the latest years, especially called forth by the anti-discrimination and equality process.

> According to the Czech and Slovak literature deinstitutionalization of social services has brought series of changes. First of all, in regard to the approach to the recipients of services – the "objects of the services" were supposed to gradually turn to "subjects of services" increasing their participation in the decision-making procedures. Concerning the form of services, emphasis on groups should have shifted more and more to individualized services. Thirdly, the aim of services should not be only to ensure services for the recipients and protect them, but to integrate them and treat them as equal partners (Rozvoj komunitných sociálnych služieb, 2006, p. 14). Although the 1990s brought series of novelties, the crucial reforms were conducted only after 2000. The Czech Republic building upon British good practices introduced *community planning of social services* in order to better comply with local needs of people and set quality standards to improve the services (Act. No. 108/2006 of Coll.).

The relationship between the citizen/users/clients and the employees within the process of innovation has resulted in a number of studies on *employee driven innovation* (Kristensen 2011; Kristensen and Voxted, 2009) and *user driven innovation* (Jæger 2011; Forman and Haugbølle 2011; Agger and Hedensted Lund, 2011). From a management perspective, the processes of innovation take place at all levels in the organisation, which is why the perspectives of employee and user are relevant (Bason, 2007). Following Kristensen&Voxted (2011, p. 38), employees and users are central actors in innovation processes, even though the new ideas

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[41] Background of the Innovation 4 Welfare Initiative, leaflet, www.innovation4welfare.eu.

[42] Quality of social and health services, Social NGOs' recommendations to EU decision makers, May 2008.

and/or initiatives are not necessarily established by these groups of actors but by the management. The Danish literature on involving users and employees in processes of innovation has demonstrated that when the knowledge of the users comes into play the productivity in the public sector increases (Agger& Lund, 2011).

> Kristensen&Voxted (2009, pp. 38-39) distinguish between three forms of user and employee participation in processes of innovation: Actor initiated innovation (they create the ideas and initiatives); Actor involved innovation (the actors are involved in the process of innovation, but the process is initiated by e.g. the management); Actor leaded innovation. The management of the processes of innovation relies on the participants (users and/or employees). Thus, the users have a crucial influence on the process of innovation.

The process of innovation is based on un-fixed relations between the different groups of actors (employees, top management, mid-level managers, users etc.). For example the management can both set the premises of the process of innovation as well as being active participants in the phase of implementing. Likewise, the management can encourage the employees to take part in creating new ideas or in the initiation phase.

Discussing the perspective of *user driven innovation,* Agger& Lund (2011, p. 178) argue that the way in which the citizens or users are involved is crucial in terms of how the process of innovation is driven. In relation to public innovation, the user can be offered different roles: client, customer, "lead users", users as public innovators and co-producers in the process of innovation. Bringing the users into play in the process of innovation, as a best practice, Agger and Lund (2011, p. 194) emphasise that there is a need for institutionalising the user as a co-producer within the process of innovation at a policy level. At the same time, they underscore that users are a highly diverse social group.

Literature evidences that <u>involvement of final users </u>is considered an innovation able to promote equality, effectiveness and control, and adherence to the needs of users.

> Practice has shifted from the creation of clients dependent on services controlled by professionals, to working in partnerships with disabled people to secure their rights as equal citizens of the state. A pivotal moment was the World Summit for Social Development (Copenhagen, 1995) which established the concept of social integration to create "a society for all," as one of the key goals of social development.

- The implementation of the principles of the involvement of final users, in particular as far as the disabled are concerned, rests on anti-discrimination legislation that helps to view services within a rights based framework[43].

- The promotion and *development of the self-help sector*, mainly pushed through increased networking of self-help institutions, represents an essential element for the empowerment of disabled people by providing care in another way, user-oriented objectives are realized:

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[43] Evans, John: Independent Living and Direct Payments in Europe: Rethink Disability Annual Conference, Ipswich, November 2003.

quality of life (social, emotional and physical health), self-reliance (to decide about one's own care project and life in general with adapted support), participation, cohesion and inclusion (Vranken&Hermans, 2009). These care objectives are generic, prevalent in the different sectors of social services (Vision text (e)careful Flanders, 2012).

- The emergence of direct payment in Sweden, Norway, Finland and Denmark is tied to the social welfare system in these countries. Uloba[44] in Norway is mentioned as a champion of *user controlled service* scheme The Stockholm Independent Living Centre (STIL)[45] is mentioned as the longest running and most successful scheme of all and another cooperative model.

- *Partnerships with users*, family carers and user organizations actively participate in care at the micro (care project), meso (organizations) and macro level (policy) or start up new practices themselves, e.g. parents founding a co-operative organization for babysitting.

During the last ten years we have also seen a closer cooperation between academia and the practice. New initiatives have been developed and evaluated. Some of the interesting projects have been the partnership between service users, practitioners, researchers and teachers in the field of welfare services (Askeland, 2011; Gjernes&Bliksvær, 2011; Johannessen, Natland&Støkken, 2011). An interesting finding is that it has been easier to develop a closer cooperation between academia and the services users, than integrating the practitioners in this work.

Another relevant actor coming on in the welfare arena is *private for profit and nonprofit*. Literature focus on its role and implications. An example is in the Swedish literature: traditionally, Swedish welfare services were almost exclusively produced by the public sector. Opening this field for private for profit and nonprofit providers implied an innovation process which started in 1990s and still is going on. The major rationale behind the reforms is to increase diversity and freedom of choice in welfare provision.

In the Danish literature a number of studies investigate how user driven innovative practices are based on the collaboration between public and volunteer organisations (NGOs) or between civil and local networks in collaboration with public organisations and social enterprises in order to create better social services or to do better social work. Delica (2011) focuses on how social service at libraries is combined with social work among vulnerable citizens as way to include them in the local area. Such studies draw on the literature on user driven innovation, social innovation and network theory (Delica, 2011; Pedersen, 2012; Larsen, 2009) or theory on social entrepreneurship and social enterprises (Hulgård, 2007).

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[44] Included as an innovative practice example in WP3.

[45] Included as an innovative practice example in WP3.

2.2.4   Governance, networks and ways of interaction/cooperation

Innovation refers also to new arrangement between one or more government agencies and/or external organization.

Governance

Because the social sector is embedded in the logic of the care state, government intervenes in financing, price setting, quality control and regulation. In this way, government creates the conditions for innovation (Leys, 2009). But since the way government does so has changed from "government" to "governance", it will facilitate social services based on accountability, networking, envelope financing and market steering (periodical welfare province of Antwerp). In general the new role of governance of the system played by central (or local depending on national arrangements) government is to:

- manage the whole system: Paul Stubbs warns that beyond the EU and particularly in the Western Balkans, "the more successful initiatives to strengthen inclusive and integrative social policies have been those which have emphasized the importance of governance, horizontal and vertical co-ordination, and the budgetary planning process[46].

> Central governments have a key role to play in developing inclusive policies in particular as far as coordinating policies is concerned. This means giving consideration to the legal frameworks in operation, to the development of training for the professionals involved, the involvement of other statutory services and the community at large. Monitoring the course of these reforms is also an essential component of coordination[47].

- manage the service provision starting by outcomes.

> The government specifies an outcome (or outcomes); pay the external organization a pre-agreed sum (or sums) if it is able to accomplish the outcome(s); place controls (but they can also be few, if any) on the way that the external organizations accomplish the outcome; cooperate with the external organization so that it is able to take the actions necessary to achieve the outcome—for example, by ensuring access to relevant data

- protects the user (privacy, social protection, affordability, right to community care, right to freedom of choice and participation) to steer the input of industry (www.innovatiecentrum.be);

- stimulate different fields of policy to collaborate;

- Government itself can also tackle societal challenges.

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46 Stubbs, Paul, Building Capacity to Promote Social Integration and Social Inclusion in the Western Balkans. Paper produced for Expert Group Meeting on Practical Strategies to Promote Social Integration: Lessons learned from existing policies and practices, Accra, Ghana, 17-19 November 2009, p.6.

47 OECD, Centre for Educational Research and Innovation Governing Board Sustaining Inclusive Education: Including Student with Special Educational Needs in Mainstream Schools, 1999.

Since an important part of the Flemish population has not acquired sufficient skills for language, mathematics and use of computers, they risk facing problems in their personal life or at work. Therefore, the Flemish government adopted the "Increasing Literacy" Plan inviting different domains of policy to take action (www.ond.vlaanderen.be/geletterdheid).

Some EU Government have launched plans for the Innovation in social services. Sweden in one of them:

In 2012 the Swedish government has established a "national innovation strategy" including welfare as one of the key areas (http://www.regeringen.se/sb/d/14440/a/161379). A parallel political initiative is the so called "future commission" consisting of the chairpersons of the ruling parties and nine persons from other fields of Swedish society including welfare. The task of the commission is to identify long term challenges for Swedish society (http://www.framtidskommissionen.se).

Cooperation between sectors, actors and different forms of provision

In the social services a lot of innovative practices originate from collaboration between various sectors. Innovation is not only the result of research but also of sharing of knowledge, of collaboration and interaction between a great number of actors and institutions (Van Geyes en Vandenbrande, 2005). Just because social services providers are situated in a wider policy domain together with other providers offering the same services to other groups or other services to the same users, networking is necessary for innovation (Vranken&Hermans, 2010).

Examples of collaboration between policy fields and sectors

In Belgium in the welfare sector, a growing demand exists to live independently with some support (e.g. persons with functional impairments). In social housing an increasing group of vulnerable tenants wants more support (e.g. former psychiatric patients). When the residential/home sector asks for an adapted supply of care and the welfare sector asks for an adapted supply of housing, the solution lies in collaboration between both sectors. Through the Flanders' Care project, the Flemish government wants to stimulate networking between care actors, companies and knowledge centers/institutions in order to convert more concepts, ideas and technologies into sustainable care practices (periodical welfare province of Antwerp). 77% of the Flemish providers are part of some collaboration in the same or in other sectors mostly dealing with ICT, training, quality, and HRM resulting in a higher efficiency and cost savings through scale enlargement, exchange of knowledge and information and the opportunity for specialization (Weliswaar febr-ma 2012).

An innovation in Germany is the creation of a consistently inclusive service addressing children under the age of three (Project 'A garden for children' of the city of Hannover). From birth to school age, children with disabilities are entitled to early intervention, which is designed as an interdisciplinary and complex service (§ 30 paragraph1 SGBIX), i.e. education and medical and therapeutic assistance should be provided from one source. Concrete action is demanded primarily at the interfaces between the individual service providers, since in practice the 'pillarization' of the aid as well as a diffusion of responsibility blocks professionally required interdisciplinary work constantly (Arbeiterwohlfahrt Bundesverband e. V. et al., 2009).

In the area of labor and employment a relevant innovation relies in the effort to create more tailored job opportunities for people with disabilities and to provide targeted counseling services linking to these (Bundesministerium für Arbeit und Soziales, 2011d): for this purpose a *cooperation of different stakeholders* is important (firms, trade unions, rehabilitation institutions, associations of disabled people) in order to raise awareness of employers.

Cooperation between local actors

Co-operation between local actors in care and employment enables social economy to respond to opportunities in the regional, societal growing markets (www.socialeeconomie.be/ innovatiepunt).

According to the literature referring in particular to disability and mental health, two areas where community care has been more developed, the key to implement a real change is to establish a solid partnership between all individuals and organizations involvedin the community in providing support to disabled people. Key stakeholders such as service providers in health care, social assistance, social and labour inclusion, NGOs, policy makers, the main actors of the local community are asked to be part in providing support on a professional or voluntary level in the local area where persons with disability and mental health problems live:

- Coordination is essential to the process of deinstitutionalisation, and the neglected relationship between community services and hospitals continues to pose a barrier to deinstitutionalisation. It has been argued by Mechanic and Rochefort (1990), for example, that this relationship requires the long-term co-operation of multiple public bodies at various levels of government and probably the implementation of some form of case management system (Dill and Rochefort, 1989)"[48]. According to the Report of the Ad Hoc Expert Group[49] a key is to "Ensure coordination of different government departments and agencies involved in the transition process (from institutional to community-based care). The successful implementation of reform plans requires a strong coordination between all the relevant actors, both at horizontal (various ministries, such as ministries of health and social affairs) and vertical (national and local authorities) level."

> Examples:
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> *Example of local collaboration on home care in Belgium*
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> A new decree allows collaboration between home care and residential care. The residential care center delivers services in the neighborhood while the elderly living at home can use the facilities of the residential care center.

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[48] Medeiros H., McDaid D., Knapp M., and the MHEEN Group (2008) Shifting care from hospital to the community in Europe: Economic challenges and opportunities.

[49] European Commission - DG Employment (2009).

Another interesting example is the collaboration between local police and home care to watch over elderly people with dementia, at risk from running away (periodical welfare province of Antwerp).In home care, collaboration between volunteers and professionals leads to new services giving people with limited need for care the possibility to stay at home. Examples include night care and a 24 hours care service point. In the project "somebody needs some buddy" volunteers meet a person with psychiatric problems every (two) week(s) (periodical welfare province of Antwerp).

Example of local collaboration on childcare in France

The Colline network—ACEPP (Association des Collectifs Enfants Parents Professionnels) has been set up as an association since 1990 in the Nord-Pas de Calais region of France. It groups together a regional network of childcare structures (Petite Enfance) which are members of ACEPP, an association of childcare professionals and parent groups. The structures are essentially day care centres for small children that ensure that parents have access to childcare centres, working toward the definition of such structures and encouraging collaboration between parents and childcare professionals. It also develops partnerships with the networks involved via a territorial approach based on participation of local citizens. COLLINE-ACEPP represents the Petite Enfance network and takes part in several multi-partner working groups set up to examine the childcare issues at the institutional level.

Example of local collaboration for troubled young people

The CMCA network "JEUNES EN ERRANCE" (YOUTH IN TROUBLE) was instituted in 1997 based on the first experiments with caring for troubled young people in large-scale festivals, when local and well-established assistance structures began to emerge. It was created to act as a nationwide federating mechanism for all such initiatives, covering 210 different teams and associative and public-funded structures: teams on the street, day care centres, housing, local missions, spaces and services specialised in drug abuse, in-the-field medical care (nursing), among others. There are 22 "central network offices" on the national level, 210 organisations acting in the field, 12 social work training centres, 17 researchers and consultants. This allows for a concentration of very diverse institutions (in-the-field teams, day care, community action centres, mobile teams of psychiatric and social work specialists, etc.) who all work with the same social strata. It is a space for exchanges, sharing and interprofessional, cross-discipline work, which enables a "mix" of professional cultures and practises outside of local or institutional contexts. Within the network, there is permanent give and take relationship based on sharing information and supporting in-the-field practices, researching the target population concerned and defining procedure for various actions.

Example: *Régie de quartier Villeneuve - Village Olympique* (a Neighbourhood Association)

The Régie de Quartier is an association set up to allow people in the concerned neighbourhood to express their needs and to co-provide services to meet those needs. Through the activities launched, the Régie proposes jobs to local people in difficulty. This project requires preliminary discussions and setting up a large-scope partnership arrangement to engender contacts among the inhabitants, institutions, (especially cities, public housing managers, etc.), associations, social workers and in general all players active in local

social and economic development, in conjunction with city management policies. As set out in the Charter of the Régies de quartier, it must participate actively in defining the process of finding new forms of local democracy, which lends this association a political dimension.

In care and employment a collaboration on a local level enables social economy to respond to opportunities in the regional, societal growing markets (www.socialeeconomie.be /innovatiepunt).

Ajduković[50] warns that the future of social work as a respectable profession requires that in addition to advocacy for inclusion of user perspectives and individual empowerment, it must address structural problems and influences by global trends and behavior of all actors - including users – but also policy makers and experts. A deeper integration of social policy and social work in community development is required. The idea of 'smart social policy based on dialogue of all stakeholders that is not reserved only for politicians, experts, policy makers, or existing institutions'[51] (UNDP, 2006, p. 144). Whereas this is an interesting idea, Ajduković asks WHO is responsible to implement it and HOW[52].

Management style

Innovations only have a chance of success when teamwork, leadership and networking are present in the organization, as well as learning-, co-operation and participation power (Hermans&Vranken, 2010). Innovative organizations have a long term vision and leaders who are coaches giving space to proper initiative and experiment and stimulate external contacts of collaborators (advice SER, 2006). A traditional top-down management style hinders innovation. Social innovation requires space for experiments, multifunctional teams and more say for the workers (Serv, 2010).

Joint decision making as a factor of innovation

In the process of innovation, prior to modifying systems of organisation, there is an indispensable phase of discussions among stakeholders in order to give substance to their social demand, express their need, to commence formulating possible responses after *defining a common basis of reference*: a shared common project. Value judgements, in essence, "have an implied propositional content, they refer to a more desirable situation that they help bring about by establishing a measurable relationship between a goal and activities that might help reach that goal". (Dewey et al., 2011, p. 15). The process of innovation is begun by the stakeholders themselves (users, employees, volunteers, etc.) as they start the joint decision process to construct the supply and the demand, underpinned by a body of shared standards, rules and values. The process of identifying this shared objective is—because it concerns actual

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[50] Ajduković Marina, Social Problems, social risks and Modern Social Work, *Rev. soc. polit., god. 15, br. 3, str 395-414, Zagreb 2008,* p. 18.

[51] United Nations Development Programme: *Neumreženi: lica socijalne isključenosti u Hrvatskoj*, www.undp.hr, 2006.

[52] Ajduković Marina, Social Problems, social risks and Modern Social Work, *Rev. soc. polit., god. 15, br. 3, str 395-414, Zagreb 2008.*

innovation—out of synch, or even "out of the box" compared to the existing institutional context, both on the micro level (the association, the sector) and from the macro-economic standpoint (public policies, the environment, etc.).

> Example: "AMAP"s - Associations for the preservation of small farming
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> AMAP associations are intended to support small or organic farmers who have difficulty surviving alongside the agri-foods industry. The principle is to create a direct link between farmers and consumers, who commit to purchasing those farmers' produce at a fair price by paying in advance. Before setting up the buy/sell framework, the stakeholders agree on the common principles of reference in the "Farming Charter": the social dimension involves employment, solidarity among farmers, regions, farmers of the world (respecting each farmer's and each region's right to produce is a fundamental prerequisite). The arrangement must be economically viable and create added value in terms of means of production and volumes; it must respect consumers and nature; it must contribute, with the citizens, to making a living rural environment and a way of life appreciated by all. Taking these factors into account depends on the personal choices of the farmers and consumers in the association.

Joint decision making (different from joint production) implies that the user and his or her cohorts intervene as a resource in the search for a solution. "Both offering providers and those requesting the service participate in defining and setting up the service and integrating it into the determined public space" (Degavre et Nyssens, 2008, p. 98). From this perspective, the social innovation becomes more specific through the newness of the proposed solution, leading to forms of solidarity and more intricate cooperation between actors—implying new debate forums—and to processes of translation between actors (Richez-Battesti et Vallade, 2009, p. 43). This generates controversy in debates between stakeholders, either in the emerging stages or all through the cycle of transformation and adaptation of the forms of organisation and governance. Resolving certain problems and answering user needs creates micro-forums through "opening debates on the respective positions of all stakeholders (users, employees, volunteers)" (Laville, 2011, p. 13). Social innovation is born of such decision making, resultant from the dialog between persons involved and based on their mutual trust. The absence of "formatting" these solutions to meet requirements for a return on investment or administrative standardisation, allows for the joint construction of the supply and demand that brings together providers and users in a way that goes well beyond the joint production inherent to all services (Laville, 2011, p. 11).

> Example: The "ADVOCACY" association
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> ADVOCACY is a group citizens' movement, a solidarity-based practise which helps persons temporarily in difficulty to live freely and independently by facilitating access to rightful benefits, aids, public services and facilities and by influencing decision making. Through ADVOCACY, an outside party provides a voice for victims of wrongdoing or negligence on the part of institutions or their agents and/or those who encounter obstacles in exercising their citizens' rights. In particular, this means all forms of help where persons suffer from exclusion, segregation, or are deprived of their individual freedoms. The advocate in these cases does not assume the role of the barrister in the legal system. Advocacy is a means of social mediation

that introduces a third party who bolsters the claim of the patient/user without speaking for him or her and allowing for the adjustment of all viewpoints in a respectful dialog. People in situations of vulnerability, who suffer from a psychological or mental weakness or disability, characteristically have difficulty asserting their rights and expressing their points of view.

Example: "A LA MARGE" , SCIC (*Société cooperative d'intérêt collectif*)—A cooperative society as social enterprise with user's involvement:

The activity of this SCIC contributes to the local development of a territory through promoting healthy living. This is accomplished by introducing processes to help the population act individually or collectively on its health and related determining factors. The word "health" in this instance is not to be understood in the bio-medical sense, but rather to denote the ability of a population to adapt and act on its environment in view of improving life in the territory. This SCIC thus endeavours to develop autonomous projects to promote community well-being (an approach which involves enhancing the knowledge, abilities and skills of the inhabitants in the projects that they develop). The main activity is one of communication. It takes the forms of events, design and production of enhancement supports (paper supports and web sites, multimedia), assisting in managing the communication project, learning aids and books jointly developed with the users. A specific development and training unit enables user/customers to gain autonomy in order to manage their means of communication by themselves.

The spreading and diffusion of the innovation

Social innovation is conducive to "forming hybrid institutional subsystems which, in many cases, reconfigure relationships between the private, public and community levels—frequently in the form of partnerships" (Mendell, 2006, p. 7). Constituting new and "viable forms of organisation and partnerships through social innovation contributes to establishing areas of dialog and cooperation among diverse kinds of actors, which leads to the spread of those innovations. "Coordination among stakeholders in a given territory is organised from time to time around the creation of innovative services which, in a logic of supporting innovation, round out the local offering around the margins (Fraisse, Lhuillier et Petrella, 2008, p. 15). Moreover, the innovations triggered by those services are not limited to their own scope of operation; their influence spreads very effectively to other economic sectors (induced innovation). These micro-changes raise questions, which in turn generate dialogs and, in some cases, negotiations with the actors "of the dominant model" up until "a breaking point, where the question of changing the established order emerges as a necessity" (Fontan, 2008, p. 6).

In countries such as Hungary, were innovation in social services is not at the core of the agenda and of public debate and there's no literature on the issue, innovative practices to think and disseminate innovations have been elaborated. This is the case of the Social Innovation

Foundation for the Development, established in 1997[53]. It is funded by social scientists and social workers to promotion of innovation of social services. Their main aim was to improve and develop the professional level of the social care system in Hungary. They initiated new methods and creative toolkit to strengthen and renew the quality of social care services. For instance they worked out the Societal Justice Index (Társadalmi Igazságosság Index) that would be able to measure the quality of the organizations even if not yet been implemented).

The impact of innovation on the institutional framework

As one of the aims of innovations is transformation, they can indeed go beyond seeking improvements or new answers to inspiring aspirations to other models of society. Thus, we can speak of joint construction of a space for public action (Laborier et al., 2003), in which social actors and public authorities are stakeholders in a process of redefining public governance bodies and methods. To go in this direction, it is also necessary for public authorities to assume a role of facilitators of innovation to rely systematically on social innovations in territories; secondly, the political role of social innovations would appear crucial to understanding the determining factors for local policies" (Loncle, 2005, p. 401). Where this is not the case, the process of remodelling institutions, albeit ineluctable, can be very slow: "The opposition between innovative practices and prolonged insistence on a model that corresponds less and less to reality—which reflects the intransigence of those who would defend it—ultimately crumbles, even if the coherent model remains to be found, as well as its application." (Racine, 2000 quoted by Mendell, 2006, p. 5).

Sørensen and Tofing (2011; CLIPS) approach welfare innovation and its impact on the institutional framework by stressing the collaborative aspect between different groups of actors within the public sector. They introduce the concept of *collaborative innovation in the public sector*. New Public Management (NPM) reforms, from the end of the 1990s, contributed to enhancing the efficiency of the public sector. Nonetheless, NPM reforms have not been able to develop the quality of social services (ibidem) and NPM has met resistance from welfare organisations and within research. On the other hand, NPM reforms have provided ground for multiple collaborations across organisations and sectors. By contrast, the idea of innovation has been welcomed by the public sector and viewed as a positive tool, since the purpose of innovation is to improve the quality of social services involving every level of the public organisations (Sørensen&Torfing, 2011, p. 24). The innovative initiatives and practices spring from the collaboration between different public organisations and discourses as well as collaboration between the public sector and private sector (Sørensen&Torfing, 2011, p. 433).

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[53] http://www.szia.org/en/content/about-us.

2.2.5   New approaches to acquire funding and monitoring results

Innovation is a condition for the sustainability of the service delivery. Innovative practices can lead to a higher cost efficiency both at the organizational level as for society (more effective use of public spending). How to overcome obstacles to financing social innovation? There are three key principles for successful social-innovation finance. First, innovation requires appropriate levels of financial backing at each stage of the process, with small sums available for promising ideas and larger sums for proven innovations that merit scaling up. Second, money must follow success, rewarding new ideas that work and pulling funding away from less-successful innovations. Finally, it sometimes makes sense for government funds to be supplemented by contributions from private-sector nonprofits—especially for the most experimental ideas[54].

The question of how to fund innovation is tackled in literature by different perspectives:

1) The involvement of private investors.

2) The introduction of special funds.

3) The purchase of innovative practices by final users.

4) Hybridisation of resources.

The involvement of private investors

A first perspective relates to the different forms investment in welfare services by private investors. Examples are the cases were private investors take over for example rest homes with private partners guaranteeing service delivery: their aim is economic exploitation of a diffused social need. Other commercialized services are transport of patients and childcare (periodical ING Institutional 2006). To establish a proactive sustainable welfare and healthcare Flanders for example is moving towards the improvement of innovative care by stimulating responsible entrepreneurship in the care economy (Vision text (e)careful Flanders).

Social entrepreneurship has become a catch word in the attempt to solve problems, which neither public, private nor voluntary services manage to handle. There is a gradually increasing recognition that the public welfare services have their limitations, and even the wealthy Norwegian welfare state has had to look for alternative ways of coping with social problems. One of these initiatives combines the cooperation between the different actors and new innovative services are shaped in the interface between them (Sandal 2007; Schei&Rønning, 2009).

The introduction of special funds

The Introduction of special funds is another way of funding innovation.

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[54] Costa, Kristina, Innovation for the Public Good: Financing Tools for Social Innovation, Three Financing Principles to Guide Social Innovation, Center for American Progress, October 2011.

Example: the Social Innovation Fund (SIF)

In the Republic of Serbia, a Social Innovation Fund (SIF) was introduced in 2001 and 2002 to support the first wave of social welfare reforms. SIF became operational in 2003. It was envisaged as a transitory mechanism providing competitive funding and management support to reform-oriented social services projects at the local level. In particular, it was designed to promote the development of a coherent and sustainable range of community-based, alternative, social services implemented through partnerships between a plurality of service providers, in order to ensure that local level innovations inform central level reforms, and provide opportunities for knowledge transfer. Instead of duplicating existing systems of social protection, the SIF aimed to increase their outreach while also identifying, testing and replicating new, innovative ideas. SIF has been funded from combined state and donor funds, including the Norwegian Government, the European Commission and UNDP. SIF's annual budget was between €1.3m and €1.7m, with the average size of funding for each project increasing over time. SIF promotes partnerships between state providers and non-government organizations. SIF has succeeded in enhancing the role of Civil Society Organisations as service providers, creating an emerging market for their services, and has helped to break down resistance to non-state providers from within state services.

Example: funds for innovation in Slovakia and Czech Republic

For both countries international organizations offered funding and awards for innovation such as the Sozial Marie Prize at a regional level; several other competitions announced by private organizations at the national level had considerable motivating effect and accelerated the processes of innovations in great deal.

Example: Flanders' Care Invest

In Flanders, a new risk capital fund (Flanders' Care Invest) is supposed to stimulate companies to enter the social services sector. Its fields of interest are ageing, the increase in chronic diseases, inefficiencies in health care and the self-reliance at home with a.o. assistive devices for elderly and disabled people (vision text (e)careful Flanders).

Example: The Innovation and learning program

The objective of Innovation and learning (IAL) program[55] is to support development of innovative models of service provision at the local community level. The program is supported by the World Bank. It emphasizes community links, knowledge sharing and filling in the gaps from a service user perspective. Two rounds of calls for applications were held in 2007 and 2008. In total, the Ministry supported 34 projects amounting to a total of 26.971.863,68 kn.

The purchase of innovative practices by final users

Innovation can be funded also by supporting the individual choices of final users to help them to buy the best answer to their personal needs.

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[55] Implemented by Ministry of Social Policy and Youth, Republic of Croatia and funded by the World Bank.

Internationally, there is a shift from the traditional model of funding for example disability support services to an individualized approach with an increasing trend to direct-funding[56]. This alternative to traditional model goes under many different names, including: person-centered services, self-directed support, person-directed service, independent living, consumer control, self-determination, self-directed services, IF. The underlying principle is that PWDs must have a choice and control over the funding and support they need to go about their daily lives[57]. Challenges of the individualized resource allocation systems based on the experience in Ireland[58] include identification of best practice.

Main innovative trends consistent with and emerging for example from the independent living philosophy pertain to empowerment of PWDs through individualized funding. It is currently regarded as one way of progressing community living for PWDs beyond residential models. The Final report on funding and service options for people with disabilities in the US[59], identifies the following emergent trends: self-directed care/self-determination/ individualized funding, and independent living with services provided in the community.

Hybridisation of resources (commercial, non-commercial and non-monetary)

The socio-economic dimension of social innovations lies particularly in their capacity to combine diverse economic resources stemming from three economic principles: the hybridisation of commercial resources (sales of goods and services in the market), non-commercial resources (state aids or subsidies, according to a redistribution of funds logic) and non-monetary resources (donations or charity contributions, following a logic of reciprocity) (Gardin, 2006). In a way, hybridisation supports innovation in that it makes certain emerging experiments economically viable, thanks to the addition of non-monetary resources at different stages of the process. It also guaranties a degree of autonomy for participating actors, allowing them to experiment with the help of a diversity of resources.

Example: the "MOM'ARTE" network

The Môm'Arte network sets up previously non-existing after-school day care spaces to stimulate child development, particularly through art. Such spaces are adaptable to different levels of income (variable fee scales) and working schedules of families in difficulty, while ensuring a real mix of social strata. Môm'Arte employs struggling artists to develop access to art and culture, and develops professional counselling for parents in difficult situations. The network's economy works by combining the participation of citizens

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[56] Australian Institute of Health and Welfare, 2002.

[57] Glynn, M., Beresford, P., Bewley, C., Branfield, F., Butt, J., Croft, S., Pitt, K. D., Fleming, J., Flynn, R., Parmore, C., Postle, K., & Turner, M.: *Person-centred support: What service users and practitioners say*. York: Joseph Rowntree Foundation, 2008.

[58] Power, Andrew, Centre for Disability Law and Policy, National University of Ireland, Galway, Republic of Ireland: *Individualised Resource Allocation Systems: Models and Lessons from Ireland*, Policy Briefing No. 2, July 2010.

[59] Chenoweth, Lesley and Clements, Natalie: *Final report on funding and service options for people with disabilities*, Griffith University, Queensland, June 2009.

(non-monetary resources), of local municipalities (non-commercial resources) and of corporate sponsors (private-sector resources) plus resources stemming from sales of services. This engenders a modern service which functions according to a social- and solidarity-based logic.

Example: The MICRO DON card

The MicroDON card is an operation set up to encourage donations to associations. A donation card with a value of 2 euros is offered next to supermarket check-out counters during a particular event that generally lasts a week end. These cards, each with a bar code that can be scanned at the counter like any other article, enables consumers to make spontaneous donations to an association. Each card describes the specific project of the association concerned, with details on its means and purpose. Generally this type of operation is organised around a public-private partnership between a municipal body (a town, larger townships (*communauté de communes*), town councils, etc.) and the points of sale of various supermarket chains. The customers' donations revert entirely to the association's project. In these times when subsidies for associations are diminishing and fund raising is becoming difficult, the MicroDON card is a true source of new growth for financing associations. The target of the card operations is mainly to finance local associations, but it can also be used to fund larger NGOs which are privileged partners of MicroDON or of the chain.

A number of studies (see e.g. Pedersen 2011; Kristensen, 2011; Hulgård&Andersen, 2009; Andersen&Hulgård, 2008) focus on how innovation in social services takes place within the nexus of or collaboration between the first sector (private enterprises), the second (public organisations) and third sector (NGOs, philanthropy and voluntary organisations and associations) in the context of the welfare state. Hulgård&Andersen (2009) discuss the concept of *social entrepreneurship and enterprises* in a Danish context. This literature focuses on how social entrepreneurship and enterprises create and implement new ideas, social services and practices e.g. within elderly care, health care, forms of day care etc. Such organisations are defined as hybrid organisations that are able to embrace both profit and non-profit aspects. This means that such enterprises have to manoeuvre in the intersection of creating profit and social value, market conditions and public subsidy, local market and global market, monitor social needs and focus on competency development. The literature on social innovation (Kristensen, 2011) is often discussed in relation to social entrepreneurship. The literature on innovative social enterprises focuses on how new ideas and transformations take place in order to create better social services, whereas the literature on social innovation focuses on how 'third sector organisations' (such as volunteer organisations) carry out social service focusing on processes of inclusions of socially marginalised citizens (Kristensen, 2011, p. 99), for example the social integration of migrants in local communities.

Assessment of innovation

An important source of welfare developments (and innovations) in Sweden are the so called Public Evaluations of the State (Statens Offentliga Utredningar, SOU). In Swedish politics there is a tradition of basing reforms and policies on evaluations of experts and researchers. Before taking important decisions the responsible government department commission researchers and experts commissioned to give an overview of the issue in question. Every year more than

100 SOUs are produces, about of 30-50 of them concerning the field social welfare. Often they include reports and analyses of best practices. At the turn of the millennium an evaluation series about challenges in welfare and care was produced. Some of the volumes focus also on innovations(cf. for example SOU 2000, p. 3; 2000, p. 38; 2001, p. 79). Many more SOUs deal with specific issues in the various areas of welfare.

2.2.6   New perspectives, new targets, new practices for old targets,

As described before innovation may derive from the emerging of new social needs and new demands but also from the evolution of the paradigm of welfare. An example, more widely described in the health section, is linked to disability.

New perspectives for old target groups

The evolution from a deficit oriented perspective to the concept of functional health is pivotal. The most important developments in the disability sector are closely linked to shifts in the understanding of disability. Until the1990s, the paradigm was predominant that disability is mainly characterized by loss, deficit and limitation. The introduction of the ICF in 2001 (*International Classification of Functioning, Disability and Health*) evoked a fundamental transformation in the understanding of disability. The ICF follows the concept of functional health. It is not only focused on dysfunctions of the body structure, limitations of activity and participation, but also involves resources. Environmental factors are also being classified. Thereby the formerly personalized causal attribution of social impairment was abandoned in favor of an interdependent relationship between the individual and society. This has meant a change of focus of welfare-state efforts on the participation of disabled people in community life and no merely on aspects of medical rehabilitation and labor market integration. These developments led to a shift away from the concept of 'integration' and to a turn towards the concept of 'inclusion'.

Together with a revolution in the perspective of seeing the disabled and the support to be provided a new attention has also been drawn towards subcategories of disabled not considered in specific in the past:

- *Women with disabilities:* The debate about the implementation of equal rights for women and men, articulates a special need to reduce inequalities of disabled women. Initial findings on disability-related discrimination against women and systematic characteristics of their life situation draw a picture of multiple discrimination against the affected group. Even more special needs arise for women with disabilities that have an immigrant background (Bundesministerium für Arbeit und Soziales, 2011a) (Bundesministerium für Familie, Senioren, Frauen und Jugend, 2009).

- *Children with disabilities*: the innovation resides in particular in the approach to their special needs. Taking into account their special needs, they shall be promoted in their development from the start and should be involved in all decisions affecting them in an age-

appropriate way. A common upraising and education of children with and without disabilities is sought (Arbeiterwohlfahrt Bundesverband e. V. et al., 2009). In Netherlands for parents and families of disabled children the so-called care hotels are built to give them the opportunity to have a rest (www.alsliga.be).

