Integrated Care, Choice and Competition

Challenges and strategies of care coordination in the context of market-oriented governance in Germany and Sweden

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Introduction

This study addresses one of the most puzzling dilemmas in the political, economic and professional development of long-term care (LTC) over the past few decades – the question whether market-oriented governance based on competition and choice is compatible with the most desirable and allegedly most effective delivery of integrated long-term care.

Long-term care services and facilities have gained in importance as a significant segment of European welfare states due to rising demand, changing gender relations and consequently to their growing professionalisation and commodification. Placed at the interface between acute health care and social care, long-term care is still mainly provided by unpaid family members, but a growing sector of economic activities with a wide range of stakeholders, e.g. professionals, provider organisations, funders and purchasing agencies, has taken shape – with new types of services and stakeholders that intensified fragmentation and multi-stakeholder governance structures.

Today, this sector represents added value that has exceeded that of agriculture and forestry (Güntert & Thiele, 2008) with public expenditures of up to 4% of GDP as in Sweden and the Netherlands, even if in many countries in East and Southern Europe long-term care is only slowly starting to become acknowledged as a social risk. The long-term care sector, together with health care, has also been one of the most important drivers of employment growth in most European countries – even during the period of the global financial crisis (European Commission, 2014). Despite this, the sector is facing huge challenges to close the gap between further rising demand and a dwindling supply of labour force (Schulz & Radvansky, 2014).

Health and long-term care provision have undergone a series of transformations in the past decades while trying to cope with increased demand brought by demographic ageing and calls for more efficiency as available budgets tightened. Among the transformations implemented, a number of countries introduced market mechanisms to govern the provision of both health and long-term care. These market mechanisms brought about increased possibilities of choice for end users of care and arguably increased competition between different providers as a mixed economy of care provision was established (Rodrigues et al., 2014). One concern arising from these market developments is that competition may have contributed to further fragmentation of care provision and to new challenges for users, many of which are in a vulnerable situation and now have to navigate an ever more complex system of providers to address their care needs (Leutz, 1999; Gage et al., 2012).

Methodology

The key-question, how increasingly fragmented provider markets that promote choice in a competitive environment are compatible with more integrated health and long-term care delivery, has been approached in this study by a mixed methodology. This included a literature review and three case studies in Germany and Sweden, namely in Dortmund, Leipzig and Norrtälje (Stockholm County) where key-stakeholders were interviewed following a semi-structured questionnaire (see Annex).

The two countries were chosen for comparison to contrast the country with the most pronounced open market for care services in Europe (Germany) with Sweden, where the market share of private providers is growing, but still comparatively low, and where the 'customer choice' model has only been introduced since 2008. The sites for case studies were selected after an intensive search for

examples of integrated care networks in Germany and Sweden, and collection of comprehensive information, supported by national experts. Once identified, it was essential to get support by key-stakeholders in the chosen sites for selecting interviewees and getting access to information. In Sweden this could unfortunately be realised in only one site, in spite of several attempts to bring potential sites into this study (one reason for this might be that many integrated care sites and municipalities that introduced the customer choice model have already been subject to several evaluations and research projects over the past few years).

In each of the three municipalities between 5 and 7 semi-structured interviews were carried out with key stakeholders (in most cases face-to-face, in a few cases by phone; see Annex 2) between Autumn 2014 and Spring 2015 to shed light on the consequences of enhanced user choice and competition between providers for endeavours to form integrated care networks. The key-questions in these interviews focused on potential contradictions and compatibilities of competitive markets with the necessities of coordination and integration inherent to long-term care delivery (see Annex 1). In order to gain insight into daily practice and related strategies it seemed coherent to choose two local experiences that have made explicit efforts to better coordinate LTC delivery and to promote integrated care. As already mentioned, this could be realised only in Germany, while in Sweden only one case study could be carried out. The interviews were recorded, partly transcribed and synthesised in English translation from German, respectively Swedish. Interviewees were asked to consent to the use of their statements for the purpose of this study, as complete anonymity could not be guaranteed, given their often unique positions in their organisations.

While this report will present and analyse the results of these three case studies in Dortmund (North-Rhine Westphalia), Leipzig (Saxony) and Norrtälje (Stockholm County), it should be noted that a supplementary survey is currently on-going, by which both German and Swedish care managers' views on integrated care, choice and competition will be collected and analysed, based on an online questionnaire.

The interviews were carried out by Rebecka Falk in Norrtälje and by Juliane Winkelmann in Dortmund and Leipzig. Ricardo Rodrigues and Kai Leichsenring wrote the theoretical parts, supported by Juliane Winkelmann, and analysed the transcripts and other material to compile this report.

Structure of the report

The present report provides an overview of theoretical considerations concerning the compatibility of choice and competition with integrated care as well as definitions of key concepts in Chapter 1. Chapter 2 is dedicated to the presentation of general framework conditions of health and long-term care systems in Sweden and Germany, and to the presentation of the selected sites of case studies. Chapter 3 then presents the most important findings from expert-interviews in a comparative perspective. Finally, the discussion of findings leads to general conclusions and potential opportunities for mutual learning in Chapter 4.

Acknowledgements

Chapter 1

Theoretical considerations on the compatibility of choice and competition with integrated health and long-term care

As most health and social care systems were only poorly prepared for the rising demand for long-term care, many scholars have argued that more integration between health and social care services would be needed to create coherence and synergy between the various parts "to enhance system efficiency, quality of care, quality of life and consumer satisfaction, especially for complex and multi-problem patients and clients" (Kodner 2009, p.7).

The dynamics in the debate on integrated care have taken place in the context of a major paradigm shift in the area of public administration towards new types of governance mechanisms, generally synthesised under the heading of 'New Public Management'. By increasing competition between providers, introducing purchaser-provider splits and competitive tendering, efficiency of services would be improved and, at best, public expenditures would be reduced. Concomitantly, a strong consumerism discourse emerged, which sought to provide citizens and clients of hitherto public services with more choice over the provider or services to receive.

It seems to be evident at first sight that this kind of market-oriented governance and based on competition and user choice and the above mentioned discourse on integrated care might not easily be compatible, although both allegedly intend to reach similar objectives, namely more user satisfaction and better efficiency. But is it possible to align 'working in partnership' with competition on the market? Are public purchasers able to define market-rules that promote cooperation and coordination? Can long-term care services be defined and controlled in the same way as products and services such as telecommunication, public transport or waste management? Are users able to choose between individual providers or between 'care packages' offered by various agencies? And if yes, are providers competing for 'care packages' or for individual chunks of services? Are competition and choice based on prices and/or quality? What consequences do professionals and users of 'integrated care services' experience under conditions of competition and increased user choice? And how can services be integrated/coordinated across social and health care sectors, if they are subject to different regimes of funding and regulation?

While some of these issues were addressed in previous research (Rodrigues et al., 2014) this chapter will address them by providing insight in the two strands of theoretical discourse that are dealing with market-oriented governance and with integrated care. These strands have only recently started to 'meet' each other, which will be shown by a brief review of relevant literature. As a corollary, this Chapter will draw conclusions and open questions from theoretical deliberations and general insights to develop the guiding queries for the empirical part of the study. In its first section, some basic and general definitions and concepts of 'integrated care' will be discussed with a focus on long-term care for older people, including some examples to illustrate practice in selected European countries. The second section will exhibit the theoretical consequences and problems of integrated care delivery in the context of market-oriented governance.

1 The discourse on 'integrated long-term care': Co-ordination, linkage and the divide of health and social care

The rising numbers of older people with complex and long-term conditions and multiple chronic diseases have resulted in a significantly growing need for medical and social services on a short and long-term basis (Mathers & Thomas, 2012; Leutz, 1999). In fact, life-expectancy has been prolonged thanks to important achievements of medical progress, but neither health care systems nor social services, have been well prepared to deal with its consequences, thus placing huge pressure on family carers and other types of informal care. Although the latter remain to be the backbone of long-term care delivery, the health and social care systems across Europe continue to grow, though in a fragmented and not always well coordinated way. Against this backdrop there are increasing concerns about the fiscal sustainability of health and long-term care systems.

In this context, the quest for more efficient provision of care and better outcomes for patients and patient satisfaction triggered a whole range of concepts that elaborated on the need for more integrated approaches of medical and social service delivery (Leutz, 1999; Leichsenring, 2004; Kodner, 2002). The various concepts of integrated care have come under different names to create connectivity, alignment and cooperation between specialised and differentiated sectors of health care, but also between cure and care sectors. Integrated care is most frequently equated with managed care (US), transmural care (NL), shared care (UK), case management or disease management (Kodner & Spreeuwenberg, 2002; Leichsenring, 2004; Kodner, 2009). Given the diversity of terminology of integrated care a definition of the concept is necessary in order to ensure common understanding of this concept across different health and care systems.

Integrated care can be commonly defined as a process in which single units of the health care system (e.g. acute, primary care) and long-term care (e.g. home care, residential care) act in a coordinated way with the aim to ensure cost-effectiveness and improve quality outcomes for users, quality of life and consumer satisfaction for patients with complex, long term conditions cutting across multiple services, providers and settings (Kodner, 2009; Leichsenring, 2004; Leutz, 1999; Kodner & Spreeuwenberg, 2002). Integration can take place at different levels of service delivery. Integration processes can aim at the individual level (e.g. multi-professional teams, case management), defined as horizontal or institutional integration while vertical integration relates to different levels such as coordination and integration between primary, secondary and tertiary care (Gröne & Garcia-Barbero, 2001; Leichsenring, 2004). Furthermore, methods and models of integration do not only concern alignment processes at the individual, service delivery or clinical levels and related interfaces (e.g. hospital discharge, transition) but may also refer to governance, administrative and funding processes such as, for instance, joint health and social care funds, joint training and prevention approaches (Allen et al., 2013; Kodner & Spreeuwenberg, 2002).

In his seminal article Leutz (1999) discussed 'Five laws for integrating medical and social services' in terms of *linkage*, *coordination* and *full integration* that are necessary to address different needs of different types of patients and clients:

- *Linkage* is the looser form of integration in fragmented systems, with professionals from different backgrounds and institutions establishing working relationships between them (e.g. gaining knowledge about whom to contact, eligibility criteria and who is responsible for payment), while

services maintain their independence and broad scope of intervention. Another term that is often being used for this stage of integration is *networking*.

- *Coordination* takes this one step further by creating explicit structures and individual positions that are charged with coordinating services across different systems of care that nonetheless remain separate. The coordination often focuses on sharing information, managing transitions, coordinating the use of services or eligibility for people that require treatment from different systems of care. It seeks to work around weak points and barriers by identifying discontinuity or barriers between systems.
- The third and final level of integration, *full integration*, creates a new functional unit that pools resources (e.g. benefits, staff) from different systems or providers under one organisational roof. Services operate virtually or through common ownership with direct control over resources (e.g. information is no longer shared, but rather assembled and used in a single record). Full integration thus creates new systems or providers.

These forms of integration correspond to different levels and types of needs of individuals defined by the stability and severity of the patient's condition and duration and urgency of the intervention. While *linkage* of services is adequate for persons with mild impairments needing only limited coordination, *coordination* is most appropriate in situations with more complex needs and impairments where structures are necessary that ensure coordination in particular when capacity of self-direction is limited. *Full integration* is needed in situation where patients with severe and long-term disabilities need specialised services with close exchange across professionals (Leutz, 1999).

1.1 The divide of health and social care

Integrated care has to overcome the challenge of the organisational separation of social or community care and health care (e.g. hospital care), typically provided within two systems with separate organisational structures, policies and funding mechanisms. Over the past decades many factors have contributed to the divide of health and care systems and professional groups, among other "differing rules, inter-sectoral boundaries (as between health care, mental health care, and social care), funding streams, and institutional and professional cultures ..." (Kodner & Spreeuwenberg, 2002).

As coordination and integration have first become an increasing challenge within the health care system – among other reasons due to rising numbers of patients with chronic diseases, older patients with multimorbidities and dementia (Nolte & McKee, 2008) – a number of measures have been developed, reaching from new functions such as 'case management' and 'discharge management' to re-defined processes such as 'disease management' and more sophisticated 'managed care' schemes (Coleman et al., 2009). These mechanisms were designed to help solve some issues of fragmentation within the health system, namely the increasing differentiation and specialisation within the medical professions and organisational arrangements (Axelsson & Axelsson 2006), but also disease-oriented hospital financing to enhance efficiency and to reduce patients' length of stay (Busse et al., 2011).

As a result of improvements in medicine and the health care system in general, the structural arrangements of ensuing care provision in the community (often including primary care) have often been overburdened or not sufficiently prepared. In addition, people in need of long-term care and their carers often saw new types of boundaries arising within the formal care system(s) and between

those and the informal care sector that continues to play a decisive role in the provision of help and support.

A number of reforms and interventions could therefore be observed that contributed to the emergence of new funding mechanisms, though still distinct from health care financing, as well as new policies, political responsibilities and organisational structures that address long-term care, in particular related to older people, as a social risk of its own. Still, the emergence of LTC as an own system with a distinct identity, new linkages and coordination mechanisms (Figure 1.1), remains characterised by fragmentation due to cultural and professional boundaries as well as to different funding arrangements and eligibility rules with distinct goals and incentive structures (Leichsenring et al., 2013).

Figure 1.1   Towards long-term care as an integrated system of care provision?
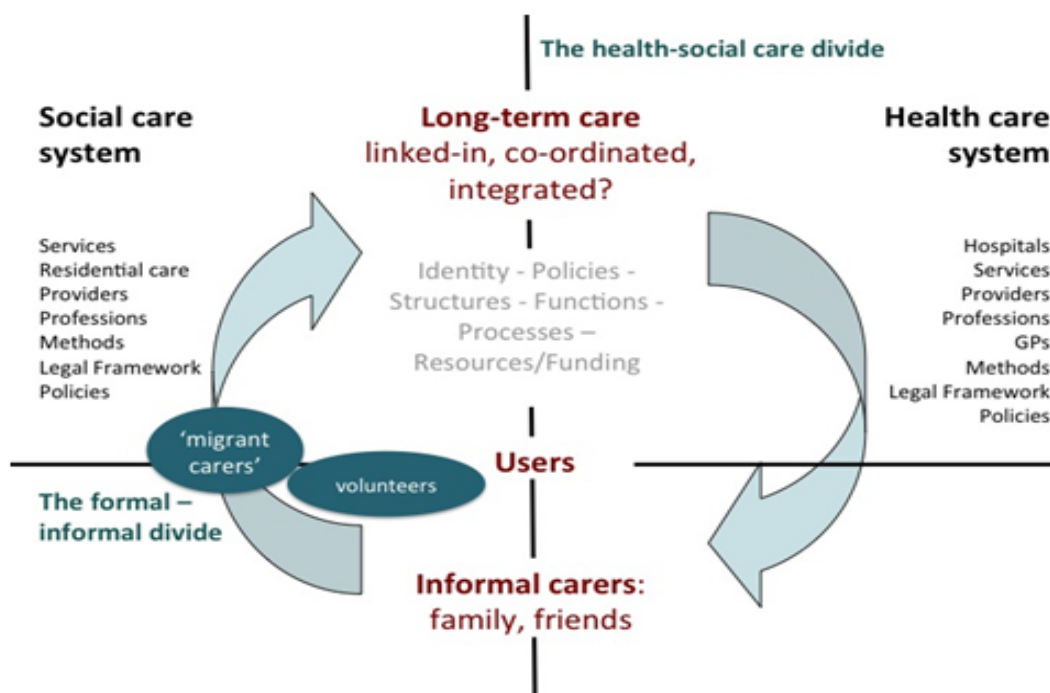
Source: http://interlinks.euro.centre.org, Leichsenring et al., 2013.

- Cultural and professional boundaries are due to the fact that medical and nursing professionals are mainly educated and trained in hospital environments with a strong focus on 'cure' rather than (long-term) care. Such approaches often clash with more socially oriented values such as dignity, privacy and quality of life in community care, but also in other long-term care settings.
- Different funding and governance mechanisms in LTC have contributed to complexity at two levels. On the one hand, some countries (e.g. Germany) have based the development of LTC systems on access to individual cash payments or vouchers (Ungerson & Yeandle, 2007; Yeandle et al., 2012; Da Roit & Le Bihan, 2010), considering beneficiaries as customers that are able to compose their care arrangements with the help of informal and formal care providers. Furthermore, health and social care budgets, respectively those for LTC, have traditionally been administered by different levels of governance – e.g. county and municipal levels in Sweden or national (social health insurance) and local (social assistance) levels in Germany. On the other hand, and sometimes concomitantly, the 'care market' was opened to new types of providers that enhanced possibilities of choice, but also fragmentation and complexity.

The different welfare traditions and contextual conditions have created a large variety of approaches to address and overcome the specific challenges linked to fragmentation alongside the continuum from linkage, networking and coordination to full integration. An important aspect of contextual conditions is represented by the implementation of New Public Management tools such as, for instance, the creation of quasi-markets in the area of health and long-term care.

1.2 Practice examples of integrated care

In practice, a variety of designs for integrated care have developed across the globe, often creating new types of boundaries as well as new challenges for user choice and competition. In the following, some examples from England, France, Switzerland will illustrate these challenges and the range of responses to integrated care that can be found across Europe.

1.2.1 Linkage between hospitals and community care: The Express Service in Switzerland

In the German speaking cantons of Switzerland, there is a commissioning approach involving managed competition between service providers. Thus users can choose between mostly private non-profit home care providers.

The Express Service from the home care organisation of the City of Bern aims to provide and organise home care for older people (80 years and older) after a hospital stay that is in most cases unplanned. Within the Express Service the hospital, general practitioners, informal carers or the patient him/herself are enabled to announce the impending discharge to the home care organisation, by mail or by phone, through a single entry point. The request for care is forwarded to the home care centre of the district in which the patient is a resident. The home care professional who is usually the person taking care of the patient at home, carries out the initial assessment while the patient is still in the hospital. The hospital doctor gives the information on the spot, in presence of the patient (Gobet, 2011).

This organisational setting enables a more direct and efficient communication between the parties involved during a hospital discharge as gaps and ambiguities are immediately clarified and needed home care services adequately planned. Thus, the information flow between both institutions is guaranteed and the customer is informed by a single home care nurse.

1.2.2 Networking in the community: Coordinating Care for Older People (COPA) in France

The French long-term care system is characterised by trends both towards consumer orientation, through vouchers and fiscal incentives, and towards provider competition. With the introduction of the newly created pre-paid service voucher, the 'personalised independence allowance' (APA – Allocation Personnalisée à l'Autonomie), users of long-term care services are allowed to directly employ a domestic worker who could also be any family member. Thus beneficiaries became entitled to use the allowance for hiring private employees or selecting a supplier (Bode et al., 2011).

The pilot programme COPA was initiated by the public health department of St. Quentin University and aims to allow frail older people to remain at home as long as possible and to improve discharge from hospital. The care of individual patients is managed by a team led by a case manager and a primary care physician. The network involves all voluntary health and social care organisations

(nursing homes, nursing and home help agencies) located in the catchment area of the University hospital as well as voluntary self-employed health and social professionals. All partners are able to participate in the development of new care pathways. The case manager takes a central role in the process as he/she discusses the care plan with the multidisciplinary team, first of all with the general practitioner, and coordinates health and social services among the care providers (Naiditch, 2011).

