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par

M. Matthias Brunn

Idées globalisées, défis nationaux : l'introduction du Disease Management et du paiement à la performance en France et en Allemagne

Global ideas, national challenges: the introduction of disease management and pay-for-performance in France and Germany

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List of abbreviations

Abbreviation	French/German term	English term
BÄK	Bundesärztekammer	Federal Physicians' Chamber
BVA	Bundesversicherungsamt	Federal Insurance Office
CAPI	Contrat d'amélioration des pratiques individuelles	Individual contract for professional practice quality improvement
CC	Koordinierungsausschuss	Coordinating Committee
CCM		Chronic Care Model
CNOM	Conseil National de l'Ordre des Médecin	National Council of the Physicians' Association
BQS	Bundesgeschäftsstelle für Qualitätssicherung	Federal Office for Quality Assurance
DAM	Délégué de l'assurance maladie	SHI medical representative
DM	-	Disease Management
DKG	Deutsche Krankenhaus-Gesellschaft	German Hospital Federation
DSES	Direction de la stratégie, des études et des statistiques	Directorate for strategy, expertise and statistics (at SHI)
DSS	Direction de la sécurité sociale	Directorate of Social Security (at MoH)
EBM	-	Evidence Based Medicine
GBA	Gemeinsamer Bundesausschuss	Federal Joint Committee
GKV-SV	GKV-Spitzenverband	Federal Association of Sickness Funds
HAS	Haute Autorité de santé	National Health Authority
IGAS	Inspection générale des affaires sociales	Inspector of Health and Social Affairs
IT		Information Technology
IOM	-	Institute of Medicine
IQTIG	Institut für Qualitätssicherung und Transparenz im Gesundheitswesen	Institute for Quality and Transparency in Health Care
KBV	Kassenärztliche Bundesvereinigung	Federal Association of SHI Physicians
KHSG	Krankenhausstrukturgesetz	Hospital reform act (2015)
MoH	-	Ministry of Health
NHS	-	National Health Service
NPM	-	New Public Management
P4P	-	Pay-for-performance
QOF	-	Quality and Outcomes Framework
SC	Selektivverträge	Selective contracts
SHI	-	Statutory Health Insurance
SQG	Sektorenübergreifende Qualitätssicherung	Quality assurance measures across sectors
SVR	Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (früher: für die Konzertierte Aktion im Gesundheitswesen)	Advisory Council for the Assessment of Developments in the Health Care System (previously Advisory Council for "Concerted Action in Health Care")
VHI	-	Voluntary Health Insurance

The terminology was, whenever possible, adapted from the Health System Reviews series of the European Observatory on Health Systems and Policies (Busse and Blümel, 2014; Chevreul et al., 2010).

Global ideas, national challenges: the introduction of disease management and pay-for-performance in France and Germany

1. Introduction

> *"The essential blocks of expenditure - hospital, pharmaceuticals and ambulatory care - have been increasing between 20 and 70 percent over the past ten years. Since the influence on cost of the individual claims cases is limited, health insurers recognise the necessity and opportunity to turn from an administrator into an active manager of care and morbidity of their insured. Morbidity is becoming the currency of the German health insurance system."*[1] *[Accenture 2007, p. 3]*

This quote from an advertisement brochure of a large international consulting firm provides a vivid example of discourse and institutional changes in health reform over the past 20 years. As a solution to the suggested challenges, the consulting firm proposes that insurers buy "coaching programmes", with proven clinical effects and acceptance by patients and providers, well established in the American context and accompanied by an expected return on investment of at least 160%.

This is set within a wider transformation of the health insurance landscape in France and Germany. Although both systems remain Bismarckian at their core (primarily financed by social contributions, managed by health insurance funds, delivering public and private health care, with greater freedom than in national health systems), they have undergone divergent reform paths since the 1990s. France has seen a strengthening of the State, which has re-strained the scope for collective negotiations between providers and insurers. At the same time, in Germany, competition between insurance funds has been increased, expanding the role of collective negotiations.

[1] Accenture Gesundheitscoaching. *Krankenversicherungen betreten Neuland — vom Kostenträger zum aktiven Manager der medizinischen Versorgung*. Accenture, 2007.

In fact, the French health insurance system has focussed on the goal of changing "from administrator/payer to active manager of care", while German insurers have put much effort into introducing morbidity as a determining variable in allocating budgets between insurance funds. Both systems now use tools that, on a technical and operational level, put these policy goals into practice. This was in part facilitated by support from international organisations or firms. In the case of France, it was done with help by a commercial partner of Accenture. In the case of Germany, the system incorporated ideas from a variety of foreign sources. In both cases, study trips or other forms of exchange with Anglo-Saxon countries played an important role in the process.

Do all health system actors now favour morbidity as "a currency" in designing reforms? Who are the main players? What arguments are used to counter resistance? What underlying developments and meanings have led to this situation? To the extent that innovations such as coaching programmes have seen widespread implementation, do all systems use them for the same reasons? Are they generally purchased from foreign firms? What are the expected benefits to the systems and the interests of policymakers and other stakeholders?

These questions are indeed the starting point for this study, and the following introduction aims to provide a context that will allow for thorough analysis.

In a first section of this introduction, we will outline the key transformations that welfare states and health systems currently undergo, by appraising the scholarly approaches for studying them.

The second section will introduce two concrete examples of programmes that are being used as part of larger system reforms. It will also discuss several ways to explore the use of knowledge from abroad, and propose France and Germany as proper settings for comparative analysis.

Finally, the third section will operationalise our research questions and introduce data sources and means of analysis.

1.1 The transformation of governance in welfare states and health systems

Welfare states and health systems have undergone several transformations in recent years. According to Lester Salamon's "The tools of government: A guide to the New Governance" (2002), classic forms of government ("command and control") are increasingly losing their legitimacy, while market interactions (particularly privatisation) and public/private collaborations (contracts, voluntary initiatives) have multiplied. This search for alternative models to the traditional bureaucratic one has also favoured the development of procedural rather than substantive instruments, evoking the picture of a state which should concentrate on "steering" as opposed to "driving". These hybrid regulatory methods do not necessarily mean a distancing of the state; however, they raise important questions concerning the transparency, accountability and legitimacy of decision-making processes (Lascoumes and Simard, 2011; Salamon, 2002).

In the case of health systems, Richard Saltman[2] maintains that the transition was explained by a duality that, on the one hand, resulted from a desire to experiment with deregulatory and market-derived instruments. On the other hand, Saltman saw an increasing awareness of the critical role of the State in structuring and establishing the institutional infrastructure for key human services such as health following the collapse of the Soviet Union. This situation "*served as the intellectual backdrop to the search for new hybrid organisational models that could combine the benefits of market incentives with the stability and social responsibility of State control*". Saltman saw significant implications for the actual behaviour of regulators in European health systems. In fact, governmental control over public providers has given way to more complicated institutional incentives. Consequently, instead of controlling, the state has focused on regulatory oversight and supervision. Most importantly, "*this new role has required the state to shift from a focus on inputs to an evaluation of outputs and outcomes"* (Saltman, 2002).

[2] In 2002, Professor of Health Policy and Management at the Rollins School of Public Health, Emory University, USA, and Research Director of the European Observatory on Health Care Systems, Brussels, which he co-founded in 1998.

Marc Danzon, World Health Organisation (WHO) Regional Director for Europe from 2000 to 2010, explains the mindset of key policymakers in his foreword to the book "Regulating entrepreneurial behaviour in European health care systems"[3]:

> "*[T]he art of regulating well […] is to develop regulatory strategies and frameworks that pursue a middle path, by allowing the carefully controlled introduction of innovative approaches without surrendering major responsibility for achieving good overall outcomes for patients. It is in this balance, in understanding regulation as a means rather than an end, that the way forward must lie. By developing these new regulatory approaches, and by working with countries as they adapt these methods to their own unique health sector circumstances, international organisations can ensure that policy combines the necessary dynamism that entrepreneurialism brings with the essential stability that good public health policy requires. Ultimately, regulation should be understood as a major instrument in the pursuit of effective stewardship." [Danzon in* (Saltman et al., 2002)*, p. XIII]*

This account addresses three important points that seemingly were of relevance to the authors and their commissioners. First, there is the idea that entrepreneurialism is a "necessity" that can be introduced via "innovative approaches". Second, international organisations such as WHO can play a facilitating role in the adoption of such approaches. Third, the responsibility of regulators is implicitly underscored by linking it to the term "stewardship"[4]. The term was widely used in the 2002 World Health Report by WHO (World Health Organisation, 2000), stating that "*governments cannot stand still in the face of rising demands. They face complex dilemmas in deciding in which direction to move: they cannot do everything. But in terms of effective stewardship, their key role is one of oversight and trusteeship – to follow the advice of 'row less and steer more'*" [(World Health Organisation, 2000), p. 119]. Subtitled "Health Systems: Improving Performance", the report actually proposed itself as part of the solution by providing the first international "ranking" of health systems, based on indicators in five dimensions: overall level of health; distribution of health in the population; overall level of responsiveness; distribution of responsiveness; distribution of financial contribution. Underlying this benchmarking exercise (which sparked controversy across Europe) was the

[3] Edited by the European Observatory on Health Systems and Policies which is hosted by the WHO Regional Office for Europe; see also http://www.euro.who.int/en/about-us/partners/observatory

[4] See also the in-depth conceptualisation by (Saltman and Ferroussier-Davis, 2000).

idea that policy-makers need to know why health systems perform in certain ways and what they can do to improve the situation. Comparing the way health system functions are carried out is seen as a basis for understanding performance variations over time and among countries (World Health Organisation, 2000).

1.1.1 Analytical approaches: past and present

To understand how political science as a part of the social sciences addresses such issues one may consider the functionalist view of political systems and processes as a starting point for reflection and a frequent reference or comparator for analysis. Functionalism is a theory based on the premise that all aspects of a society (institutions, roles, norms, etc.) serve a purpose and that all are indispensable for the long-term survival of society. In this theory, a social system is assumed to have a functional unity in which all parts of the system work together with some degree of internal consistency. Present-day scholars challenge the notions that policy making is an act of deliberate problem solving and that decisions and actors are set within a context of rationality. Instead, those involved in politics and policies are increasingly seen as acting with "bounded rationality" that puts constraints on decision making (Simon, 1985). Contemporary social sciences have studied the interaction of "problems" (framed as such) and "solutions" within a system in different ways. We will explore the contributions of Paul Pierson and Peter Hall to the neo-institutionalist tradition, before assessing how contemporary French political sociology frames the research challenges.

Pierson's approach is grounded in social processes that he conceptually derives from economists, called "increasing returns", equivalent to self-reinforcing or positive feedback processes. He conceptualises path dependence in the sense that the "*probability of further steps along the same path increases with each move down that path*". This is highly relevant in contexts where there is high complexity or opacity, since individuals in such settings particularly rely on "mental maps" to process new information. For Pierson, the very need to employ mental maps induces increasing return: information that fits the mental map is incorporated, and information that does not is filtered out. Accounting for path dependence provides *"an important caution against a too easy conclusion of the inevitability, 'naturalness', or functionality of observed outcomes. […]. More significant, increasing returns arguments justify efforts to stretch the temporal horizons of political analysis.*" This argument is relevant because earlier events of a sequence matter significantly more than later ones, and an event

that happens "too late" in the process might have no effect. This supports the contention that historical events and trigger points must be included in political science analysis, rather than focussing on the association of current variables and outcomes:

> "*We should turn to history because important aspects of social reality can best be comprehended as temporal processes. It is not the past per se but the unfolding of processes over time that is theoretically central.*" [(Pierson, 2000a), p. 264]

Pierson embeds path dependence within a broader theory for the analysis of institutions. In his claim for new approaches, he criticises the dominant tradition of explaining institutional forms by their functional consequences and limiting the focus on formal political institutions. Indeed, Pierson challenges the assumptions that institutional design is *intentional*, and questions whether actors act *instrumentally* and in a *far-sighted* manner. Instead, "*actors may be motivated more by conceptions of what is appropriate than by conceptions of what would be effective*", which poses the problem that "*such arrangements may actually be dysfunctional for the particular local context*". Therefore, Pierson suggests using input from disciplines such as sociology in order to better understand the limitations of functionalist approaches so as to evaluate the impact of contextual factors on institutional outcomes (Pierson, 2000b).

An important foundation for this political neo-institutionalism was also developed by Peter Hall. He proposed the framework of the "three I" to account for the interactions between actor's *interests* and their *ideas* in the *institutional setting* in which they take place. His contribution to theory emphasises that, via ideas, there is a link between cognitive processes in society and policy making. Hall defines the implications of ideas and discourse as follows:

> *"Politicians, officials, the spokesmen for social interests, and policy experts all operate within the terms of political discourse that are current in the nation at a given time, and the terms of political discourse generally have a specific configuration that lends representative legitimacy to some social interests more than others, delineates the accepted boundaries of state action, associates contemporary political developments with particular interpretations of national history, and defines the context in which many issues will be understood." [*(Hall, 1993)*, p. 289]*

Finally, the work of Hall conceptualises changes in public policy with the model of "three orders", depending on the degree that prevailing paradigms of policy instruments, instrument settings and goals are altered or not. A first order change occurs when instrument settings are

changed while overall goals and instruments remain the same. Conversely, an alteration of policy instruments and their setting in light of past experience represents a process of second order change. Third order change is considered rare and requires changes in all three components: the policy instruments themselves, instrument settings and the hierarchy of policy goals (Hall, 1993).

The particularity and strength of the "three orders" model is the use of policy instruments as markers of change. Indeed, this framework has been extended in the analysis of social sciences by Bruno Palier, who underscored that all potential combinations are possible: changing instruments without changing goals; changing the degree of instrument utilisation; change of objectives necessitating a change of instrument(s); changes in instruments modifying objectives and results (Palier, 2005).

1.1.2 A focus on public policy instruments

A recent stream of research, rooted mainly in the tradition of French and European sociology, has started to look deeper into the implications of instruments in the analysis of public policy. They refer to the seminal work of Christopher Hood, who in his book "The Tools of Government" takes an explicit perspective in looking at government activities as the application of a set of tools or instruments. He has also proposed a typology of instruments (Hood, 1983) (see Appendix). Pierre Lascoumes and Patrick Le Galès have proposed the following definitions of instruments:

> *"A public policy instrument is a technical and social device ("dispositif") that organises specific social relationships between public power and its addressees depending on the representations and meanings it conveys.*
>
> *The "instrumentation of public policy" refers to all problems posed by the choice and usage of instruments (techniques, means of operating, devices) that allow materialising and operationalising governmental action. It is about understanding not only the reasons that push to retain one instrument over the other, but also to consider the effects produced by these choices."* (Lascoumes and Le Galès, 2005)

One way to think about the use of public policy instruments is to consider them as a means of reaching public policy goals (Lascoumes and Simard, 2011). Indeed, there is now a large body of literature exploring numerous variables to explain instrument choice and their mode of

application in public policy, which is often presented in a functionalist manner. These approaches, in the normative and functionalist tradition of "policy analysis" and "public choice", see instruments as adopted according to limited rationality; instead of aiming to optimise, decision-makers look either for a minimal degree of coherence, or they seek to signpost a change (Landry and Varone, 2005).

This has important methodological implications, as highlighted by Lascoumes and Simard. In fact, the instrument becomes a dependent variable, whereas before it was considered an independent variable. Therefore, instrument choice is viewed as the result of a process and of reasoning within the larger design of an already institutionalised public policy. Moreover, this type of research has turned the instrument into a discrete entity for observation, thus "*opening up a new field of research on the historicity of instruments, the ways in which they have been used, and how they have been transposed to other contexts*" (Lascoumes and Simard, 2011).

Another approach, represented by Lascoumes and Le Galès, treats instruments as "sociological institutions"[5]. It is centred upon the dynamics of permanent construction and appropriation by actors in less formal, symbolic, and cognitive dimensions.[6] In this body of literature, three dimensions seem of particular importance for the domain we study.

First, as Lascoumes and Simard note, one theoretical foundation of the analysis of instruments is to draw on the literature on government technologies, highlighting that "*their technical nature is inextricably linked to the effects of social constraint they produce and the ways in which they legitimise state positions*". This means that, for a certain research tradition represented by Michel Foucault[7] and others, instruments are closely related to the imposition of power (Lascoumes and Simard, 2011).

Second, instruments can be a means to aggregate heterogeneous actors around certain questions. In this process, initial conceptions are modified, and the "actor-network" exhibits a

[5] Based on a typology in Christopher Hood, "Intellectual obsolescence and intellectual makeovers: reflections on the tools of government after two decades", Governance, 20(1), 2007, 127-44.

[6] North has defined them as follows: "*Institutions are the rules of the game in society or, more formally, are the humanly devised constraints that shape human interaction. In consequence they structure incentives in human exchange, whether political, social, or economic*." North, DC: *Institutions, Institutional Change and Economic Performance.* Cambridge, Cambridge University Press, 1990.

[7] See for instance : Foucault, M, « *La "gouvernementalité"* » [1978], Dits et Écrits, tome 3, Paris, Gallimard, 1994a, p. 635-657.

certain degree of inertia through the instrument (Callon, 1986; Lascoumes and Simard, 2011). These "instrumental" coalitions are indeed far easier to reach than agreements on objectives, which is a way to avoid problematic issues and thereby a means of de-politisation (Lascoumes and Le Galès, 2005; Weaver, 1986). This is distinct from the notion of coalition in the Advocacy Coalition Framework by Sabatier and Jenkins-Smith emphasising the "*particular belief system*" shared by people from a variety of positions who show a "*non-trivial degree of coordinated activity over time*" (Sabatier, 1988).

Third, Lascoumes and Simard hold that an instrument produces a direct cognitive effect via the cognitive representation of the issue. Even further, it implies *"specific problematizing of the issue in question in so far as it arranges variables in a hierarchy and may go so far as to propose an explanatory system*", with the search for statistical regularities leading to causal systems of interpretation (Lascoumes and Simard, 2011). It is indeed the faculty to shed light on the specific effects of the instrument on the actors that makes this analytical approach particularly interesting for the health sector, which can be characterised by highly technical and at the same time emotionally loaded issues.

The most critical point made by Lascoumes and Le Galès is that instruments are indicative of an "implicit theorisation" of the relationship between the governing and the governed, since each instrument is a condensed form of knowledge on social power and on how to exert it (Lascoumes and Le Galès, 2005). Finally, an important notion regarding the technicity of instruments is seen in Kent Weaver's work. His key assumption and analytical angle is that politicians are motivated primarily by the desire to avoid blame for unpopular actions rather than by seeking to claim credit for popular ones (Weaver, 1986). As one possible consequence, Weaver found that governments increasingly use quantitative policy signals as "automatic triggers" for adjustments of policies. Such triggers, as part of instruments, may for example be certain pension cuts in response to deficit levels. For Weaver, policymakers want the programme adjustments to take place, but want them to occur with "clean hands" (Weaver, 1989). This principle is a constituent element of New Public Management (NPM), a shift towards "accountingisation" observed in the 1980s in many OECD countries. According to Hood, NPM encompasses the following doctrines for change:

- from policy making to management skills,
- from a stress on process to a stress on output,

- from orderly hierarchies to a more intentionally competitive basis for providing public services,
- from fared to variable pay,
- from a uniform and inclusive public service to a variant structure with more emphasis on contract provision (Hood, 1995).

1.1.3 Application to the health sector

These approaches constitute the analytical landscape in which the analysis of public policy is currently set. In their seminal book "Political Sociology of Health", Henri Bergeron and Patrick Castel (2015) have conceptualised these questions and developments for the health sector. Like many other analysts, they contend that European health systems are characterised by a growing role of market and competition logic between individual and collective actors. This is marked by four broad policy directions, including more patient choice in National Health Services (NHS, notably in Britain); increasing competition for coverage (for sickness funds in Germany or voluntary health insurance in France); competition between providers for funding and patients; the growing evaluation of health care performance and the transformation of providers into "care entrepreneurs". At the same time, Bergeron and Castel see similarities in the "solutions" associated with these health system transformations. They categorise them into three interdependent groups:

- Governance: solutions (or measures) in this group redistribute responsibilities and reorganise relations between actors in charge of care, support, financing and patients. Examples include the restructuring of hospital planning in the context of the 2009 hospital reform in France[8] or the creation of "trusts" in the NHS, where primary care physicians act as purchasers of services from hospitals.
- Control of health expenditure: following a first wave of increases in the revenue base, since the 1970s most health systems have adopted measures to control their budgets. Ceilings were introduced, and payments designed to be "prospective" instead of

[8] The 2009 Hospital, Patient, Health and Territory Act (HPST) strengthened the role of the hospital director, named by the director of a dedicated state agency, the CNG. In addition, the law addressed the geographical repartition of and access to physicians, including the organization of a continuity of care system (*permanence des soins*) in each region. Provisions for cooperation between health professionals were improved, including a reinforced role for paramedical professions. Finally, a main pillar of the reform was the creation of Regional Health Agencies (ARS), to allow implementing the HPST measures at a regional level. Under the roof of each ARS, formerly distinct regional agencies of the state and SHI were regrouped.

"passive" reimbursements. The most prominent measure in this respect is the quasi-global introduction of case-based hospital payment systems based on Diagnosis Related Groups (DRGs). Further developments in this group include decreases in coverage by statutory health insurance (SHI) and a growing focus on generic prescription.

- Quality control and improvement: the measures in this group are structured around the dimensions of patient safety; comparisons of performance including potential incentives; and standards for clinical practice. The starting point for "quality actors" is to acknowledge that there are several solutions for a given health problem, and that practice should be changed in order to apply the most appropriate solution. In this context, many countries have set up agencies that are tasked with the evaluation and standardisation of clinical practice (Bergeron and Castel, 2015).

In the next section, we propose a closer examination of two health policy instruments currently in use that, in the above categorisation of groups, would fit the criteria for both "health expenditure control" and "quality control and improvement". The previous use of these instruments in other systems raises the question to what degree processes such as transfer and translation have played a role in their introduction. Thus, we will first outline these concepts and related theoretical notions (policy transfer, diffusion, convergence, programmatic actors, translation and hybridisation) before justifying our country choice and addressing our research questions.

1.2 Disease management and pay-for-performance as "solutions from abroad"

Health systems in Europe and elsewhere are facing economic pressure, with policy makers generally advocating more effective and efficient care against the financial backdrop of generally increasing health expenditures and a parallel increase in public debt in most European countries in recent decades. Table 1 provides an overview of these figures for France and Germany.

Table 1: Current expenditure on health (% of GDP) and total central government debt (% of GDP) in France and Germany, 1980-2015

Year		1980	1985	1990	1995	2000	2005	2010	2015
Health expenditure	France	6.7	7.6	8.0	9.8	9.5	10.2	10.7	11.0
	Germany	8.1	8.5	8.0	9.5	9.8	10.2	11.0	11.1
Government debt	France	-	-	-	41.6	47.4	53.3	67.4	-
	Germany	13.0	18.3	19.7	21.1	38.4	40.8	44.4	-

Source: OECD statistics http://stats.oecd.org/

In addition to these material aspects, health policy actors voice a growing demand for more patient-centeredness and improved quality, especially in the field of chronic diseases where, in addition to a substantial and rising burden of disease, studies suggest that care is often not delivered based on state-of-the-art evidence (Schoen et al., 2011, 2009). In response, countries have undertaken similar micro-level reforms concerned with changing the behaviour of providers and patients (Groenewegen, 1997). These reforms include the introduction of disease management programmes (DMPs), which appear to improve quality only moderately without reducing expenditures (de Bruin et al., 2011; Mattke et al., 2007). Examples include the French DMP for diabetic patients and the German DMPs offered for a range of chronic conditions including diabetes (Bourgueil and Or, 2010; Busse, 2004). In addition, pay-for-performance (P4P) has been proposed as a further innovation for improved chronic care by creating financial incentives for doctors to provide more appropriate care (Brunn and Chevreul, 2013; Busse et al., 2010). The history and concepts behind both approaches are briefly outlined below.