- Social exclusion does not concern only people with disabilities and mental illnesses, but their *family members* as well. Parents are involved as target groups under two different perspectives: On the one hand they focus on enabling parents to have some time for relaxing, on the other hand they offer educational and consultancy activities for parents to better cope with the arising difficulties. An example in the Czech Republic is *Association Helping People with Autism*[60] offers services not only for the children, but for their parents, family members as well.

New practices for old target groups

Marginalisation and poverty are central issues in the debate around the success of the welfare state (Hasløf&Seim, 2008; Underlid, 2009). Poverty and over-indebtedness have always been needs tackled by the welfare state: the innovation resides in new practices to tackle them.

- As part of the general social counselling, debt counselling is the institutional expression of help and support services for people in situations of over-indebtedness or with debt problems. Services are usually offered by debt counselling offices and include not only financial and legal, but also psycho-social counselling.

In Germany debt counselling has been introduced in the early 1980s. Due to the ever-growing number of over-indebted households the number of debt counselling institutions grew accordingly. The focus of the consulting lay primarily on financial aspects. With an increasing number of over-indebted families the focus shifted away from the mere financial distress of the clients to include psycho-social support to those affected and their families. This meant that in the 1990s, municipalities, welfare and private organizations subsequently developed more specialized offers (Groth, 1994). This still ongoing development led to a holistic approach to over indebtedness (Gastiger& Stark Marius, 2012), which takes into account the legal, economic, social and cultural backgrounds that have contribute to the problem formation (Schruth, 2011). Currently debt counseling is facing challenges in putting their ambition of a holistic approach into practice face to increasing expectations: in 2005 the number of over-indebted households in Germany rose to about 8%. This led to a quantitative increase for counseling on the demand side. Since the activities of debt counseling are closely linked to the development of relevant areas of law, changes in the latter in recent years have additionally contributed to an intensification of work. In this tension field there is a lot to be done, because the offer of debt counseling advice, support and guidance cannot cover the present needs of over-indebted people, due to restrictions inhuman resource capacity.

- Homeless Assistance represents a diffused practice normally financed by public (municipal) budgets and means of voluntary welfare organizations. The facilities for homeless people are additionally funded through donations and can furthermore be considered as an area where

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[60] http://www.praha.apla.cz.

volunteering and civic engagement does not only have a long tradition, but embodies a constitutive part of the entire aid system. The innovation here resides in the changing of the paradigm underpinning support and assistance to homelessness.

In the 70s and 80s a paradigm of individual-specific treatability dominated the field of homeless assistance. Based on the Federal Social Security Act (BSHG) a phenomenology of homelessness has been developed that ascribed certain emotional, communication, performance and motivational problems, and difficulties in social behavior and addiction tendencies to individuals. Consequently, a therapeutic approach to homelessness was the tool of choice with regard to targeted individual assistance and the eventual aim of are-education of attitudes. At the beginning of the 1980sacounter-discourse in relation to the therapeutic approach came into play that criticized the deficit-oriented perspective on the homeless and called for the inclusion of social contextual factors in the genesis of this phenomenon. The change in perspective on homelessness from the classification as an individual to the one of a social problem occurred in the 1990s (Heins, 1993). With increasing tendency issues of poverty and structural factors that cause homelessness have been discussed. Also a new aspect was the opening of the 'gender-blindness' in homeless assistance (Fichtner, 2004). The male-centered focus has been abandoned in favor of 'gender-sensitive' explanatory models and help. Homelessness is now understood as a 'complex of multiple social deprivations' (Lutz & Simon, 2007).A current topic in this field is e.g. the increased consideration and implementation of the gender perspective inform of an expansion of services addressing homeless women (Rosenke&Schröder, 2006). Besides, there is an emphasized focus on homeless people with foreign nationality (Hammel, 2000). Issues to be developed further are e.g. the link of homelessness to mental illness (Nouvertné, 2002; Preisinger, 2011). Finally, the professional discourse increasingly problematizes the discrimination against homeless people and asserts it to be a result of the economization of the social field (Heitmeyer, 2008).

It can be noted that the positive developments in the area initiated in the 80s are currently stagnating on the side of public administration. Provided support is even declining with the further restructuring of the welfare state, especially in the highly relevant fields of law, employment and housing (Specht-Kittler, 2005).

- The *Roma Community* across Europe has been estimated to consist of more than 10 million people: it is the biggest minority group in the EU. The cultural and historic differences among sub-communities impact strongly on their status, opportunities and quality of life, but in particular on their level of integration in the broader national community, even though most of these sub-communities have being suffering since centuries from the same structural discrimination all over Europe, in particular, segregation in the fields of employment, education, training and housing. The European Union set ambitious goals in the Lisbon Strategy relating to the creation of more jobs, social cohesion and sustainable development: combating the social exclusion of the Roma in the name of fundamental rights and their common European environment is a key aspect to turn social cohesion and local development into a common resource, applying even to the more vulnerable and marginal sectors of national

citizenries[61]. The literature on the inclusion and integration of Roma communities evidences an evolution occurred on the approaches adopted by countries in Europe.

The evolution of the approach to an old target group: the Roma (Source: World Bank, 2005 and Samek Lodovici et al., 2009)

The first model – *Exclusion policies* – reflects a long historical legacy of policies oriented to maintain, or even reinforce, Roma marginality vis-à-vis the majority society, often on the grounds of their radical strangeness, of their perceived dangerousness, or even of their supposed "inferiority". In different guises, such orientation is far from eradicated even nowadays. Its after-effects apply, for instance, in the frequent cases of Roma geographic marginalization, or in their segregation from mainstream society institutions.

A second ideal type, *(Forced) Assimilation policies,* shares with the former a fundamental concern to reduce the visibility of Roma communities. Assimilative policies aim to make Roma adopt the majority society's values, lifestyles and behaviours. Belonging to the mainstream society is supposed to be the way both to facilitate interaction between Roma and non-Roma, and to provide the former with many more benefits and opportunities than the traditional identities they may be losing, while assimilating. A typically assimilative approach towards Roma minorities, for instance, underlay socialist policies in Eastern Europe during the Cold War.

Throughout the last decades, however, quite different minority policy models have gained prominence – at least in terms of public discourse – in liberal democratic states, also under the impulse of international organizations. The two ideal types involved here share a public recognition of minority civil and political rights, but differ as to the privileged focus of such rights: whether an individual, or a group. The *Integration policies* approach involves, in principle at least, the recognition of Roma as individually full members of society, irrespective of their peculiar cultures. The latter can even be maintained, provided they do not prevent the adoption of the majority society's lifestyles – supposed to be a vehicle for their achievement of equal opportunities with non-Roma individuals. Conventionally progressive approaches to Roma inclusion in the labour market, in the education system, etc., on equal footing with any other individuals, fall within this policy model.

A more recent version of the liberal-democratic approach, placing greater emphasis on group rights, has to do with *Minority rights policies.* In this perspective, improving Roma (or any minority) living conditions and opportunities entails greater respect for their cultural self-determination, along with their attainment of full individual rights. Indeed, a significant development in the last few decades has been the recognition of minority rights, as a result first of OSCE and Council of Europe initiatives, and then in a common EU framework. On a national level, the increasing importance of minority rights protection – including, in some cases at least, the Roma – should be understood in this perspective (European Commission, 2006).

Poverty among children is another focus that received much attention in the last few years (Fløtten 2011; Nuland, Reegård&Sandlie, 2010).

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[61] Crepaldi C., Barbera M., Boccagni P., Naaf S., "*The social situation of the Roma and their improved access to the labour market in the EU*", European Parliament 2008; Samek Lodovici M., Crepaldi C., Boccagni P., Vasilescu C,.and Corsi M., with Eggsi Network "*Ethnic minority and Roma women in Europe: A case for gender equality*?"[61] Eu Commission, DG Employment 2009**.**

New target groups

Literature analysed do not present real new target groups per se, but groups of users of services accessing services they were not used to attend.

- A case is for example that of parents and families of disabled children: for them the so-called care hotels are built to give them the opportunity to have a rest (www.alsliga.be).

- Another example of an emerging target group are elderly immigrants and immigrants accessing to the pension system. Immigrants have accessed Europe looking for a job in their early stages of working life, but the oldest generations of immigrants are now approaching the pension age. This situation is going to pose serious and unexpected challenges to the welfare systems: among various other factors various studies have evidenced that the most serious obstacle to the access of migrants to pension rights is associated with their more difficult access to the regular labour market: to acquire pension rights the level and duration of contributions to the social protection system count, and it is common for migrants to work for several years within the black economy, or without documentation or with a fragmented career, or for several different employers. Migrant workers often have short professional biographies, sometimes even in different countries, which influence their pensionable rights. For women the situation is even worse as undocumented but also legal migrant women are more exposed than men to relegation to the informal sector of the host country. In this framework migrant women with very limited access to social protection system have difficulty in meeting the minimum qualifying requirements for old age benefits and therefore do not profit from portable rights to long-term benefits[62].

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[62] Manço, Altay & Baily, Bibiane, Valorisation identitaire et professionnelle des travailleurs migrants âgés en Belgique francophone: une recherche exploratoire, IRFAM, 2009 and Samek et al. 2012.

2.3   Health

Most of the challenges and options presented in the previous chapter on welfare belong also to the areas of education and health. In the following two sections only specific aspects affecting these two areas have been evidenced.

As far as health is concerned it is important to define the boundaries of this reflexion. Here the focus is not on innovation from a medical perspective (therapies and clinical practices), but it is on social innovation, that it to say the innovation brought about by the evolution of social needs, social practices, social behaviours and attitudes.

2.3.1   Origins of innovation and factors driving innovation

The previous chapter showed that innovation has been brought about by the demand side, the supply side and by the emerging of new paradigms. Let's concentrate on the specific case of health.

Current facts and studies show that the health sector is strongly in flux (Bäcker, Naegele, Bispinck, Hofemann&Neubauer, 2010), changes in the disease panorama, the changing role of medicine in society, but also the medical and technological progress are key aspects to changing conditions in the health care system. It is becoming clear that there is a high demand for long-term and sustainable services and benefits in the health sector. The requirements arising from the forecasts and elaborate studies need to be addressed by health services and handled professionally.

From the demand side innovation is linked either to the evolution of demographic and health trends, to new perspectives and expectations of final users of services, and thanks to a new attention of gender differences in health care.

The current challenges are mainly influenced by demographic change and by resulting need-related implications, but also by the unequal distribution of health risks and diseases along socioeconomic indicators.

From one side:

- The consequence of demographic change on the health care system lies not only in an additional demand for aged care facilities, but also for more professionals. Rising life expectancy raises questions about the implementation of long-term care models that ensure nursing as well as medical care. The special care needs, dementia seniors have, represent a unique challenge to the nursing staff as to the organization of nursing services. The financing of rising health care costs for public agencies, health insurance, but also for the patient, requires sustainable solutions and structural reforms.

- The rising number of some chronic diseases (diabetes, Alzheimer, Parkinson) involves the transition from cure to care. This will result in an increase of (new) services in the sector of healthcare (Flemish Council for Science Policy, 2006).

- Relationships between social status and disease suggest that health policies cannot be reduced to purely medical issues, but have to take place upon the background of bio-psychosocial considerations. The fact that the socio-economic status of a person has a direct impact on their life expectancy is only an indication how strongly the issue of HEALTH must be coupled to the area of WELFARE, especially in connection with developments in patterns of poverty and poverty risk.

- In all European Member States, women live longer than men. The longer life expectancy of women is mainly explained by biological and genetic factors, as well as by differences in health behaviour: men take more health risks and are less conscious about health than women[63]. Since women live longer than men, they are more likely to experience more years of poor health. Moreover women than men suffer from long-standing illnesses or health problems. Women experience more chronic ill health, distress and disability, especially in old age, also due to their longer life expectancy[64].

- Anxiety, depression and stress-related disorders rank high among the common mental disorders in the general population in Europe. They are likely to be the major cause in the increase in the burden of disability in years to come: according to the most recent available data (2002)[65], the increase of mental health problems necessitates a longer treatment in a collaboration between the care and the health sector (speech minister Van Deurzen, Van Kammen, 2002).

- Health care is a growing market which is not quickly satisfied. Once a disease is restrained, people live longer and other diseases will dominate (Van Kammen, 2002).

- Spread of unhealthy lifestyles.

On the other sidepatients/clients are increasingly assertive and want to steer their proper welfare, care and health (Vision text (e)careful Flanders), thereby no longer accepting to depend on a single caregiver. Users considering government and care insurance as patronizing, look for other forms of insurance and advocacy (Van Kammen, 2002). Better knowledge and access to information by patients has heightened public demand for better (and more expensive) care and

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[63] European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels. http://www.europarl.europa.eu/activities/committees/studies/download.do?file=16337#search=%20Discrimination%20against%20Women%20and%20Young%20Girls%20in%20the%20Health%20Sector%20.

[64] Eurostat (2008), The life of women and men in Europe - A statistical portrait, Luxembourg. http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1073,46587259&_dad=portal&_schema=PORTAL&p_product_code=KS-80-07-135.

[65] WHO (2008), New WHO report: Policies and practices for mental health in Europe, Factsheet. 10 October 2008 http://www.euro.who.int/document/mediacentre/fs_mh_10oct2008e.pdf.

treatment. Self-management will continue to be a vital feature of healthcare especially for the chronically ill. This will continue to be enabled by advances in information and communication technologies. However, Greenhalgh (2009) has written that self-management modelled on the 'expert patient' has been shown to be limited and has called for the use of richer and more holistic models particularly those which 'consider a person's family, social and political context' (Greenhalgh, 2009, p. 631) especially in places where social determinants of health inequalities are widespread. Greenhalgh (2009) argues further that these models should account for the role and 'place of activism and critical consciousness in settings where poor health outcomes for oppressed groups are politically rooted' (ibidem).

A core issue to be considered in analysing factors of innovation in health care is also linked to *social concerns*: while health care systems have contributed to significant improvements in health in Europe, access to health care remains uneven across countries and social groups, according to socio-economic status, place of residence, ethnic group, and gender. Gender plays a specific role both in the incidence and prevalence of specific pathologies and also in their treatment and impact in terms of well-being and recovery. This is due to the interrelations between sex-related biological differences and socio-economic and cultural factors which affect the behaviour of women and men and their access to services (Crepaldi, 2010). The Member States are implementing policies at national or local levels to reduce these inequalities and to overcome present barriers to accessing to healthcare in terms of financial, cultural and geographical obstacles. "Virtually all Member States have implemented universal or almost universal rights to care and have adapted services to reach those who have difficulty accessing conventional services due to physical or mental disability or to linguistic or cultural differences. Few have begun to address health inequalities systematically and comprehensively by reducing social differences"[66].

From the supply side prominent roles is played by technological innovation, the use of ITC, or are associated with medical innovations. Especially in the health care sector product innovations have enhanced the spreading of interventions in preventive, curative and rehabilitative areas, while process innovations have increased overall efficiency and effectiveness. The race for progress is manifest in the tendency of legislative bodies to favour different forms of partnerships between the public and corporate sectors in order to encourage technological innovation. This was the origin of the Act on innovation and research dated 12 July 1999 (Loi I&R)[67]: "the scientist is an economic player" (Ghrenassia, 2002, p. 19).

From the supply side healthcare systems also face other challenges:

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[66] Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, DG Employment, Social Policy, Health and Consumer Affairs, Brussels.
http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf.

[67] To implement the I&R Act, technological innovation research networks (RRIT) were set up, as was the "Technologies for health" network which in 2000 had a budget of 110 million francs. In addition to this specific fiscal measure, funds were raised for the creation of innovative companies by researchers and practicioners, such as the BIOAM (a venture capital fund) for biotechnologies.

- reduced capacity of health systems because of financial constraints and smaller workforce;

- advances in technology-based cures which extend lives but drive up costs;

- legacy healthcare structures which are characterized by fragmentation in both financing and delivery of healthcare, and which remain focused on the provision of acute, instead of chronic, care (Economist Intelligence Unit 2011a; Economist Intelligence Unit 2011b);

- in addition, the economic impact of climate change will have consequences on the distribution of workforce and its health consequences will demand a different set of service responses to deal with potential changes on the nature of disease (Wakerman, 2009).

Another perspective on innovation from the supply side focuses on the *development of quality*. The attention to quality has been introduced as an innovation during the pre-EU-accession: to accomplish EU requirements in Czech Republic monitoring of patients' satisfaction with the services of healthcare institutions was unified. Moreover a webpage was created to enable people to view and compare the quality of services in different types of healthcare institutions. The data are collected by using questionnaires. The institution achieving the highest level of quality is awarded with a certificate issued by the Ministry of Health[68].

According to the literature healthcare innovations are also necessary to *address the rising cost of healthcare*. In many developed economies, healthcare spending amounts to 10% of GDP (the figure is 17% for the U.S. [Sairamesh et al., 2011] and expenditures are growing at almost double the rate of economic growth (OECD 2010 cited in Kuenne et al., 2011). Healthcare innovations are hence geared towards reining in the cost of health care while at the same time improving the efficiency of its delivery and the quality of care delivered (Kuenne et al., 2011).

In many *developing countries*, healthcare innovations have not only targeted problems in the delivery of healthcare. They have included institutional, if not systemic, reforms to address, for example, fundamental problems of poverty, social injustice, disenfranchisement, and inequalities of access to healthcare (for samples of innovations, see Banteyerga 2011; Becker et al., 2005; Bhattacharyya et al., 2010; Billings et al., 2007; Coelho and Shankland 2011; Fonn, Ray, and Blaauw 2011; Logie, Rowson, and Ndagije, 2008; Morel, 2005; Nyonator, 2005; Squire et al., 2011; Victora et al., 2011).

The emerging of new paradigms

A changing in paradigm is particularly evident in two fields: the field of disability and the field of mental health, but it is also interesting in the case of sexual transmission of diseases.

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[68] http://www.hodnoceni-nemocnic.cz.

Disability: from rehabilitation to integration and then to inclusion

The most important developments in the disability sector are closely linked to shifts in the understanding of disability. Until the 1990s, the paradigm was predominant that disability is mainly characterized by loss, deficit and limitation. Resulting from this were corresponding rehabilitative frameworks. The ICIDH (*International Classification of Impairment, Disability and Handicap*) published by the WHO in 1980 is a manual for medical classification of disability. It already addresses social implications of disability, but remains deficit-oriented and does not follow a comprehensive health concept. Instead it defines disability based on a model focusing on consequences of the 'illness' (Deutsches Institut für Medizinische Dokumentation und Information (DIMDI), 2005; World Health Organization, 2001). The deficit orientation diverged during the evolution of the 'normality principle' (Thimm, 2005) – which called for realizing a 'normal' life for disabled people – and the growing amount of consideration of the 'quality of life' concept (Beck, Düe& Wieland, 1996; Nirje, 1994) .The introduction of the ICF in 2001 (*International Classification of Functioning, Disability and Health*) evoked a fundamental transformation in the understanding of disability.

The ICF follows its own bio-psycho-social basic model, a concept of functional health. It is not only focused on dysfunctions of the body structure, limitations of activity and participation, but also involves resources and assets in the investigation. Environmental factors are also being classified. Thereby the formerly personalized causal attribution of social impairment was abandoned in favor of an interdependent relationship between the individual and society. In Germany the ninth Social Security Code, which was passed in 2001, defines disability rights. It calls for self-determination and equal participation of disabled people or people at risk of disability in social life. Besides it demands to avoid or counteract discrimination. In 2002 an additional Disability Discrimination Act (BGG) has been passed that explicitly banned discrimination from public authority and stressed accessibility for disabled people in a broad sense (architecture, communication). The new legal changes are compatible to the statutes of the ICF.

A gradation with regard to the concept of disability is applied through degrees of disability. In the 1990s, this distinction was based on the degree of working incapacity. Since the introduction of the SGBIX in 2001 it is no longer merely oriented upon labor-market directed criteria. Rather, the SGB IX explicitly refers back to a holistic understanding of disability. The legislature sets the focus of welfare-state efforts on the participation of disabled people in community life and not merely on aspects of medical rehabilitation and labor market integration. The emphasis on self-help and self-organization in the selection and design of support –not least through the introduction of personal budgets– illustrates the increasing importance of self-determination of disabled people and consequently the emancipation of experts.

These developments – from a reductionist, deficit-oriented and pathogenic to a holistic, resource-oriented salutogenic perspective on disability – become stronger on the national and international level and led to a shift away from the concept of 'integration' and to a turn towards

the concept of 'inclusion'. This is liked to an understanding of disability as an element of human / social norm that is not only accepted, but welcomed as a source of cultural enrichment with regard to the issue of diversity.

The aspect of inclusion is furthermore an integral part of the UN Convention on the Rights of Persons with Disabilities which was passed in 2006 and formally confirmed by the EU in 2010. The particular innovation potential of the Disability Convention results from its specific accentuation: Empowerment to overcome the deficit-oriented approach, social inclusion as well as humanization of society as a whole (Bielefeldt, 2009) form target categories and are starting points for action plans and actions of government and private organizations. Moreover the German Convention derives its innovative power from the explicitly required participation of civil society (Bundesministerium für Arbeit und Soziales, 2011d).

The latest developments in the field are marked by the implementation efforts of the Disability Rights Commission. The activities can be primarily located in the following areas: labor and employment, education, prevention, rehabilitation, health and care, children, youth, family and relationships, women, elderly people, home and construction, mobility, culture and recreation, political participation, individual rights, international cooperation (Bundesministerium für Arbeit und Soziales, 2011b; Bundesministerium für Arbeit und Soziales, 2011d).

Mental Health from segregation to inclusion and community care

The other main area where there seems to be innovations in the health sector is related to mental health. The innovations can best be described as new treatment models, or new ways of thinking related to user participation, or related to different ways of organizing the mental health treatment system.

Since the early 19th Century residential institutions have been the most common response to the needs of people with mental health illness, but they gradually became a place of segregation and control, with poor standards of care. After the Second World War, some countries began to move away from large residential institutions, developing policies for the shift from institutional care to the provision of care and support in local communities. "Three movements in particular have been influential in this process: 1) The Independent Living Movement began among people with physical impairments and has focused on providing personal assistance and adapted environments to enable people to live like anyone else in the community; 2) The Anti-Psychiatry Movement began in mental health services. It has focused on empowering service users and survivors to live in society and on the adoption of a social model of mental health rather than a medical model; 3) Deinstitutionalisation and community living has been particularly important in services for people with intellectual disabilities and it has also been influential in mental

health services. It has focused on the orderly abandonment of large institutions and their replacement by personal assistance and accommodation in the community"[69].

A recent study commissioned by the European Commission on the comparison between institutional and community-based care presents in a clear and concise way the underlying philosophy underpinning the most recent trends in EU political commitment in the care of mental health: "In an age when non-material aspects such as human dignity, autonomy and inclusion in the community are increasingly recognised as being of paramount importance, European societies should aim for more humane, person-centred, individualised models of care. The users themselves and, where applicable, also their families should become partners and take part in all decision-making. Everyone should be enabled to reach their full potential"[70].

Literature evidences that traditional psychiatric hospitals are part of an outdated system of service provision which is going to be abandoned or entirely transformed: "Although failures exist and they replicate at a stubborn pace, psychiatric hospitals have been successfully closed in several countries or regions, whilst in other areas these services have been changed into integrated health care systems"[71].

In Western Europe in particular, the main trend has been the transfer from long-term psychiatric hospital residence to other settings such as general hospitals, or (more commonly) to various forms of community–based living establishments. Medeiros et al. (2008) study has evidenced that in three countries – Iceland, Italy, and Sweden – there are no longer psychiatric hospitals and care is provided in beds in general hospitals or in community-based facilities."Important country reforms were initiated in this period. For example, the famous Italian Law 180 called for a gradual dismantling of all psychiatric hospitals by forbidding new admissions to these institutions. Hospitalisation, both voluntary and compulsory, henceforth had to take place in small acute psychiatric wards (no more than 15 beds each), located in general hospitals and administratively part of local Community Mental Health Services.

"During the last years, a new balance of care model is providing a broader view of the mental health system. Person- centered approaches and longitudinal perspectives are key to this new framework. It takes into consideration the equilibrium between residential and community care, primary and specialized care, or health, social and forensic care within an integrated (multi-sectoral) approach to the delivery of services"[72].

Within mental health care, an evolution is apparent from mainly residential care to more differentiated community-based care. New legislation allows hospitals to reallocate financial

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[69] Mansell J., Knapp M., Beadle-Brown J., and Beecham J. (2007) *Deinstitutionalisation and community living – outcomes and costs: report of a European Study*. Volume 2: Main Report. Canterbury: Tizard Centre, University of Kent.

[70] European Commission - DG Employment (2009), *Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care.*

[71] LUIS SALVADOR-CARULLA (2008) *Bridging experience and evidence in mental health care reform.*

[72] LUIS SALVADOR-CARULLA (2008) *Bridging experience and evidence in mental health care reform.*

means for new functions (ambulant treatment) executed in networks (rehabilitation teams working on social inclusion) (periodical of welfare province of Antwerp). Different new treatment models or ways to deal with or to involve patients or users have been put into practice. For instance ambulant mental health services towards children and youth as an alternative to treatment in institutions (Kunnskapssenteret, 2006). Treatment of mental health and behavioral problems in children and youth is studied in relation to their living conditions where family, school and friends have a significant position in relation to their mental problems and treatment. Several methods to be used in their daily-life and environment have been developed, and ambulant psychiatric treatment is one of them.

Tuseth, Sverdrup, Hjort and Fristad (2006) draw attention to a model of Client Directed Outcome Informed therapy (CDOI). Based on Duncan and Millers model their report demonstrates the usefulness of this method, by illustrating who clients can be directly involved in their own treatment. This is research converted into practice, increasing the effect of the treatment based on constant feedback from the clients.

Another attempt to involve users is illustrated by Sverdrup, Myrvold and Kristofersen (2007). They discuss what user participation in mental health means in practice, and how the concept has been developed over time. Both the situation of users and their next to kin are discussed. User participation in the way it is drawn up, can be seen as an innovation. The same topic is more broadly presented by Sverdrup (2007) who draws attention to user participation in mental health, and on five different research projects that study this in different ways and by different methods.

Another structural aspect of importance, and of innovative significance, is related to care-homes for patients with mental health problems (Dyb and Myrvold, 2009). They show how particular care-homes for people with mental health problems have been built in Norway, and of the cooperation between various institutions and government in the building process.

HIV from segregation/stigmatisation to awareness campaigns to promote self protection

In Europe every year there are about 25,000 newly diagnosed cases of HIV and heterosexual transmission is responsible for 50% of the cases[73]. Over a third of the cases (36%) of HIV infection were registered in women (2005)[74]. 13 % of the cases were in young people between 15-24 years of age. Women are more likely to be in risk to HIV infections due to biological reasons[75] than men, but in some countries also due to their unequal economic, social or cultural status.[76]

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[73] European Commission (2007), Healthier together in the European Union, Luxembourg.

[74] EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-Year report 2005. No.73. European Centre for the Epidemiological Monitoring of HIV/AIDS WHO and UN AIDS Collaborating Centre on HIV/AIDS. Saint-Maurice. http://www.eurohiv.org/reports/report_72/pdf/report_eurohiv_72.pdf.

[75] Women are more likely to get HIV during vaginal intercourse for several biological reasons: 1. the lining of the vagina provides a large area, which can be exposed to HIV-infected semen; 2. semen has higher levels of HIV than vaginal fluids do; 3. more semen is exchanged during sexual intercourse than vaginal fluids; 4. having untreated sexually transmitted infections (STIs) makes it more likely for women to get HIV. http://www.womenshealth.gov.

[76] European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health,

Women are often more unaware of the risks of HIV infection, do not have information on the ways to protect themselves (and methods of contraception), and might lack access to methods of contraception, prevention and care services. In Europe, over 41% of the population still does not take precautions during sexual intercourse[77]. The groups with the highest risk are people with limited social standing or economic security, or those who are involved in coercive or abusive relationships[78] (Crepaldi et al., 2010). Traditionally the approach to sexually transmitted diseases was segregation and stigmatisation, and initially this has been the attitude towards HIV. In the latest years a shift has been introduced in the approach to this disease: the European Union has begun to actively promote sexual health and to encourage the development of a healthy lifestyle regarding sexual behaviours.[79] This objective, with a focus on young people, is included in the EU Health Programme for 2008-2013. As reported by the EU-Health website[80], the EU wants to develop ways to improve the sexual health status of all citizens and to promote the exchange of good practices and information to address major concerns such as teenage pregnancy or the prevention of sexually transmitted diseases. Many European Countries have implemented programmes for sexual education and the promotion of Safer-Sex for preventing HIV/AIDS.

A specific European concern relates to the paradigm of *Health for all*. A major issue concerning the difficulty of innovation within healthcare systems relates to the 'tension between efficiency and social solidarity' (Economic Intelligence Unit 2011a, 16). Whereas economic markets are known to create efficiency and effectiveness, they are notorious for not bringing about equality. In contrast, healthcare provision particularly in Europe is invested with a strong sense of ethical responsibility that obliges it to provide 'health for all', 'at least to the extent that people do not suffer ill health merely because they are poor' (Economic Intelligence Unit 2011a, p. 16).

2.3.2 *Main types of innovation and new forms of social services*

Innovation in health care can be found for example in the area of *prevention*, of *treatment* and if the introduction of new technologies.

In the first area, *prevention*, a pivotal innovation introduced in the latest years is cancer screening programmes. The European Union Health Ministers have unanimously adopted a recommendation on cancer screening in 2003[81], based on the positive experience of the

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Brussels.http://www.europarl.europa.eu/activities/committees/studies/download.do?file=16337#search=%20Discrimination%20against%20Women%20and%20Young%20Girls%20in%20the%20Health%20Sector%20.

[77] European Commission (2007), Healthier together in the European Union, Luxembourg.

[78] EUGLOREH (2009), The Status of Health in the European Union: Towards a healthier Europe, 2009. EU Public Health Programme project, Global Report on the health status in the European Union.

[79] See also http://ec.europa.eu/health-eu/my_lifestyle/sex/index_en.htm.

[80] European Commission, Health EU, the Public Health Portal.
http://ec.europa.eu/health-eu/my_lifestyle/sex/index_en.htm.

[81] Council of the European Union (2003), Council Recommendation of 2 December 2003 on cancer screening (2003/878/EC). Official Journal of the European Union 16.12.2003. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:327:0034:0038:EN:PDF.

innovative Europe Against Cancer programme and its key achievements. The Council Recommendation spelled out the fundamental principles of best practice in early cancer detection and invited Member States to take common action to implement national cancer screening programmes with a population-based approach and with appropriate quality assurance at all levels, taking into account European Quality Assurance Guidelines for Cancer Screening, where they exist.

A second field referred to prevention where innovative practices have been introduced address maternity. Despite significant improvements in recent decades, mothers and their babies are still often at risk during the perinatal period, which covers pregnancy, delivery, and the postpartum period: "Perinatal health problems affect young people - babies and adults starting families – and, as such, have long term consequences. Impairments associated with perinatal events represent a long-term burden for children and their families as well as for health and social services. It is increasingly understood that a healthy pregnancy and infancy reduce the risk of common adult illnesses, such as hypertension and diabetes"[82]. In order to better monitor such factors, in 2000 the European Commission launched the project *PERISTAT - Indicators for monitoring and evaluating perinatal health in Europe*[83] coordinated by INSERM (France). Building on the work of the PERISTAT Projects, in 2007 the Commission funded an innovative project for a *Better Statistics for Better Health for Pregnant Women and Their Babies*[84] coordinated by Assistance Publique-Hôpitaux de Paris (France). Maternal deaths occur today in relatively small numbers, but an analysis of the causes is essential for developing strategies to prevent them. In almost all EU countries, *prenatal screening tests* for the most common risks for foetuses and pregnant women have progressively been introduced in the latest years and are now widely available and free-of-charge.

In the area of *treatment*, as shown in the preceding paragraphs, and described in the Joint Report on Social Protection and Social Inclusion (2008)[85] on average, people with lower levels of education, wealth or occupational status have shorter lives and present more difficulties in accessing health care and these gaps are not declining. "Income inequality, poverty, unemployment, stress, poor working conditions and housing are important determinants of health inequalities, as are lifestyle and willingness and ability to bear the costs. While health care systems have contributed to significant improvements in health across the EU, access to

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[82] EURO-PERISTAT (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (INSERM). http://www.europeristat.com/publications/european-perinatal-health-report.shtml.

[83] European Commission, DG Health and Consumer Protection, Public Health. http://ec.europa.eu/health/ph_projects/2000/monitoring/monitoring_project_2000_full_en.htm#7.

[84] EURO-PERISTAT (2008), European Perinatal Health Report, Project coordinated by the Assistance Publique-Hôpitaux de Paris (AP-HP) and the Institut de la santé et de la recherche médicale (INSERM). http://www.europeristat.com/publications/european-perinatal-health-report.shtml.

[85] Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, DG Employment, Social Policy, Health and Consumer Affairs, Brussels. http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf.

health care remains uneven across social groups". Member States are implementing policies at national or local levels to reduce these inequalities and to overcome present barriers to accessing healthcare in terms of financial, cultural and geographical obstacles. "Virtually all Member States have implemented universal or almost universal rights to care and have adapted services to reach those who have difficulty accessing conventional services due to physical or mental disability or to linguistic or cultural differences. Few have begun to address health inequalities systematically and comprehensively by reducing social differences"[86]. Literature of several languages shows innovations introduced to overcome these disparities:

Health promotion programmes and campaigns specifically targeted at more vulnerable groups are presented in many countries:

In Spain this line of action has particularly focused on the Roma community and their specific disadvantages to accessing health services: the gender perspective has been explicitly addressed, not only as a general principle, but also regarding the problem of domestic violence, as one of the main priorities.

In Slovenia some health promotion programmes and campaigns are specifically targeted at more vulnerable groups (prisoners, refugees), and encourage the education of health workers regarding health promotion for vulnerable groups. In Austria marginalised target groups such as homeless women, sex workers, women living in women's shelters, etc. are addressed by female-specific health promotion projects

In Austria, a gender-specific HIV/AIDS Programme of the Aids Hilfe Wien aims at the sexual empowerment of women, including also migrant women, women in prison and partners of HIV-positive men.

Also in Norway, there is an increased focus on homosexual men, as well as on women, especially ethnic minorities, which show a higher incidence of infections.

Gender-specific health-related risk behaviour is starting to be documented[87] and knowledge about the necessity to provide gender-specific health treatment is increasingly diffused. However, gender differences in most treatments are often not taken into account, apart from reproductive care (basic service provisions for pregnant women and childbirth).

An innovative field of treatment refers to domestic violence. In some European countries there is increasing recognition of domestic violence as a source of physical and mental illness among women and children and special health care treatment services have been implemented. Specialised training has been provided in some cases to general practitioners (GP's) and emergency room personnel in order to increase their awareness regarding the physical or mental complaints of women, victims of partner abuse or domestic violence. In many countries

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[86] Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, DG Employment, Social Policy, Health and Consumer Affairs, Brussels.
http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf.

[87] See for instance European Parliament (2007), Discrimination against women and young girls in the health sector, Directorate-General Internal Policies, by the European Institute of Women's Health, Brussels.
http://www.europarl.europa.eu/activities/committees/studies/download.do?file=16337#search=%20Discrimination%2 0against%20Women%20and%20Young%20Girls%20in%20the%20Health%20Sector%20.

special initiatives have been put into effect to strengthen the quality of public health services in treating sexually and physically abused children and women. Greater awareness of domestic violence within all kinds of public services, including health and medical services is emphasised.

Another innovative area is related to the access to treatment for women of ethnic origin. In general, the ethnic minority population, and especially the Roma population, have worse health conditions than the national population, due to the effects of hard working conditions, social and economic exclusion, lack of information and isolation[88]. Differences in language, culture and religious beliefs, practices and interpretations may lead to less effective care for ethnic minority women. The lack of adequate preparation by health professionals to adapt to these aspects reduces the accessibility of these services for ethnic minority women. In most countries there is also a lack of information material in minority languages, and there is a need to develop interpreting and mediating services to assist ethnic minority women in hospitals. Literature evidences the implementation of innovative programmes addressing this issue:

In Germany within the National Action Plan for Integration (Nationaler Aktions plan für Integration), the federal states agreed on better integration for migrants and people with a migration background in the health system through an "inter-cultural" opening[89], with the support of integration counsellors.

