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Chapter Three

Markets, networks and the quest for coordination. The story of Solimed Enterprise Health

Laura K. Schang¹

SETTING THE STAGE.

Over the past decade, the international and national health policy community has increasingly highlighted a quest for coordination in health care. The OECD identified coordination deficits between health care disciplines and sectors as a key cause of the quality and efficiency problems faced by many health systems, and proposed integrated care as a remedy for the perceived lack of coordination (Hofmarcher et al., 2007). At national level in Germany, integrated care is praised as a structural innovation for better coordination in the best interest of patients, providers, payers and the public (SVR, 2009²). Over the past decade, German health policy has intensely tried to stimulate integrated care at local level, in order to enhance coordination and, thus, quality and efficiency of care. In other words, coordination is presented as the holy grail of health care.

In this context, integrated care is usually framed as part of a broader paradigm shift – from corporatist to allegedly more effective and efficient market structures, from the physician to the physician as entrepreneur and manager,

¹ I am very grateful to my six interview partners from Solimed Enterprise Health (two office-based physicians, a hospital manager, a hospital medical director), from AOK Rheinland/Hamburg, and from Kassenärztliche Vereinigung Nordrhein. They kindly invested their time to talk with me about their work, their experiences, and their perspectives and I offer my view of Solimed Enterprise Health in return.

² This Advisory Council is an interdisciplinary expert committee appointed by the Federal Ministry of Health to compile advice on the current status of health services and future potential for development.

from fragmented to integrated care (Lisac et al., 2008; Amelung, 2009). Integrated care has, thereby, become an acknowledged vision of health policy reforms. However, integration is easier said than done. In fact, many studies show how difficult inter-organisational coordination actually is (Axelsson & Axelsson, 2006; Amelung et al, 2008; Weatherly et al, 2007; Durose & Rummery, 2006; Davies, 2007).

In this study, I will provide an insight into the mechanisms that play a role in realizing integrated care in practice. To that purpose, I reconstruct the development of *Solimed Enterprise Health*, an interdisciplinary and cross-sectoral enterprise in the German city of Solingen. Solimed is one of the few cases recognized as successful integration of care. In 2009, Solimed members received the Innovation Prize of the regional association of statutory health insurance physicians, because they “implemented and live the vision of integrated care as in only few other places in Germany” (KV, 2009: p.2, translation). Moreover, Solimed made the second place of the Northrhine-Westphalian health prize. The Minister of Health appreciated networking among Solimed members as “exemplary and in the best interest of patients” (MAGS, 2009: p.1, translation). The 75 Solimed physicians were praised for investing €700,000 in total into a common software package to exchange information, and for establishing pathways to coordinate treatment across disciplines and sectors. As proactive entrepreneurs, Solimed members had seized the opportunity created by recent health reforms, and had concluded integrated care-contracts with sickness funds (Auschra, 2008).

However, in order to gain insight into the strategies that made Solimed a success, one needs to look beyond these success stories and these words of praise representing the front stage of innovation, and to take a look backstage. It was Goffman (1959) who introduced the metaphors front- and backstage as part of his dramaturgical sociology. He proposed that human identities are constructed in interaction with others, and that to understand the development of selves, we have to look beyond the presentation of the self front-stage where it will align with various conventions, and to study the self backstage, where quite other ideas might be articulated. Thus, to study the development of Solimed as an example of successful integration of care, one should not rely on the front-stage representation of Solimed, but study the backstage.

The front-stage of innovation, that is Solimed standing in the limelight of two innovation prizes, easily implies that governance by market mechanisms has enabled integration of care. Implicitly Adam Smith’s ‘invisible hand of the market’ is ascribed much power in realizing integrated care. After all, Solimed is called an *enterprise*. But innovation prizes tend to strip a case of its context and focus on *what* has been achieved, not on *how* it has been achieved. This *how*-dimension is essential to enable learning processes in other regions and other countries. Arguably, the strategies for governing the struggles of integrating care can best be identified when analyzing the process, not the product of innovation. Therefore, this story does not primarily focus on the product – integrated care – but on the process of integrating care. How did Solimed members build their Enterprise Health?

To understand the case of Solimed, I went behind the curtain and talked to six actors backstage. Based on the analysis of their accounts, and complemented

through analysis of web-pages, newspaper articles and documents, I hereby present my account of how Solimed Enterprise Health evolved. The story unfolds in four stages – the initial network, the enterprise, the enterprise in a health care market and, finally, embedding the local case in a health system context. Behind the limelight of two innovation prizes, the story will reveal whether it really was Adam Smith’s ‘invisible hand of the market’ that did the work.

FROM LONE WARRIORS TO A SENSE OF WE

Networks are usually portrayed as a rather loose set of linkages between independent actors who develop a shared goal (Knoke & Kuklinski, 1991). In Solingen, the emergence and increasing dynamic of a network among ambulatory physicians represents a first stage of integrating care. We zoom in and listen to the medical director of a hospital who was – at that time – still an external observer.

“Do you know the history of Solimed? It all started with an association, where a hard core of office-based colleagues came together. In order to think about: what could we do as an association to improve communication? Then – and I consider this a great achievement! – they managed to involve half of all office-based physicians in Solingen in the association. Really, that you don’t only fight your way and muddle through as a lone warrior, but think about: what could we improve?”

In 2004, a hard core of 28 of the 220 office-based physicians in Solingen founded an interdisciplinary practice network called *Solimed medical quality network*: *Solimed* being a play on the words *Solingen* and *solidarity*, and *medicine*. Open to all office-based physicians in Solingen, the network grew rapidly and in 2010 it included 145 office-based specialists and general practitioners.

Why did office-based physicians, who were perceived as lone warriors, that is, as heterogeneous individuals valuing their independence and autonomy, suddenly decide to team up? The medical director explains this shift with a perceived need to improve communication. Indeed, the physicians state better communication as their first goal in the association statute. In particular, they aim at:

“improvement of communication among participating practices with the medium-term goal to implement this on an IT-steered basis: development and implementation of standards on the communication around the patient. The association establishes communication guidelines (IT/fax/accompanying letter) whose adherence/compliance is mandatory.”

However, they present many more goals – and thereby driving forces – for the association, including the:

“improvement of medical quality by developing quality standards through internal treatment guidelines; the creation of a basis for further projects e.g. integrated care; external representation of the association, public relations, maybe development of internet presentation; measures for health promotion and prevention.”