This initiative demonstrated that a common culture for planning and implementing new care pathways is possible and can be achieved across different professions and providers.

1.2.3 Full integration by joint funding: The Torbay and Southern Devon Health and Care NHS Trust

Torbay Care Trust was created in 2000 as a single organisation with responsibility for the commissioning and provision of health and social care. Since 2002 health and social care professionals work jointly together providing services to the population of Torbay (135,000) which led to the legal establishment of a Care Trust in December 2005. The Care Trust is a NHS body, from which Torbay Council commissions its adult social care services. Its objective is to improve quality of care for users, simplify access, reduce number of assessments, improve referral times, improve independence and reduce hospitalisations.

Care is provided by multidisciplinary health and social care teams, with care co-ordinators who work in geographical 'zones' aligned to general practices. Each team has one manager, and one referral entry point, and uses one assessment process. The teams provide a range of services that meet the specific needs of older people that are discharged from hospital or that are at risk of hospitalisation living in the community. The teams include care co-ordinators, community nurses, occupational therapists, physiotherapists, social workers, family physicians, hospitals and home care (Øvretveit, 2011).

This example shows a successful 'merger' between health and social care professionals and hints at the importance of joint commissioning in integrating health and social care.

2 The discourse on integrated care in the context of quasi-markets

Health and long-term care provision have undergone a series of transformations in the past decades in the attempt to cope with increased demand brought by demographic ageing. Against this backdrop, achieving increased efficiency in the delivery of care has become an ever more salient issue. Market-based mechanisms (choice and competition) and new forms of public management based on the reorganisation of services through greater disaggregation of public organisations into separately managed units (Hood, 1995) were two of the strategies implemented to achieve greater efficiency, progressively also in the area of care service delivery. Concomitantly, greater integration of care was also presented as a possible efficiency-enhancing strategy by avoiding duplications and streamlining care provision (Gröne & Garcia-Barbero, 2001; Leichsenring, 2004).

Similar policy developments have taken place in health and long-term care sectors across Europe, in particular in Germany and in Sweden. In Sweden, competition and choice were introduced in health and long-term care by the so-called Ädel reform (1992 and LOV, 2009) with the aim to improve efficiency in care delivery, which led to both a decentralisation of health care and a fragmentation of health and long-term care (Andersson & Karlberg, 2000; Ahgren & Axelsson, 2011; Erlandsson et al.,

2013; Ahgren & Nordgren, 2012). At the same time, an alternative discourse based on the concepts of 'chain of care' and 'local health care' has been promoted by policymakers in order to foster integration between professionals and organisations as a remedy for fragmentation of health care delivery (Ahgren & Axelsson, 2011).

In Germany, the comprehensive long-term care insurance (1994) was introduced in a general context of public management reforms ('Neue Steuerung') that also came with market-oriented governance, more user choice and enhanced competition. The German 'care market' had thus been opened to new, private for-profit organisations to complement the hitherto prevailing 'oligopoly' of non-profit organisations in the delivery of long-term care. Still, also in Germany these developments were complemented by claims for better coordination and integration under the heading of 'Integrierte Versorgung', which was often restricted to disease management in health care (Glaeske, 2002; Mühlbacher et al., 2006; Weatherly et al., 2007; Lange et al., 2012) and with a larger perspective in long-term care (Roth & Reichert, 2004; Expertenkommission Pflege, 2008).

In theoretical argumentation, as well as in the policy discourse, these two policies – promoting competition and user choice as against aiming for integration of care – have often been presented as opposites (Ham, 2012). This begs the question of just how (in)compatible competition and user choice are with integrated health and long-term care. There is however a dearth of theoretical reflection and empirical research on this aspect of care provision.

This section aims to review the theoretical and empirical arguments on the effects of choice and competition in the integration of health and long-term care, discussing both challenges and opportunities that market mechanisms entail for integrated service. These theoretical underpinnings will inform the design of the qualitative and quantitative research in a selected set of municipalities with integrated care initiatives in Germany and Sweden that will be undertaken in the next part of this project.

2.1   Conciliating choice and competition with integrated care

Competition and choice are in many perspectives apparently contradictory with the characteristics of integrated care networks, particularly if the latter translate into greater market concentration and reduced possibilities of choice for the user due to vertical integration (Ham, 2008; Ham & Smith, 2010). Conversely, features of competition and choice seem also incompatible with integrated care. For instance, integration of care might be inhibited by users and/or public purchasers (case managers) buying individual services rather than 'packages' of care or if competition between providers prevails over cooperation and transparent information (Rodrigues et al., 2014). This does not mean however, that some elements of competition and choice cannot be incorporated into integrated care. Users might be allowed to choose between integrated care networks that compete with each other for users (Ham, 2008). Payments and incentives may be designed in ways that foster cooperation between providers and/or by outcomes-based payment (Ham & Smith, 2010). Furthermore, integration in itself is a well-known response by organisations to competitive environments, and institutional economics have long studied the conditions under which organisations might find it more efficient to integrate (Williamson, 1975; Williamson, 1985; van Raak et al., 2005).

The next sections review some of the arguments and evidence regarding these challenges and opportunities for conciliating competition and choice with integrated care.

2.2 Challenges for conciliating choice and integrated care

User choice (e.g. facilitated by vouchers or cash benefits) enables users to change care providers according to their preferences. This entails several challenges for integrated care provision. Firstly, it can lead to greater financial uncertainty for care providers, particularly if financing entails that 'money follows the user' (Baxter et al., 2011), which has been demonstrated to be a potential barrier to integrated care (Cameron et al., 2014).

Secondly, depending on how user choice is being operationalised, it can also contribute to greater fragmentation and discontinuity of care provision, by rendering continuous contact and coordination among providers more difficult. This is the case when users have choice only over individual parts of the integrated care network, e.g. over GPs or home care providers, instead of choice between different integrated care networks (Ahgren & Nordgren, 2012). The potential for fragmentation and increased costs is even higher if choice within the care network is coupled with fee-for service payments (Hawkins, 2011).

Thirdly, some forms of integrated care may hamper user empowerment. One of the strongest arguments in favour of user choice has been the empowerment of users vis-à-vis professionals, particularly in long-term care (Kremer, 2006). In integrated care, key workers (e.g. case managers, care counsellors) are often positioned at the boundaries between systems or providers to help users make links between different types of care. One concern raised by these forms of integrated care is that they place too much power in the hands of professionals (Rummery, 2009), potentially leading to paternalism and disempowering mechanisms that were at the heart of salient claims for user choice.

The above arguments notwithstanding, there is some evidence that the potentially hampering effect of integrated care on user choice, and vice versa, might be overstated (Goodwin, 2006; Fotaki, 2006). Individuals tend to be much more conservative in changing providers in both health and long-term care, unless services are perceived as inaccessible or completely unacceptable (Ahgren, 2010). The opportunity to take advantage of choice also depends on users' abilities to travel to alternative providers and it is very much shaped by geographical factors such as proximity (Ahgren & Nordgren, 2012). Patients with chronic conditions and older people often have limited cognitive capacities that may affect their ability to manage the information needed to carry out informed decisions (Meinow et al., 2011). Older people or patients with complex conditions prefer continuity of relationships with a defined care provider in order to maintain good interpersonal relations both in long-term care (Rodrigues & Glendinning, 2014) and in primary health care (Freeman & Richards, 1993; Ahgren & Nordgren, 2012), thus further limiting the ability to exit a provider. In general older people seem less interested to frequently change their care provider (Freeman & Richards, 1993; Lisac et al., 2010; Rostgaard, 2011). User choice might be more appropriate in a context where users have time to make decisions, such as elective surgery or choice of GPs, rather than when they are under duress, as it is often the case with chronic patients in need of long-term care (Castle, 2003).

Finally, in the context of integrated health and long-term care, user choice is not reduced to the choice of provider, but may involve rather more complex decisions about treatment pathways, care arrangements and self-care options. This in turn, may require a highly coordinated system of care and appropriate assistance in order to empower users, in particular those with complex conditions and needs, with choice and control over care arrangements and self-manage conditions (Goodwin, 2006; Goodwin et al., 2012).

2.3 Introducing elements of user choice in integrated care

The success of integrated care can be gauged by how well it fulfils patients' needs (Kodner & Spreeuwenberg, 2002). Allocation efficiency, i.e. provision of services that correspond to what users need, is therefore an important aspect of integrated care. Over-reliance on professionals to steer users' choices may not only be disempowering, but may result in forms of integrated care that leave users' priorities or needs unaddressed (Roberts, 2001). Choice can therefore provide users with a powerful lever for improving allocation efficiency in the delivery of services.

One issue with choice in integrated care is how to maintain the seamless provision of care when users can choose providers along the continuum of care (Ahgren, 2010). Choice between individual providers within a network may also create an element of competition with adverse effects on cooperation between participants (Cameron et al., 2014), e.g. in relation to mutual information exchange. One alternative that has been applied in integrated care without apparently having negative consequences in the joint working of organisations and professionals is to move choice to a somehow higher level by allowing for choice between insurance companies and/or integrated care networks (Ham, 2006; Ham et al., 2011). This allows for users to exert change while strengthening networking elements and continuity of integrated care. In Germany and the Netherlands, the ability to choose between integrated care networks was indeed the approach taken to spur integrated care while maintaining some elements of user choice inherent to their insurance-based healthcare systems (Schaeffer & Ewers, 2006). In both cases, however, integrated care is disease-based, e.g. for diabetes patients, rather than population-based, which can also be seen as a limitation in choice.

A more radical option is to use voice, e.g. expressing complaints (Hirschman, 1970) as an alternative to choice to bring about improvements in allocation efficiency of care, as well as quality. Compared with choice, voice has the advantage of stemming from users' needs and wants and providing much detailed information about what users prioritise (Le Grand, 2007). Furthermore, while choice allows users to select the best performers it might not produce actual changes in the performance of providers (Berwick et al., 2003). The existing evidence of the positive impact of user involvement in successful integrated care seems to reflect the impact of Hirschman's (1970) concept of voice rather than choice (Roberts, 2001; Andrews et al., 2004). Coulter et al. (2008) have shown that shared decision-making and self-management do not only reduce unplanned and unnecessary visits to primary and secondary care, they also promote better quality of life in patients. However, both user choice and voice may be powerless to affect how and what services are provided in integrated care in the absence of at least some form of competition or market contestability (Egger de Campo, 2007).

2.4 Challenges for conciliating competition for integrated care

The objectives of integrated care may also seem to be contradictory to the workings of New Public Management (NPM) and market mechanisms, particularly competition. Integrated care is based on cooperation and takes a holistic approach to conditions or populations, while competition is based on differentiation and specialisation as key drivers for efficiency gains in the provision of care. Differentiation is deemed to be a natural response of organisations faced with complex environments (Lawrence & Lorsch, 1967). Specialisation allows organisations or professionals to benefit from what is termed as increasing returns to scale, i.e. a cost advantage derived from focusing on a narrow set of tasks or activities, and it is a key concept from international trade to public health (Axelsson et al., 2006).

This is not to say that integrated care is not concerned with efficiency, as the need for efficiency gains has also been a strong driver for integrated care (Leichsenring & Alaszewski, 2004). Instead of specialisation, however, integrated care seeks to enhance efficiency by reducing transaction costs and eliminating the unnecessary duplications (Andersson & Karlberg, 2000). The risk of integrated care networks established between physicians, hospitals and social care providers is that they can lead to the creation of monopolies which would in turn limit competition.

Establishing trust and having long standing relationships between organisations or professionals are key facilitators of integrated care (Cameron et al., 2014). Intrinsic motivation and social norms might prove to be a stronger incentive to bring about the kind of cooperation between providers and professionals on which integrated care hinges, particularly as a significant share of providers might be non-profit (Bielefeld, 1990). However, according to transaction costs theory, trust is the type of specific asset that can give incumbent providers an advantage over competitors and that can hinder competition (Williamson, 1975). Competition within integrated care networks seems to hinder more than facilitate cooperation between different professionals and providers (Ham & Smith, 2010).

Finally, another main tenet of NPM is benchmarking and assessment of performance against clearly measureable targets (Hood, 1995). In integrated care networks the outcomes or performance of one element is dependent on the performance of other elements along the continuum or care and assessing performance and assigning responsibilities may therefore be less straightforward (Rummery, 2009).

2.5 Integration as a response to a competitive environment

While competition and integrated care tend to be viewed as opposites (Ham, 2008), there are strong arguments from economic and organisational theories for pursuing integrated care in a quasi-market (i.e. competitive) environment. As mentioned earlier, one of the arguments in favour of integrated care is to achieve efficiency gains through the reduction of transaction costs (Williamson, 1975). Continuous joint working can create inter-organisational trust that reduces the incentive for opportunistic behaviour and therefore the costs that occur with monitoring compliance in contractual arrangements (Williamson, 1991).

Cooperation may also be a strategy used by different organisations in order to gain an advantage in market contexts. Integration may reduce costs, spread risks between partners, provide scope for economies of scale, limit competition or access markets that are dominated by strong incumbents (van Raak et al., 2005). Integration may also be a strategy used in face of monopsonic purchasers of care that enjoy great market power, e.g. insurance funds seeking to secure their position in the market increase their bargaining power vis-à-vis a price-setting purchaser if they negotiate as one (van Raak et al., 2005). Another example would be 'Accountable Care Organisations' that have emerged in the US or 'Bundled Payments' in the Netherlands (de Bakker et al., 2012), where regulatory frameworks explicitly promote and incentivise cooperation within a consortium of providers.

Another stream of thought argues that organisations seldom operate in isolation and seek to draw resources from the environment that surrounds them, including other organisations (van Raak et al., 2005). These resources may take the form of financial resources, knowledge or other inputs and this in turn fosters the creation of complementary relationships between organisations.

Finally, integration of care provision can take place in quasi-markets for reasons beyond economically driven motivations. Organisations may cooperate because they are genuinely committed to serve their stakeholders in what is also termed as social responsibility (van Raak et al., 2005). This might be a particularly salient driver for cooperation for organisations that have a non-profit status and that therefore pursue other goals beyond profit-maximization (Evers & Laville, 2004). Non-profit organisations form an important share of providers in some countries, particularly in long-term care (namely in Germany), and therefore this is likely to be a non-negligible factor in driving integrated care and in alleviating the 'pure' cleavage between public and private providers. A related issue is the impact that social norms may have on the behaviour of professionals and organisations, particularly in the health and long-term care sectors (Titmuss, 1968). Intrinsic motivations to ensure the best possible delivery of care by professionals or societal expectations for organisations to cooperate if this is in the best interest of patients or users can be a powerful nudge towards better coordination of care (van Raak et al., 2005).

2.6   Using competition as an incentive for integrated care

The challenges to the conciliation of integrated care and competition (as well as choice) notwithstanding, successfully implementing and designing elements of competition can also create opportunities for the development of integrated care.

Competition can be an important driver for innovative solutions in care provision and to improve outcomes of care (Thorlby & Curry, 2012). Several studies have shown that by combining competition with incentives for providers to maintain people's health and independence with competitive elements can lead to high levels of performance (Ham, 2008). A well-studied example is the integrated system of Kaiser Permanente and Intermountain Health Care. Kaiser Permanente is a network for patients in the US (mainly California) whose integration is driven by competition (Schrijvers, 2007). It integrates inpatient and outpatient care and prevention. The organisation includes three partners: a health insurance company ('Kaiser'), primary health care doctors and medical specialists ('Permanente'), and hospitals (Schrijvers, 2007). Unlike the purchaser-provider split advocated by NPM, the Kaiser Permanente combines the responsibility for funding (and commissioning) and provision of care. Patients with a membership of Kaiser Permanente can only refer to providers that are part of the network. However, patients are able to leave for another system in case care is unsatisfactory. Kaiser Permanente has been credited with achieving cost effective, integrated services based on efforts in health care prevention with agreed protocols and coordinated services outside the hospital (Light & Dixon, 2004).

Establishing competition *for* the market (i.e. between different integrated care networks) rather than *within* the market (i.e. choosing between competing individual providers) through competitive tendering can be a way to introduce elements of competition while preserving networks, as discussed above, regarding user choice. Competitive tendering is used to select a single provider or a group of providers of a service for a given patient group (e.g. diabetes). Tender specifications can include the re-design of disease treatment pathways or the requirement to enable additional providers to join the integrated network. Further, not only providers have to co-operate in order to submit joint bids, competitive tendering may encourage co-operation and information-sharing among providers along patient pathways, in particular of patients with complex needs and conditions. Under this form of competition bundled service payments are often used in contracts with providers (Hawkins, 2011; Ham et al., 2011). There is some evidence that competition for the

market can result in improvements in performance that lead to better outcomes for patients (Ham, 2008; Struijs et al., 2012). An underlying issue with incorporating elements of competition with integrated care is designing contracts or payments that provide the right incentives for joint work.

2.7 Aligning payments with integrated care

The discussion on integrated care and competition has focused on (integrated) provision of care, but integration may occur at other levels too, namely in financing (Leutz, 1999). Financing mechanisms that are linked to different budgets, either horizontally – e.g. different budgets for health and social care – or/and vertically – e.g. reflecting divisions of responsibility for funding between different levels of government – may inhibit integration and coordinated care provision as they generate possibilities for cost-shunting (Hultberg et al., 2005). Similarly, different financing logics – universal in the case of healthcare and means-tested in long-term care as it is the case in many EU countries – may also act as barriers to integrated care or provide perverse incentives for users (e.g. institutionalisation).

Besides barriers to integrated care arising from the co-existence of different budgets and financing rules, particular payment schemes within the same budget envelope have also been referred as a barrier to joint working. This is the case with payments based on fee for service – not only that this type of payments provides little incentive for joint working, but it might also have other adverse effects such as unnecessary hospital readmission (Tsiachristas et al., 2013; United Health Center, 2012; Godfrey et al., 2008).

Integrated funding mechanisms are one way to overcome these barriers for joint work. Table 1.1 provides an overview of additional aspects that have been identified as potentially beneficial impacts of integrated funding, yet there is little evidence that integrated funding alone may trigger all these beneficial effects, even if it may contribute to offer value for money (Mason et al., 2015).

As mentioned earlier, Kaiser Permanente is a good example in which responsibility for budget lies with the integrated care network (Ham, 2008). Another example is that of pooled budgets in England (Hultberg et al., 2005). Under this initiative budgets from the National Health Service (NHS) and local authorities are pooled and may be spent without reflecting the proportion in which they were contributed. This would allow the allocation of the budget to more closely reflect the needs of users and for changes in the distribution of financial resources (e.g. from acute care to long-term care).

In the Netherlands arrangements of joint responsibilities for funding and providing care have been developed in the form of bundled-payment systems, similar to the Accountable Care Organisation (ACO) experiment in the US (Damberg et al., 2014). Within the bundled-payment system for chronic care, insurers pay a single fee to a principal contracting entity – the 'care group', which are often general practitioners (GPs) for a fixed period of time. The bundled payments cover full treatment pathways of chronic diseases (diabetes, chronic obstructive pulmonary disease (COPD), and vascular risk management). The care group is responsible for financing and care delivery and may also subcontract services to other providers (Struijs & Baan, 2011).