In the Netherlands, considering that the Islamic tradition does not allow women to talk to men they are not married to, a care-consultant who is equipped with knowledge and experience with different cultures mediates between the health care user and health care provider. However, the care-consultant cannot replace a medical professional. Therefore, it is still necessary to develop intercultural competences among health care professionals.

In some areas of France, Médecins du monde (MDM) provides free health care to socially disadvantaged and excluded people and to illegal immigrants in particular. There are 31 free medical centres managed by the association, one in Paris and others in different towns. Women represent an increasing proportion (45%) of the patients consulting the MDM centres, they are mostly quite young (under 25) or older (55 and over) patients; nine out of ten are foreigners, especially from Sub-Saharan Africa, Maghreb and Romania[90]. The same happens in Italy with the NGO NAGA.

A programme promoted by the Centre for Clinical Research Västerås of the University of Uppsala dedicated to overcoming cultural barriers was initiated by Asylhälsan (Asylum Seekers Health Care) with

[88] Corsi, M, Crepaldi, C., Samek Lodovici, M, Boccagni, P. Vasilescu. C. (2008), Ethnic minority and Roma women in Europe: A case for gender equality? – report prepared by the Network of experts in gender equality, social inclusion and health- and long-term care (EGGSI network) for the European Commission, DG Employment, Social Affairs and Equal Opportunities. http://ec.europa.eu/social/BlobServlet?docId=2481&langId=en; Fagan, C., Burchell, B. (2002), Gender, jobs and working conditions in the European Union. European Foundation for the Improvement of Living and Working Conditions, Dublin. http://www.eurofound.europa.eu/pubdocs/2002/49/en/1/ef0249en.pdf.

Fagan, C., Hebson, G., 'Making work pay' debates from a gender perspective. A comparative review of some recent policy reforms in thirty European countries. Report prepared by the Group of Experts on Gender, Social Inclusion and Employment for the Unit Equality for women and men, DG Employment, Social affairs and Equal opportunities of the European Commission, Office for Official Publications of the European Communities, Luxembourg, 2005.

[89] Bundesministerium für Gesundheit, BMG (2007), Mitglieder, mitversicherte Angehörige und Krankenstand, Jahresdurchschnitte 1998 bis 2007, Berlin.

[90] Boisguérin B., Haury B. (2008), Les bénéficiaires de l'AME en contact avec le système de soins, Etudes et résultats, Drees, n° 645, July.

participation in an Equal project on Asylum seekers in the region of Uppsala and Västmanland carried out by the non-governmental organisation of UP AROS ASYL[91]. The overall objective of the programme was to reach Arabic speaking women and provide information of self care as well as to develop competencies at the county council to better treat and understand their needs.

Another social factor affecting access to health care is related to geographical barriers, such as distance from hospitals and health care centres, as well as lack of accessible transportation systems, and physical barriers such as facilities for the disabled.

Geographical coverage represents a relevant barrier to accessing health care as supply is typically greater in bigger cities and more densely populated areas, whilst there is a lack of GPs or family doctors and certain basic specialist services in small, rural and remote areas. Hospitals are often unevenly distributed and specific geographical features (islands, mountains) exacerbate disparities[92]. Literature evidences initiatives to improve access in rural locations and to promote alternative service access.

The form of so-called **telemedicine** is used to provide treatment over great distances. Thereby telemedicine can be used for applications where there is need for medical advice, but a direct doctor-patient interaction on site is not possible. Where medical care is widely available, telemedicine can contribute to quality enhancing by acting as a medium of access to second opinions. It may also be utilized in contexts of training and education (Duesberg, 2010). Laberg, Aspelund and Thygesen (2005) draw attention to so-called smart home technology and planning and management in municipal services. They are occupied by the question and practices to illustrate how technology can help to decrease barriers for disabled persons and help them to improve their way of living.

Telehealth and ehealth have been shown to help in the delivery of healthcare services particularly in rural and remote communities or regions (e.g. Mitton et al., 2011). Telecare is seen by many European governments as offering great potential in improving care through improving capacity for self-management (Pols and Willems, 2011) and hence for service users to be able to remain in their own homes and participate in the community (Bayer, Barlow, and Curry, 2007).

In UK for example, via NHS Direct and the internet. Mobile services, for example, mobile mammography screening units, have successfully been delivered in rural communities[93].

In Poland there are examples of arrangements intended to overcome geographical barriers in accessing health treatment, targeted especially at the female population. Under the programme "Early Diagnosis of the Breast Cancer", mobile mammography units, special "Mammobuses" equipped with units for

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[91] UP AROS ASYL (n.y.), Asyl- och Integrationshälsan, slutrapport.
http://193.13.74.89/d2/public/153/071025Asylhalsan.pdf.

[92] European Commission (2007), Joint report on social protection and social inclusion – Supporting document, SEC(2007) 329, Brussels.

[93] Baird G. A., Wrights N. (2006), Poor Access to Care: rural health deprivation?, British Journal if General Practice, August, pp. 568.

performing mammography screening have been widely used. They function in all regions (voivodships), and the schedule of their operations (places and times) is posted on the internet and in local health care centres.

In Norway Tveito (2005) presents how x-ray equipment can be brought out to the nursing-care institutions. This both reduces the costs of hospitalization and at the same time makes it easier for elderly people, as the equipment is brought to places where they are – and not the other way round. The same ideas are put into practice in another area. More than 200.000 Norwegians suffer from Cronic Obstructive lung-disease (COLS). There has been a developmental project with a so-called COLS-suitcase from Dalane Districts Medical Center, bringing technological equipment to the patients with this diagnosis (Bergsåker-Aspøy, 2008). The same topic is also focused by Jeppesen, Brurberg, Lidal, Holte and Vist (2011), in a study of intermediary units and «home-hospital» in the treatment of patients with acute COLS-problems. Treatment in home-hospital of patients with COLS and who have had a worsened acute condition seems to cause fewer re-admittances to hospital as compared to patients who have been hospitalized with conventional treatment in hospital.

Referring to physical barriers in access to health care a wide progress in this sense has taken place in the last few years, based on the new paradigm of access and participation of the disabled in all aspects of life.

The introduction of new technologies represents a pivotal innovation in health care. A current trend in health care is described by the terms *e-health*[94] and *e-care*. These refer to the use of modern information and communication technologies for health-related data processing, but also their application in the area of indirect patient treatment / counseling, for example the usage of "health information networks, electronic health records, telemedicine services, wearable and portable monitoring systems, and health portals". The term e-care includes also those developments where technical equipment itself has an effect on the treatment. Means are innovations such as smart pills, which dose drugs at a specific time or into certain parts of the human body, brain implants that prevent or alert seizures at an early stage, contact lenses with microchips for early detection of glaucoma or bio-printing for the production of new skin.

In the administrative area, e-health plays a role especially in electronic file management, but also as a way to issue paperless prescriptions. Through the storage of patient data (diagnosis, treatment, medication), and the networking of different practitioners, loss of information and multiple investigations can be prevented just as medical errors can be ruled out more effectively and cost savings can be realized.

On-line platforms for patients have become available also to provide information about illnesses and rare conditions. They enable people with similar conditions to network and collaborate. These websites make it possible for patients to gain a better understanding of their health condition, hence contributing to their capacity to manage it. Also, in addition to providing

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[94] EU Definition: "E-Health refers to the use of modern information and communication technologies to meet needs of citizens, patients, healthcare professionals, healthcare providers, as well as policy makers." (http://ec.europa.eu/information_society/eeurope/2005/all_about/ehealth/index_en.htm).

information and health advice, these platforms foster the building of patient communities (Coye, Haselkorn, and DeMello, 2009, p. 129; Kuenne et al., 2011).

Examples of Health 2.0 platforms are PatientsLikeMe and Gemeinsamfuer die Seltenen. PatientsLikeMe provides patients with rare diseases personal health records that are graphically enhanced; allows open sharing of personal health data in a social network; and enables matchmaking between patients and researchers (Kuenne 2011, n.p.). In Gemmeinsamfuer die Seltenen, members can initiate and participate in finding ideas and solutions for the conditions of people with rare diseases. The platform conducts innovation contests to develop innovative solutions to problems or conditions shared by members (Kuenne 2011, n.p.).

The Danish project *Preventive self-monitoring in health* (see Healthcare Innovation Lab) is about giving citizens access to more information about their own health, health and disease parameters, and thereby supporting individuals from controlling their own lives and act proactively to changes in their own health (studies on care work that promote self-help among different groups of citizens is cross-sectoral with education services).

2.3.3 New actors, new roles and new relationships between stakeholders and end users

The key issue here is the **user value** of social services. The approach is based on the following questions: in which way do the users utilize the "socially-constituted services of social work"? , What is the practical value of the services for the life of the users? Which barriers and restrictions are there which limit the usability and benefit? The socio-educational user research is about to reconstruct the subjective perspective in social services. Schaarschusch and Oelerich emphasize the interaction process, which is linked to three levels: professional, organizationally-institutional and social conditions. (1) Clients are understood as **creators/producers** of services and the professional actors as **co-producers**. (2) Organizations or institutions provide the context of provision. (3) Life situations, social structures and political-economic conditions provide the level of societal conditions of provision. Social services are strongly influenced by these factors.

In the health-care system not only the gradual *integration of private providers* and its effects was discussed (Lindkvist&Aidemark 2005; Hjertqvist, 2000; Blomqvist& Rothstein, 2000; Blomqvist, 2007), but also the changed distribution of welfare responsibilities between the municipalities, the regions and the nation state (Socialstyrelsen, 1994; Helander, 1997), in particular in the field of mental health care (MaycraftKall, 2010; Nyström Petersson, 1998).

A new feature of the service is partnership among key actors in the development of a social services network outside of institutions. Service users typically have a hard time moving around their home and spend most of the day alone.

Halo pomoć offers an alarm system with the operational center in the Nursing home and with trained nurses as operators. Service users and service providers receive training. Assistance is offered 24/7. The operater motivates and supports users to seek individualized service as required. Once the service is

requested, the operator takes action. Users need to have a phone line, a home unit, a mobile button, a two way communication throughout their appartment/home and a trustworthy person (children, neighbours, friends…) they can rely on. They receive education and are active players in service evaluation and adjustment.

Profit organizations are becoming interested in the (market) opportunities of the social services sector. Social services providers themselves try to keep existing clients and win new ones with innovative products and services and try to find new sources of revenue (http://www.managementkennisbank.nl).

The presence of conflicting interests

Healthcare systems are complex and huge organizations with varied and oftentimes conflicting vested interests (ibid; see also Bate, Robert, and Bevan, 2004). Herzlinger (2006) writes in the context of the market-dominated U.S. health system that stakeholders in the healthcare sector with substantial resources and power can influence public policy and opinion either by attacking or helping an innovator. Some stakeholders or organizations may resist and kill an innovation that threatens their position and power. Professional networks have been shown to act as barriers in the spread of innovations (Ferlie et al., 2005). There are thus tensions between medical and business interests as well as tensions between practices that have been institutionalized and those engendered by innovations (Cho, Mathiassen and Robey, 2006).

Another issue that may be raised referring to conflicting actors and roles is the applicability of 'disruptive innovation' to the healthcare sector. 'Disruptive innovation' has become a frequently used concept in the innovation literature. Developed in the context of the United States in the area of healthcare delivery, it refers to those that 'have coupled cost-reducing technologies with innovative business models to deliver increasingly affordable and accessible products and services' (Hwang and Christensen, 2008, p. 1329). Frequently cited as examples of disruptive innovations (products) are cars, mobile phones, and photocopying machines that do not perform as well as top-end products but which are cheaper and are therefore affordable to that segment of the population that cannot afford the better performing but more expensive products. Disruptive innovations are therefore those that cater to a population that has been excluded by other innovations.

Soleimani and Zenios (2011) have pointed out that 'in most cases it is not acceptable to develop a lower quality health product and accept lower margins to make up for it. Moreover, it is difficult to challenge non consumption and develop a new value chain, as the consumers in health care (patients, doctors, providers, and insurers) are well-defined and their roles are well established. Most importantly, existing regulatory and reimbursement systems are designed to evaluate innovations relative to an established 'gold' standard, which again favors incrementalism over disruptiveness, as defined in non-health care sectors' (Soleimani and Zenios, 2011, p. 205).

Not with standing the important point raised by Soleimani and Zenios, there have been 'disruptive' innovations that have impacted on healthcare, which Soleimani and Zenios themselves recognize. They cite for example the disposable syringe and the use of coronary artery stents which effected changes in cardiac surgery (see also Dalziel and Shah, 2010). Other examples are haemoglobin A1C testing and hand-held glucose monitors which have enabled non-specialists to manage diabetes (Dalziel and Shah, 2010, p. 4). In the United States, the employment of Nurse Practitioners (NPs) is seen as a disruptive innovation inasmuch as they 'provide an equivalent quality of care compared to physicians in a number of settings' (Dalziel and Shah, 2010, p. 5).

In relation to disruptive innovations contributing to cost-cutting, it is worth mentioning here what has been called 'reverse innovation'. 'Reverse innovation', as initially practised, refers to the streamlining or simplification of surgical procedures thereby cutting the cost of these procedures. The process was derived by American doctors serving as volunteers in Africa from their African counterparts who they saw perform successful surgical procedures with minimal equipment (UK Department of Health, 2011).

2.3.4 Governance, networks and ways of interaction/cooperation

Healthcare innovations and interventions are material practices situated in specific cultural, institutional, organizational and other settings and relationships (May and Finch 2009). Hence, the implementation and routinization of innovation depend on many factors such as organizational structure, leadership and management, human resource issues, funding, intraorganizational communication, interorganizational networks, feedback and adaptation/reinvention (Greenhalgh et al. 2004, pp. 610-612; also Barnett et al., 2011; see 2.3.2 below).

The aspect of organizational innovation has to be embedded into surrounding structures. Relating to the macro background of innovative social services in health, it has to be stressed that **structural deficiencies** in health care are, among others, are based on the architecture of the health system. The individual sectors' pillarization often blocks an efficient supply, due to different legal rules, responsibilities and funding bases. Depending on the situation in the health system the areas of health, nursing, accident, pension or unemployment insurance apply as single conflicting service providers or complementary parts. This is not only a great administrative burden, but also leads to a loss of quality for the beneficiaries, for example, when ambiguities affect jurisdiction and delay the service process. These problems are particularly evident in the *cooperation network between outpatient, inpatient and rehabilitation facilities.* Current trends and problem-solving strategies move from the tension field of demand growth, (structural and staffing) shortages and financing difficulties.

The management of care

Managed care models with their emphasis on an intersectoral, controlled and steered care and a replacement of the traditional insurance model (Amelung, Amelung& Schumacher, 2004) gain importance as a solution strategy.

- 'Control' refers to the use of business management tools as well as to self-regulation of the health system. The latter shall be realized by creating market-like relationships between stakeholders in the health sector.

- Demand, supply and financing of health care services shall be aligned along effectiveness and efficiency criteria.

- Service delivery and performance based funding shall be coupled by the introduction of mandatory standards – their separation is thus partially undermined – by the establishment of selective cooperation agreements between the various stakeholders.

- As an essential element of managed care, pilot projects on integrated care are becoming increasingly important (Amelung, 2008). This is an attempt to build networking structures between the various disciplines and health care organizations and to thereby enhance the coverage of multidisciplinary patient care through coordinated collaboration of care providers from different sectors. The objective is to increase the quality of health services while reducing health care costs. Especially in the field of integrated care there is a need for innovative developments.

The integration of services

A general issue in health care is the one of 'integrated services': "Integrated processes are all those service activities that are carried out with the involvement of the external factor." (Reckenfelderbäumer 1995, p. 119). As the previous chapters have widely described all innovations present a cross-sectoral perspective, either in terms of policies involved (welfare, health, education, housing, labour, antidiscrimination involved all together at the same time or paired differently among them) and of service provisions involved (home care, community care, institutionalization).

Related is the discussion about the distinction between the nature of the external factor, the degree of interaction, the consideration of customer-related expectations and activities. Issues of customer integration, process orientation, trust, human resource management or local governance come into play.

Example "LA SANTE COMMUNAUTAIRE" action (Community Health Action)

This action aims at improving the health of a community through involving elected officials, health care professionals and social services, and the inhabitants of a city—especially in sensitive urban areas. The primary objective is to establish synergies among diverse health care skills, while implicating the beneficiaries as fully active players in the process. The aim is to promote a positive and dynamic image of health care on the basis of participation, implication and enhancing the image of the inhabitants as empowered actors in their own health issues. This is done by creating networks of local inhabitants in order to share information and review practises, as well as by setting up "human-sized" joint projects in different territories, and integrating territorial actions and projects into regional and national frameworks.

Cross sectoral perspective is particularly important with regard to the specific target group of elderly whose needs require a wide spectrum of policies to be mobilized: health care (either in hospital and as home care), social support (in terms of economic support for those who live on a minimum pension, in terms day life support for personal care, home cleaning, shopping, maintaining social relations, etc), housing (remove of physical barriers), not self sufficiency that means leaving owns house to go to an institution.

An ageing population together with its epidemiological consequences of chronic disease and co-morbidity demands a shift from the present functional and fragmented service delivery to the integration of care services (Economist Intelligence Unit, 2011a; Mur and van Raak, 2003). Integration of services helps address the changing needs and demands of ageing Europeans: 'smaller social networks, growing dependency, less mobility and psycho-geriatric syndromes' (Mur and van Raak, 2003, p. 1). Equally importantly, integrated care is intended to address what is wrong with current health and social care systems, namely:

- lack of 'ownership' for patients and their problems, so that information gets lost as they navigate the system;

- lack of involvement by the users/patients in the management and strategy of care;

- poor communication with users/patients as well as between health and social care providers;

- treatment of patients for one condition without recognising other needs or conditions, thereby undermining the overall effectiveness of treatment;

- lack of recognition of how decisions made in the social care setting affect the impact of health care treatment, and vice versa (Lloyd and Wait 2005, p. 7).

As such, integrated care 'seeks to close *the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery* and makes redundant old-supply driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless' (Lloyd and Wait, 2005, p. 7; emphasis in original).

The case for integrated care in Europe is driven by five factors. These are:

- the changing demand for care – it is estimated that by 2050, more than 30% of the European population will be over 60 whereas only 13% will be below the age of 15;

- interdependence of health and social care outcomes – there is increasing recognition of the link between an individual's health and social needs;

- social integration of society's more vulnerable groups – addresses the social isolation of disadvantaged groups, ethnic minorities, people with mental health problems, etc.

- better systems efficiency – better coordination and more appropriate use of human (professional) and financial resources;

- improved quality and continuity of care (Lloyd and Wait, 2005, pp. 11-13).

Some examples of integrated care practice in Europe are:

- Standardised communication protocols and formats (e.g. MedCom in Denmark and Wiesbaden Geriatric Rehabilitation Networks in Germany).

- Single assessment processes incorporating multi-disciplinary assessment (e.g. Single Assessment Process in the UK; Multi-dimensional assessment plans in Italy).

- Single access points to care (e.g. One-Window in Netherlands; CARTS in the UK).

- Defined pathways of care (e.g. Hospital at Home in the UK)(Lloyd and Wait, 2005, p. 14).

- Social support and preventive medical services for the elderly (Open Care Centres for the Elderly (KAPI) in Greece) (Daniilidou et al., 2003).

<u>Issues in the Integration of Care in Europe</u>

According to the OECD, Long term care (LTC) can be defined as a range of health and social services provided to individuals in need of permanent assistance due to physical or mental disability for short or long periods. LTC includes rehabilitation, basic medical services, home nursing and empowerment activities[95]. In short, LTC consists of a wide set of different services provided to people who are dependent in conducting the Activities of Daily Life (ADLs)[96] or Instrumental Activities of Daily Living (IADLs)[97].

Literature distinguishes service provision on the basis of two variables: those <u>who provide care</u> and <u>the place where care is provided</u>. "Concerning the first variable - care providers - a difference must be recognized between formal and informal care. With reference to the second variable –where the care is provided- a distinction has to be made between institutional care and care at home. Institutions include nursing homes, residential care homes and old age homes where there is a permanent presence of care assistants. Care at home may include care provided in houses and apartments that are not built specifically for persons needing LTC, as well as adapted housing, group living arrangements and wherever there are no permanent care assistants[98]. The mix of benefit types - formal/informal, economic support/direct provision of services and institutionalisation/care at home - varies among European countries, reflecting the

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[95] Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, Brussels.

[96] ADLs are activities that a person must perform every day such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet, and controlling bladder and bowel.

[97] IADLs include preparing own meals, clearing, laundry, taking medication, getting to places beyond walking distance, shopping, managing money affairs and using the telephone/Internet.

[98] OECD (2005), Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability?, Paris.

organisational features of each system more than population structure and demographic developments. In particular, these variations reflect different national approaches to familial solidarity (incidence of informal care and support for carers)[99]" (Crepaldi, 2010) .

In the last fifteen years, European countries have experienced reforms aimed at removing inequalities in access to LTC and at improving the quality of care. According to the Centre for European Social and Economic Policies (CESEP)[100], in European Countries, the Social Care Model – including LTC - can be placed on a 'continuum' with the Family Care Model at one extreme and the State Responsibility Model at the other[101]. A third model, called the Subsidiary Model, can be found in the middle.

The first model is called by some authors the *Informal care-led model*[102]. This model is characterized by limited public service coverage. The mix of services is generally imbalanced, with a predominance of institutional services, and involves a certain level of cash transfers. Public intervention is generally aimed more at supporting the incomes of persons in need of care than providing them with the LTC services they need. Public intervention occurs when family support isn't sufficient or the income of the person is very low and is not sufficient to pay informal caregivers. It is described in Portuguese, Spanish, and Italian literature.

The *State Responsibility Model,* mainly described in Nordic countries literature, public services are much more developed and public institutions more often provide direct care rather than cash transfers. The underlying objective of this model is to promote a high level of regular employment in the care giving sector and to meet the care needs of those who are not self-sufficient[103].

The *subsidiary model* is described in the Francophone literature and in other Central European countries. It relies on the family as the primary, responsible care giver for the elderly, with intermediate organisations providing services that replace informal care when necessary[104].

The balance between health services and social services in LTC provision is another element that varies among Member States, according to the welfare culture and tradition of each country but the boundary between social and health services is often not so clear.

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[99] Council of the European Union (2008), Joint Report on Social Protection and Social Inclusion, DG Employment, Social Policy, Health and Consumer Affairs, Brussels.
http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf

[100] CESEP is an independent research consultancy specialising in the development and assessment of employment policies, as well as on policies for ensuring equal opportunities and combating discrimination. CESEP collects and analyses qualitative and quantitative information, and provides econometric testing and modelling. CESEP provides policy recommendations for the integration of disadvantaged groups, the management of European programmes and the evaluation of projects and policies (from CESEP website: www.cesep.eu)

[101] Ranci C., Pavolini E. (2007), New Trends of Long-Term Care Policy in Western Europe, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

[102] Ranci C. Pavolini E. (2007), New Trends of Long-Term Care Policy in Western Europe, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

[103] Ranci C., Pavolini E. (2007), New Trends of Long-Term Care Policy in Western Europe, paper presented at the APSA Annual Meeting 2007, Chicago, Illinois.

[104] CESEP ASBL (2007), Exploring the synergy between promoting active participation in work and in society and social, health and long-term care strategies, Brussels.
http://ec.europa.eu/employment_social/spsi/docs/social_protection/final_report_en.pdf.

The Role of Informal Care

The existence of a strong family orientation plays an important role in how integrated care is delivered and has a significant impact on the use of human or professional resources. However, in Spain and Austria where there is a strong familiar culture, the availability of informal care for the elderly in these two countries is seen to have slowed down professionals, care agencies and policy makers in developing integrated formal care arrangements (Mur and van Raak, 2003, p. 1).

On the other hand, in Greece, a programme of integrated care for the elderly, known as KAPI (Open Care Centres for the Elderly), responded precisely to the disappearance of traditional forms of care for older people due to social change and public financial constraints. KAPI enabled healthy older people with social problems to obtain care and services while staying home (Daniilidou, 2003).

Competing Policy Agendas

Tension is created by the integration of social and health care services and the existence of policies promoting provider competition which many governments see as helping spur reform, efficiency and quality improvement. As a result, a mix of public, private and voluntary sector providers now deliver healthcare and social care services (Blue-Howells, McGuire, and Nakashima, 2008, pp. 220–221). Lloyd and Wait (2005) argue that the increase in the diversity of provision may negatively affect the development of integrated care as the 'coordination challenges involved in delivering a complex set of services within a coherent integrated care package may increase' and as 'it may be more difficult to ensure equitable access for all users in a highly diversified quasi-market'.

2.3.5　New approaches to acquire funding and monitoring results

In the United States especially, one of the most important areas of healthcare innovation is in the generation and development of new business models, 'particularly those that involve the horizontal or vertical integration of separate health care organizations or activities' (Herzlinger, 2006, p. 3). These new business models for healthcare are part of attempts to reform or replace the Medicare fee-for-service model 'which is controlled by special interests with political control over the regulatory and reimbursement system' (Grossman, 2008).

In Europe, financing healthcare is proving to be a major concern. With an ageing population and increased longevity, fewer people will be of working age while healthcare capacity is strained by the demands of looking after people with chronic illnesses and multiple morbidities. Taxation and insurance, which are the sources of public finance for healthcare, are not able to keep up with such health demands (Economic Intelligence Unit, 2011b). There is an increasing trend for the adoption of market-oriented reforms in countries where healthcare has historically been provided through centralized and non-market means (Gaynor, Moreno-Serra, and Propper

2012; see also Peckham et al., 2012; Propper, 2010 for a discussion of the increasing prominence of competition in health care in England).

The marketization of the health sector

Changing patterns in the health system also affect conditions in the hospital sector. One factor is the marketization of the hospital sector characterized by increasing competition and a boom of privatization. Second, the shift in the financial logic from a daily rate system to a prospective payment system (DRG system, *diagnosis related groups*) in 2003 has to be underlined (Rapp, 2008). Objectives of the reforms have included developing an incentive system that rewards clinics for realizing a "slim" treatment, through the introduction of the DRG system. This measure should reduce costs, increase transparency in accounting and the quality of the treatment.

These developments are critically evaluated in the current discourse. Previous studies have shown that the introduction of the DRG system went in hand with a deterioration of working conditions for doctors as well as an increase in conflicts between cost pressures, the quality of care and medical ethics (Klinke, 2007). It also appears that the introduction of DRGs has changed the living and working conditions for nurses in hospitals for the worse. It does not only result in an increasing bureaucratization and a compression and acceleration of everyday work, but also seems to produce conflicts between the nursing-professional self-image and fiscally motivated efficiency requirements of the organization (Marrs, 2008). Moreover, the reform seems to have produced substantial additional costs of administrative activities for the entire medical staff, which has a negative impact on the core processes in health care. Finally, the budgeting of hospitals and the associated narrowing of maximum utilization limits is said to lead to a capacity problem and the loss of flexibility in occupancy.

The 'Empowered Customer'

In developed economies, there has been in the last two decades a move towards a 'consumerisation' of their health policies which has led to the shift from the 'passive patient' to the 'empowered customer' (Windrum and García-Goñi, 2008). This change in the status of the service user was thought to effect changes in individual behaviour that would lead to better efficiency and cost savings. Such expectation was based on the idea that empowered customers will take more personal responsibility for their own health, contributing to a reduction in the financial stress on the health system (ibidem).

Windrum and Garcia-Goni (2008) write that 'consumerisation' raises two issues. The first relates to the difference between the citizen and customer. Citizens and customers differ in how their rights and responsibilities as well as their relationship with the state are conceived of. Consequently, there is a need to rethink how civil society is understood and the role of the public sector within it. The second issue concerns the conditions for consumer sovereignty. They include 'knowledge, information, choice, and effective relationships between buyers and sellers'.

EU funded innovation

EU funded Innovation 4Welfare brings together policy makers, knowledge providers, economic and social intermediaries and health institutions implementing projects and policies across six regions. These stakeholders share, exchange, transfer and implement good practices and will renew the regional policy agenda's. Through regional cooperation, Innovation 4 Welfare builds new coalitions of economic and social actors. I4W will become a European generator for new solutions promoting health and welfare[105].

Problematic situations create market opportunities

Good Healthcare Innovation Practice (GHIP), founded as network organization in 2001, later became an independent consultancy company for care business development and care innovation: for pharmaceutical companies in search of new user oriented markets, service deliveries skilled in logistic processes which want to bring care at people's home, care institutions wanting to enter new markets, etc. (www.ghip.nl).

2.3.6 *New perspectives, new targets, new practices for old targets*

Scientific and technological progress result in other approaches to (health) care as well as in the interaction between caregiver and patient (who is able to consult his medical history) and between caregivers (who can share vital data) (Van Kammen, 2002).

According to the Dutch literature among the relevant innovations in healthcare has also to be mentioned the introduction of electronic patient dossiers and the use of a multidisciplinary approach with the integration of knowledge fields. They have created the possibility of self-diagnosis and self-treatment and made the transition into ambulant care. Using ICT, the transfer can be made from written to electronic medical files. The latter can then be shared by carers (Vision text (e) careful Flanders, 2012). A lot of ICT innovations are used by people at home for self-diagnosis and self-care.

- With the use of assistive technology, care of disabled persons can be personalised. Thus, care becomes coaching.

- In the social services sector, a strong differentiation appears (also facilitated through ICT) with a higher specialization of professional carers and aid workers (Vision text (e) careful Flanders).

- Multidisciplinarity over different fields of knowledge (biotechnology, neurosciences, etc.) and care offers a great potential for new and more patient-oriented applications.

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[105] Background of the Innovation 4 Welfare Initiative, leaflet, www.innovation4welfare.eu (November 3, 2010).

2.4   Education

According to the 'Learning from the Extremes' Report (Leadbeater, Wong, 2010) the two biggest educational challenges in the next years will be (i) 'how to provide learning at scale to millions of poor people in places that are ill-served by traditional public services, including schools' in the cities of the developing countries while as far as the developed world the main educational challenges consist of (ii) 'delivering reliable quality at scale….cracking the culture of failure… the failure of mass schooling to deliver on its promise of social mobility and economic improvement for significant numbers of children…Governments also face a challenge of whether schools systems derived from the industrial era provide the capabilities—for curiosity, collaboration, and creativity—that are needed in modern, innovation driven economies' (pp. 5-20). In addition, immigration represents an innovative driving force for innovation in education services.

As highlighted in the Report above mentioned, social innovation and 'new ways for people to learn' are required for facing these challenges; specifically different strategies can be identified. In fact, combining *types of learning* (formal and informal settings for learning) and *kinds of innovation* (sustaining and disruptive), the authors distinguish four main strategies that can be adopted by governments, schools, and families, namely: improve, supplement, reinvent and transform learning (ibidem, pp. 3-4). Main features and some examples of each of the types of innovation developed are synthesized in the table below.

Table 2: The Education Innovation Grid

	Formal Learning	**Informal Learning**
Sustaining Innovation	Sustaining innovation in formal learning - **IMPROVE** schools through better facilities, teachers, and leadership	Sustaining innovation in informal learning - **SUPPLEMENT** schools by working with families and communities
	Sustained educational improvement (e.g. Finland)	*Learning Beyond the Classroom and Spreading a culture that values learning* -families with high-quality childcare and family support services in Finland; - more comprehensive earlyyears provision based around Sure Start preschools and Children's Centers in UK; -the community-based, integrated child development approach pioneered in the city of Reggio Emilia in Italy; - programmes to develop pupils' social and emotional skills and to compensate for social and emotional deficits in their home life (e.g. the Social and Emotional Aspects of Learning program launched in 2006 in UK); - programs to help vulnerable parents to build up their parenting skills, to improve their relationships with their children at home, and to stimulate learning (e.g The Family Nurse Partnership in UK)

	Formal Learning	**Informal Learning**
Disruptive Innovation[106]	Disruptive innovation in formal learning - **REINVENT** schools to create an education better fit for the times	Disruptive innovation in informal learning - **TRANSFORM** learning by making it available in radically new ways
	More personalized approaches to learning Personalised learning = learning with and by Place,Timing, Pace, Space (Leadbeater, 2008, p. 16)[107] -more child centred education; -the open-air school movement; -open plan schools, schools catering for children with special needs; -schools influenced by alternative pedagogies; -schools in special circumstances; -schools created by academies, which are sponsored by a company and often - specialize in a field such as media, arts, or business (UK); -new routes for new entrants to create new kinds of schools	*Using the web, particularly through mobile phones, to promote learning* -Google, Wikipedia, YouTube, Educational talks; -learning through mobile phones (e.g. a BBC service to teach English in Bangladesh through mini-lessons on mobile phones)

Readapted by Leadbeater, Wong, 2010 (pp. 3-20)

As far as actors and origins of transformational innovation, a particular emphasis is given to those services and activities provided by social entrepreneurs working with outsiders in developing-world cities. 'Pull Not Push', 'Learning Through', 'Learning as Play', 'Learning as Problem Solving', 'Many Places for Learning', 'Learning without Teachers', 'Learning from Peers', 'Learning as Production', 'Old and New Technologies for Learning', 'A New Logic for Learning' (ibidem, pp. 21-5) are some key messages that exemplify novel approaches developed by these social entrepreneurs.

Focusing on European context, despite the differences in education systems within the European countries, the literature review shows how innovation in the field of education mainly concerns (a) alternative schools, non-regular schools and informal education with a particular attention on services designed for those children and young people who are typically regarded as very 'hard to reach' (inclusive and multicultural education) and (b) cross-sectoral services (i.e. connecting education and the system of social services). Innovation refers also to the integration of disciplines[108], to experimental learning and to the development of educational laboratories (practical or cross-sectoral) for disadvantage people and people at risk of labour exclusion.

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[106] See Christensen with Horn, M. and Johnson, C. (2008) Disrupting Class: How Disruptive Innovation Will Change the Way the World Learns.

[107] Power point presentation available at http://www.charlesleadbeater.net/home.aspx.

[108] Cfr the case, in Netherlands, of a new postgraduate program for elderly care based on medical and social-scientific insights and elements of occupational therapy and physiotherapy (www.phl.be).

Finally, innovative education services, or practices, are connected with (c) the introduction of new technologies.

2.4.1 Inclusive and multicultural education

The introduction of new methodologies and new teaching method is often a way to promote the principles of an inclusive and multicultural education.

Following the Unesco documents (1994) inclusive education: (i) challenges all exclusionary policies and practices in education; (ii) is based on a growing international consensus of the right of all children to a common education in their locality regardless of their background, attainment or disability; (iii) aims at providing good-quality education for learners and a community-based education for all.

Disabled people

While integration was the main issue on the agenda when the international community and national governments discussed how to promote the right of disabled persons to an appropriate education until the end of the 1980s, inclusion has captured the field during the 1990s. The main question is, of course, whether the new terminology means only a linguistic shift or a new agenda. A first step towards a clarification might be to note under what circumstances – and when – the shift first came to be internationally recognized. In that respect, the World Conference on Special Needs Education in Salamanca in 1994, with the adoption of the Salamanca Statement and Framework for Action on Special Needs Education, represents the event that definitely set the policy agenda for inclusive education on a global basis (Unesco, 1994). The Salamanca Statement acknowledged the new policy and a new term, which has an effect on the international discourse in the field. A main argument for a linguistic shift to be introduced with the Salamanca Statement was the different roles of international organizations and, in particular, the wider international context to which the policy and action now became orientated. Before Salamanca, integration had served as a descriptor of a particular policy concern in the western countries in the 1970s and 1980s. The OECD projects on the integration issue were organized in this first period and continued into the 1990s. By the turn of the 1980s, Unesco formally adopted inclusion as a descriptor for the organization's main activities in the field. Unesco's actions in the field went beyond the western region and had a global orientation. A policy vision for a wider world context needed a new label to avoid giving the wrong signals to significant actors representing relevant interests and partners on a wider international arena.