Disease management (DM) emerged from the broader rubric of managed care that developed in the USA in the 1970s in an effort to contain increasing health expenditures. It uses organisational techniques in order to reduce health care utilisation by increasing quality of care through promotion of provider adherence to good clinical practice to name one example (Bodenheimer, 1999). In practice, managed care refers generally to an organisation that delivers and finances care, often under the form of a partnership of providers and insurers (e.g., a health maintenance organisation – HMO[9]). These organisations often deliver DM under the form of DMPs that were commercially developed in the USA since the 1990s. There are different definitions of DM and DMPs such as "distinct programmes aiming to reduce costs and improve outcomes for patients with specific conditions" (Rothman and Wagner, 2003) or a "systematic approach that identifies persons at risk, intervenes, measures results and delivers continuously an improvement of the quality of care" (Epstein and Sherwood, 1996). Further, there is a range of terms often used interchangeably with DM such as care management, case management and multidisciplinary care, although these are conceptually different. DM, by definition, traditionally targets patient groups with specific conditions, such as diabetes, while case management, for example, is aimed more broadly at people with complex needs arising from multiple chronic conditions, coupled with the increasing needs of old age. Boundaries are not clear-cut, with more recent definitions of DM explicitly adopting a broader view towards a population-based approach that addresses multiple needs (The DISMEVAL Project Consortium, 2011). In practice, DMPs include several of the following components: (I) patient education aiming at increased self-management, (II) structured care that coordinates different practice specialities, (III) decision algorithms based on clinical guidelines and (IV) an information system allowing patient follow-up (Epstein and Sherwood, 1996; Nolte and McKee, 2008).

The term P4P encompasses additional payment schemes aimed at aligning payments more precisely with payers' goals for quality improvement (Charlesworth et al., 2012). In practice, this means that healthcare providers receive either additional or reduced payment, based on

[9] See Bergeron and Castel for a detailed account of HMOs. In short, they were introduced under the Nixon administration in 1973 and expanded in the 1990 under the Clinton administration with support from employers. Health system users pay a flat contribution to be covered by an HMO and have access to a predefined set of services. At the same time, the HMO contracts with providers are based on capitation or salary payments, thereby shifting financial risk. Providers must respect quality rules and request pre-authorization for costly procedures (Bergeron and Castel, 2015).

their performance. P4P emerged as a complementary payment method in two settings. In the US, a significant number of health care delivery organisations introduced P4P schemes starting in 2003, following pilot projects dating back to 1985 (Baker and Delbanco, 2007). In 2004, the British NHS introduced the Quality and Outcomes Framework for paying general practitioners (GPs). The evidence on P4P in Europe suggests a positive impact on quality, while a review of controlled studies in the USA found only limited evidence in this direction (Christianson et al., 2007; Scott et al., 2011).

1.2.1 Using policies from elsewhere – theories from political and social science

Due to increasingly available comparative information and communication channels, the circulation of policies is an increasingly frequent phenomenon (Dolowitz and Marsh, 2000; Frinault and Le Bart, 2009; Kimberly et al., 2008) and has led to the elaboration of several theories conceptualising it: policy transfer, diffusion and convergence, as well as the role of "programmatic actors", translation and hybridisation.

1.2.1.1 Policy transfer

From a political science perspective, one could consider the introduction of DMPs and P4P in Europe as a policy transfer from the USA, based on the most widely used definition of policy transfer analysis as occurring when:

> *"knowledge about how policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting"* (Dolowitz and Marsh, 2000).

Historically rooted in the notion of institutional mimetism between states (e.g., in the construction and development of constitutions), policy transfer studies generally refer to a "model system" (the exporter), a "client system" (the importer) and the characteristics of the actors and processes linking them (Russeil, 2010).

The policy transfer literature most frequently refers to conceptual categories defined by David Dolowitz and David Marsh (Delpeuch, 2008), including: the object of the transfer, which may comprise any kind of 'public policy solution', such as policy goals or instruments, programmes or management techniques; the motivation for policy transfer, which may be voluntary (in which case it is referred to as rational lesson drawing), coercive or a mixture of both; the

actors, who may be elected officials, civil servants, institutions or non-state/national actors or networks, some of whom are "transfer agents" particularly engaged in the promotion of solutions the favour; the degrees of transfer, representing the gap between the model and its imitation, which can vary from replication without substantial modification to inspiration; the geographical and institutional origin of the model (including local, national and international dimensions); and elements for success or failure such as the complexity of the policy, the trajectory of past policies, feasibility, cultural proximity and language.

1.2.1.2 Diffusion

According to Dobbin *et al.* (2007), there are four different streams among diffusion theories, but all theorists agree that policy choices of one country are shaped by the choices of others. First, constructivists see the diffusion of policies generally as a matter of ideology. According to them, experts and international organisations promote theories with policy implications, and their rhetorical power carries new policies around the world. Moreover, countries that see themselves as members of groupings based on history, culture, etc. may copy one another's policies because they suppose that what works for a peer will work for them. Second, coercion theorists maintain that few powerful players exercise uneven influence over others by using incentives, by serving as focal points or through hegemonic ideas. Third, competition theorists describe a mechanism whereby a policy that gives one country a competitive edge leads others to follow, even if those countries would have preferred not to adopt the policy. Fourth, learning theorists, like constructivists, link changes in policy to changes in ideas, with the difference that rational learning theory implies a kind of cost-benefit analysis. The roots of this theory are psychological, and the main question is how policy makers draw lessons from the experiences of other countries in their search for effective policies (Dobbin et al., 2007).

However, there have been criticisms about the notion of diffusion. Most importantly, it is seen as too mechanistic in its reasoning and as focusing too much on interpersonal relations (Dumoulin and Saurugger, 2010). According to Hassenteufel and de Maillard (2013), this leads to a neglect of the transformation a model may undergo during diffusion and the resistance to change or conformism. The authors hold that true comparative analysis is blurred by the *a priori* assumption of convergence and the conceptual priority given to cognitive mechanisms

and incentives in order to explain why similar policies are adopted (Hassenteufel and de Maillard, 2013).

1.2.1.3 Convergence

The notion of convergence is closely tied to those of transfer and diffusion. Although convergence can be viewed as the result of transfer and/or diffusion, it is most commonly and more broadly considered as the dynamic process of two countries becoming alike in terms of their public policies. Countries can converge on different dimensions including policy goals, content, instruments, outcomes or consequences and, finally, policy style, which is a relatively diffuse notion signifying the process by which policy responses are formulated (Bennett, 1991). The overlap with transfer and diffusion becomes clear when considering the different mechanisms of convergence as proposed by Katharina Holzinger and Christoph Knill (2005). These include imposition (based on a power asymmetry between exporter and importer), international harmonisation (application of supra-national norms), regulatory competition (based on competitive pressure), transnational communication (regrouping phenomena such as lesson drawing and emulation that are purely based on communication) and independent problem solving (implying independent similar responses to parallel problems) (Holzinger and Knill, 2005). While the concept of convergence addresses many elements of high importance to the analysis of policy change in different countries, it appears not to be specifically geared towards policy innovation. Indeed, although innovation *can* be part of the convergence process, it is not *per se* anchored in the overall theoretical framework. This is illustrated by the notion of independent problem solving or the fact that convergence can, in theory, take place by regression.

1.2.1.4 The role of "programmatic actors" in extending the approaches of transfer, diffusion and convergence

While the approaches addressed so far have the merit of clearly addressing cognitive and formal processes at different levels, they only implicitly acknowledge the importance of the implicated actors. In the tradition of the sociology of elites, these actors have been described as "brokers" between the international and national domain in the sense that they build upon international operations in order to reinforce their national influence and *vice versa*. These actors can be considered both exporters and importers of knowledge (Dezalay, 2004; Hassenteufel and de Maillard, 2013). The eminent role of such "programmatic actors" in the

wider arena of health care reform in Europe has been underscored by Hassenteufel et al. (2010) in their analysis of the introduction of quasi-market mechanisms in France, Germany, the UK and Spain. The authors conclude that small, closely integrated groups of policy professionals, motivated by a desire to wield authority through the promotion of programmatic ideas, rather than by material or careerist interests, act both as importers and translators of ideas and as architects of policy (Hassenteufel et al., 2010). The extended notion of "professional programmatic actors" is complemented by the work of Diane Stone (2004) who points out the importance of international organisations, NGOs and other non-state actors and networks in the spread of policies and ideas (Stone, 2004).

1.2.1.5 Translation and hybridisation, two essential mechanisms across theories

The term translation appears more or less implicitly in the concepts presented above but should to be clarified in greater detail to fully understand the levels at play when a policy is transformed during its circulation. Much like the literal preoccupations of language translators, translation implies that the original content rarely matches the connotations and cultural context of the receiving entity. Instead, it requires a re-creation of the original, which in the context of public policies can reformulate orientations, action principles and instruments (Hassenteufel and de Maillard, 2013). This is accompanied by the confrontation and negotiation of the translator with other actors, which is a political process. The other actors, driven by national strategic objectives, go through the process of appropriation and re-interpretations of the external model (Hassenteufel and de Maillard, 2013). Finally, adding to these dimensions, translation also depends on institutional arrangements and the organisational capacity to implement change (Campbell, 2004). The implications of translation are well summarised by Lendvai and Stubbs (2007), who note that "*a series of interesting, and sometimes even surprising, disturbances can occur in the spaces between the creation, the transmission and the interpretation or reception of policy meanings*" (Lendvai and Stubbs, 2007). Finally, the notion of hybridisation as a combination of external and internal elements is a way to characterise the outcomes of translation in the context of public policy analysis. It can result either from cognitive re-creation of a model or as a product of negotiations and interactions with other actors (Hassenteufel and de Maillard, 2013).

1.2.1.6 Conclusion on the analytic approaches presented

While the notions of diffusion and convergence may tend to interpret policy change as the result of a passive process, and learning does not necessarily lead to action, the notion of transfer approaches decision-making dynamics by focusing on the logic of choice and the interpretation of circumstances (Stone, 2004). Indeed, Hassenteufel and de Maillard (2013) note three main advantages of the policy transfer approach in analysing the transnational circulation of public policies. First, it more comprehensively conceptualises the content of transfer in terms of the reasoning, institutions and instruments involved. Second, it explicitly acknowledges the implication of different actors who appear to be crucial in the selection of models prior to the actual transfer (Ancelovici and Jenson, 2012). Third, the policy transfer approach pays close attention not only to process but also to expected and unexpected outcomes (Delpeuch, 2008). This is why the theoretical framework provided by policy transfer currently appears to be of particular interest in elucidating the international circulation of micro-level health reforms such as DM and P4P. However, the term transfer will be used in a cautious manner: it refers to a concept and a hypothesis and in this study is not to be understood in a positivist way.

1.2.2 Policy transfer in the health sector: many examples, less analysis

There have been numerous presumed policy transfers in the health sector (Kimberly et al., 2008; Strandberg-Larsen et al., 2008), of which two influential examples stand out. The first is the 1985 "Enthoven report", commissioned by the UK Nuffield Provincial Hospitals Trust and undertaken by the US economist Alain Enthoven, professor of healthcare management at Stanford University and consultant to the Kaiser Permanente Medical Care Program[10]. He recommended the introduction of managed competition via an "internal market", highlighting his experience with HMOs. His "Reflections on the management of the National Health Service" (Enthoven, 1985) were well received by the Thatcher administration, leading to the 1990 NHS and Community Care Act. It separated purchase from provision, making purchasers out of the bodies formerly responsible for the operation of local facilities, thereby turning their hospitals into autonomous Trusts. Richard Freeman stated that "*Britain presents the clearest example of single-idea reform of the health sector, though it is important to recognise*

[10] Kaiser Permanente is a consortium of for-profit and not-for-profit entities, currently the largest managed care organization in the USA. It was a frontrunner for the introduction of HMOs.

that what was being transferred, if anything, was an American idea, not American practice" (Freeman, 1999).[11]

The second key example is the global spread of DRGs. Developed in the late 1960s at Yale University by Robert Fetter, professor of administrative sciences, DRGs were first intended as a management tool that grouped hospital patients into distinct categories. They were then piloted as a means to pay hospitals and compare their outputs, which laid the groundwork for presumably fairer competition. Under the market-oriented presidency of Ronald Reagan, DRGs were introduced nationwide in the US in 1983, at a time of heightened budgetary pressure. In the 1990s and 2000s, variations of the system were adopted in most European countries, including France and Germany, where they were fully implemented (except for psychiatry departments) in 2008 and 2004, respectively. In virtually all countries, the impact of DRGs is considered mixed, with expected effects such as shorter hospital stays coinciding with unintended consequences such as the so-called "bloody discharge": the release of patients before full recovery (Kimberly et al., 2008).[12]

Despite these prominent examples, there is little literature providing in-depth analyses of transfer processes as such. They include a comparison of the introduction of market elements on the macro-level (Freeman, 1999), the uptake of the WHO concept of social determinants of health by local actors in France and Denmark (Clavier, 2013) and the impact of Dutch health reform on the regulation of sickness funds in Germany (Leiber et al., 2010). The paucity of analyses in this domain is all the more surprising given the number of examples revealing that such transfers do not always yield the desired outcomes. For example, the expert patient programme, introduced in the NHS in 2002 and modelled on the *Stanford arthritis self-management program* (USA), received negative evaluations and decreasing patient enrolment despite the great success it enjoyed in its original setting (Griffiths et al., 2007). An even worse outcome was seen in a telephone coaching intervention in Birmingham that had been

[11] The impact of these reforms is complex and controversial and is beyond the scope of this thesis. As starting point, see, e.g., Mays N, Mulligan JA, Goodwin N. *The British quasi-market in health care: a balance sheet of the evidence*. J Health Serv Res Policy 2000;5:49–58.

[12] For a recent overview of the implementation and challenges in European countries, see Busse R, Geissler A,, Quentin W, Wiley M (eds.) 2011. *Diagnosis-Related Groups in Europe: Moving towards transparency, efficiency and quality in hospitals.* Maidenhead, Open University Press and WHO Regional Office for Europe.

commercially developed in the USA, which had to be stopped because it led to increased hospital admissions (Steventon et al., 2013).

In sum, there appears to be a mismatch between the growing occurrence of health policy transfers and the lack of insights into their mechanisms and implications. For instance, the extent to which DM and P4P were adjusted during transfer is unknown. However, this information would appear to be very important based on the literature on innovation in healthcare systems underscoring the importance of matching an innovation to its environment (Denis et al., 2002; Ilinca et al., 2012). In the context of complex organisational innovations such as DM and payment innovations such as P4P the need for in-depth analysis is critical given the fundamental differences in prevailing payment schemes in the ex- and importing countries, such as capitation payments in the NHS versus fee-for-service payments under social health insurance systems as in France and Germany.

1.2.3 France and Germany: a sound basis for comparative analysis through a mix of commonalities and differences

The analytical perspective of policy transfer is rarely taken in the study of health reform and may contribute to the understanding of barriers and success factors in the introduction of innovations such as DM and P4P.

Limiting the main body of analysis to two countries is known to allow a more in-depth analysis of the complex institutional settings at play (Marmor and Wendt, 2012), which is linked to and complemented by the notion of the *most similar systems design* (Anckar, 2008; Bandelow and Hassenteufel, 2006). Likewise, Marmor has pointed out that, in case similar starting points lead to different outcomes, this approach allows examination of whether key factors were configured differently during the policy process (Marmor, 2012). We therefore chose to analyse the introduction of DM for diabetic patients – currently the most studied DM intervention in the literature (de Bruin et al., 2011; The DISMEVAL Project Consortium, 2011) – in France and Germany, where there seem to be clear distinctions in the way DM is operated[13]. As a further example of transfer in both countries, we included the case of P4P in ambulatory care which has the particularity that its (full) introduction in Germany is still under discussion while it is already in place in France.

[13] See the case descriptions for more details on the basic features of the respective DMPs

Moreover, the choice of France and Germany seems particularly worthwhile because both health systems have major commonalities due to their common Bismarckian origins as well as some distinct differences. The commonalities include the financing of health risk via social contributions (employees and employers), the managing role of SHI where payers are represented on an equal basis, an ambulatory care sector dominated by self-employed, office-based physicians, a hospital care sector dominated by public hospitals with salaried physicians, and a relatively comparable level of health expenditure as a share of GDP. Germany's differences when compared to France include greater diversity and decentralisation of sickness funds with higher autonomy, generalised third-party payment, an income threshold above which SHI contribution is voluntary (consequently, about 10% of the population have substitutive private insurance), the absence of extra billing[14] for SHI patients, the greater role of collective negotiation between sickness funds and doctors and hospitals and a federal system with delegation of competences to the *Länder*[15], especially for hospitals.

The current comparative literature on health systems in France and Germany allows identification of further elements that support and provide nuance to the theoretical concepts and overall health system description outlined above. These particular elements can be grouped into three broad categories, including the main actors and interests, the role of the medical profession in relation to state-driven health reform and the regulation and governance of the social health insurance systems.

1.2.3.1 Main actors and interests

In terms of main actors and their interests, the current literature underscores a difference in the health systems that is explained in part by the overall political system, which is pluralistic and centralised in France and federal and corporatist in Germany. Yet, in both countries, the literature suggests an increasing role of non-traditional actors in breaking physicians' veto power within the health system. In France, these are specialised civil servants with a high degree of influence situated within key bodies of the health system: the Ministry of Health (MoH), the Inspector of Health and Social Affairs (IGAS), and the largest sickness fund (CNAMTS)[16], which highlights the direct influence of the administration over SHI. It constitutes

[14] Charges above the official SHI tariffs
[15] Germany is a federal republic consisting of sixteen federal states, the *Länder* (singular: *Land*)
[16] The *Caisse nationale d'assurance maladie des travailleurs salariés* is the largest sickness fund of the French SHI and is known as the general scheme.

a strong and homogenous group, bound by the norms of the founding principles of SHI and fiscal pressures which result in a generally closed decision making process. Another group of actors is comprised of journalists, who facilitate debates that are carried in the mass media that can radicalise political positions. Both groups have a rather weak influence in Germany, where the historical role of doctors, worker's unions and employers in discussions about cost-containment initiatives has been complemented by an increasing role of expert committees that have bridged partisan gaps since 2003. However, polarised partisan discussions have arisen over recent financing reforms based on the Swiss model vs. an enlarged SHI revenue base. Like in France, there is an increasing role of SHI in leading efficiency measures (Bandelow and Hassenteufel, 2006).

1.2.3.2 The role of the medical profession

In terms of the role of the medical profession, the main differences between France and Germany have been described within its collective organisation and relation to the reform dimensions of cost containment, reorganisation of the care system and access to care (Hassenteufel and Davesne, 2013). In France, the dominant conception in terms of collective organisation is that of the self-employed, independent physician (based on the intellectual character of the profession and the free choice by patients). In Germany, the dominant collective identity of the *Kassenarzt* (self-employed physician with strong regulatory ties to sickness funds) prevails. Further, while in France the professional representation is fragmented between and within specialties and seniority levels with professional societies and associations (*ordres*) having relatively little power, in Germany chambers (*Kammern;* that also have responsibility over training), physician's associations (*Kassenärztliche Vereinigungen*, KV) and federations of medical specialties have a strong role, leading to a regulated but complex competition for decision power and resources. The institutionalisation within the French health system appears to be relatively limited with low participation in elections that is not counterbalanced by other bodies that would allow a "unified voice". In contrast, Germany's representation of doctors is institutionally and legally integrated in the welfare state with a relatively high participation in elections and thus internal legitimacy. Differences are also seen in doctors' roles in cost containment measures. In France, such agreements between the state, SHI and physicians are generally difficult due to high fragmentation and often extreme positions within unions; however, since 2004, increased cost-sharing for patients and "medically-based cost containment measures" have been rather well accepted since they did

not impose constraints on doctors. On the other hand, in Germany, cost containment measures do constrain doctors and include budget caps within the physicians' associations (federations) that were met with relatively high cooperation and almost no strikes, although resistance has increased since around 2000 (Hassenteufel and Davesne, 2013).

Reorganisation of the care systems in both countries has affected physicians in similar ways as a result of the increased role of GPs and their representatives and the focus on cooperation between health professionals. In France, the reorganisation overall was limited and based on pilot projects and voluntary measures, so as not to interfere with patients' free choice or the established fee-for-service payment system. Major initiatives included the introduction of a soft-gatekeeping system in 2004 and the inception of an electronic patient file, which has had a very low uptake due in large part to physicians' reluctance to use information technology (IT).

Provider networks have been established bottom-up since the 1980s and were, until the introduction of Sophia, the main means to deliver specific care for patients with chronic conditions. Their legal status was clarified and reinforced from 1996 onwards, in part based on the top-down idea to include elements from HMOs (Armbruster, 2004). However, provider networks failed to play a greater role due structural obstacles, e.g. the divisions between care sectors, a lack of formal organisation and the fee-for-service payment system. In 2006 there were approximately 450 networks in France of which 69 targeted diabetic patients, reaching less than 5% of the eligible population (Durand-Zaleski and Obrecht, 2008).

The degree of reorganisation has been greater in Germany albeit with local variation. It includes the introduction in 2003 of multi-professional care centres, accompanied by financial incentives that were opposed by doctors' representatives since they can be directed by non-physicians. Since 2000, selective contracts between physicians and sickness funds are possible, bypassing the KV and thus ending their monopoly. Since 2002, DMPs and integrated care for specific types of care, such as ambulatory surgery, have been introduced, alongside small-scale provider networks and the promotion of ambulatory care in hospitals. Finally, although physicians in both countries invoke the phenomenon of "medical deserts" as a means to obtain political leverage, access to care has been a major issue only in France, with public discussions over the effects of increasing co-payments and extra-billing. Taken together, fragmentation of the medical profession has been observed in both countries, but has not

necessarily led to reduced power. This is particularly true in France, where physician unions were able to keep their veto power and their ability to mobilise the public and "blame" politicians (Hassenteufel and Davesne, 2013).

1.2.3.3 Regulation and governance of the social health insurance systems

In analysing the relation between the state and SHI systems in France and Germany, Hassenteufel (2011) found that one of the main characteristics is governance in terms of the power structure of sickness funds. He notes that is preferable to use the term government, providing an emphasis on the notion of verticality that implies that *de facto* state-related institutions are gaining power in both countries. Indeed, there is a strong implication of the state in sickness funds that is readily apparent in France, with SHI contribution rates fixed by MoH, the director of CNAMTS nominated by the government, the budget controlled by ministries and collective conventions being approved by MoH, which also has a strong role in hospitals. A more in-depth examination of the differences reveals that differences between the countries increased during the 1990s, with increased competition between sickness funds and a greater importance of collective negotiations seen in Germany. Overall, liberal reforms were operated by the funds (and not the State) against a backdrop of political consensus, and collective negotiations were partly extended from the ambulatory care to hospital and drug sector. In the same period, the role of the French State was emphasised and marked by the Juppé reforms that introduced the annual social security financing law passed by parliament following government proposal. This means that collective negotiations operate within a tight scope and raises the possibility of intervention by MoH if no agreement is reached. State control was further increased through the introduction of regional hospital agencies (integrated into regional health agencies since 2009) (Hassenteufel, 2011; Hassenteufel and Palier, 2005).