Proponents of payment schemes such as bundled payments argue that the capped payments for pathways lead to value-based competition (Hawkins, 2011). The shift from activity-based payments such as the fee for service to outcome-based payment systems encourages organisations with integrated systems to compete with usual care settings. Also individual providers have to compete with other members in the care chain as they have to sell themselves and their preventive messages

in order to obtain referrals (Schrijvers, 2007). Critics of bundled payment systems point to the risk of new forms of fragmentation across pathways for the different conditions to which bundled payments apply, which is in particular a threat for coordination of care for older people with multiple conditions and needs. Unlike ACOs in the US, which are population-based, the bundled payments in the Netherlands are disease-based. Also, pilots of bundled payments systems have shown that there are a number of technical requirements for these systems to work out, e.g. information systems, clinical guidelines, monitoring and data audit (Hawkins, 2011). Another issue identified in the bundled payments experiment in the Netherlands is that care groups have great market power and can therefore act as price-setters when contracting out care (Tummers et al., 2013).

Table 1.1   Potential impacts of integrated funding of health and social care

Potential impact	How might it work?
Improve access to care	Integrated funds can facilitate access if they are used to ensure the supply of services matches clients' needs
Increase community care (health and social care)	Integrated funds can be used to purchase the right mix of community services, helping to prevent deteriorations in health/functioning and/or supporting rehabilitation and recovery following hospitalisation
Reduce unplanned admissions and readmissions	Tailored packages of integrated care in the community, purchased through integrated funds, may help maintain health and functioning and avoid unplanned hospitalisations
Reduce total costs	Higher levels of expenditure in the community may reduce total costs if subsequent hospital and residential care use is reduced or averted
Improve outcomes	Individually tailored packages of care can maintain or even improve health status and functioning
Improve the quality of care	Poor quality health care may increase the costs of social care and vice versa, potentially increasing total costs. In the context of integrated budgets, all providers should have an incentive to ensure the quality of care is acceptable
Reduce length of stay	Integrated funds can be used to assemble appropriate care packages to support timely discharge from acute care wards
Reduce residential care	Integrated funds can be used to provide services that support independent living in the community. For example, recovery, rehabilitation and reablement services may provide an alternative to long-term residential care following hospitalisation
Improve patient and user experience of care	If integrated funds are successful in facilitating integrated care, the patient and user experience could improve

Source: Mason et al., 2015: 2.

What seems evident from the cases above described – as well as other experiments with managed care dating back to the 1980s in Darlington, England (Challis et al., 1995) – is that value for money can be achieved when payments are linked to achieving good health outcomes and integrated care networks are responsible for the budgets and reap the savings of achieving better care (Ham, 2012; 2008).

Chapter 2

Contextual framework conditions and local approaches to integrated care in Germany and Sweden

This chapter provides information on the contextual framework conditions of health and long-term care for older people in Sweden and Germany, i.e. from countries with a marked impact of market-oriented governance in health and long-term care delivery. Section 2 of this chapter will then introduce the selected case studies of three local approaches to integrated care in Dortmund, Leipzig (Germany) and Norrtälje (Sweden).

1 Two distinct health and long-term care systems

1.1 The German health and long-term care system

The long-term care system in Germany is traditionally based on the principle of subsidiarity with large non-profit welfare organisations providing care in close cooperation with local and state authorities. In 1995 a statutory long-term care insurance (LTCI) that is aligned to the statutory health insurance system was introduced and established the universal right for support in dependency which represented a considerable increase in the coverage of long-term care.

The LTCI is based on market-oriented governance, meaning that any provider that meets certain formal criteria can enter the local market, independent on existing capacity or providers, and is eligible to be contracted by the long-term care funds ('Pflegekassen') that are affiliated to health insurance funds (Theobald & Hampel 2013). The objective of the introduction of the LTCI was to insure comprehensive provision of care services by opening up the market, particularly in the home care sector, and to introduce competition between non-profit long-term care providers by reducing barriers to entry faced by for-profit providers. The LTCI was intended to break the 'cartel' of the traditional non-profit welfare organisations that were in privileged positions but that provided only a limited number of services (Glendinning & Moran, 2009; Theobald, 2012; Leichsenring et al., 2010). As a consequence of the opening of the long-term care market an increasing number of small private for-profit and non-profit agencies entered the home care market (Allen et al., 2011) and created a vibrant provider market.

User choice was facilitated by the opening up of the market, enabling care recipients to choose between benefits in cash and services in kind from a wide range of public, for-profit and non-profit care providers both for home care and residential care. In practice, LTCI recipients can choose to use their LTCI benefits to pay for home or residential care in what is similar to a voucher system. They may also opt for cash benefits which are granted at a lower rate and may be used to compensate the work of informal carers, or users may choose a combination of cash and in-kind services (Theobald & Hampel, 2013; Eichler & Pfau-Effinger, 2009). However, with the increasingly diversified provider market and complex benefit schemes, care recipients and their relatives have difficulties to have to make decisions regarding the type of services and choice of provider (Döhner et al. 2008).

LTCI funds are key actors in the assessment of needs, setting of prices, definition of care packages and the inspection of quality of care provided. Since the introduction of the LTCI municipalities have

only a marginal role in that their responsibilities are limited to the organisation and financing of long-term care for people relying on social assistance. LTCIs are in responsible for the provision of care, the organisation of care arrangements and contacts with care providers. With the adoption of the Long-term Care Further Development Act ('Pflegeweiterentwicklungsgesetz') in 2008 they are also obliged to conduct individual counselling and case management in order to assist beneficiaries and their relatives in the complex choices of appropriate care providers and in organising tailored care arrangements (Rothgang, 2010; Rosenbrock et al., 2009). Given this new mission of LTCI funds the German government allocated additional funding for the creation of 400 new community care centres ('Pflegestützpunkte') in 14 federal states that are set up by LTCI funds. These information centres help to systematically analyse needs of care beneficiaries, provide care management and counselling services about legal claims against LTCIs as well as available services in the neighbourhood (Glendinning & Moran, 2009; Rothgang, 2010). Via these community care centres LTCIs perform their legal function to establish networks and relationship with regional and community care providers in order to improve local care provision for dependent people. By this, LTCIs also closely cooperate with residential and home care providers to ensure appropriate provision of care and coordinate care arrangements adapted the individual needs of the care recipient (Social Code XI, § 12).

Since the introduction of Long-term Care Further Development Act (2008) LTCIs have the possibility to establish integrated care arrangements with care providers and other contracting partners, e.g. general practitioners. These integrated care contracts in which service provision and reimbursement are aligned to contracts of integrated care between health insurances and care providers (Social Code XI). The possibilities for integrated care arrangements that were created in recent years focus in particular on medical care and there were until now no legislation that considers the integration of the entire system of care provision (Rosenbrock et al., 2009).

The **health care system** is a statutory insurance-based system with comprehensive insurance coverage. 85% of the population are covered by statutory health insurance, while 10,9% have private health insurance. Members of the statutory health insurance have free choice over the 146 health insurances that exist in Germany. Certain groups of the population also have the possibility to adhere private health insurances. Since 2008 all statutory health insurance have a standard contribution rate of 15.5% of the gross wage. Since 1995 the health insurances also collect the compulsory LTCI insurance contribution of 2,05% (increasing to 2,3% in 2015). With a public health care expenditure of 11,3% of GDP (2009) Germany is the third country in Western Europe with highest spending levels. Respectively density of physicians and hospital beds is also one of the highest in Europe and high per capita health care spending (Busse et al., 2013).

Since 1999 patients have free choice of doctors and service providers. However, reforms of the health insurance system in 2004 and 2007 limited this choice as the system was characterised by over- and misuse of health care services (Lisac et al., 2010). Following these policy reforms users were required a co-payment for visits to outpatient physician offices that was charged until 2012. With the 2007's Statutory Health Insurance Competition Strengthening Act choice over insurance funds has moved towards choice among different additional premiums or refunds, alongside with increasingly differentiated benefit packages, quality and service aspects. Patients can choose among different benefit packages and insurance products offered by insurances, such as GP-centred care, deductible health plans, disease management programmes or integrated care. At the same time,

when choosing such benefit packages patients accept restriction of choice of, and access to, providers but are rewarded with refund of premiums (Lisac et al., 2010).

Health insurances are able to facilitate the establishment of cooperation by setting up contracts between residential homes and resident physicians and general practitioners that have contracts with statutory health insurances. Further, health insurances can also establish integrated care contracts with providers across care sectors (Social Code V). These mechanisms for integrated care have a strong focus on medical care and strongly rely on the competition between health care insurances. Until now there was no legislation that considers the integration of the entire system of care provision, namely social care services (Rosenbrock et al., 2009).

1.2 The Swedish health and long-term care system

The health and long-term care in Sweden are based on a tax-financed system with a high degree and intensity of service coverage and a broad range of services. Sweden's public expenditure for health care and long-term care amounts to around 10% and to 3,6% of GDP (2010) respectively, the latter represents the second highest spending level in the OECD (OECD & European Commission, 2013; Erlandsson et al., 2013).

The national government is responsible for overall health policy, while county councils are responsible for funding and provision of health care services, i.e. primary care centres, almost all hospitals and rehabilitation. Municipalities are responsible for the organisation of care of older and disabled people (Anell et al., 2012) whose medical treatment has been completed and who have been discharged from hospital care. They are purchasing care from both public and private providers, and many long-term care recipients have the possibility of choosing across competing public and private for-profit providers through services vouchers that were implemented by the *Act on System of choice in the Public Sector* (LOV) (Emilsson, 2011; Erlandsson et al., 2013).

With the Ädel reform in 1992 and the shift of responsibilities for home and residential care to municipalities, case management and financial incentives have been implemented to avoid prolonged hospital stays of people with long-term care needs by coordinating municipalities' home care services with county council's hospitals. It was hoped that with these changes the high number of patients that were 'blocking the beds' in acute hospitals could significantly be reduced by this measure. Thus fewer resources were shifted from municipalities to county councils as municipalities became liable for payments for these 'bed-blockers' to county councils (Allen et al., 2013).

In the 1990's quasi-market models in health care were introduced and enabled citizens to act as purchasers when choosing the primary care centre (Ahgren & Nordgren, 2012). However the 'choice of care' models were differently adopted by each county council (Ahgren, 2010). The 'choice of care' model and the increased competition between providers have largely contributed to a decentralization and specialisation of health providers which in turn also led to increased fragmentation of the care provider market. In this context of differentiation of services integration between organisational units and specialists becomes increasingly difficult although the 'chain of care' and 'local health care' concepts have received high priority in policy in the last decades (Ahgren, 2010; Ahgren & Axelsson, 2011). However, many county councils have made slow progress in developing and implementing chains of care (Ahgren & Axelsson, 2007).

As outlined above, services for dependent older people are fragmented between two different systems that each have different legal and financial frameworks, geographical boundaries, accountability mechanisms and cultures (Ljunggren & Emilsson, 2010). The marketisation in home and residential care that was marked by the introduction of service vouchers and the opening of the market to private for-profit providers in a large number of municipalities have also contributed to fragmentation (e.g. different organisations providing different care services) as well as concentration in the private provider market in Sweden (Erlandsson et al., 2013).

1.3 Key differences between the German and Swedish health and long-term care systems

There are four most important differences between the German and the Swedish way of organising long-term care that need to be underlined in order to contextualise and classify the findings of empirical research on choice and competition in LTC in these two countries:

- Germany has a long-standing tradition of private non-profit providers of health and social care (long-term care) services reaching back to the origins of the German welfare state. These large organisations are often affiliated to the churches (e.g. Caritas, Diakonie) or to social movements (e.g. 'Arbeiterwohlfahrt'). They have gained trust and influence over time both in relation to citizens and with respect to policy-makers. Before the introduction of the LTC insurance they had become an oligopoly of care provision and were criticised for being an obstacle to competition and for using their power to raise prices. Public providers, which play a most important role in Sweden, are almost absent from the German LTC market, except for a small proportion of care homes.

- With the introduction of the LTC insurance the German government installed an 'open market' for long-term care, triggering the accreditation of private for-profit providers that appeared as new stakeholders. LTC insurance agencies set up 'delivery contracts' ('Versorgungsverträge') with all types of providers that comply with legally defined requirements. These organisations, however, entail small care agencies with less than ten employees in the area of home care as well as large holdings (incl. investment firms) in the area of residential care. In this context, social planning in the area of LTC, hitherto carried out by regional and local authorities, was almost completely abandoned. Compared to this situation, the share of private providers in Sweden is still rather low, although marketization has increased it consistently, in particular in those municipalities that implemented the 'choice model'.

- The German social insurance system, in particular its social health insurance branch and, since 1994/95, the affiliated LTC insurance, has its roots in corporatist structures. Today, German citizens are obliged to register with one of the more than 120 health insurers from which they can choose, albeit independently from their professional background. Social assistance rationales and the general principle of subsidiarity are therefore shaping the area of LTC in Germany, while the Swedish welfare regime is based on individual citizens' rights and public funding, also when it comes to LTC.

- Although the German LTC insurance is affiliated to the health insurance, health and LTC remain financially separated. Local authorities have remained responsible for social support and assistance, but not for the delivery of LTC services. In Sweden, the division of health and social care budgets is based on multi-level governance, in which counties are holding health-related budgets while the municipalities are responsible for social and long-term care.

The following overview summarizes the differences between Sweden and Germany.

Overview 2.1   Main features of health and long-term care in Sweden and Germany

	Germany	*Sweden*
Guiding principles	Subsidiarity principle LTC as 5th pillar of the traditional social insurance	Universal access based on individual citizens rights
Legislation	LTC Insurance (SGB XI); SGB XII Regional legislation (care homes)	National framework legislation: Health care, Social Services Act Counties (Health care) Local government regulations (Social care)
Supervision	Medical Board of the Health Insurances – MDK (LTC insurance) Regions (care homes)	National Board of Health and Welfare
Eligibility	5 years in LTC insurance Individual needs assessment based on 3 levels of need assessed by specialised medical doctors (MDK)	Citizenship Individual need assessed by municipal care managers
Care provision	Cash benefit or benefits in kind (community care and residential care)	Benefits in kind
Governance	Health/LTC Insurance, Ministry of Health, Regional Governments; Municipalities	National Health System; Local authorities (municipalities with some tax autonomy)
Choice	Citizens can choose insurer, GPs, providers of services	Citizens can choose between providers (depending on municipality)
Funding	LTC Insurance; Health insurance; user-fees	General and local taxes; user fees (moderate)

Sources: Heintze, 2012; Ahgren & Axelsson, 2011, authors' compilation.

2   Description of integrated care initiatives in selected German and Swedish municipalities

This section describes the integrated care initiatives to understand the different local characteristics and approaches to integrated care in the context of user choice and competitive care markets. The selected initiatives from Germany and Sweden represent three distinct approaches to integrated care in municipalities, ranging from partial integration and networking to coordination and a type of full integration under conditions of user choice and competition.

2.1   Leipzig: A cascade of initiatives and networks to promote integrated care

Over the past 10 years, the City of Leipzig (80,000 inhabitants) and its surrounding districts (200,000 inhabitants) in the region of Saxony have seen the emergence of various initiatives addressing networking and integrated delivery of long-term care. These initiatives were partly a reaction to the competitive market environment, but mainly addressed the complexity of care for older people in health and social care.

- In 2006, a network of private for-profit providers of home care (Care Network Leipzig) came into being as an association to coordinate and improve home care provision by finding new ways for coordinating hospital discharge and community care. While this original aim failed, this network

became a means to reduce competition between its members by defining preferred neighbourhoods for care delivery and by organising common marketing activities. This network also engaged in other local initiatives as well as in care counselling and advice.

- In 2011, the 'Gerinet Leipzig e.V.' was founded as an association to promote geriatric care provision. It has its origins as one of four such networks (the others being in Chemnitz, Eastern Saxony and Radebeul) that were developed and tested between 2011 and 2013 with co-funding from the health/LTC insurances and the regional government in the context of the geriatric concept of the Land Saxony (Eastern Germany). The aim of Gerinet is to identify deficits in the provision of geriatric care in the region and to establish integrated treatment pathways for older patients in order to avoid double treatments and hospitalisation. Within an elaborated system of discharge and treatment pathways and case management, an intense exchange between medical, nursing and social care providers has been realised. In total 250 partners including home care and residential care organisations, long-term care insurances, general practitioners, health insurances, municipalities, welfare organisations, social assistance office and housing companies that cooperate in five working groups.

Figure 2.1   Overview of stakeholders involved in integrated care networks in Leipzig
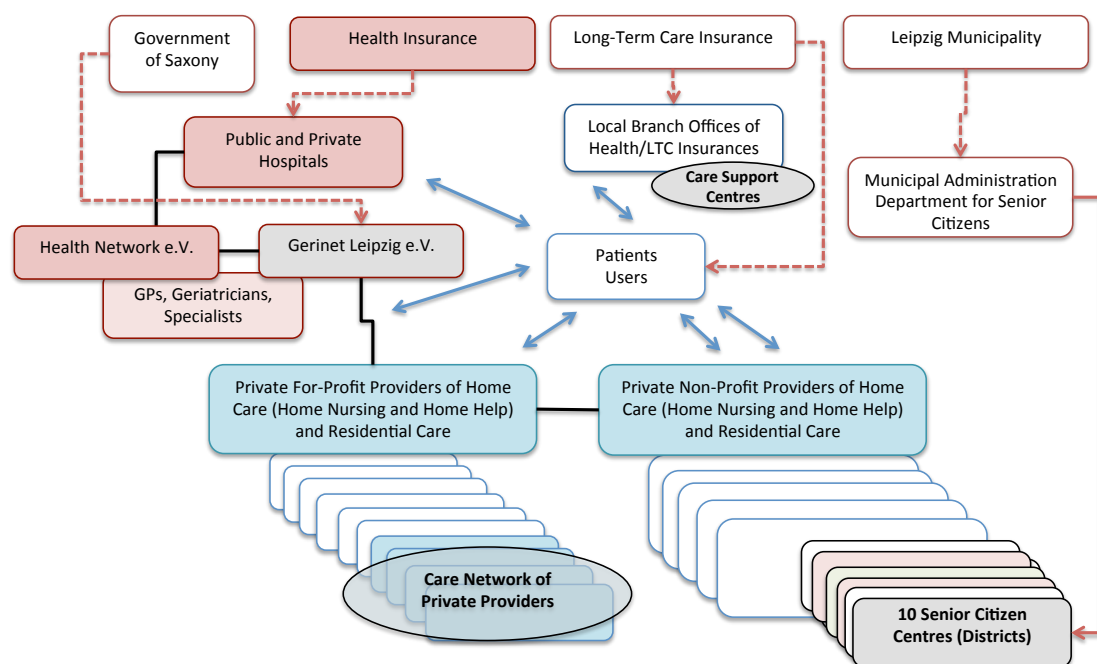
Source: authors' compilation; red, dotted connectors = funding streams; blue arrows = choice; black connectors = coordination/networking

- Since 2013, 10 'Senior Citizens Centres' (Seniorenbüros) have been installed in Leipzig, based on an initiative of the City's official responsible for senior citizens and the senior citizens council. The responsibility to run these centres has been divided between the large welfare organisations. They provide information and advice in all matters of ageing as well as opportunities to socialise.
- With the implementation of the Long-term Care Development Act (2008) the regional authorities were enabled to have so-called 'Pflegestützpunkte' (Care Support Centres) established with the local agencies of the health/LTC insurers. Their aim was to provide information and advice about local providers and supply structures to all beneficiaries of the LTC insurance, but also to coordinate local providers. The government of Saxony did not support the introduction of 'Care

Support Centres', but there are nevertheless a number of 'Care counsellors' affiliated to the local branch offices of the health/LTC insurances (since 2008).