Migrants and Minorities in Education

According to the European Parliament resolution of 18 December 2008on delivering lifelong learning for knowledge, creativity and innovation – implementation of the 'Education & Training 2010 work programme', high quality pre-primary education is 'an effective way to open

up access to lifelong learning for all children, but particularly children from deprived backgrounds and ethnic minorities' (paragraphs 3 and 15).

New programmes to overcome obstacles for receiving a good quality education include projects aimed at facing discriminatory enrolment procedures and access testing, intercultural, multicultural and antiracist curricula and school inclusion programmes for the children of Roma, Sinti and Travellers and the children of asylum seekers (FRA, 2011). Segregation of Roma kids, for example, is a great issue for the Hungarian education system. Segregation, observed both within schools (special classes) and between schools (schools with a majority of Roma kids, and schools with only non-Roma children in ethnically mixed communities), is usually assisted by the local government itself. There have been several attempts by the previous governments to decrease segregation and some of the funding for the training of teachers was gained from the EU Structural Funds. However, the majority of small, multi-ethnic towns still segregate kids. Non-governmental initiatives, like the Ámbédkár school run by a small Buddhist church in a segregated village in the North-Eastern part of Hungary, or the Igazgyöngy foundation are strong examples how *innovative teaching methods and the community work with parents and local stakeholders* can drive to the successful education of Roma and poor children.

In promoting a multicultural education, crucial is the role and lobbing activities of third sector organizations. For example, in the Czech Republic, the non-governmental organization 'People in need' is the main facilitator of multicultural education, while in Slovakia the Milan Šimečka Foundation is very active in developing practical guidance and offering courses for teachers. The Orava Association in cooperation with selected primary schools structured the standards of multicultural education, which mainly focuses on the abilities of teachers to engage children (Orava Association, 2011).

2.4.2   Human rights education

The role of historical sites and museums in Holocaust education and human rights education in the EU

As reported in the FRA publications 'most Member States have committed themselves to integrating into their school curricula human rights and democracy...and education about the Holocaust and other Nazi crimes on the other – an important, but difficult, task....[such as] there has recently been a movement to tie teaching about the Holocaust and its history to teaching about human rights (2011, p. 9). Different education programmes exists in the EU and various are the ways developed by the institutions to link Holocaust education and human rights education.

In recent years learning 'with' or 'through' human rights has been added to the distinction between learning 'about' human rights and learning 'for' human rights, already used. According to the new dimension, 'learning will take place using didactic methods that reflect the ideas behind human rights, i.e. learning will take place in a democratic fashion and with the active

participation of all those involved. The teaching situation must guarantee that the equal value of each student is respected' (2011).

2.4.3 Non-regular schools, informal education and the link between formal and informal education

New methodologies and new teaching methods, mainly based on the principles of involvement and inclusive education, have been introduced. These methodologies are established to involve (and impact), not only the participating students, but also the schools, the families, other young people, the territorial organizations and the community in general. Several projects have been implemented by third sector organizations in order to reach new target groups or to face unmet needs.

Alternative schools

The main sources of pedagogical innovations in Slovakia and the Czech Republic were the alternative schools, which introduced new approaches and principles. Besides the internationally well-known alternative schools based on methods of Waldorf, Montessori or Dalton schools, the program "Obecnáškola" [Ordinary school] was launched in the Czech Republic, which offered drama courses for children, and courses focusing on family relations. Průcha in his book reflects on the lack of data on the accomplishment of these schools in comparison with standard schooling (Průcha, 2004, p. 106). Moreover the few researches conducted showed that there is only slight difference between the two types of school, and in some of the categories, standard schools achieved even better results. In the year 1999/2000 82.2% of students attended standard schools, 11.8% attended the above mentioned alternative school, 4.3% studied in private schools (Průcha, 2004, p. 108). In Slovakia there are two main alternative initiatives, which proved to be effective. Both projects are intended for kindergartens and first stage of primary schools. The first one is the so called "ŠkolaDokorán", which builds upon the premise of the partnership of teacher-child-parent. The child is viewed as the subject of education, who is encouraged to share his/her feelings, opinions and experiences. Particular attention is devoted to developing the child's identity and advancing interpersonal relations and tolerance (ibid., p. 69). The method is primarily applied in segregated localities, educating socially disadvantaged children (Foundation ŠkolaDokorán, Annual Report, 2010). Since 1994 the method has reached 864 kindergartens and 876 primary schools. 3178 teachers and 526 teachers assistants have been trained (Foundation ŠkolaDokorán, Annual Report, 2010). The other successful project is run by the Orava Association for Democracy in Education called "Škola, ktorej to myslí…" [Thinking school], which facilitates active learning using social, interactive and cooperative teaching methods . 38 primary schools are engaged in the program. The Association offers a series of courses for familiarizing teachers with these methods. In the past four years around 1900 teachers from 62 primary and secondary schools participated in the training, which means the method could reach approximately 25 000 students (Orava Association: Annual Report 2011). According to the survey of State Pedagogical Institute

teachers favour these methods and they selectively apply them (State Pedagogical Institute, 2011). In recent years particular emphasis was put on inclusive education in both states. It is intended not only to integrate disable children or children with special needs into mainstream education, but to improve the education of Roma children as well. Taking into account the high number of children attending special schools, which in certain regions seems to be a mean for segregate Roma and non-Roma children , this strategy could be very important in reducing the inequality and social exclusion of these children.

Working 'through relationships' with children and young people who have been permanently excluded from school

To face school exclusion (a) the relationships between staff and parents and between staff and young people and children students permanently excluded from school and (b) taking into account their past history account are considered ways to engage or re-engage excluded young people with educational and the wider context of their opportunities. Specifically, a research carried out by the Joseph Rowntree Foundation (2007) on the topic - School exclusions: Learning partnerships outside mainstream education - focused on two voluntary sector organisations supporting predominantly black and dual-heritage students. The research highlights the main features of a new education approach: it 'caring adults who want to develop relationships with these 'hard to reach' individuals, rather than on a specified list of formal procedures. This makes the appointment of the right people to do this job particularly important. The approach also relies on staff being free to take the initiative; having flexible working procedures; and being creative in order to respond to students and their parents (p. 1 , Executive Summary).

> New initiatives tackle new needs that are not addressed in the regular system, as learning impairments and the risk of drop-out, are emphasized in the Dutch language literature review. Some examples are the private school Eureka that teaches children with learning impairments how to compensate for their impairments, an approach unknown to regular education. This school is recognized but not subsidized by government[109].
>
> 'Playing for Success'[110] is a project for pupils who risk dropping-out of school because of lack of motivation or a troublesome family situation. On a voluntary basis they participate in learning activities in a natural way outside the school. This is steered by a team of teachers and top-class sporters. Their successes are fundamental for them to get motivated (www.playingforsuccess.be).

Action research to enhance skills for inclusion and improve inclusion in the classroom. The Appreciative Inquiry

Using Appreciative Inquiry to improve social dynamics in mainstream classrooms and social inclusion in classes is a prominent field of research. Appreciative Inquiry is a management

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[109] www.eureka.be.
[110] www.playingforsuccess.be.

change process that starting 'on recognising the positives that already exist within a situation, and building on these' (Doveston, Keenaghan, 2006, 2006b)[111], suggests that 'visualising a positive future helps that future to occur; 'momentum and sustainable change require the energy that stems from positive emotions and relationships' (ibidem, p. 3). Different case studies are reported in education and evaluation literature. Among other, the Growing Talents for Inclusion (GTI) should be mentioned. It is an action research implemented in Northamptonshire, a 'whole-class intervention which promotes emotional wellbeing through the development of positive and collaborative peer relationships using solution focused and appreciative inquiry approaches' (Benson, 2011). Beyond Appreciative Inquiry, the project was based on the collaborative consultation and co-researching with students principles.

More specifically, the 4-D Cycle of Appreciative Inquiry used in the project includes the following stages: Discovery: appreciating and valuing the best of 'what is'; Dream: envisaging 'what might be'; Design: co-constructing the future; and Destiny: innovating 'what will be'. In the latter stages the 'talents they had identified were explored through a number of multi-sensory sessions, typically eight sessions over a period of six to eight months. The sessions involved fun activities, but no writing, and positive rewards such as a celebratory cake at the end' (ibidem, p. 2). Using the Appreciative Inquiry in education action research represents one of the innovative practices introduced in the education field in relation both with teaching method and evaluation.

The use of comics to favour intercultural dialogue

In Italy, the association 'Africa and Mediterranean', has introduced into secondary school of different regions the 'media education' method and the use of comics with the collaboration of writers and African artists. COMIX drawn by African artists are a mean for exploring the complex reality of migrants having a great impact on young people. In particular, the association promoted educational laboratories on the themes of immigration experiences in schools and it was mainly targeted at students of secondary schools wishing (a) to raise awareness about immigration amongst the new generations (G2 and natives); (b) to face school drop-out and; (c) to favour social inclusion and access to labour market of the second generations of migrants; (d) to improve intercultural dialogue and integration as an opportunity for all; (d) school openness towards the territory (associations, the Municipality, students' families, etc....).

2.4.4 The use of technology

Innovation in the field of education is also connected with the introduction of ICT in schools (i.e. Web-based resources in higher education; the role of students as effective technology mentors) and with the debates around *e-inclusion* and digital divides. Underlining the use of digital

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[111] Synthetic documents available at the link http://www.education.gov.uk/schools/toolsandinitiatives/ tripsresearchdigests/a0013242/themes-behaviourthat summaries research written for practitioners on managing behaviour in the classroom (Department for Education, UK).

technologies to enable children with learning difficulties there is the refusal of a medical and deterministic model in favour of a social model of inclusion. As highlighted in the report E-inclusion: Learning Difficulties and Digital Technologies (2007): 'E-inclusion is a much more recent term which is often used to refer to the use of digital technologies to break down barriers of gender, race, age, sexuality or class….e-inclusion has links with developments in the disability studies movement, and the emphasis to be found there on issues such as culture, agency and identity' (Abbott, 2007; Riddell and Watson 2003; Shakespeare 1994).

Cross-sectoral services

One example of innovation in education- based on IP communication- for access to the labor market is the 'Business Network of Persons with Disabilities' developed in Croatia. The Network is a call center that enables people with disabilities to work from remote locations, overcome architectural barriers and prejudice and to offer a competitive cost of labor. The network seeks to gain national coverage and good contacts with employers, centers for social welfare and all other actors in the labor market. The Business Network seeks to (a) assist four PWD categories in entering the labor market (visual impairment, speech and hearing impairment, physical disability and mental disability); (b) active inclusion of PWDs who are most distanced from the labor marke; (c) active support to PWDs who are out of school with special attention to the highly educated persons; (d) strengthening presentation and employment skills; (e) education of employers and service users in the open labor market; (f) monitoring of and support to employers/employees during contractual terms; (g) work rehabilitation of PWDs who are out of job for 5+ years; (h) innovation regarding employment of persons with severe and multiple disabilities. The Network serves persons aged from 18 to 65 years. While the Business Network seeks to become a Croatian brand, it also plans to offer services beyond Croatia.

2.4.5   Governance, networks and ways of interaction/cooperation

Networks of schools

'Circles of life' (2011-2012) is an educational project which was founded by the San Paolo Foundation of Turin, in Italy, to introduce innovation in the field of education by working with 'networks of schools'. Five schools in Sanremo and Taggia (from kindergarden to elementary, middle and high schools) collaborated to plan, to implement and to evaluate some educational blocks which were competency-based and problem-based. Italian students have in fact lower scores in scientific disciplines (mathematics, biology, chemistry, physics etc) than other Countries, as it results in the international surveys (i.e OCSE PISA survey). Some Italian teachers say that they have difficulties motivating their students to study scientific disciplines. In most of the Italian schools teachers prefer to use more teacher centered methods and the transmission of theoretical knowledge instead of adopting a student centered education and experiential, active and interactive learning. The project's goals are to introduce an approach which is competency-based, student-centered and problem-based. The project had 4 phases: 1.

Teacher training and supervision; 2. Planning of the educational activities; 3. Implementation of educational activites in the classrooms with students; 4. Evaluation of the educational experience. The project is innovative because: (a) teachers coming from different schools were encouraged to work together (collaborative educational planning among teachers); (b) in each class students worked in active and interactive ways using PBL methodology (introduction of Problem based learning methodology); (c) high schools students taught kindergarden and elementary students (vertical peer education); (d) PBL methodology made students more acquainted with the scientific method which is inductive; (e) students were more motivated to study scientific disciplines (augmentation of intrinsic motivation); (f) comparative evaluation showed that students were more motivated to study scientific disciplines in comparison to other classes which didn't use PBL methodology and their knowledge was significantly better. To share information the Moodle platform (http://formazione.fondazionescuola.it//) has been created. 'Circles of life' project by San Paolo Foundation (Turin) is innovative also for its funding system based on a combination of private resources (the Foundation for School (San Paolo Company of the San Paolo Foundation - 20.000 euro) and public resources (schools involved in the project).

3 FRAMING AND MAPPING INNOVATION IN SOCIAL SERVICES: MAIN CRITERIA

According to the findings of the literature review, the identification of the main criteria of innovation in social services are based on the assumptions that:

i. the social service sector is part of a complex system.

   Social services organizations are (a) confronted with the continuous tension between the legal and institutional logic for service, the modalities of service provision, the relationship between public authorities and external service providers, financing sources for service provision, procedures for setting up quality frameworks/tools and the logic of demand of needs and requirements of clients (i.e. the relational dimension, quality and trust); (b) often the objectives of the actors involved in the social service delivery are contradictory; (c) 'the responsibility for the planning, organization and to some extent funding of services can be highly decentralised'; EC, p. 2011, p. 11);

ii. innovation is a 'context dependent novelty in action'. It involves 'translating new ideas into new forms of action and improved…services' (Jalonen, Juntunen, 2011, p. 402). It also takes forms of 'new practices, intuitions, rites, techniques, customs, manners and mores' (Hochgerner, 2010; Leo, 2001);

iii. the interactive processual dimension involved in social services innovation;

iv. the innovative capacity of service providers may depend on the organizational characteristics, on their structure or culture (organizational level) but also on the interaction of these organizations with the institutional, economic and politic environments (subsystems);

v. innovation in social services have an impact on the institutional framework;

vi. third sector organizations have a relevant role in promoting cultural and organizational innovation in the social sector;

vii. value systems are the socio-cultural foundations of innovations in the social sphere (Hochgerner, 2010, p. 6).

Innovations emerge from particular social contexts (needs, policy frameworks, etc.) and are embedded (or will be embedded) in various cultural, human, organizational and other forms of environment. Enabling conditions for innovation (structures, laws, cultures and values) can be traced in the market, state and civil society such as by crossing the boundaries of these sectors (Murray, Caulier-Grice, Mulgan, 2010, p. 9). As such, innovations must possess some attributes to give them the best possible chance of adoption or success. According to Simmons and Shiffman (2007), innovations must be:

✓ based on sound evidence or espoused by respected persons or institutions in order to be credible (see also Barnett et al. 2011; Fitzgerald et al. 2002; Sibthorpe, Glasgow, and Wells 2005);

✓ observable to ensure that potential users can see the results (see also Racine 2006).

The process of innovation is in motion when it spreads to other actors or in other sectors. To promote the spread of innovation, the full value of new practices and new reference frameworks (in terms of standards, rules) must be made evident. To accomplish this, fitting evaluation processes prove indispensable in order to demonstrate the full scope of innovations introduced in social services;

✓ relevant for addressing persistent or sharply felt problems;

✓ have a relative advantage over existing practices;

✓ easy to install and understand (see also Atun et al. 2006b; Brooks, Pilgrim, and Rogers 2011);

✓ compatible with potential users' established values, norms and facilities;

✓ testable without committing the potential user to complete adoption (Simmons and Shiffman 2007, 6-7; emphasis in original).

Novelty, improvements in effectiveness and efficiency, and sustainability are a first set of criteria to identify innovation in social services. Innovation in social services can be referred both to the social services delivering (new services, new forms of organizations; resources hybridation; targeted action) and to the process of service delivering, including effectiveness of service delivery, quality of provision and potential impact, on the one hand on the provider organization and user, and on the other on institutional, political, organizational, cultural environments and the civil society. Values and the socio-cultural foundations of innovations in the social sphere also should be considered.

Following a comprehensive innovation paradigm, criteria of innovation need also to include change (Hochgerner) in: 'roles (of individuals, CSOs, corporate business, and public institutions); relations (in professional and private environments, networks, collectives), norms (on different levels, legal requirements) and values (custom, manners, mores, ethic/unethical behaviour)' (p. 6).

Criteria and key words highlighted by the review should be analysed considering both different levels of innovation and the processual dimension of innovation.

Levels of innovation are:

- organizational level (i.e. organization of the provision of social services, type of service, target group, delivering logics);

- regulamentory and legislative level ('how services are regulated, organised, provided and financed, the modalities of service provision, the types of relationships between external service providers and public authorities'; EC, 2006, p. 8);

- interactional level – connection and cooperation (partnership, networks, governance);
- professional level (social work methods and practices);
- users level;
- conceptual level and values;
- public policy level (policy framework, programs and social policies);
- financial and economic sustainability level (and scaling-diffusion-transferability of innovation);
- evaluative level and attention to quality (quality standards);

Criteria (and key words) identified are the following:

Organizational level (policy, organizational, sectors)

- New social services designed to face new needs or unmet needs

- Search for new solutions to old needs, new mechanisms or practices introduced in pre-existing social services:

  - to improve access to social services (i.e. more information, increased professionalism in social work sector);

  - to guarantee entitlements (rights) for specific groups or minorities;

  - to satisfy the demand for social services in a more complete and broad way (holistic approach);

  - to guarantee more participation and inclusion of citizens

- New and increased Cross-Sectoral social services

- Cross-Sectoral social services (i.e. teaching art to children while helping their mothers for job seeking and offering jobs for young artists)

- Integrated care practices

- Tearing down walls between sectors and the role of informal care

- Sharing of knowledge

- Better integration of Health and Social sector services

- Territory based social services that contribute to the creation of training and job opportunities for disadvantaged people

- Solidarity-based social services

- Social mediation for impaired and weakened people

- Easy access to housing for poor families

- New interfaces with clients

- Logic(s) of service: Self help or mutual aid logic; Social care logic; Multi-stakeholders logic; Social movements logic

- The development of the self-help sector

- Actors: New organizations (Cooperative society for social service provision –SCOP; Cooperative society as social enterprise with user's involvement –SCIC)

- New legal forms within structured public frameworks (Italy social cooperatives)

- New provider organizations and existing organisations refashioned by new dynamics

- New roles and relations among actors

- New private organizations for profit and non-profit

- Management style in the organization

Regulamentory and legislative level

- New architecture of the provision system

- Socially responsible public contracts and social clauses (outsourcing)

- Adherence to EU standards in transitional economies

- Impact on institutional framework that shape innovation in social services

- New arrangement between one or more government agencies and/or external organization.

Interactional level – Connection and Cooperation (governance and partnership)

- New networks and social movements established in order to design, deliver and finance social services

- Cooperation between sectors, actors and different forms of provision

- Cooperation between local actors

- Increasing communication responsiveness

- Utilizing connectivity and interdependencies

- Modification of organizational systems (models of governance, work organisation, number of involved stakeholders in governance)

- Public sector and local authorities as promoters of innovation and promoters of cross-sectoral policy strategies

- Third sector and user as promoters of innovation

- Volunteer workers and initiatives launched by a group of citizens

- Third sector and user's engagement design (co-design and re-design services)

- Joint decision process

- Decision-making power not based on capital ownership

- Employee and user driven innovation

- Partnerships with users, family carers and user organizations

- Partnership between service users, practitioners and academics

- Community-based and participative health network in a local territory

- Collaboration between public and volunteer organisations (NGOs) or between civil and local networks in collaboration with public organisations and social enterprises

- New techniques for partnership building and functioning

- Impact on social and power relations

Professional level (practitioners)

- New practices in social work

- Innovative tools (i.e Theatre of the Oppressed) and the use of participated methods in social work (i.e. self-help group)

- Networking

- Individualised supports

- New professional skills in social work

- The use of informatics and new technologies in social work

Users

- Participation and involvement of final users of services in designing, delivering and evaluating social services

- Empowerment

- Involvement of final users in promoting equality, effectiveness and control, and adherence to the needs of users

Conceptual Level (and value)

- New models of society - Social goals: participation, user involvement, community benefit

- New paradigms underlying a new social service concept or service delivery model (i.e. new inclusion paradigm; active ageing)

- Relationships and trust

- Pursuing diversity

- Better adjustment to users' needs, more person centred support

- More social services provision in less developed regions

- New concept of accessibility of the service (i.e. for Roma families)

- The concept of 'progressive universalism'

- The Social Care Model

- De-institutionalization and community care; Improved home-based and community services

- Independent living

- Gender and diversity perspectives

- Anti-discrimination and equality process

- Increase of the level of recognition of social values, objectives, paradigms and goals

- New models of interaction leading to social innovation processes

Public policy level (policy framework, programs and social policies)

- The new role of the system governance played by central (or local depending on national arrangements) government

- Impact on public policies: new public policy, programme, measure or intervention

- Joint construction of a space for public action and redefinition of public governance bodies and methods

- Innovative logics for public policies

- Innovating the public sector

- The new wide attention on anti stigma policies

- E-government

Financial and economic sustainability level (and scaling-diffusion-transferability of innovation)

- New ways to overcome budgetary constraints

- New approaches to acquire funding:

- The involvement of private investors

- The introduction of special funds

- The purchase of innovative practices by final users

- Hybridization of resources (market, redistribution, and reciprocity resources)

- New investment sources

- Mobilising community resources, taking full advantage of all endogenous resources

- Improvement in efficiency and effectiveness

- Financial and systemic sustainability, Impact on the economy

- Economic, Environmental and Social Sustainability of Territory based social services

- Financial tools necessary to territorial social initiatives and the way to unlock them

- Capacity of spreading and diffusion

Evaluative level and attention for quality

- Affordability, availability and accessibility

- New standards expected

- New feedback loops from users and specialists

- Social services of excellence as for quality, efficiency and efficacy

- New methods and creative tool-kits to strengthen and renew the quality of social care services

- Low-cost (for user) and high level quality of social services

- Quality assurance, moderation and accreditation mechanisms

- New tools for monitoring social services - hearing all voices (users, organizations, practioners, staff, family and friends):

- Action research

- Alternative economic and social indicators

- Social impact and contribution of innovation in social services to social innovation and social change – Assessment of innovation

- Learning approach to evaluation – 'to learn from failures'

- Developmental evaluation

Specifics for the Health sector

- Disability: from rehabilitation to integration and then to inclusion

- Mental Health: from segregation to inclusion and community care

- HIV: from segregation/stigmatization to awareness campaigns for promoting self protection

- Innovation in the area of prevention, of treatment and in the introduction of new technologies

- Emphasis on an inter-sectoral, controlled and steered care in managed care models, replacement of the traditional insurance model

- Integrated services

- Technological progress

Specifics for the Education sector

- Inclusive education

- Inclusive education and training in collaboration with the civil society

- Multicultural education

- Integration of disciplines

- Alternative schools, non-regular schools and informal education

- Link between formal and informal education

- Community development based approaches

- Connection between regular school and the system of social services

- Experiential learning

- Human rights education

- Working 'through relationships' with children and young people

- Problem based learning methodology

- The 'media education', The use of comics

- ICT in schools

- E-inclusion

- Networks of schools

- Improve, supplement, reinvent and transform learning

- Sustained educational improvement

- Learning Beyond the Classroom

- Spreading a culture that values learning

- More personalized approaches to learning

- Using the web

- Learning with and by not to and from

…..from criteria to dynamics and pattern to change: A Social Services Innovation Framework

Criteria are dynamics and path-dependents. In practice, several of the listed criteria (and/or enabling factors) play their role simultaneously and in different ways depending on context, on the implementation environments and on stages of the social service innovation process. All these factors have a significant effect on the capacity of innovation to spread and to be sustainable. Contextual fit (and diffusion), improve quality and sustainability are hallmarks of an innovation.

Following a complexity and a systemic perspective, the criteria listed above are useful in framing and mapping (and evaluating) dynamics and pattern of change driven by innovations in social services. These dynamics and pattern of change need to be analyzed in relation to the social sector level and to other subsystems (or sectors) that interact with the social service sector.

Combining the theoretical contributions with the empirical studies selected for the literature review carried out and presented here, the resulting conceptualization of innovation in social services in Europe can be understood as an innovation process framework. The focus is on social services innovation as a process by which different sector of society responses to current socio-demographic and policy challenges both changing service policies and impacting on the real life of people.

According to this framework, social service can only be considered innovative if introducing:

- new forms of service,

- new forms of outcome,

- new ways of delivery/process,

- new forms of governance,

- new forms of resourcing,

- new way of monitoring,

establishes new practices for old needs, new perspectives on old needs or new practices for a new need. As a result of this literature review, the 'Blurring Approach' (e.g. blurring boundaries profit and nonprofit organization, integrated social services approaches, sectors and professional expertise) there emerged as the most promising avenue for future social services innovation.

ANNEX 1: TEMPLATE FOR LITERATURE REVIEW

In order to collect the kind of information we are looking for and subsequently to systematise the literature search, the follow list of key word has been used:

Themes

> Innovation, Social Innovation, Innovation in Social Services.
>
> Socio-Institutional and Governance Factors supporting the innovation in SS (i.e. institutional framework, model of financing SS, governance, partnership and networking).
>
> New/emerging social problems and challenges (i.e. disability and increasing life expectancy), new Approach to an old Social Problem.
>
> New Social Services.
>
> Mixing Different Fields of Services.
>
> Knowledge Creation Process and Experience Knowledge.
>
> Methods of Service Delivery with or not a technological component.
>
> The introduction of Informatics and New Technologies (i.e. devices, teleassistence) in social work.
>
> Process Innovation and Territorial-Local Development.
>
> Social Reforms introduced.
>
> Evaluating Innovation in Social Services, Performance Indicators, Social Benefits.
>
> Failures in Supporting, Researching and Evaluating Innovation in SS.
>
> New perspectives in the concept of wellbeing.

Actors

Innovators: main actors in the innovation process.

The new role of patients and users (as expert users/patients directly involved in care activities).

The new role of the family and relatives in care.

Fields (Social Services)

> Innovation and Health, Education and Welfare Services.
>
> Innovation in terms of integration between policy fields and approaches (i.e. integrated care, cooperation between health and social care, intergenerational project).
>
> Social Innovation and Education.
>
> Innovation in Parenting Support and child policies.
>
> Innovation in the reconciliation between Family and Working Life.
>
> Innovation in the support to mental health.

Innovation in old age policies and challenges(i.e. new technologies, new forms of housing for the elderly).

Innovation in Disability policies and challenges (i.e. new technologies, new forms of housing, community care).

Innovation in Migration policies and challenges and Access to Social Rights.

Innovation in Poverty and Social Exclusion policies and challenges.

Please add key words if you have the feeling the words below do not cover the relevant issues in your country/language.

The above keywords are, of course, not exhaustive. LR is an ongoing process and doing it the list of key words first suggested can be better refined .

Key words	
Themes	....
Fields	....

TEMPLATE

Definition of 'innovation in social services' and 'social innovation' as in the LR of the covered language;

An overview of the main research fields and findings on innovation in social services:

Innovation in the field of Health Services.

Innovation in the field of Education Services.

Innovation in the field of Welfare Services.

Innovation in Cross-Sectoral Social Services.

Trends for social service provision, their logic, problematic aspects and gaps within our scientific knowledge;

Socio-economic impact of innovations in SS, assessment and evaluation.

Total length: approximately 5 pages. When no information is available please mention so and concentrate on the other sections. Please indicate the documentation you refer to and provide references for all information you give.

BIBLIOGRAPHY

General literature on service innovation, social innovation, innovation and social services

Abernathy, W. J., Utterback, J. M. (1978) 'Patterns of Industrial Innovation'. *Technology Review*, 80(7), 40-47

Alter, N. (1998) 'Action, culture et logiques d'innovation (Commentaire)'. *Sciences sociales et santé*, pp. 123–134

Altshuler A. A., and Zegans, M. D. (1997) 'Innovation and Pub-lic Management: Notes from the State House and City Hall', in Altshuler A. A. and Behn, R. D. (eds.), *Innovation in American Government. Challenges, Opportunities, and Dilemmas.* Brookings Institution Press: Washington D.C.

Bandt, J. de, Gadrey, J. (1994) *Relations de service, marchés de services.* Paris: CNRS editions

Barthélemy, A., Romain, S. (2011) *Entrepreneuriat social: innover au service de l'intérêt général: panorama, enjeux, outils.* Paris: Vuibert

Bason, C. (2007) *Velfærdsinnovation - ledelse af nytænkning i den offentlige sector.* København: Børsen Offentlig

Bessant, J., Davies, A. (2007) *Managing service innovation in Innovation in services*, DTI occasional paper no. 9. UK

Borzaga, C., Santuari, A. (2001), 'Italy. From traditional co-operatives to innovative social enterprises', in Borzaga, C. and Defourny, J. (ed.), *The Emergence of Social Enterprise*, pp. 166-181

Bouchard, M. J. (2005) 'De l'expérimentation à l'institutionnalisation positive, l'innovation sociale dans le logement communautaire au Québec'. *Annales de l'économie publique, sociale et coopérative /Annals of Public and Cooperative Economics*, pp-139–166

Bouchard, M.J., et Université du Québec à Montréal. Chaire de recherche du Canada en économie sociale (2006) *L'innovation sociale en économie sociale.* Montréal: Chaire de recherche du Canada en économie sociale, Université du Québec à Montréal

Bührlen, B. (Hg.) (2008) *Innovationssystem Gesundheit: Ziele und Nutzen von Gesundheitsinnovationen. Ergebnisse des 1.* MetaForums 'Innovation im Gesundheitswesen'. Stuttgart: Fraunhofer-IRB-Verl

Bundesverband der Deutschen Industrie - BDI (2011) *Für eine starke Gesundheitswirtschaft in Deutschland. Positionen für ein innovationstreibendes, dynamisches und solidarisches Gesundheitssystem.* Online verfügbar unter http://www.wirtschaftfuergesundheit.de/files/Broschuere_BDI_Gesundheit.pdf

Bührlen, B., Kickbusch, I. (2008) *Innovationssystem Gesundheit. Ziele und Nutzen von Gesundheitsinnovationen: Ergebnisse des 1. Metaforums 'Innovation im Gesundheitswesen'.* Stuttgart: Fraunhofer IRB Verlag

Camacho, J.A., Rodriguez, M. (2008) 'Patterns of innovation in the service sector: some insights from the Spanish survey'. *Economics of innovation & new technology*, 17 (5), pp. 459-471

Christensen, C. (1997) *The innovator's dilemma: when new technologies cause great firms to fail.* Boston, Mass: Harvard Business School Press

Chesbrough, H.W. (2003) *Open Innovation: The New Imperative for Creating and Profiting from Technology.* Boston, Mass: Harvard Business School Press

CLIPS [http://www.ruc.dk/en/research/search-research-centers/demnetgov/research-projects/clips/] down loaded 03.04.2012

Cooke, P., Schwartz, D. (eds) (2007) *Creative Regions. Technology, culture and Knowledge Entrepreneurship.* London and New York: Routledge

Cornforth, C. and Spear, R. (2010) 'The governance of hybrid organisations', in David, B. (ed.) *Hybrid Organizations and the Third Sector: Challenges for Practice, Theory and Policy.* Basingstoke, UK: Palgrave

Dandurand, L. (2005) 'Réflexion autour du concept d'innovation sociale, approche historique et comparative'. *Revue française d'administration publique* , 115(3):377

Degavre, F., Nyssens, M. (2008) 'L'innovation sociale dans les services d'aide à domicile. Les apports d'une lecture polanyienne et féministe'. *Revue Française de Socio-Économie*, 2(2):79

Djellal, F., Gallouj F. (2000) 'Le «casse-tête» de la mesure de l'innovation dans les services : enquête sur les enquêtes'. *Revue d'économie industrielle*, n°93, 4ème trimestre, pp. 7–28

Djellal, F., Gallouj, F. (2009) 'Innovation dans les services et entrepreneuriaT : au-delà des conceptions industrialistes et technologistes du développement durable'. *Innovations*, 29(1):59

Djellal, F., Gallouj, F. (2011) *Social Innovation and Service Innovation.* Power point presentation at the Challenge Social Innovation Conference, Vienna, 19-21 September 2011

Döhner, H. (2002) Projekt 'Synopse innovativer Ansätze zur vernetzten Versorgung älterer Menschen in Deutschland' ProNETZ. Im Auftrag des AOK Bundesverband. Online verfügbar unter http://www.uke.de/institute/medizin-soziologie/downloads/institut-medizin-soziologie/ProNETZ_BERICHT_030614.pdf

Drejer, I. (2004) 'Identifying Innovation in Surveys of Services: A Schumpeterian Perspective'. *Research Policy*, 33(3), 551-562

Drucker, P. F. (1985) *Innovation and Entrepreneurship: Practices and Principles.* Oxford: Butterworth-Heinemann Ltd

EC with Europe Innova, The Expert Panel on Service Innovation in the EU (2011) *Meeting the challenge of Europe 2020. The transformative power of service innovation*

Fagerberg, J., Mowery, D.C., Nelson, R.R. (eds) (2005) *The Oxford Handbook of Innovation*. New York: Oxford University Press

Faridah, F. , Gallouj, F. (2000) 'Le «casse-tête» de la mesure de l'innovation dans les services : enquête sur les enquêtes'. *Revue d'économie industri elle*, pp. 7–28

Fazzi, L. (2011) *L'innovazione nelle cooperative sociali in Italia*, Euricse, Confcooperative Federsolidarietà. Available at http://www.federsolidarieta.confcooperative.it/ Lists/MediaStampaPubblicazioni/Attachments/3/Innovazione%20nelle%20cooperative% 20sociali.pdf

Gadrey, J. (2003) *Socio-économie des services*. Paris: La Découverte

Gallouj, F. (2002) *Innovation in the service economy: The new wealth of nations*. Edward Elgar, Cheltenham

Gallouj, F., Savona, M. (2009) 'Innovation in services: a review of the debate and a research agenda'. *Journal of evolutionary economics*, Volume 19, Number 2 (2009), pp. 149-172

Gersch, M., Schröder, S., Hewing, M. (2011) *E-Health@Home. Forschung – Gestaltung – Implementierung. Verbundprojekt „Entwicklung von Geschäftsmodellen zur Unterstützung eines selbst bestimmten Lebens in einer alternden Gesellschaft. Erlös- und Finanzierungsmöglichkeiten innovativer Versorgungs- und Geschäftssysteme im Gesundheitswesen – Systematischer Überblick und exemplarische Analyse ausgewählter Geschäftssysteme'*. Bundesministerium für Bildung und Forschung. Online verfügbar unter http://www.wiwiss.fu-berlin.de/institute/abv/gersch/ressourcen/E-Health/Gersch-Schroeder-Hewing_2011_Erloes _und_Finanzierungsmoeglichkeiten_innovativer_Geschaeftssysteme.pdf

Greß, S. (2010) *Investitionsförderung für eine soziale und innovative Gesundheitswirtschaft. Bewertung unterschiedlicher Optionen*. Expertise im Auftrag des Gesprächskreises Sozialpolitik der Friedrich-Ebert-Stiftung. Bonn: Friedrich-Ebert-Stiftung, Abt. Wirtschafts- u. Sozialpolitik

Greenhalgh, T., Robert, G., MacFarland, F., Bate, P., Kyriakidou, O.(2004) 'Diffusion of innovation in service organizations: Systematic review and recommendations'. *The Milbank Quarterly*, 82(2), pp. 581-629

Hage, J., Meeus, M. (eds) (2006) *Innovation, Science, and Institutional Change: A Research Handbook*. Oxford: Oxford University

Hayes, R.H., Wheelwright, S.C. (1984) *Restoring our Competitive Edge: competing through manufacturing*. New York: John Wiley & Sons