Since the 2000s, the two countries have seen similar developments of what has been described as a regulatory change via a "government from afar" (Epstein, 2005) or "more steering, less rowing" (Saltman, 2002). In Germany, the stronger role of state has become apparent in particular through the health fund introduced in 2009 (operated by the Federal Insurance Office, BVA) and a unique contribution rate now set annually by the government as well as increasing fiscal state contributions to the fund, similar to the shift towards a greater share of general revenue funding of health care in France. Enhanced state control is also evident in

both countries by the creation or expansion of administrative bodies. In Germany, a neutral and professional chairperson has been introduced in the Joint Committee of funds, physicians and hospitals (GBA, set up in 2003), thereby facilitating state control. In France, in 2004 the Health Insurance Reform Act created the "Alert Committee", whose role is to inform the parliament, SHI and the government if health expenditure exceeds the anticipated spending level approved by parliament. The Directorate of Social Security (*Direction de la sécurité sociale;* DSS) of MoH is then required to take measures to reduce expenditure[17] (Chevreul et al., 2010). Further, agencies were created or enlarged, notably the National Authority for Health (*Haute Autorité de Santé, HAS*) in 2004 (and regional health agencies in 2009), similar to the IQWIG[18] in Germany. Overall, there was an increase of measures such as audit and benchmarking, in particular with the scope of agencies and within the mindset of NPM, lowering political risk since agencies can be blamed in case of failure. Harnessing of the interaction of non-state actors by the state became a *leitmotif* of public health policy in both countries.

These increasing similarities on the institutional meso-level of SHI regulation seem to operate via the transfer of public policy instruments by international institutions and transnational experts. According to Hassenteufel (2011), this process is driven by programmatic actors using these instruments to increase their power, which is tied to the State and in opposition to that of "established" SHI actors. In France, these programmatic actors are mostly constituted by an elite of senior civil servants in social security with a common mindset and similar training in the central administration, who have recently used budget constraints as a resource to increase power. In Germany, three types of actors comprising an SHI expert group have been described, the first being political (in particular, ministers), the second senior civil servants (which are not, however, of the long-term career type predominant in France), and third members of parliament, in particular party leaders and health spokespersons. Overall, in both countries these programmatic actors are specialised and politicised, and distinguished/complemented by content experts, other decision makers and operational

[17] E.g. increasing co-payments on drugs or visits by self-employed doctors or postponing planned increases in professionals' fees.

[18] The Institute for Quality and Efficiency in Health Care (*Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen*, IGWIG) assists the Federal Joint Committee in its decision-making. The Institute is financed by the stakeholders in the system of joint self-government. Its primary task is evaluating the efficacy of drugs as a basis for determining whether or not a drug falls under the reference price scheme It also writes scientific reports and statements on questions regarding the quality and efficiency of SHI benefits (Busse and Blümel, 2014).

implementers (interest groups, social partners and physicians). The effectiveness of these arrangements for the implementation of health reforms has been suggested to be only moderate in France, since the political responsibility rests with the executive power and is sensitive to opposition, while in Germany the negotiated nature of reforms seems to facilitate their adoption and effectiveness (Hassenteufel, 2011).

A final point in this comparison is made in Freeman's 1999 analysis on the potential transfer of managed competition, which highlights the complexity of the challenges facing transfer. For Freeman, there is more evidence in France than in Germany of enhanced management capacity for public hospitals, reflecting greater central government institutional responsibility for them. He links this to the lack of interest in competition within the French health system and claims that in ambulatory care "*competition was probably the problem rather than the solution*" while attributing cost problems to oversupply on the part of local practitioners that operate in an unrestricted environment. Linking the issues of regulation and transfer, Freeman asserts:

> *"French public policy is etatist, led by a technocratic civil service. Its sensitivity to national identity means that it would risk isolationism as soon as champion changes perceived to be British or American (or worse, both) in origin."* (Freeman, 1999)

1.3 Research questions and data

In a context in which there is no certainty as to whether what works in one system may work in another, the preceding sections have set out that the introduction of health policies "from abroad" seems to be an increasing phenomenon of recent health reforms in Europe, including in the historically similar SHI systems of France and Germany.

While there are similarities in both systems in terms of the role of the state and that of the medical profession and the apparently similar choices that have been made regarding the introduction of the micro-level policies DMP and P4P, the nature, extent and timing of these policies differ to a certain extent, which we hypothesise to be related to differences in the configuration of institutions and key actors.

From an analytical perspective, the angle of *public policy instruments* seems to be particularly appropriate to highlight the cognitive processes at play and the potential re-structuring of social relationships. The concept of *policy transfer* is used as a pragmatic hypothesis (amongst others) to account for potential influence from other countries or systems. Finally, the approach of *programmatic actors* creates a link between *policy instruments* and *policy transfer*, with the assumption that such actors are "importers and translators of ideas" and "architects of policy" (Hassenteufel et al., 2010).

Based on these elements and the theoretical frameworks introduced, this study is guided by the following research questions:

- Who are the main groups of actors responsible for and concerned with the introduction of DM and P4P in France and Germany? What are the interactions of the groups, and in what way (deliberate or not) are these interactions altered by the instruments?
- In what way do the instruments relate to long-term transformations or conflicts within the health system?
- What are the cognitive, historical and institutional factors that structure the implementation and/or translation of the instruments?

For consistency with the policy instruments approach, groups of actors will be termed "coalitions" in the sense of Lascoumes and Le Galès (Lascoumes and Le Galès, 2005). In this definition, heterogeneous actors are grouped around certain questions. Unlike coalitions in the sense of Sabatier and Jenkins-Smith, actors in these groups do not necessarily share a belief system, nor do they need to exhibit a significant degree of coordination among each other (Sabatier, 1988).

The final part of this introduction will describe in more detail the selection of cases as well as data sources and analytical methods.

1.3.1 Case study design

The design for this study is a comparative case study design (Rowley, 2002) with four cases: the introduction of DMPs for diabetic patients in France in 2008 and in Germany in 2002; and the introduction of P4P in ambulatory care in France in 2009 and its potential introduction in Germany.

The choice of France and Germany was based, in addition to the more general rationales addressed above, on the presence of a small but growing body of literature comparing health system and policy elements in both countries, either in a two-case study design or in designs with three or four countries. The data and conclusions from this body of literature inform the theoretical framework of this study and allow us to contrast our findings and conclusions with the greatest possible number of relevant health system characteristics.

1.3.2 Scope and selected cases

A brief overview of the selected cases is provided at the beginning of the respective main parts (DM and P4P).

For purposes of this study, we centred our analysis on the processes leading up to the implementation of the initial operational versions of the respective DMPs. Our focus on this "first version" may be distinguished from a second phase in which the DMPs have been rolled out on a wider scale. In the case of P4P, we chose to focus on the first operational P4P pilot in France (CAPI) that occurred while there was still an ongoing discussion about the full introduction of P4P in Germany.

1.3.3 Data sources

Data were obtained using a literature review and semi-structured interviews. Data sources for the literature review comprised the scientific and grey literature, including administrative documents, websites of stakeholders, party manifestos, press releases and primary and secondary scholarly works. Google searches were performed using key words based on DM, P4P and the derived national terminology for programmes and concepts.

Interviewees were selected using purposive and snowball sampling: based on an initial literature review, key actors of the process were identified who in turn could provide the names of further actors during their interviews (Mosley, 2013). Important resources in both countries were expert reports publicly available for all case studies, listing the lead experts who were consulted in the expertise process. These documents are presented in Table 2.

Table 2: Key expert reports used for the identification of interviewees

Year	Case study	Title	Author(s)	Institution	Reference
2001	DM in Germany	Disease Management in Germany. Conditions, context, factors for development, implementation and evaluation	Karl Lauterbach	University of Cologne, Institute for health economics and epidemiology	(Lauterbach, 2001)
2006	DM in France	Improve chronic disease care: lessons from foreign experiences with disease management	Pierre-Louis Bras, Gilles Duhamel, Etienne Gras	Inspector of Health and Social Affairs (IGAS)	(Bras et al., 2006)
2008	P4P in France	Paying doctors based on their performance: lessons from foreign experiences	Pierre-Louis Bras, Gilles Duhamel	Inspector of Health and Social Affairs (IGAS)	(Bras and Duhamel, 2008)
2012	P4P in Germany	Pay-for-performance in the health care system: report on evidence and realisation as well as presentation of foundations for future development	Christof Veit, Dagmar Hertle, Sven Bungard, Andrea Trümner, Verena Ganske, Bettina Meyer-Hofmann	Federal Office for Quality Assurance (BQS)	(Veit et al., 2012)

Potential interviewees were invited by email, with information explaining the background of the study. Upon agreeing to participate, participants were given further information on the key topic areas to be covered in the interview. Interviews were undertaken face-to-face

(n=18), as phone-interviews (n=3) or by audio-video communication (n=1). We collected data through in-depth interviews with actors involved in the decision making and implementation processes (members of the administration, insurers, provider and patient representatives, academics and experts). Between August 2013 and July 2015, 14 actors in France and 9 in Germany were interviewed. All but two interviews were held with a single interviewee (see Table 3).

To ensure consistency in data collection across the interviewees and countries we developed an interview guide that was informed by the theoretical framework, focussing on the main actors, facilitators and resistance, as well as the sources of inspiration. The guide was incrementally refined during data collection so as to improve clarity and emphasis. In preparation for each interview, publicly available biographic data was obtained for triangulation. The interviews were semi-structured so that questions could be modified during the interview to follow-up new ideas. Examples of the interview guide per prototypical actor profile (decision maker, provider representative, researcher/expert, patient organisation) are provided in the original languages in the Appendix. Participants were informed about the background and objectives of the study and invited to ask questions at any point before, during or after the interview. They were assured of the anonymity of their participation, unless they explicitly stated that the data fully represented the view of the interviewee's organisation and that their identity could be disclosed. In case full anonymity was not possible (e.g. for the head of a specific organisation), this was clarified in advance. On request, participants received a final draft of the respective case study so they could determine whether their statements were reproduced in the correct context. All interviews were held in the native language of the interviewee, recorded[19] and transcribed verbatim and analysed in the interviewee's language in order to preserve linguistic nuances. Emerging topics were then translated into English for further analysis (see below).

[19] With one exception, where it was requested that only written notes were taken

Table 3: Interviewees in France (14) and Germany (9)

Code and country	Position (at time of interview), additional information stated in the thesis text	Interview mode	Length (min)	Date
FR1	Deputy head of unit, CNAMTS	Face-to-face	39	07.08.2013
FR2	Auditor, IGAS	Face-to-face	58	19.05.2014
FR3	Cabinet of department director, CNAMTS	Face-to-face	49	23.05.2014
FR4	Deputy programme manager, CNAMTS	Face-to-face	42	28.05.2014
FR5	Chief auditor, IGAS	Face-to-face	61	30.05.2014
FR6	President, national union of liberal professions (UNAPL)	Face-to-face	51	30.06.2014
FR7*	Director, MoH statistics department (DREES)	Face-to-face	75	10.06.2014
FR8*	Head of unit, MoH statistics department (DREES)	Face-to-face	75	10.06.2014
FR9*	Member, MoH statistics department (DREES)	Face-to-face	75	10.06.2014
FR10	Head of patient organisation	Face-to-face	50	10.07.2014
FR11	Head of professional organisation	Face-to-face	33	21.07.2014
FR12	Cabinet of general director, CNAMTS	Face-to-face	71	26.08.2014
FR13	Cabinet head of deputy general director, CNAMTS	Telephone	55	12.06.2015
FR14	Professor for health management, EHESP	Face-to-face	55	18.06.2015
DE1	Professor for health management, TU Berlin	Face-to-face	57	19.11.2014
DE2	Professor for health economics, Univ. Cologne	Telephone	49	25.03.2015
DE3	Head of federation of sickness funds	Telephone	57	14.04.2015
DE4	Neutral member of GBA	Face-to-face	61	21.04.2015
DE5	Head of hospital department, GKV-SV	Face-to-face	54	30.04.2015
DE6	Former head of KBV	Face-to-face	61	12.05.2015
DE7°	Deputy head of unit, MoH	Face-to-face	50	30.06.2015
DE8°	Head of unit, MoH	Audio-Video	50	30.06.2015
DE9	Director, IQTIG	Face-to-face	27	07.07.2015

*Interviews marked with * or ° were held at the same time.*

1.3.4 Data analysis

Qualitative content analysis was performed based on the framework method, a flexible tool that can be adapted for use with many qualitative approaches that aim to generate themes (Gale et al., 2013; Ritchie and Lewis, 2003). It is distinct from a number of other approaches to qualitative data analysis, for example those that pay close attention to language and its use in social interaction such as discourse analysis (Fairclough, 2010), approaches concerned with experience, meaning and language such as phenomenology (Merleau-Ponty, 1962) and narrative methods (Reissmann, 2008), and approaches seeking to develop theory derived from data through procedures and interconnected stages such as Grounded Theory (Charmaz, 2006). Many of these approaches are linked to specific disciplines and related philosophical ideas, which inherently impact the analytic process. This appears to be overcome by the pragmatic approach of the Framework Method, which is not aligned with a particular philosophical or theoretical approach (Gale et al., 2013). We deemed it to be the most appropriate for the present study that draws on a variety of disciplines.

The main stages of the Framework Method as suggested by Gale and colleagues (2013) and as applied in this study are detailed in the Appendix. In short, the key feature of the Framework Method is to apply categories (or codes) to literature sources and interview transcripts, which constitute a working analytical framework. For each source or interviewee, the content of the analytical framework is then transferred into a matrix (in practical terms, a spreadsheet) which serves as a basis for further interpretation.

Overall, the analyses and comparisons took place on the policy level (for DM and P4P each, comparison between countries) and the country level (for each country, comparison between policies). In order to guide our comparison at the policy level, we used three broad categories to understand the nature of transfers. According to Dolowitz and Marsh, they are related to the questions *Who*, *Why* and *What.* Dolowitz and Marsh further suggest four different degrees of transfer: copying, which involves direct and complete transfer; emulation, which involves transfer of the ideas behind the policy or programme; combinations, which involve mixtures of several different policies; and inspiration, where policy in another jurisdiction may inspire a policy change, but where the final outcome does not actually draw upon the original (Dolowitz and Marsh, 2000).

To provide a framework for the description of all elements constituting and relating to DM, we applied categories used by the DISMEVAL project to map organisational approaches to chronic disease management in Europe (The DISMEVAL Project Consortium, 2011). These categories include key strategies and approaches used per key strategy informed by the Chronic Care Model (CCM) (Wagner, 1998), as well as their practical applications (see Table 4). Further, we described which structural elements where transferred and/or adapted in addition to the key strategies, using the following categories proposed by the DISMEVAL project: providers involved, degree of patient involvement, financing and setting (The DISMEVAL Project Consortium, 2011); to which we added: patient eligibility and selection, enrolment and risk stratification (see Table 5).

Table 4: Key strategies of the Chronic Care Model and approaches per key strategies as used in the DISMEVAL project (The DISMEVAL Project Consortium, 2011)

Key strategy	Approach
Self-management support	Patient education Active involvement in developing care/treatment plan and goal setting Regular assessment and documentation of self-management needs and activities Provision of self-management tools Routine assessment of problems and accomplishments Other
Delivery system design	Clearly defined roles of staff Regular staff meetings Use/development of integrated care-pathways Individualised care plan Medicines management for co-morbidities Case finding Follow-up (in person; telephone; email) Case management Other
Decision support	Evidence-based guidelines Provider education Access to specialist expertise and experience Other
Clinical information systems	Reminder systems on patient notes and monitoring systems Disease registries Monitor performance of practice team Provider feedback Electronic booking systems Shared information system Other

Table 5: Structural elements used to describe DMPs (The DISMEVAL Project Consortium, 2011) plus additional elements*

Elements	Items considered
Providers involved	GPs, specialists, nurses, allied health professionals, pharmacists, hospitals, other
Degree of patient involvement	Participation in care plan, needs assessment, delivery of self-management support, structured support activities outside routine care
Financing	Funding sources, incentives targeted at providers, patients, funders
Setting	GP practice, networks, community, hospital, other
***Eligibility and selection**	Identification of target population, inclusion and exclusion criteria
***Enrolment**	Invitation, charges
***Risk stratification**	Data base, determination of strata, algorithm

In the case of P4P, our framework was based on the Donabedian model for assessing health services and evaluating quality of care. It constitutes the most widely used model to describe dimensions of care, which in turn are used for performance measurement and the design of indicators. The three dimensions are structure (the setting, resources), process (provider and patient activities) and outcomes (effects of care on the wider health status) (Donabedian, 1988). In order to capture the more practical topics of P4P design, we also focussed on a series of points raised in a report of the US Agency for Healthcare Research and Quality that was targeted at purchasers of P4P initiatives (see Table 6) (Dudley and Rosenthal, 2006).

Table 6: Elements of P4P programme design, adapted from (Dudley and Rosenthal, 2006)

Elements	Items/explication (if applicable)
Providers targeted	Hospitals, physicians, specialists or primary care providers; individual clinicians versus groups
Provider participation	Voluntary or mandatory
Incentive types	Bonuses or penalties—or a combination
Structure of the bonus	Rewarding only those providers that meet or exceed a single threshold of performance Differentially rewarding providers for achievements along a continuum of performance thresholds Rewarding providers that meet or exceed a single threshold of performance combined with incentive rewarding of those that improve, regardless of whether they meet the threshold Rewarding providers in a continuous manner in proportion to their achievement
Performance thresholds	Relative or absolute
Origin of funding	New money Redirection of annual payment updates Reallocation of payment among providers, e.g., through a combination bonus-penalty payment scheme Cost savings resulting from improved quality and special cases of shared savings
Size of funding	In proportion to current payment/income
Risk adjustment	If yes, how?

1.3.5 Structure of this thesis

This thesis is divided in two main parts.

The first part provides an analysis of the introduction of DM in Germany and France. After a presentation of the reform context, the analysis will be structured around the groups of actors driving the change as well as the interactions, conflictual or not, with the professional coalitions. Finally, key elements of translation and implementation will be compared.

The second part compares the introduction of P4P elements in both health systems, using analytical categories comparable to those used in the first part.

The thesis will conclude with a discussion of the remaining and emerging transversal challenges.

First part: Disease Management

2 Overview: National Disease Management Programmes in Germany and France

Comparing the introduction of National Disease Management Programmes in Germany and France is challenging given that the two programmes were implemented or tested at different points in time, are set within distinct reform trajectories and have their own meaning to the actors concerned.

We will start with brief overviews of the programmes and the tangible elements of foreign origin that were used in this process.

2.1 How do the programmes work in practice?

In Germany, the first DMPs for diabetes enrolled patients in 2003. They are operated by individual sickness funds that in turn contract with regular health care providers. All DMPs must be accredited by the Federal Insurance Office (BVA) and comply with a regulatory and financial framework set out for diabetic patients[20] in 2002, based on a programme structure proposed by a technical committee (Coordinating Committee, CC) to MoH. Sickness funds received a financial incentive to enrol patients in their DMPs via a risk compensation scheme between funds (Busse, 2004). Further, while DMP ownership in the USA is generally commercial, Germany opted for a regulatory framework to stimulate broad introduction of national, "public" DMPs. The programme did not encompass accreditation of DMPs by private insurers[21]. However, private insurers could offer "free" DMPs outside of the regulatory framework. Participation in a DMP is voluntary both for patients and providers. It is centred on the GP[22] who coordinates care according to guidelines provided by sickness funds, which is another key difference from the majority of DM initiatives in the USA. In practice, the GP operates and controls many of the elements of the DM. For example, the patient must formally choose a physician with whom he/she wishes to participate in the DMP, although in

[20] There are distinct DMPs for type 1 and type 2 diabetes; for the purpose of this study we consider them together as a single entity. Other DMPs exist for coronary heart disease, chronic respiratory disease, asthma and breast cancer.

[21] In Germany, private health insurance can be substitutive to statutory health insurance.

[22] Or a specialist in internal medicine in private practice

practice the physician proposes participation to the patient. Patient eligibility and enrolment are determined by the physician. In addition to certifying medical criteria, physicians consider whether the patient could benefit from the therapeutic targets of the programme, is willing to participate in managing his or her own disease and the patient's quality of life may be improved through programme participation (Stock et al., 2011). This "opt-in" procedure contrasts with the general practice of "opt-out" in DMPs in the USA. Likewise, the matching of the intervention intensity to the disease severity and the needs of the target group is not the domain of the insurer but left to the discretion of the physician (who must follow clinical guidelines). Thus, there is no data-driven risk stratification or patient identification in the proper sense but reliance on the traditional physician-based delivery system structures. Once enrolled, patients typically receive regular follow-up visits and blood tests as well as referrals to specialists in pre-defined intervals depending on the clinical status. Patients benefit from educational workshops held by the physician or more likely a practice nurse auxiliary, consisting of four or five 90-minute sessions that may vary in content as long as they meet legally-defined criteria (Siering, 2008). By signing up for a DMP, physicians commit to transmitting patient follow-up data to sickness funds in exchange for a regular practice feedback and a financial incentive. An incentive for patients was provided via the exemption of a €10 quarterly fee for practice use[23], and the possible waiver of some co-payments by the sickness funds (Stock et al., 2011).

In France, the DMP Sophia for diabetic patients was introduced in 2008, following the recommendation in an Inspector of Health and Social Affairs (IGAS) report and implementation by Statutory Health Insurance (SHI). It is financed and operated by SHI, which has contracted a private provider[24] for support services. The main intervention is carried out by health coaches (trained nurses) who counsel patients via a call center. The frequency and content of the calls are based on a software algorithm and vary depending on the clinical status. They include nutritional information, advice on self-management, reminders and linkage with health care providers. Patients may also call the hotline on their own initiative. Further, Sophia features a dedicated website and information leaflets. The main adaptation of the original DMP concerned the involvement of GPs, who were not an integral part of the original

[23] Until 2013, when the fee was abandoned
[24] Health Dialog until 2011, followed by Altran/Healthways

programme. However, the implication of GPs has remained limited with Sophia: they receive a notification by SHI when a patient enrols and are then requested to perform check-up exams for which a financial incentive has been set up (Jourdain-Menninger et al., 2012). The main initiative and control lies, by and large, with SHI. The role of the GP can therefore only be considered as a focussed "add-on" to the main intervention, which is patient counselling via a call centre. Patient participation is voluntary after reception of an enrolment dossier directly from SHI that the patient must return (opt-in). As in Germany, this shift from "opt-out" to "opt-in" constitutes a major adaptation undertaken in comparison to the US model, where patients insured under certain health plans could benefit from the DMP without a specific enrolment (enrolment is presumed but patients can choose to opt-out at any time). In this model, any patient in the health plan can in theory call the health coaches at any time. In both the US model and Sophia, eligible patients are identified through claims data, based on their diagnosis in the US and on their diabetes medication and coverage by the ALD scheme (*Affections de Longue Durée*[25]) in France.

2.2 How do DMPs compare in terms of the Chronic Care Model, providers and financing?

The approaches chosen in Germany cover all four key strategies of the CCM, with an emphasis put on patient education in small groups, structured follow-up and referral, the use of clinical guidelines and monitoring-, feedback- and reminder systems (see Table 7). A key difference, however, is decision support. The French DMP only implicitly provides decision support by using risk stratification techniques in order to assist health coaches in identifying patients at risk, while in the German DMP clinical guidelines are an integral part of the programme logic and explicitly aim to structure GP behaviour. A further difference lies in the way the key strategies and approaches were put into practice, which is notable for example in terms of the approaches chosen for patient education: in the French DMP, this is essentially done via phone

[25] The ALD scheme was designed as a financing mechanism, through exempting those with long-term conditions from co-payments. It was developed further to incorporate a more structured approach to the care of those with recognized ALD. This involves the requirement for GPs to develop a care protocol for each patient requiring ALD exemption. Protocols are defined for each condition within the ALD system by HAS. In 2012, 9.5 million people benefited from exemptions through this scheme (Chevreul et al., 2015).

calls from dedicated call centres, while in the German DMP practice nurse auxiliaries lead educational workshops in small groups, generally in proximity to the GP practice.[26]

The range of professionals involved and their inter-relation is low in both countries, with nurses and GPs in France and GPs and practice nurse auxiliaries in Germany. Although orientations (France) and/or referrals (Germany) are integrated into the programmes, there is neither coordination with other providers in terms of a regular or structured information flow nor is there any physical integration.