- Finally, in 2009 an additional 'Health Network' (http://www.gesundheitsnetz-leipzig.de) was founded by more than 100 medical doctors (GPs and specialists) and other health care providers in Leipzig to shape primary care from prevention and diagnosis to therapy, nursing care and rehabilitation.

2.2 Dortmund: A voluntary public-private partnership to gather stakeholders at the 'Round Table'

The City of Dortmund in North Rhine-Westphalia has about 600,000 inhabitants with 25% of the population older than 60 years and 5% above the age of 80. Various stakeholders have been involved to generate the innovative 'Dortmunder Modell' that is characterised by a more coordinated approach to demographic ageing in general, but in particular in health and social care delivery. This approach has to a large degree been influenced by the rising complexity of LTC for regulators, providers and citizens. The 'open market of care' in combination with increased user choice through benefits in kind and in cash from the LTC insurance had created a situation that called for guidance of beneficiaries and better coordination of providers.

Figure 2.2   Overview of stakeholders involved in integrated care networks in Dortmund
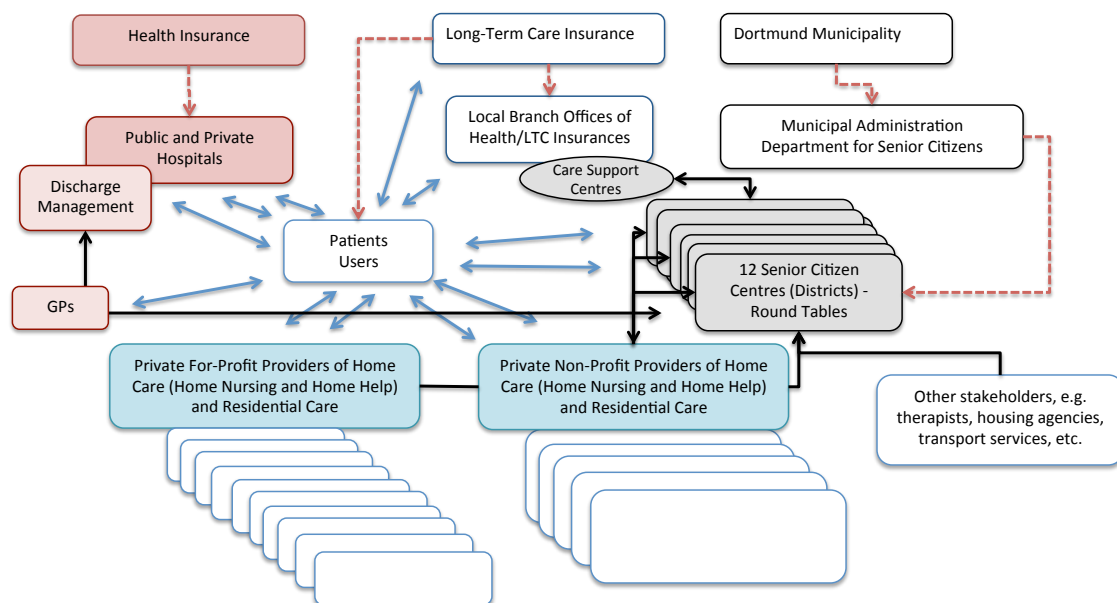
Source: authors' compilation; red, dotted connectors = funding streams; blue arrows = choice; black connectors = coordination/networking.

This has been realised, among other things, by installing 12 'Seniorenbüros' (Senior Citizens Centres) in each of Dortmund's districts since 2005. The objective of the centres is to enable older citizens to remain at home as long as possible with the support of a local network that is best able to meet the needs of older people. This entails local counselling and advice services (including visits at home) and decentralised networks between service providers of long-term care, e.g. by gathering relevant stakeholders at 'Round Tables' to discuss issues of care coordination, case management and the acquisition of volunteers. The Senior Citizens Centres cooperate with all types of home care

providers, residential care homes, general practitioners, housing companies, hospitals (discharge managers), police and volunteer organisations.

The Senior Citizens Centres are run as a public-private partnership between the local authorities and the welfare organisations. This means in practice that public officials are working in co-located offices with employees of the large welfare organisations that are reimbursed for this service by the local authorities.

2.3 Norrtälje: Public guidance through complexity by joining forces and budgets

Norrtälje municipality is part of the County Council of Stockholm and is geographically the largest municipality in the County. The growing population of the municipality amounts to nearly 57,000 inhabitants. One third of the inhabitants live in the regional central city Norrtälje while the other two thirds live in other urban areas and in rural zones that also include some islands.

In 2006, an integrated care network was initiated by the responsible authorities – the Norrtälje municipality (responsible for social care services) and the County Council of Stockholm (responsible for health care services) – when civil protests had stopped the County Council's plans to transform Norrtälje hospital from an acute care hospital to a local care home. As a result the County Council decided to preserve the acute care hospital in Norrtälje and to collaborate with Norrtälje municipality in an integrated care project. The acute care hospital, the Council of Stockholm's primary care and the municipal social care in Norrtälje were thus gathered in a new joint organisation – TioHundra – with the main goal to integrate care for older people with multiple and complex needs.[1] The TioHundra-project was originally started as a five-year project, and has been extended until 31 December 2015 with good chances to become a mainstream operating model.

The key idea behind TioHundra was to address demographic challenges in health and social care by establishing a coherent financial and organisational responsibility with an increased focus on health promotion and rehabilitation across governance levels and sectorial boundaries. Based on joint funding the development of a more cohesive health and long-term care delivery should be facilitated in the direction of a 'fully integrated' model.

The integrated network consists of:

- A joint *health and social care board*, with the political responsibility to meet the need for care and healthcare among the local population,
- A joint *health and social care administration*, responsible for care planning, purchasing, contracting and controlling on behalf of the board,
- An outsourced stock company – TioHundra AB – that acts as a provider organisation for health and social care. This stock company is owned by a purposely established municipal association and has the County Council and the municipality as sole shareholders.

The activities and responsibilities that were passed to the TioHundra project are:

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[1] The initiative also entails other areas such as services for people with disabilities at working ageing, mental health etc.; this description is only focused on those parts that affect LTC for older people.

- From the municipality: Care for older people, social psychiatry, support and services for specific disabilities (LSS), youth counselling, the municipal counselling centre, parts of the school health services and the public health function.
- From the County Council: Primary care, geriatrics, psychiatry, hospital care, specialist care, maternal and child health care, rehabilitation, child psychiatry and addiction treatment.

When the TioHundra project started in 2006, before the introduction of the 'user-choice' model, the purchasing and provision functions were combined and managed solely by one municipal association, but already by the end of 2006 a purchaser-provider split was implemented. The integration of purchasing, financing and supervising health and social care thus became the responsibility of the joint Health and Social Care Board. The decisions of the Board are implemented by the joint Health and Social Care Administration, while the main function of the municipal association became to exercise formal ownership of the joint stock company TioHundra AB that now performs all provider functions in health and social care in Norrtälje.

Figure 2.3   Overview of stakeholders involved in integrated care provision in Norrtälje
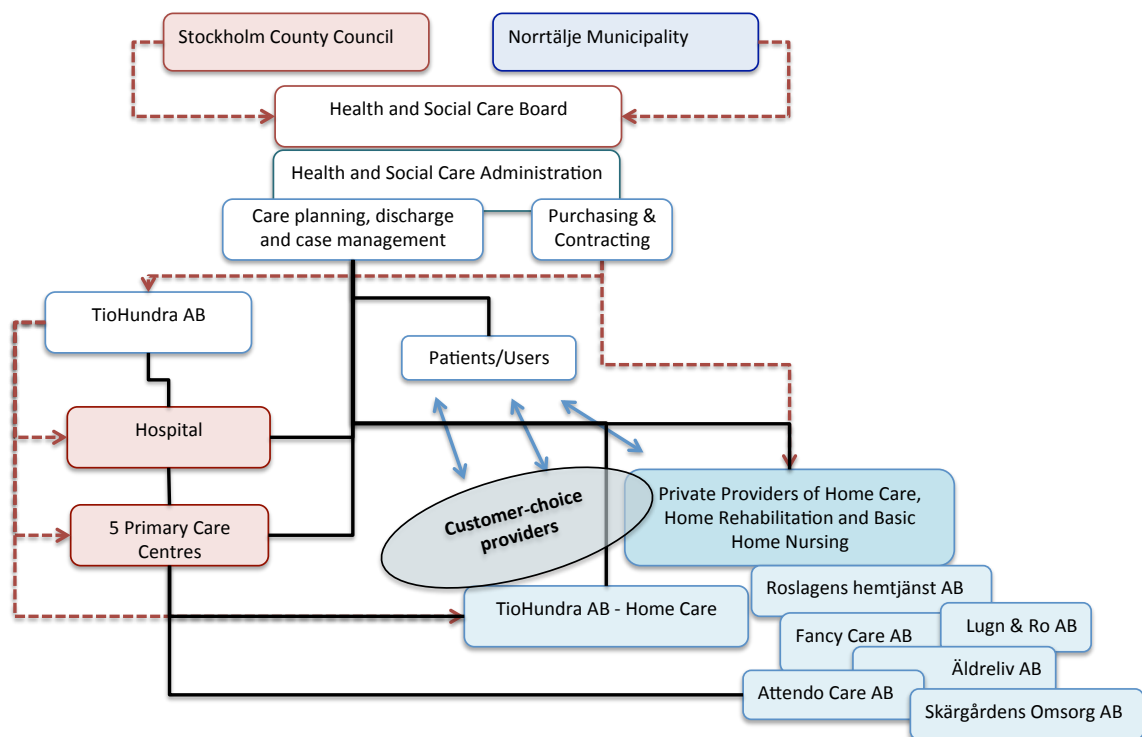
Source: authors' compilation; red, dotted connectors = funding streams; blue arrows = choice; black connectors = coordination/networking.

The Swedish Social Service Act is a goal-oriented framework law that guarantees a general right to public services that has to be satisfied by the municipalities. However, the legislation does not regulate or define 'need'; it only states that home care services should ensure an adequate standard of living. Swedish municipalities thus have a high degree of autonomy in setting local tax rates, budgets and local guidelines for different welfare areas, resulting in great differences regarding, for example, coverage of home care, extent of public and private home care provision and the extent of market-inspired models between municipalities (Erlandsson et al., 2013).

The usual process to receive long-term care starts with an application at the municipal department for eldercare. A care manager then assesses the older person's needs and evaluates whether the individual is entitled to home care and, if yes, to which type of services and what amount of time. Since September 2009, in Norrtälje it is possible for older citizens over 80 years to get access to selected home care services (social alarm, food box, cleaning, washing, shopping and walking) through simplified care assessment without an assessment by a care manager. This procedure lowers the threshold for receiving care services and decreases the workload of care managers so that they are able to dedicate more time and effort to cases requiring integration and collaboration (Schön et al., 2011).

In September 2009, the municipality of Norrtälje adhered to the 'user-choice' model by introducing a customer-choice system for home care, home rehabilitation and basic home nursing as well as a freedom of choice-system for the provision of health care. This gave rise to the establishment of new and additional provider organisations that could apply for accreditation in at least one of the four geographic zones, in which Norrtälje municipality is divided. Today, there are seven home care providers in Norrtälje – TioHundra AB, Fancy Care AB, Attendo Care AB, Äldreliv AB, Lugn & Ro AB, Roslagens hemtjänst AB, Skärgårdens Omsorg AB. TioHundra AB is the only publicly owned care company while the others are privately owned. While users in zone 1 may only choose from three providers, they may choose from six in the other zones, i.e. choice is restricted to those providers that operate in the specific zone (Schön et al., 2011; Hjalmarson, 2013).

The user-choice model was implemented in Norrtälje based on the main goals and ideas of the TioHundra-project – integration and coordination of care services through a coherent chain of care. This requirement is imposed equally on all providers. In order to be accredited as a home care provider in Norrtälje the organisation must be able to supply for home care, home rehabilitation and basic home nursing.

- **Home care services** are divided into household work (cleaning, cooking, washing, shopping, walking et cetera) and personal care (personal hygiene, getting dressed, support at meals, assistance when moving, supervision etc.).
- **Home rehabilitation** is carried out by physiotherapists or occupational therapists after an assessment that a person could achieve sufficient rehabilitation results in their own home rather than in a health care clinic.
- Access to **basic home nursing** is based on an assessment from a physician or a nurse. It is provided on a permanent basis by an authorised nurse or by home care professionals at the nurse's delegation.

To comply with the requirement to provide all three types of services, different solutions are allowed. For instance, the public home care provider, TioHundra AB, organises home care, home rehabilitation and basic home nursing separately, other providers chose to have a more coherent organisation with all functions included, but in particular smaller providers are in some occasions working with personnel hired according to demand, e.g. concerning home rehabilitation (Schön et al., 2011; Hjalmarson, 2013).

All older people entitled to home care, social alarm, basic home nursing or home rehabilitation can choose the provider they want to perform these services from a list of accredited providers that operate in the geographic zone in which they are living. However, if they need different types of services they need to choose one organisation for all their services, i.e. they cannot choose one

provider for delivering home care and another for delivering home rehabilitation. If users do not want to or are not able to choose a provider, they are assigned a provider in accordance with a rotation list. If users are not satisfied with their provider, they have the right to switch to another organisation.

Competition between providers in Sweden is based on quality only, as all users pay the same fee for their care services regardless of whether they are provided by public or private agencies. However, user fees are, to some extent, related to individual income and the amount of care provided. Older people with low or no income are exempt from paying any user fee. The local authorities have the autonomy to set up local user-fee systems up to a maximum of 1,776 SEK per month (about 190 €). In Norrtälje, the joint Health and Social Care Board, responsible for setting the user fees for home care services, decided that home rehabilitation and basic home nursing are free of charge.

Chapter 3

Empirical evidence on the compatibility of integrated care and market mechanisms from German and Swedish municipalities

This chapter will present and analyse the findings from selected local experiences of integrated care in Norrtälje, Dortmund and Leipzig in a comparative perspective. Information gathered from the interviews with key-stakeholders will be used in the following to illustrate:

- how local stakeholders reacted to increased competition and the creation of a 'care market',
- how local stakeholders perceived the necessity and opportunities to realise approaches to integrated care in a market-oriented environment,
- what mechanisms were seen as hampering or promoting coordination and integrated working,
- what tools were developed to implement more coordinated, multi-organisational and multi-professional working, and
- how integrated care can be conciliated with enhanced market-conditions and user choice in the context of the respective LTC system.

1   Enhancement of choice by means of market mechanisms and competition – Supporting users to act

There is quite a broad support for the users' right of choice between providers among the interviewees in all three municipalities. In Sweden the user choice model had only been introduced in 2008, but key stakeholders are convinced that it *"increased the quality"* (N5, Manager, Care Management Department, Health and Care Administration) and *"improved integration of care and collaboration"* (N1, Manager, Purchaser Department, Health and Care Administration), as *"older people can choose again within five days, if a provider does not perform"* (N4, Manager, TioHundra AB Home Care) and they *"can choose with their feet"* (N2, Manager, Administrative Department, Health and Care Administration). A high-ranking official in Norrtälje even sustains that *"the choice-system has implied a shift of power from the municipality and the council to the individual"* (N3, Director, Health and Care Administration).

However, in the context of Norrtälje there are also critical voices that sustain that *"the introduction of choice has negatively affected integration of care, at least if we look at basic home nursing and home rehabilitation. It has fragmented the system, made it hard to interact and collaborate. It has fragmented the provision in such a way that we at the primary care centre, need to collaborate with several different actors"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation). In addition, the introduction of the customer-choice system in combination with the basic home nursing within the home care organisation generated new challenges related to the required skills of staff and, as a consequence, quality assurance. Whilst the seven different home care companies would require seven district nurses, there is a general lack of district nurses in all Stockholm county. This forced the Health and Social Care Board to lower the requirements concerning district nurses for the provision of basic home nursing. One of the private home care providers synthesised this caveat as follows:

"It takes a lot more nurses and district nurses to implement this organisation [i.e. customer choice in home care provision] (…) with several different providers. And if there is anything lacking, it is nurses, and in particular district nurses. But the purchaser realised from the beginning that they could not define the district nurse as a requirement, because then you cannot implement this model." (N7, Private home care provider)

Similarly, the operational manager at TioHundra AB acknowledges the risk of quality issues related to the eliminated prerequisite regarding district nurses: *"Several of the home care providers in the customer-choice system do not have a district nurse, they only have regular nurses. And we often think that this leads to deficiencies in quality"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation).

German citizens have had a longer tradition of choice between providers, given that also before the introduction of the 'open care market' there had been different types of non-profit organisations with a political or confessional background to choose from – though at a general much lower level of overall supply than Swedish citizens. The enhancement of choice for users and clients has been elicited in Germany by means of more competition between providers as an explicit goal of the LTC insurance. This entailed the accreditation of all existing providers as well as new for-profit organisations that mushroomed in the area of community care – in general as small local agencies with less than 10 staff members – but also in residential care where large investors appeared on the emerging 'care market'. In particular in larger cities there are now dozens of private for-profit providers from which users may choose.

"Through the introduction of a care market in Germany (…) long-term care has gained a new status in terms of individual rights, but also a confusing market with which people with long-term care needs and their family carers are often overburdened" (D1, Head of the Department for Senior Citizens, City of Dortmund)

The issue of 'overburdened users' is a recurrent feature of interviewees' statements also in Sweden as *"it is more confusing to them when they need to choose from several providers"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation*) and "many older people do not want to make that choice (…) and the information that older people get might not be sufficient in order to make a choice"* (N1, Manager, Purchaser Department, Health and Care Administration). This is not only dependent on the users' health status, but allegedly on expectations and generational differences:

"There will come a generation of older people who will be much more aware (…) we will learn and grow into this. The older generation today is not really accustomed to have so many options" (N2, Manager, Administrative Department, Health and Care Administration)

As a consequence, there is also a wide consensus that older people with long-term care needs and their families need independent support and guidance to get an overview of the care market – which is still not always organised in a satisfying manner:

"The care manager brings information material about the providers when the individual has to make his choice – but the care managers need to be neutral. They can only inform about the name and the profile of each provider, they are not allowed to recommend or to support the older

person's choice (…) Relatives are the only actor to facilitate the choice." (N5, Manager, Care Management Department, Health and Care Administration)

However, the right to choice has become a common standard that is being acknowledged by all interviewees as an important feature of the care market, even if only a restricted number of clients are able or willing to actively exert their right to choose and change providers in case of discontent.

"For people with care needs it is important to have choice … it depends on the individual and on the service provider whether they fare well with each other. I know many older people who have used the same provider for many years. But I also know of some who are not satisfied with the services of a provider (...), who have special requests, who complain about delays (…) then they or their family call the next so that there is also some 'hopping' … it depends on individual cases (…) Generally, senior citizens need to have a right of choice to be able to change (the provider) if they are not satisfied (…)" (D2, Manager, Senior Citizens Centre, District of Dortmund)

"If an older person is dissatisfied, he or she can choose a new provider. I do not think it is common but the possibility exists nonetheless." (N1, Manager, Purchaser Department, Health and Care Administration)

For some interviewees the alleged incompatibility between competition and choice in LTC seems to be rather unproblematic.