Improving internal and external communication, promoting health and medical quality, establishing a basis for further projects such as integrated care – the network statute comprises ambitious goals. More importantly, the goals were turned into action. In 2005, the physicians created a template for a patient-accompanying letter with information on diagnoses, findings, allergies and medication for internal communication. For each referral of a chronically ill patient, a network physician would be required to fill out the template and directly fax it to the physician of referral. Every practice was obliged to ensure availability of a fax for this purpose (Solimed, 2005). In 2006, treatment guidelines for eight common conditions such as cough and dizziness were established.

Gradually, the network physicians widened their scope of engagement. Three notable examples are a Health Academy (*Gesundheitsakademie*), the Medi-Mobil and transition agreements with local hospitals. The Health Academy was founded in cooperation with the local adult education centre. Solimed physicians started to organize monthly information sessions on prevention and treatment methods free to all citizens – a health literacy initiative for the general public that clearly goes beyond traditional curative medicine. Moreover, 20 Solimed physicians engaged in a street medicine initiative. They committed themselves to driving regularly to known places of homeless people with a Medi-Mobil. The idea is to actively bring health care to those not able, or not willing to attend physician practices, and, similar to the Health Academy, it is also a cooperation project (here with the *Wuppertaler Tafel*, an organisation for people in poverty).

Closely observed in local newspapers, the network developed several branches. This story will follow only one of them, namely the process of integrating care. Before turning to the transition agreements with local hospitals, which were important milestones in this process, let us cast a short glance at the idea of integration. Essentially, one can conceive of a continuum ranging from communication – or information exchange – via coordination to integration. Thus, communication forms the backbone of effective coordination and finally of integration (Hill, 2009). At this stage, we look at a network of still rather independent physicians who had recognized a certain need to improve communication, but who were already aiming at more elaborate integrated care as stated in the network statute. This goal did not emerge out of the blue – indeed, health policy reforms in 2004 had created several incentives for concluding integrated care-contracts. We have not yet reached the contractual stage of development, but the process of integrating care had already started.

Integration of care started at an interdisciplinary level, among office-based GPs and specialists, with internal communication standards such as the patient-accompanying letter. Soon, the networking physicians proceeded to the cross-sectoral level by concluding transition agreements with hospitals as

external partners. Through adjusting and standardizing hospitalization and dismissal, these transition agreements were meant to smoothen patients' transitions between hospital and ambulatory sectors. Moreover, the transition agreements apparently served as an important catalyst for further integration of care. This was not primarily because they created some experience for later, more elaborate patient pathways, but rather because the physicians discovered the strength and potential of their consensus-driven network. A physician explains:

“You need to consider, since 2004 we work together as a network, as an association, simple registered association, and we realized that if we agree we have relatively many opportunities. We have moved a lot here. For example that we could, say, make clear to the hospitals how we want patients discharged and how not. In former times we had incidents when we wanted to make arrangements with certain people, they said: ‘Well, you say that, but the next person says differently!’. We created a uniform structure with the association – after all with half of all physicians in Solingen. Then we said: Half of all want it this way. Then we realized that if we agree we can achieve much.”

Previous to the transition agreements, dozens of single office-based physicians had independently struggled as lone warriors to convince hospital physicians how to discharge patients and how not. In turn, hospital physicians had blocked and refused to cooperate in view of the multiple and contradictory voices: *‘Well, you say that, but the next person says differently!’*. The physicians participating in the association – half of all office-based physicians in Solingen – then used their network structure to channel divergent voices, and to coordinate their actions.

Having achieved consensus among themselves, they became aware of the range of opportunities now open to them. In the active effort to grasp some of these opportunities – such as better coordination of patients' cross-sectoral transitions – the physicians realized that their consensus resulted in real changes. They managed to develop a structured mechanism for hospital discharges, and succeeded in concluding agreements with the hospitals. Thus, the network started to mean not only future opportunities, but also factual achievements. Office based physicians started to express a *we*-spirit, consensus acted as a catalyst and once things began to move, they developed intrinsic motivation to go further. The physician adds:

“... And then we thought about what else we could do. We thought let's do a full supply chain model. Then we have put money onto the table. What was even worse than the money was the loads of work.”

The above quotation conveys an essential pull factor for further integration of care: motivation derived from joint successes. Star and Griesemer (1987) introduced the notion of ‘boundary objects’ to identify factors which hold diverse actors together, and, thereby, enable joint working. Was intrinsic motivation the only reason, or ‘boundary object’, why the physicians put money

onto the table and shouldered ‘loads of work’? Before exploring how exactly the physicians approached a full supply chain model, let us turn to another essential ‘boundary object’ – here a push factor – for further joint action and integration of care.

“Previously we had used the patient-accompanying letter, that would have been sufficient in my eyes. But this lives from being used for chronically ill patients, for whom there are important details. And experience says: ‘Now it’s stressful, I don’t have time for this’ and then it doesn’t work. Exchange of these letters was too low. Then we thought about: how could we make that work better? The best solution is obviously that the physician doesn’t have to do anything, that the software automatizes everything.”

To recall, in 2005, the patient-accompanying letter had been introduced to improve information exchange – and hence communication and coordination – among physicians. However, in practice this innovative idea proved to be ineffective. Giving information means taking time, and this appeared to be particularly true for the patient-accompanying letter. Written manually, the letter often caused delays in daily practice. Because of these delays, many physicians were not willing to communicate patient information to their colleagues via paper-based letters, even though better information exchange was desirable. How did the physicians deal with this challenge?

One essential feature of any network is to deal with – or govern – challenges in a way most convenient to the network members. In a hierarchical organization, non-compliance with the rule to use patient-accompanying letters could have resulted in formal sanctions for the deviant. Whether such punishments would have been effective in ensuring careful communication is, obviously, another question. In contrast, a network cannot afford to ‘scare off’ its members. Networks are inherently characterized by trust and reciprocity (Knoke & Kuklinski, 1991). Sanctions and punishments would have probably undermined trust, simply because members were not willing to invest time into writing letters – time that delays treatment of other patients – and, thereby, disrupted the network.

Refraining from any action is also a way to govern challenges (Hill, 2009). Accepting fate, the physicians could have simply abolished their ideas of better information exchange. However, instead of stepping back, they decided to step forwards. They decided to switch from paper-based to software-driven communication so that the individual physicians would be relieved from bureaucracy. The physicians recognized that automatization would be the best solution to genuinely living information exchange. Interestingly, their association statute from 2004 already included the medium-term goal of a common IT-platform. In that view, the idea of electronic integration did not emerge out of the blue.