In terms of financing, in both countries financial incentives are targeted at physicians. In France, the physician receives compensation for completing the initial patient data sheet and each annual follow-up sheet. In Germany, physicians receive compensation per enrolment, per initial and follow-up data sheet and per patient participating in an educational workshop. A small incentive has also been introduced for patients via a waiver of fees. In Germany, DMP regulations provide for a flat payment to sickness funds from the risk structure compensation scheme for each enrolled patient as a means to reduce risk selection (Busse, 2004). In France, no such incentives exist because sickness funds do not compete, and no specific compensation per patient was foreseen. However, the government plan for the improvement of care for the chronically ill has, for the period 2007-2011, granted CNAMTS a budget of almost €60 million for the first phase of Sophia (DGS, 2009), representing considerable financial leverage.

[26] These difference in practical applications seem to mirror a distinction in the extent of regulatory depth: while the French DMP is rather prescriptive, with newly designated health coaches and GPs having little discretion in their action within the programme, Germany has opted for a channelling approach in which already established providers have a certain degree of freedom, e.g. in implementing educational workshops or clinical guidelines (there are no sanctions if the latter are not respected).

Table 7: Comparison of the CCM components in DMPs in France and Germany, by corresponding key strategy and approaches according to (The DISMEVAL Project Consortium, 2011)

Key strategy	Approaches and their practical applications	
	DMP Sophia (France)	**DMP diabetes (Germany)**
Self-management support	Patient education via phone calls (at enrolment and, later, pertaining to certain campaigns e.g. nutrition, for all patients), an educative website, information leaflets and a magazine Provision of self-management tools (a patient logbook/diary)	Patient education (in small groups, led by physician auxiliary) Goal setting (only HBA1c) Provision of self-management tools (patient logbook/diary)
Delivery system design	Case finding (identification of patients at risk) Follow-up (by telephone for patients at risk and yearly by GP) Guidance (towards other resources in the patient's area such as provider networks, patient associations, etc.)	Follow-up (e.g. periodic blood tests or ophthalmology check-ups) Structured referral (by GP, according to pre-defined criteria)
Decision support	None/implicit (for health coaches, via risk stratification)	Evidence-based guidelines (form the foundation of detailed specifications of the DMP)
Clinical information systems	Monitoring system (Use of existing SHI claims data and initial/yearly patient datasheet filled in by GP) Disease registry (Existing SHI claims data and database on patients enrolled in the chronic care scheme ALD[27] used to identify eligible patients)	Monitoring system (Use of initial/bi-annual patient datasheet filled in by GP) Provider feedback (comparison of physician performance with local/regional average; no sanctions) Reminder system (in case data sheet not filled in; in case programmed check-up not initiated)

[27] ALD is an SHI scheme for 100% coverage of patients suffering from one of 30 long-term illnesses including diabetes.

2.3 Are we comparing two transfer processes?

In the terms proposed by Dolowitz and Marsh to describe the degree of transfer, the French DMP was modelled on a pre-existing DMP in the USA (the Health Dialog Primary Health Coach Model), developed and operated by a single commercial provider in the USA. Hence, its introduction represents both the copy of an existing programme "*en bloc*" (conserving virtually all elements of the original) and a "blend" with some existing health system components. In order to illustrate the notion of "copy", it is worth noting that Sophia continued to be supported by its original US provider and that the transfer also included human and physical assets, such as senior managers (moving from the USA to France), technology and the training of the French health coaches (Bupa World, 2010). In the case of Germany, the introduction of the diabetes DMP consisted of a selection of approaches pertaining to the four CCM key strategies. The particularity of this selection was that some of the approaches were already known and applied in Germany, although not on a wide scale, before the introduction of the DMP. This was the case for self-management support via patient education (Petermann, 1995) and the use of evidence-based guidelines (Ollenschläger et al., 2000). Hence, there was no clear-cut and tangible model in the form of a single programme. Instead, it comprised the larger theoretical components constituting DM that had already largely been reported on in the US scientific literature. Consequently, the introduction of DM in the case of Germany can be considered as "selective emulation" of DM concepts and practice in the USA. It allowed consolidation and promotion of existing approaches by complementing them "under one roof" with elements of a reference model.

These relatively tangible elements, based on the identification of health service components and the policy transfer theory, can provide a first taste and preliminary statements with respect to our research questions. Yet, the thematic analyses of our interview data revealed topics that were difficult to capture within the concept of policy transfer, including notions of ambivalence and alliances as well as discursive elements such as meanings and representations.

In fact, in order to analyse DMPs as policy instruments, we need to appreciate them as set within their wider reform trajectories. This requires considering different temporalities, and we have already introduced the broader-term context for health reform in Europe, based on growing budget pressure, the appearance of market and competition elements, a shift in the

way regulation takes place in practice and a growing focus on the notions of quality and its measurement.

In concrete terms, these trajectories represent and require the interactions of individuals. The following analysis will therefore be structured around a first group of actors in favour of the introduction of DM, termed the reform coalition. In both countries, unsurprisingly, this group would include institutions and individuals related to the State and SHI, notwithstanding a certain ambivalence of some of them. In France, a patient organisation also belongs to this group, but this is not the case in Germany.

A second group of actors is termed the professional coalition and includes mostly health professionals. However, the institutions and individuals in this group need not necessarily be opposed to the reform. Yet, we deem this categorisation useful in accounting for some of the "historical" aspects related to the *status quo* and the strong ambivalence in this group.

Finally, DM is translated and implemented in a context of perceptions, traditions, expertise and other elements whose origins are often difficult to disentangle. Thus the third part of the analysis gives scope for analysing all aspects that are set between the two heuristic poles of national and foreign experience.

3 Context and reform coalitions

The key to grasping the elements associated with change in both Germany and France is the fundamental transformation of the role and configuration of SHI. Despite differences in timing, the origins of this transformation lie within the Bismarckian nature of both systems. Heavily relying on wage-based contributions, increasing them represents a threat to national economic competitiveness. Therefore, budget control had become a paramount matter of concern and a means to frame health system change.

What followed was, again in both countries, a stronger role of the State. Yet, this translated into distinct patterns in Germany and France, owing to different configurations in SHI setup. In Germany, SHI has traditionally been constituted by hundreds of different sickness funds, historically linked to certain professional groups. These funds have undergone a strong concentration process, accelerated by measures to facilitate competition between them[28]. In this respect, the German system was more fertile ground for the introduction of marketing and privatisation elements[29]. It is this idea of competition that structures actors and processes, and DMPs were seen by many (but not all) as a tool within the highly complex landscape of funds, self-governing bodies, federal and regional power levels.

In France, there is no competition between funds. Instead, efforts by the central State to contain expenditure focused on budget control and measures to seize efficiency and payment margins within the care delivery system (termed "medically-based cost containment"). It is within this logic that SHI's emblematic shift "from payer to player" is set, emphasising the notion of risk management, of which the DMP Sophia is the practical application. The unique power position of SHI - closely linked to the persona of its new director - facilitated alliances (in this case with patient organisations) but also sparked scepticism by its tutor (MoH) and thematically close agencies (HAS).

Yet changes in both countries enter and modify the remit of health professionals due to their similar traits, as well as the cognitive processes underpinning the transformations.

[28] Note that in this process both centrifugal (competition, blaming) and centripetal forces (friendly mergers, federations) are at play. The Federal Association of Sickness Funds (GKV-SV) represents all funds vis-à-vis the other members of the joint self-administration. It was created by a 2007 law (previously there were seven different associations) and has since gained influence.

[29] Note also the existence of a dual insurance system (and hence, dual competition), with the possibility to subscribing to substitutive private insurance.

3.1 Context in Germany

In Germany, a primary contextual driver for the introduction of the DMP instrument was the need to react to the changes that the sickness fund system underwent after the introduction of the free choice of sickness funds in 1996. Therefore, DMPs were set within the scope of a risk structure compensation scheme (the RSA), aiming to ensure fairer competition between funds. At the same time, the institutional setting within which the actors of the self-governing bodies interact and negotiate was changed through the introduction of the Coordinating Committee (CC), which induced a subtle change in the balance of power in favour of SHI. The political momentum for DM was driven by a coalition of politicians, civil servants at MoH and a semi-political expert with high technical proficiency (Karl Lauterbach), in conjunction with the dominant share of sickness funds anticipating an improvement of their position within the RSA through DMPs. The momentum of this coalition was further completed by a shared will to improve the position of GPs, while GP representatives as such did not take leading positions in the public discussions over DM.

3.1.1 RSA and financial incentives for fairer competition between sickness funds in Germany

Overall, the introduction of DM in Germany falls within a period of considerable institutional change and cannot be disentangled from these developments, the most important of which are the introduction of the Coordinating Committee (CC) and the modifications of the risk structure compensation scheme (RSA). It should also be noted that the work on the introduction of DMPs was accomplished in a relatively short time span, which many interviewees described as a feeling of time pressure. One important factor behind this may have been the political momentum for change after 16 years of rule by the Christian Democratic-Liberal government under Chancellor Helmut Kohl (1982–1998).

Under the health care legislation enacted by the successor Social Democratic-Green government, the majority of legal arrangements preceding the change of government (increased out-of-pocket payments, reduction of preventive and rehabilitative benefits) were removed and replaced by cost-containment measures. Further, the benefit catalogue was extended to include minor benefits (socio-therapy, patient information). Following a change of minister in 2000 and a “roundtable” consultation of a broad range of actors, a variety of small acts were introduced: pharmaceutical spending caps were lifted and replaced by negotiation powers for

the self-governing SHI actors and prescription feedback for physicians. In addition, the SHI Reform Act of 2000 set out the regulations to introduce DRGs as a payment system in hospitals, which took effect in 2004 (Busse and Riesberg, 2004). Finally, the work on DMPs coincided with the September 2002 elections, which saw the Social Democratic-Green government re-elected.

3.1.2 The Coordinating Committee (CC), a "new instance of power"

In 2000, the CC was legislatively created to coordinate the existing federal committees for ambulatory physician care and hospital care. It was charged with identifying areas of over- or under-utilisation as well as with passing intersectoral health care treatment guidelines as well as proposing the requirements for DMPs. A 2001 act defined the process for the introduction of DMPs: The CC was charged with recommending to MoH the selected chronic diseases and the minimum common requirements for DMPs. This was a new division of labour, with the self-governing bodies proposing, and the Ministry passing, an ordinance (Busse and Riesberg, 2004). The CC was composed of representatives of SHI and provider groups (Federal Association of SHI Physicians, KBV), Federal Association of SHI Dentists, German Hospital Federation, DKG, and Federal Physicians' Chamber, BÄK)[30]. The distribution of voting members meant that a vote by SHI could only be countered by a united vote of the physician and hospital representatives. The official Journal of German Physicians held that this "*new instance of power*" would "*stronger than originally intended intervene in the daily delivery of care*" (Gerst, 2002). Likewise, a former senior member of the CC argues that the CC was viewed by physicians as an "*affront*", since thereby SHI was given an "*equal vote*" for the introduction of a "*new care system*", instead of deciding on "*classical HTA-themes*" where new treatment or diagnosis was assessed. According to him, "*in particular BÄK was massively irritated*", which he holds was "*part of the dynamic in Germany*" [DE4 p. 1]. According to him, they performed "*radical opposition*" with the BÄK head arguing "*we do not want that decisions about medicine are taken here*". He holds that by doing so BÄK acted "*childish*" and forewent the chance to take part in DM design [DE4, p. 2].

[30] With the SHI Modernization Act in force since 2004, the joint committees for the ambulatory sector, the hospital sector and the CC have been unified into a single committee: the Federal Joint Committee (GBA).

3.1.3 The Risk Structure Compensation Scheme (RSA), intrinsically linked to DMPs

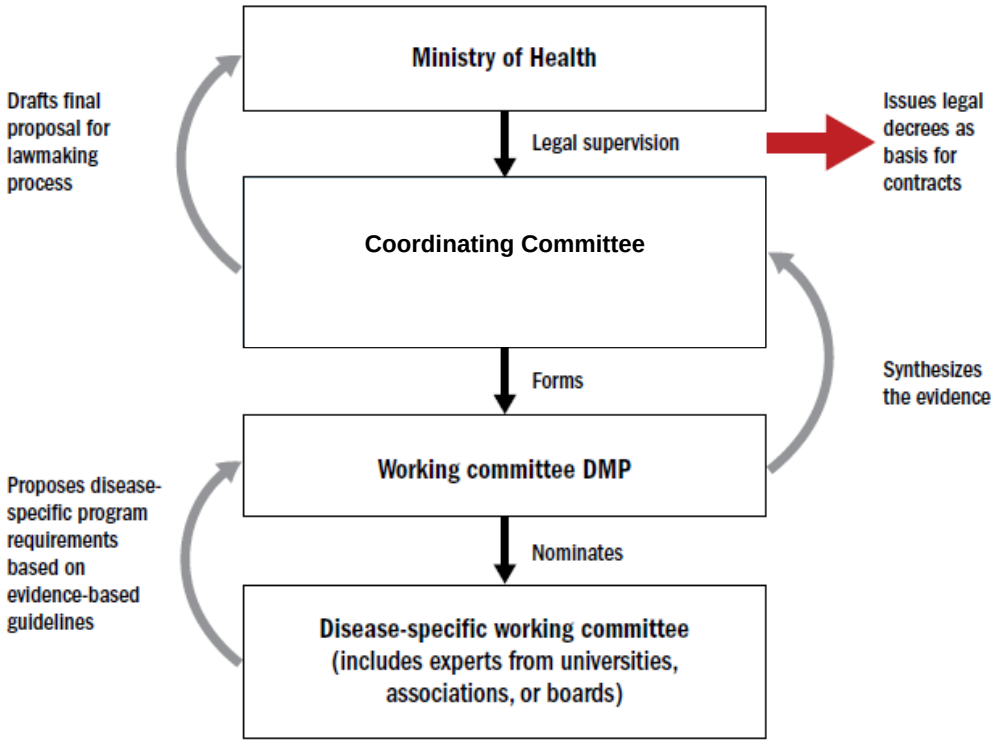
The Act to Reform the Risk Structure Compensation Scheme[31] was passed in 2001 to better compensate for differences in the morbidity structure, to avoid cream-skimming among sickness funds and to give them an incentive to offer special treatment options to chronically ill patients. In addition to the existing compensation for differences in income as well as expenditure by age, sex and invalidity among the insured, the law introduced a 'high risk pool' and distinct categories for people participating in DMPs, representing an incentive for sickness funds. The Act also stipulated the factors to be taken into account when selecting a disease for DMPs, namely the number of patients, potential for quality improvement, existence of evidence based guidelines, need for trans-sectoral care, potential for improvement through patients' initiative, and high expenditure. Based on the defined minimum requirements, sickness funds then contracted with providers and installed their own provisions of informing and convincing their members to enrol voluntarily. Other requirements included patient education and an evaluation of the programmes. Sickness funds then applied for accreditation of their DMP at BVA, which mainly checked whether the DMP fulfils the legal requirements. Upon accreditation, the sickness funds could run and coordinate the DMPs (Busse and Riesberg, 2004). The modification of RSA using DMPs as an adjustment category was seen as a short-term, intermediary solution while it was planned to eventually develop an allocation scheme based on morbidity for 2007 (Jacobs, 2003), but the data infrastructure was still lacking at the time [DE1, p. 1].

The perceived imbalance of the existing allocation schemes in 2000 seems to have led to significant time pressure for the representatives of sickness funds, who held that competition was focusing on "good risks" rather than on improving care. Indeed, in a 2000 press release following the results and recommendations of an interim report on RSA-reform by the Advisory Council for the Concerted Action in Health Care (SVR[32]) put forward that "*in light of the problem pressure, the short-term feasibility is a particular focus of attention*" (AOK-

[31] The Health Care Structure Act of 1993 gave almost every SHI member the right to freely choose a sickness fund from 1996 onwards and to change between funds on a yearly basis. To provide all sickness funds with a level playing field for competition, the RSA was introduced in 1994 and 1995. It seeks to equalize differences in expenditures among the insured (due to age, sex and disability) and contribution rates due to differences in income levels from proportional contributions (Busse and Riesberg, 2004).

[32] *Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen*. Based on a survey of all major stakeholders in health care, including payers, providers, self-help groups and government agencies, SVR documented evidence for under-provision of health care services as well as over-provision and avoidable harm due to the omission or commission of health care interventions (Busse and Riesberg, 2004)

Bundesverband et al., 2000). Graph 1 provides an overview of the involved actors and regulatory steps. A researcher argues that "*ping-pong was foreseen*" between the actors: one party choosing the indications, the other recommending the required components to MoH, with an accreditation by BVA [DE1, p. 3]. On a wider scale, it is an illustration of the policy process in the German health system, which is characterised by several decision nodes that allow for a balance between the interests of the various self-governing bodies, the State as well as external stakeholders.



Graph 1: Actors and regulatory steps in the German DMP. Adapted from (Stock et al., 2011)

3.2 The reform coalition in Germany

3.2.1.1 MoH under Green and Social Democratic ministers

Beyond its role of legal design and supervision, MoH and in particular the Social Democratic Minister Ulla Schmidt were crucial in politically advocating the idea of DM, which sparked little controversy within the political arena. The parliamentary discussions did not reveal any fundamental disagreements over the concept or potential content of DMPs[33], unlike the discussion within the physician community. Several actors agree that the personal friendship between the health economist (and later SPD politician) Karl Lauterbach and Minister Schmidt was the key driver of the political support for DMPs, which will be examined in section 3.2.1.2.

There were, however, other factors shaping MoH's motivation to support DM. The new Social Democratic/Green Coalition Government (1998–2004) wanted to emphasise not only financing, but also quality of care. Indeed, SPD was already in favour of the Health Care Structure Act of 1993 and the introduction of DRGs approved in 2000 (Gerlinger, 2002). Just like the preceding government, the SPD/Green coalition wanted to prevent increases in SHI contributions (borne by employers and employees) so as to protect the competitiveness of the German economy[34].

DMPs also included the patient as "co-producer of health", which was one of the recurrent themes of Green party Minister Andrea Fischer[35]: patient-centeredness of the health system[36]. Indeed, DMPs imply an active role for the insured through coaching and educational elements. In this regard, prevention and health promotion were also identified as responsibilities of sickness funds in 2000 (§§ 20 and 20a SGB V, 21. June 2000). Further, there was support

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[33] It appears that it was not planned to have extended discussions, since the scheduled time for the combined second and third reading on the subject was 30 minutes on a Friday afternoon (*Plenarprotokoll 14/199, Deutscher Bundestag, Stenographischer Bericht, 199. Sitzung, Berlin, Freitag, den 9. November 2001);* fundamental opposition was voiced, however, on the principle of the extension of the RSA, which members of the conservative CDU saw as destructive to the competition between sickness funds, "*paving the way towards one unified fund*" (*Deutscher Bundestag Drucksache 14/739514, 08. 11. 2001, Bericht des Ausschusses für Gesundheit (14. Ausschuss)).*

[34] *Aufbruch und Erneuerung - Deutschlands Weg ins 21. Jahrhundert*. Koalitionsvereinbarung zwischen der Sozialdemokratischen Partei Deutschlands und Bündnis 90/Die GRÜNEN. Bonn, 20. Oktober 1998.

[35] Member of the Green Party, Minister of Health from October 1998 until January 2001, Andrea Fischer resigned amidst the mad-cow-disease (BSE) crisis. Her successor Ulla Schmidt, SPD, remained in office until October 2009, when the conservative/liberal government (CDU/CSU and FDP) won the elections. For the following 4-year term, the MoH was headed by a FDP Minister (first Philipp Rösler, then Daniel Bahr). Since the "grand coalition" in December 2013, Hermann Gröhe (CDU) has been the Minister of Health.

[36] See for instance: *Der Patient als Kunde und Konsument. Wie viel Patientensouveränität ist möglich?* Andrea Fischer, Rainer Sibbel, 2011. Gabler Verlag, Wiesbaden.

of DMPs from workers' unions and the influential Hannover social medicine professor Friedrich-Wilhelm Schwarz, the former head of SVR [DE3, p. 4].

On a more conceptual level, MoH viewed the most important element of DMPs for Germany was that the care delivered was based on clinical guidelines. Since January 2000 all SHI physicians have been legally obliged to "*take into account guideline-based criteria for the effective and efficient delivery of care*"[37]. There was a progressive wing within the physician representatives who wanted guidelines, too. The Association of the Scientific Medical Societies (AWMF) has coordinated the elaboration of guidelines since 1995, without input by SHI or the State (and with quality issues for some of the output) (Ollenschläger et al., 2000). In 1999, the annual federal conference of health ministers (*Gesundheitsministerkonferenz, GMK*[38]) recommended in its Goals for a joint quality strategy in the German health system that guidelines be recognised by the self-administration bodies (including SHI). A joint "clearing procedure"[39] was thus initiated in the same year by BÄK, KBV and the Federal Association of Sickness Funds (GKV-SV) under the roof of ÄZQ[40], as a prime example of regulatory delegation within the German system. It provided that a guideline must automatically become part of a DMP concerned by it. However, all sides have consistently highlighted that a guideline is no directive and that physicians have therapeutic discretion to deviate, if justified (Ärztliches Zentrum für Qualität in der Medizin, 2006).

A former senior MoH actor in charge of the directorate responsible for DMPs argues that "*the political interest of MoH was to overcome the stagnation of the late Kohl era*" (until 1998), where "*nothing happened*". He described the new government's perception of the "guidelines vs. cookbook-medicine" debate as favourable in this context, given their party programmes since 1990 promoted a shift from ambulatory to chronic care, to which DMPs were an answer. He noted that DMPs were seen as a significant support for documentation in medical practice,

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[37] Deutscher Bundestag 1999: *Gesetz zur Reform der gesetzlichen Krankenversicherung ab dem Jahr 2000*.

[38] GMK is rather explicit in its normative and benchmarking approach: „*With the formulation of jointly accepted goals for a joint quality strategy as a basis of the respective action of actors in the health system, GMK goes in Germany a new, norm-setting way, that has already been taken successfully with the same goals in other countries (e.g. UK, the Netherlands, Norway or Sweden)*." (Gesundheitsministerkonferenz 1999. Ziele für eine einheitliche Qualitätsstrategie im Gesundheitswesen)

[39] Following the international models of guideline assessment instruments of the AGREE collaboration and the international guideline network G-I-N (Weckert, 2013).

[40] Ärztliche Zentrum für Qualität in der Medizin (ÄZQ), http://www.aezq.de/, is a joint „competence centre" of BÄK and KBV for quality in medicine, founded in 1995. Its missions include medical guidelines (development, assessment, distribution, methods), patient information, patient safety, and quality development.

while specifying that "*filling out standardised sheets*", if possible on a computer, was the main object of physician resistance [DE3, p. 2]. The former MoH actor maintained that the steering of the adaptation of DM to the German system was a "*classical MoH job*" by a working group including two senior civil servants and a parliamentary SPD member, with contacts to sickness funds and KBV [DE3, p. 5]. However, this perspective was qualified by a former SHI and CC actor, who argued that MoH did not play a role concerning the contents of the DMP besides occasional attempts to influence certain points, pursuant to its general role and linked to its function to monitor the legal aspects. This involvement concerned mostly the choice of diseases to be addressed by DMPs[41]. Likewise, this actor held that there were no fundamental modifications once the recommendations were handed over to MoH, adding that MoH's concerns were more linked to the fact that the DMPs had an impact on financing in the context of the RSA reform (DE4, p. 4].

These diverging views on the implication of MoH in the development of DMPs gain meaning in light of the findings of Burau and Fenton on the negotiation process at the CC. In fact, MoH participated in the deliberations as an observer and was also in charge of monitoring the tight time table. In the event no agreement was reached, MoH would have made a unilateral decision. The context of this "steering at a distance", according to Burau and Fenton, provided a platform for SHI and KBV to form an alliance to "*secure the legitimacy vis-à-vis the parties involved in the negotiations*", namely the medical community at large and MoH (Burau and Fenton, 2009). Hence, although MoH and SHI were both in favour of DMPs, DMPs as an instrument that structures power relations had very distinct implications for these two main actors.