Hermel, L., Gérard, L. (2008) *Innovation dans les services*. La Plaine Saint-Denis, France: Afnor

Hilbert, J., Evans, M., (2009) *Mehr Gesundheit wagen! Gesundheits- und Pflegedienste innovativ gestalten; Memorandum des Arbeitskreises Dienstleistungen*. Bonn

Hochgerner, J. (2010), 'Considering the social relevance of innovations' (preface), in Howaldt, J., Schwarz. M., *Social Innovation: Concepts, research fields and international trends*. RWTH Aachen University - Department of Information Management in Mech. Engineering: Aaachen

Hochgerner, J. (2011) *Social Innovation. A Call for Broadening of the Innovation Paradigm* at the 'Capacity Building on Social Innovation Research and Management in South East Europe' Conference, May 4, 2011, power point presentation

Howaldt, J., Schwarz. M. (2010*) Social Innovation: Concepts, research fields and international trends*. RWTH Aachen University - Department of Information Management in Mech. Engineering: Aaachen

Hermans, K., Vranken, R. (2010) *Switch the light on green for innovation in care. Practice book*. Brussels: Flemish federation of welfare

Hermel, L., Louyat, G. (2008) *Innovation dans les services*. La Plaine Saint-Denis. France: Afnor

Jæger, B. (2011) 'Brugerdrevet innovation i den offentlige sector', in Kristensen, C., Voxted, S. (eds) *Innovation og entreprenørskab*. København: Hans Reitzels Forlag

Jalonen, H., Juntunen, P. (2011) 'Enabling Innovation in Complex Welfare Service Systems'. *Journal of Service Science and Management*, 4, 401-418

Kallen, H. (1949) *Innovation*, in *Encyklopedia of the Social Sciences*, Vol. 8

Kartte, J. (2005) *Innovation und Wachstum im Gesundheitswesen*. Hg. v. Roland Berger Strategy Consults. Online verfügbar unter http://www.hem.bwl.uni-muenchen.de/studium/download/gs_puo/rb_studie.pdf

Keller, C., Gare, K., Edenius, M., Lindblad, S. (2010) 'Innovations in Health Care: Design Theory and Realist Evaluation Combined'. *Sprouts: Working Papers on Information Systems*, 10(66). http://sprouts.aisnet.org/10-66

Klein, J., Harrison, D. (2007), *L'innovation sociale émergence et effets sur la transformation des sociétés*. Montréal: Presses de l'Université du Québec

Kristensen, C., J., Voxted, S. (2009) *Innovation. Medarbejder og bruger*. Hans Reitzels Forlag: København

Kristensen, C. J., Voxted, S. (2011) *Innovation og entreprenørskab*. Hans Reitzels Forlag: København

Laborier, P., Trom, D., Groupe de sociologie politique et morale (Paris), et Centre universitaire de recherches administratives et politiques (Amiens) (2003) *Historicités de l'action publique*. Paris: Presses universitaires de France

Laville, J. (2005) *Sociologie des services: entre marché et solidarité. Ramonville Saint-Agne*. France: Erès

Laville, J. (2011) *Innovation sociale, économie sociale et solidaire, entrepreneuriat social. Éléments pour une mise en perspective historique* (Document de travail)

Leadbeater, C. (2007) *Social enterprise and social innovation: Strategies for the next ten years.* A social enterprise think piece for the Office of the Third Sector. UK

Leich, D. M., Gökduman, B. S., Baaken, T. (2009) *Service Innovation. An evaluation of new service development practice.* Project Report. Germany

Leo, N., (2001) *Der sechste Kondratieff. Wege zur Produktivität und Vollbeschäftigung im Zeitalter der Information.* Rhein-Sieg Verlag: St. Augustin

Leys, M. (2009) *Technology and innovation in the elderly care.* Care symposium, Aalst 10 september 2009

Lévesque, B., La jeunesse-Crevier, F., CRISES (2005) *Innovations et transformations sociales dans le développement économique et le développement social: approches théoriques et politiques publiques.* coll. « Études théoriques ». Montréal: Centre de recherche sur les innovations sociales (CRISES)

Lipietz, A. (2001) *Pour le tiers secteur: l'économie sociale et solidaire: pourquoi, comment.* Paris: La Documentation française/La Découverte

Loncle, P. (2005) 'Territoires et innovation sociale'. *Revue française d'administration publique,* 115(3):399

Lucas, R. (1988), 'On the mechanisms of economic development'. *Journal of monetary economics,* 22, pp.3–42

Mendell, M. (2006) 'Karl Polanyi et le processus institué de démocratisation économique'. *Revue Interventions économiques,* 33

Moulaert, F., Martinelli, F., Swyngedouw, E., Gonzalez, S. (2005) 'Towards Alternative Model(s) of Local Innovation'. *Urban Studies,* 42 (11), pp. 1669-1990

Mulgan, G., Tucker, S., Ali, R., Sanders, B. (2007) *Social innovation: What it is, why it matters and how it can be accelerated.* London: The Young Foundation

Murray R., Caulier-Grice J., Mulgan G. (2010), *The open book of social innovation.* London: NESTA

Nussbaumer, J., & Moulaert, F. (2007), 'L'innovation sociale au coeur des débats publics et scientifiques', in Klein J. & Harrison, D. (eds.), *L'innovation sociale: émergence et effets sur la transformation des sociétés.* Montréal: Presses de l'Université du Québec

OECD (2002) *Frascati Manual 2002: Proposed Standard Practice for Surveys on Research and Experimental Development,* The Measurement of Scientific and Technological Activities. OECD Publishing

OECD/Statistical Office of the European Communities, Luxembourg (2005), *Oslo Manual: Guidelines for Collecting and Interpreting Innovation Data, 3rd Edition,* The Measurement of Scientific and Technological Activities. OECD Publishing

Osborne, S. (1998), 'Naming the Beast. Defining and Classifying Service Innovations in Social Policy'. *Human Relations,* (51, 9) pp. 1133-1154

Osborne, S., Brown K. (2005) *Managing Change and Innovation in Public Service Organizations*. London and NY: Routledge

Osborne, S., Chew, C., & McLaughlin, K. (2008) 'The innovative capacity of voluntary organizations and the provision of public services: A longitudinal approach'. Special issue on Innovation in Public Services. *Public Management Review*, 10:1, pp 51-70

Pack, J., Buck, H., Kistler, E., Mendius, H. G., Morschhäuser, M., Wolff, H. (2000) *Zukunftsreport Demographischer Wandel. Innovationsfähigkeit in einer alternden Gesellschaft*. Online verfügbar unter http://www.demotrans.de/documents/Zukunft-dt.pdf

Patton, M. Q. (2011) *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use*. New York: The Guilford Press

Pavitt, K. (1984) 'Patterns of technical change: towards a taxonomy and a theory'. *Research Policy*, 13, 343-373

Perrin, B. (2001) 'How to — and How Not to — Evaluate Innovation'. *Evaluation*, January 2002, vol. 8, 1: pp. 13-28

Pestoff ,V., Brandsen, T. (2009) 'Public governance and the third sector: opportunities for co-production and innovation?', in Osborne, S. (eds.), *The New Public Governance? New Perspectives on the Theory and Practice of Public Governance*. London & New York:Routledge

Phills J. A., Deiglmeier, K., Miller D.T. (2008) 'Rediscovering Social Innovation'. *Stanford Social Innovation Review*, Vol.6, No.4, pp. 34-43. Available at http://www.ssireview.org/articles/entry/rediscovering_social_innovation

Radice, H. (2000) in Mendell, M. (2006) 'Karl Polanyi et le processus institué de démocratisation économique'. *Revue Interventions économiques*, 33 french rev.

Rees, J., Mullins, D., Bovaird, T. (2012) *Third sector partnerships for public service delivery: an evidence review*, Working Paper 60. Birmingham: Third Sector Research Centre

REVES - European Network of Cities and Regions for Social Economy (2007) *A guide for a local strategic approach to the reconciliation of work, family and public life*. Catania: Mesogea

Richez-Battesti, N., Vallade, D. (2009) 'Économie sociale et solidaire et innovation sociale: Premières observations sur un incubateur dedié en Languedoc Roussillon'. *Innovations*, 30(2):41

Romer, P. (1986) 'Increasing returns and long-run growth'. *Journal of political economy*, 94, pp.1002–1037

Romer, P. (1990) 'Endogenous technical change'. *Journal of political economy*, 98, pp.71-102

Rubalcaba, L. (1999) *Business Services in European Industry: Employment, Growth and Competitiveness*. European Commission

Rubalcaba, L. (2011) 'The challanges for service innovation and service innovation policies', in UNECE (ed) *Promoting innovation in the service*. New York and Geneva: United Nations

Schalock, R. L. (2004) 'The emerging disability paradigm and its implications for policy and practice'. *Journal of Disability Policy Studies*, 14(4), pp. 204-215

Schultz, C., Zippel-Schultz, B., Salomo, S. (2011) *Innovationen im Krankenhaus sind machbar! Innovationsmanagement als Erfolgsfaktor*. Stuttgart: Kohlhammer

Schumpelick, V. (Hg.) (2010) *Innovationen in Medizin und Gesundheitswesen*. Beiträge des Symposiums vom 24. - 26. September 2009 in Cadenabbia. Freiburg im Breisgau; Basel. Wien: Herder

Shaping Our Lives, National Centre for Independent Living and University of Leeds Centre for Disability Studies (2007) *Developing social care: service users driving culture change*. London: Social Care Institute for Excellence

Sørensen, E., Torfing, J. (eds) (2011) *Samarbejdsdrevet innovation – i den offentlige sektor*. København: Jurist og Økonomiforbundets Forlag

Spear, R. (2011) *Innovation and collective entrepreneurship*, in *FIESS - International Forum on the Social and Solidarity Economy*, 17-20 October 2011, Montreal

Spear, R. (2012) 'Hybridite des co-operatives', in Jérôme, B., Colongo, D. (eds.) *Les contributions des coopératives à une économie plurielle. Les cahiers de l'économie sociale. Entreprendre autrement*. Paris: L'Harmattan

Tether, B., Howells, J. (2007) 'Changing understanding of innovation in services', in DTI (eds), *Innovation in Services*, Dti Occasional paper No 9. Department of Trade and Industry. UK

United Nations Economic Commission for Europe (UNECE) (2011) *Promoting innovation in the service*. New York and Geneva: United Nations

Van Ark, B., Broersma, L. and den Hertog, P. (2003) *Services innovation, performance and policy: a review. Synthesis report in the framework of the SID project (structural information provision on innovation in services)*. The Hague: Directorate-General for Innovation, Ministry of Economic Affairs

Van Gyes, G., Vandenbrande, T. (2005) *Innovation and labour issues. A literature study of policy uncertainties from the Flemish point of view*. Leuven: Higher Institute for Labour

Webpages:

http://www.ciriec.ulg.ac.be/en/pages/6_0publications.htm

http://euricse.eu/it/pubblicazioni

http://www.socialinnovationeurope.eu/

http://socialinnovator.info

http://www.ssireview.org/articles/entry/rediscovering_social_innovation/

European Documents and Publications

BEPA – EC (2011) *Empowering people, driving change. Social Innovation in the European Union.* Luxembourg: Publications Office of the European Union

Corsi, M., Samek Lodovici, M. with Eggsi Network (2011) *Active Ageing and Gender Equality Policies: The employment and social inclusion of women and men of late working and early retirement age,* for the DG Employment of the European Commission. Luxembourg: Publications office of the European Union

Council of Europe (2007) *Study on Integrated Social Services*

Crepaldi, C., Barbera, M., Boccagni, P., Naaf, S. (2008) *The social situation of the Roma and their improved access to the labour market in the EU*, European Parliament http://www.europarl.europa.eu/activities/committees/studies/download.do?file=23375

Crepaldi, C., Samek Lodovici, M., Corsi, M. (2010) *Access to Healthcare and Long-Term Care: Equal for Women and Men?,* for the DG Employment of the European Commission. Luxembourg: Publications office of the European Union, ISBN 978-92-79-14854-5 http://ec.europa.eu/social/BlobServlet?docId=5590&langId=en

Crepaldi, C., Pasquinelli, S., Castegnaro, C., Naaf, S. (2011) *Parenting support in Europe: a comparative study of policies and practices,* for the European Founadtion for living and working conditions,* November 2011

European Commission (1995) *Green Paper on Innovation*, COM(95) 688, December 1995

European Commission (2004) *Green paper on public-private partnerships and community law on public contracts and concessions* (COM/2004/327 final)

European Commission (2005) *Communication on public-private partnerships and community law on public contracts and concessions* (COM/2005/0569 final)

European Commission (2005) *Report on the public consultation on the green paper on public-private partnerships and community law on public contracts and concessions.* SEC(2005)629

European Commission (2006) Equality and Non-Discrimination: Annual Report 2005

European Commission (2006) *Communication of the Commission on SSGI*

European Commission (2007) *Communication of the Commission on SGI and SSGI, including the frequently asked questions (FAQ) documents on EU rules and SGI/SSGI*

European Commission (2006/2007) *Study on Social and Health Services of General Interest in the European Union*

European Commission (2008) *First Biennial Report of the European Commission on Social Services of General Interest*

European Commission (2009) *Mobilizing private and public investment for recovery and long term structural change: developing Public Private Partnerships* (COM/2009/615 final)

European Commission - DG Employment (2009) *Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care*

European Commission (2010) *Buying Social - A Guide to Taking Account of Social Considerations in Public Procurement*

European Commission (2010) *Guide to the application of the European Union rules on state aid, public procurement and the internal market to services of general economic interest, and in particular to social services of general interest*

European Commission (2010) *Second Biennial Report on Social Services of General Interest*

European Commission (2010) *Social innovation as part of the Europe 2020 strategy*

European Commission (2011) *Study on social services of general interest. Final Report*

European Parliament resolution of 18 December 2008 on delivering lifelong learning for knowledge, creativity and innovation - implementation of the 'Education & Training 2010 work programme'

European Social Network (2011) *Mental Health and Wellbeing in Europe – A Person-Centered Community Approach*

FRA (2010) *The fundamental rights of persons with intellectual disabilities and persons with mental health problems. http://fra.europa.eu/fraWebsite/attachments/disability-factsheet_EN.pdf*

FRA (2010) *Key rights of persons with disabilities: an introduction. http://fra.europa.eu/fraWebsite/attachments/disability_key%20rights_factsheet_EN.pdf*

FRA (2011) *Human rights education at Holocaust memorial sites across the European Union: An overview of practices.* http://fra.europa.eu/fraWebsite/research/publications/ publications_per_year/2011/pub-holocaust-education-overview-practices_en.htm

FRA (2011) *Respect for and protection of persons belonging to minorities 2008-2010.* http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/2011/pub -respect-protection-minorities_en.htm

FRA (2011) *The legal protection of persons with mental health problems under non-discrimination law. http://fra.europa.eu/fraWebsite/attachments/FRA-2011-Legal-protection-persons-mental-health-problems_EN.pdf*

Freyhoff, G., Parker, C., Coué, M., Greig, N. (2004) *Included in Society: Results and recommendations of the European research initiative on community-based residential alternatives for disabled people*. Brussels: Inclusion Europe

Huber, M., Maucher, M., Sak, B. et al. (2006) *Study on Social and Health Services of General Interest in the European Union*. Final Synthesis Report (SHSGI Report)

McCollam, A., O'Sulliva Maarit Mukkala, C., Stengård, E., Rowe, P. (2008) *Mental Health in the EU Key Facts, Figures, and Activities, A Background Paper provided by the SUPPORT-project*. European Commission DG health and Consumers

Pro Inno Europe (2008), *European Innovation Progress report*

Samek Lodovici, M., Crepaldi, C., Boccagni, P., Vasilescu, C., Corsi, M., with Eggsi Network (2009) *Ethnic minority and Roma women in Europe: A case for gender equality*?, Eu Commission, DG Employment http://ec.europa.eu/social/main.jsp?catId=748&langId =en&moreDocuments=yes

Social Protection Committee (SPC) (2008) *Report of the Social Protection Committee on the application of Community Rules to SSGI*, December 2008

Social Protection Committee (2010) *A Voluntary European Quality Framework for Social Services* (SPC/2010/10/8 final)

Croatian literature

Ajduković, M. (2008) 'Social Problems, social risks and Modern Social Work'. *Rev. soc. polit., god. 15, br. 3, str 395-414, Zagreb 2008,* p. 18

Aralica, Z., Bačić, K. (2010) 'Evaluation of Croatian Innovation Capability'. *The Institute of Economics*

Švarc, J. (2004) *Innovation Policy in Croatia: the First 10 Years*. Institute of social sciences "Ivo Pilar", Zagreb, Croatia. http://socialinnovationeurope.eu/directory/croatia/social-innovation-croatia

Stubbs, P. (2011) *Promoting Social Innovations for Inclusion in the Western Balkans: key challenges*. The Institute of Economics Zagreb, presentation at Challenge Social Innovation, Innovating innovation by research – 100 years after Schumpeter, ICICI 2011 International Conference on Indicators and Concepts of Innovation

UNDP (2006) *United Nations Development Programme: Neumreženi: lica socijalne isključenosti u Hrvatskoj,* www.undp.hr

Zagreb B. E., Švarc, J., 'Smart specialisation: some considerations of the Croatian practice'. *Int. J. Transitions and Innovation Systems*, Vol. 1, n. 1, pp.25–43. Inderscience Enterprises Ltd.

Webpages:

SIL http://socialinnovationeurope.eu/directory/organisation/social-innovation-laboratory

BTD http://www.gmfus.org/grants-fellowships/grantmaking-programs/balkan-trust-for-democracy

Czech and Slovak literature

Allen et al. (2011) 'Správa, riadenie a financovanie dlhodobej starostlivosti v Európe', in Repková K. (Ed.) *Dlhodobá starostlivosť o starších ľudí na Slovensku a v Európe (3) - Správa, riadenie a financovanie*. Bratislava: Inštitút pre výskum práce a rodiny

Almerová, Z., Kubálková, P., Kundra, L., Ladmanová, M., Lukášová, M., Vrbová, L. Wennerholm Čáslavská, T. (2008) *Projekt Prolomit Vlny – záverečná správa*. Praha: Open Society Foundation

Association Orava for Democracy in Education (2011) *Report on Activities and Management, Plan of activities*

Bednárik, R., Brichtová, L., Repková, K. (2011) *Národná správa o riadení a financovaní dlhodobej starostlivosti – Slovensko*, in Repková K. (Ed.) *Dlhodobá starostlivosť o starších ľudí na Slovensku a v Európe (3) - Správa, riadenie a financovanie*. Bratislava: Inštitút pre výskum práce a rodiny

Bočková, L., Hastrmanová, Š., Havrdová, E. (2011) *50+ Aktivně - Fakta, inspirace a rady do druhé poloviny života*. Praha: Respekt Institut

Czech Statistical Office (2007) *Výsledky výbêrového šetření zdravotnê postižených osob za rok 2007*

Dobrotková, M. (2011) *Sociálne služby sú vizitka štátu a samospráv*. Presentation at Conference on Future of the Slovak Social System, October 2011

Foundation Škola Dokorán (2010) *Annual Report 2010*

Holubová, B. (2011) '*Aktívne otcovstvo a inovatívne verejno-politické opatrenia pre jeho podporu*', in Lubelcová G. (ed.) *Inovácie v sociálnych a verejných politikách – Problémy konceptualizácie nových nástrojov*. Bratislava: Vydavateľstvo Univerzity Komenského v Bratislave

Kočišová, A., Žiaková, E., Šiňanská, K. (2010) 'Prínos chránených dielní a chránených pracovísk pri sociálnej inklúzii osôb so zdravotným znevýhodnením', in Sedláková M., Šlosár, D. (eds.) *Budovanie spoločnej cesty k sociálnej inklúzii*. Košice: Technical University

Kottulová, J. (2011) 'Štrukturálne fondy ako nástroj rozvoja spoločenských inovácií? Príklad uplaťnenia rodového hľadiska', in Lubelcová G. (Ed.) *Inovácie v sociálnych a verejných politikách – Problémy konceptualizácie nových nástrojov*. Bratislava: Vydavateľstvo Univerzity Komenského v Bratislave

Krupa, S. et al. (2006) *Rozvoj komunitných služieb – učebné texty k projektu Transformácia zariadení sociálnych služieb s cieľom sociálnej a pracovnej integrácie ich obyvateľov*

Kvašňáková, L., Balogová, B. (2011) 'Sociálnoprávna ochrana detí a posudzovanie situácie ohrozenej rodiny', in Sipko, J., Chovanec M. (eds.) *5. Študenstská vedecká konferencia*

Ministry of Employment and Social Affairs (2005) *Preliminary National Report on Health Care and Long-term Care 2005*

Musil, L., Hubíková, O., Kubalčíková, K., Havlíková, J. (2007) *Působení politiky sociálních služeb na kulturu poskytování osobních sociálních služeb ve vybrané organizaci*. Praha: Výzkumný ústav práce a sociálních věcí

Pilát, M. (2011) 'Standardy kvality sociálních služeb v České republice', in Kamanová, I., Štefánková, L., Juhásová, L. (eds.) *Inovácie, plánovanie a kvalita sociálnych služieb v komunite*. Ružomberok

Petrasová, A., Maslová, M., Hubová, M. (2011) *Model profesijných štandardov multikultúrnej výchovy pre učiteľov ZŠ.* Bratislava: Orava Association for Democracy in Education

Průcha, J. (2004) *Alternativní školy a inovace ve vzdělávání.* 2. Vydání. Praha: Portál

Repková, K. (2005) 'Verejná podpora zamestnanosti občanom so zdravotným postihnutím', in Reichová, D., Repková, K. (eds.) *Podpora zamestnávania osôb občanov so zdravotným postihnutím.* Rodina a Práca 7/2005. Bratislava

Repková, K. (2008) 'Občianska organizovanosť osôb s zdravtoným postihnutím a sociálny capital'. *Sociológia 40,* No. 4. 326-346

Sedláková, M. (2010) 'Nezávislý život osôb so zdravotným znevýhodnením', in Sedláková M. and Šlosár D. (eds.) *Budovanie spoločnej cesty k sociálnej inklúzií.* Košice: Technical University

Staroňová, K., Malíková, Ľ. (2008) 'Inovácie v sociálnych službách: Prípadová štúdia domovov dôchodcov na Slovensku'. *Sociológia 40,* No. 5. 435-450

State Pedagogical Institute (2011) *Pedagogické inovácie na Slovensku z pohľadu učiteľov a riaditeľov ZŠ – Priblížnie výsledkov výskumu.* Bratislava

Webpages:

http://www.inovaceprospolecnost.cz/clanky
http://www.navrat.sk/?lang=SK&cat=a5ec1d344ccb3dedec6354de61dafe01

http://nadacesirius.cz/en/activities/child-in-danger-diagnostics

http://www.obecpratelskarodine.cz/cz/o-soutezi/

http://www.slovo21.cz/nove/index.php?option=com_content&view=article&id=52:rodina-od-vedle&catid=36:integrace-cizinc&Itemid=41&lang=en

http://inbaze.cz/en/index.php?option=com_content&view=article&id=5&Itemid=14

http://www.zdruzenieorava.sk/projekty/preco-skola-ktorej-to-mysli_sk

www.multikulti.sk

http://www.ptac.cz/index.php

http://www.hodnoceni-nemocnic.cz/

http://www.health.gov.sk/?vseobecne-informacie-o-ehealth

http://www.chodicilide.cz/#o-projektu

http://www.kontobariery.cz/home.aspx

http://www.praha.apla.cz/

http://www.lepsisvet.org/text/4/Sluzby

http://www.zpmpvsr.sk/index.php?option=com_frontpage&Itemid=1

http://www.esfem.sk/

http://www.aspekt.sk/

Danish literature

Agger, A., Lund, D. H. (2011) 'Borgerne og brugerne i samarbejdsdrevne innovationsprocesser', in Sørensen, E., Torfing, J. (eds) *Samarbejdsdrevet innovation – i den offentlige sektor* (Collaborative Innovation in the Public Sector). Jurist og Økonomiforbundets Forlag: København

Andersen, J., Delica, K., Frandsen, M. (2012) 'From library to community centre', in Moulaert, F., MacCallum, D., Mehmood, A., Hamdouch, A. (eds) *International Handbook on Social Innovation*. Edward Elgar Publishing, Incorporated

Andersen, L. L., Hulgård, L. (2008) 'Workplaces with an Inclusive Profile - and their Everyday Strategies. Social Enterprises and Work Integration in Denmark'. Paper for International Workshop on Ethnographies of the Social Economy, pp. 14-15. March 2008, Cosin's Hall, Palace Green, University of Durham (Paper)

Andersen, T., Foss, N., Laursen, K. (2011) 'Linking Customer Interaction and Innovation: The Mediating Role of New Organizational Practices'. *Organization Science* n. 22(4) pp. 980-999

Andersen, T., Hansen, M., Larsen, M., Petersen, B., Wad, P. (2009) *Strategies in emerging markets: A case book on Danish multinational corporations in China and India.* Copenhagen Business School Press

Bason, C. (2007) *Velfærdsinnovation - ledelse af nytænkning i den offentlige sektor.* København: Børsen Offentlig

Bason, C. (2010) *Leading Public Sector Innovation - Co-Creating for a Better Society.* Bristol: Policy Press

Bendix, H.W. (2009) *Repenser l'hôpital - une interview d'Henrik W. Bendix, MidtLab,* 8 September (http://la27eregion.fr/Repenser-l-hopital-une-interview-d) downloaded 03.04.2012

CLIPS, http://www.ruc.dk/en/research/search-research-centers/demnetgov/research-projects/clips/

Dahl, H. M. (2001) 'Empowerment og disempowerment?: to historier om hjemmehjælperfeltet'. *Kvinder, køn & forskning*, n. 10(2), pp. 58-68

Digmann, A. (2011) 'Skolen i Morgen'. *Tidsskrift for skoleledere*, n. 5 (14)

Delica, K. (2011) 'Social innovation og områdebaserede indsatser mod en kritisk socialvidenskab om innovation', in Kristensen, C., Voxted, S. (eds) *Innovation og entreprenørskab.* København: Hans Reitzels Forlag

Ejrnæs, A., Boje, T. P. (2008) *Family Policy and Welfare Regimes.* Department of Society and Globalisation, Roskilde University (paper)

Ejrnæs, A., Boje, T. P. (2011) 'Different routes to social security in Europe: social protection or social invesment'. *Comunitania. International Journal of Social Work and Social Sciences*, n. 11(1), pp. 45-67

FOA (2009) *Velfærdsledelse* (welfare managment). *Seks indlæg om offentlig ledelse - dokumentation fra en offentlig høring. September 2009.* FOA (The Care and Service Union) (report)

FOA (2008) *Trepartsaftale: Aftale mellem regeringen*, KL, Danske Regioner, LO og AC (). Paper. http://www.foa.dk/Search.aspx?q=innovation&l=1 down loaded 10.04.2012

Forman, M., Haugbølle, K. (2011) 'Brugere og innovation i byggeriet' *(Users and innovation in constructions)*, in Kristensen, C., Voxted, S. (eds) *Innovation og entreprenørskab*. København: Hans Reitzels Forlag

Hansen, M. B. (2011) Brugerinnovation i den offentlige sektor, *Væksthus for Ledelse 04.02.11* http://www.lederweb.dk/Strategi/Innovation/Artikel/85312/Brugerinnovation-i-den-offentlige-sektor downloaded 03.04.2012

Healthcare Innovation Lab, http://www.regionh.dk/CenterforSundhedsinnovation/Menu/Projekter/Healthcare+Innovation+Lab/

Holter, Ø. (ed) (2007) *Män i rörelse. Jämställdhet, förändring och social innovation i Norden.* Gidlunds Förlag

Hulgård, L. (2007) *Sociale entreprenører*. København: Hans Reitzels Forlag

Hulgård, L., Andersen, L. L. (2009) *Socialt entreprenørskab i Danmark - status 2009.* Center for Socialt Entreprenørskab, RUC (report)

Hvenegård-Lassen, K. (2007) 'Viljen til valg: Kommunalt integrationsarbejde i Sverige og Danmark', in Alsmark, G., Moldenhawer, B., Kallehave, T. (eds) *Migration och Tillhörighet: Inklusions- och exklusionsprocesser i Skandinavien.* Göteborg & Stockholm: Makadam Förlag

Jensen, T., Krøjer, J., Hansen, K. G. (2010) *Inklusion i interaktiv deltagelse i folkeskolen: Et forskningsprojekt om køn, teknologi og læring.* Roskilde: Roskilde University Forlag

Jæger, B. (2011) 'Brugerdrevet innovation i den offentlige sektor', in Kristensen C., Voxted, S. *Innovation og entreprenørskab*. København: Hans Reitzels Forlag

Jørgensen, M. B. (2010) 'Turks in Denmark: Patterns of Incorporation and Collective Organizing Processes'. *Insight* (Turkey), n. 12(1), pp. 163-183

Kristensen, C. J. (2011) 'Socialt entreprenørskab og social innovation' (Social entrepreneurship and social innovation), in Greve B. (ed) *Grundbog i Socialvidenskab*. København: Nyt fra Samfundsvidenskaberne

Kristensen, M., Stokholm, M. (2002) 'Frit plejemarked fostrer kvindelige iværksættere, i Vækstraket med klare mål: Fra ISS-karriere til børnehaveejer', in *Børsen, KarriereJob* (newspaper) 2002-12-13, pp. 10-11

Kristensen, C. J., Voxted, S. (2009) *Innovation. Medarbejder og bruger*. København: Hans Reitzels Forlag

Kristensen, C. J., Voxted, S. (2011) *Innovation og entreprenørskab*. København: Hans Reitzels Forlag

Larsen, T. S. (2009) *De Forsømte: Skitse til en socialvidenskabelig analyse om relationerne mellem produktionen af forsømte boligområder, de sociale kampe om det boligsociale integrationsarbejde og den boligsociale integration.* Institut for Samfund og Globalisering, Roskilde University, PhD thesis

Lauring, J. (2007), 'Managing Cultural Diversity and the Process of Knowledge Sharing'. *Scandinavian Journal of Management*

Lauring, J. (2005) *Når Organisationen Bliver Mangfoldig – Om Vidensdeling Og Interaktion I Etnisk Mangfoldige Organisationer.* Århus: Handelshøjskolen i Århus

la Cour, A., Højlund, H. (2001) Den fleksible hjemmehjælper. *Social kritik*, n. 13(76), pp. 6-19

MindLab (2010) *MindLab annual Results Report* 2009-2010. (http://www.mind-lab.dk/) down loaded 03.04.2012

MidtLab (http://www.midtlab.dk/om+midtlab/in+english)

Nielsen, S. B. (2011) *Nordiske mænd til omsorgsarbejde. En forskningsbaseret erfaringsopsamling på initiativer til at rekruttere, uddanne og fastholde mænd efter finanskrisen.* Roskilde Universitet, Center for Velfærd, Profession og Hverdagsliv, Nordic Ministers (report)

Nählinder, J., Sundin, E. (2009) 'Everyday innovation in elderly care and health care', in Döös, M., Wilhelmson, L. (eds) *Organising work for innovation and growth. Experiences and efforts in ten companies* (VR 2009:22). Stockholm: Vinnova

Pedersen, A. S. og Plum (2001), 'Det gør en forskel – at turde se dem – forskellene: Om mangfoldighedsledelse som virksomhedsstrategi'. *Tidsskrift for ARBEJDSLIV*, 3. årgang, n. 4

Pedersen, N. V. (2011) 'Frivillige organisationers rolle i samarbejdsdrevne innovationsprocesser inden for den forebyggende sundhedsindsats', in Sørensen, E., Torfing, J. (eds) *Samarbejdsdrevet innovation – i den offentlige sektor.* København: Jurist og Økonomiforbundets Forlag

Randøy, T. et al. (2006) *A nordic perspective on corporate board diversity.* Nordic Innovation Centre

Rose, C. (2007) 'Does female board representation influence firm performance? The Danish evidence'. *Corporate Governance*, volume 15, n. 2

Rostgaard, T., Bjerre, L., Sørensen, K., Rasmussen, N. (2011) *Omsorg og etnicitet. Nye veje til rekruttering og kvalitet i ældreplejen.* København: SFI. Report, pp. 11:16

Rådet for Innovation (National Council for Innovation) (2010) *InnovationDanmark 2010-2013. Viden til virksomheder skaber vækst. Handlingsplan fra Rådet for Teknologi og Innovation. Forsknings- og Innovationsstyrelsen* (Actionplan)

Sundbo, J., Fuglsang, L., Larsen, J. N. (2008) *Innovation med omtanke*. København: Hans Reitzels Forlag

Sørensen, E., Torfing, J. (eds) (2011) *Samarbejdsdrevet innovation – i den offentlige sektor*. København: Jurist og Økonomiforbundets Forlag

Vinther, H. (2007) *Rundt om forebyggelses- og sundhedscentre. Muligheder og barrierer for udvikling af forebyggelses- og sundhedscentre i Danmark*. SFI (The Danish National Centre for Social Research)

Waldorff, S. B. (2011) 'Sundhedscentre – som resultat af samarbejdsdrevet innovation', in Sørensen, E., Torfing, J. (eds) *Samarbejdsdrevet innovation – i den offentlige sektor*. København: Jurist og Økonomiforbundets Forlag

Dutch and Flemish literature

Advice SERV (2010) *Social innovation in the Flemish practice of companies–part 1*

Hermans, K., Vranken, R. (2010) *Switch the light on green for innovation in care*. Praktice Book. Flemish federation of welfare

Kolen, M. (2005) *Cream in/on (?) the coffee? Ethical reflection and discussion about the starting points in the youth care*. Amsterdam: SWP

Leys, M. (2009) *Technology and innovation in the elderly care*, Care Symposium, Aalst 10 september 2009

Lieten, I. (2012). *ICT and care*. Brussels: round table February 13th

Looise, N. (2009) *Innovation triangle*

NN. (2011) *Innovation in home and elderly care*. Antwerp: Periodical of Welfare, no.16, annual 5

NN. (2006) *Social innovation*. Brussels: Periodical ING Institutional

Oeij, P., Dorenbosch, L., Klein Hesselink, J, Vaas, F. (2010) *Working smarter and social innovation – Integratlon organisational innovation*

Social Economic Council. (2006) *Building blocks of innovative organizations*. The Netherlands

Vandenbempt, K. & Demeyer B. (2003), *Beroepsproi el. Ervaringsdeskundige in de armoede en sociale uitsluiting*. Leuven: KULeuven, HIVA: 48p

Van Deurzen, J. (2012). *ICT and care*. Brussels: round table February 13th

Van Gyes, G., Vandenbrande, T. (2005) *Innovation and labour issues. A literature verkenning of policy uncertainties from the Flemish point of view*. Leuven: Hoger Institute for Labour

Van Kammen, J. (2002) *Technology of care, opportunities for innovation and use*, STT

Vision text (2012) *(e)Careful Flanders. Data sharing in social services sector*

Flemish Council for Science Policy, (2006) *Technology and innovation in Flanders: priorities*

Vranken, R., Hermans, K. (2009) *Innovation of care: user oriented innovating and changing – Chapter 3: Innovation processes investigated*

Weliswaar (2012) *Periodical for welfare and health*, n. 104 Feb-Mar

Webpages:

www.alsliga.be

www.bednet.be

www.eureka.be

www.groenezorg.be

www.habbekrats.be

www.innovatiecentrum.be

www.managementkennisbank.nl

www.ond.vlaanderen.be/geletterdheid/plan/svz2010.htm

www.phl.be

www.playingforsuccess.be

www.socialeeconomie.be/innovatiepunt

www.steunpunt.wvg

English Literature

Abbott, C. (2007) *E-inclusion: Learning Difficulties and Digital Technologies*. FutureLab Series: UK.