Let us now return to the story of the full supply chain model, sometimes also called the integrated delivery system. This model is rooted in the managed care tradition, and is intended to improve quality and efficiency of care (SVR, 2009). Indeed, this model has been defined as a vision of integrated care, because

it integrates three dimensions of integration: medical, functional and technological integration (Amelung, 2009). What do these dimensions imply? *Medical* integration refers to coordination of all relevant providers across the entire chain of care, to enable ‘seamless’ provision of health services. Functional integration comprises the integration of non-medical services, such as strategic management, controlling and financing. Finally, electronic integration refers to the integration of information systems in order to facilitate medical and functional integration (ibid.).

Medical, functional and electronic integration obviously do not develop overnight, without any effort. Only a *hard core* of all physicians in Solingen had formed the initial network and, again, only a *hard core* of network physicians were willing to invest further efforts. Between 70 and 80 physicians crystallized out of the existing network. In spring 2007, they started to meet weekly to discuss ways of electronic integration, as a first step. Interestingly, despite general consensus on implementing electronic integration, there was heated debate on *how* to achieve this:

“The group nearly became divided, because there were two approaches. One side wanted a completely joint software, the others wanted a reduced version. They wanted to keep their own software, and only establish small-scale integration on top ... there was much interaction in the group.”

At this point we witness another governance challenge: The networking physicians had seen their strength in their consensus, based on the idea that if we agree we can achieve much. Now they were confronted with critical disagreement. Indeed, other practice networks in Germany had already become shipwrecked on the critical reefs of how to integrate their information systems. How did the physicians in Solingen proceed?

INSTITUTIONALIZING THE NETWORK: INFORMATION TECHNOLOGY AS BOUNDARY OBJECTS

The physicians did not reconcile all interests. After two months of discussion, they decided by majority vote. And the majority voted for completely new, joint software. At this point, we have reached another stage of development, because the decision for a new software package transformed the idealistic network structure into a materialistic one. Now trust came to be materially embedded. The notion of the boundary-object, introduced by Star and Griesemer (1987), points to the power of specific material objects to connect different stakeholders by enabling a certain standardization without erasing the differences: a museum can be considered a boundary object for different kinds of art as they are exhibited in a similar manner while preserving their diversity. Star and Griesemer specifically pointed to the function of information infrastructures as boundary objects, and this is the sort of boundary object that plays an important role in institutionalizing *Solimed Enterprise Health*.

To implement the decision to buy a new software package, the physicians founded the limited liability company Solimed Enterprise Health. This company set the legal frame for a full supply chain model. In contrast to a simple network

or association, a company would be able to contract with sickness funds, and, thereby, mobilize requisite funds for a full supply chain model. But Solimed Enterprise Health would only be able to contract once its internal structures were adequately developed. Internal structures were, first of all, electronic integration with all members. Thus, the physicians made the switch to common software a precondition for joining Enterprise Health. Of the 70 to 80 physicians involved in the debates, 60 physicians agreed to buy new software to become a member of Enterprise Health. Some of them, though, perceived this switch as a bitter pill:

“The bitter pill that all had to swallow with Enterprise Health was the electronic integration. The software in our practice worked well. Actually we had a much better system which we liked much more than the network solution. Thus we had to abandon our quite excellent software in favour of the network software. For us that was a really bitter pill in the beginning, not only in financial terms. The practices had to put 15,000-20,000 Euro onto the table, depending on the number of workplaces. But our own former software had worked great, with text modules tailored to the practice. That was the bitter pill many colleagues didn’t want to take. The financial barrier and, second, I like my own software much better.”

Above, we face a remarkable paradox of innovation. An essential ‘push factor’ for electronic integration was that information exchange via patient-accompanying letters was laborious, time-consuming, and thereby caused delays in daily practice. Electronic integration was expected to save time and facilitate communication. But electronic integration was not a magic bullet. The innovation had negative side-effects, namely costs in both financial and administrative terms.

These negative side-effects deterred many physicians from changing their software. Nevertheless, we observe that 60 physicians decided to become members of *Solimed Enterprise Health*, and to install the new software. This number may seem low, as it equals only half of the *Solimed network* members, and only one quarter of all office-based physicians in Solingen. But the number is surprisingly high in view of the high financial and administrative costs incurred. How can we understand this?

Besides the *we*-spirit derived from joint successes in the network, at a more technical level, the ineffectiveness of the patient-accompanying letter fostered further action. But there are often different layers of context that underlie action (Hinds et al, 1992). Indeed, the idea of founding *Enterprise Health* is also embedded in a wider context, or background, as a physician recounts:

“Joining Solimed happened, for the single practice, against the background to assert yourself in the market. As one single practice, we were concerned whether we would still exist in ten years – or whether there would only be ‘Medizinische Versorgungszentren’. That was our motivation to join Solimed Enterprise Health.”

Medizinische Versorgungszentren (MVZs, medical treatment centres) were introduced in 2004 – the year when *Solimed medical quality network* was founded – and are promoted by the Federal Government as an innovative model to improve quality and efficiency of care (BR, 2009). Physicians from several disciplines work as salaried employees, usually under one roof to create organizational synergies and facilitate coordination. Notably, MVZs can be run by hospitals. Thus, they are an opportunity for hospitals to engage in ambulatory care (Amelung et al, 2008). At local level in Solingen, MVZs were apparently perceived as a threat to the independent practice. The physician-led *Solimed Enterprise Health* was an explicit counter-proposal in this context.

The Solimed physicians pro-actively approached the three hospitals in Solingen. They managed to involve all of them in the *Enterprise Health* as partners; not as potentates: In the shareholders' meeting each hospital counts as one member, and the general rule is 'one member, one vote'. While the two larger hospitals, nevertheless, each hold three votes, their voting power remains limited, in view of the 75 office-based physicians involved. Thus, *Solimed Enterprise Health* has clearly been organized as a physician-led company, related to concerns that hospitals might otherwise monopolise the shareholders' meeting. But why did the hospitals join this physician-led Enterprise? A hospital manager explains the rationale:

“An important issue for us was certainly to strengthen the referrer bindings. Large hospital chains follow a different strategy. They just buy ambulatory practices and thereby generate their own referrers. But here, we want to come to arrangements based on trust. And peu à peu, we did succeed.”

Traditionally, the relationship between hospitals and office-based physicians in Germany has been characterized by a certain dependence of the former on the latter. Ultimately, hospital activity depends on referrals from the ambulatory sector. Recent health policy reforms, notably the introduction of MVZs in 2004, however, shifted the balance to a certain extent. Hospitals, and in particular large hospital chains, can and do buy ambulatory practices and employ their own referrers. The hospitals in Solingen chose differently. A hospital manager emphasizes the value of trust in this context. It seems that Solingen was a special case.