"There will always be competitive thinking as long as there are entrepreneurs. For each of them is convinced of his quality and this is all right – but the end-user should be able to choose and to decide." (L1, CEO, Gerinet Leipzig, Case Manager)

However, there are different perceptions of the relationship between competition and choice by providers in Dortmund and Leipzig. Whereas in Dortmund there is widespread conviction that the Senior Citizen Centres are enabling users to choose within a competitive market, this is still not the case in Leipzig.

"This is exactly the rationale of the Senior Citizen Centres – we do not want to send older people on 'pilgrimage' … until they get the advice they need. The Senior Citizen Centres can offer variety and try to sort out how this fits with the individual's preferences, e.g. if there is a link to the church most probably a religiously affiliated provider will be proposed etc." (D5, Home Care Manager, Private non-profit provider, Diakonie Dortmund)

"A neutral advice [by Senior Citizen Centres] is difficult. If somebody calls in and looks for a provider, the Senior Citizen Centres will provide the addresses of the large welfare providers in the first place. In the long-run we [in Leipzig] would also need a neutral and independent advice so that people can get an overview within their neighbourhood." (L2, Project manager, Gerinet Leipzig)

The compatibility of choice and competition is seen more critically by some observers in Norrtälje. When the integrated care organisation (TioHundra AB) was complemented by an open market for specific parts of the care chain, namely home care, home rehabilitation and basic home nursing,

TioHundra AB certainly had a competitive advantage against the new home care providers. However, they are not allowed to advertise their merits when advising clients.[2]

> *"We in TioHundra AB have all parts of the care chain in the same company but we are not allowed to tell the patient that the best thing would be if he chose TioHundra in all steps of the care chain (…) to get the best continuity. But we cannot advise the client in that direction, i.e. it is not possible to compete by underlining the fact that we offer a functioning care chain." (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation)*

As already mentioned before (see Chapter 1) some of the characteristics inherent to long-term care may restrict the possibilities of choice as compared to conventional services. Indeed, interviewees reported on challenges for older people to choose between providers, including trust and the fact that continuity of care is often more important to them than searching for a potentially better alternative. However, some groups of clients are more inclined to look for more appropriate alternatives than others:

> *"Independence and decision-making by the older person comes first, and he or she should remain unaffected in his or her possibilities to choose … but in our counselling we also underline that changing providers will also imply new care staff." (D3, CEO, Private non-profit provider, DRK Dortmund)*

> *"Care is a matter of trust, meaning that you do not change (provider) every week. You change if you are not satisfied. If you are a 'changer', you might change more often, every 2-3 years for you'll always have issues you do not like (…) So we have these classical 'changers' and everything else is a matter of trust, needs time and I do not want to have always a new person undressing and washing me." (D6, Owner of a private for-profit home care agency)*

As the market of long-term care is often confusing for users, guidance and support in the situation of choice – in particular under conditions of time pressure – becomes crucial. The challenge consists in designing, funding and organising independent, but well-informed and locally accessible information and consultancy. In Germany, a number of agencies have emerged to provide such support in different settings and various organisational designs – from web-based platforms to small local initiatives by independent individuals or attached to provider organisations. In some cases, former care staff offers 'care counselling' as a paid service, while provider initiatives often use it as an unpaid marketing activity. Although the LTCI has combined already a wide range of roles reaching from funding and needs assessment to purchasing and quality assurance, LTC insurance agencies were obliged by law (since 2009) to assume an additional function – to provide neutral advice through so-called 'Pflegestützpunkte' (Care Support Centres). These are usually situated at local branch offices of the larger health insurances, providing this service also for smaller health insurances, but opinions about their effectiveness and 'neutrality' are divided.

> *"In our counselling as health insurance we provide advice neutrally in terms of effect on competition, this is also our legal obligation. However, we indicate that there is a possibility of choice. Here at the AOK [health insurance agency] we got the 'care navigator' which offers a range*

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[2]   As a 'quasi-public' provider TioHundra AB Home Care Services are not permitted to offer additional services (household tasks) to clients who are willing/able to pay for these out-of-pocket (but tax-deductible). This is only allowed to private for-profit providers.

of information about providers. And there is also the care data base of the City of Dortmund (…).”
(D7, Manager at the regional agency of a large health insurance, AOK Nordwest)

“[All people who apply for benefits of the LTC insurance] receive a letter that informs about the opportunities of care counselling. It depends on the beneficiary to accept it. If he avails himself of this opportunity, it is a professional and objective guidance as far as I perceived it.” (L3, CEO, Care Network Leipzig)

In the City of Dortmund the Care Support Centres of the health insurances are cooperating to some extent with the 'Senior Citizens Centres', e.g. by offering consultancy within each district once per week.

“Family members are often helpless in front of the entire system of provision and support. Actually, since 2009, the LTC insurances got the legal mandate for counselling and case management, but this does not work due to a number of reasons: first, the structures of insurance companies are too complex, e.g. the TK [Health Insurance for Technicians] has only one care counsellor sitting in Kiel, secondly, such a task should not be hosted by the payors as they cannot be neutral. Furthermore they were conceived to carry out case management, but the care package must be organised locally and calls for knowledge of the local infrastructure (…) and if I call them to join for a domestic visit they are mostly not allowed to do so as they are only doing counselling by phone.” (D2, Manager, Senior Citizens Centre, District of Dortmund)

The Senior Citizens Centres in Dortmund therefore try to provide independent and targeted counselling at district level and fulfil a much broader function, including coordination, networking, volunteer management and awareness raising.

“Staff in 'Senior Citizens Centres' are better able to provide independent counselling. They are funded by the local administration and the welfare organisations [providing staff that is reimbursed by the local administration]. Private providers do not pay any fees.” (D3, CEO, Private non-profit provider, DRK Dortmund)

The conflicting statements about the appropriate approach to care counselling also give evidence of the above-mentioned challenges involved in creating a 'level playing-field' for different providers, e.g. by organising 'neutral' and independent advice to empower users to choose. This is even more difficult in the German context if purchasers and providers are often directly involved in this function. While this challenge has been addressed consciously in Dortmund, the situation in Leipzig is less transparent:

“Staff in Senior Citizens Centres [in Leipzig] are employed by the welfare organisations, i.e. by competitors, so to speak. That's difficult … Although we collaborate relatively well with one of the Centres that is run by the Caritas (…) I would probably not share details of our organisation with them as I would not know what they'll do with this information.” (L3, CEO, Care Network Leipzig)

Indeed, the decentralised approach to care advice and counselling in a cooperation between the municipal administration of Dortmund and the welfare organisations has clearly emerged as a reaction to the confusing market situation that called for a citizen-oriented approach.

“The Senior Citizens Centres originate from the market situation, because people need this guidance just now, because they do not know what's appropriate for them, how they get financial

support, how they can find the proper care home etc. (...) When we started with the Senior Citizens Centres 10 years ago, there was only one office for care counselling here in our central administration, similar to most other municipalities. Thus the responsible politicians can claim that they comply with the legal obligations. Here in Dortmund we were not satisfied with this and expanded our consultancy into the city districts. Today we got 12 such centres with 24 well-trained employees." (D1, Head of the Department for Senior Citizens, City of Dortmund)

Also in Leipzig, Senior Citizens Centres were introduced, but only in 2012: *"We had the 'Dortmunder Modell' in mind, but here we are still lacking resources. We are only at the beginning, the last of the 10 Senior Citizens Centres was opened only one year ago"* (L5, Authorised Representative of Senior Citizens).

It is interesting to note that in the Swedish context there are no distinct structures for 'care counselling', as stakeholders are rather inclined to have decisions made during the assessment procedure by the care manager[3] or during joint discharge meetings at the hospital with the older person (including relatives, GP, a specialist doctor and the home care provider, if it has already been chosen). If necessary, the home care provider can also meet with clients, their family and a multi-disciplinary team in the home of the client to give advice and set-up a care plan (home care organisations are reimbursed for this activity). Indeed, the improvement of care management and discharge planning has been a major focus of the Health and Social Care Administration.

"We now have a good care planning team of care managers who, in turn, have a good relationship with the hospital. With 'WebCare' [an IT application that is available for the whole of Sweden] the discharge manager at the hospital notifies the department. Then a care manager from this department starts to organise a care planning day one (…) to get the person out of hospital as soon as possible." (N3, Director, Health and Care Administration)

In Norrtälje, the Health and Social Care Board and thus the administration is developing the structures and routines regarding discharge processes at the hospital. As a part of this development, four care managers are working exclusively with discharge processes. They are available at any time of the year with the aim to facilitate the smooth transfer of older people from the hospital into receiving care in their own home.

However, the care managers in the Swedish context are only responsible for assessing the need for home help, but they are not in charge of assessing needs for basic home nursing and home rehabilitation. This division of responsibility for needs assessment implies that care managers need to collaborate with those responsible for assessing basic home nursing and home rehabilitation. Consequently, if an older person needs home help as well as basic home nursing and home rehabilitation three different stakeholders are involved. Still, only one organisation (the home care provider) is responsible for providing the services. Integration has thus taken place at the level of provision, but not at the level of needs assessment, which might be a reason for the absence of independent care counselling in Norrtälje and in Sweden in general. Another reason might be the relatively small number of seven home care providers in Norrtälje, compared to, for instance, 111 care provider organisations in Leipzig.

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[3]   There are 14 care managers employed at the Health and Social Care Administration, four of them are only focusing on care planning and discharge procedures at the hospital.

2 The need for networking and coordination in long-term care markets – Closing gaps between sectors and across organisations

Notwithstanding the competitive environment that has been created by the introduction of 'quasi-markets' in long-term care, there is ample consensus about the necessity to coordinate the various stakeholders, both vertically and horizontally.

The interviewed representatives of stakeholders report broad support for networking and coordination. While this is less surprising for promoters of integrated care networks, in Germany there seems to be rising awareness among care providers that participation in integrated care networks is conducive to improving their position on the market.

Support for users to choose between different providers – both in community care and in residential care – is an important tool (see below) of integrated care in a competitive market environment. However, it covers only a small part of the complexity of long-term care delivery under competitive market conditions, with a large number of important stakeholders reaching from funding agencies (Health and LTC Insurances), investors, hospitals, General Practitioners, specialist doctors and other providers of health and social care services to medical stores, pharmacies, housing agencies and many others. Still it is unusual in Germany that municipalities take the lead in promoting collaboration and coordination in LTC. For instance, in Leipzig local authorities have outsourced the only recently established 'Senior Citizens Centres' to the large welfare organisations. The innovative approach of the 'Dortmunder Modell' has therefore been to promote a public-private partnership as a first step towards more integrated care.

> *"Only when we started to get organised on a decentralised level it became evident that we needed cooperation [between public administration and welfare organisations] (…) as there were so many interfaces that could allow for synergies. Initially it was unthinkable for the administration that an employee of the AWO [Arbeiterwohlfahrt, one of the larger welfare organisations] could work in our facilities. Then we tried it in two districts and it made an impact because the two teams worked well together, they worked hard and defined the Senior Citizen Centres." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

Discharge from hospital is a crucial interface in LTC provision and a most important process to verify, how far a care network is on its way to integrated care. Over the past decades, in particular with the introduction of DRG-financing of hospitals, case management and social work in hospitals have developed to assume responsibilities for this task, though based on quite distinctive rationales and organisational designs. This specialisation is particularly meaningful for patients who will be discharged with LTC needs as organisational cleavages and barriers to integrated care may be overcome by means of professional cooperation.

> *"Hospital nursing staff cannot do this. The market has become quite confusing, this calls for time to keep constantly up to date, and otherwise you loose the overview who's on the market. If patients are discharged to go back home, the case manager takes over, if they move to rehabilitation or a nursing home, the social worker is in charge with his competences regarding funding and means-testing. In case of doubts both professional groups collaborate to sort it out." (D4, Discharge Manager, Public Hospital Dortmund)*

The cooperation with the 'Senior Citizens Centres' is most fruitful for hospital discharge managers in Dortmund as their competencies end at the hospital's entrance door. By participating in 'Round Tables' and collaborating with the 'Senior Citizens Centres' they are able to inform about hospital issues and to get information about problems of patients when they get back home, what went wrong and what could be improved in the future. In daily practice, patients to be discharged are also advised by the case managers to contact the 'Senior Citizen Centres' or to accept a visit by the Centres' staff to check for additional needs.

This function of linking hospitals and primary care has been addressed in a slightly different way in Leipzig, where the main thrust of Gerinet was to form an integrated network to improve geriatric care delivery to overcome difficulties at the interfaces between primary and secondary care. It started as a model project promoted by the regional government in four areas of Saxony, one of which has been Leipzig. Rather than being a reaction to the market situation in LTC, Gerinet tries to shape common approaches and procedures across sectors and organisations. For instance, the participating stakeholders have developed formal tools such as the 'Angelina' screening scheme for geriatric patients that is being used across all facilities from hospital to primary care and home care. The screening scheme was generated by a Gerinet working group. All service providers were trained accordingly and are using it in daily practice. However, before getting to this point a demanding process was necessary to gather the various actors around one table and to develop a common language.

"(…) there was first of all a need to establish structures, to illustrate that the hospital is not a competitor but a partner, and that it is necessary to value each other. This did cost a lot of work to make people understand that such a network facilitates work, even if sometimes moderation or mediation is necessary (…) And now, after 3.5 years we can sustain, that they talk to each other." *(L1, CEO, Gerinet Leipzig, Case Manager)*

Norrtälje is already some steps ahead with respect to integration and coordination between the hospital and the primary care sector. However, the integration of basic home nursing within the home care organisation was accompanied by the appearance of new interfaces between primary care and home care. Due to the new integrated care organisation, the district nurses are now employed by the home care companies, rather than by the primary care centres.

"Whatever you do when you change an organisation, new boundaries occur and we now have a new boundary between the doctor at the primary care centre and the district nurse at the home care provider. The question is: Where do we draw the boundaries and where will it do least harm?" (N3, Director, Health and Care Administration)

In any case, the new interface between the home care provider and the primary care center created challenges related to integration.

"Given that we have a customer-choice system in home care, it is even more important to work closely with the primary care doctors […] the district nurse works within the home care company instead of in the primary care. So we separated the doctor at the primary care center and the district nurse from each other." (N1, Manager, Health and Social Care Administration)

As a consequence of the new integrated care model's combination with the customer-choice system the medically responsible doctor at the primary care centre now needs to collaborate with up to

seven different district nurses from seven different home care companies. The related difficulties and deficiencies at the new organisational boundaries could complicate communication and collaboration between the home care provider and the doctor at the primary care center. At the same time, as one of the home care providers argued, the introduction of customer-choice brought an increased emphasis on collaboration between different care providers, for instance, due to the structural integration of health and social care in one organisation, and to supportive tools such as 'WebCare' and shared electronic calendars to book care planning meetings. However, *"we are still working on improving that, especially when it comes to the transition from the hospital to the home. We still think that the home care providers are not informed when an older person is being discharged from hospital, we are not prepared – and that affects the customer in the end"* (N4, Manager, TioHundra AB Home Care).

3 New challenges and opportunities for cooperation and networking in a competitive environment – Reducing complexity, shaping the market and improving communication

Organisational changes towards integrated care networks and the move towards 'quasi-markets' in LTC have created new contextual conditions both in Sweden and Germany, thus triggering the development of new strategies by the various stakeholders, behavioural change and the search for solutions to newly arising challenges. For instance, with the new organisational setting and the ensuing appearance of new home care providers on the market, new challenges arose for coordination and networking in Norrtälje:

- Competition could be an obstacle to collaboration if home care providers do not share information or ideas with each other: *"This situation is given in a system of choice and competition – the home care providers are partners but also competitors. And that is a balancing act"* (N1, Manager, Purchaser Department, Health and Care Administration).
- Coordination between primary care and home care becomes more complex as GPs need more time to communicate with the nurses in up to seven different home care companies: *"It became harder to organise smooth care transitions, for us in primary care at least, due to the fact that the doctors at the primary care centre have to cooperate with … five different home care companies instead of one"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation).
- In order to reduce complexity, a kind of 'preferred provider' system might develop inherently, at least in those districts where TioHundra AB also provides home care: *"It is easier for us to interact with our own customer-choice provider"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation).
- Competition and the increased number of stakeholders involved in care provision can certainly trigger additional efforts that are not always perceived as effective, even when working in an integrated network: "*Home care providers and their nurses are not required to access our medical record at the primary care centre. They document in another medical record called ProCapita that is appropriate for community care. Our doctors can access and read those documents, but they do not, they do not have time. (They) document in a record called TakeCare, which also includes the medication list. (…) The fact that we document in two different records is a major patient safety risk"* (N6, Operational Manager, TioHundra AB, Primary Care and Rehabilitation).

Apart from the sometimes ideological cleavages between the traditional welfare organisations and the newly founded for-profit providers in Germany, competition is partly attenuated by the fact that the demand for care is by far greater than supply – in Leipzig even more than in Dortmund. This means that the main challenge is more often to respond to the rising demand, and thus to find and to retain professional staff.

> *"It is mainly about the issue, which organisation figures as an attractive employer, where can future care staff get appropriate training etc. – care providers receive job applications, if they are good. This implies that providers need to be good employers in the first place, and in this respect they are certainly competing with each other." (L1, CEO, Gerinet Leipzig, Case Manager)*

Indeed, the rising opportunities for staff to choose between different employers are adding one more challenge related to competition and choice. In the context of a general lack of care professionals this often leads to discontinuities and high staff-turnover in all three cities, but for Norrtälje it is a relatively new issue that providers have to compete for staff, e.g. by means of paying slightly higher wages. While this could certainly hamper the motivation to collaborate, there are different ways to overcome such tendencies.

In Norrtälje it has been made mandatory for providers to participate in organised care chains, while German cities are struggling with voluntary participation and the lack of incentives for a range of stakeholders to take part in the network. In Dortmund enhanced networking and cooperation would be needed between hospitals and primary care, palliative care teams, providers of auxiliary means and payers, but here it seems that competition is even fiercer, and networking (as an unpaid activity) is suffering from restricted participation. This may, among other things, create a new insider-outsider situation and thus lead to reduced choice for users, respectively unequal access to integrated care provision:

> *"The network, and that's very important for me, does not abolish the right to choose for patients – they may choose a service provider who does not participate. However, only within the network I can build transitions, structures and IT platforms (…) And there is choice within the network, i.e. that supply processes can be organised with the opportunities given by the network. This is impossible for patients who choose an outsider, with the risk of remaining without supply if the care provider fails to deliver. Within the network I can immediately find a replacement or organise a short-term care facility." (D4, Discharge Manager, Public Hospital Dortmund)*

For the private for-profit providers it is certainly an investment to engage in networking activities and to participate in 'round table' discussions. However, the networking activities also generate new contacts and the possibility to delegate tasks that are not reimbursed by the LTC insurance, e.g. counselling, applications for day care facilities or social assistance.