Ashman, B., Ockendon, J., Beadle-Brown, J., Mansell, J. (2010) *Person-centred active support: a handbook*. Brighton: Pavilion

Atun, R. A, Kyratsis, I., Jelic, G., Rados-Malicbegovic, D., Gurol-Urganci, I. (2006) 'Diffusion of Complex Health Innovations--implementation of Primary Health Care Reforms in Bosnia and Herzegovina'. *Health Policy and Planning* no. 22 (1) (December 8), pp. 28–39

Atun, R. A, Menabde, N., Saluvere, K., Jesse, M., Habicht, J. (2006) 'Introducing a Complex Health innovation—Primary Health Care Reforms in Estonia (multimethods Evaluation)'. *Health Policy* no. 79 (1) (November), pp. 79–91

Bacon, N., Nusrat, F., Mulgan, G., Woodcraft, S. (2008) *Transformers: How Local Areas Innovate And Address Changing Social Needs*. London: NESTA. www.nesta.org.uk/assets/documents/transformers

Banteyerga, H. (2011) 'Ethiopia's Health Extension Program: Improving Health Through Community Development'. *MEDICC Review* no. 13 (3), pp. 46–49

Barnett, J., Vasileiou, K., Fayika, D., Brooks, L., Young, Y. (2011) '«Understanding Innovators» Experiences of Barriers and Facilitators in Implementation and Diffusion of Healthcare Service Innovations: a Qualitative Study'. *BMC Health Services Research* no. 11 (1), p. 342

Bate, P, Robert, G., Bevan, H. (2004) 'The Next Phase of Healthcare Improvement: What Can We Learn from Social Movements?'. *Quality and Safety in Health Care* no. 13 (1) (February 1), pp. 62–66

Bayer, S., Barlow, J., Curry, R. (2007) 'Assessing the Impact of a Care Innovation: Telecare'. *System Dynamics Review* no. 23 (1), pp. 61–80

Beadle-Brown, J., Mansell, J. and Kozma, A. (2007) 'Deinstitutionalization in intellectual disabilities' . *Current Opinion in Psychiatry*, n. 20, pp. 437-442

Becker, D., Edmundo, K., Nunes, N. R., Bonatto, D., de Souza, R. (2005) 'An Innovative Geographical Approach: Health Promotion and Empowerment in a Context of Extreme Urban Poverty'. *Promotion and Education* no. 12, pp. 48–52

Benson, Y. (2011) 'Growing Talents for Inclusion (GTI)', in *Talents for Inclusion Chapter in Northamptonshire TaMHS Project – Evaluation of Interventions April 2009 – March 2011*

BEPA (2010) *Empowering People, Driving Change: Social Innovation in the European Union.* Luxembourg: Publications Office of the European Union. ec.europa.eu/bepa/pdf/publications_pdf/social_innovation.pdf

Berry, L., Mirabito, A. M. (2010) 'Innovative Healthcare Delivery'. *Business Horizons* no. 53 (2) (March), pp. 157–169

Bhattacharyya, O., Khor, S., McGahan, A., Dunne, D., Daar, A. S., Singer, P. A. (2010) 'Innovative Health Service Delivery Models in Low and Middle Income Countries - What Can We Learn from the Private Sector?'. *Health Research Policy and Systems* no. 8 (1), pp. 24

Billings, D. L., Crane, B. B., Benson, J., Solo, J., Fetters, T. (2007) 'Scaling-up a Public Health Innovation: A Comparative Study of Post-abortion Care in Bolivia and Mexico'. *Social Science & Medicine* no. 64 (11) (June), pp. 2210–2222

Blue-Howells, J., McGuire, J., Nakashima, J. (2008) 'Co-Location of Health Care Services for Homeless Veterans: A Case Study of Innovation in Program Implementation'. *Social Work in Health Care* no. 47 (3) (August 11), pp. 219–231

Bradley, E. H., Webster, T. R., Baker, D., Schlesinger, M., Inouye, S. K. (2005) 'After Adoption: Sustaining the Innovation A Case Study of Disseminating the Hospital Elder Life Program'. *Journal of the American Geriatrics Society* no. 53 (9) (September), pp. 1455–1461

Brimacombe, G. (2005) 'Health, Healthcare and Nation-Building: A Three-Dimensional Approach to Innovation in Canada'. *Healthcare Quarterly* no. 8 (3), pp. 61–68

Brooks, H., Pilgrim, D., Rogers, A. (2011) 'Innovation in Mental Health Services: What Are the Key Components of Success?'. *Implementation Science* no. 6 (1), pp. 120

Calnan, M., Wainwright, D., Glasner, P., Newbury-Ecob, R., Ferlie, E. (2006) '«Medicine's Next Goldmine?» The Implications of New Genetic Health Technologies for the Health Service'. *Medicine, Health Care and Philosophy* no. 9 (1) (March), pp. 33–41

Chataway, J., Chaturvedi, K., Hanlin, R., Mugwagwa, J., Smith, J., Wield, D. (2007) *Building the Case for National Systems of Health Innovation*. Johannesburg: NEPAD. www.nepadst.org/doclibrary/pdfs/nsi_case_jan2007.pdf

Christensen, C., Horn, M., Johnson, C. (2008) *Disrupting Class: How Disruptive Innovation Will Change the Way the World Learns*. New York: McGraw-Hill

Cho, S., Mathiassen, L., Robey, D. (2006) 'Dialectics of Resilience: a Multi-level Analysis of a Telehealth Innovation'. *Journal of Information Technology* no. 22 (1) (December 19), pp. 24–35

Cooksey, Sir D. (2006) *A Review of UK Health Research Funding*. UK HM Treasury. www.hm-treasury.gov.uk/d/pbr06_cooksey_final_report_636.pdf

Coye, M. J., Haselkorn, A., DeMello, S. (2009) 'Remote Patient Management: Technology-Enabled Innovation And Evolving Business Models For Chronic Disease Care'. *Health Affairs* no. 28 (1) (January 5), pp. 126–135

Dalziel, P., Shah, T. (2010) 'Disruptive Innovation'. *The Medicine Forum* no. 12 (4), pp. 4–7.

Daniilidou, N., Economou, C., Zavras, D., Kyriopoulos, J., Georgoussi, E. (2003) 'Health and Social Care in Aging Population: An Integrated Care Institution for the Elderly in Greece'. *International Journal of Integrated Care* no. 3, pp. n.p.

Dove, J. T., Douglas Weaver, W., Lewin, J. (2009) 'Health Care Delivery System Reform'. *Journal of the American College of Cardiology* no. 54 (11) (September), pp. 985–988

Doveston, M., Keenaghan, M. (2006) 'Improving classroom dynamics to support students' learning and social inclusion: a collaborative approach'. *Support for Learning*, 21 (1), 5-11

Doveston, M. and Kenaghan, M. (2006b) 'Growing talent for inclusion: using an appreciative inquiry approach to investigating classroom dynamics'. *Journal of Research in Special Educational Needs*. 6(3), pp. 153-165

Economist Intelligence Unit (2011a) *Future-proofing Western Europe's Healthcare: A Study of Five Countries*. Geneva: Economist Intelligence Unit http://www.eucomed.org/medical-technology/futureproofing-western-eu-s-healthcare

Economist Intelligence Unit (2011b) *The Future of Healthcare in Europe*. Geneva: Economist Intelligence Unit http://www.eufutureofhealthcare.com/

Ferlie, E. Fitzgerald, L., Wood, M., Hawkins, C. (2005) 'The Nonspread of Innovations: The Mediating Role of Professionals'. *The Academy of Management Journal* no. 48 (1), pp. 117–134

Fidler, A., Bredenkamp, C., Schlippert, S. (2009) 'Innovations In Health Services Delivery From Transition Economies In Eastern Europe And Central Asia'. *Health Affairs* no. 28 (4) (July 13), pp. 1011–1021

Finch, T.L., Mair, F. S., May, C. R. (2007) 'Teledermatology in the U.K.: Lessons in Service Innovation'. *British Journal of Dermatology* no. 156 (3) (March), pp. 521–527

Fitzgerald, L., Ferlie, E., Wood, M., Hawkins, C. (2002) 'Interlocking Interactions, the Diffusion of Innovations in Health Care' in *Human Relations* no. 55 (12) (December 1), pp. 1429–1449

Fonn, S., Ray S., Blaauw, D. (2011) 'Innovation to Improve Health Care Provision and Health Systems in sub-Saharan Africa – Promoting Agency in Mid-level Workers and District Managers'. *Global Public Health* no. 6 (6) (September), pp. 657–668

FORA (2009) 'New Nature of Innovation'. FORA. www.newnatureofinnovation.org

Frankham, J., Edwards-Kerr, D., Humphrey. N., Roberts, L. (2007) *School exclusion: learning partnerships outside mainstream education*. Joseph Rowntree Foundation

Frew, S., Sammut, S., Siu, W., Daar, A., Singer, P. (2006) 'The Role of the Domestic Private Sector in Developing Countries for Addressing Local Health Needs'. *International Journal of Biotechnology* no. 8 (1/2), pp. 91–102

Gardner, C. A., Acharya, T., Yach, D. (2007) 'Technological And Social Innovation: A Unifying New Paradigm For Global Health'. *Health Affairs* no. 26 (4) (July 1), pp. 1052–1061

Gaynor, M., Moreno-Serra, R., Propper, C. (2012) 'Can Competition Improve Outcomes in UK Health Care? Lessons from the Past Two Decades'. *Journal of Health Services Research & Policy* no. 17 (Supplement 1) (February 7), pp. 49–54

Goldenberg, M. (2004) *Social Innovation in Canada: How the Non-profit Sector Serves Canadians and How It Can Serve Them Better*. Ontario: Canadian Policy Research Networks. www.cprn.org/documents/33235_en.pdf

Greenhalgh, T. (2009) 'Chronic Illness: Beyond the Expert Patient'. *British Medical Journal* no. 338 (March 14), pp. 629–631

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., Kyriakidou, O. (2004) 'Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations'. *The Milbank Quarterly* 82 (4), pp. 581–629

Grossman, J. (2008) 'Disruptive Innovation in Health Care: Challenges for Engineering'. *The Bridge* no. 38 (1), pp. 10–16

Harris, M., Albury, D. (2009) *The Innovation Imperative*. NESTA. www.nesta.org.uk/library/documents/the-innovation-imperative.pdf

Health Directorate of DG Research and Innovation (2011) *Innovation in Healthcare: From Research to Market: Conference Report*. Brussels: Health Directorate of DG Research and Innovation, DG Enterprise and Industry, and DG Health and Consumers. http://ec.europa.eu/research/health/events-04_en.html

Herzlinger, R. (2006) 'Why Innovation in Health Care Is So Hard'. *Harvard Business Review* no. 84 (5), pp. 58–66

Homer, C. J., Baron, R. J. (2010) 'How to Scale Up Primary Care Transformation: What We Know and What We Need to Know?. *Journal of General Internal Medicine* no. 25 (6) (May 14), pp. 625–629

Hwang, J., Christensen, C. M. (2008) 'Disruptive Innovation In Health Care Delivery: A Framework For Business-Model Innovation'. *Health Affairs* no. 27 (5) (September 1), pp. 1329–1335

Kaner, E., Steven, A., Cassidy, P., Vardy, C. (2003) 'Implementation of a Model for Service Delivery and Organisation in Mental Healthcare: a Qualitative Exploration of Service Provider Views'. *Health and Social Care in the Community* no. 11 (6), pp. 519–527

Knapp, M., McDaid, D. (2007) 'The Mental Health Economics European Network'. *Journal of Mental Health*, 16, 2, pp. 157-165

Kuenne, C., Rass, M., Adamcyzk, S., Bullinger, A., Moeslein, K. (2011) 'Patients as Innovators: An Open Innovation Perspective on Health 2.0'. *Proceedings of MCPC 2011*. San Francisco

Leadbeater, C., Wong, A. (2010) *Learning from the Extremes*. San Jose, CA: Cisco

Lehning, A., Austin, M. (2011) 'On Lok: A Pioneering Long-Term Care Organization for the Elderly (1971-2008)'. *Journal of Evidence-Based Social Work* no. 8 (1) (January), pp. 218–234

Lehoux, P., Williams-Jones, B., Miller, F., Urbach, D., Tailliez, S. (2008) 'What Leads to Better Health Care Innovation? Arguments for an Integrated Policy-oriented Research Agenda'. *Journal of Health Services Research & Policy* no. 13 (4) (October 1), pp. 251–254

Lehoux, P., Daudelin, G., Demers-Payette, O., Boivin, A. (2009) 'Fostering Deliberations About Health Innovation: What Do We Want to Know from Publics?'. *Social Science & Medicine* no. 68 (11) (June), pp. 2002–2009

Lloyd, J., Wait, S. (2005) *Integrated Care: A Guide for Policymakers*. Alliance for Health and the Future. www.ilcuk.org.uk/files/pdf_pdf_7.pdf

Logie, D. E., Rowson, M., Ndagije, F. (2008) 'Innovations in Rwanda's Health System: Looking to the Future'. *The Lancet*, no. 372 (9634) (July), pp. 256–261

Mansell, J., Knapp, M., Beadle-Brown, J., Beecham, J. (2007) *Deinstitutionalisation and community living – outcomes and costs: report of a European Study*. Volume 2: Main Report. Canterbury: Tizard Centre, University of Kent

Mansell, J., Beadle-Brown, J. (2010) 'Deinstitutionalisation and community living: position statement of the Comparative Policy and Practice Special Interest Research Group of the International Association for the Scientific Study of Intellectual Disabilities'. *Journal of Intellectual Disability Research* n. 54(2), pp. 104-112

May, C., Finch, T. (2009) 'Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory'. *Sociology* no. 43 (3) (June 15), pp. 535–554

McCarthy, M. (2011) 'European Health Research and Globalisation: Is the Public-private Balance Right?'. *Globalization and Health* no. 7 (1), p. 5

Medeiros, H., McDaid, D., Knapp, M., the MHEEN Group (2008) *Shifting care from hospital to the community in Europe: Economic challenges and opportunities.* http://www.mhe-sme.org/assets/files/MHEEN%20policy%20briefs_4%20Balance%20of%20care.pdf

Mitton, C., Dionne, F., Masucci, L., Wong, S., Law, S. (2011) 'Innovations in Health Service Organization and Delivery in Northern Rural and Remote Rigions: a Review of the Literature'. *International Journal of Circumpolar Health* no. 70 (5), pp. 460–472

Montagu, D., Elzinga, G. (2003) 'Innovations in Access to TB and HIV/AIDS Care in Sub-Saharan Africa: Dynamic Engagement of the Private Sector'. *Applied Health Economics and Health Policy* no. 2 (4)

Morel, C. M. (2005) 'Health Innovation Networks to Help Developing Countries Address Neglected Diseases'. *Science* no. 309 (5733) (July 15), pp. 401–404

Moulaert, F., Martinelli, F., Swyngedouw, E., González, S. (2005) 'Towards Alternative Model(s) of Local Innovation'. *Urban Studies* no. 42 (11) (October 1), pp. 1969–1990

Mugabe,. (2007) 'Health Innovation Systems in Developing Countries: Strategies for Building Scientific and Technological Capacities'. *New Partnership for Africa's Development.* www.nepadst.org/doclibrary/pdfs/hisdc_2007.pdf

Mugwagwa, J., Hanlin, R., Adesina, I., Chataway, J., Wield, D., Smith, J. (2010) 'Systems f Health Innovation in Africa: Policy Lessons from Home and Abroad'. *Proceedings of the Second Science with Africa Conference.* Addis Ababa. http://www.uneca.org/sciencewithafrica/swa2proceedings/Systems%20of%20Health%20Innovation.pdf

Mulgan, G. (2006) 'The Process of Social Innovation'. *Innovations: Technology, Governance, Globalization* no. 1 (2) (April), pp. 145–162

Mulgan, G., Tucker, S., Ali, R., Sanders, B., (2007) *Social Innovation: What it is, Why it Matters and How it Can be Accelerated.* Oxford SAID Business School, Skoll Centre for Social Entrepreneurship, Working Paper, 8

Mur, I., van Raak, A (2003) 'Editorial: Integration of Services and the European Union: Does EU Policy Make Sense?'. *International Journal of Integrated Care* no. 3 (October), pp. 1–2

Murray, R., Caulier- Grice, J., Mulgan, G. (2010) 'The Open Book of Social Innovation'. London: The Young Foundation. www.nesta.org.uk/library/documents/Social_Innovator _020310.pdf

Nelson, K., Wright, T., Connor, M., Buckley, S., Cumming, J. (2009) 'Lessons from Eleven Primary Health Care Nursing Innovations in New Zealand'. *International Nursing Review* no. 56 (3) (September), pp. 292–298

Neumeier, S. (2012) 'Why Do Social Innovations in Rural Development Matter and Should They Be Considered More Seriously in Rural Development Research? - Proposal for a Stronger

Focus on Social Innovations in Rural Development Research'. *Sociologia Ruralis* no. 52 (1) (January), pp. 48–69

Nyonator, F. K. (2005) 'The Ghana Community-based Health Planning and Services Initiative for Scaling up Service Delivery Innovation'. *Health Policy and Planning* no. 20 (1) (January 1), pp. 25–34

O'Sullivan, C., Mulgan, G., Vasconcelos, D. (2010) *Innovating Better Ways of Living in Later Life: Context, Examples and Opportunities*. London: The Young Foundation. https://www.youngfoundation.org/files/images/novating_better_ways_of_living_in_later_life.pdf

Peckham, S., Mays, N., Hughes, D., Sanderson, M., Allen, P., Prior, L., Entwistle, V., Thompson, A., Davies, H. (2012) 'Devolution and Patient Choice: Policy Rhetoric Versus Experience in Practice'. *Social Policy & Administration*, no. 46 (2) (April), pp. 199–218

Phills, J. Jr., Deiglmeier, K., Miller, D. (2008) 'Rediscovering Social Innovation'. *Stanford Social Innovation Review* no. 6 (4), pp. 34–43

Pols, J., Willems, D. (2011) 'Innovation and Evaluation: Taming and Unleashing Telecare Technology'. *Sociology of Health & Illness*, no. 33 (3) (March), pp. 484–498

Propper, C. (2010) *The Operation of Choice and Competition in Healthcare.* London: 2020 Public Services Trust

Racine, D. P. (2006) 'Reliable Effectiveness: A Theory on Sustaining and Replicating Worthwhile Innovations'. *Administration and Policy in Mental Health and Mental Health Services Research* no. 33 (3) (May 11), pp. 356–387

Riddell, S., Watson, N., (eds) (2003) *Disability, Culture and Identity.* Harlow: Pearson Prentice Hall

Robertson, M. (2007) 'Translating Breakthroughs in Genetics into Biomedical Innovation: The Case of UK Genetic Knowledge Parks'. *Technology Analysis & Strategic Management* no. 19 (2) (March), pp. 189–204

Sairamesh, J., Griss, M. L., Weber, P. A., Hum, S., Garverick, S. L., Nemana, R., Yu, W., Hosea, F. W., Das, A. K., Garner, H. (2011) 'Innovation in Healthcare Intelligence'. *American Journal of Preventive Medicine* no. 40 (5) (May), pp. S234–S237

Salvador-Carulla, L. (2008), *Bridging experience and evidence in mental health care reform* World Psychiatry, June. *http://ukpmc.ac.uk/articles/PMC2408401/reload=0;jsessionid=31A17E51E6A213349C14782DE35423D9*

Saxena, S., Sharan, P., Garrido Cumbrera, M. (2006) *World Health Organization's Mental Health Atlas 2005: implications for policy development. World Psychiatry.* http://ukpmc.ac.uk/articles/PMC1636128

Schmid, E. F., Ashkenazy, R., Merson, J., Smith D. A. (2009) 'Will Biomedical Innovation Change the Future of Healthcare?'. *Drug Discovery Today* no. 14 (21-22) (November), pp. 1037–1044

Schrijvers, G., Oudendijk, N., de Vries, P. (2003) 'In Search of the Quickest Way to Disseminate Health Care Innovations'. *International Journal of Integrated Care* no. 3 (December), pp. 1–22

Scott, S. D, Plotnikoff, R. C., Karunamuni, N., Bize, R., Rodgers, W. (2008) 'Factors Influencing the Adoption of an Innovation: An Examination of the Uptake of the Canadian Heart Health Kit (HHK)'. *Implementation Science* no. 3 (1), p. 41

Shakespeare, T (1994) 'Cultural representation of disabled people: dustbins for disavowal'. *Disability, Handicap and Society*, 9(3), 283-301

Shortell, S., Gillies, R., Wu, F. (2010) 'United States Innovations in Healthcare Delivery'. *Public Health Reviews* no. 32 (1), pp. 190–212

Sibthorpe, B., Glasgow, N., Wells, R. (2005) 'Emergent Themes in the Sustainability of Primary Health Care Innovation'. *The Medical Journal of Australia* no. 183 (10), pp. 77–80

Simmons, R., Fajans, P., Ghiron, L. (eds) 'Scaling up Health Service Innovations: A Framework for Action'. *Scaling up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. Geneva: World Health Organization

Soleimani, F., Zenios, S. (2011) 'Disrupting Incrementalism in Health Care Innovation'. *Annals of Surgery* no. 254 (2) (August), pp. 203–208

Squire, S. B., Ramsay, A. R. C., van den Hof, S., Millington, K. A., Langley, I., Bello, G., Kritski, A., et al. (2011) 'Making Innovations Accessible to the Poor Through Implementation Research [State of the Art Series. Operational Research. Number 7 in the Series]. *The International Journal of Tuberculosis and Lung Disease* no. 15 (7) (July 1), pp. 862–870

Starfield, B., Shi, L., Macinko, J. (2005) 'Contribution of Primary Care to Health Systems and Health'. *The Milbank Quarterly* no. 83 (3), pp. 457–502

Swendeman, D., Rotheram-Borus, M. J. (2010) 'Innovation in Sexually Transmitted Disease and HIV Prevention: Internet and Mobile Phone Delivery Vehicles for Global Diffusion'. *Current Opinion in Psychiatry* no. 23 (2) (March), pp. 139–144

Temmink, D., Francke, A., Hutten, J., van der Zee, J., Huijer Abu-Saad, H. (2000) 'Innovations in the Nursing Care of the Chronically Ill: a Literature Review from an International Perspective'. *Journal of Advanced Nursing* no. 31 (6), pp. 1449–1458

Thakur, R., Hsu, S. H. Y., Fontenot, G. (2012) 'Innovation in Healthcare: Issues and Future Trends'. *Journal of Business Research* no. 65 (4) (April), pp. 562–569

UK Department for Business Enterprise and Regulatory Reform (2008) *Supporting Innovation in Services*. United Kingdom: Department for Business Enterprise and Regulatory Reform. www.bis.gov.uk/files/file47440.pdf

UK Department of Health (2011) *Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS*. London: UK Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd Guidance/DH_131299

Victora, C. G., Barreto, M. L., do Carmo Leal, M., Monteiro, C. A., Schmidt, M. I., Paim, J., Bastos, F. I., et al. (2011) 'Health Conditions and Health-policy Innovations in Brazil: The Way Forward'. *The Lancet* no. 377 (9782) (June), pp. 2042–2053

Wakerman, J. (2009) 'Innovative Rural and Remote Primary Health Care Models: What Do We Know and What Are the Research Priorities?'. *Australian Journal of Rural Health* no. 17 (1) (February), pp. 21–26

Weatherill, S. (2007) *Laying the Groundwork for Cultural Change: The Legacy of the Primary Health Care Transition Fund.* Ontario: Health Canada. http://www.healthcanada.gc.ca/phctf

Windrum, P., García-Goñi, M. (2008) 'A neo-Schumpeterian Model of Health Services Innovation'. *Research Policy* no. 37 (4) (May), pp. 649–672

World Bank (2005) *Roma in an expanding Europe: breaking the poverty cycle* http://siteresources.worldbank.org/EXTROMA/Resources/roma_in_expanding_europe.pdf

World Health Organization (Hg.) (2001) *International classification of functioning, disability and health.* Genf

French Literature

Alter, N. (1998) 'Action, culture et logiques d'innovation (Commentaire)'. *Sciences sociales et santé*, pp. 123–134

Alter, N. (2005) *L'innovation ordinaire.* Paris: Presses universitaires de France

Bandt, J. de, Gadrey, J. (1994) *Relations de service, marchés de services.* Paris: CNRS éditions

Barthélemy, A., Slitine R. (2011) *Entrepreneuriat social : innover au service de l'intérêt général : panorama, enjeux, outils.* Paris: Vuibert

Bouchard, M. J., Université du Québec à Montréal (2006) *L'innovation sociale en économie sociale.* Montréal: Chaire de recherche du Canada en économie sociale, Université du Québec à Montréal

Bouchard, M. J. (2005) 'De l'expérimentation à l'institutionnalisation positive, l'innovation sociale dans le logement communautaire au Québec', in *Annales de l'économie publique, sociale et coopérative / Annals of Public and Cooperative Economics,* pp. 139–166

Bélanger, P. R., Lapointe, P.A., Lévesque, B. (1998) 'Innovations organisationnelles et blocages institutionnels. Le cas des entreprises au Québec', in *Cahiers du Centre de recherche sur les innovations sociales (CRISES)* (ET9809)

Dandurand, L. (2005) 'Réflexion autour du concept d'innovation sociale, approche historique et comparative'. *Revue française d'administration publique* n. 115(3), p. 377

Degavre, F., Nyssens, M. (2008) 'L'innovation sociale dans les services d'aide à domicile. Les apports d'une lecture polanyienne et féministe'. *Revue Française de Socio-Économie* n. 2(2), pp. 79

Dewey, J., Bidet, A., Quéré, L., Truc, G. (2011) *La formation des valeurs*. Paris: la Découverte

Djellal, F., Faïz, G. (2009) 'Innovation dans les services et entrepreneuriaT: au-delà des conceptions industrialistes et technologistes du développement durable'. *Innovations* n. 29(1), p. 59

Fontan, J. M. (2008) 'Développement territorial et innovation sociale: l'apport polanyien'. *Revue Interventions économiques* (38)

Fraisse, L., Lhuillier, V., Petrella, F. (2008) 'L'accueil des jeunes enfants en Europe: vers des formes de gouvernance multilatérale et intégrée?'. *Revue Française de Socio-Économie* n. 2(2), p. 141

Gadrey, J. (1988) 'Des facteurs de croissance des services aux rapports sociaux de service'. *Revue d'économie industrielle*, pp. 34–48

Gadrey, J. (1990) 'Rapports sociaux de service: une autre régulation'. *Revue économique*, pp. 49–70

Gadrey, J. (2003) *Socio-économie des services*. Paris: La Découverte

Gadrey, J. (2006) *Contribution lors de la Conférence PEKEA* 'Construire ensemble des indicateurs locaux pour le progrès sociétal', 30-31 octobre 2008

Gaglio, G. (2011) *Sociologie de l'innovation*. Paris: Presses universitaires de France

Gallouj, F. (1994) *Économie de l'innovation dans les services*. Paris: L'Harmattan

Gallouj, F., Faridah, D. (2000) 'Le «casse-tête» de la mesure de l'innovation dans les services: enquête sur les enquêtes'. *Revue d'économie industrielle*, pp. 7–28

Gardin, L. (2006) *Les initiatives solidaires. la réciprocité face au marché et à l'Etat*. Paris : Erès

Ghrenassia, F. (2002:juin) 'Favoriser la création d'entreprises de technologie innovante', in Couty, E. (dir), 'L'innovation en santé'. *Revue Actualité et dossier en santé publique*, n. 39, pp. 19-21

Grand, A., Durand, P. (2006) 'L'organisation des services', in *Santé, Société et Solidarité,* pp. 129–133

Hermel, L., Louyat, G. (2008) *Innovation dans les services*. La Plaine Saint-Denis. France: Editions Afnor

Haut Conseil de l'Education (2011), *Les expérimentations réalisées dans le cadre des projets d'école ou d'établissement*. Article 34 de la loi du 23 avril 2005, 29 novembre 2011

Jany-Catrice, F. (2009) 'La santé sociale des territoires. Un indicateur de santé sociale pour les territoires français'. *Futuribles* (350)

Klein, J. L., Harrisson, D. (2007) *L'innovation sociale émergence et effets sur la transformation des sociétés*. Montréal: Presses de l'Université du Québec

Laborier, P., Trom, D., Groupe de sociologie politique et morale (Paris), Centre universitaire de recherches administratives et politiques (Amiens) (2003) *Historicités de l'action publique*. Paris: Presses universitaires de France

Laville, J. L. (2005) *Sociologie des services: entre marché et solidarité*. Ramonville Saint-Agne: Erès

Laville, J. L. (2011) *Innovation sociale, économie sociale et solidaire, entrepreneuriat social. Éléments pour une mise en perspective historique*. Document de travail

Lipietz, A. (2001) Pour le tiers secteur : l'économie sociale et solidaire : pourquoi, comment. Paris: La Documentation française/La Découverte

Loncle, P. (2005) 'Territoires et innovation sociale'. *Revue française d'administration publique* n. 115(3), p. 399

Lévesque, B., La jeunesse-Crevier, F., CRISES (2005) 'Innovations et transformations sociales dans le développement économique et le développement social: approches théoriques et politiques publiques', dans coll. *Études théoriques*. Montréal: Centre de recherche sur les innovations sociales (CRISES)

Mémeteau, G. (2002) 'La protection des personnes dans le cadre de l'innovation', in Couty, E. (dir), 'L'innovation en santé'. *Revue Actualité et dossier en santé publique*, n. 39, juin

Ménard, J., Graman-Kibleu, P. (2002) 'L'innovation dans le domaine de la santé', in Couty, E. (dir), 'L'innovation en santé'. *Revue Actualité et dossier en santé publique*, n. 39, juin

Mendell, M. (2006) 'Karl Polanyi et le processus institué de démocratisation économique'. *Revue Interventions économiques* n. 33. http://interventionseconomiques.revues.org/744#quotation

Nyssen, J. (2000) 'Croissance, innovation et éducation', in *Annals of Economics and Statistics* n. 57, jan. mar, pp. 125–157

Organisation of Economic Cooperation and Development, OCDE (2002) *Frascati Manual. Proposed Standard Practice for Surveys on Research and Experimental Development*. Paris

Organisation de coopération et de développement économiques (2001) *Panorama de la société: les indicateurs sociaux de l'OCDE*. Paris: OCDE

Reuter (dir.) (2011) *Rapport sur les expérimentations liées à l'article 34 de la loi d'orientation et de programme pour l'École de 2005*. Rapport de recherche remis au Haut Conseil de l'Éducation le 27 juin 2011. Lille: Université Lille 3, Théodile-CIREL

Richez-Battesti, N., Vallade, D. (2009) 'Économie sociale et solidaire et innovation sociale: Premières observations sur un incubateur dedié en Languedoc Roussillon'. *Innovations* n. 30(2), p. 41

Teboul, J., Malleret, V. (1985) 'Vers une définition opérationnelle des services'. *Politiques et management public*, pp. 21–49

Webpages:

Académie de Paris - Autour de la définition de l'innovation en éducation et en formation.http://www.ac-paris.fr/portail/jcms/piapp1_70427/autour-de-la-definition-de-l-innovation-en-education-et-en-formation?cid=piapp1_70365&portal=piapp2_69419

Ecole changer de cap! Consulté mars 27, 2012c. http://www.ecolechangerdecap.net/

Les Journées de l'innovation - Les journées de l'innovation à l'Unesco, le 28 et 29 mars 2012 - Éduscol. http://eduscol.education.fr/pid25272-cid59102/les-journees-innovation-unesco-29-mars-2012.html

Livre blanc "Un monde d'innovation "Santé 2025". http://www.sante-2025.org/?p=757

'L'innovation: une histoire contemporaine du changement en éducation - Scérén.com - La librairie en ligne de l'éducation'. Information et formation des équipes éducative p. 182

Repousser les frontières de la connaissance - Stratégie Nationale de Recherche et d'Innovation. http://forums.snri.enseignementsup-recherche.gouv.fr/spip.php?rubrique3

Respire. http://www.respire-education.fr

RETIS. 2008. Livre blanc sur l'innovation. http://www.retis-innovation.fr

German literature

General literature

Bartholomeyczik, S., et al. (2010) *GePsA Forschungsverbund Gesundheit Pflege Soziale Arbeit. Kooperationsverbund Hochschulen für Gesundheit e.V*. Online verfügbar unter http://www.hochges.de/tagung2011/pdf/GePsA_Version2010-E2.pdf

Blanke, B., Brandel, R., Hartmann, A., Heinze, R. G., Hilbert, J., Lamping, W. et al. (2000) *Sozialstaat im Wandel. Herausforderungen. Risiken. Chancen. Neue Verantwortung*. Wissenschaftliche Eingangsuntersuchung für das Ministerium für Frauen, Jugend, Familie und Gesundheit des Landes Nordrhein-Westfalen. Online verfügbar unter http://www.iatge.de/aktuell/veroeff/ds/brandel01a.pdf

Böhm, K., Tesch-Römer, C., Ziese, T. (2009) *Gesundheit und Krankheit im Alter. Beiträge zur Gesundheitsberichterstattung des Bundes*. Berlin: Hg. v. Statistisches Bundesamt, Deutsches Zentrum für Altersfragen, Robert Koch-Institut. Online verfügbar unter: http://edoc.rki.de/documents/rki_fv/reJBwqKp45PiI/PDF/21r1eZ1NVL2AY_02.pdf

Bono, M. L. (2006): *NPO Controlling. Professionelle Steuerung sozialer Dienstleistungen*. Stuttgart: Schäffer-Poeschel

Bormann, R., Dauderstädt, M., Fischer, M., Schreyer, M. (2009) *Deutschland 2020. Aus der Krise in eine soziale Zukunft. Ergebnisse des Projektes Zukunft 2020 der Friedrich-Ebert-Stiftung*. Bonn. Online verfügbar unter http://library.fes.de/pdf-files/wiso/06453.pdf

Braun, B. (2012) 'Symposium Demografischer Wandel im Gesundheitswesen'. *Dr. med. Mabuse. Zeitschrift für alle Gesundheitsberufe n.* 37 (195)

Buestrich, M. (Hg.) (2008) *Die Ökonomisierung sozialer Dienste und sozialer Arbeit. Entwicklung - theoretische Grundlagen - Wirkungen*. Baltmannsweiler: Schneider-Verl. Hohengehren

Dahme, H. J. (2000) *Netzwerkökonomie im Wohlfahrtsstaat. Wettbewerb und Kooperation im Sozial- und Gesundheitssektor.* Berlin: Ed. Sigma

Dierks, M. L. (2006) *Bürger- und Patientenorientierung im Gesundheitswesen.* Berlin: Hg. v. Robert Koch-Institut

Downs, M. (2009) *Peer Review zu Sozialschutz und sozialer Eingliederung 2009. Alzheimer und ähnliche Erkrankungen: Der Umgang mit Demenzen in der Hauspflege. Synthesebericht.* Online verfügbar unter http://www.peer-review-social-inclusion.eu/peer-reviews/2009/alzheimers-and-related-diseases/synthesebericht-fr09-de

Eisen, R. (Hg.) (1999) *Pflegebedürftigkeit und Pflegesicherung in ausgewählten Ländern.* Opladen: Leske + Budrich

Enquete-Kommission Demographischer Wandel Deutscher Bundestag (2009) *Herausforderungen unserer älter werdenden Gesellschaft an den Einzelnen und die Politik.* Heidelberg: Decker.