Arguably, office-based physicians in Solingen were more active than in other regions; already in 2004 they had been networking, and *Enterprise Health* was created on their initiative. The hospitals joined the company immediately, but after some basic decisions such as the legal structure and the method of electronic integration had already been taken by the physicians. Hospitals in Solingen were thus not the initial change agents. They sensed how networking in the ambulatory sector gathered momentum, and decided to support this development. Besides the economic rationale for cooperation – namely better bonding with office-based physicians to generate sufficient referrals – the hospitals seem to have been well aware of their mutual dependence on information, the backbone of effective coordination. A hospital medical director, whose position had now changed from an external observer to an internal

partner, depicts this interdependence between ambulatory and hospital sectors as follows:

“In former times, hospital discharges were often Friday afternoon. That worked well when the operation was on Monday. But then the patient stood before closed doors of the office-based colleague, for example to get a prescription. Thus we developed a system of previous announcements to let the physician know: ‘I still need to arrange a nursing service’. And this with rapid communication, not – as it is still widespread – on a hand-written note which not everyone can read. We don’t send the letter by post anymore, but through the software and the letter arrives immediately. The office-based physician knows what to expect. In turn, of course, we also need anamnestic data, when the patient comes to us. We ask for medication and the patient says ‘that small white pill, Doc, you know ...’. We need much information which the patient often cannot give to us; on X-ray images, laboratory findings etc. Thus, we arranged that we can view the findings for every patient immediately.”

While office-based physicians depend on information from the hospitals, such as dates of hospital discharge or continuing care needs of patients, hospitals, in turn, require also a range of details about referred patients. This cross-sectoral interdependence on information had already been acknowledged in 2006, as mentioned previously, when the hospitals and *Solimed medical quality network* had concluded transition agreements to smoothen patients’ transitions between the sectors. However, as the hospital medical director illustrates, the effectiveness of paper-based letters for information exchange is limited by, for example, the time lag between sending and receiving. Electronic integration, by contrast, enables viewing essential patient data immediately. Updated from paper-based to electronic means, communication between ambulatory and hospital sectors is now perceived as more rapid and effective.

However important, electronic integration only constitutes a technical tool. To realize a full supply chain model, *Solimed* members also engaged in what has been called medical integration (cf. Amelung, 2009): They started developing standardized treatment pathways to coordinate patient care across sectors. The treatment guidelines created in 2006 by the *Solimed medical quality network* had been rather basic, covering only ambulatory disciplines. The envisaged treatment pathways, contrastively, are supposed to accurately define across sectors who does what, when, how, and in which timeframe. Agreeing upon such complex pathways requires thorough discussion and negotiation, both between the disciplines and the sectors involved. The *Enterprise Health* members tackle this challenge by creating small working groups. In order to represent all relevant groups, each group comprises at least one general practitioner, one office-based specialist, and one hospital chief physician. Moreover, each group focuses on a specific condition. Based on existing guidelines of the medical societies, treatment pathways were and are developed

for major conditions such as diabetes and stroke.³ But the process of agreeing on common standards can be a struggle, as a physician notes:

“Well, in these working groups there is the dancer, who wants to show off; another one is exceedingly talkative; other people may have a hidden agenda –strange contracts with pharmaceutical companies; there can be many connections. Bringing this down to a purely objective level: ‘what is evidence-based?’ ‘What is quality?’ That is very time-consuming. And if some people are destructive in their communication, or tend to blabber, such a group can also fail.”

The physician alludes to several challenges surrounding standardization. On the one hand, working groups for developing standards face similar struggles as any other group: Groups rarely constitute a unified block; there can be dancers, gossip-mongers, those with a hidden agenda. Converging these different interests and characteristics of group members towards a common goal is a general challenge for groups. On the other hand, standardization is a particularly delicate process. Professionals tend to perceive standards as limits to their professional autonomy, and if they agree on the need for standards, they often disagree on the relevant criteria for these standards (Hill, 2009). *Solimed* members had decided to take scientific evidence as their basic criterion – in contrast to personal preferences, for example – but determining what constitutes evidence, quality and objective facts is not self-evident and, therefore, another challenge. With regard to governance strategies, how were these challenges addressed? This question takes us to the dimension of functional integration of decision-making processes.

Taking the development of treatment pathways as an example, decision-making processes unfold in two main stages. First, *Solimed* members chose to delegate the development of treatment pathways to small working groups. This means that neither a single individual devises the pathways (not only time-consuming, but also with certain dictatorial appeal), nor do the *Solimed* group as a whole design the pathways (very democratic, but most likely rather ineffective in view of the multiplicity of voices involved). The choice of small working groups, with balanced representation of the main stakeholders, reflects thus the choice of a middle way. In order to ensure timely results, the functioning of the working group is embedded in internal rules of procedure. For example, each working group has a deadline to deliver. Having passed the deadline without deliverables, the group can be dissolved, and a new group be created. How can such internal rules of procedure foster effective communication? Rules stand above personal preferences of individuals and, thereby, evoke a hierarchical mode of governance. Governing by rules means that deviants face sanctions. These sanctions are not necessarily financial; social aspects such as saving face in front of peers can create a very effective pressure to meet the deadline.

As soon as a working group has delivered, the second stage of decision-making unfolds. Drafts of the pathways are presented to all shareholders, that is,

³ Some treatment pathways have already been implemented, others are in development.

the currently 75 office-based physicians plus the three local hospitals. While *Solimed Enterprise Health* has an executive management like any other company, the shareholders' meeting is the basic decision-making body. In this respect, *Solimed Enterprise Health* has retained a grassroots-democracy which is also typical of a network. Once presented to the shareholders, the treatment pathways are, therefore, not imposed as a given, but open to discussion. Indeed, sometimes the entire group strongly opposes the draft of the working group:

“I remember the treatment pathways for diabetes. The working group had selected such strict Hb1c values, that are the long-term blood sugar values, and the Solimed group was ... well ... furious and said: ‘We will never reach these limit values, we will cook us a goose if we take such strict limits – they can never be met with Average Joe and Jane!’ You see, the Solimed group does not wave through everything.”