> *"I must say that the network makes me feel basically stronger for if I got a problem I can call A, B or C, or those from the Senior Citizens Centre. Or there is a service within the network which I cannot afford, but I can recommend it to my clients (…) I can diversify by using the network partners – this results in feeling stronger. We can reach more people through collective activities so that, in the long-term, the individual will gain." (D6, Owner of a private for-profit home care agency)*

In Leipzig, some for-profit providers of home care joined up in a network as a direct reaction to their perceived marginalisation by the large non-profit welfare organisations and the local authorities:

> "The City of Leipzig tends to concentrate on the large welfare organisations [who are running the 'Senior Citizen Centres' – authors' note]. So as a private for-profit provider in Leipzig you always suffer a setback. This thinking – that the welfare organisations are the good and the for-profit providers are the bad – is plain silly." (L3, CEO, Care Network Leipzig)

Originally, also the Care Network Leipzig derived from the intention to improve transitions from the hospital into home care, but failed in its intentions because the hospitals were not interested at that time (2005). As a consequence, and as a response to the increasingly competitive environment, the initiators turned the network into a collaboration of seven for-profit home care providers with the aim to improve their visibility on the market, to increase efficiency (e.g. by dividing districts among themselves to reduce travel time and cooperating in staff training) and to offer additional services such as courses for family carers, counselling and public relations.

> "With the certainty of being able to exchange ideas and knowledge we also generated projects such as small living units, assisted living, day care etc. This is not driven by competitive thinking as each of us is only active in his neighbourhood and does not pick the cherries in his partner's garden (…) This would be irritating, although the costumer should have the right to choose …" (L3, CEO, Care Network Leipzig)

At first sight it might appear that the Care Network Leipzig, the Health Network and Gerinet were competing networks of integrated care. In reality both the Health Network and the Care Network are partners of Gerinet covering different sectors such as community care at district level, general medical practice and the primary-secondary health care interface (geriatric care). One of the latest developments is that Gerinet offers case management in cooperation with a GP specialising in geriatrics (member of the Health Network): once a week the Gerinet case manager is present in the doctor's office to carry out assessments and to prepare appropriate care arrangements for geriatric patients.

Not surprisingly, there are different opinions whether competition functions as an incentive for cooperation and communication or as a major obstacle. In Norrtälje, the governance of the integrated network is trying to nudge providers in the 'right' direction: *"You are forced into cooperation when there is competition. One must talk to each other"* (N4 *Manager, TioHundra AB Home Care*). However, this 'enlightened coercion' is not always straightforward: *"We need to communicate a bit more. If TioHundra AB's night patrol supports a customer during the night who had chosen Attendo as a provider, we need to communicate and collaborate with Attendo a lot more than if the customer had chosen TioHundra AB (…) We are forced to do it in order to prevent older people from falling between the gaps"* (N4, Manager, TioHundra AB Home Care).

In any case, integrated care is never a stable status, but a dynamic process of 'integrating' care that calls for continuous improvement – even more under conditions of competition and choice. For instance, TioHundra AB in Norrtälje employed two additional geriatricians within the primary care organisation to better support basic home nursing for older people with multiple and complex care needs, and the Health and Social Care Administration appointed four care managers to specialise in discharge management and care planning for this group of users.

4 The development of networks to counteract market failure – A response to competition and individual needs

It has become evident that competitive environments are shaping efforts to organise more coordinated or integrated care provision at various levels, to different degrees and with distinct outcomes, depending on a number of framework conditions. Many stakeholders that are involved and dedicated to provide user-centred care perceived this new and changing situation as a chance for improvement or at least as a motivation for avoiding 'market failure'. Based on this widespread attitude, a wide array of contingent strategies, steering mechanisms and behaviours can be observed.

Even if all stakeholders agree that more coordination in LTC would be needed it is a great challenge to install a coordinating agency such as the 'Senior Citizens Centres' in Dortmund under conditions of competition and user choice. In particular the organisational design based on a collaboration between local administration and large welfare organisations initially triggered suspicion that clients of the 'Senior Citizens Centres' would only be placed and guided towards facilities of the large welfare organisations.

> *"Indeed, I heard such voices in the beginning and at first sight it might look so. Therefore we campaigned and were able to show that the result is quite different, in particular because the demand for support is much larger than what the large welfare organisations may supply, i.e. that private for profit providers need not worry to get clients through our counselling centres, that they'll be in the data base and that they will be presented to all clients in each district. This has become a sustainable dialogue by means of the 'round tables' where all stakeholders gather so that a joint action has formed." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

The 'Round Tables' take place three times per year in each district of Dortmund and gather all relevant stakeholders that partly also form working groups on specific issues: *"The providers should have an interest to present themselves at the 'Senior Citizen Centres' to get known in each district"* (D3, CEO, Private non-profit provider, DRK Dortmund). Therefore all actors know each other and if a client urgently needs a service, the collaborators of the 'Senior Citizens Centre' are able to find an appropriate solution quickly: *"In such cases I won't meet the lady and tell her: 'Here you are, these are the 14 care providers, please choose one!' – but I'll propose an accurately fitting arrangement"* (D2, Manager, Senior Citizen Centre, District of Dortmund).

The 'Senior Citizens Centre' is hence also well-positioned to find solutions at short term, for instance if a private provider fails or does not want to take an economic risk, for instance to accept cases where the reimbursement has not yet been resolved as the request for LTC insurance or the means-test may take some time: *"If you take a small care provider with two home care nurses, these cannot afford to pre-finance a client for months, they cannot survive on the market, if they get their money only 10 months later"* (D2, Manager, Senior Citizen Centre, District of Dortmund).

Cooperation and competition seem to have become compatible in Dortmund through the introduction of fair-play, mutual understanding and collaboration that work without a formal contract between the stakeholders involved. Even if not all providers are always present at the 'round tables' and some do not participate at all, there is a broad understanding that no individual provider is able to satisfy all needs. In general, the situation of restricted supply is contributing to a state of 'competitive collaboration':

"(…) because I cannot offer everything. We are a large organization, I can do a lot but I sometimes have to say no if a setting doesn't fit (…) There are situations in home care where you need to ask another provider to take over. So I consider other providers as a healthy competition – they spur myself on to do more and better. It's also good to know that there is a good partner by my side, meaning a competitor that can be seen as a partner. For let's face it – if I look at the demographic development in Dortmund I cannot shoulder that as an individual care provider alone! (…)" (D5, Home Care Manager, Private non-profit provider, Diakonie Dortmund)

Although the Gerinet in Leipzig was generated mainly to promote improvements in geriatric care, rather than to address confusing market situations, also this network was confronted with the consequences of a competitive market causing detrimental effects on collaboration.

"For instance, during Christmas time a transport service accepted 14 patients who had to be driven home from the clinic at exactly the same time, with the result that even five hours later not all patients had reached home. This is a typical 'market-behaviour', to first block everything in order to refrain the clinic from contacting other providers, which is ultimately detrimental for both patients and the provider himself – nobody will commission them once more." (L1, CEO, Gerinet Leipzig, Case Manager)

Compared to the coordination efforts realised in Dortmund and Leipzig the centralised and almost fully integrated model in Norrtälje has overcome a basic barrier to integration – fragmented funds for health and social care – and addressed a number of issues to counteract market-failure. Based on joint funding the Health and Care Administration as a purchaser is able to steer processes from hospital discharge and primary care to home care, basic home nursing and even home rehabilitation: *"Through the contracts we can require collaboration between different providers and stakeholders"* (N2, Manager, Administrative Department, Health and Care Administration). Nevertheless it is necessary to put efforts in joint meetings, to have home care providers involved in discharge planning, and in the improvement of still separated documentation.

Another important aspect in the context of Norrtälje is that user-choice and competition were introduced after the implementation of integration. Thus the health and long-term care systems were forced to implement freedom of choice after the integrated care project had started. Consequently, integration has not been implemented as a strategy to deal with possible implications of marketisation. However, one home care provider argues that the introduction of competition and user-choice could have complicated the process of coordination and integration: *"The purpose when they started the integrated care project and TioHundra AB was that they wanted to coordinate and integrate as much as possible. And of course, it is clear that the freedom of choice and the customer-choice system complicates that"* (N4, Manager, TioHundra AB Home Care).

Further, the design of the customer-choice system in home-based care, including the demands on providing integrated care, has therefore been a way for the municipality to avoid some of the main apprehensions concerning choice and competition, such as an overload of providers and deficiencies in quality: *"We tried to get around the consequences of choice by placing demands on the home care providers, i.e. that they must provide for home rehabilitation and basic home nursing"* (N2, Manager, Health and Social Care Administration).

There are different types of regular meetings organised by the Health and Social Care Administration. One gathers only the providers within the customer-choice system, i.e. the seven home care providers, while the joint 'Care Council' gathers all organisations involved in health and long-term care in Norrtälje municipality. These meetings serve to give feedback and to discuss planning procedures, issues of home care and rehabilitation, but also remuneration. Furthermore there are joint meetings targeted on a specific theme, for example discharge processes, to which only the involved stakeholders are invited. The home care providers are not yet organising meetings among themselves, but it might be a matter of time until they recognise that they *"could work as a driving force against us as purchasers"* (N5, Manager, Care Management Department, Health and Care Administration), as a manager at the Health and Social Care Administration put it.

Apart from the 'soft' instruments to steer the 'customer-choice' model it should be mentioned that competition in Norrtälje is strictly based on the quality of services, as prices (reimbursements) are equal for all competitors according to the zones they are working in. Some providers considered reimbursement in some zones as insufficient and decided not to be present in all zones, e.g. TioHundra AB Home Care is only providing services only in two of the four zones.

One issue that is blurring this 'level playing-field' is the fact that, due to national legislation, only the six for-profit providers are able to offer additional (household) services against users' out-of-pocket payments, which may be deducted from taxes. Quality as defined by the legal requirements is being assured by constant monitoring of the purchasing unit of the Health and Social Care Administration, using both indicators from the national system of 'open comparisons' (a system of registries by which all providers' quality of care is assessed and publicly reported) and user satisfaction surveys as well as by individual audits with providers.

> *"We do these audits every year with each home care provider, have meetings with them where we go through their results from statistics, open comparisons etc. These meetings always result in identifying some areas that need further improvement (…), for example to work better with documentation. It is actually easier to ensure quality in the user-choice model with the home care providers than within the district health centre." (N1, Manager, Purchaser Department, Health and Care Administration)*

> *"All our providers have to ensure the quality of the services and fulfil the contracts (…) The providers and those who manage this new system have to show that this is a good alternative to the former way of organising health and long-term care for older people (…) The providers really need to show that they can provide a good quality – and preferably to a slightly lower cost, of course." (N2, Manager, Administrative Department, Health and Care Administration)*

Also in Germany competition of providers is not based on price competition. However, in Germany local stakeholders, in particular social administration, do not have any mandate in relation to quality assurance in LTC as this is the responsibility of the Medical Board of the Health Insurers (MDK) that carries out yearly audits with all providers. The results have been publicly reported on a dedicated website by means of school marks (see Rodrigues et al., 2014), but this system is currently being revised and will be replaced during the next few years.[4] However, some initiatives to further improve

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[4] For current developments see: http://www.krankenkassen-direkt.de/news/Pflege-TUeV-Schulnoten-fuer-Pflegeheime-ausgesetzt-neues-System-fruehestens-ab-2018-577820.html

the quality of LTC by better coordination have been taken also at the local level, e.g. by Gerinet in Leipzig and by further cooperation of the local authorities in Dortmund with social health insurers that also participate in the Senior Citizens Centres, e.g. concerning disease management and ways *"to strengthen the principle community care, rather than residential care"* (D1, Head of the Department for Senior Citizens, City of Dortmund).

5   Barriers and facilitators to coordination, networking and integrated care in a competitive environment

In the daily practice of care providers, competitive markets are seen as only one of a number of aspects that are detrimental to integrated care. Competition may contribute to some providers' resistance to networking, but in the current situation of under-supply general features such as legal, financial and professional divisions are seen as more important by a majority of interviewed experts. In reality, a range of aspects can be identified as barriers to collaboration due to competition, but many of them have been rooted in general framework conditions, welfare traditions or even ideological cleavages. In some cases, however, market-oriented governance mechanisms may even have contributed to search for new ways and find new opportunities to overcome such cleavages, to empower users, to work at alleged boundaries, and to construct new types of win-win situations for all stakeholders involved.

The interviews with relevant stakeholders in Dortmund, Leipzig and Norrtälje have illustrated, how shortcomings at the interfaces between health and social care have triggered different types of solutions to the identified challenges. These often depend on individual engagement, but to a large extent also on local specificities and political constellations. However, there are a number of common traits to facilitate integrated working under market conditions that are presented in the following.

5.1   Creating a cooperative culture

In theory, competitive thinking has always been identified as a major threat to cooperation and networking. The challenge consists in gathering different organisational and professional cultures, different corporate and political attitudes around a table to identify common objectives, to define mutual agreements and to develop a common language. Both Dortmund and Leipzig present examples of how a competitive culture can be turned into collaborative networking, by installing new organisational cultures and shared visions to new ways of public-private collaboration.

> *"There was competitive thinking. It was quite difficult, because it was a new story to bring in private for-profit providers, also from the welfare organizations' identity, and to say that we need to bring all providers at the round table. This was accompanied by scepticism, but eventually succeeded – by means of various joint projects that were implemented together, there is local acceptance and recognition by policy makers, senior citizens and providers." (D3, CEO, Private non-profit provider, DRK Dortmund)*

> *"If patients are discharged from a hospital without medicine for the next three days (…) this represents a huge effort for home care providers – to organise a prescription from the GP and the pharmacy on the same day of discharge from hospital … and to understand this pattern, the efforts and the processes behind them, what it means for the others in regard to responsibility, if I*

[the hospital] don't do it – this produced the eye-opener, when a lightbulb went off in their head."
(L1, CEO, Gerinet Leipzig, Case Manager)

It seems that such issues played a minor role in Norrtälje, where new home care providers were confronted with an already established integrated care model, with defined hierarchies and procedures, with which they had to comply based on contractual agreements. This type of 'forced cooperation' bears the risk *"that providers only see an economic interest and start to fight over customers to increase their market shares"* (N4, Manager, TioHundra AB Home Care). However, in the area of health and social care providers usually share a certain vision and mission that might alleviate purely competitive thinking.

The 'Dortmunder Modell' also emphasises cooperation based on common values and missions shared by stakeholders, such as working for a 'common good' (e.g. improving the well-being of users). Even though it can take a lot of effort to gather different stakeholders around a table, for those interviewed it seems possible to develop mutual understanding and a common language among a broad number of stakeholders. In the German context, the large welfare organisations with their long tradition as both providers and advocates of their clients were widely perceived as important stakeholders in promoting this 'common good'.

> *"There are certainly situations of competition, each welfare organisation also runs care homes. However, I think we are comparable in our principles, with values and attitudes that put similarities in the first place – we got a good collaboration, and otherwise it would not be possible." (D3, CEO, Private non-profit provider, DRK Dortmund)*

This new mix of market-principles, a tradition of co-production and the quest for a 'common good' was at the origin of what may be called, in New Public Management jargon, the public-private partnership of the 'Dortmunder Modell'. This model has shown that new forms of trust-building may contribute to overcoming competitive thinking in a complex care market.

> *"(Resistance) has disappeared, I haven't heard that any more for quite some time. If there appears a new home care agency on the market, they turn up here and want to become members of the network. Then they join the round tables and want to become registered in the data base … the scepticism that had definitely existed in the beginning has disappeared." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

This did not mean however, that aggressive methods to gain market share would be completely abandoned by all providers:

> *"And then there are always some with other methods, which I cannot accept as good, those that pick your clients behind your back … that's not nice, but this can also happen if you are very open (…)" (D6, Owner of a private for-profit home care agency)*

Yet, the cooperative climate found in Dortmund was less palpable in Leipzig, in particular between for-profit home care providers and the large welfare organisations. Also, the political background of undertakings in the field of health and social care must not be underestimated. For instance, the expansion of Gerinet has been promoted by the regional government under a conservative administration, while the local administration in Leipzig has traditionally been guided by a majority of the Social Democratic Party. An additional factor to be considered as influential is given by the

regional and national federations of provider organisations that are shaping policies, legal and financial regulations.

Political factors (party politics) seem to play a minor role in Norrtälje although the initial decision about the introduction of the customer-choice model has been widely debated on ideological grounds. Some stakeholders even fear that political changes in the structure of the Health and Social Care Board could affect the future of competition and user-choice in the provision of long-term care for older people: *"This is the risk with party politics, it can change. And if the party politics change towards a government that wants more municipal provision the private companies might get less influence. And vice versa, when there is a right wing government, the municipal providers might get less influence"* (N7, Private home care provider).

The fact that the seven home care providing organisations have not yet started to meet each other autonomously may be a sign that mutual trust and a collaborative climate, both among competing home care providers and between them and other key-stakeholders – namely TioHundra AB as provider and the Health and Social Care Administration as purchaser – have only slowly developed, with joint meetings as a facilitator. In the absence of trust, accreditation and contractual compliance are likely to be used as main mechanisms to shape the relationship between providers. Some home care providers are seen by medical staff as a critical factor due to high staff turnover, thus compromising continuity, others are acknowledged for competent professionals, in particular within TioHundra AB. Mutual understanding thus seems to be more a matter of professional cultures, rather than between organisations.

The creation of win-win situations is yet another facilitator both at the organisational and at the professional level. Again, the experiences in Dortmund, where insiders of the network provide time and efforts in order to participate in market transactions, to gain and retain clients, and to stay tuned about new developments and initiatives, provide an example of 'good practice': *"The Senior Citizens Centres always try to underline cooperation, they promote all facilities equally, distribute demand evenly and let us operate side by side"* (D6, Owner of a private for-profit home care agency).

5.2   Organisational design – Specialisation vs. inclusion

The complexity of LTC delivery with its different autonomous stakeholders represents the most difficult challenge for integrated care. It comes with no surprise that integrated care networks are often restricted to specific themes such as, for instance, disease management programmes that specialise on the implementation of common guidelines or expert standards focusing on a defined disease (e.g. COPD, stroke). Other approaches such as the 'Dortmunder Modell' gear to a broader approach focusing on local collaboration or to a specific service such as home care, which has been the approach of the 'Care Network Leipzig'. With no individual stakeholder being in the driver's seat, the development of parallel structures and networks is easily understandable, in particular in the German multi-level and multi-stakeholder governance context. Local policy-making is therefore largely dependent on national and regional policies that are not always compatible with integrative approaches at the local level.

One example is represented by the legally prescribed 'Care Support Centres' that are run by the health/LTC insurance agencies since 2009. Due to their organisational design 'care counsellors' of these centres have had a restricted impact only – some (smaller) insurance companies are not able to guarantee nationwide coverage, and even the existing counselling centres are not sufficiently

staffed to carry out visits at beneficiaries' homes or to activate networking in the neighbourhood. They may provide information about administrative procedures and on accredited providers based on databases, but they are not designed to create integrated networks. The proactive coordination of care pathways and networking between providers thus remains uncovered, unless municipalities such as Dortmund provide low-threshold counselling centres that combine information, counselling and case management in the local context at least at district level.

The creation of different networks in Leipzig to supplement 'Care Support Centres' shows that more efforts are needed at the interfaces between health and social care, and that specialisation can sometimes be helpful to address specific voids between sectors and/or in defined areas.