Gaber, E. (2011) *Sterblichkeit, Todesursachen und regionale Unterschiede.* Berlin: Hg. v. Robert Koch-Institut

Golz, H. G., Öztürk, A., Piepenbrink, J., Seibring, A. (2010) *Gesundheit. Aus Politik und Zeitgeschichte*, 45/2010. Online verfügbar unter http://www.bpb.de/files/LKYM51.pdf

Grobe, T. G., Schwartz, F. W. (2003): *Arbeitslosigkeit und Gesundheit.* Berlin: Hg. v. Robert Koch-Institut

Hagemeier, O. von, Bertram, N., Reibnitz, C. (Hg.) (2005) *Homecare. Ein Versorgungskonzept der Zukunft.* Heidelberg: Economica

Hasseler, M. (2011) P*rävention und Gesundheitsförderung in der Pflege - ein konzeptioneller Ansatz.* Weinheim; Basel: Beltz Juventa

Hensen, G. (Hg.) (2006) *Markt und Wettbewerb in der Jugendhilfe. Ökonomisierung im Kontext von Zukunftsorientierung und fachlicher Notwendigkeit.* Weinheim; München: Juventa-Verl

Hey, G. (2000) *Perspektiven der sozialen Arbeit im Gesundheitswesen. Personenbezogene Dienstleistungen als habilitative Ressourcen.* Lage: Jacobs

Hielscher, V., Ochs, P. (2009) *Arbeitslose als Kunden? Beratungsgespräche in der Arbeitsvermittlung zwischen Druck und Dialog.* 1. Aufl. Berlin: Edition Sigma

Hofmeister, C. (2010) *Die Spezialimmobilie Patientenhotel. Als neues Immobilienmodell in Österreich und Deutschland.* Saarbrücken: VDM Verlag Dr. Müller

Hurrelmann, K. (Hg.) (2006) *Handbuch Gesundheitswissenschaften.* 4. Aufl. Weinheim; München: Juventa-Verl

Hurrelmann, K. (Hg.) (2010) *Lehrbuch Prävention und Gesundheitsförderung.* 3. Aufl. Bern: Huber, Hans

Institut für Sozialarbeit und Sozialpädagogik e.V. -Beobachtungsstelle für die Entwicklung der sozialen Dienste in Europa (Hg.) (2001) *Observatorium für die Entwicklung der sozialen*

Dienste in Europa. 4. Arbeitspapier. Angebotsformen und Trägerstrukturen sozialer Dienste im westeuropäischen Vergleich. Online verfügbar unter http://www.soziale-dienste-in-europa.de/Anlage16933/Arbeitspapier_Nr._4.pdf

Knatz, B. (2003) *Hilfe aus dem Netz. Theorie und Praxis der Beratung per E-Mail.* Stuttgart: Pfeiffer bei Klett-Cotta

Koch, B. (2010) *Ressourcen von Nutzern. Eine qualitative Studie zur Erschließung von Ressourcenpotenzialen im Gesundheitssystem.* Hamburg: Kovač

Kruse, A. (2002) *Gesundheit im Alter.* Berlin: Hg. v. Robert Koch-Institut

Kuntz, B., Thier, R., Reichelt, A. (2010) *Bildung und Gesundheit.* Frankfurt, M: Mabuse-Verl

Kürschner, N., Weidmann, C., Müters, S. (2011) 'Wer wählt den Hausarzt zum „Gatekeeper"? Eine Anwendung des Verhaltensmodells von Andersen zur Beschreibung der Teilnahme an Hausarztmodellen in Deutschland'. *Bundesgesundheitsblatt - Gesundheitsforschung – Gesundheitsschutz* (2), S. 221–227

Lademann, J., Kolip, P. (2005) *Gesundheit von Frauen und Männern im mittleren Lebensalter. Beiträge zur Gesundheitsberichterstattung des Bundes.* Berlin: Hg. v. Robert Koch-Institut, Statistisches Bundesamt. Online verfügbar unter: http://www.rki.de/DE/Content/Gesundheitsmonitoring/Gesundheitsberichterstattung/G BEDownloadsT/mittleres_lebensalter.pdf;jsessionid=4B2ADD464514234E05EECDCCFA BAD92B.2_cid238?___blob=publicationFile

Lampert, T., Hagen, C., Heizmann, B., *Gesundheitliche Ungleichheit bei Kindern und Jugendlichen in Deutschland. Beiträge zur Gesundheitsberichterstattung des Bundes.* Berlin: Hg. v. Robert Koch-Institut. Online verfügbar unter: http://www.rki.de/EN/Content/Health_Reporting/GBEDownloadsB/soz_ungleichheit_k inder.pdf?___blob=publicationFile

Lamping, W., Schridde, H., Plaß, S., Blanke, B. (2002) *Der Aktivierende Staat. Positionen, Begriffe, Strategien.* Studie für den Arbeitskreis Bürgergesellschaft und Aktivierender Staat der Friedrich-Ebert-Stiftung

Leichsenring, K. (2010) *Peer Review zu Sozialschutz und sozialer Eingliederung 2010. Qualitätssicherung der Langzeitpflege in Alten- und Pflegeheimen. Synthesebericht.* Online verfügbar unter http://www.peer-review-social-inclusion.eu/peer-reviews/2010/achieving-quality-long-term-care-in-residential-facilities/synthesis-report-germany-2010-de

Leichsenring, K., Stadler, M.(2000) *Persönliche soziale Dienstleistungen: Qualität der Dienstleistung und Qualität der Arbeitsbedingungen.* Österreich: Hg. v. European Foundation for the Improvement of Living and Working Conditions. Online verfügbar unter http://edz.bib.uni-mannheim.de/daten/edz-ma/esl/00/ef0083de.pdf

Leichsenring, K., Stadler, M. (2000) *Persönliche soziale Dienstleistungen: Qualität der Dienstleistung und Qualität der Arbeitsbedingungen.* Österreich: Hg. v. European Foundation for the Improvement of Living and Working Conditions. Online verfügbar unter http://edz.bib.uni-mannheim.de/daten/edz-ma/esl/00/ef0083de.pdf

Lütz, S., Czada, R. M. (Hg.) (2004) *Wohlfahrtsstaat. Transformation und Perspektiven.* 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften

Maynard, A. (2009) *Peer Review zu Sozialschutz und sozialer Eingliederung 2009. Aufrechterhaltung einer intakten Gesundheitsversorgung in Regionen mit Bevölkerungsschwund und Bevölkerungsalterung. Synthesebericht.* Online verfügbar unter http://www.peer-review-social-inclusion.eu/peer-reviews/2009/ensuring-a-functioning-healthcare-system-in-regions-with-declining-and-ageing-populations/synthesis-report-de09_de

Meyer, D. (2003) *Für mehr Wettbewerb im stationären Altenhilfesektor. Handlungsbedarf aufgrund Kapazitätsprognose 2050.* Berlin: Duncker & Humblot GmbH

Müller, M., Böhm, K. (2009) *Ausgaben und Finanzierung des Gesundheitswesens.* Berlin: Hg. v. Robert Koch-Institut

Nagel, E., Braasch, P. (Hg.) (2007) *Das Gesundheitswesen in Deutschland. Struktur, Leistungen, Weiterentwicklung*; mit 56 Tabellen. 4. Aufl. Köln: Dt. Ärzte-Verl

Nowossadeck, E. (2012) 'Demografische Alterung und stationäre Versorgung chronischer Krankheiten'. *Deutsches Ärzteblatt* n. 109 (9), S. 151–157

Oberender, P. (2002) *Wachstumsmarkt Gesundheit. Mit einem Glossar.* Stuttgart: Lucius & Lucius

Pick, P. (2004) *Pflege.* Berlin: Hg. v. Robert Koch-Institut

Ochs, P., Petrenz, J., Reindl, J. (1996) *Ressource. Handbuch zur arbeitsnahen Gesundheitsförderung im Betrieb.* Saarbrücken: ISO

Preusker, U. K. (2008) *Das deutsche Gesundheitssystem verstehen. Strukturen und Funktionen im Wandel.* Heidelberg, München, Landsberg, Berlin, Heidelberg: Economica; MedizinRecht.de

Razum, O. (2008) *Migration und Gesundheit.* Berlin: Hg. v. Robert Koch-Institut

Rebscher, H., Achermann, R. (Hg.) (2009) *Gesundheitssysteme im Wandel.* Heidelberg, München, Landsberg, Frechen, Hamburg: Economica-Verl

Rehfeld, U. G. (2006) *Gesundheitsbedingte Frühberentung.* Berlin: Hg. v. Robert Koch-Institut

Robert Koch-Institut (Hg.) (2004) *Gesundheit von Kindern und Jugendlichen. Schwerpunktbericht der Gesundheitsberichterstattung des Bundes.* Berlin

Robert Koch-Institut (Hg.) (2006) *Gesundheit in Deutschland. Gesundheitsberichterstattung des Bundes.* Berlin

Robert Koch-Institut (Hg.) (2010) *Ziele, Aufgaben und Nutzungsmöglichkeiten. Zahlen und Trends aus der Gesundheitsberichterstattung des Bundes.* GBE Kompakt 1/2010. Online verfügbar unter https://www.gbe-bund.de/gbe10/owards.prc_show_pdf?p_id=12654&p_sprache=d&p_uid=gastg&p_aid=96785405&p_lfd_nr=1

Robert Koch-Institut (Hg.) (2011) *Kompetenz und Souveränität im Gesundheitswesen – Die Nutzerperspektive.* Online verfügbar unter http://www.gbe-

bund.de/gbe10/owards.prc_show_pdf?p_id=13955&p_sprache=d&p_uid=gast&p_aid=2
5931844&p_lfd_nr=1

Robert-Bosch-Stiftung (Hg.) (1999) *Ehrenamt und Wirtschaft. Internationale Beispiele bürgerschaftlichen Engagements der Wirtschaft. Beiträge zum Eherenamt II*. Online verfügbar unter http://www.ehrenamtsbibliothek.de/literatur/Ehrenamt%20und %20Wirtschaft.pdf

Schaarschusch, Oelerich (2005) 'Theroretische Grundlagen und Perspektiven sozialpädagogischer Nutzerforschung', in Oelerich, Schaarschusch (Hrsg.) *Soziale Dienstleistungen aus Nutzersicht. Zum Gebrauchswert Sozialer Arbeit*. S. 9-25. Ernst Reinhardt: München/ Basel

Schmähl, W. (2009) *Soziale Sicherung: ökonomische Analysen*. 1. Aufl. Wiesbaden: VS, Verl. für Sozialwiss

Schölkopf, M. (2010) *Das Gesundheitswesen im internationalen Vergleich. Gesundheitssystemvergleich und die europäische Gesundheitspolitik*. 1. Aufl. Berlin: MWV Medizinisch Wissenschaftliche Verlagsgesellschaft

Schott, T. (Hg.) (2010) *Die Gesellschaft und ihre Gesundheit. 20 Jahre Public Health in Deutschland; Bilanz und Ausblick einer Wissenschaft*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften

Schütte, F. (2003) *Auswirkungen der Pflegeversicherung. Strukturelle und sozialökonomische Folgen für die ambulanten sozialpflegerischen Dienste in Schleswig-Holstein - Handlungsstrategien für frei-gemeinnützige Träger*. 1. Aufl. Bern: Huber

Schwartz, F. W. (Hg.) (2011) *Public Health. Gesundheit und Gesundheitswesen*. 3. Aufl. München: Urban & Fischer in Elsevier

Spatscheck, C., Arnegger, M., Kraus, S., Mattner, A., Schneider, B., (Hg.) (2008) *Soziale Arbeit und Ökonomisierung. Analysen und Handlungsstrategien*. Uckerland: Schibri-Vlg

Specht-Kittler, T. (2005) *Modernisierung des Sozialstaats - Modernisierung der sozialen Ausgrenzung. Auswirkungen auf die Wohnungslosenhilfe in Deutschland*. Bielefeld: VSH, Verl. Soziale Hilfe

Steen, R. (2005) *Soziale Arbeit im öffentlichen Gesundheitsdienst*. München: Reinhardt

Stegmann, R., Huber, A., Berger, J.-J. (Hg.) (2006) *Beschäftigung fördern und sichern. Vereinte Dienstleistungsgewerkschaft*. 1. Aufl. Berlin: Scholz direct (2)

Stöbe-Blossey, S. (2008) 'Soziale Dienste zur frühkindlichen Bildung und Betreuung', in Evers, A., Rolf, G. H., Olk, T. (Hg.) *Handbuch Soziale Dienste*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften, pp. 369–388

Tippelt, R., Hippel, A. von (Hg.) (2009) *Handbuch Erwachsenenbildung, Weiterbildung*. 3. Aufl. Wiesbaden: VS, Verl. für Sozialwiss

Weyerer, S. (2005) *Altersdemenz*. Berlin: Hg. v. Robert Koch-Institut

Wittchen, H. U., Nöthen, M, Jacobi, F., Böhm, K., Klose, M., Ryl, L., Ziese, T. (2009) *Krankheitskosten*. Berlin: Robert Koch-Institut

Care

Bihr, D., Fuchs, H., Krauskopf, D., Ritz, H. G. (Hg.) (2006) *SGB IX - Kommentar und Praxishandbuch*. 1. Aufl. Sankt Augustin: Asgard-Verl

Blass, K. (2011) *Altenpflege zwischen Jederfrauqualifikation und Expertentum. Verberuflichungs- und Professionalisierungschancen einer Domäne weiblicher (Erwerbs-) Arbeit*. Saarbrücken: Iso-Verl

Hörstmann-Jungemann, M. (2007) *Die Pflegeversicherung. Hintergrund und Entwicklung*. München: Grin

Klinger, R., Kunkel, P.-C. (1996) *Sozialhilferecht. Lehr- und Praxisbuch mit systematischer Darstellung*. 5. Aufl. Stuttgart, Berlin, Köln: Kohlhammer

Krahmer, U. (Hg.) (2010) *Hilfe zur Pflege nach dem SGB XII. Leistungen der Sozialhilfe bei Pflegebedarf*. 4. Aufl. Hannover: Vincentz Network

Naegele, G. (2008) 'Soziale Dienste für ältere Menschen', in Evers, A., Rolf, G. H., Olk, T. (Hg.) *Handbuch Soziale Dienste*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften, pp. 404–424

Pfau-Effinger, B., Eichler, M., Och, R. (2006) 'Ökonomisierung und die widersprüchlichen Dynamiken im gesellschaftlichen Arrangement der Altenpflege', in Rehberg, K.-S. (Hg.) *Die Natur der Gesellschaft*. Verhandlungen des 33. Kongresses der Deutschen Gesellschaft für Soziologie in Kassel 2006. Frankfurt/Main [u.a.]: Campus-Verl, S. 2665–2677. Online verfügbar unter http://www.ssoar.info/ssoar/View/?resid=18230

Debt counseling:

Gastiger, S., Stark, M. (2012) *Schuldnerberatung. Eine ganzheitliche Aufgabe für methodische Sozialarbeit*. Freiburg im Breisgau: Lambertus

Groth, U. (Hg.) (1994) *Praxishandbuch Schuldnerberatung*. Köln: Luchterhand

Groth, U. (1994) *Schuldnerberatung. Prakt. Leitf. für d. Sozialarbeit*. Frankfurt/Main, New York: Campus-Verlag

Schruth, P. (2011) *Schuldnerberatung in der Sozialen Arbeit. Sozialpädagogische, juristische und gesellschaftspolitische Grundkenntnisse für Theorie und Praxis. Neuausg*. Weinheim u.a.: Juventa-Verl

Thomsen, M. (2008) *Professionelle Selbstverständnisse in der Schuldnerberatung. Typen und ihre Wechselwirkungen mit individuellen Faktoren und strukturellen Rahmenbedingungen*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften

Disability

Arbeiterwohlfahrt Bundesverband e. V.; Deutscher Caritasverband e. V.; Der Paritätische Gesamtverband e. V.; Deutsches Rotes Kreuz e. V.; Diakonisches Werk der Evangelischen Kirche in Deutschland e. V.; Zentralwohlfahrtsstelle der Juden in Deutschland e. V. et al. (Hg.) (2009) *Gemeinsame Stellungnahme zur Weiterentwicklung der Komplexleistung „Interdisziplinäre Frühförderung".* Online verfügbar unter http://www.dvfr.de/fileadmin/download/Fachaussch%C3%BCsse/Fr%C3%BChf%C3%B6 rderung/Positionspapier_Komplexleistung_Interdisziplin%C3%A4re_Fr%C3%BChf%C3 %B6rderung.pdf

Beck, I., Düe, W., Wieland, H. (1996) *Normalisierung. Behindertenpädagogische und sozialpolitische Perspektiven eines Reformkonzeptes.* Heidelberg: Winter, Programm Ed. Schindele

Bielefeldt, H. (2009) *Zum Innovationspotenzial der UN-Behindertenrechtskonvention.* 3. Aufl. Hg. v. Deutsches Institut für Menschenrechte. Online verfügbar unter http://www.institut-fuer-menschenrechte.de/uploads/tx_commerce/essay_no_5_zum_innovationspotenzial_der _un_behindertenrechtskonvention_aufl3.pdf

Bösl, E., Klein, A., Waldschmidt, A. (Hg.) (2010) *Disability History. Konstruktionen von Behinderung in der Geschichte.* Bielefeld: Transcript

Bundesarbeitsgemeinschaft der Integrationsämter und Hauptfürsorgestellen (Hg.) (2009) *Hilfen für schwerbehinderte Menschen im Beruf. Jahresbericht 2008/2009.* Wiesbaden. Online verfügbar unter http://www.integrationsaemter.de/files/11/JB_BIH2009.pdf

Bundesarbeitsgemeinschaft der Integrationsämter und Hauptfürsorgestellen (Hg.) (2010) *Hilfen für schwerbehinderte Menschen im Beruf. Jahresbericht 2009/2010.* Wiesbaden. Online verfügbar unter http://www.integrationsaemter.de/files/11/JB_BIH10_screen.pdf

Bundesarbeitsgemeinschaft der Integrationsämter und Hauptfürsorgestellen (Hg.) (2011) *Hilfen für schwerbehinderte Menschen im Beruf. Jahresbericht 2010/2011.* Online verfügbar unter http://www.integrationsaemter.de/files/11/JB_BIH10_screen_1.pdf

Bundesarbeitsgemeinschaft der Integrationsämter und Hauptfürsorgestellen (2007); Bundesagentur für Arbeit (Hg.) *Behinderte Menschen im Beruf. Leistungen an Arbeitgeber.* Online verfügbar unter: http://www.guetersloher-stiftung.de/images/custom/info_GT_Aktiv_02_2007.pdf

Bundesministerium der Justiz (2001) *SGB-IX – Rehabilitation, Schwerbehindertenrecht.* 1. Aufl., Stand: 1. Juli 2001. Altötting: KKF, der Fachverl. für Sozialversicherung. Online verfügbar unter: http://www.gesetze-im-internet.de/bundesrecht/sgb_9/gesamt.pdf

Bundesministerium für Arbeit und Soziales (Hg.) (2011a) *Übereinkommen der Vereinten Nationen über Rechte von Menschen mit Behinderungen.* Erster Staatenbericht der Bundesrepublik Deutschland. Online verfügbar unter http://www.bmas.de/SharedDocs/Downloads/DE/staatenbericht-2011.pdf;jsessionid=F4E5FEF3D1AFB5F3C3746745E8BC13A7?__blob=publicationFile

Bundesministerium für Arbeit und Soziales (Hg.) (2011b) *Vorstudie zur Neukonzeption des Behindertenberichtes*. Endbericht

Bundesministerium für Arbeit und Soziales (Hg.) (2011c) *Ratgeber für Menschen mit Behinderung*. Online verfügbar unter http://www.bmas.de/SharedDocs/Downloads/DE/PDF-Publikationen/a712-ratgeber-fuer-behinderte-mens-390.pdf;jsessionid=2F51F32DB6B952BD2D3F4A5841ECDAC3?__blob=publicationFile

Bundesministerium für Arbeit und Soziales (Hg.) (2011d) *Unser Weg in eine inklusive Gesellschaft*. Der Nationale Aktionsplan der Bundesregierung zur Umsetzung der UN-Behindertenrechtskonvention. Online verfügbar unter http://www.bmas.de/SharedDocs/Downloads/DE/PDF-Publikationen/a740-nationaler-aktionsplan-barrierefrei.pdf?__blob=publicationFile

Bundesministerium für Familie, Senioren, Frauen und Jugend (Hg.) (2009) *Lebenslagen behinderter Frauen in Deutschland. Auswertung des Mikrozensus 2005*. Online verfügbar unter http://www.bmfsfj.de/BMFSFJ/Service/Publikationen/publikationsliste,did=132950.html

Bundeszentrale für politische Bildung (Hg.) (2003) *Aus Politik und Zeitgeschichte*. Beilage zur Wochenzeitschrift Das Parlament. Online verfügbar unter http://www.bpb.de/files/Q72JKM.pdf

Dederich, M. (2007) *Körper, Kultur und Behinderung. Eine Einführung in die Disability Studies*. Bielefeld: Transcript

Deinert, O., Bieritz-Harder, R., Deinert-Neumann (Hg.) (2009) *Rehabilitation und Teilhabe behinderter Menschen*. Handbuch SGB IX. 2. Aufl. Baden-Baden: Nomos

Demke, F. (2011) *Das Übereinkommen der Vereinten Nationen über die Rechte von Menschen mit Behinderungen* (UN-Behindertenrechtskonvention). Auswirkungen auf Sozialpolitik und Behindertenhilfe in Deutschland. 1. Aufl. s.l: GRIN Verlag

Deutsches Institut für Medizinische Dokumentation und Information (DIMDI) (Hg.) (2005) *Internationale Klassifikation der Funktionsfähigkeit, Behinderung und Gesundheit (ICF)*

Feldes, W. (2003) *Handbuch Integrationsvereinbarung. Regelungsmöglichkeiten nach dem SGB IX*. Frankfurt am Main: Bund-Verlag

Hermes, G., Rohrmann, E. (Hg.) (2006): *"Nichts über uns - ohne uns!". Disability studies als neuer Ansatz emanzipatorischer und interdisziplinärer Forschung über Behinderung*. 1. Aufl. Neu-Ulm: AG-SPAK-Bücher

Hinz, A. (2004) *Inklusion - mehr als nur ein neues Wort!?* Online verfügbar unter http://www.gemeinsamleben-rheinlandpfalz.de/Hinz__Inklusion_.pdf, zuletzt aktualisiert am 2004

Huber, A., Meissner, F., Stegmann, R., Berger, J.-J. (Hg.) (2006) *Alter, Behinderung und Arbeitsgestaltung. Vereinte Dienstleistungsgewerkschaft*. 1. Aufl. Berlin: Scholz direct (4)

Huber, A., Stegmann, R., Berger, J.-J. (Hg.) (2006) *Gesundheitsprävention durch betriebliches Eingliederungsmanagement. Arbeitsfähigkeit erhalten und sichern. Vereinte Dienstleistungsgewerkschaft*. 1. Aufl. Berlin: Scholz direct (3)

Kastl, J. M. (2009) *Soziologie der Behinderung. Eine Einführung*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften

Kultusministerkonferenz (Hg.) (2011) *Inklusive Bildung von Kindern und Jugendlichen mit Behinderungen in Schulen*. Online verfügbar unter http://www.kmk.org/fileadmin/veroeffentlichungen_beschluesse/2011/2011_10_20-Inklusive-Bildung.pdf

Nirje, B. (1994) 'Das Normalisierungsprinzip. 25 Jahre danach', in *Vierteljahresschrift für Heilpädagogik und ihre Nachbargebiete* n. 63, pp. 12–32

Stegmann, R., Huber, A., Berger, J.-J. (Hg.) (2006) *Zentrale Aufgaben der Schwerbehindertenvertretung. Gundlagenseminar. Vereinte Dienstleistungsgewerkschaft*. 1. Aufl. Berlin: Scholz direct (1)

Thimm, W. (2005) *Das Normalisierungsprinzip - eine Einführung. Ein Lesebuch zu Geschichte und Gegenwart eines Reformkonzepts*. Marburg: Lebenshilfe-Verlag

Waldschmidt, A. (2005) 'Disability Studies: Individuelles, soziales und/oder kulturelles Modell von Behinderung?'. *Psychologie & Gesellschaftskritik* n. 29 (1), pp. 9–31

Wansing, G. (2005) *Teilhabe an der Gesellschaft. Menschen mit Behinderung zwischen Inklusion und Exklusion*. 1. Aufl. Wiesbaden: VS Verlag für Sozialwissenschaften

Managed Care Models

Amelung, V. E. (2008) *Integrierte Versorgung und medizinische Versorgungszentren. Von der Idee zur Umsetzung*. 2. Aufl. Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft

Amelung, V. E., Amelung, A., Schumacher, H. (2004) *Managed care. Neue Wege im Gesundheitsmanagement; mit 12 Fallstudien aus den USA, der Schweiz und Deutschland*. 3. Aufl. Wiesbaden: Gabler (u.a.)

Brinkmann, V. (Hg.) (2006) *Case management. Organisationsentwicklung und change management in Gesundheits- und Sozialunternehmen*. 1. Aufl. Wiesbaden: Gabler

Busse, R., Schreyögg, J., Tiemann, O. (Hg.) (2010) *Management im Gesundheitswesen*. 2. Aufl. Berlin: Springer

Haubrock, M. (Hg.) (2009) *Betriebswirtschaft und Management in der Gesundheitswirtschaft*. 5. Aufl. Bern: Huber

(2010) *Managed Care. Perspektive für das deutsche Gesundheitswesen?* 1. Aufl. Berlin: PVS

Homeless assistance

BAG Wohnungslosenhilfe e. V. (Hg.) *Wo + Wie. Verzeichnis der sozialen Dienste und Einrichtungen für wohnungslose Personen in der Bundesrepublik 2011/2012.* Bundesarbeitsgemeinschaft Wohnungslosenhilfe Eigenverlag

Ballweg, T., Rosenke, W. (2011) *Ein weites Feld: Wohnungslosenhilfe - mehr als ein Dach über dem Kopf. Bewährtes verbessern, Neues annehmen, Kooperation gestalten, für Gerechtigkeit streiten.* [neue Ausg.]. Bielefeld: Verl. der Bundesarbeitsgemeinschaft Wohnungslosenhilfe, BAG W-Verl

Fichtner, J. (2004) 'Männliche Wohnungslosigkeit sehen. Theorie und Erforschung einer Scheinbaren Selbstverständlichkeit'. *Wohnungslos* 2004 (2), pp. 50–55

Hajen, L., Ishorst-Witte, F. (2008) *Stationäre Versorgung Wohnungsloser in einem System der Fallpauschalenfinanzierung.* Bielefeld: BAG W-Verl

Hammel, M. (2000) *Zur Stellung der allein stehenden Wohnungslosen ausländischer Nationalität im Hilfesystem des BSHG.* Bielefeld: VSH, Verl. Soziale Hilfe

Heins, R. (1993) *Obdachlosenreport. Warum immer mehr Menschen ins soziale Elend abrutschen.* Düsseldorf: Zebulon.

Heitmeyer, W. (Hg.) (2008) *Deutsche Zustände.* 1. Aufl. Frankfurt am Main: Suhrkamp

Lutz, R., Simon, T. (2007) *Lehrbuch der Wohnungslosenhilfe. Eine Einführung in Praxis, Positionen und Perspektiven.* Weinheim ;, München: Juventa-Verl

Nouvertné, K. (2002) *Obdachlos und psychisch krank.* Bonn: Psychiatrie-Verl

Preisinger, J. (2011) *Zwischen den Stühlen. Psychisch kranke Frauen in Einrichtungen der Wohnungslosenhilfe; eine qualitative Befragung von Sozialpädagoginnen.* Hamburg: Diplomica-Verl

Rosenke, W., Schröder, H. (2006) 'Frauen und Wohnungslosigkeit. Zur Erscheinungsweise weiblicher Wohnungslosigkeit und den Angeboten der Wohnungslosenhilfe'. *Wohnungslos* n. 48 (1), pp. 1–8

Schröder, H. (2008) *Ist soziale Integration noch möglich? Die Wohnungslosenhilfe in Zeiten gesellschaftlicher Spaltung.* 1. Aufl. Bielefeld: Bundesarbeitsgemeinschaft Wohnungslosenhilfe

Senne, V. (2011) *Weibliche Wohnungslosigkeit. Eine Herausforderung für die Wohnungslosenhilfe*; [Studienarbeit]. 1. Aufl. München: GRIN-Verl (166255)

Hospitals

Rapp, B. (2008) *Praxiswissen DRG. Optimierung von Strukturen und Abläufen.* 1. Aufl. Stuttgart: Kohlhammer

Marrs, K. (2008) *Arbeit unter Marktdruck. Die Logik der ökonomischen Steuerung in der Dienstleistungsarbeit.* Berlin: Edition Sigma

Lauterbach, K. W. (Hg.) (2009) *Gesundheitsökonomie. Lehrbuch für Mediziner und andere Gesundheitsberufe*. 2. Aufl. Bern: Huber

Klinke, S. (2007) *Auswirkungen des DRG-Entgeltsystems auf Arbeitsbedingungen und berufliches Selbstverständnis von Ärzten und die Versorgungsqualität in deutschen Krankenhäusern*. Hg. v. Wissenschaftszentrum Berlin für Sozialforschung (WZB). Online verfügbar unter http://bibliothek.wzb.eu/pdf/2007/i07-301.pdf

Fischer, W. (2002) Dia*gnosis related groups (DRGs) und Pflege. Grundlagen, Codierungssysteme, Integrationsmöglichkeiten*. 1. Aufl. Bern (u.a.): Huber

E-Health

ALIS-Connect; eHealth Suisse; VGIch (Hg.) (2011) *eHealth in der Praxis*. Online verfügbar unter http://www.e-health-suisse.ch/umsetzung/00203/index.html?lang=de

Bauer, S. (Hg.) (2008) *E-mental health. Neue Medien in der psychosozialen Versorgung*; mit 28 Tabellen. Heidelberg: Springer

Duesberg, F. (Hg.) (2010) *E-Health 2011. Informationstechnologien und Telematik im Gesundheitswesen*. 1. Aufl. Solingen: medical future Verl

Jähn, K., Nagel, E. (2004) *e-health*. Berlin: Springer-Verlag

Räpple, B. (2011) 'E-Health und Social Media. Wenn sich Patienten im Internet schlau machen', in *Krankenpflege* n. 7

Reiter, B., Turek, J., Weidenfeld, W. (2011) *Telemedizin-Zukunftsgut im Gesundheitswesen. Gesundheitspolitik und Gesundheitsökonomie zwischen Markt und Staat*. 1. Aufl. München

Grey Literature on Disability - Enil

Alvares, L., Case A. H., Kronenberger J. E., Ortoleva, S., Tosti-Vasey L., J., NOW Foundation Disability Rights Advisory Committee (2011) *Reproductive Health Justice for Women with Disabilities* (*Barbara Faye Waxman Fiduccia Papers on Women and Girls with Disabilities,* Center for Women Policy Studies), April 2011

Background of the Innovation 4 Welfare Initiative, leaflet, November 3, 2010. Available at www.innovation4welfare.eu

Barnes, C. (2008) *An Ethical Agenda in Disability Research: Rhetoric or Reality?* Sage

Barton, L., Oliver, M. (eds) (1997) *Disability studies: Past, Present and Future*. The Disability Press Leeds

Chenoweth, L., Clements, N. (2009) *Final report on funding and service options for people with disabilities*. Griffith University: Queensland, June 2009

Costa, K. (2011) *Innovation for the Public Good: Financing Tools for Social Innovation, Three Financing Principles to Guide Social Innovation.* Center for American Progress, October 2011

Elder-Woodward, J. (2002) Workshop Paper: *Social Work and Disabled People: From crafting clients to sustaining citizens*, Social Work & Disabled People Conference, February, 2002

European Union of Supported Employment Toolkit (2010). Available at www.euse.org

EUSE, *A Quality Standards Framework for Supported Employment Providers.* Available a7 www.euse.org

Evans, J. (2003) *Independent Living and Direct Payments in Europe: Rethink Disability Annual Conference*, Ipswich, November 2003

Finkelstein, V. (1999) 'Doing disability research'. *Disability and Society*, n. 14 (6), pp. 859-67

Genio, *Real, Positive and Lasting Social Change.* Available at www.genio.ie

Glynn, M., Beresford, P., Bewley, C., Branfield, F., Butt, J., Croft, S., Pitt, K. D., Fleming, J., Flynn, R., Parmore, C., Postle, K., Turner, M. (2008) *Person-centred support: What service users and practitioners say.* York: Joseph Rowntree Foundation

Garland-Thomson R. (2001) *Re-shaping, Re-thinking, Re-defining: Feminist Disability Studies, (Barbara Waxman Fiduccia Papers on Women and Girls with Disabilities*, Center for Women Policy Studies)

Kramer, M. R. (2005) *Measuring Innovation: Evaluation in the Field of Social Entrepreneurship*, April 2005

Kohli, J., Besharov J. D.,Costa, K. (2012) *What Are Social Impact Bonds?* Center for American Progress, March 22, 2012

Lawton, A. (2009) *Personalization and learning disabilities: A review of evidence on advocacy and its practice for poeple with learning disabilities and high support needs.* Social Care Institute for Excellence

Mercer, G. (2002) 'Emancipatory Disability Research', in Barnes, C., Oliver, M., Barton, L. (eds) *Disability Studies Today.* London: Polity, pp. 228 – 249

Mulgan, G., Tucker, S., Ali, R., Sanders, B., (2007) *Social Innovation: What it is, Why it Matters and How it Can be Accelerated.* Oxford SAID Business School, Skoll Centre for Social Entrepreneurship, Working Paper, 8

OECD, Centre for Educational Research and Innovation Governing Board Sustaining Inclusive Education (1999) *Including Student with Special Educational Needs in Mainstream Schools*

Oliver, M. (2002) *Using Emancipatory Methodologies in Disability Research, Emancipatory Research: A Vehicle for Social Transformation or Policy Development*, 1ST Annual Disability Research Seminar. Hosted by The National Disability Authority And The Centre for Disability Studies, University College Dublin

Power, A., Centre for Disability Law and Policy, National University of Ireland, Galway, Republic of Ireland (2010) 'Individualised Resource Allocation Systems: Models and Lessons from Ireland?, in *Policy Briefing* n. 2, July 2010

(2001) *Rethinking care from different perspectives.* Collection of papers, Global Conference on Rethinking Care, Oslo

Schalock, R. L. (2004) 'The emerging disability paradigm and its implications for policy and practice'. *Journal of Disability Policy Studies* n. 14(4), pp. 204-215

Stubbs, P. (2009) *Building Capacity to Promote Social Integration and Social Inclusion in the Western Balkans.* Paper produced for Expert Group Meeting on Practical Strategies to Promote Social Integration Lessons learned from existing policies and practices, Accra, Ghana 17-19 November 2009

ULOBA, *A survey on Personal Assistance in Norway.* http://www.uloba.no/templates/Page.aspx?id=16537

UNDESA (2009) *Report of the Expert Group Meeting on Practical Strategies to Promote Social Integration: Lessons learned from existing policies and practices Convened in preparation for the 48th session of the Commission for Social Development*

UNESCO and Ministry of Educational, Scientific and Education and Science (1994) *The Salamanca Statement and Framework for Action on Special Needs Education*, adopted by the World Conference on Special Needs Education: Access and Quality, Salamanca, Spain, 7-10 June 1994. Available at http://www.unesco.org/education/pdf/SALAMA_E.PDF

Vislie, L. (2003) 'From integration to inclusion: focusing global trends and changes in the western European societies'. *European Journal of Special Needs Education*, Vol. 18, n. 1 Integration and inclusion in western societies p. 19

Hungarian literature

Babusik, F. (2003) 'Késői kezdés, lemorzsolódás – cigány fiatalok az általános iskolában', in *Új Pedagógiai Szemle*, 2003/10. Letölthető http://www.oki.hu/oldal.php?tipus=cikk&kod=2003-10-ta-Babusik-Kesoi

Bagyinszki, Z., Kovács, I., Péntek, B. (2004) *Idősek szociális ellátása. Segédanyag a szociális szakvizsgához.* Budapest: Nemzeti Család-és Szociálpolitikai Intézet

Bass, L. (szerk.) (2008a) *'Amit tudunk és amit nem...' Az értelmi fogyatékos emberek helyzetéről Magyarországon.* Budapest: Kézenfogva Alapítvány

Bánfalvy, C. (1998) 'Az intézetekben élő értelmi fogyatékosok életminősége és a kitagolás aktualitása', in Zászkaliczky, P. (szerk.) *A függőségtől az autonómiáig. Helyzetértékelés és jövőkép a kiscsoportos lakóotthonokról*, pp. 177–189. Budapest: Kézenfogva Alapítvány