The shareholders' meeting could be seen as a symbol of *Solimed Enterprise Health*: a cross-sectoral group of various office-based physicians and three hospitals, who are separate entities, but bound together by the rules and structures they develop by and for themselves. How they define their rules, where they set their limits, may have a critical impact on whether their actions can be considered a success. The software turnover required a one-time investment, but the monthly shareholders' meetings require ongoing commitment. Pathways need to be developed, discussed, decided on and implemented – and this without any certainty of return on investment. Whether the *Solimed* members are financially rewarded for their internal efforts, depends on their external connections. To study how this works, we turn towards *Enterprise Health* becoming active in the health care market where insurers play an important role.

COOPERATION AND COMPETITION, COSTS AND QUALITY

Over the past decades, corporatism has been the dominant mode of governance in the German health system (cf. also SVR, 2005). Particularly in the ambulatory sector, the *Kassenärztliche Vereinigungen* (KVs; regional associations of statutory health insurance physicians) had a relatively strong position: They were empowered to conclude collective contracts with the sickness funds on behalf of their members; mandatorily all office-based physicians treating patients with statutory health insurance (over 90% of all insured). These collective contracts were then applicable to all statutory health insurance physicians of a certain region. At the *beginning* of the 20th century, collective contracts had been an achievement – an innovation in health care – because the single office-based physician could be protected against the unequally larger contracting capacities of a sickness fund. By the *end* of the 20th century, collective contracts concluded by KVs were increasingly denounced as monopolist arrangements, allegedly inhibiting greater efficiency. Several health policy reforms have tried to incentivize a paradigm shift from corporatist to more market-oriented structures. Notably, since 2000, office-based physicians are allowed to conclude integrated-care contracts directly with sickness funds, and since 2004, these selective contracts have received financial incentives (Amelung et al, 2008).

Integrated care-contracts, as a novel form of selective contracting directly between sickness funds and an interdisciplinary or cross-sectoral set of providers, mushroomed: the number of contracts rose to over 6,000 by the end of 2008 (Grothaus, 2009). For providers, these contracts raised the prospect of additional funds on top of their regular budgets, while sickness funds did not take financial risks, because they had been permitted to withhold 1% of the total payment for all office-based physicians as agreed in the collective contracts with KVs, in order to finance selective integrated care-contracts. But this seed financing ended in 2008. Afterwards, sickness funds had a genuine incentive to scrutinize whether integrated care-contracts did indeed bring value for money; whether all of them really added value to improving coordination and, ultimately, quality and efficiency of care. Solimed Enterprise Health engaged relatively late in negotiations with sickness funds; in 2007, when seed funding was already drawing to a close and a certain disillusionment about the magic pill-character of integrated care-contracts had arisen. How then did the *Solimed* physicians enter into negotiations with sickness funds?

Interviewer: *“Did you actually negotiate with the entire Solimed group with the sickness funds?”* – Physician: *“No, this requires trust first of all! To begin with, we built up the company. Then we developed a management model – I am Chief Executive Officer, but two of my colleagues count as well and we always decide unanimously. Then we sent off a negotiation delegation, who proposed a complete contractual offer to the sickness funds, a 100-page integrated care-contract that we had worked out”.* – Interviewer: *“Did you develop this contract only among the physicians?”* – Physician: *“A manager from Landshut advised us a lot. At least half of the contract was penned by him”.*

We see that the *Solimed* physician and Chief Executive Officer sees trust as a necessary prerequisite for negotiations with sickness funds. He frames this trust as a form of business professionalism: *Solimed* physicians first of all needed to elaborate strong internal structures, including a management model, before they could take external action. Moreover, they did not approach the sickness funds with empty hands, but with a fully developed contract proposal which they had prepared together with a professional manager. This manager had helped to build up a similar health enterprise near Landshut, in the region of Oberpfalz. One could, therefore, deduce that the negotiations of *Solimed* physicians were backed up by two learning processes: the physicians learned from experiences made in another geographical region, and they learned from the fields of management and business. A hospital manager involved in *Solimed Enterprise Health* confirms the need for linkage and learning between medicine and business:

“I learned that physician networks function best if they are led by physicians, so that physicians are motivated to participate. But they still need the competence of business people, in order to be economic. As a hospital we can support this, we have always been negotiating directly with the sickness funds. The physicians are slowly growing into it. And that is why it’s such a great project, everyone contributes know-how in

the best interest of the issue. If you always ask 'what's in for me?', then it doesn't work. For me this is a long-term investment and not 'do we have a return on investment after two years'. Peu à peu, we have to see what is developing with the big players, KV, and the sickness funds AOK and Barmer who represent here about 70-80% of all insureds: selective contracts! I want to stay on the ball with my hospital, of course. And this is much better when I'm already cross-linked in a network. When I can already offer a complete range of services."

The hospital manager develops a remarkable account of how *Solimed Enterprise Health* became active in the health care market. While the hospital manager learned to leave leadership to the physicians, the physicians learn from hospital managers about negotiation tactics with sickness funds. Thus, *Solimed Enterprise Health* became active in the health care market by, first of all, valuing mutual learning. A spirit of cooperation in the best interest of the issue supports this process. Engaging in negotiations with sickness funds simultaneously occurs in recognition of broader trends, notably the apparent trend towards selective contracts. The hospital manager emphasizes that in this context single-mindedness can be short-sighted: Cross-sectoral cooperation may later prove to be an essential asset for negotiations with sickness funds – also for the single hospital – because cross-sectoral cooperation enables them to offer a continuum of services.

So far, the cross-sectoral cooperation between hospitals and office-based physicians in *Solimed Enterprise Health* has led to integrated care-contracts with two large sickness funds: *AOK Rheinland/Hamburg* and *Barmer*. What motivates the managers of a sickness fund to conclude an integrated care-contract? A referee of *AOK Rheinland/Hamburg* explains:

"The main reason for us was that we want to offer guidance for our patients to help them find their way in the complex health system, and to simplify the ways. Then, there is the over-, under- and misuse of health services, that is more the scientific reason. Optimizing health service quality, increasing efficiency – that made us conclude such a cooperation." - Interviewer: *"What is special about the contract with Solimed?"* - Sickness fund referee: *"For the first time we have concluded a contract with an enterprise, not directly with providers. Secondly, there is an electronic patient file which facilitates exchange of data. The third issue is the remuneration, we want to move from fee-for-service-payment to a budget, a capitation scheme."*

The perspective of *AOK Rheinland/Hamburg* embraces, first of all, their prime mandate as a social health insurance body: to support their insured when in need of care, that is, to help them receive timely and appropriate care. This care needs to be of high quality and high efficiency, neither leading to overuse, underuse nor misuse of health services (cf. SVR, 2000/01). In this context, the *AOK Rheinland/Hamburg* views their contract with *Solimed* as an opportunity to fulfil their mandate. *Solimed Enterprise Health* is a company with – as we have seen – binding and specific internal rules of procedure, not a loose set of individual

providers. An electronic patient file and a budget model are two other elements of the contract. Before digging deeper into the budget model, let us take a closer look at the meaning of electronic integration in a health care market.