From an organisational design perspective, the broadly integrated care model in Norrtälje has significant advantages by having a clearly defined lead agency based on joint funding and a joint administration. Governing by contracts and financial incentives is therefore seemingly easier, and the restricted number of competitors can be integrated to a large degree. Issues of organisational design are therefore focusing on a number of details such as, for instance,

- whether home nurses, district nurses and rehabilitation staff would better be allocated at the primary care centres or at the home care providers,
- whether all providers should be enabled to cover all four zones (to increase user choice) or whether it would be preferable to assign some zones, in particular the more remote areas, to one specific provider only (with potential economic savings, but at the detriment of user choice),
- how it can be avoided to change a provider, if it turns out that a patient will need more than two weeks of home care,[5]
- how coordination between the primary care centres and home care providers can be further improved, e.g. by shared medical records and a reduction of interfaces, and
- how quality assurance and follow-up processes could be improved.

It could be argued, however, that user choice has been rather restricted in Norrtälje, and that 'medical paternalism' is shaping care pathways as well as the collaboration with care providers. This is highlighted by some remarks concerning the (un)ability of users to choose, the scarce development of enabling mechanisms for users and carers, and the fact that users might be able to choose the provider, but they *"cannot choose the content"* (N2, Manager, Administrative Department, Health and Care Administration). This latter issue is currently under discussion with suggestions how users could be enabled to choose the content of their assessed home care services.

5.3 Funding structures – Prolonging the social-health care divide vs. joint funding

The legal and financial division between health and social care has been recognised as the most important structural barrier for integrated care throughout the relevant literature. Yet, decision-makers need to deal with the given situation in looking for solutions under different national framework conditions.

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[5] Current practice in Norrtälje stipulates that patients with an envisaged need for care of no more than two weeks are not entitled to the 'choice model'.

The German LTC insurance has been tied quite strongly to the health insurance and thus also to a more medicalised approach to LTC, while social care remains a separated issue largely governed by regional legislation and implemented by local authorities. When it comes to community care and the integration of services around users' needs, the distinct funding structures therefore remain a major barrier to for users to receive the care most suited to their needs and individual circumstances:

> *"We know that home care can currently only cover a minimum arrangement … often only selective support in daily living, but in domestic settings people are increasingly living alone, with children living elsewhere. So what we would need more is support and respite for family carers such as day care facilities. In this context the LTC insurance does not help (…) This is due to legislation and funding in silos … and as long as this persists one remains stuck." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

Funding issues are also a reason for not participating in integrated networks. For instance, the 'Care Network Leipzig', which is funded almost exclusively by contributions of their member organisations, has experienced the exit of three partners who were not able to sustain the monthly membership fees (although it was able to find another three partners to join). This is a different arrangement than in Dortmund, where only the large welfare organisations contribute to funding of the 'Senior Citizens Centres' that are mainly financed from the municipal budget.

The unique situation in Norrtälje was in the first place facilitated by the way in which policy-makers found a way to establish a joint health and social care budget across government levels. The integrated care model that had been constructed before the introduction of the 'user choice model' was sufficiently robust to also integrate competition and choice, some interviewed stakeholders even sustained that the *"LOV [the Act on the system of choice] has been a blessing for Norrtälje"* (N5, Manager, Care Management Department, Health and Care Administration). It remains to be seen whether it would be possible to create an integrated care initiative under conditions of an already established 'user choice model'.

5.4   Continuous dialogue

A constantly changing care market calls for coordination and networking not as a one-off activity but as a continuous process based on sustainable structures and a dynamic multi-professional team. The original 'bell ringing', i.e. creating contacts and informing all care agencies, but also police stations, housing agencies, pharmacies and other local key-persons served to raise awareness for the needs of an ageing society in the local context. Based on this first impact there needs to be constant follow-up through activities ('action days') and up-to-date information on the changing care market.

> *"The dialogue has developed in a sustainable way by means of the round tables that continue to bring all stakeholders together so that a common ownership is being generated." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

Similar experiences were reported by interviewees in Leipzig where there are no 'round tables' at district level, but within Gerinet there are a number of working groups and teams to implement various projects that keep up information exchange and involvement of stakeholders.

In Norrtälje, the discourse is much more focused upon care delivery and chains of care, rather than the wider context of users' living conditions in the community. Housing, security and other issues of

daily living of older people with LTC needs are hardly ever mentioned by the interviewees that are mainly occupied with the integrated care network, rather than with its boundaries to the community. The dialogue is therefore mainly restricted to the participants in integrated care.

6 Tools to underpin coordination and networking

It may be argued that the open market-governance of LTC has both boosted the necessity for more coordination and facilitated the creation of coordination and networking tools. While the increasing number of providers has changed the structure of the 'care market', which has become confusing in particular for users who are supposed to choose between providers, all stakeholders have an interest to get into and to remain on the market. Apart from basic marketing activities that might be costly and time-consuming, e.g. distributing flyers in hospitals, participation in a network of providers is therefore a convenient strategy both in Dortmund and in Leipzig. In Norrtälje, home care providers do not have the choice, as there is no competing network which they could join, and their presence on the market is clearly linked to the compliance with contractually agreed performance. The tools used to underpin this arrangement are nevertheless similar.

6.1 Case/care management

Case and care management is one of the most prominent and classical instruments to address problems at the interfaces within the health system and between health and social care. In particular with rising financial pressure on hospitals through DRG-funding, case management has become a popular function in hospital organisation.

> *"Case managers use half of their working time to organise discharge of patients into domestic settings, the other part of the time is used for coding of diagnosis and procedures, with the exception of those that need to be coded by medical doctors. So we can see in how far we comply with thresholds for length of stay according to DRGs (…) to increase the monetary benefit. And as we also manage the transfer to the post-acute phase we can follow patients proactively and see where we need to organise their discharge." (D4, Discharge Manager, Public Hospital Dortmund)*

However, discharge management often terminates at the exit door of hospitals so that patients remain without a follow-up structure in their own home. The Senior Citizens Centre and its network in Dortmund offer such follow-up as a first step towards more integration. Currently it is planned to complement this service in terms of disease management programmes in cooperation with the health insurances, but further integration for people with dementia and multi-morbidities would be needed.

A further expansion of case management is also planned within Gerinet, where currently the main focus is put on the introduction of discharge sheets and feedback to hospital discharge managers by subsequent care providers.

Also in Sweden, legislation and the search for ways to reduce the length of stay in hospitals, have put pressure on home care providers and thus on municipalities to improve home care.[6] This is also the

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6   By law, municipalities have to provide home care within five days, if the hospital declares a patient ready for discharge, otherwise they have to reimburse the county administration for hospital costs.

case in Norrtälje – even if there is a joint budget of the County council and the municipality, the administration has to report accounts to both entities – but the main aim is to provide high quality care: "*If you merge municipal home care with the councils' basic home nursing and home rehabilitation you will create a form of competent team which in turn facilitates for the older person to live in their own home as long as possible. I think it is important to keep it together if you want to provide health and social care of high quality in the home*" (N3, Director, Health and Social Care Administration).

Case management and discharge planning have therefore become the central tools to avoid 'bed-blocking' and to prepare patients for being cared for in their own home (or in a nursing home). Norrtälje municipality have developed the discharge procedures in order to get a closer proximity between the hospital, the care managers and the home care providers: "We used to have a lot of problems with discharge processes, and we had high costs for people ready for discharge. The change is about how the care managers work with discharges. Now, they have a good discharge process team who, in turn, have a good relationship with the hospital" (N3, Director, Health and Social Care Administration). All relevant stakeholders are invited to and participating in discharge conferences to prepare a smooth transition of patients from hospital back home, at best by including the chosen home care provider. Altogether, 14 care managers are dealing with assessment and care coordination in the Health and Social care Administration, 4 of which are exclusively focusing on complex discharge processes: *"We want to organise the care planning procedure at the hospital so that we get together the primary care, the home care provider, the hospital and other necessary actors. And we can do that, because we have both the health care and social care provision. We do not have to knock on the door of the county and ask them what they think about the idea"* (N5, Care Management Department, Health and Social Care Administration).

6.2 'Round tables'

A relatively cheap, but quite effective tool to realise coordination and integration in LTC is to organise space and time to gather the relevant stakeholders at one table. While this may be useful for strategic decision-making at municipal level, it is even more so at the level of direct provision, i.e. at district or even neighbourhood level. Individual stakeholders thus get the opportunity to get to know each other, to exchange information, to develop trust and to elaborate on common challenges.

> "*At the round tables you meet other service providers that are not able to offer occupational therapy or physiotherapy. Then you pull in another partner. We are currently trying to develop small living units for people with dementia, and Caritas has already experience with six such facilities, so I was able to see what they are doing, I could learn from them … and for day-care I have known some people from AWO, so if I got questions in this area I turn to them.*" (D5, Home Care Manager, Private non-profit provider, Diakonie Dortmund)

Not all providers will always be able to participate in round table discussions, in particular for smaller organisations such unpaid activities are difficult to schedule, even if they may replace other marketing activities. However, an open platform offers broader opportunities for networking.

The 'Care council' in Norrtälje plays an important role in exchanging experiences and ideas. The Director of the Health and Social Care Board is having these joint meetings with all health and long-term care providers in Norrtälje municipality 1-3 times per semester. The councils often focus on a specific topic, such as discharge processes, and those providers involved are invited to the meeting.

Sometimes the councils have more of a general approach to provide information that concerns all care providers. In addition, the manager at the Health and Social Care Administration responsible for contracting invites all home care providers to councils 1-2 times per semester. These councils often focus on information from the administration to the providers, changes in contracts or areas of improvement. Some of the interviewees, both from the Health and Social Care Administration and the home care providers, acknowledge that it could be beneficial if only the home care providers would meet with each other, too. If they had councils of their own they could be able to act as a joint force against the Health and Social Care Administration.

6.3 Counselling and coordination centres in the neighbourhood

Even 20 years after the introduction of the LTC insurance and the acknowledgement of LTC as a social risk, citizens need information and advice once they come into the situation of being in need of assistance and support. They need to be empowered to realise the opportunities of choice, voice and exit due to their fragile situation in a changing and often confusing market situation, and pertaining differences in local supply. To combine counselling and coordination in a proactive one-stop shop at the local level, at best in each neighbourhood, is a first step towards a strategy to identify citizens in need of care and to connect them with the formal care market as well as to construct and maintain a network of providers.

> *"It would be presumptuous to sustain that Dortmund's Senior Citizens Centres are reaching each and every potential user and satisfying everybody. We certainly contribute, but it would be desirable to have more funding to cover more neighbourhoods." (D1, Head of the Department for Senior Citizens, City of Dortmund)*

Counselling and coordination centres represent transaction costs that can hardly be borne by an individual stakeholder. There are no concrete data about potential savings and/or a (social) return on investment of such facilities but it is likely that both health and social care providers will benefit from their activities. Joint funding would therefore be suitable, rather than the creation of 'parallel structures' as in the German case with 'Care Support Centres' funded by the Health/LTC insurances on the one side and 'Senior Citizens Centres' funded by the municipality on the other side. The attempt of the Senior Citizens Centres in Dortmund to invite the care counsellors into their premises once a week is a first step towards more integrated support and counselling, but a more structural integration would be needed.

In Norrtälje there are no independent care counselling centres. Potential users and their families have to turn to the Social and Health Care Administration to apply for services or facilities of long-term care. Following an assessment by the care manager they are entitled to the assigned services and may choose, from which of the seven provider organisations they would like to receive services.

6.4 Contracts to boost collaboration

The German LTC insurance system is based on an open market approach with accredited providers that have to sign a 'provision contract' *(Versorgungsvertrag)*. These contracts do not stipulate any paid working time for coordination and networking, but payment for defined care activities according

to a modular system of points for each accomplishment.[7] In this context it is therefore difficult for other stakeholders to add contractual agreements as they do not appear as commissioners (who would actually be the service users).

> *"We only have contracts with the providers of auxiliary means. With these we have negotiated that they deliver their products immediately at low costs, even if reimbursement has not yet been approved. (…) So we can reduce the length of stay in the hospital. (…) With home care agencies we do not have contracts (…) the patient should decide how satisfied he is with their quality." (D4, Discharge Manager, Public Hospital Dortmund)*

> *"No, we do not have contracts, we have meetings with open agreements, depending on the issue we try to gain people for different working groups or projects, or to organise action days, e.g. recently for an action day about safety for carers in daily practice … but the collaboration is always voluntary." (D2, Manager, Senior Citizen Centre, District of Dortmund)*

In Norrtälje contractual arrangements are definitely shaping the integration of providers, with in-built mandatory participation in care planning and adherence to the collaborative procedures in primary care. Regulation and contracts are important tools in order to govern customer-choice and integrated care in the organisation of home-based care, to sort out unreliable providers at the onset and thus to ensure high quality care.

> *"The Health and Social Care Board and its administration (…) developed a list of requirement which implies that there are no providers in Norrtälje that do not meet this requirements (…) So if a customer is not able to make a choice it will still be a good choice, because there are certain requirements." (N3, Director, Health and Social Care Administration)*

All interviewees underlined that the contractual requirement to be able to provide integrated home care including home help services, basic home nursing and home rehabilitation has affected the number of home care providers.

> *"The requirements are actually very hard and it is a lot of different criteria that we must fulfil. And there is monitoring and follow-ups. I think it is pretty hard." (N7, Private home care provider)*

6.5   Financial incentives towards integrated funding

In Germany, the debate about moving away from fee-for-service reimbursement is only at the very beginning. It is interesting to note that both at municipal level and on the side of health/LTC insurers there are no strategies to change financial incentives towards more integrated funding and/or towards funding mechanisms that could trigger more coordinated and integrated working.

> *"We [the Senior Citizens Centres] would need much more staff in this sector of coordination and networking, but I think it is difficult to ask providers for co-funding, this would 'smell' like a commission fee, which would make us loose acceptance. We should remain independently funded to maintain our credibility." (D3, CEO, Private non-profit provider, DRK Dortmund)*

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[7]   The Medical Board of the Health Insurances (MDK) has started to think about adding 'readiness for integrated care provision' to its accreditation criteria for care providers.

"Our policies are not targeted on integrated care – this is left over to the local authorities." (D7, Manager at the regional agency of a large health insurance, AOK Nordwest)

The integrated care model in Norrtälje, though bundling health and social care budgets within the public Health and Social Care Board, is based on traditional fee-for-service financing of individual providers. However, some forms of financial incentives have been introduced to promote cooperation and to compensate for specific situations. For instance,

- Providers are paid different fees according to the area in which they are operating – urban, rural or remote rural (islands),
- Primary health care doctors are paid additional fees for patients over 80 years of age,
- Providers are reimbursed for participation in care planning or discharge meetings, and for multi-disciplinary visits of clients at their homes.

Chapter 4

Discussion and conclusions

The findings of this qualitative study showed a nuanced picture as to the conciliation of choice and competition, on the one hand, and integrated care, on the other hand. The overall opinion of those interviewed in the three sites was that it was possible to achieve integrated care in a context of user choice and competition. For many of the different stakeholders interviewed – particularly in Germany – user choice had been internalised as a *de facto* right of users. Integrated care initiatives in the German sites are thus forced to work in a context of choice and competition, in some cases they even were a reaction to this basic framework condition, while in the Swedish site, competition became a new challenge for an already established integrated care model.

Identifying barriers …

There were however a number of possible barriers to collaboration identified across the three sites. One of these barriers was the issue of information, i.e. of providing users with sufficient and adequate information for them to make their choices. This issue was particularly salient in the narratives of interviewees in Germany, where users have been empowered with choice since the introduction of the long-term care insurance in the mid-1990s. Interviewees did not challenge the wisdom of placing choice in users' hands, but questioned their ability to act as consumers.

In the Swedish site, the issue of information for users is restricted to information about the home care providers. Older people in Norrtälje receive information about all seven home care providers when they are about to make a choice. However, the information is scarce and it is up to the individual to seek information online or by calling the different home care providers. Furthermore, the interviewees worried about whether there was a 'level playing field' in the local care market. As the *de facto* incumbent provider, TioHundra AB Home Care, though formally being considered as just one of seven 'customer choice' providers, could benefit from a privileged position at the start, but decided to provide services only in two of the four zones. Conversely, TioHundra AB Home Care staff are not able to offer additional (household) services as the other six providers and is not allowed to advertise its ability to offer services across the entire 'chain of care'. This was also seen as a limitation to competition.

Issues concerning fair competition were also present in the German sites, but with a slightly different twist. In Dortmund, private providers were sceptical, when the large welfare providers set up the Senior Citizens Centres as a public-private partnership. And in Leipzig private for-profit providers still are doubtful, as the management of the Senior Citizen Centres – responsible among other things for providing information to users – were outsourced to the large welfare organisations, i.e. their most important competitors.

The German models for integrated care operating in the two sites represent relatively loose forms of integrated care (Leutz, 1999). This created challenges of its own when it came to ensure collaboration among different providers, as participation was voluntary and financial incentives scarce or not really aligned with promoting integrated care. In fact, for-profit providers in the German sites even had to pay a small fee to participate in the integrated care network (Leipzig) or at least set aside resources to attend meetings at the 'round tables' (Dortmund) – and these costs were

perceived as possible barriers, too. The challenges faced by the German sites in integrating care were increased by the much greater number of providers (and competitors) that are operating in each of the German sites as against the seven provider organisations in Norrtälje. The Norrtälje model, with its integrated funding streams, had to face these problems at a much lower level – only some stakeholders (Primary Care Centres) criticised the rising amount of communication efforts – and seemed to be able to allocate funding according to the users' needs to a degree, which is impeded by German legislation. Fragmented funding in silos is still prevalent and this was perceived to structurally hamper integrated care both in Dortmund and Leipzig.

Another barrier identified in the narratives was of a more logistical nature: how to exchange information (e.g. user's needs) between providers. Here again, it seemed that the more integrated care model in Norrtälje had significant advantages as against the German sites as a much smaller number of providers (including GPs) have to be coordinated, and contractual relationships (accreditation) include agreements about basic data exchange. Given the fact that the number of providers alone is hampering both coordination and information exchange, it is certainly important to regulate access to the market to avoid mushrooming with the risk that particularly some of the smaller providers are constantly at the brink of failure, e.g. due to a lack of liquidity. This situation in Germany has been created by the relatively weak accreditation mechanisms that aimed at generally increasing supply. The Health and Social Care Board in Norrtälje avoided this by increasing the threshold to enter the market, e.g. by the requirement that each provider needs to offer home nursing care, household and rehabilitation services.

Market-oriented governance as a way of managing public affairs has often replaced trust (e.g. professional and organisational ethics) by contracts and control. In the area of LTC (including health and social care), where co-production (of users, but also of carers and civil society) plays a major role to reach satisfying outcomes, trust has been a driving force for both its quantitative and its qualitative extension, in particularly in Germany, where the large welfare organisations contributed to the extension of services. This traditional link between the public administration and the welfare organisations had been criticised for generating oligopolies and 'old boy's networks' without transparent control and competition, thus driving rising prices and budgets. Indeed, the introduction of competition through market-oriented governance had been a reaction to these shortcomings. With the appearance of new private for-profit providers and new contractual rules for all participants in the 'care market' new models needed to be found to satisfactorily deal with information sharing, cooperation and coordination among the now larger number of stakeholders. While no strong evidence is available about the impact of the policy change on prices and transaction costs, it seems that after a lengthy process trust and cooperation between different (selected) providers have been partly (re-)created.