3.2.1.2 The "bird of paradise"[42]: Karl Lauterbach

The rapid national implementation of DMPs was a political decision, with direct support from Health Minister Ulla Schmidt, who took office in January 2001 [DE2, p. 1]. Indeed, a researcher argues that, for the introduction of DMPs, the "*main axis was of course the personal relationship between Karl Lauterbach and Ulla Schmidt, who just became minister*" [DE1 p.2]. According to him, Lauterbach "*brought the idea*" from the USA and conceived the RSA

[41] In the case of breast cancer, this was largely a political decision. Conversely, the DMP for patients with diabetes was based on a long-standing consensus conveyed by institutions such as SVR.
[42] [DE3, p. 8]

extension as a means to safeguard the concepts against influence from external actors[43]. He considers it was "*rather an internal German affair, and no DMP-Gurus from abroad (and I wouldn't know who that should be) were invited to present here*" [DE1, p. 2]. This perspective is confirmed by a former SHI and CC actor, arguing that most likely Lauterbach had a "*very strong influence*" and convinced MoH via "*his excellent contacts to SPD*" that "*with DM a success model of the USA should be transferred to Germany*", underscoring that it was a political decision [DE4, p. 1]. The eminence of Lauterbach, even given the time lapse since the reform, also becomes tangible in the account of a former MoH actor who considers him as one of those who "*brought knowledge and trends from the US*A". He describes how he became member of SVR in 1998 and "*heated the debate via the transmission-belt SVR*", leading to the "*great report of 2001*" [DE3, p. 1]. He holds that Lauterbach was the most important actor on the political stage, who had the "*youth-like image of the guy who lived in the US for 10 years, taught in Harvard*" and "*constructed an omni-presence in the media*", giving speeches "*ready to print in all formats, from 10 sec to 2,5h discussions*" [DE3, p. 1].

Besides the 2001 SVR report, Lauterbach and colleagues from his institute at the University of Cologne had also drafted a white paper on DM on behalf of sickness fund federations (Lauterbach, 2001). However, a former SHI and CC actor argues that the expertise played "*a minor role*", arguing that the "*continuous and lengthy reference to the USA*" was important for the political decision and to convince MoH and parliament, while it only had "*little importance*" for the self-governing bodies [DE4, p. 5]. While the above sections highlight Lauterbach's role in "higher politics", the present account implies that he indeed may have had limited relevance with the implementing bodies. This view is plainly confirmed by an additional perspective of the former KBV head. He said that Lauterbach, during his development from scientist to politician, had started criticising the system, using provocative communication that "*almost neutralised him*". He was "*demonised*" in public discussion and potentially "*public enemy number one*" since he was not in constructive dialog with the physician community. Within that community, those considering his arguments were in danger of being "*demonised*" as well [DE6, p. 8], explaining why his scientific work found little echo in the respective committees.

[43] See also box "the shadow actors"

3.2.1.3 SHI: economic interests as a consequence of competition

Within SHI, there were clearly divided positions. A former senior SHI and CC actor holds that DM was "*disputed*" within SHI but that many sickness funds expected economic advantages [DE4, p. 1]. This situation is explained by the changes in the SHI landscape after the free choice of sickness funds was introduced in 1996. For example, the large general regional funds (AOK) with a high share of retired and low-income insured exhibited high contribution rates. By 2000, it lost approximately 2.3 million insured to the cheaper company-based funds (BKK), in particular those newly funded and operating mostly via internet and call-centres. As a result, AOK was a frontrunner in developing programmes for more efficient care for the chronically ill (Erler, 2002).

At the same time, the sickness funds that benefited from the new competition were highly sceptical towards DMPs. As put by the former senior SHI and CC actor (AOK), "*the 'rich' substitute funds,* [traditionally with white-collar membership (Busse and Riesberg, 2004)]*, feared to be disfavoured by the new RSA-DMP scheme which would coerce them to transfer further funds to the 'proletarian' AOK*" [DE4, p. 1]. He claims that these "*hefty disputes*" were underway before the actual discussions about DMPs even started [DE4, p. 2]. Yet, according to him, despite scepticism whether the single-disease approach of DMPs could sufficiently address the challenges of multi-morbidity, the content-based discussion was over as soon as the majority of funds were in favour [DE4, p. 1].

Eventually, the favourable final position of SHI can be easily explained by the power structure in place despite the shifts of insured: in January 2004, 37% of all SHI members were insured with AOK, 33% at one of the substitute funds, 21% with BKK and 6% with a guild fund (IKK) (Busse and Riesberg, 2004); hence, general regional funds and substitute funds still held a dominant position. The "battle" between funds was carried out in part via the use of expertise: while the Federal Association of Substitute Funds (VDAK)[44] commissioned in 2001 a report to Karl Lauterbach in which an exemplary model of a DMP for diabetes was developed (Lauterbach, 2001), the white-collar substitute fund TK commissioned the IGES institute to develop a white paper concluding that DMPs are not cost-effective and that "*the health*

[44] Substitutive funds were formerly open to either white collar workers or to blue collar workers (Busse and Riesberg, 2004), which explains a certain degree of internal dissent. After 1996 however, although they initially attracted more insured, they lost a total of 740.000 members between 1997 and 2000, leading them to support DMPs overall (Erler, 2002).

system goal to improve care for patients with diabetes becomes secondary" to the concern regarding financial compensation (IGES Institut, 2004).

The notion that DMPs may not represent a major improvement or innovation of care seems to be shared by the former senior SHI and CC actor (and physician by training), who maintained that "*DMPs today are no revolutionary instrument*". According to him, they are interesting and associated with "*some change*" but have "*neither turned upside down the parallelogram of power, nor medicine*" [DE4, p. 2].

Finally, a senior researcher stated that SHI explicitly requested that DMPs be coupled with the RSA financial incentive so that there could be "*more competition*" [DE2, p. 5]. Another researcher adds that linking DMPs to RSA was "*clever*" since chronically ill individuals could "*flag themselves*" as such on a voluntary basis. According to him "*this mixture was ingenious*" and "*disinterest turned into interest*" [DE1, p. 1]. He also notes that, although results are showing only moderate benefits, SHI is still very favourable for DMPs, suggesting that "*customer loyalty*" may play a role just as it does in the case of P4P for hospitals [DE1, p. 3] (see section 7.3).

The shadow actors: private provider organisations

A senior researcher gave an account of players who were not mentioned by official actors or manifest in the literature, but who probably had an indirect influence on the course of events. He describes that, by that time, there were care delivery programmes that "*made sense*" and were "*considered as promising*". Yet, they were operated by consultancy firms and linked directly or indirectly to the pharmaceutical industry [DE1, p. 1]. According to him, it was uncertain but considered possible that funds could purchase DMPs from private operators entering the German market at that moment, which ultimately did not happen since sickness funds "*took it in their own hands*" [DE1, p. 1], possibly reinforced by the need to generate data for RSA [DE1, p. 3]. In the context of our analysis, this appears very plausible and is substantiated in the section on "data struggle".

For this interviewee, another reason for the absence of private actors is the fact that DMP evaluation is mandatory and that data had to be undisclosed to the BVA. This set "*higher barriers*", since private actors would have had to reveal their "*DMP-recipe*". Such individual programme architecture was not possible since the all components were set out in detailed regulations. In the words of the actor: "*through the transparency it is more difficult to cook your own soup*" [DE1, p. 3]. In this respect, it seemed that by that time SHI (or a coalition to which it belonged) preferred to maintain (full) control over the specifications of DMPs. However, in the introduction to this thesis, we have seen that "add-on" programmes such as phone-coaching have become a way for sickness funds to distinguish themselves from others (to compete for "good risks" or to reduce costs for "bad risks"). This development is in part explained by the introduction of a morbidity-adjusted risk structure compensation scheme (*Morbi-RSA*) in 2009. With this new scheme, statutory DMPs lost much of their importance as allocation tools, and sickness funds needed to find other ways to compete. This was the occasion for the "shadow actors" to step into the light.

One example for a recent "add-on" programme for individual sickness funds is telephone-based health coaching for chronically ill patients. It uses a service developed by Health Dialog and was implemented by the fund *Kaufmännische Krankenkasse Hannover* (KKH) in 2007, with an estimated number of 12,000 participants in 2013. The programme is similar to Sophia and it main goal is to avoid hospital admissions (Dwinger et al., 2013).

3.3 Context in France

Compared to Germany, the introduction of national DMPs in France was more centred on a single institution, SHI, as embodied by CNAMTS. This is a result of the strengthening of the institution, set within a series of measures introduced through two subsequent reforms in 2004 that generally emphasised the organisation of care and tightening of regulation in favour of the state. Within the reform coalition led by SHI, its new director held an important role in transforming SHI into a more direct actor in health care through the reinforced notion of risk management. To that end, significant resources were devoted to a strategy department that scanned foreign evidence on innovative approaches to chronic disease care, and direct contacts were established with private DM providers in the USA. Throughout the process, SHI received strong support from a patient organisation that shared its goal of increased "patient coaching".

The 2004 Health Insurance Act, which renewed the organisation and management responsibility of SHI, set out measures to improve the long-term disease scheme ALD. The law also introduced a form of gatekeeping through the preferred doctor scheme (*médécin traitant*) in the ambulatory care sector with higher co-payments for patients accessing care outside of this coordinated care pathway. It also created HAS which, among other things, was given authority to develop guidelines for the treatment of chronic diseases and to define eligibility criteria for inclusion in the ALD system. In the same year, the 2004 Public Health Act defined five major health plans and 100 public health priorities with individual target indicators for the period 2005–2009. Targets were organised into 22 categories, 11 of which concerned chronic conditions or diseases. The law also foresaw the development of a national public health plan for those with chronic illness, which was ultimately published in 2007[45]. Patient education, prevention and treatment information for the chronically ill also played a major role in the 2006–2009 triennial contract that SHI signs with MoH that defines the objectives for the management and governance of SHI (C*onvention d'Objectifs et de Gestion*, COG).

Concomitantly, in September 2006 IGAS[46] published a report about the "lessons on foreign experiences with disease management". The 210-page document was based on study trips to

[45] Ministère de la Santé et des Solidarités (2007). Plan pour l'amélioration de la qualité de vie des personnes atteintes de maladies chroniques (2007-2011).

[46] *Brief auto-description of IGAS according to its website :* The "Inspection Générale des Affaires Sociales" (IGAS) is the French Government audit, evaluation and inspection office for health, social security, social cohesion,

the USA, England and Germany, and recommended developing DM pilot programmes in France (Bras et al., 2006). The 2007 Social Security Financing Act authorised SHI to put in place chronic care programmes (article 91-II of LFSS 2007). This provision, however, was not included in the government's initial proposition. Rather, it was introduced in the Senate text as an amendment (n° 37, article 47) by Alain Vasselle (UMP, centre-right) in the name of the Commission of Social Affairs with reference to the COG 2006-2009[47]. It was subsequently adopted without discussion and approved by the National Assembly. Finally, the contours of the DMP were outlined in SHI's annual report in July 2007, and 2008 saw the launch of the regional pilots of the programme named Sophia.

employment and labour policies and organizations. Established in 1967, IGAS is a high level internal unit which has oversight over all social programmes and operations through internal audits and investigations. IGAS contributes also, as an internal consulting unit, to the efficiency and quality of government decision making. It is a major source of advice for the Government in the area of social policies. It is also one of the most trusted sources of information and expertise for all public and private stakeholders and the general public in these areas. Led by a General Inspector, it includes around 125 professionals from various origins (ENA – National School of Administration, hospitals, labour administration, medical doctors, pharmacists, engineers…). *See* http://www.igas.gouv.fr/spip.php?article490

[47] « *Les caisses nationales d'assurance maladie peuvent mettre en place des programmes d'accompagnement des patients atteints de maladies chroniques visant à leur apporter des conseils en termes d'orientation dans le système de soins et d'éducation à la santé* ». Art.91-II, Loi n° 2006-1640 du 21 décembre 2006 de financement de la sécurité sociale pour 2007.

3.4 The reform coalition in France

"We were motivated, young and handsome." [FR10, p .2]

"We are old and free." [FR2, p .5]

The set of principal actors in the introduction of the Sophia programme is limited: it was led by SHI with backing from patient organisations, and IGAS played a role at the early conception phase. This section will first examine where the main momentum came from and which elements structured support and frictions between the principal actors. In a later section, we will analyse the interactions with a wider set of actors whose influence was less determining.

3.4.1 The new role of SHI: from risk management to coaching

For SHI as the principal reform actor, the initiation of Sophia was very closely linked to institutional change triggered by the 2004 reform act. An important element in the leading role of SHI was played by its director Frédéric Van Roekeghem, who was appointed by government in 2004 and remained at the helm of the institution until 2014. The particular role of the SHI director himself, emphasised by almost all interview partners, is in part conveyed by the nickname "Rocky", used by several of them and ubiquitous in media coverage (Chastand, 2012). The connotation may be interpreted in the light of the director's training and work experience: after graduating from France's prestigious engineering school *École polytechnique*, he started his career in the Ministry of Defence. After posts occupied in several ministerial cabinets and the social security system, he was made head of the cabinet of the Minister of Health in 2004, becoming a lead figure in the negotiations of the SHI reform act of the same year (Hassenteufel, 2009).

In 2005, SHI underwent a major audit which led to the creation of a dedicated strategy department within the directorate for strategy, expertise and statistics (DSES) as part of a larger restructuring of SHI administration. The rationale was that SHI should not only handle the day-to-day work but make propositions for the future, in line with the 2004 reform act that charged SHI with the annual propositions report submitted to parliament [FR7, p.1]. According to a senior SHI manager, an objective of the new SHI director was to rebalance SHI action from the supply to the demand side by trying to overcome the dichotomy between medical content and the management/administrative component. This new, more medical approach was

perceived as being closer to what other countries did [FR12, p. 1]. In the words of another collaborator, SHI wanted:

> *"Not to be seen as a simple payer anymore but as a true insurer, not limiting its role to reimbursements but accompanying the insured." [FR3, p. 1]*

Thus, Van Roekeghem is seen as having implemented an international benchmark logic, not only in the strategy department, but also in the medical products department that had acquired international databases to determine how France had done: "*this culture was spreading by that time*" [FR12, p. 2-3]. Part of the change was also the recruitment of people with an interest in international comparison [FR12, p. 2-3]. This also was the perception outside SHI: a senior DSS actor stated that the recruitment of the DSES head Dominique Polton[48] was a "*new generation*" and that she had added an academic perspective, until then little common in French public decision making [FR5, p. 4]. Further, Van Roekeghem, who has himself studied one year in the US, introduced systematic yearly study trips abroad with an increasing number of participants, including members from technical departments, such as the directors of local SHI funds. [FR12, p. 3]

A senior SHI actor describes how SHI was "*on the search*" for its new role as insurer, with Van Roekeghem maintaining that SHI should not only fix tariffs but prevent risk through primary, secondary and tertiary prevention. She adds that for SHI, there had always been a strict separation of prevention and care, and that SHI initially was not supposed to finance prevention. The separation was then attenuated, with a special fund for prevention. She argues that the programmes in this fund such as dental prevention were the "*ancestors*" of Sophia [FR12 p. 4].

The 2004 reform act had conferred on SHI an explicit risk management objective, and the new director had the board approve a 20-page, comprehensive strategy memorandum in June 2005[49].

[48] Mathematician and economist by training and alumna of the ENSAE statistics school, Dominique Polton was director of the IRDES institute for research and information in health economics before joining the SHI.

[49] CNAMTS : Orientations de la politique de gestion du risque et objectifs prévus pour sa mise en œuvre. Texte voté par le conseil du 2 juin 2005.

"Strategy for risk management and implementation objectives": the 2005 strategy memorandum

In its introduction, the document underscores two benchmarks with other European countries: the increased mortality before the age of 65 and significant inequalities depending on social category, as well as a high number of specialists and doctors in general. It states that quality and efficiency of the health system need to be improved, but that information on quality is absent, making it difficult to make "*trade-offs between providers and care processes*". Noting similar challenges in other European systems, it sets out the path to "*adapt solutions proven to be effective, and develop in parallel specific solutions adapted to our needs and means*".

Risk management measures are then defined for five domains: 1) prevention and information; 2) health professionals; 3) coverage; 4) service planning; 5) tariffs. Within the first domain, the specific goal is defined to "*develop coaching of chronically ill patients in terms of complication prevention, care organisation and compliance*". In a dedicated sub-objective, SHI plans to "*support innovative care experiments*", which "*must be evaluated in light of their generalisation*". The time horizon is defined as the period before 2009.

The level of detail in the document is striking and suggests that some of its content was conceived before 2005. Most noteworthy is the fact that SHI kept this schedule to the letter, since Sophia was launched in 2008. Finally, it contains clear references to European neighbours and the "commitment to be inspired" by promising models.

According to a senior SHI actor, the notion of risk management had evolved over time: at first, it was limited to the individual control of the insured (for example, sick leave) and later focused on the collective practice of health professionals, which somehow dominated SHI's activity since it was in charge of collective agreements. The new director initiated a shift of activity towards the "*demand side*" (the insured), to which Sophia belongs [FR12 p. 1-2]. As an SHI actor with operational responsibility for Sophia puts it, Van Roekeghem had the "*strong intention to position SHI as direct actor close to its insured*", and DM was a way to pursue this objective [FR4 p. 1]. Another SHI actor specifies that risk management also meant patient coaching[50], linking it to notions such as advice and support and distinguishing it from

[50] *Accompagnement des patients*; we will use the word *coaching* as did the US provider commissioned by SHI (Reuters, 2008). In an article by SHI actors, it is reported that a direct translation of *disease management* into French would have been "*opaque and little attractive*", which is why *coaching* was chosen, being closer to the "*basic concept*" (Lemaire and Lennep, 2009). It could be argued that the use of the word *coaching* served two purposes: first, to distinguish the programme also semantically from other and existing areas of care; second, to avoid associations with the loaded term *management*.

prevention [FR3, p. 1]. These notions were associated with a minimisation of disease complications, having "*guided SHI in its will to enter systems like DM*" [FR3, p. 2].

To pursue this task, Van Roekeghem instigated institutional changes that facilitated the necessary hybridisation of bureaucratic and medical concepts. According to a senior actor, he created a linkage between medical and administrative staff and departments, allowing at the time more targeted work (for example, concerning prescription behaviour), similar to what the actor had seen previously in the UK [FR12, p. 1-2]. Likewise, he created a dedicated strategy unit in 2006, headed by an alumnus of the National School of Statistics and Economic Administration (ENSAE), who described the department as being in charge of delivering national and international analyses for the SHI annual report, relying extensively on the previously recruited head of the directorate for strategy, expertise and statistics (DSES) and her network in Europe [FR7, p. 1].

Thus, from 2005 onwards, SHI was equipped with clear direction. Searching for a new role in close proximity to the insured backed by a well-suited concept of coaching, it proceeded with the explicit mission and dedicated staff to examine the foreign experience.

3.4.2 The international stimulus

A senior SHI actor holds that the actual trigger for the programme was "*some sort of international stimulus*" with two parts: a joint mission to three countries and a sustained collaboration with a sickness fund in Germany [FR12, p. 2].

First, in 2006, SHI joined a one-week IGAS mission to the US, England and Germany. The team was composed of two SHI members: the head of the strategy department and the head of the chronic disease department[51], along with a HAS member and the three IGAS civil servants who organised and led the mission. The second head of the strategy department holds that, while IGAS members were more in an "*exploratory logic*", "*all went there together, split up the study sites between them, and returned with materials and convictions that were forged there*" [FR3, p. 2]. The notion of a collective cognitive process is substantiated by an actor who joined SHI

This distinction has also been noted by other actors. The SFD president argues that the SHI medical director perceived Sophia neither as patient education nor as coaching but "*only piloting diabetics in the health care system*" [FR11, p. 1]. Similarly, an official 2008 MoH report states that Sophia is distinct from patient education and that its coaching approach was linked to the "*observance*" concept (Saout et al., 2008).

[51] Trained at the National School of Administration (ENA), she became head of the Sophia programme in 2007.

in 2007, describing that the involved core actors worked on Sophia in a prolongation process of SHI's "*progressive transformation*" when they "*travelled and reflected together*" [FR4, p. 1]. The apparent importance of the mission, almost reaching the status of an initiating rite, is best summarised by one of the SHI participants: "*we asked ourselves all the questions based on what we saw in the USA … all began with that one-week study trip*". He underscores it was the first time that SHI sought inspiration from foreign experience in such a voluntary and large manner [FR7, p. 2].

The second head of the strategy department specified that SHI joined the trip also because they realised they did not have the competencies to set up a programme themselves, particularly with respect to information systems and techniques of population segmentation, which SHI "*needed to learn*". There was the feeling that for a "*relatively rapid start*" external expertise was needed, which is why SHI launched a new tendering process. Based on simulations of economic benefits and the specifications elaborated by the SHI members of the mission [FR7, p. 7], it undertook several meetings with competing providers [FR3, p. 2-3]. Only US providers answered, and they reportedly were the only ones with a "*commercial offer allowing doing [DM]*" [FR3 p. 3]. The scale of the tender was big for SHI [FR7, p. 2-3], with a sub-contractor suggesting that Health Dialog had a €12 million contract for three years to deploy Sophia (Oracle, Undated)[52]. While "*all was very inspired by the USA*" [FR7, p. 2], SHI realised the significant implications that such an inspiration entailed. Modifications of the model were necessary in terms of the IT system, the role of the GP and patient enrolment. The first head of the strategy department notes that although Van Roekeghem immediately appreciated the innovation and political advantage, he needed time to be convinced that SHI could handle the material challenges in terms of recruitment (nurses) and the tender[53], since it was not an option for SHI to externalise DM as insurers in the USA do. So, providers came to Paris to present the project, "*the time Frédéric Van Roekeghem needed to persuade himself that 'we can do it'*" [FR7, p. 7].

Second, in addition to the US model, SHI had regular exchanges with the German AOK about policies and issues and looked closely at German DMPs that were perceived as "*extremely*

[52] For the period 2007-2011, the government plan for the improvement of care for the chronically ill has, granted CNAMTS a budget of almost €60 million for the first phase of Sophia (DGS, 2009).
[53] This is specified by a former SHI actor as having mobilized significantly more resources than CAPI, with several teams, two evaluations, the pilot sites, trainers and a dedicated information system [FR8 p.12].

different" from what SHI was doing [FR12, p. 2]. The senior SHI actor perceives this as a kind of "*misunderstanding*" by noting "*what the Germans do has nothing to do with it [DM]*". She argues that with the exception of some programmes resembling the French plans - detachment from the system, phone platforms and nurses - Germany essentially had tried to implicate the entire system, mostly GPs, in patient education and documentation of their activities. "*So it was a kind of programme they also called DM but which …*" [she does not think it is]. She concludes that all these programmes were difficult to evaluate because of their heterogeneous content, making it difficult to draw conclusions [FR12, p. 4]. Yet, German DM has for a long time been considered very successful [FR12, p .5]. Interestingly, the authors of the IGAS report similarly concluded that DM in Germany was taking place "*around the development of patient education*", although its appendix analyses the full structure of German DMPs including the central role of the GP and clinical recommendations (Bras et al., 2006)[54]. This suggests selective perception of elements resembling French experience within a complexly regulated public German DMP that, admittedly, offered few transposable aspects. In the perception of such (non-)transferability, practical aspects of "who and how" may have played a role: the second head of the strategy department notes that "*Germany had chosen another mode of action; they did not have the means to provide France with a coaching service*" [FR3, p. 3].

Although the explorations with Germany may have provided interesting contrasts and insights, the US experience and model finally convinced the critical mass of decision makers. According to a senior actor, Van Roekeghem was looking for something with a "*good return on investment*" (in practice: a delay of hospitalisations), and for diseases like diabetes they concluded that the evidence was sufficient [FR12, p. 4]. Consequently, SHI contracted with a private US provider to help them set up the phone coaching service Sophia for people with diabetes.