To recall, all *Solimed* members are connected through their software systems in order to facilitate and speed up information exchange. But the idea of an electronic patient file is a delicate issue in Germany: legal barriers, privacy and patients' rights, fears of misuse of confidential data stored somewhere on a central server, are held high. Sensing these concerns, *Solimed* members decided to leave patient data decentralized with the respective provider. Only if patients agree can their data be exchanged through the common software. For this purpose, *AOK* and *Barmer* insurees in Solingen can enrol cost-free in a *personal health network*. Afterwards, personal data do not circulate freely among *Solimed* members, but the patient defines who may or may not have insight into diagnoses, medication, findings. It is a market arrangement – the two sickness funds pay for the extra time that physicians invest into adjustment of medication, thus, only the *AOK* and *Barmer* insurees in Solingen can reap the benefits of improved communication with regard to medication and coherent treatment pathways.

Another element, only of the contract with the *AOK*, is the shift from fee-for-service to a budget model. The basic idea is capitation: to pay a lump sum per insured, not per service provided. Starting in 2010, *Solimed* will, thus, receive an annual budget to finance the entire range of services across sectors for each *AOK*-insuree enrolled in the personal health network. An *AOK Rheinland/Hamburg* referee explains the rationale for a budget model as follows:

“In the German health system, the different sectors are paid out of different pools. Because of budgeting of the individual sectors, the provider has no interest in doing more than what he is paid. With the budget model you have the opportunity to calculate a lump sum for all services and reward when e.g. office-based physicians can avoid unnecessary hospital admissions.”

In the view of the sickness fund, capitation can provide a market incentive for providers to render their treatment services more efficient. In a way, capitation is the response of insurers to the health system quest for coordination. Capitation means that a set of providers receives a fixed amount, thereby stimulating providers to avoid (unnecessary) costly interventions, and to coordinate among themselves who can provide the relevant service in the most efficient way. Per capita allocations are obviously attractive to insurers, as they facilitate long-term planning and may help insurers receive the best value for their money. For providers, however, capitation can be quite risky. Ultimately, capitation means that the insurance function – insurance for the risk of illness and the associated costs – is shifted from sickness fund to provider. With a given amount of money, the provider has to cover the morbidity risk of a given insured, that is, assume all treatment costs incurred over a year. Why should any provider accept this financial risk? What drives a provider to choose capitation? We listen to an office-based *Solimed* physician:

“I don’t like capitation for its own sake. Capitation is sensible only if you can represent the entire chain of care; outpatient and inpatient. If you do that, you have to agree with all people. And that is our aim. We have excellent medical quality in our practices, I don’t think we can improve much there. But the friction losses are enormous. If I tackle them, I want to have a share in the efficiency gains. The capitation model also has another advantage. We suffer from all this bureaucracy. I am not allowed any more to do gastroscopies, although I’m capable and have all good devices. A colleague trained as cardiologist can do marvellous cardiac ultrasound, but must not, because he is licensed as a general practitioner. And with a capitation model, we agree among ourselves by looking into each other’s eyes: ‘You make the best cardiac ultrasounds, you two can make the best gastroscopies, thus you do it’. That is how we achieve quality ... and not with formalities. That would be our dream. For this I would ... say ... consider the capitation model.”

From the view of the office-based physician, capitation seems to have two promises; but only under a certain condition: providers need to agree across sectors and across disciplines, that is, they need to control to a certain extent the services provided by others. The first promise of capitation is that providers can benefit from the quality and efficiency gains achieved through cross-sectoral care coordination. The physician sees friction losses in terms of communication and coordination deficits between providers as a main area for action. In Solingen, these friction losses are tackled through electronic integration, treatment pathways, and other forms of cross-sectoral agreements.⁴ These agreements are expected to improve both quality and efficiency of care. In principle, sickness funds are the primary beneficiaries of these improvements – due to immediate savings, or due to the improved health of their insured (and thereby lower health care costs in the future) that presumably result from adjusted medication, rapid availability of important patient details and provision of optimal care along standardized pathways. Capitation embodies the promise that the lump sum received is not exhausted due to efficient care provision, and that the efficiency gains can subsequently be shared with the sickness fund. The Solimed members hope to be financially rewarded for their efforts and investments by the end of 2010 or 2011.

Second, capitation promises to be a counter-proposal against hierarchical health system governance. The physician seems to perceive capitation as a means to escape from the bureaucracy and formalities imposed top-down from the health system onto a single practice. Providers agree among themselves who can provide the necessary service in the best way, both in terms of quality and efficiency. This logic exemplifies the double-edged-sword-character of many innovations: while capitation does imply a financial risk for providers, it also implies the opportunity of more freedom and self-governance. But apart from the potential complexities associated with calculating which financial amounts

⁴ Apart from treatment pathways defining which provider does what, when and how for a given disease, there are also positive lists on agreed pharmaceuticals. Hospitals and office-based physicians agree on the most cost-effective pharmaceuticals that are to be provided.

would be necessary to cover all costs for any given insured, enhanced self-governance can also lead to a dilemma of two strong concepts: cooperation and competition.

On the one hand, a capitation model requires cooperation in terms of adherence to common agreement in order to realize quality and efficiency gains. But on the other hand, there is the more or less explicit driver of competition: who provides the best care? This question is not relevant when an entire set of providers equally shares the overall lump sum received for a patient. But if only providers who actually provided care receive a share, a spirit of competition is self-evident. Largely depending on referrals from the ambulatory sector, hospitals may then be the ‘losers’ in this competitive process. Hospital treatment tends to be more costly because of the technology and infrastructure involved, and, as the *AOK* referee noted in his account above, avoidance of expensive hospital admissions is therefore an obvious strategy to generate cost-savings. Thus, why should a hospital be willing to participate in capitation? We listen to a manager of one of the hospitals participating in *Solimed*, and see that the meaning of capitation to a hospital is not necessarily what it seems:

“We started very euphorically with such a capitation model. The more you engage in the topic, the more you realize its complexity. What does it mean for you? Of course, a hospital cannot be a stone quarry for a physician network: due to our volume we have of course quite a big financial budget. For us the question is whether we acquire new patients. Or whether we, I say this very consciously, are unburdened by patients who need our diagnostics for a short time, go home the next day and say ‘well apparently it was rather some little malaise’. Huge costs for us, nothing gained ... we are not adequately remunerated for such cases. But then, there could be a strategy to prevent such costs! Of course, this needs to develop peu à peu. Obviously it’s not the purpose that 20% of our budget wander to Solimed and we cannot cover our operating expenses anymore.”