During this process the presence of the large welfare organisations, which usually dubbed as advocates for users in Germany, has been perceived by many interviewees as having a mixed effect in (re-)creating trust and cooperation. On the one hand, the presence of stakeholders with different 'values' (i.e. cooperative action driven by a shared concern for users) was seen as a facilitator. On the other hand, some stakeholders pointed out that even large non-profit welfare organisations were actually aiming to gain market share, which explains the above-mentioned reservations that they would not provide independent advice when managing the Senior Citizens Centres (Leipzig). Values such as user-orientation and 'working towards the common good' that are often attached exclusively to non-profit organisations were actually expressed by some private providers, too. This certainly

reflects the particular sector in which they are operating: health and long-term care. Although this latter view was also found in some statements by stakeholders in the Swedish site, the cleavages are much more accentuated between public and private providers in this country, even if a level-playing field between organisations seems to have been found. In Germany, the large welfare organisations, representing the 'third sector', may be perceived as an intermediate agent between the state and the market.

It would go beyond the scope of this study to enter into a larger debate about this difference between Sweden and Germany, but it might be useful to consider their impact on the political cleavages linked to choice, competition and integrated care in both countries. Under conditions of market-oriented governance a number of observers have stated that all types of providers within the welfare mix were undergoing a 'hybridisation' of values and identities, in particular in the area of health and social care (Evers, 2005). In the German context this still means that the 'third sector' remains a distinct entity that is not different *from* the market sector, but *within* a broad and diverse market sphere (Bode & Evers, 2004). It could be argued that also the publicly funded and regulated for-profit providers in Swedish health and social care provision have become hybrid organisations as well as the 'outsourced' public enterprises such as TioHundra AB. The absence of a 'third sector' in the Swedish welfare mix of LTC service provision might thus facilitate integration, but it is solid public regulation, rather than civic dialogue, that governs care pathways and cooperation.

In general it can be underlined that the barriers identified in this study are therefore very much in line with previous studies, which have also identified the role of financial barriers or disincentives, lack or difficulties in creating a shared culture for joint working, and strains in sharing information as key factors that are hampering integrated care delivery.

... and enhancing opportunities for collaboration

As opposed to barriers, there were also narratives throughout the interviews of how competition and user choice had actually enhanced or contributed to integrated care. In the fragmented care market of Germany, being part of an integrated care network was seen by some providers as having enhanced their capacity to draw on other providers to supplement their services or to channel users to partners in the network that would be more suitable to deal with particular needs. This was often accompanied by views that, given demographic ageing, demand for care services would likely continue to outstrip supply. While this process of 'enlightenment' towards voluntary cooperation is still an on-going process in Germany, the customer choice providers in Norrtälje were invited – some even used the word "forced" – to complement the already existing integrated care model, to work within predefined integrated structures and processes – and eventually to contribute to their continuous improvement. With the Health and Social Care Board in the driver's seat, cooperation and collaboration are certainly easier to accomplish than on the basis of voluntary engagement.

In the context of a competitive environment, some providers in Germany had also decided to specialise in particular services or specified groups of users as a strategy to differentiate themselves from other providers within the integrated care network. This could have contributed to fill gaps of care provision, although it was not possible to determine the outcomes for users of this specialisation. Similarly in Norrtälje the possibility to specify in certain areas is seen as a strategy to attract different groups of older people and thus to compete with other care providers. However,

some interviewees acknowledge that specialisation could be risky in the provision of home care as reimbursement is not sufficient and it is not sure if enough clients could be attracted.

Being part of an integrated care network was also used by some providers as a strategy to gain or at least maintain market shares in the German sites. This was pursued via three channels. Firstly, being part of an integrated network was used as a 'marketing tool' to signal higher quality or concern of users' well-being to prospective users. This seemed to indicate that integrated care was at least perceived by providers and/or users as a 'positive' or 'desirable' concept. Secondly, by participating in an integrated care network, providers also hoped to attract users indicated by the information centres, discharge managers or other providers in the network. Thirdly, forming a network with other (for-profit) providers facilitated the definition and distribution of 'catchment areas' among those participating in the network, thus reducing competition and improving efficiency, e.g. through shorter travel times. Again, these views were for the most part confined to the German sites, where competition was probably fiercer and users had a greater scope for choice. In Norrtälje it is up to the home care providers to choose the zones in which they want to operate, based on a differentiation of fees according to the geographical characteristics. Both in Swedish and German sites there is, however, fierce competition for appropriate staff, and it seems that this type of competition is often more detrimental to cooperation than competition for clients, in particular under conditions of undersupply.

However, it is worth bearing in mind that being part of an integrated care network was not only or mostly driven by business considerations. Providers expressed views that they saw integrated care as beneficial to users and that being part of such network helped them to better fulfil their tasks and improve users' outcomes.

Finally, competition was seen as an important element to drive up quality within the care networks, as it spurred providers to constantly improve and learn from other providers/competitors.

The above narratives of how competition and choice could enhance integrated care are in line with the findings of other studies (van Raak et al., 2005). In the case of the present study it is interesting that they were most evident in the German sites, where competition and user choice were arguably greater. Statements of German providers that being part of an integrated care network could be seen as a competitive advantage in a contestable market are even more salient as this membership was not without costs to providers. This may partly be explained by the fact that formal care provision in Germany is only covering a relatively small part of people in need of care. With the possibility of users to choose between benefits in cash or in kind (more than 60% choose the cash benefit) it must be a common interest of formal care providers to generally promote their services as an advantageous solution for users. Still, also in Norrtälje providers valuate the participation in integrated care as positive, though also in this case TioHundra AB Home Care has the big advantage, for instance, to be part of an internal TioHundra AB working group that continuously improve the chain of care within the organization, to avoid gaps in the chain of care, to reduce the number of professionals around clients, and to improve quality by means of support by geriatricians.

Context matters

Compared with a previous evaluation of the Norrtälje experiment (Øvretveit et al., 2010), it seems that the experience of pooling budgets had matured and allowed for an apparently smoother

allocation of funding across the health and care divide. Exchange of information remained an issue, as reported before. This did not seem to arise due to difficulties in setting up an infra-structure that allowed for sharing information, but rather from the increasing number of stakeholders and from occasional uncooperative attitudes from some among them.

While it may seem that the Norrtälje model fared better in achieving integrated care, it is important to stress some important contextual differences that help to frame the findings. Firstly, long-term care providers in Germany operate under a much more open market as they are free to establish themselves in each municipality. Secondly, the two German sites had a far greater number of providers (e.g. 111 in Leipzig alone compared with seven in Norrtälje), which means that efforts to integrate care met with a much more fragmented market. Thirdly, new entrants to the care market in Norrtälje are required to adhere to the integrated care network, which facilitates the power to define procedures, while participation in a network in Germany remains a voluntary process. Fourthly, the governance structure of health and long-term care in Germany helps to explain why the German models examined here are local initiatives and, for example, virtually unable to bundle or integrate payments.

Finally, it is important to stress that the establishment of the integrated care model in Norrtälje preceded the introduction of the user choice model; in Germany, both integrated care initiatives had to be constructed within the context of a rather mature competitive care market with user choice already in place.[8]

However, it seems that users in Norrtälje had much more limited choice, both in terms of providers and care tasks or packages. As Norrtälje was seriously considering moving from zoning of providers (where some providers are allocated to different geographical areas) to a system of preferred provider, user choice risks being limited further. The limits of the decidedly more top-down approach followed in Norrtälje were evident also in the lack of empowering tools for users and on the more 'medicalised' approach inherent to its care pathways. Furthermore, it is worth stressing that the Norrtälje model had been in operation for some time and that the cooperative environment and pooled financial resources now established had actually taken quite some time to be implemented (Øvretveit et al., 2010).

Lessons to be learned

It is worth referring that direct comparisons between the three sites should be considered with caution, given the underlying governance differences between the German and Swedish health and long-term care systems; as well as the differences in size as well as the degree of integration between the three study sites. Furthermore, some of the findings may reflect some self-selection of interviewees. Almost all of them were part of an integrated care network, as this study sought to

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[8] It should also be kept in mind that the large welfare organisations have a long tradition in social service provision in Germany, representing the institutionalised third sector between the state and the market with a large degree of trust from both policy-makers and citizens. Although the newly installed and extended 'care market' during the 1990s has changed this identity to some extent, their influence on users' choice and their market shares, respectively, remain a decisive factor.

understand barriers and facilitators in operating integrated care models. Their generally more positive views about integrated care could therefore be somehow expected.[9]

Despite the inherent differences between the three sites and their context, there are however a number of salient lessons and recommendations arising from this study that are liable to be applicable to other contexts and will be briefly outlined in the following.

Different ways to overcome barriers – Competition and choice as accelerators?

Although quite distinct in their approaches, the three study sites showed that it is possible to build common values and to enhance trust and joint working through quite dissimilar approaches to integrated care. In other words, full integration such as the Norrtälje model is not the only way to achieve (better) collaboration. There is no 'one-size-fits-all' solution, but it is necessary to leave enough time and space to stakeholders to find common grounds. In all sites it became clear that it takes several years to develop ways of cooperation and mutual understanding. This means that short-term projects of integrated care can hardly be successful, though competition and customer choice may accelerate the search for solutions.

Pooling resources is as salient as difficult to accomplish

The ability to allocate resources according to needs rather than to institutional settings and budget lines (e.g. health vs. long-term care) is extremely important for integrated care. Governance structures, often beyond the control of the bodies establishing integrated care networks, can be a powerful barrier to pool resources.

The importance of transparency and a level-playing field

Creating trust among otherwise competing providers also means having transparent procedures in the allocation of users or funding. Potential conflicts of interest should therefore be avoided as well as opportunities for 'cherry-picking' or free-riding. Furthermore transparency of prices and quality have certainly an important influence on trust-building and hence collaboration.

Organisational design plays a major role in creating collaborative structures

It is helpful to create time and space for exchange and cooperation. In the context of LTC for older people it is also necessary to define integrated care in a broad perspective, as shown by the case study sites, rather than to restrict it to managed care for selected diseases.

Sophisticated organisational design may facilitate networking and integration, if both the structural preconditions and local specificities are taken into account. For instance, to create a network in public-private partnership with the large welfare organisations would not easily be transferable to other countries such as Sweden. However, three features of the 'Dortmunder Modell' may be considered for any attempt to improve collaboration in LTC, in particular at district or neighbourhood level:

- to install a co-management for 'Senior Citizens Centres' consisting of a representative of the public administration and a representative of (non-profit) providers,[10]

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[9] A comparison of both German and Swedish care managers' views on integrated care, choice and competition is the subject of an on-going supplementary study, based on an online survey.

- to share offices of the public administration that host both public officers and staff from welfare organisations (in this case even reimbursed by the local authorities),
- to involve all stakeholders in 'round tables' and working groups as tools (see below) to create transparency, mutual understanding and problem-solving.

The supportive structures that have been implemented in Norrtälje are an example of classical models of integrated care, in this case always based on joint funding and administration of health and social care:

- A sophisticated discharge management in combination with intense care planning involving users, their family and other key-stakeholders,
- The integration of home care, basic home nursing and rehabilitation provided in the home of the user (at best guided by district nurses), and
- Regular joint meetings with all stakeholders in long-term care to provide feedback and to discuss shortcomings or potential improvements.

Competition seems compatible with (sometimes even reinforcing) integrated care

User choice and competition can be drivers for integrated care, even in very competitive environments, as the German experiences show. As they must be considered as a reaction to an increasingly competitive environment, it should be underlined that additional efforts are needed to prevent market-failure that would occur under conditions of an unregulated market. The Swedish case study showed a much more regulated approach to competition, with an already established integrated care model and an appropriately funded lead-agency in the driver's seat.

Empowering users to reconcile user choice and integrated care

Although most stakeholders were in favour of user choice, this issue remained arguably more contentious. The more integrated care models are the more they may put into question user choice and empowerment – particularly if based on a more medicalised, disease-focused model. In any case, putting in place appropriate, empowering support mechanisms and appropriate means to convey information for user choice remains a general challenge in LTC. In competitive environments, it is useful to look for independent, professional and low-threshold solutions that promote transparency and, at best, evidence-based knowledge. This is difficult to realise as empowering structures such as, for instance, 'Senior Citizens Centres' need to be close to the network of providers to be able to foster locally relevant information, which is not always based on measurable quality indicators. Well-trained professionals are therefore needed to balance individual clients' preferences and given supply structures.

Moving from fee-for-service to value-based provision

It will be necessary to focus further research efforts on the issues addressed in this study, a major caveat of which is undoubtedly that differences as to the outcomes for users could not be assessed and compared. Apart from major methodological problems inherent to such measurements of quality of care or quality of life (OECD & European Commission, 2013), even within single regions or countries, further efforts to promote integrated care delivery will entail thinking about new types of

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[10] The solution found in Leipzig, i.e. to outsource Senior Citizens Centres to individual welfare organisations alone, seems to be less 'integrative', but their further development remains to be followed-up.

incentive structures for integrating care (WHO, 2015). This study has shown, as many others before, that current ways of funding in 'silos' based on fee-for-service payments remain an important barrier for collaboration. As all providers are chiefly driven by chasing for clients ('cases') or service hours within a taylorised system of professionally divided tasks, general aims such as social and individual well-being often get out of sight. If regulators even in the most marketised system of health and social care delivery, in the US, have started to tackle 'market-failures' it remains to be seen, how business-models for LTC in Europe can be moved towards value-based purchasing and incentives for population-based payments. Under conditions of market-oriented governance the challenge is therefore to find new ways to use those aspects of positive dynamics of competition that have been identified in this study to enhance vertical and horizontal collaboration in long-term care, be it as 'Accountable Care Organisations' (Damberg et al., 2014) or by means of other financial and professional incentives.

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Annex 1
Interview guidelines
"Integrated care, choice and competition"

Target group

- Managers/founders of integrated care networks/organisations (ICN)
- Case/care managers, care counsellors in the area of long-term care
- Purchasers/insurers (adapted version needed?)

Intro

- What are your responsibilities in your organisation and in relation to the integrated care network?
- How long have you been working in this position?

Integrated care in municipality – the organisation

- What is the primary focus of the integrated care network in your community?
- Which providers are taking part in the integrated care network? What are the roles of the providers and what is your role in the integrated care network?
- How did you (the ICN) choose the partners? Have any partners been excluded (for what reasons)? Did any partner leave the network? If yes, for what reasons?
- What common actions are taking place? E.g. care plan, regular meetings, technical tool (IT infrastructure) etc.?
- [Level of integration]: Have particular institution(s) or position(s) been created that are in charge of coordinating all services across different providers or are the different providers (Coordination) working together and share their knowledge (linkage)?
- How does the process of the delivery of integrated care take place? What happens, for instance, when a patient is discharged form hospital or if a client needs different kinds of health and social care services or therapies?

Choice and fragmentation of providers

- Has the issue of 'user choice' been an issue in your ICN?
- How would you define 'user choice' in the context of your ICN? (what kind of choice?)
- Is the choice for patients of providers facilitated by the integrated care network? What or which stakeholders are facilitating the choice of providers and/or types of services?
- In your view, how important is it to maintain choice for users of integrated care groups? Does this hamper your objectives of integrated service delivery?
- Which measures and steps would be needed to maintain the choice for users in integrated care networks?
- What do older patients prioritize most in their choice of care providers? (Continuity of care, personal relationships, accessibility, etc.)?
- Are patients aware of the competition between providers (i.e. home care providers) and do they base their choice on the quality of the care provider (e.g. through recommendations, information of public reporting etc.)?
- Do patients also choose care providers that are not part of the integrated care network? If so, what happens if a patient chooses a care provider outside the network? Are patients allowed to do that? (incentives to remain in the network)

Competition, performance and integration

- As partnership working is a complex task based on a shared vision and relationships that are high in trust, is competition not a hindering factor for collaboration between providers? If yes, what experiences did you make with different partners (e.g. non-profit vs. for-profit)?
- Which other organisations, people or professional groups do you perceive as 'competitors' on the care market?
- How did you perceive the initial phase of the integrated care services? What were major obstacles and challenges?
- Do care providers that participate in the network have developed competitive advantages over each other, e.g. …? Did you experience that providers that coexist in the same integrated care structure compete for patients/clients?
- Does competition between care providers within an integrated care network take place? If yes, how do providers compete which each other and what are benefits/detrimental effects of this competition?
- What do you think would be the results of increased competition between integrated networks?
- Are providers that compete across integrated care networks improving their performance? And if yes, how, i.e. responding better to individual needs, stronger patient focus, enabling more seamless care, etc.? How do you measure achievements?
- Could competition between different integrated care networks provide mutual learning opportunities and thus underline the strengths of provider/each network while at the same time they are able to better streamline their services?
- Are providers that participate in the integrated care network less vulnerable to competition, i.e. to be exchanged by more profitable providers?

Collaboration between different providers

- Is the type of ownership of the providers (public, non-profit and private) an issue in their collaboration and in your network?
- Does it involve any challenges given the different working conditions, management or care organization across different types of providers?

User perspective: outcomes for users

- Do you think competition between several integrated care groups may be beneficial for the users of care?
- Do you think competition within an integrated care network would be beneficial for the users of care?

Commissioning and financing

- How is the integrated care scheme financed? Common financing mechanism?
- How is your relationship with the purchaser(s) of care? Negotiations, contract, monitoring, etc.
- How should contracts with LTCIs be designed to enhance collaboration between competing providers? (e.g. should an entire contract for an integrated service be put out to tender?)
- How does the role of the commissioner (LTCI, Germany) need to change in order to enhance integrated care networks?

- Which financial incentives need to be set in order to stimulate effective integration of care services?
- Germany: Is the competition between LTCIs a barrier for LTCIs to set up good commissioning or contracting arrangements that enhance integrated service provision?
- What financial incentives should be set to stipulate competition between integrated care systems?

Quality assurance

- How is quality of care ensured within your network?
- Are there any incentives for quality management (contracts)?
- Do you use performance indicators to (a) better position yourself on the market or (b) to improve quality together with other providers or (c) to attract new clients?

Annex 2
List of interviewed experts and key-persons in integrated care networks

Leipzig

- L1: CEO, Gerinet Leipzig, Case Manager
- L2: Project manager, Gerinet Leipzig
- L3: CEO, Care Network Leipzig
- L4: Geriatrician
- L5: Authorised Representative of Senior Citizens, City of Leipzig

Dortmund

- D1: Head of the Department for Senior Citizens, City of Dortmund
- D2: Manager, Senior Citizens Centre, District of Dortmund
- D3: CEO, Private non-profit provider, DRK Dortmund
- D4: Discharge Manager, Public Hospital Dortmund
- D5: Home Care Manager, Private non-profit provider, Diakonie Dortmund
- D6: Owner of a private for-profit home care agency
- D7: Manager at the regional agency of a large health insurance, AOK Nordwest

Norrtälje

- N1: Manager, Purchaser Department, Health and Social Care Administration
- N2: Manager, Administrative Department, Health and Social Care Administration
- N3: Director, Health and Social Care Administration
- N4: Manager, TioHundra AB Home Care
- N5: Manager, Care Management Department, Health and Social Care Administration
- N6: Operational Manager, TioHundra AB, Primary Care and Rehabilitation
- N7: Manager, Private home care provider