3.4.3 Assuming a solitary role

Subsequently, SHI could proceed without major obstacles. As the second head of the strategy unit stated, Sophia was shouldered "*exclusively*" by SHI and the IGAS work, with MoH being

[54] In fact, the actual role of patient education in German DMPs may even be less important than what was foreseen by regulators. A former SHI and CC actor in Germany argues that patient education components are "*not as strong as necessary*", that little is known about real-life practice, which is a "*black box*", although it has been properly set out in the initial regulations [DE4, p. 2-3].

neither implicated nor in charge of "*any tool of this nature*" [FR3, p. 3]. Likewise, an IGAS actor states:

> "*I was surprised to see at what point SHI seized the opportunity. Later, I told myself that SHI is better than MoH; SHI understood the political interest and institutional positioning they could draw from it, which MoH had not seized. MoH was neutral on this subject. SHI was proactive.*" [FR2 p. 5]

Such dynamic action in addition to the legislative scope that SHI had already been granted may be explained by the determination of its director, overriding arguments by other institutions. A senior SHI actor interpreted the IGAS report as demonstrating that "*they were quite convinced something like this had to be implemented*", but assumed that IGAS actually wanted HAS to undertake this effort. Finally, SHI had felt it was operationally better placed to do it [FR12, p.4] and did so without further major input by HAS. Likewise, a former DSS actor "*agrees with the IGAS report*" that "*it was not up to SHI to do it*". Personally, she did not "*believe in it*", the "*telephone thing with non-selected patients*". Conceding that Van Roekeghem had undeniably "*transformed SHI in ten years*", she claimed that he "*wants to control everything*" and "*is not used to being contradicted*" [FR5, p.10]. Consequently, there was no formal role for DSS either, and SHI "*did what they wanted to and informed us [DSS]*". She expresses scepticism about the evaluation results, arguing that SHI "*had to say it works, and then generalised*", specifying that Van Roekeghem employed the logic of French administration to "*not wait for clear results of a public policy before generalising*". She caricaturised him: "*I did something that works, even if it's not optimal I continue because I want to show I did a good job*" [FR5, p. 11][55].

3.4.4 IGAS: an explorative approach

The role of IGAS differed substantially from that of SHI. The initiative for the 2006 report came from the two authors themselves who put the subject on the internal IGAS work plan, which was then discussed and validated by MoH. One of the authors describes that the idea was original, not based on a specific need, but on a prospective approach to international literature: based on interest, on "*research without hypotheses*", with an "*open mind*" [FR2, p.

[55] A former SHI actor qualifies this by noting that, for the first evaluation, SHI chose process indicators "*with the idea that with outcome indicators you would not see much, on a short time horizon we would risk concluding the programme is not efficient*", underscoring that the literature indicates that such a programme shows its effect after 7-8 years [FR8, p. 12].

1-2]. The profiles of the authors, who had shared an office at IGAS for many years, can be described as complementary. The lead author, Pierre-Louis Bras, is an alumnus of ENA, which traditionally trains the elites in central administration and politics, and he has occupied senior ministerial posts in social security and the health sector. Gilles Duhamel, by contrast, is a former hepatologist with experience in the pharmaceutical sector, health agencies and ministerial cabinets. Both have authored several IGAS publications together. These two senior actors were joined by a junior inspector, Etienne Grass, who was also trained at ENA.

Without "*fully understanding how things feed into each other between SHI and IGAS*", a former SHI actor describes the decision for a DM mission was probably made during a meeting between DSS, IGAS and SHI. He argued that both Van Roekeghem and Bras may claim the initial idea [for DM] for themselves [FR7, p. 1]. A participating IGAS actor said that they wanted to include someone at HAS with whom they had previously worked, but did not remember how the linkage with SHI came about. He described the mission as "*let's go together and see what we all think*", instead of the more "control-my-turf" logic he describes as prevalent in the face of transversality in public policy [FR2 p.1]. The choice of Germany had been in part chance-driven because one of the inspectors spoke German and could identify initiatives to examine [FR2, p. 3]. Hence, while it appears that the idea to closely examine DM experiences abroad emerged concomitantly in several institutions, it is clear that the motivations of SHI and IGAS for the DM mission did not align: SHI was on a targeted search for a clearly circumscribed instrument for their new risk management role, while IGAS had an open-ended explorative approach. Unsurprisingly, there were different conclusions. We will later explore the diverging opinions on the role of nurses. Moreover, while the IGAS report did not formulate concrete elements for DM pilots in France, it recommended a wide stakeholder discussion under the auspices of the High Council for the Future of Health Insurance, HCAAM[56] (Bras et al., 2006), which never took place. Among other factors, this may explain why IGAS ultimately "*did not really support SHI with Sophia*", as noted by a former SHI actor [FR7, p. 8].

[56] *Haut conseil pour l'avenir de l'assurance maladie,* an independent advisory committee that publishes a yearly report on the status of the health system.

3.5 Patients: mutual support and personal affinities in France, exclusion in Germany

A senior SHI actor reports strong support from patient organisations that initially had to be reassured that Sophia was not about expenditure cuts; "*thanks to their support we could make it happen*". She explained that alongside Sophia, SHI financed expert-patient groups founded by the diabetes patient organisations. These were not in competition with Sophia but complementary and part the strategy, since Sophia should also refer/orient patients towards local resources [FR12, p. 6]. An SHI actor with operational responsibility for Sophia added that this support by the patient organisations was decisive because SHI could "*say the entire time that patients were with us*" [FR4 p.1].

> *"Everyone knows I supported Sophia; … maybe if I had not been there, Sophia would not exist" [FR10 p.1].*

Indeed, the support of the French Federation of Diabetics (FFD, previously AFD) was explicit and quite institutionalised; it also relied significantly on the person of its president, who is an elected patient representative at SHI pursuant to the 2004 Act. He explained that diabetes is important at SHI due to "*its evolution, cost and complications*". He added that there had been a joint reflection process with the SHI management since 2005/2006 about the improvement of diabetes care, with the patient organisations reflecting in parallel about a peer support programme [FR10, p. 1]. The FFD president said he was part of an initial inner circle composed of SHI, UNOF-CSMF and FFD, with rather informal meetings in Van Roekeghem's office [FR10, p. 2]. He described a "certain affinity" with the UNOF leader Michel Combier, with whom he had worked previously in Toulouse. He also actively supported SHI by facilitating the piloting work in his home region, Midi-Pyrenees [FR10, p. 6].

The FFD president described how Van Roekeghem was enthusiastic about the experiences in the USA and Germany and had summoned him to his office to announce that SHI would opt for telephone coaching, arguing that SHI should adapt the US experience in a French way [FR10, p. 2]. He said the SHI director had already further plans: "*when Frédéric Van Roekeghem has an idea, there are already three others in the back of his mind*" [FR10 p.1]. He suggested that one may have been the diversification of GP payment, with the flat payment for data transmission that Sophia physicians receive representing a prefiguration of P4P [FR10, p. 2]. Likewise, the discussion had been about a pilot, but "*everyone knew it wasn't one*" [FR10, p.

2]. He described telling the other actors that it was preferable to join and contribute than to oppose SHI and have them do it alone [FR10 p. 5].

> *"SHI must evolve to keep its 2004 role. Chronic care is too severe to be left to doctors." [FR10 p.6]*

It is striking the degree to which the FFD president adopted similar talking points to SHI, evoking, for example, "AFD's [FFD's] vision of behaviour change facing diabetes, including that of GPs" [FR10, p. 4]. This may stem in part from the fact that FFD itself ran a "Diabetes Hotline" that was stopped when their focus shifted to peer support; so there was awareness of the perceived need of patients to have exchanges on the phone. The FFD president described Sophia as an opportunity to train "*in our way*" non-specialised nurses to become coaches and listeners [FR10, p. 1]. "*At the beginning they were nurses, now they are coaches*", he said, using language similar to that of SHI [FR10, p. 2]. He used technical language to argue that the population must be segmented and the intervention adapted ("*obliged to segment*") and conceded that Sophia does not reach the socially deprived population [FR10, p. 3]. His confidence about FFD's role in Sophia was also evident by his interpretation that the IGAS report concluded "*it should not be SHI but the patients who run Sophia*" [FR10, p. 6], a statement that *per se* is not included in the said report. Overall, he saw Sophia as a "*nice human adventure, quite revolutionary in our cooperative system*" [FR10, p. 6], reinforcing the impression that FFD had a sceptical stance with regards to the medical profession.

However, the clear positioning of the FFD president is nuanced when he describes how FFD accepted phone coaching with a "*why not*" attitude, as long as there was no "*surveillance*[57]" of patients [FR10, p. 1]. This suggests that there may have been critical voices, and that the actor had to balance his support with considerations about legitimacy with peers and partners from his constituency. That notion is substantiated by his description of "leaks" about the plans of the "inner circle", which is why he personally had to summon all actors from the diabetes arena who were suspicious, implicitly asking "*what do you do in the evening at SHI?*" [FR10, p. 2]. This, again, suggests the FFD president had a high individual and institutional commitment that is further illustrated by his acknowledgement that "*we* created a scientific board" [FR10, p. 2], which was necessary to "stabilise things" [FR10, p. 6]. These implications

[57] *Flicage*, the idea that information is collected in a police-like manner

are best summarised by the actor himself: "*we are victims of our success*" [FR10, p. 3]. It appears that, in addition to his commitment, the FFD president saw this as a window of opportunity for patients, suggesting that other actors had "*complicated relations*" with SHI [FR10, p. 5].

The situation was different in Germany, where patient organisations had no formal role in the introduction of DMPs. A former senior MoH actor maintained that patient organisations for diabetes "*were and are pharma-contaminated*". He said that this facilitated the introduction of DMPs via the law-making process, since it was seen as a way to ensure a certain degree of transparency [DE3, p. 3]. Likewise, a former SHI and CC actor said that, although the direct influence of patient associations was minimal, the influence of lobbies on them was well known. He explained that the German Association of Diabetics (DDB) "*massively criticised*" the development of DMPs [DE4, p. 6]. Indeed, a 2002 public statement by DDB called for rejection of DMPs that do not include the BÄK-backed national diabetes guidelines[58] (Deutscher Diabetiker Bund, 2002).

These striking differences between the roles of patient organisations in France and Germany underscore potential structural differences, one of which is financing. In France, FFD received direct payments by SHI. The declared 2010 revenues of FFD (total: €1.8 million) relied mostly on private donations (50%), with 22% from companies (based on advertisement sales) and only 9% came from MoH and SHI. In 2013, according to a public database, FFD received €492,000 in donations from the health industry, ranking first among all French patient organisations[59]. Another important actor in the sphere of patient organisations in France is the Inter-association Collective of NGOs Acting for Patient Rights (*collectif interassociatif sur la santé, CISS*), whose head Christian Saout has been a constant critic of private practice physicians. Unlike FFD, in 2014, CISS received 78% of its total budget (€2.8 million) from MoH and 7% from SHI[60]. This budget scheme has led critics of CISS (in this case, a GP blogger) to suggest that the head of the Collective may actually "serve" the interest of regulators[61]. Although this represents a solitary opinion, it most likely illustrates the problematic and

[58] See section 4.1for more background on guidelines
[59] http://www.has-sante.fr/portail/jcms/c_1768212/fr/declarations-des-aides-versees-aux-associations-par-les-industriels-de-sante-la-has-publie-les-chiffres-2013
[60] http://www.leciss.org/qui-sommes-nous/budget-du-ciss
[61] http://enattendanth5n1.20minutes-blogs.fr/archive/2010/02/12/patients-si-vous-saviez-qui-vous-represente-au-sommet-de-l-e.html

conflictual relationship between physician and patient organisations. In Germany, no statement about the budget structure of DDB could be found in the public domain. However, two important firms producing analogous insulin (Novo Nordisk and Lilly) were among the DDB sponsors during the period in question[62], and the former pharmaceutical industry lobbyist Heinz Windisch[63] became president of DBB in 2008. A 2006 report by researchers of Bremen University estimates the overall level of private funding of German patient organisations at 24% in 2004 (Schubert and Glaeske, 2006).

It is impossible to undertake an exhaustive exploration of the financing of patient organisations in France in Germany. With the presently available data, the only preliminary conclusion we can draw is that pharmaceutical industry financing of patient organisations for diabetes seems to be similarly important in both countries. Ultimately, the essential difference for purposes of this study may be the expected impact of the respective DMPs on prescriptions for enrolees, suggested by higher drug spending in France and lower costs in Germany. As discussed in section 4.1.3, a working group for the diabetes DMP in Germany recommended the use of established rather than newer (and more expensive) drugs. Conversely, in France, the available evidence from evaluations of the programme precursor in the USA clearly showed that drug spending for programme participants increased compared to controls (Wennberg et al., 2010), which is explained by increased compliance with prescription guidelines. Indeed, the evaluations of Sophia showed similar results, although at a low significance level (CNAMTS, 2015). Assuming an influence due to industry funding, the positioning of diabetes patient organisations with respect to DMPs may gain meaning. However, investigation of such a link is beyond the scope of this thesis. Further long-term implications of patient organisations will be discussed in section 9.1.3.

[62] http://www.aerzteblatt.de/archiv/57598

[63] Representing Abbott Diabetes Care as Head of Professional Relations, https://de.linkedin.com/in/heinz-windisch-67279245

3.6 Interim conclusion

Some key differences are evident in term of the overarching impetus and lead actors of DMP reforms. In Germany, there was a high density of inter-related reforms of which DMPs constituted some sort of crystallisation point, while the French DMP reflects the continuity of a series of SHI measures, set within a logic that found its prolongation with the P4P programme (see second part of the thesis). Yet, it is necessary to understand whether (and if so, how) these developments were structured by health professionals and the themes of importance to them.

4 Professional coalitions

The pattern of action in this group is mainly (but not exclusively) structured around opposition to DM, although we will see that this discussion is only the tip of the iceberg. The key issue, relatively similar in both countries, is the question of how the medical profession should position itself with respect to the increasing "intrusion" of State and SHI into doctors' regulatory authority. This must be understood as an almost inevitable re-negotiation of social rules within the far-reaching shift of governance towards a tighter regulation of clinical practice. Traditionally, this governance has been characterised by self-regulation, allowing physicians considerable autonomy over their work. In contrast, the new, micro level instruments of governance strengthen public accountability and are based on the logic of hierarchy (Burau and Fenton, 2009).

Against this backdrop, the observed arrangements in Germany and France differ substantially, owing to underlying differences in their corporatist structures. Hence, in Germany, we note a cleavage within physician groups and their representatives with, initially, the expression of strong scepticism. This debate was particularly heated and often emotional because DM was closely linked to more general lines of conflict within the medical profession, most prominently linked to the question of clinical guidelines, which became "institutionalised" (and thereby more binding) through DMPs. Yet, the particularity of the German corporatist system is the close integration of physician representatives in the joint self-regulating bodies, with decision power over funding modes and volumes, among other areas. Following this logic, KBV leaders backed DMPs, with the further incentive of potential financial gains and the goal of preserving their role as legitimate co-regulators. At the same time, critics were able to identify with BÄK and its leadership, who ultimately withdrew from the negotiations, or to externalise their ambivalence via the "blame figure" Peter Sawicki (an expert physician for clinical guidelines).

By contrast, the inclusion of French physicians in regulatory decision-making is far less institutionalised. The guiding theme structuring the relationship between ambulatory care physicians and SHI is the principle of "liberal medicine", in which the dyad doctor-patient is subject to limited interference by third-party payers. Collective agreements between doctors' unions and SHI are often conflictual, and fragmentation among the unions has led to varying constellations between partnership and conflictual opposition with SHI. As a result, the major

union MG France did not even position itself publicly regarding Sophia, while its competitor UNOF-CSMF became a (temporary) ally of SHI. This window of opportunity was also reinforced by the fact that major discussions about clinical guidelines had already been held (and in fact Sophia contained few elements of evidence based medicine, EBM), so that Sophia was not perceived as a high-conflict subject. Moreover, it received upfront and strong backing by patients, reducing the margin for challenge.

The price to pay, as suggested here, is an overall decrease in the cohesion of the medical profession in both countries.

4.1 The professional coalition in Germany: a continuation of related themes, deepening the divide between doctors

The initial, significant tensions within KBV are indicative of the fundamental debates and currents in the wider physician and scientific community at the time; indeed, DMPs may be viewed as a manifestation or even culmination of these issues. The themes, often overlapping, are centred on EBM and the derived clinical guidelines; the autonomy of the physician vs. external regulatory control, as illustrated by "struggle" over control of data; and the role of the pharmaceutical industry.

4.1.1 Ambulatory physicians: deepening fracture lines

If the positioning within SHI was characterised by an initial split, the ambiance within the self-regulatory body of ambulatory SHI physicians can be described as highly conflictual and ambivalent throughout the process leading to the introduction of DMPs. This environment is illustrated by the language used by the former KBV head (2004-2014), describing the events at the "*famous German Medical Assembly in Rostock*" in May 2002[64]: he (at the time vice president), the KBV president in office and the head of department for general matters favoured DMPs, and he said that "*there were considerations to fire the three of us*". The discussions were "*hefty, emotional and tied to persons that either liked or disliked DMPs*", and they were reproached for their "*betrayal of physician ideals*" in what was a "*terrible discussion*". In particular, professors of diabetology proclaimed structured programmes with specific requirements as "*betrayal of the pure doctrine as propagated in universities*". The former KBV head said that a "*very small group*" (to which he belonged) was in favour, based upon the additional financing, as well as the care deficits pointed out by SVR. According to him, their mindset was to co-design rather than to have the reform imposed. Yet, power considerations played a very important role and continue into the present, as illustrated by the rhetorical question: "*do we deliver ourselves to SHI?*". He notes that with DMPs "*it started that SHI has a say when determining 'what is quality', which is not unproblematic for a free profession*", explaining that it was perceived as a threat. Reflecting on the consequences and expressing his own ambiguity, he qualified the introduction of DMPs as a "*change of era*", an "*intrusion*":

[64] The German Medical Assembly (Deutscher Ärztetag) is the annual meeting of the Federal Physicians' Chamber. The State Chambers of Physicians send a total of 250 delegates who discuss and adopt cross-state professional regulations and formulate the positions of the medical profession on current health-related and socio-political debates (http://www.bundesaerztekammer.de).

"*since then SHI co-determines almost everywhere what quality in physician practice is*". Likewise, he adds that the CC was perceived as contributing to the external control of doctors [DE6, p. 7].

The ambivalence of KBV was also expressed in its relations with other actors. After the initial draft of the RSA reform act provided that SHI alone would define the requirements of DMPs, KBV outlined their own DMP concept, which they hoped to offer in competition to SHI's DMPs (Erler, 2002). Eventually, the final draft of the act stipulated that CC (which includes KBV) must define the DMP requirements. In a subsequent statement describing an alliance with patient organisations, KBV drew legitimacy from it by stating that "*patients apparently … wish a ruling hand*", which implicitly suggested that this should be the role of physicians (Maus, 2001).

Adding a layer of complexity, a senior researcher (health economist and physician) said that the position of physicians was also moderated by a wait-and-see attitude, since many anticipated that the Social Democratic/Green government would not be re-elected in the 2002 elections and that a new (conservative) government would stop DMPs, which ultimately did not happen [DE1, p. 2].

> *"There were indeed regional associations of SHI physicians, in particular North Rhine, that actually were in favour [of DMPs] but were 'whistled back', although their majority was in favour, and they said: 'OK we will see how the elections go', and then in a way they started at the very election evening, when it was obvious that 'petering out'*[65] *was not an option" [DE1 p.2].*

Thus, KBV ultimately participated in the preparatory work within CC on the DMP regulations. The former KBV head describes that KBV "*did it with its own juice*" and very quickly. They relied upon the literature, but there was no explicit structured dialog with experts. Limited input came from the directors from the US ODP-network[66], a "*RAND-like structure*" that "*explained what DM is*". He described KBV's development of a specific IT-tool in preparation for the electronic documentation, with insiders suggesting they should receive "*€30 for 1 min of documentation*" [DE6, p. 8].

[65] "*Im Sande verlaufen*"
[66] Office of Disease Prevention (ODP) at the National Institutes of Health (NIH), https://prevention.nih.gov/

Economic considerations also appear to have played a major role for KBV as an institution. In the opinion of a former SHI and CC actor, KBV was "*initially highly sceptical*" until they figured that DMPs would result in an "*excellent additional income*" for ambulatory SHI physicians. Thus, "*resistance crumbled suddenly*", at least within the GP fraction, and the remaining opposition was merely procedural, "*not ideological-fundamental anymore*", focusing on aspects such as documentation requirements [DE4, p. 2]. Likewise, the former KBV head considered it a "*success model*", pointing out an additional €560 million in revenues for physicians, the improvement of care and complications and the fact that at present a DMP for depression is being discussed. Returning to his ambivalence and seeming to try to convince himself, he stated:

> "*It was hefty. The first time that SHI was actively involved in quality assurance. Was it right? Yes*" [DE6, p.8].

4.1.2 The epic of Peter Sawicki and the de-professionalisation of debate

A former SHI and CC actor suggested a link between DMPs, the "*promotion of the cognitive sphere of EBM*" and the evolution of guidelines, noting that guidelines reflect the interests of specialist physicians to a greater extent than DMPs [DE4, p. 6]. Likewise, according to a researcher, DM was considered as a means of integrating the "*tender plant EBM and clinical recommendations*" as well as patient self-management support into clinical care [DE1, p. 1].

We have already examined the position of MoH with regards to guidelines, which were strongly promoted. One could expect that the MoH's position would spark resistance by physicians, a matter we will address further. Yet, a first-order issue with the use of evidence-based guidelines in DMPs concerned more empirical questions. The debate was centred on the figure of Peter Sawicki, head of working group on diabetes in the CC. According to a former MoH actor, Sawicki was the lightning rod in the "*dispute of schools*", with the Düsseldorf diabetologists Pr. Michael Berger and Pr. Peter Sawicki against "*the rest of the world*", which structured later arguments that were never resolved [DE3, p. 3]. In fact, the dispute featured Sawicki as head of the Institute for EBM (DIeM) versus the German Society for Diabetes (DDG) on matters such as the question whether HbA1c values as an indicator of blood sugar levels should generally be aimed at a low level (<8%) (Richter, 2002).

A former SHI and CC actor explained that this dispute was taken to the CC, where Sawicki used his previous work on clinical guidelines for diabetes, which were integrated into the regulations "*to a significant extent*". The actor described this as an "*affront*": that a group of physicians had elaborated content upfront, in concertation with SHI. He says this differed from previous practice, where SHI would wait for and comment on physician initiatives in committees. He explained that a prominent figure in German EBM, ÄZQ-leader Günter Ollenschläger, co-led the design and guided the discussions on behalf of physicians, thereby "*striking the balance between EBM and physicians' interest*". He said the fact that ÄZQ later developed specific guidelines for DMPs provided a means to "*regain interpretative leverage*", given that ÄZQ is a joint institution of KBV and BÄK and not dependant on other actors [DE4, p. 5].

It appears, however, that Sawicki was balancing on a tightrope, attempting to reconcile positions that may have been unsatisfactory to the respective parties in three aspects: first, too administrative for practitioners; second, too great a compromise for the EBM-community; and third, too evidence-focused for specialists. The first point was supported by a researcher who stated that KBV initially saw DMPs as "*cookbook medicine*" leading to a "*glass physician*", thus rejecting it and applying the arguments against EBM, since "*DMP is an implemented guideline*" [DE2, p. 2]. Similarly, a former MoH actor explained that the term "*cookbook medicine*" was also used by former BÄK head Jörg-Dietrich Hoppe to oppose DMPs and was part of the "*turmoil*" at the Rostock Medical Assembly [DE3, p.4]. At the same time, a former SHI and CC actor argued that EBM as such was highly debated since Sawicki, as a "*bone-dry methodologist*", was "*public enemy number one*". However, he also was head of an Internal Medicine department in a hospital, a credential which helped to convince many critics [DE4, p. 4]. Similarly, the former KBV head noted that Sawicki had very clearly commented on the deficiencies of the care system and had been "*pulled aside by SHI*", leading to polarisations portraying him as an "*enemy image*" and "*staining the nest*" [DE6 p.7-8].