Operating in a health care market, in a health enterprise such as *Solimed*, the participating sectors face the challenge of balancing the spirits of cooperation and competition. While it seems, at first glance, that a hospital can only lose in a capitation model where savings are generated through reduced hospital admissions, this is not necessarily true. The current payment system of hospitals, based on diagnosis related groups (DRGs), is primarily based on diagnoses instead of actual services provided. However, the diagnosis may emerge only after expensive diagnostics have already been performed – to the detriment of the hospital, if the diagnosis turns out to be a minor malaise. Capitation would motivate office-based physicians to scrutinize more closely the necessity of hospital admissions and, thereby, also disburden a hospital of cases that dissipate those resources which are needed for genuinely sick patients. But what does this mean for patients? In the U.S., where capitation models had been introduced by managed care-organizations, providers were accused of withholding necessary treatment to their patients for financial reasons. As a result, the concept of “managed care” became increasingly discredited as “managed costs”

– even though managed care, as such, cannot be equated with capitation financing. Nevertheless, the members of *Solimed Enterprise Health* seem to be well aware of the dangers of bad publicity. An office-based physician elaborates on this concern, and the precautions that have been taken:

“We are good, we increase quality’ - everyone can say that. But when you do a model where you profit from efficiency gains, this quickly raises suspicion that you save at the expense of patients. Therefore, we have quality indicators to confirm that we are better than normal treatment. If I prove this, nobody can accuse me. And I’m indeed concerned that someone accuses me ‘but you economize your patients to death’! Thus, I have to prove the quality”. – Interviewer: “How do you do this?” – Physician: “We use quality indicators such as hospital re-admission rates twelve months after a heart attack due to another acute coronary syndrome. This shows a) how good the hospitals performed the acute treatment, and b) covers pharmaceutical therapy in the ambulatory sector. The more rapid and coherent the treatment, the lower the rates of renewed infarction in the first year.”

The *Solimed* members chose to prevent bad publicity by an explicit commitment to monitoring and evaluation. Along implementation of each treatment pathway, indication-specific quality indicators are introduced simultaneously. Notably, the indicators need to reflect performance of all the sectors involved: both hospital and ambulatory therapy. These quality indicators also seem to reflect the recognition that pure cost containment can only bring short-term benefits: As the physician illustrates, even after one year, hospital admission rates may be significantly higher if treatment of heart attacks was too slow or incoherent.

So far, we have explored different stakeholders involved in *Solimed* – insurers, hospitals, patients, and office-based physicians. However, one should not forget that not all physicians in Solingen participate in the *Enterprise Health*, be this out of financial, administrative or other reasons. What does this mean for the relationship to the physicians who did not join *Solimed Enterprise Health*? A physician reflects:

“The others eye us suspiciously, because they are concerned that they are having the butter taken off their bread, that ultimately the insurers tell their insurees: ‘guys, if you enrol in Solimed, please take care that you consult only Solimed physicians’. Currently, this is not the case. But the other colleagues are concerned, of course, when such a strong group manifests. Personally, I maintain a good relationship to the colleagues who chose not to collaborate here, but you simply see each other less often. Through this close cooperation in Solimed, you lose contact to the others. Such an enormous wave was kicked off in Solingen, and the others are swimming a bit beside.”

The creation of *Solimed Enterprise Health* created certain boundaries between the physicians in Solingen: speaking of ‘exclusion’ would not be true, as *Solimed Enterprise Health* was and is in principle open to anyone willing to participate

and to invest in the joint software. Rather, there seem to be concerns regarding competition for patients, especially when insurers should, at sometime in the future, recommend their insured to consult *Solimed* physicians as the preferred providers. Moreover, *Solimed medical quality network* still co-exists with *Solimed Enterprise Health*, and the traditional ways of communication, such as the patient-accompanying-letter or use of fax, are still in place. But informal communication and cooperation – that create a sense of coherence among *Enterprise Health* members – become less frequent with other office-based physicians in Solingen. In this respect, the local innovation unites and divides at the same time.

BEYOND THE ‘INVISIBLE HAND OF THE MARKET’

This story has reconstructed the development of *Solimed Enterprise Health*, one of the few cases recognized as successful integration of care. I looked at early initiatives in the form of a medical quality network, explored the institutionalization of this interdisciplinary cooperation and its expansion to the cross-sectoral level, and followed *Solimed Enterprise Health* engaging in the health care market. Which lessons can we draw from this local case given the quest for coordination at health system level?

A first lesson relates to the mix of governing modes for achieving care coordination. My story suggests that the success of *Solimed Enterprise Health* – reflected in the two innovation prizes – may have resulted from commitment to a mixed-mode of health care governance, rather than a single strategy. Along the process of integrating care, we have seen that *Solimed* incorporates trust- and partnership-based features typical of a network, but also hierarchical elements in the form of clear rules, and market-like modes of choice and competition. The notion of ‘hybrids’ is not new to organizational theory (Williamson 1996). How to achieve such a critical mix for integrated care is more intricate (Zelman 1996). This story has unfolded the stages in Solingen: winning the hearts and minds of clinicians was central, and only then did business management and hierarchies follow to facilitate clinical, functional and technological integration of care.

A second lesson concerns the process of integrating care from the grassroots. Using new legislative opportunities, such as integrated care-contracting with sickness funds, the *Solimed* physicians were apparently stimulated by respective health policy reforms. However, they were not simple implementers of health policy goals. The health policy quest for coordination in terms of improved quality and efficiency of care was certainly relevant. Nevertheless, the physicians attached their own local meaning to this abstract quest for coordination. Indeed, they had their own drivers for improving coordination: particular problems encountered at local level, and the momentum and we-spirit created by previous successes. This might seem irrational to a neoclassical economist who reduces human motivation to price signals. It proved to be essential for integrating care in Solingen. Interestingly, another driver was the effort to protect oneself against health policy developments looming large as threats for the single provider: such as the introduction of medical treatment centres/ MVZs, increasing bureaucracy, and the trend towards selective contracting where single providers felt the need to stay on the ball in order to assert themselves in the market.