Baracsi, Á. (2005) *Iskolai lemorzsolódás Szabolcs-Szatmár-Bereg megyében*. Nyíregyházi Főiskola, Neveléstudományi és Szociálpedagógiai Tanszék. Szimpózium-összefoglaló www.ektf.hu/onk/dl/p_szimp_osszefog_szimp_eload.doc

Blaskó et. al. (2009) *Az 1-3 éves gyermekek napközbeni ellátásának bővítése: Költségvetési ráfordítás és várható társadalmi hatások*. Budapest: Budapest Szakpolitikai Elemző Intézet

Budapest Institute (2011a) *The Education System of Hungary – General Overview Handout for the FIO study visit in Hungary, 2011 September*. Available at http://www.budapestinstitute.eu

Budapest Institute (2011b) *School quality and segregation in Hungary. Case study for the project "Good national practices in financing and quality control of rural schools in the European Union: First steps" 26 September 2011*. Available at http://www.budapestinstitute.eu

Budapest Institute (2011c) *The Education System of Hungary – Financing Non-state School Handout for the FIO study visit in Hungary, 2011 September*. Available at http://www.budapestinstitute.eu

Budapest Institute (2010) *Equal opportunity and integration in public education - evaluation of the SROP 331 project*

Bugarszki, Z., Eszik, O., Szentkatolnay, M., Sziklai, I. (2012a) *A nagy létszámú intézmények kitagolása és az önálló életvitel támogatása Magyarországon*. Budapest: Soteria Foundation – Eötvös Loránd University of Sciences

Bugarszki, Z., Eszik, O., Szentkatolnay, M., Sziklai, I. (2012b) *Deinstitutionalisation and Promoting Community-Based Living in Hungary*. Budapest: Soteria Foundation – Eötvös Loránd University of Sciences

Bugarszki, Z., Eszik O., Soltész, Á., Sziklai, I. (2010) *Egy lépés előre, kettő hátra. A nagy létszámú intézmények kitagolása és az önálló életvitel támogatása Magyarországon az Európai Unió strukturális alapjainak felhasználásával*. Budapest: Soteria Foundation – Eötvös Loránd University of Sciences

Bugarszki, Z. (2009) *A nagy létszámú intézmények kitagolásának alakulása az Európai Unió tagállamaiban*. Budapest: SZMI. Kézirat

Bugarszki, Z. (2006a) 'A szociális szolgáltatások várható alakulása – 2005-2015', in Tausz K. (szerk.) *A társadalmi kohézió erősítése. Stratégiai Kutatások – Magyarország 2015*. Új Mandátum Könyvkiadó, Budapest

Bugarszki, Z. (2006b) 'A közösségi pszichiátriai ellátásról'. *Esély* 2006/1

Beadle-Brown, J., Kozma, Á. (2007) *Deinstitutionalisation and community living – outcomes and costs: report of a European Study. Country Reports*. Volume 3. Canterbury: Tizard Centre, University of Kent

Cerami, A., Vanhuysse, P., (eds) (2009) *Post-Communist Pathways: Theorizing Social Policy Transforamtions in Central and Eastern Europe.* Basingstoke, UK/New York: Palgrave/Macmillan

Darvas, Á., Mózer, P. (2004) 'Kit támogassunk?'. *Esély* n. 6, pp. 64-99

Darvas, Á. (2000) *Utak vagy tévutak? A családtámogatások alakulása Közép-Kelet-Európában a rendszerváltás óta.* PhD disszertáció. ELTE BTK Szociológiai és Szociálpolitikai Intézet

Dávid, A., Móricz, R. (2000) *Támogatott foglalkoztatás. Értelmi sérült emberek a nyílt munkaerő-piacon.* Budapest: Salva Vita Alapítvány

Erdős, Z. (2010) 'Gyermekszegénységet, családokat érintő jogszabályváltozások 2005 és 2009 között', in Ferge, Z., Darvas, Á. (eds) *Gyerekesélyek Magyarországon. A "Legyen jobb a gyermeknek!" Nemzeti Stratégia Értékelő Bizottságának 2009. évi jelentése.* Budapest, pp. 172-218

Eurydice (2010) *National system overviews on educational systems in Europe and ongoing reforms*, Chapter on Hungary, available at http://eacea.ec.europa.eu/education/eurydice/documents/eurybase/national_summary_ sheets/047_HU_EN.pdf

Farkas, P. (2002) *A roma tanulók iskolai sikerességének és a roma kisebbség helyzetének javítását szolgáló eszközök és a Nemzeti Fejlesztési Terv.* Új Pedagógiai Szemle, 2002/11

Fazekas, K., Scharle Á. (szerk.) (2012) *Az eltűnt egymillió munkahely nyomában.* Budapest Intézet – MTA KTI http://www.budapestinstitute.eu/index.php?page=11&lang=_hu&msg=118

Fazekas, K., Köllő, J., Varga, J. (2009) *Green Book for the renewal of public education in Hungary*, Budapest. Available at: http://www.econ.core.hu/file/download/letoltes/zoldkonyv_angol.pdf

Fábián, K. (2009) *Contemporary Women's Movements in Hungary. Globalization, Democracy, and Gender Equality.* Washington, D.C./Baltimore: The Johns Hopkins University Press/Woodrow Wilson Center Press

Fehérvári, .(szerk.) (2008) *Szakképzés és lemorzsolódás.* Oktatáskutató és Fejlesztő intézet, Budapest. Letölthető: http://www.ofi.hu/kiadvanyaink/kiadvanyaink/ofi-kotetek

Ferge, Z., Darvas, Á. (2010) *Gyerekesélyek Magyarországon. A "Legyen jobb a gyermekeknek!" Nemzeti Stratégia Értékelő Bizottságának 2009. évi jelentése.* Budapest: MTA Gyerekszegénység Programiroda

Ferge, Z. (1990) 'A törékeny öregek és a közösségi gondoskodás'. *Esély* 1990/2

Ferge, Z. (1969) *Társadalmunk rétegződése. Elvek és tények.* Bp., KJK

Ferge, Z. et al. (2006) *National Program to Combat Child Poverty. Short Program. (Gyermekszegénység Elleni Nemzeti Program. Rövid Program.).* Budapest: Child Program Office of the Hungarian Academy of Sciences

Fónay, M. (2004) 'Romák és az iskola: Lehetőség a kitörésre?', in Mayer, J., Singer, P. (szerk.) A *tanuló felnőtt – a felnőtt tanuló. Felnőttoktatási Akadémia, Gyula 2003.* Szept. 10-12. Budapest, OKI, 2004

FRSZ (2006) *Hungarian Research report on people with disability and employees with changed capacity for work.* 2006. október 16. Szombathely, Foglalkozási Rehabilitációs Szolgálat

Gábor, P., Vályi, R. (2009) *Autizmus – Tény – Képek.* Budapest, Autisták Országos Szövetsége – Jelenkutató Alapítvány

Gyarmati, A. (2010b) 'Changing values and measures in population policy, social policy and child protection in the Hungarian system of family benefits from 1989 to 2008', in *Manka goes to work. Public childcare in the Visegrad countries, 1989-2009.* On line publication, Budapest Institute, Budapest. http://www.budapestinstitute.eu/uploads/manka_goes_to_work_2010.pdf

Hablicsek, L., Pákozdi, I. (2004) 'Az elöregedő társadalom szociális kihívásai', in Gyulavári T. (szerk.) *Az Európai Unió szociális dimenziója.* Budapest: OFA Kht

Hagemann, K., Jarausch, K., Allemann-Ghionda, C. (eds) (2011) *Child Care and Primary Education in Post-War Europe.* New York/Oxford: Berghahn Books

Haney, L. (2002) *Inventing the Needy: Gender and Politics of Welfare in Hungary.* Berkeley/Los Angeles: University of California Press

Harangozó, J. (2000) 'Közösségi pszichiátria – mint a lakóhelyi rehabilitáció modellje', in Huszár, I., Kullmann, L., Tringer, L. (szerk.) *A rehabilitáció gyakorlata.* Budapest: Medicina Kiadó, pp. 131–146. o.

Hazai, I., dr. (1999) 'A szolgáltatások szerepe a szociális ellátásokban', in Tóbiás, L. (szerk.) *Együttműködési lehetőségek civil szervezetek és a helyi önkormányzatok között. Kézikönyv civil szervezetek és önkormányzatok számára.* Hálózat a Demokráciáért Program, Budapest

Hoffmann, I. (2011) 'A helyi önkormányzatok szerepe a személyes jellegű szociális szolgáltatások megszervezésében'. *Esély* 2011/6

Hungarian Helsinki Committee (2008) *Asylum in Hungary. A guide for foreigners who need protection* http://helsinki.hu/wp-content/uploads/Asylum_in_Hungary_info_leaflet_2008_English.pdf

Idősgondozás (2007) *Geriátriai szolgáltatók kézikönyve. Magyarországi idősotthonok, otthoni ápolók és hospice-ok adatbázisa.* Budapest: Geriáter Service Kiadó

Inglot, T. (2008) *Welfare States in East Central Europe, 1919-2004.* New York/Cambridge UK: Cambridge University Press

Jeszenszky, Z. (2010) *Kihívások és feladatok az idősödő társadalomban.* Előadás, Szombathely, 2010. április 29

Jeszenszky, Z. (2006) *Demens idősek ellátásának irányelvei. Kapocs,* 2006. december

Jeszenszky, Z., Rosner, I. (2006) Az időskorú népesség társadalmi helyzete. *Időskorú értelmi fogyatékos emberek kísérése, segítése.* Akadémiai Kiadó, Budapest

Kertesi, G. Kézdi, G. (2005) Általános iskolai szegregáció I-II' in *Közgazdasági Szemle,* LII. évf., április-május

Kézdi, G. (2007) *A szakképzés munkaerőpiaci értékének és struktúrájának változása Magyaroroszágon a rendszerváltás előtt és után.* Budapest: OKA Háttértanulmány, 2007 09.01

Kozma, Á. (2008) 'Az intézetben élő értelmi fogyatékos emberek helyzete', in Bass, L. (szerk.) *„Amit tudunk és amit nem…" Az értelmi fogyatékos emberek helyzetéről Magyarországon.* Budapest: Kézenfogva Alapítvány, pp. 157–177

Köllő, J., Scharle, Á. (2009) *Female labour supply and childcare provision in Europe.* socsci/research/nec/workcare/documents/working_paper6_tarki.doc

Köllő, J., Varga, J. (szerk.) (2009) *Zöld Könyv a Magyar Közoktatás Megújításáért.* Budapest

Köllő, J. (2006) *Workplace literacy requirements and unskilled employment in East-Central and Western Europe.* Evidence from the International Adult Literacy Survey (IALS), Budapest: Working Papers on the Labour Market 2006, n. 7 http://www.econ.core.hu/doc/bwp/bwp/bwp0607.pdf

Központi Statisztikai Hivatal (2011) *StaDat Adatbázis. Óvodák* (StaDat Database. Kindergarten)

Krizsán, A., Zentai, V. (2006) 'Gender Equality Policy or Gender Mainstreaming: the case of Hungary'. *Policy Studies* n. 2, pp. 135-151

Lada, L. (2003) *A hátrányos helyzetből fakadó iskolai kudarcok leküzdésének és a tanulási sikerek kialakításának eszközei és módszerei a közoktatásban.* Letölthető: http://www.oki.hu/oldal.php?tipus=cikk&kod=eselyt-Lada-hatranyos

Liskó, I. (2008) 'Szakképzés és lemorzsolódás', in *Zöld Könyv a Magyar Közoktatás Megújításáért*

Liskó, I. (2003) *Kudarcok a középfokú iskolákban.* Oktatáskutató Intézet. Kutatás Közben sorozat, 250. sz. www.hier.iif.hu/en/letoltes.php?fid=kutatas_kozben/196

Making it Better for our Children. („Legyen jobb a gyermekeknek!") National Strategy. 2007 – 2032 (2007) Declaration of the Parliament, no. 47/2007. (V. 31.). Budapest

Mayer, J. (2006) *Hátrányos helyzetű tanulók és az iskolai előrehaladás problémái.* Esélynövelő és hátránykompenzáló iskolák http://www.oki.hu/oldal.php?tipus=cikk&kod=eselynovelo-Mayer-I

Meyer-Sahling, J. H. (2009) *Sustainability of civil service reforms in Central and Eastern Europe five years after EU acccession*, OECD SIGMA paper no. 44

Ministry of Welfare and Employment (Hungary) (2007) *Report on the implementation of the Hungarian National Action Plan on Social Inclusion for the period 2004 - 2006*

Molnár, E., Dupcsik, C. (2008) *Country Report on Education: Hungary*, EDUMIGROM Background Papers, 2008, available at http://www.edumigrom.eu/sites/default/files/ field_attachment/page/node1817/edumigrombackgroundpaperhungaryeducation.pdf

Mózer, P. (2011) *Szociálpolitika jövő időben. Esély* 2011/6

MTA Gyermekszegénység Program Iroda (2010) *«Give Kids a Chance» Program of Szécsény.* Budapest: Child Program Office of the Hungarian Academy of Sciences http://www.childpoverty.hu/docs/szgyep_2010_en.pdf (13 Septermber, 2011.)

OECD (2008) *Education at a Glance. Enrolment rates of 15-19 year-olds (1995, 2000 and 2007)*
http://www.oecd.org/document/24/0,3343,en_2649_39263238_43586328_1_1_1_1,00 .html

OECD (2008) *Reforms for Stability and Sustainable Growth: An OECD Perspective on Hungary*. Available at http://www.oecd.org/dataoecd/10/60/40415872.pdf

OECD (2007) *Family Database. Chart PF1.1: Public spending on family benefits in cash, services and tax measures* www.oecd.org/els/social/family/database OECD (2006): Equity in education: Thematic review, country note Hungary. Paris: OECD

OECD (2004). *Early Childhood Education and Care. Country Note for Hungary*, OECD Directorate for Education

Pascall, G., Kwak, A. (2005) *Gender Regimes in Transition in Central and Eastern Europe.* Bristol: Policy Press

Péntek, B., Zoltán, L. (2008) 'Idősotthonok. Hol töltsem idős éveimet?'. SpringMed Kiadó: Budapest

Radó, P. (2006) *Small Schools of Small Settlements*. Budapest: SuliNova Kht. 2006

Soós, Z. (2009) 'Reform után. A kistérségi közszolgáltatási reform hatásai a Téti kistérség szociális szolgáltatási rendszerére'. *Esély* 2009/1

Scharle, Á. (2011) *Foglalkoztatási rehabilitációs jó gyakorlatok Magyarországon*. Budapest Intézet, kutatási jelentés, 2011. Április *http://www.budapestinstitute.eu/uploads/BI_tenyek_javaslatok_2011.1.pdf*

Széman, Z. (2006) 'Idősek otthon – új lehetőségek', in Giczi, J. (szerk.) *Öregedés – öregség. Tanulmánykötet a 2006*. június 8-án megrendezett Öregedés – öregség konferencia előadásaiból. KSH, Budapest

Széman, Z. (1995) 'A társadalmi öregedés és következményei az idősgondozásban', in *Kötet az idősekről. Esély füzetek 2*. „ESÉLY" Közösségfejlesztő és Családsegítő Szolgálat

Szikra, D. (2011) 'Tradition Matters: Child Care and Primary School Education in Modern Hungary', in Hagemann, K., Jarausch, K., Allemann-Ghionda, C. (eds) *Child Care and Primary Education in Post-War Europe*. New York and Oxford: Berghahn Books

Szikra, D. (2010) *Iskolai lemorzsolódás*. MTA Gyerekszegénység Program. Available at http://www.gyerekesely.hu

Szikra, D., Szelewa, D. (2010) 'Do Central and Eastern European Countries Fit the Western Picture? The Example of Family Policies in Hungary and Poland', in Klenner, C., Leiber, S. (eds) *Welfare States and Gender Inequality in Central and Eastern Europe: Continuity and Post-Socialist Transformation.* Brussels: European Trade Union Institute (ETUI)

Sziszik, E. dr. (2004) *Az alapellátás, szakellátás és speciális ellátások viszonyrendszere – Humán szolgáltatási koncepció.* Készült a SZOLID projekt megbízásából http://www.google.hu/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCYQFjAA &url=http%3A%2F%2Fwww.szmm.gov.hu%2Fdownload.php%3Fctag%3Ddownload%26d ocID%3D1764&ei=fTCXT_moOcmj-galqqDfDQ&usg=AFQjCNH1s2dcuDFg-DdwW9OeW3kMHPYQzg&sig2=S2N8AyxlMnkgDGmLXf8dLQ

Transmonee Database, Table 7.1 and 7.2 (2011). Available at http://www.transmonee.org/

UN High Commissioner for Refugees (March 2010), *Refugee Homelessness in Hungary.* Available at http://www.unhcr.org/refworld/docid/4bb4b9ac2.html

UN High Commissioner for Refugees, *Hungary as a country of asylum.* http://www.unhcr-centraleurope.org/pdf/resources/legal-documents/unhcr-handbooks-recommendations-and-guidelines/hungary-as-a-country-of-asylum-2012.html

Verdes, T. (2009) '«A ház az intézet tulajdona» A totális intézmények lebontásáról, humanizálásáról és modernizálásáról'. *Esély*, n. 21, 3, pp. 92-114

Legislation, governmental reports:

1949. évi XX. Törvény a Magyar Köztársaság Alkotmánya. (The Constitution of the Republic of Hungary, Act XX of 1949) available at http://www.lectlaw.com/files/int05.htm (accessed 20 April 2012)

Magyarország Alaptörvénye (Fundamental Law of Hungary, 25 April 2011) available at http://www.kormany.hu/download/0/d9/30000/Alapt%C3%B6rv%C3%A9ny.pdf (accessed 20 April 2012)

1993. évi III. törvény a szociális igazgatásról és szociális ellátásokról. (Act III of 1993 on Social Administration and Social Benefits, Hungary, Act III of 1993) http://net.jogtar.hu/jr/gen/hjegy_doc.cgi?docid=99300003.TV

Act LXXX of 2007 on Asylum (Hungary), Act LXXX of 2007, 25 June 2007, available at http://www.unhcr.org/refworld/docid/4979cc072.html (accessed 20 April 2012)

Act XXVI of 1998 - 29(5)

1062/2007. (VIII. 7.) *Nemzeti Fogyatékosügyi Program* (National Disability Program)

EU Commission (2005) *Joint Report on Social Protection and Social Inclusion* (COMM (2005)14 final

Explanatory guideline of the Office of Immigration and Nationality Budapest (2011). Not available for public use

Websites:

Website of the Office of Immigration and Nationality (www.bevandorlas.hu)

Magyar Máltai Szeretetszolgálat honlapja

http://www.maltai.hu/?action=program&programid=18

Website of the Menedék – Hungarian Association for Migrants (www.menedek.hu)

Media sources:

ENSZ: bántalmazzák a menedékkérőket Magyarországon (UN: abusing of aslyum-seekers in Hungary) available at

http://hvg.hu/itthon/20120424_menekultek_jogsertes_ensz (accessed 25 April 2012)

UN slams Hungary for abuse of asylum-seekers

http://www.google.com/hostednews/ap/article/ALeqM5h8-8-tu3HcIX1REFrQxYfRru4hBw?docId=4908975d775d48b4a5e0f78ccc5344f9

Norwegian literature

Health services

Bakke, T., Holte, H. H., Kirkehei, I. (2010) *Kartlegging av nye eier- og driftsformer i omsorgssektoren basert på samvirke, brukerstyring og kooperasjon.* Oslo: Nasjonalt kunnskapssenter for helsetjenesten

Evjemo, B., Stenvold, L. A., Rinde, E. (2010) *Sensorbaserte hjelpemidler i hjemmetjenesten: erfaringer fra 5 sørlandskommuner.* Fornebu: Telenor

Godø, H., Røste, R. & Broch, M. (2005) *Innovation in the public sector: Innovation in home based services for the elderly.* Oslo: NIFU STEP, accessed 14 April 2012 from http://survey.nifu.no/step/publin/reports/d13-5norway.pdf

Holbø, K. et al. (2009) *Kartlegging av behov og muligheter for bruk av robot- og sensorteknologi i helse- og omsorgssektoren.* Trondheim/Oslo: Sintef Helse

Hviding, K. (2006) *Ambulante psykiatriske helsetjenester til barn og ungdom som alternativ til institusjonsbehandling.* Oslo: Nasjonalt kunnskapssenter for helsetjenesten

Jeppesen, E. et al. (2011) *Intermediære enheter og "hjemmesykehus" ved behandling av pasienter med akutt KOLS-forverring.* Oslo: Nasjonalt kunnskapssenter for helsetjenesten

Johansen, V. et al. (2010) *Stabilitet og endring: utviklingen av brukerstyrt personlig assistance.* Hamar: Østlandsforskning

Laberg, T., Aspelund, H., Thygesen, H. (2005) *Smart home technology: planning and management in municipal services*. Oslo: Directorate for Social and Health Affairs, the Delta Centre

Myrvold, T. M., Kristofersen, L. B., Sverdrup, S. (2007) *Brukermedvirkning i psykisk helsearbeid: idealer og realiteter*. Oslo: Norsk institutt for by- og regionforskning

Nordic Council of Ministers (2010) *Health innovation in the Nordic countries: public private collaboration*. København: Nordic Council of Ministers

NOU (2011: 11) *Innovasjon i omsorg*. Oslo: Helse- og omsorgsdepartementet

Sverdrup, S. et al. (2011) *Evaluering av tverrfaglig enhet for dobbeltdiagnoser (TEDD): Resultater fra første fase i en følgeforskning*. Oslo: Diakonhjemmet høgskole

Thygesen, H. (2011) *Teknologi og god omsorg*, Høyskoleforlaget

Tuseth, A.-G. et al. (2006) *Å spørre den det gjelder: erfaring med klient- og resultatstyrt terapi i psykisk helsearbeid*. Oslo: Regionsenter for barn og unges psykiske helse, Helseregion øst og sør

Øderud, T. (1996) *Innovasjon i helsesektorene: kartlegging av innovasjonsprosjekter i Norge, Norden og EU*. Trondheim: SINTEF Unimed

Øderud, T., Holbø, K. (2011) *Sosiale medier for demente*, Sintef - Helse, Trondheim

Welfare services

Aadland, E. (ed) (2009) *Kan institusjoner elske? Samtidsessayer om diakonale virksomheter*. Oslo: Akribe forlag

Aamodt, L. G. I., Aamodt, I., Størkersen, L., Schellenberg, L. (2011) *Samhandling mellom barnevern og BUP: Kunnskapsutvikling i praksis*. Oslo: Gyldendal Akademisk

Andreassen, T. A., Fossestøl, K. (2011) *NAV ved et veiskille: organisasjonsendring som velferdsreform*. Oslo: Gyldendal akademisk

Ask, T. A., Berg, B. (eds.) (2011) *Minoritetsperspektiver i sosialt arbeid*. Oslo: Universitetsforlaget

Askeland, G. A. (eds.) (2011) *Kritisk refleksjon i sosialt arbeid*. Oslo: Universitetsforlaget

Bredland, E. L., Linge, O.A., Vik, K. (2011) *Det handler om verdighet og deltakelse: verdigrunnlag og praksis i rehabiliteringsarbeid*. Oslo: Gyldendal akademisk

Dahle, S., Trauten. T. I. (2010) *Utviklingshemning og tros- og livssynsutøvelse: rettigheter og tilrettelegging*. Oslo: Universitetsforlaget

Djuve, A. B., Tronstad, K. R. (2011) *Innvandrere i praksis: om likeverdig tjenestetilbud i NAV*. Oslo: Fafo

Eide, K. (2009) *Over profesjonelle barrierer: et minoritetsperspektiv i psykososialt arbeid med barn og unge*. Oslo: Gyldendal akademisk

Erdal, B. (2006) *Ute – inne: oppsøkende sosialt arbeid med ungdom.* Oslo: Gyldendal akademisk

Fløtten, T. (ed.) (2009), Barnefattigdom. Oslo: Gyldendal akademisk

Gjernes, T., Bliksvær, T. (2011) *Nye samarbeidsformer – nye læringsformer? Sluttrapport fra evalueringen av forsøket Høgskole- og universitetssosialkontor.* Bodø: Nordlandsforskning

Halvorsen, A., Gjedrem, J. (2006) *Bedre praksis i sosialt arbeid: Evaluering og fagutvikling.* Oslo: Universitetsforlaget

Harsløf, I., S. Seim (eds) (2008) *Fattigdommens dynamikk: Perspektiver på marginalisering i det norske samfunnet.* Oslo: Universitetsforlaget

Heløe, L. A. (2010) *Velferd på avveier? Utviklingslinjer og dilemmaer i helse- og sosialpolitikken.* Oslo: Abstrakt forlag

Hernes, T., Heum, I., Haavorsen, P., Saglie, T. (2010) *Arbeidsinkludering: om det nye politikk og praksisfeltet i velferds-Norge.* Oslo: Gyldendal akademisk

Kunnskapsdepartementet (2012) *Utdanning for velferd: samspill i praksis*, St. meld nr 13 (2011-2012)

Lie, G., Granby, I. (2011) *Mennesket bak rusen: Om Selbukollektivets historie, ungdommenes utviklingsprosess og betydningen av anerkjennelse.* Bergen: Fagbokforlaget

Jakobsen, R., R. Solholm (2009) *Evaluering av PMTO-kurs for fosterforeldre: en effektstudie.* Bergen: Barnevernets utviklingssenter på Vestlandet/UNIFOB Helse

Johannessen, A., Natland, S., Støkken, A. M. (eds) (2011) *Samarbeidsforskning i praksis.* Oslo: Universitetsforlaget

Nuland, B. R., Reegård, K., Sandlie, H.C. (2010) *Tiltak for fattige barn og unge: evaluering av fattigdomstiltakene innenfor tilskuddsordningen Barne- og ungdomstiltak i større bysamfunn.* Oslo: FAFO

Rønning, R., Starrin, B. (2009) *Sosial kapital i et velferdsperspektiv: om å forstå og styrke utsatte gruppers sosiale forankring.* Oslo: Gyldendal akademisk

Sandal, J. (2007) *Sosialentreprenør: en agent med rett til å endre.* Oslo: Kolofon

Schafft, A., Spjelkavik, Ø. (2006) *På vei til jobb? Evaluering av arbeidsmarkedssatsningen for sosialhjelpsmottakere.* Oslo: Arbeidsforskningsinstituttet

Schei, B., Rønning, E. (eds) (2009) *Vilje til endring: Sosialt Entreprenørskap på norsk.* Latvia: Dardedze Holography

Seim, S., Slettebø, T. (eds) (2007) *Brukermedvirkning i barnevernet.* Oslo: Universitetsforlaget

Stamsø, M. A., Hjelmtveit, V. (eds) (2009) *Velferdsstaten i endring: norsk sosialpolitikk ved starten av et nytt århundre.* Oslo: Gyldendal akademisk

Strømberg, S. T. (2007) *Normalisering og hjemliggjøring i en offentlig omsorgsinstitusjon: en studie av personalets omsorgsarbeid og arbeidssituasjon i en omsorgsbolig for utviklingshemmede*. Oslo: Hovedoppgave i sosialantropologi, Universitetet i Oslo

Ulvestad, A. K. (ed) (2007) *Klienten – den glemte terapeut: brukerstyring i psykisk helsearbeid*. Oslo: Gyldendal akademisk

Underlid, K. (2009) *Sosial rettferd: fattigdom og rikdom i det moderne Noreg*. Oslo: Samlaget

Education services

Hagen, A., Nyen, T. (2010) *Kjedeskoler - internopplæring i varehandelen*. Oslo: Fafo

Hansen, Ø. L., Fossan-Waage, T. (2012) *Erfaringer fra bransjerettet samarbeid om opplæring i grunnleggende ferdigheter: En evaluering av prosjekter i samarbeid med Byggnæringens Landsforening (BNL)*, Vox Nasjonalt fagorgan for kompetansepolitikk

Integrerings- og mangfoldsdirektoratet (2011) *Godt no(rs)k? - om språk og integrering, Integrerings- og mangfoldsdirektoratet*. Oslo

Kavli, H. C., Hagelund, A., Bråthen, M. (2007) *Med rett til å lære og plikt til å delta: en evaluering av introduksjonsordningen for nyankomne flyktninger*. Oslo: Fafo

Kunnskapsdepartementet, Kommunal- og regionaldepartementet & Nærings- og handelsdepartementet (2009) *Handlingsplan: Entreprenørskap i utdanningen – fra grunnskole til høyere utdanning 2009–2014*. Oslo: Kunnskapsdepartementet, Kommunal- og regionaldepartementet og Nærings- og handelsdepartementet

Lund, M. (2003) *Kvalifisering for alle: utfordringer ved obligatorisk introduksjonsordning for nyankomne flyktninger*. Oslo: Fafo

Lund, M. et al. (2001) *Fra sosialhjelp til lønnet kvalifisering: resultater fra forsøk med heldags introduksjonsprogram for flyktninger*. Oslo: Fafo

St.meld. nr. 7 (2008-2009) *Et nyskapende og bærekraftig Norge*. Oslo: Nærings- og handelsdepartementet

Ungt entreprenørskap (2005) *Ungt entreprenørskap: entreprenørskap i grunnskole, lek eller alvor?*. Oslo: Ungt entreprenørskap

Ungt entreprenørskap (2010) *Ungt entreprenørskap 2009: Årsmelding* (Young entrepreneurship 2009: Annual report). Oslo: Ungt entreprenørskap

Cross-sectoral social services

Lund, M. (2003) *Kvalifisering for alle: utfordringer ved obligatorisk introduksjonsordning for nyankomne flyktninger*. Oslo: Fafo

Paulsen, V. et al. (2012) *Flyktningguiden som døråpner: Nasjonal evaluering av Flyktningguiden i Røde Kors*. Trondheim: NTNU Samfunnsforskning AS: Avdeling for mangfold og inkludering

Schafft, A., Spjelkavik, Ø. (2011) *Evaluering av Kvalifiseringsprogrammet: sluttrapport*. Oslo: Arbeidsforskningsinstituttet, accessed 30 April 2012 from http://www.afi.no/stream_file.asp?iEntityId=5550

Swedish literature

Health services

Blomqvist, P. (2007) *Vem styr vården? Organisation och politisk styrning inom svensk sjukvård*. Stockholm: SNS

Blomqvist, P., Rothstein, B. (2000) *Välfärdsstatens nya ansikte. Demokrati och marknadsreformer i den offentliga sektorn*. Stockholm: Agora

Dahlin, J. (2008) *Vårda idéerna! Trots många framgångsrika projekt inom vård och omsorg skapas inte varaktiga effekter. Varför förvaltas och utnyttjas inte idéerna?* Stockholm: Vinnova

Helander, A. (1997) *Distriktssköterskans förändrade yrkesroll mot bakgrund av organisatoriska förändringar inom öppen hälso- och sjukvård*. Uppsala: Sociologiska institutionen

Hjertqvist, J. (2000) *Sjukvårdens kulturrevolution. Den stora upphandlingen. Visioner och förberedelser*. Stockholm: Timbro

Lindgren, B., Prütz, C. (1995) *Ädelreformen och organisationsförändringar inom äldre- och handikappomsorgen. En enkätundersökning bland kommunerna i Skåne*. Lund: Samhällsmedicinska institutionen vid Lunds universitet

Lindkvist, L., Aidemark, L.-G. (2005) *Sjukhus som bolag. Om legitimitet och identitet*. Stockholm: SNS

Maycraft Kall, W. (2010) *The governance gap. Central-local steering and mental health reform in Britain and Sweden*. Uppsala: Statsvetenskapliga föreningen i Uppsala

Nyström-Petersson, M. (1998) P*syksikt störda människors livssituation. En delrapport om psykiatrireformens avnämare*. Borås: Högskolan i Borås

Socialdepartmentet (2012) *Uppdrag angående social innovation i vården och omsorgen om de mest sjuka äldre*, S2011/5887/FST, 9 mars 2012. Stockholm: http://www.regeringen.se/content/1/c6/18/81/60/a818735d.pdf (accessed 27.04.2012)

Socialstyrelsen (1994) *Vård och omsorg efter Ädel. Några erfarenheter från Stockholm*. Stockholm: Socialstyrelsen

Socialstyrelsen (2007) *FoU-miljöer på äldreområdet. En explorativ studie med fokus på bidrag till utveckling av vård och omsorg för äldre*. Stockholm: Socialstyrelsen

Welfare services

Socialstyrelsen (2009). *Boendelösningar för hemlösa personer – en kunskapsöversikt.* Stockholm: Socialstyrelsen

SOU (2007: 82) *Samordnad och tydlig tillsyn av socialtjänsten. Slutbetänkande av Utredningen om tillsynen inom socialtjänsten.* Stockholm: Fritzes

Söderholm, J., Wijkström, F. (2002) *Offentlig sektor, näringsliv eller ideell regi – hur påverkar valet av institutionell form vården av missbrukare?* Stockholm: Socialstyrelsen

Cross-sectoral social services

Andreasson, S., Winge, M. (2010) *Innovations for sustainable health and social care. Value-creating health and social care processes based on patient need.* Stockholm: Vinnova

Dahlberg, L. med, Folkesson, H., Lundmark, L.-E. (1991) *Ju fler kockar - desto bättre? Tendensanalys av den svenska välfärdsstatens försök med den tredje decentraliseringen.* Stockholm: Socialstyrelsen

Gavelin, K. (2010) *Uppföljning av överenskommelsen mellan regeringen, idéburna organisationer i det sociala området och Sveriges kommuner och landsting.* Stockholm: Överenskommelse

Gavelin, K. (2011) *Samverkan och påverkan. En studie av överenskommelser mellan två kommuner och idéburna organisationer.* Stockholm: Överenskommelse

Gavelin, K., Kassman, A., Engel, C. (2010) *Om idéburna organisationers särart & mervärde. En forskningskartläggning.* Stockholm: Överenskommelse

Johansson, H., Kassman, A., Scaramuzzino, R. (2011) *Staten och det civila samhällets organisationer i ett föränderligt välfärdssamhälle Perspektiv på en överenskommelse.* Stockholm: Överenskommelse

Johnasson, O. (2011) *Tjäna eller tjäna? Privatisering av vård, omsorg och skola. Vilka tar över?* Stockholm: Famna

Johansson, S. (2005) *Kommunalt stöd till sociala ideella organisationer.* Stockholm: Socialstyrelsen

Möller, T. (1996) *Brukare och klienter i välfärdsstaten. Om missnöje och påverkansmöjligheter inom barn- och äldreomsorg.* Stockholm: Publica

SOU (2000:3) *Välfärd vid vägskäl. Delbetänkande från Kommittén Välfärdsbokslut.* Stockholm: Fritzes

SOU (2000:38) *Välfärd, vård och omsorg. Forskarvolym från Kommittén Välfärdsbokslut.* Stockholm: Fritzes

SOU (2001:79) *Välfärdsbokslut för 1990-talet. Slutbetänkande från Kommittén Välfärdsbokslut.* Stockholm: Fritzes

SOU (2003:23) *Vårda vården. Samverkan, mångfald och rättvisa. Slutbetänkande från Vårdens ägarformer - vinst och demokrati, Statens offentliga utredningar.* Stockholm: Fritzes

SOU (2007:37) *Vård med omsorg. Möjligheter och hinder. Slutbetänkande från Vårdens ägarformer - vinst och demokrati, Statens offentliga utredningar.* Stockholm: Fritzes

SOU (2007:66) *Rörelser i tiden. Slutbetänkande av Utredningen om den statliga folkrörelsepolitiken i framtiden.* Stockholm: Fritzes

SOU (2008:51) *Värdigt liv i äldreomsorgen. Betänkande av värdighetsutredningen.* Fritzes, Stockholm

Trydegård, G.-B. (1996) *En förändringens tid? Äldreomsorgen ur ett medborgarperspektiv.* Stockholm: Socialhögskolan vid Stockholms universitet

Websites:

www.famna.se

www.framtidskommissionen.se

National innovation strategy: http://www.regeringen.se/sb/d/14440/a/161379).(27.04.12)

www.regeringen.se

www.socialstyrelsen.se

www.ungdomsstyrelsen.se

www.vinnova.se

www.overenskommelsen.se