With respect to the view that DMPs were too compromising for the EBM-community, the former SHI and CC actor argued that "*by making EBM widely acceptable via DMPs, concessions have been made*" in the DMP regulations. He said this indicates that the "*power of definition*" had been transferred from the EBM community to the self-regulating bodies. He adds that it was "*politically wanted*" that the dispute about content be held within these bodies and not

centrally and that they were "*consensus papers*" [DE4, p. 4]. Concerning the point that DMPs were too evidence-focused for specialists, the former KBV head said that the discussions between Sawicki and professors of diabetology about the pertinence of HbA1c as a diabetes care parameter was "*observed sceptically*". According to this actor, "*it was for the first time a broad discussion: what is quality of physician practice, how to measure it, what is needed in terms of documentation and organisation*" [DE6, p.8].

Each of these accounts suggest that the establishment of a new discussion and negotiation forum (the CC) outside of the proper medical sphere and the subsequent opportunity for common interests and compromise with SHI led to Peter Sawicki's positions being perceived as de-professionalised and alienated from his former peers, which deepened the divisions within the physician community.

4.1.3 The "pharma-dispute"

The tensions between Sawicki and his opponents culminated in the refusal to integrate the national diabetes guidelines, developed with backing by BÄK, into the DMP requirements. In fact, the CC had developed minimal requirements for diagnosis and therapy, based on the work of Sawicki and backed by KBV (Stillfried et al., 2002) and SHI. Yet, they were not accepted by parts of the physician community, and in May 2002 BÄK and the savant societies published a rapidly-developed national guideline. The controversy was centred on drug therapy, with members of BÄK claiming that the CC document called for treatments "*based on old-timer drugs*" (Richter and Gerst, 2002).

Industry reportedly had a direct influence on the draft of the national guidelines [DE3, p. 3] and allegedly financially supported their development (Dammert, 2003). A former MoH actor contended that, at the introduction of DMPs, there were "*gigantic efforts*" by the pharmaceutical industry to influence drug recommendations for diabetes [DE3, p. 3]. He said that industry "*was mad*" because CC prescription guidelines for DMPs ultimately recommended cautious use of insulin, put an emphasis on diet and exercise and did not promote new drugs. The issue affected not only the interests of the pharmaceutical industry but also traditions within the care system: he described DMPs as being in stark opposition to the dogma that "*you see the doctor, take a pill and you are healed*" [DE3, p. 4]. A former CC and SHI actor added that the dispute about certain drugs and insulin formulations continues, suggesting that the

pharmaceutical industry and experts commissioned by them may play a role as they do with respect to EBM and savant societies [DE4, p. 3].

These elements illustrate how divisions among physician representatives were deepened, on the one hand by the external influence of industry, and on the other hand through internal convictions and perceptions about appropriateness and need of certain treatments. It also shows how state actors stepped in the resulting vacuum and thereby strengthened their own positions. While these questions were exchanged in a forum of actors for whom the concepts of guidelines and structured care were already accepted, the next sub-section briefly assesses the nature of the divide among physicians with respect to EBM and DMPs, which are seen as a means of external control.

4.1.4 The divide of physicians over external control and the "data-struggle"

The key challenge physicians faced with the introduction of DMPs was described by the former KBV head as "*transducing the individual doctor-patient relationship with many degrees of freedom into a structured care programme*" [DE6, p. 7]. This statement characterises the fundamental debate across all physicians' organisations. However, it is not limited to DMPs (the "implemented guideline"), but also extends to EBM. The two overlapping concepts represent a loss of autonomy for the individual physician and a modification of the traditional core of the care system, the doctor-patient relationship.

As we saw earlier, this often led to emotional and personal disputes between physician representatives, suggesting that the subject touched the "hardware" of medical professional identity. This and the fact that there was a "progressive" and "conservative" wing within the community does not, however, seem surprising and certainly mirrors the experiences many health systems faced at the advent of EBM. Moreover, EBM was most likely not generally viewed as a means of external control. Despite the regular polemics at the German Medial Assembly and elsewhere, it had been supported by the self-governing institutions and promoted through BÄK and KBV through a joint guideline programme since 1997 (Ollenschläger et al., 2000)[67].

Therefore, it was probably not only the external control through EBM and DMP *per se* that sparked resistance. Opposition was amplified by another factor that structured perceptions

[67] An exhaustive analysis of the history of guidelines in Germany and France can be found in (Weckert, 2013).

and debates: the overarching idea that state regulators were using care delivery tools as a means for *other* regulatory goals. This was clear in the opening press release of the Rostock Medical Assembly entitled "humaneness instead of economisation", in which BÄK president Hoppe stated:

> *"Coupling DMPs with RSA shows a fatal linkage of medicine and economisation. The danger is great that the chronically ill will only be dealt with as cost and norm figures in the financial allocation between sickness funds, with care programmes becoming an administrative decree of a medicine steered by SHI. The profession must not be crushed by pure economisation. Otherwise, the 'dream-job physician' will turn into a 'nightmare-job'."* (Bundesärztekammer, 2002)

In fact, government delivered a clear point of attack by entitling the act leading to the introduction of DMPs "Act to Reform the Risk Structure Compensation Scheme in Statutory Health Insurance". In the introduction to the text, it stated that "*through short term measures, the compensation of burden between sickness funds shall be improved, creating at the same time incentives for improvement of care in particular for the chronically ill*"[68]. Hence, the fact that DMPs could easily be perceived as a "by-product" of RSA and were introduced nationwide under high time pressure may indeed have hurt the pride of the medical profession and explain the personal reactions. DMPs entail issues of high relevance that, in the eyes of the profession, warranted more dedicated and longer debate. At the same time, one can argue that by being transparent in their motives, government and SHI as initiators of DMPs avoided being blamed for hypocrisy. Likewise, discussions about the medical value of DMPs did indeed take place on a political (or at least, public) level.

4.1.5 The "data struggle": who has the power of information?

Finally, the notion of external control found a very concrete correlate in the "data struggle" between KBV and SHI. In this conflict over data collection within DMPs, SHI initially proposed a small dataset, while KBV refused to collaborate. Reflecting KBV's ambiguity, a researcher argued that KBV then put forward a proposition that "*there should be more documentation*"

[68] Deutscher Bundestag, Drucksache 14/6432, 26. 06. 2001: Gesetzentwurf der Fraktionen SPD und BÜNDNIS 90/DIE GRÜNEN. Entwurf eines Gesetzes zur Reform des Risikostrukturausgleichs in der gesetzlichen Krankenversicherung.

on the hypothesis that this would "*kill DMPs*" or that it was out of vested interest since eventually there was a compromise in which KBV also received data [DE2, p. 3]. Likewise, the former KBV head stated that while DMPs "*left data to SHI*", KBV negotiated the "*split dataset*" [DE6, p. 7]. The underlying concerns over handing data to SHI may be linked to at least two factors. First, according to an analyst, physicians feared that SHI would use service utilisation data to identify and sanction physicians, even potentially excluding them from collective contracting (Erler, 2002). Second, a researcher explained that physicians also feared that, through the data collection, outcome quality could eventually be used to determine remuneration, and that physicians would be "controlled" by SHI as is the case for HMOs in the USA [DE2, p. 4]. The issue of remuneration also rose later in the context of P4P, and KBV's role in this regard is discussed in section 7.2.1.

4.1.6 Interim conclusion: good docs, bad docs

This discussion of the various issues within the wider physician community with respect to DMPs highlights a recurrent theme: the growing influence and proactivity of SHI in relation to KBV and the question of how physicians should position themselves in this respect. One aspect that explains the often emotional debate may be the long history of this duality, dating back to the 1883 law that made health insurance mandatory for certain employees (Busse and Riesberg, 2004). The fact that the power relationship is mainly constituted by a dyad makes it particularly vulnerable since it is more difficult to counterbalance shifts by new alliances. We did indeed see that KBV tried to "recruit" patient organisations as at least temporary allies in its move to re-gain influence in the DMP process. And, the medical profession at large was weakened through its ties with industry and frequent changes of position that deepened its divisions.

Yet, it is worth noting that to a certain extent this division has maintained a certain functionality. In fact, in the aftermath of the "pharma-dispute", BÄK (which only recently had become a member of the joint self-administration), had withdrawn from the negotiations in the CC. For Burau and Fenton, this represented a division of labour in the sense that it helped to strengthen the legitimacy of the joint self-administration: BÄK with its herald Hoppe became "*the host for expressing views that are highly critical of DMPs*", while KBV was empowered to "*demonstrate its moderate and constructive stance*" (Burau and Fenton, 2009). This dynamic,

however, is changing due to the growing influence of MoH and other actors gaining influence in the CC (and its successor GBA).

Epilogue: the diverging political fates of the protagonists Sawicki and Lauterbach

Although Sawicki was the first head of the IQWIG institute[69] when it was founded in 2004, his position was continuously weakened. He was not re-elected in 2010 due to claims about the improper use of his professional vehicle. Centre-left media interpreted this as a pretext by the conservative coalition government elected in 2009 (CDU/CSU and FDP, in office from 2009 and 2014) and suggested that politicians within FDP desired an IQWIG head who was more "industry-friendly" than the notorious "pharma-critic" Sawicki (Bartens and Bohsem, 2010; Hackenbroch and Elger, 2010). Indeed, both ministers of health of the coalition term were FDP members (Philipp Rösler and Daniel Bahr), and the liberal party's 2009 election programme noted that the "*health economy still is a growth market, but restricted through many regulations. Bureaucratic, centralistic solutions prevent competition that increases efficiency and innovation*" (FDP, 2009).

After the end of his mandate, Sawicki started to work as a senior scientist in the Cologne institute of health economics, headed by Lauterbach. The latter put an emphasis on his political career and became a member of parliament in 2005 (SPD) and the health policy spokesman of SPD from 2009-2013. Since 2013, he has held the position of vice chairman of the SPD parliamentary group[70]. While he, too, maintained a critical attitude towards the pharmaceutical industry, it appears that his rhetoric helped him to gain electoral success, for example, by pointing the finger at the profit-seeking behaviour of pharmacists (Rücker, 2005). In addition, he authored three books aimed at a general audience, focussing on the main themes of system inequity through private insurance and the influence of business. His last book, "the cancer industry", was ranked on the renowned Spiegel list of bestselling books in 2015[71], indicating a wide common popularity while also earning critical acclaim from the pharmaceutical industry lobby (Sucker-Sket, 2015).

[69] The Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, IGWIG) assists the Federal Joint Committee in its decision-making. The Institute is financed by the stakeholders in the system of joint self-government. Its primary task is evaluating the efficacy of drugs as a basis for determining whether or not a drug falls under the reference price scheme It also writes scientific reports and statements on questions regarding the quality and efficiency of SHI benefits (Busse and Blümel, 2014).
[70] http://www.karllauterbach.de/person.html
[71] http://www.amazon.de/Die-Krebs-Industrie-Krankheit-Deutschland-erobert/dp/3871347981

4.1.7 EBM: closely tied to DM in Germany, but different timing and actors in France

We have set forth the strong linkage between EBM and DM in Germany, where DMPs are considered by many actors as an "implemented guideline". By contrast, the idea of structured clinical recommendations was not part of the 2008 debate and introduction of the French DMP Sophia. This most likely stems from the fact that clinical guidelines already were on the health policy agenda, as reflected in the creation of HAS in 2004.

Rolland and Sicot have written a clear and critical analysis of the history of EBM in France and clinical guidelines as their operational form (Rolland and Sicot, 2012). The movement started among North American academics in the 1970s, who aimed to use the best available scientific data to inform clinical decision making. According to Rolland and Sicot, this coincided with increasing concerns by French State and SHI who were increasingly regarding health expenditure and how medical practice could be regulated. By including physicians[72] in these efforts, the Agency for the development of medical evaluation (ANDEM) was founded in 1989 as a first "*institutionalisation of EBM in France*", tasked with the diffusion of guidelines of learned societies. The latter viewed guidelines also as a means to legitimise certain practices that were not in line with the regulator's goal of budget control (Rolland and Sicot, 2012).

Over time, State control over health expenditure tightened, and the Agency (renamed ANAES after gaining competencies for accreditation) fell under more direct ministerial control. Concomitantly, mandatory clinical guidelines (*référence médicale opposable*, RMO) were issued, making it possible to sanction physicians if scientific criteria are not respected. After strong resistance by the profession and a decision by the Council of state, RMOs were abolished in 1999. HAS was founded in 2004 with a mission that extended to economic evaluation, thereby adding the issue of efficiency to that of effectiveness. According to Rolland and Sicot, HAS produces, co-produces, promotes and diffuses clinical guidelines as a means of "*regulation based on communication towards practitioners*". This is endorsed via regulation through "responsibilisation" of physicians undertaken by SHI through peer interviews, where SHI-employed physicians visit ambulatory care doctors and promote guideline-based care (see also case study on P4P). Rolland and Sicot conclude that the force of this kind of regulation of

[72] The union MG France was tasked with a report on medical evaluation in 1988 by the health minister Claude Evin.

clinical practice through guidelines is due to the absence of constraint in favour of a promoted "partnership" between State, SHI and physicians (Rolland and Sicot, 2012).

4.2 The professional coalition in France

With this in mind, the role of health professionals in the introduction of Sophia clearly differs from the debates in Germany. Important institutional developments concerning the question of EBM had already taken place in France, and despite anticipated protest over a direct link between SHI and patients, there was little public resistance by GPs except for scepticism expressed by individual practitioners.[73] At the same time, vivid criticism was voiced by the representatives of diabetologists, who left the Sophia scientific advisory board they had initially joined. Since it is unclear whether all segments of the medical profession have a shared understanding of the aforementioned "partnership" between State, SHI and physicians, the following sections will also consider the wider reform agenda with respect to the regulation of GP practice, before addressing the relevance of the French and German DMPs for other health professionals, in particular nurses.

4.2.1 The reaction of physicians as anticipated by SHI

> *"… the crazy idea that that a phone call can change things as profound as health care behaviour." [FR11 p.3]*
>
> *"Sophia exists in parallel to proper medical activity." [FR6 p.3-4]*

SHI was well aware of the implications Sophia had for the health system by establishing a direct link with patients, which a senior SHI actor describes as the "*intrusive role*" of SHI. While not competing with doctors but eliminating the need for the insured to pass through them, Sophia was a way "*not to put everything in the hands of doctors*". The actor normalised the initiative, noting that people in fact already encounter other sources of health information outside of the formal health care system, such as new technologies [FR12, p. 5].

As anticipated, there was opposition from doctors. It was most visible among diabetologists, whose head of the professional association stated that he would have accepted the initiative if it were piloted within the health care system. Yet, he argued that Sophia did not communicate with the rest of the health care system, bypassed the actual problems and reflected SHI's desire to "*organise another care system*" [FR11, p. 2]. Similarly, the former CSMF head argued that his union was "*very reserved*" because Sophia was a "*system at the margin of medical*

[73] The fact that that the regulation of clinical practice had been negotiated elsewhere and that Sophia had *de facto* very little impact on, for example, prescription behaviour most likely explains why there were no data on the pharmaceutical industry's involvement in the introduction of Sophia.

activity", noting that it was upon SHI's initiative that patients were included. He argued that there was no cooperation or interaction, "*absolutely no relation between Sophia and GPs*" [FR6, p. 3]. He said that doctors "*do not feel implicated at all*", and paramedical professions were hostile as well. His union had been little consulted and "*a little more when we negotiated the associated physician remuneration to include patients*" [FR6 p.3-4]. Finally, a patient representative argued that health professionals were concerned Sophia could "*destroy the role of doctors*" [FR10, p. 4].

In light of such criticism, the SHI actor's argumentation justified Sophia based on its elements of external reference and a "unique added value". She referenced the CCM, arguing that Sophia was essentially the only initiative in France that fostered self-management support. Moreover, the dialog with patients via Sophia was distinct from the doctor-patient relationship: it was "coaching", and while doctors could do it, they are not trained and generally have no nurse at their disposition. Finally, she framed it as serving the doctors and helping them through increased compliance and self-management, although she admitted it initially had not been designed with a strong linkage with GPs [FR12, p. 5-6].

4.2.2 Diabetologists: the outspoken outsiders

Resistance by diabetologists has been particularly marked, and the president of their professional association (SFD) provided an uncompromising account of this attitude. He said that they did not identify themselves with it and "*had the idea to block all of it*" [FR10, p. 2]. He asserts the role of the "*unloved and beaten specialists*", adding that "*de facto 90% of diabetics only see their GP*". The interactions with GPs seemed to be ambivalent: he noted that they systematically prepared prevention campaigns together but "*it is not them doing the fieldwork*" [FR10, p. 5][74]. Such an interpretation seems to be substantiated by the statement that diabetologists and their savant society (ALFEDIAM) were "*reassured*" by the fact that type 1 diabetes would not be a focus. In the end they felt "*misled*" since type 1 patients were ultimately included in Sophia. He said that the only message for type 1 patients should be: "*see your specialist*" [FR11, p. 1][75]. Such statements may highlight a concern by specialists that patients are "snatched" by GPs, a complaint also voiced in Germany.

[74] He also notes that Sophia is unable to reach the severely ill who are often outside the system.
[75] FFD had requested a similar distinction between type 1 and 2 (APM International, 2008).

The actor further described how there had been an initial change in support, with all participants initially being "*scandalised*" and later "*rushing for it*" after SHI summoned them again to participate in the scientific committee [FR11, p. 1-2]. Likewise, his colleagues provided training for nurses, saying "*there is a contract, let's go*", with the mindset "*you have to be with the thing*" [FR11, p. 3]. Under his interpretation, SHI had gained a momentum that other actors had to follow: "*once you have put the finger in there, they allow you whatever you want*" [FR11 p.3][76]. His overall view was that actors in France were "*tetanised by power*" [FR11 p.2].

SFD left the scientific committee after three sessions [FR11, p. 3]. In addition to the expected criticism that Sophia bypassed doctors and "*valorised SHI beyond its functions*", the SFD president saw two main reasons for opposition. First, he maintained that "*you do not change behaviour with more or less anonymous calls*". He also found it "*completely ridiculous*" to use a US model on how to train nurses "*in some sessions*" giving them an explanation on how to conduct a phone interview. Instead, he described how Sophia made radio messages suggesting that household activities improve diabetes. He ridiculed such messages as not supporting behavioural change: "*we transform diabetics into mentally retarded people*" [FR11, p. 1-2].

Second, he said that such messages mimic private insurance. He argues that the SHI head does not have a public health orientation but rather an insurance perspective[77]. In his view, the logic was to "*hit the client not by the core of your offer but by the annex*", in other words, providing information resembling self-management support [FR11, p. 2]. He added that there were financial interests and a marketing principle to "*catch the client*", which is why complementary insurance firms had launched similar offers [FR11, p. 3].

Finally, he argued that one of the IGAS authors had "*a profound hostility towards the medical world, like many mangers*". To him, the IGAS actor was convinced that "*doctors are a world of collaborators, thinking of themselves, sitting on their privileges*" [FR11, p. 3]. He gives an insight in his convictions about the political system, where he said commissions *a priori* find "*consensual things*" with formulations "*allowing all corporatists to agree*" [FR11, p. 4]. In this

[76] Similarly, provider networks participated but were rather reserved [FR10, p. 2]; however, the integration of Sophia in the provider networks' SUDD (*Suivi des Diabétiques en Difficulté*) programme for patients with social difficulties suggests that eventually a mutual agreement between them and SHI was found.

[77] The interview was held in July 2014; in November 2014 Van Roekeghem took a position as head of MSH International, a company specialized in international health insurance plans.

context, he argued the IGAS report could have been a pro-contra inquiry, but instead "*they make a report and say it works well abroad*". He added that "*France copies*", realising it is only "*a province anymore*" and "*fascinated by Anglo-Saxon ideas*" [FR11 p.5] [78]. For their counterarguments, SFD read the literature and their interpretation found that "*globally it was not positive*"; they were aware of the commercial practices of phone platforms, proposing to insurers "*no advance payment*" and "*50-50 of your savings*" [FR11, p. 3].

Although lengthy, we chose to highlight this actor's perspectives because they illustrate the importance of categorisations (public vs. private, doctors vs. managers, etc.) in structuring the reception of Sophia and embedding it in broader, "high-stake" concepts. The following section explores the more nuanced reactions of GPs.

[78] He elaborated his point of view, arguing that there is a dichotomy in France. On the one hand, there is a fascination with the leader-and-hierarchy model in Germany, however applied "the Italian way" with maneuvering and "friendships". At the other hand, typical of the 5th Republic "every hospital director acts like a little monarch", and people want symbols. In the end, there is no "contradictory debate", everyone thinks there has to be a consensus. If there is none, one is either the court jester or, worse, one deals with the "moaning unions" [FR11 p.5].

4.3 The role of GPs and nurses

4.3.1 Surprisingly absent from the discussion in France

An actor with operational responsibility for Sophia described the ambivalence and uncertainty regarding how GPs would react: "*will they follow or will there be massive opposition?*" As a result, SHI adopted an offensive "*we will try*" attitude, arguing that GPs were in a "*wait and see*" position, even as SHI was about to "*put a foot in the door*" and communicate directly with their patients. This ambivalence apparently persisted. While the actor argued that SHI subsequently "*associated doctors a lot*" via the scientific board, she noted that "*they were not very present*" [FR4, p. 1]. Yet, a patient representative was surprised that the right wing union UNOF-CSMF ("*the most liberal*") was part of the scientific board and not MG France, due to a conflict with the latter [FR10, p. 2]. He claimed that GPs could be convinced via a financial incentive ("*there was only one method*"), which was in his view similar to what followed in the form of P4P [FR10, p. 4]. In an early 2008 press release, the UNOF-CSMF president had this to say about Sophia:

> *"The programme […] constitutes an additional benefit for patients. The GP will find his place in the programme because he can invest himself more in the daily continuity of care […] and contribute a global vision of the disease by not excluding any professional"* (APM International, 2008).

This statement stands in stark contrast to the criticism voiced by other physicians and anticipated by SHI, suggesting that GP representatives had no interest in overt opposition. Most GPs, however, did not seem to be truly committed to Sophia: in a preliminary evaluation commissioned in 2009 by SHI[79], 50% expressed a favourable opinion; in practical terms, only 30% of medical check-up forms sent by SHI to GPs were returned in 2010 (Jourdain-Menninger et al., 2012).

Likewise, there is little literature, including scientific articles and position papers, about the implications of Sophia for GPs. Since its launch in 2008, only one medical thesis has examined the opinion of GPs with a sample of 20 physicians, concluding that globally GPs were sceptical about the programme and adherence was low (Gegonne, 2013). This absence of analysis may point towards a perceived indifference for the subject, not only by the profession but by other

[79] TNS-Kantar Health phone survey of 503 physicians (Gegonne, 2013).

actors as well. For example, IGAS did not interview physicians for their 2006 report. According to an IGAS member, this was only because the authors "*did not have a logic of feasibility or implementation but of curiosity*" [FR2, p. 5]. Similarly, we previously observed how both SHI and IGAS had perceived German DMPs as centred on patient education and not on the role of the GP (which it *de facto* is). Might this indeed imply a common and implicit understanding that GPs were not concerned by DM, reinforced by the experiences in the USA (where GPs *de facto* are *not* part of most DMPs either)? This assumption is qualified by an SHI actor who argued that she knew the inclusion of GPs was crucial since some of them may use their "*power to for example tell their patients 'do not adhere'*" [FR4, p. 3]. This would lead to the preliminary conclusion that the path chosen, the partial formal integration of GPs for a financial incentive, was an empirical compromise in a field of only moderate controversy.