In addition to these two lessons to be drawn immediately from the local case, let us consider a system-wide perspective. Solimed Enterprise Health is but one new player in an emerging playing field of selective contracting for enhanced coordination; across Germany, several more or less similar players have been emerging in a more or less successful way. Examples similar to Solimed are the physician-led and cross-sectoral health enterprises in the regions of Oberpfalz, Kinzigtal or Bünde (Weatherly et al, 2007). In total, thousands of integrated care-contracts have been concluded since 2004 (Grothaus, 2009). Few are as elaborate as Solimed when considering the dimensions of electronic, medical and functional integration, but still, there is a range of structural options as to how care can best be integrated – with differing impacts on the scope for coordination. Moreover, while the concept of “integrated care” tends to be associated with a particular paragraph of the Social Code Book V (§140), which enables the so-called ‘integrated care-contracts’, there are many other novel forms of integrating and coordinating care (Steffen & Waning, 2008). The rising number of medical treatment centres operating in the ambulatory sector with salaried physicians, often led by large hospital chains, is likewise an attempt to respond to the quest for coordination, as are the contractual opportunities for general practitioner (associations) for strengthening primary-care-centred coordination.

While new players for selective contracts emerge, the traditional player for collective contracts has to sit on the sidelines – the KV is explicitly excluded from integrated care-contracting. What does that mean for a health system, if a traditional strong and large player is weakened and various new and small players arise? There cannot be a single-sentence answer to this question. Enlarging the view, we listen to a KV representative.

“Currently there is a co-existence, if not a contra-existence, of collective contract and all these selective contract models. We as KV don’t know the content of these contracts, but still, we have the responsibility for guaranteeing provision of services. But the resources are finite, and the sickness funds clear the total compensation package for ambulatory services by the claims that are made by the selective contract partners. Thus it becomes more difficult for us to guarantee the provision of services. Also in view of the fact that politicians still approach us, if somewhere in the Eifel [a rural region in Northrhine Westphalia] there is a physician shortage. Politicians do not approach the sickness funds or the physician network XY, they approach us to complain: ‘You must close this service provision gap’.

Interviewer: *“So how can there be better coordination between sectors, if not with selective integrated care contracts?”*

KV representative: *“Well, I don’t have the perfect solution ... It is not about forced merger of the sectors, or heroic battles to tear down the walls between them, it is about finding intelligent solutions how to make sectors permeable. This does not mean that one player has to do everything; this may result in regional treatment monopolies. (...) With*

ageing of society, providers gradually achieve a better position due to scarcity of supply. But sickness funds and politics haven't fully grasped that yet. Promoting competition through selective contracts partly rests on the illusion that, thereby, prices will fall. There will indeed be competition on prices, I believe, but in the opposite direction! Because the health market is gradually developing from a purchaser market to a supplier market. In attractive areas of high population density, like Hamburg or Freiburg, there certainly is an unnecessary oversupply which could be removed by a very competitive relationship between physicians and sickness funds. But sometime the relation would turn upside down, and insurers who would need to pay any price. Imagine, if Solimed finally succeeded to line up all local providers, then no sickness fund could get around Solimed."

Interviewer: *"And no sickness fund could get around the KV?"*

KV representative: *"The question is whether politics could get around the KV. Health policymakers cannot face how sickness funds must buy services at a price they cannot afford. The responsibility to guarantee services – the raison d'être of the KV – is that unequal distribution of services produced by the market through competition is socially not desirable. Already today, all these innovations, they concentrate service supply where we already have a high density of supply, where insurers expect a marketing effect. (...) Competition does not necessarily lead to a balanced distribution of services, but rather sharpens existing disparities between highly populated and rural areas."*

Interviewer: *"How could you change this?"*

KV representative: *"Well, first of all politics needs to clarify the position of the KV. Currently there is this ambiguity 'for the limelight we have these innovative forms of care, but for remaining duties we somehow need the KV'. We need something like clear market regulations. The KV could be a market regulator, or immediately engage in contracting, or assume management and service functions ... There could be many options, also hybrids. But the main issue is a transparent regulative framework with clear competences."*

While there seems to be a paradigmatic shift from corporatist to market governance, the health system quest for coordination has not been resolved. Indeed, as the account of the KV representative illustrates, allegedly innovative market structures may create new dilemmas as they solve old ones. Coordination is a multi-dimensional concept: the Advisory Council on the Assessment of Developments in the Health System, instituted by the Federal Ministry of Health, draws attention to the need for coordination not only between disciplines and between sectors – as we explored via the story of *Solimed Enterprise Health* – but also between generations, and between regions (SVR 2009). Consideration of the health needs of different generations along the life cycle – children, adolescents, working and elderly people and respective transitions – will likely

impact on the success or failure of coordination mechanisms, such as cross-sectoral treatment pathways, to achieve integrated care.

Coordination of care across regions is a particularly challenging task. In a market-driven healthcare system, providers and insurers may have the incentive to cream-skim urban regions with sufficient insurees. However, to ensure universal equal access to health services – highly valued in the German social solidarity system – someone needs to guarantee care provision also for remote, scarcely populated regions that are less attractive to investors. Recent research highlights puzzling regional differences in the quality of care in Germany; part of which may be related to unequal capacity for coordination between ambulatory, hospital and continuing care (Bertelsmann Stiftung/IGES 2011). *Solimed* was named not only after its geographic origin, the city of *Solingen*, but also to emphasize the value of *solidarity* between disciplines and sectors. The local case revealed critical struggles and successes of this process. Now health policy will have to take on the challenge to ensure solidarity in access to care across regions.

Although ‘the market’ is often too easily accepted as the most efficient, and therefore the most appropriate, governing mode in health care, the account of the KV representative highlights that pure market-governance can lead to undesired distortions, for example between regions. Certainly, a purely corporatist model or network-based governance may not be perfect either. Nevertheless, a regulatory framework establishing clear rights and roles of the traditional, and of the emerging health care players, seems necessary.

The local case of *Solimed Enterprise Health* illustrates that it was not (only) Adam Smith’s ‘invisible hand of the market’ which enabled integration of care. It was rather the visible work of real people who were – and still are – struggling, but succeeding, in mixing various modes of governance to integrate care. At health system level the quest for coordination will most likely not be answered through a single mode of governance, either. The story of *Solimed* rather confirms the proposition that “it is the mix that matters” (Rhodes, 1997: p.34). With a new Health Care Structure Act (*Versorgungsstrukturgesetz*) under scrutiny in Parliament (Deutscher Bundestag, 2011), debate has been re-ignited on the appropriate policy measures to coordinate health care services and supply based on population need. Finding the right mix of governance modes for coordinating care across disciplines, sectors, and regions will remain a major challenge for the coming years.

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