4.3.2 Earlier reforms around gatekeeping: a link to Sophia?

At the same time, it is necessary to consider these findings in the context of previous reforms affecting GPs. One essential argument was provided by Pierre-Louis Bras, an analyst and senior civil servant at MoH. He said that the primary challenge in ambulatory care is the lack of available physician time, due to a lack of manpower and the increase of demand through chronic conditions. In his analysis and perspective, part of the answer is the provision of certain services outside the physician office, and he cited the coaching provided through Sophia nurses as one example of this externalisation (Bras, 2011a). In addition to this workforce argument, one could question whether strengthening of general medicine was on the political agenda as it was in Germany and whether Sophia could be seen as a continuation of such an agenda. It is important to consider these questions in the context of the physician gatekeeping reforms of 1996 and 2004, which are set within the same reform act that restructured SHI and provided the conditions that allowed for the introduction of Sophia. The 1996 Juppé reform sought to link gatekeeping to the improvement of medical practice via the commitment of GPs to topics including generic prescription, guidelines, prevention and third party payment in exchange for a small annual lump sum payment. With the support of MG France, the so-called "referring-doctor" scheme was introduced in 1998 (Bloy, 2010). However, it was based on voluntary adherence of doctors and patients as a concession to strong opposition from the specialist-dominated physician union CSMF. The 2004 gatekeeping reform that introduced the "preferred doctor scheme" required no commitment by the physician, but imposed financial penalties for the patient if he/she did not follow the

prescribed pathway. Part of the penalties benefited specialists, who were given the right to engage in extra-billing in case a patient did not first see a GP.

The “preferred doctor scheme” was put in place in a context in which the growing social security deficit was of utmost concern. Although the explicit aim of the scheme was to improve coordination, a critical analysis by Bras asserts that three potential sub-targets of improved coordination via gatekeeping were unlikely to be attained: 1) the declaration of a “preferred” GP, 2) the reduction of “doctor hopping” and 3) the access to specialists. Regarding the first point, Bras notes that almost all patients already had their “regular” family physician. In terms of the second issue, doctor hopping appeared to be only a marginal phenomenon at the time. Concerning the third point, Bras highlights that there were no data on the question of whether regulated access to specialists represented a quality improvement. Suggesting that the scheme was aimed at reduction of expenditure, Bras maintained that great uncertainty existed surrounding the question of whether there would indeed be a reduction of costly specialist consultations or, instead, an increase in expenses for so-called double-consultations, where a patient sees a GP and a specialist instead of only seeing a specialist. Consequently, Bras viewed the division within the medical profession as the leading force for the scheme. Historically, the idea of an “obliged passage” with the GP was a founding claim by MG France and had a “symbolic and identity” role for GPs, who were struggling for recognition vis-à-vis specialists (Bras, 2006). In this context, the introduction of the referring doctor scheme in 1998 was seen as a first step in strengthening general medicine, although it had little success with doctors and patients. The specialist-dominated union CSMF, in turn, was opposed to the idea of gatekeeping on the grounds that it introduces a hierarchical role of the GP in relation to specialists.

Bras also points out that, in 2004, change was possible because a deal could be made between CSMF and MG France: the 2004 preferred doctor scheme granted specialists the right to practice extra billing, providing an advantage for CSMF. In exchange, they supported MG France in their long-standing bid to introduce gatekeeping for all patients, not only on a voluntary basis. According to Bras, policy makers had the advantage of displaying a structural reform that touched the symbol of free choice, a core value of the system. At the same time, it was a “low risk operation” since, as mentioned above, little of current practice was expected to change. In particular, the principle of fee-for-service and the theoretical free choice of

physician (upon a penalty payment) remained in place. According to Bras, the political sphere was opportunistic on the question and dependent on the representatives of medical unions, who played an key role by determining the problems and potential solutions along the conflict lines of "GP strengthening" versus "unity of the liberal medical corps" (Bras, 2006).

4.3.3 Doctors' unions: between partnership and conflictual opposition

The line of conflict and the resulting tensions among doctors' unions have characterised the relations of regulators and physicians for decades. According to Hassenteufel, this pattern makes it difficult for a single organisation like MG France to establish a partnership with the state or SHI, since voters for the union will tend to adhere to the most radical union if they feel that they are not properly represented. This structural dilemma between partnership and conflictual opposition also explains why, after reaching an agreement with CSMF about the gatekeeping scheme in 2004, MG France reverted to clear opposition to the collective agreements that were negotiated in late 2004, on the grounds that the scheme did not sufficiently contain tangible elements to strengthen general medicine (Hassenteufel, 2010). This clearly displayed opposition to CSMF and regulators, which provided good results in the 2006 union elections, most likely explains MG France's non-role in the introduction of Sophia. As described above, MG France was absent from the advisory board and left no public statements on an initiative that had potentially significant implications for GPs, instead leaving the discursive space to UNOF-CSMF[80].

Regarding whether Sophia could be viewed in continuity with the 2004 gatekeeping scheme, important features such as the 2004 consensus between the leading doctors' unions were not present at the time Sophia was introduced. At the same time, on the side of regulators, we can almost entirely transpose the analytic pattern that Bras applied to the 2004 gatekeeping scheme: with Sophia, SHI was able to herald an initiative that offered some structural change, whilst not significantly changing healthcare practice (and thus, not threatening the prerogatives of potentially opposed actors). Concerning the idea that gatekeeping could improve coordination in the system and foster general medicine, it appears clear that Sophia was not set within this line of reasoning. The addition to the system of a distinct coaching

[80] We note again that UNOF-CSMF was, according to a patient representative, part of the initial "inner circle" of Sophia, composed of SHI, UNOF-CSMF and FFD.

approach via call centres managed by SHI does not seem to strengthen the position of a potential "cornerstone physician" (*médecin pivot*, as frequently used in the debates).

Finally, this topic is relevant to the following case study on P4P in that we can see a continuing and significant policy theme: the payment of ambulatory care physicians. While Bloy notes that there is no clearly defined and visible policy of ambulatory physician payment over time (Bloy, 2010), it is a recurrent issue for both regulators and physicians. The debate is structured in part by GPs' concern over the growing revenue divide in favour of specialists, linked to a sense of pauperisation and a lack of social recognition (Bloy, 2010). Also, there have been several attempts by MG France to introduce capitation elements into the payment mix which, as a "French exception", was almost exclusively based on fee-for-service for a long time[81]. Since 2000, regulators have tried to introduce measures to move away from this mode of payment (see also the case study on P4P). Ultimately, in the case of Sophia we could view the fee paid to physicians for their participation and documentation as part of this move, in addition to being an incentive to promote self-management support and data delivery to SHI. This assumption would make even more sense at a time when SHI has extended the Sophia concept from diabetes to asthma patients.

4.3.4 DMPs as a means to strengthen general and family medicine in Germany

In Germany, overall, the picture is not significantly different. The medical specialty of diabetologists, represented by its savant society, has played a controversial role in the introduction of DMPs by refusing the diagnostic and therapeutic standards elaborated within CC. One further aspect of their opposition may be the fact that, according to a researcher, DMPs were considered as an opportunity to strengthen general medicine, set in a context where specialists were gaining importance (within KBV and the Chambers of Physicians) and where there were several attempts to "*adjust the system in favour of GPs*" [DE1, p. 2]. Similarly, a "*health policy preference*" by SHI for a strong role of GPs in DMPs is described by a former SHI and CC actor [DE4 p.6], nuanced by an analysis holding that sickness funds, while claiming to support gatekeeping by GPs, may intend to increase their own gatekeeping role via DMPs (Busse and Riesberg, 2004).

[81] With the introduction of the ALD scheme for chronically ill in 2004, a capitation component has been introduced into the payment mix, representing on average €6000 per GP (Bras, 2006).

Likewise, strengthening general medicine was also on the government agenda as illustrated by the development of GP-centred care, as detailed by Weckert (Weckert, 2013). In short, since 2004, sickness funds had to offer the option of a "family physician care model" to their insured, with a financial incentive. Contracts were made directly between sickness funds and GPs, bypassing KVs. The legal framework was provided by the Social Democratic/Green Coalition Government of the time, which, according to Weckert, traditionally had closer ties to GPs than to specialist physicians. Weckert found that a strategic goal was the weakening of KBV/KVs that had blocked previous reforms, with the later health policy spokesman Karl Lauterbach [82] as prominent and influential proponent of this position. The conservative opposition in parliament (CDU/CSU), while principally supporting the idea of gatekeeping, rejected the initiative on the grounds that its modalities would not improve quality but only redistribute funds in favour of GPs. However, once in office in 2009, the new conservative coalition government (CDU/CSU and FDP) did not change the provisions in place (Weckert, 2013).

Despite these generally favourable conditions for GPs, lobbying on their behalf apparently did not play a major role by the time DMPs were discussed. A former senior MoH actor described little contact with representatives of physician sub-groups, underscoring that the German Association of Family Physicians (BDA) was, by then, "*by far not a politically acting and strong association*". He adds that physician groups were generally "*veto players and no-sayers*", noting that the KBV head Rainer Hess was "*pragmatic*" and acted with the conscience that he could achieve more as a collaborator than as an opposing actor, even if he did not agree with the goals [DE3, p. 5]. Similarly, a former SHI and CC actor added that BDA "*did not play a role*", that it was "*not taken serious by SHI*" since they had mostly material interests.[83] Instead, the discussion around the role of general medicine was reportedly led by the German College of General Practitioners and Family Physicians (DEGAM) representatives such as Joachim Szecsenyi and Ferdinand Gerlach (Gerlach and Szecsenyi, 2002) and by the GP wing of KBV (Wolfgang Aubke and Leonhard Hansen), who "*coined the GP-centred philosophy of DMPs*".

[82] Health policy spokesman of the SPD from 2009-2013

[83] These statements are, however, qualified by evidence suggesting an institutional linkage between the major sickness fund AOK and BDA. The physician Gabriele Müller de Cornejo led the implementation of DMPs for AOK from 1999-2004 before becoming the head of the medical-scientific department of BDA in 2005. In 2005, she also edited a book highlighting DMPs' benefit for patients, published by a publishing house (KomPart) that is owned by AOK (Müller de Cornejo, 2005).

The former SHI and CC actor noted that diabetologists claimed the case leadership for themselves, but that the opinion leaders within the physician's group realised "*that there was no argumentative case for it*" [DE4, p. 6].

While these external accounts and elements detailed in previous sections draw a relatively controversial picture of the relations between GPs and specialists, interestingly, a former KBV head maintained that, during the DMP discussions, the divide between GPs and specialists did actually not play a role except for the distinction between General vs. Internal Medicine family physicians [DE6, p. 7][84]. On a more empirical level, mentioning the experiences of the Saxony pilots (see section 5.1.1), a researcher argued that GPs did not favour referrals to diabetes specialists since patients "*did not return from the enemy mission*". Therefore, routines were introduced in DMPs that specified the rules for referral to a specialist and for back-referral [DE2, p. 3]. This solution apparently was a compromise allowing sufficient margin of manoeuvre for all involved parties. The former CC and SHI actor noted that the issue "*finally went over the table*" since the requirements *de facto* did not limit the referral needs and possibilities "*in a rigid manner*".

> "*If we had defined it in the sense of gatekeeping, it would not have worked.*"
>
> [DE4, p. 6][85]

Overall, although internal struggle between GPs and specialists seems not to have been at the heart of discussions, it appears through the preceding sections that diabetologists in particular view the introduction of the diabetes DMP as a weakening of their position. This was mediated, on the one hand, through a loss of influence in defining norms, as Peter Sawicki, in a certain sense, won the "first round" of the "guideline dispute". Since he framed his actions, not as a representative of diabetology, but as a "pure methodologist" of the EBM movement, the voice of the sub-specialty diabetology was thereby put into question. Simultaneously, the fact that GPs became the lead providers of the DMP was most likely perceived as a defeat.

[84] Note that in this document, for the German case 'GP' and 'family physician' have been used synonymously. In fact, however, the broader term family physician groups General Practitioners (GPs), family internists and family pediatricians. A diabetes DMP may be led by a GP or a family internist.

[85] He argued that the idea of creating a dedicated delivery system for DM did not play a role in discussions, suggesting that "*these are borders that cannot be crossed for such reforms*", leading to an incremental innovation [DE4, p. 6].

4.3.5 Nurses in a new role as salaried phone coaches: a paradigm shift in France

A former SHI actor argues that "*what was really inspired by the USA*" is the fact that salaried nurses worked in call-centres that were independent from the usual-care system. This was apparently a source of debate since an early point in time and sparked criticism from one of the IGAS leaders of the missions, defending the view that nurses should work under the authority of a doctor [FR7, p. 2]. Indeed, the 2006 IGAS report suggests that DM could take place where doctors in group-practice employ a nurse, however noting that such a scenario could only be envisaged in the mid-term given the tradition of solo-practice and the low degree of integration in the present system (Bras et al., 2006).

From the SHI perspective, the issue also had institutional features. Nurses were supposed to be advisors, and a senior SHI actor underscored that "*so far in SHI only doctors and pharmacists had that role*". Therefore, the new role was not consensual and opposed by doctors' unions, with the implicit argument that this new role may at some point be applied outside of Sophia [FR12, p. 13-14]. Indeed, the reaction of an SFD actor illustrates well how physicians may have perceived this issue as an intrusion into professional independence. He maintained that SHI would like to "*gain control over health care organisation*" by means of collective agreements with doctors and nurses. With salaried nurses, SHI had "*carers at their disposition*", which was different with doctors over whom SHI "*has no power*" [FR11, p. 3][86]. In turn, the position of the senior SHI actor exemplifies the internal management logic of her organisation. Drawing a parallel with DAMs[87] who were assigned their new role because a new electronic claims system made part of their job profile obsolete, nurses were supposed to have new career perspectives as advisors, while in addition being less expensive than doctors. She describes this "*transformation of human resources*" as a challenge for SHI, in this respect representing a company "*because there is production*" [FR12, p. 13-14].

Finally, these ideas and institutional aspects are set in a context where the role of nurse as such is undergoing significant change. Still considered as "*semi-domestic*" staff with limited general knowledge and some technical competencies at the end of the 19th century (Feroni and Kober, 1995), nurses in France have, over the 20th century, acquired a state diploma,

[86] In addition, he said that nurses were not appropriate to make judgements in case of actual medical questions, which is why in the case of a doubt the patient would need an emergency consultation (for example, a diabetic patient with stomach pain), countering the objective of decreasing hospitalizations [FR11 p.2].
[87] SHI medical representatives, see textbox on DAMs in section 8.1.1

increasingly extended studies, a monopoly and a clearly defined role. However, their "*social visibility*" has remained relatively low (Carricaburu and Ménoret, 2004), and only in late 2006 was the legal basis given for the creation of a specific national council. Some months later, SHI signed an agreement assigning nurses new functions in managing health care services for elderly patients with chronic diseases and in prevention programmes (Naiditch, 2007). Such measures may illustrate a mindset in which nurses are seen as a potential remedy in times of an ageing physician workforce. A 2005 IRDES report commissioned by MoH analysed how other countries integrate nurses into primary care (Bourgueil et al., 2005). Likewise, in 2004 a pilot project used task-delegation to nurses in order to improve care for chronically ill patients. After assessment by HAS in 2012 it was decided that such "ASALEE cooperation protocols" could be put in place locally after agreement by the ARS. In this context, the 2009 HPST Act has set the framework for the delegation of medical tasks to nonmedical professionals, considered as a necessary step to improve inter-professional cooperation as well as experimentation with novel care structures against a background of budget constraints and workforce shortages (Chevreul et al., 2015). These elements indicate that, although the role identity of nurses is still not fully clear-cut, the profession seems to be increasingly valued in light of demographic and epidemiological changes. This momentum was most likely set within a positive feedback-loop at the introduction of Sophia, in the sense that a re-definition of the role of nurses was already "in the air" and that, concomitantly, the fact of implicating them in Sophia reinforced their increasing autonomy.

In Germany, according to a former CC and SHI actor, more innovative elements would have been needed to integrate other professional groups in fostering patient self-management support, but these groups were absent from the discussions about DM, despite the fact that they constitute a "*substantial element*" of DMPs in the USA [DE4, p. 2]. Indeed, in contrast to France, nurses play no role in ambulatory care in Germany. Instead, all physician offices are staffed with one or more practice nurse auxiliaries. They undergo three years of training, but their licensing is under the auspices of the physicians' chambers, and membership in a professional organisation is optional (Freund et al., 2015). Although the institutional weight of the auxiliaries may be described as low, they have gained competencies through the introduction of DMPs since *de facto* most patient education sessions dispensed in physician offices are delivered by auxiliaries.

5 Translation and implementation

The preceding sections have shown that the final "products" as well as the developments leading to the implementation of DMPs in France and Germany differ substantially on several points. While institutions and individuals in both countries perceived DM within a spectrum that can be heuristically defined by the extremes of "national" and "foreign"[88], over time, there was a shift in the actors' minds along that spectrum: we will refer to this change in meaning as translation. To structure the following sections, we propose the following interpretation. In Germany, DM-meanings shifted from the "national" (or even regional) to the "foreign" pole. At the same time, in France, DM-meanings very clearly were transposed in the opposite direction – from "foreign" to "national".

Indeed, the translation and implementation of the DM concept in Germany have been operated concomitantly at different levels and with distinct temporalities. While international experience was mostly used as a source of legitimacy at higher levels, most implementation features were actually based on previous national experience. This contrasted with models from abroad and led to a "branding" process. In this process, expert groups had a particular role in building consensus and legitimacy for action.

Conversely, in France, there has been a relatively high degree of conceptual and technical transfer, linked to the fact that the Sophia programme was *de facto* purchased from abroad and that US staff were involved on the ground at many steps of the implementation process. Issues of negotiation mostly concerned differences in professional culture and training, as we will illustrate with the examples of software programmers and nurses. Finally, the translation process was characterised by a fair degree of ambivalence towards the DM model, interacting with ideas about its originator country.

[88] Although certainly worth noting, it goes beyond the scope of this thesis to discuss whether such a dichotomy is socially constructed.

5.1 Translation and implementation in Germany: national bottom-up precursors vs. international experience

We have briefly outlined that political momentum for DMPs was created through Karl Lauterbach on a political level, while the content of DMP requirements as set out by the CC was largely based on the work by Peter Sawicki and colleagues. We will now examine whether such a "separation of labour" can be substantiated and what other factors may have played a role in shaping DMPs and the conditions for their introduction.

5.1.1 Regional programmes with a concentration in the former GDR

The design of the diabetes DMP finally in place can be divided into content and structure. In terms of DMP content, it was indeed based on the primary studies of the DIeM group around Sawicki who had drafted "working papers" on diabetes, hypertension and heart failure. These "Sawicki papers" were based on a systematic review of the literature on core issues integral to diabetes care (Siering, 2008). According to a former CC actor, the savant societies were included in the work of the CC through Ollenschläger. However, they were only guests during the discussions and described as "*frustrated, since they could not make points*", mentioning the case of the head of Saxon diabetologists who had difficulties accepting they were not the ones drafting the texts but "*such a weird commission*" [DE4, p. 3]. Yet, some concessions were finally made with respect to specialists and the use of new drugs. In terms of foreign experiences, the committee had not "*seen the necessity to look how they do it in California or at Kaiser Permanente or elsewhere*". Similarly, the actor stated that the debate about structure (eventually resolved in favour of GPs) had been led internally "*without a particular attention to other countries*" [DE4, p. 5]. He adds that the designing actors were well aware of the experiences of the structured diabetes care programme in North-Rhine evaluated by the Central Institute of KBV[89], but noted that these experiences were "*not a blueprint*" since, in his opinion, they did not reflect an approach based on primary studies[90] and had a "*specialist orientation*". Yet, physician representatives of North Rhine were reportedly influential in the content debate [DE4, p. 7]. Indeed, Wolfgang Aubke and Leonhard Hansen from North-Rhine

[89] http://www.zi.de/cms/publikationen/wissenschaftliche-reihe/
https://portal.dnb.de/opac.htm?method=simpleSearch&cqlMode=true&query=idn%3D964840138
[90] As represented by Peter Sawicki.

were both members of the KBV board (Stillfried et al., 2002), and it seems likely that the experiences of the regional association shaped their work.

Likewise, a former MoH actor argues that there were indeed national precursors to DMPs, such as projects at AOK Sachsen-Anhalt, where first results were published when the law was prepared, as well as the experiences with structured diabetes care in Saxony (*see box*) [DE3, p. 2]. A researcher said that SHI indeed did preparatory work on DMPs, such as on operationalising quality assurance, based in part on the pilots in Saxony "*after which German DMPs were modelled*" [DE2, p. 3]. The former MoH actor argued that such examples were situated mostly in the eastern part of Germany, continuing the tradition of the so-called dispensaries in the former GDR but not labelling it as such. According to him, the former GDR health minister had worked in such a structure in Berlin[91]. Until 1989, local community dispensaries were one of the main pillars of ambulatory services, in conjunction with public polyclinics and company-based health care services (Busse and Riesberg, 2004). In his opinion, there was a need to give English names to "*things from the East that you wanted to keep*". Although many of the former actors from the East were still in place, few acknowledged the role of the former dispensaries [DE3, p. 1-2].

A national precursor: the Saxon diabetes agreements

In 1991, diabetologists in Saxony founded a cooperative care model with the aim of addressing quality issues. The care model is based on cooperation between GPs and diabetologists and linkage with diabetes hospital care. The objective of the improved, 3rd diabetes agreement of 1999 between sickness funds and KV was the improvement of regional networks of the care process, in particular GPs. The pillars of the process were guidelines developed in Saxony, care across sectors as well as quality improvement sessions and feedback. The guidelines specified routines for referral to diabetologists and back-referral, with financial incentives for providers. A total of 275,804 diabetics were registered in 2000 and 2001, representing patients of 2,800 general practitioners and 88 specialist practices (Schulze et al., 2003). In 2003, the initiative was replaced by the RSA-DMP for patients with diabetes[92].

[91] In fact, the former MoH actor himself was an advisor to Minister Hildebrandt in 1990.
[92] www.imib.med.tu-dresden.de/diabetes

The American way: piloting a disease management call centre in Frankfurt

A former AOK member gives an account of the 1997 attempt to transfer a US model to Germany with the help of UHC United Healthcare through an intermediary, the McKinsey consulting firm. The attempt failed after investments on a scale of €1-2 million, which was in his opinion due to "*cultural differences*". This result was not widely disseminated, since AOK by the time wanted to promote GPs (a second initiative was to create physician networks) and did not want to report on a failed attempt. The actor described the promotion of GPs as "SPD-ideology" under health minister Ulla Schmidt, with AOK exploring GP models in Switzerland and the USA. He went to see the model in the US and supervised a team in Germany with five Americans. The idea was to have DM through proper staff by phone, but finally "*it did not work to interfere into the doctor-patient interaction in Germany by phone. It does not work*."

Since consent was needed by doctor and patient, the nurse talked to the doctor who could as well talk to the patient directly and would not delegate properly unless the nurse was his employee. According to the former AOK actor, "*a kind of DM, coaching a person with diabetes through a nurse on the phone has turned out to be nonsense*". The actor claims that AOK did not want to "*get into trouble*" with GPs, and KV had "*outrageous*" claims in the sense that patients would enrol only after physician recommendation and that they should receive €100 for it. The sickness fund could not finance this expense and decided to opt for a "silent death" of the project instead of a confrontation.

As a result, nurses did not get sufficient contact time with physicians. The call centre ran for one year, but nurses did not manage to have more than ten calls per day. Obliged to get in touch with the treating physician first, the doctors "*did not let them get through*" when they tried to reach them. The actor cannot say whether this experience had an impact on the later DMPs, but he does underscore the fact that the later morbidity-adjusted RSA was clearly inspired by US groups and classifications [DE5, p. 7-9].

5.1.2 Foreign experience: inspiration and contrast

While the preceding examples illustrate how national experiences were used to structure the design of DMPs, reflections on foreign experience seem to have had an impact on the design of the German DMPs in at least two ways.

First, in what could be termed as "linear inspiration", a former MoH actor described how staff "*looked over the Atlantic*" and monitored the US system, where in the mid/late 90s DMPs, with a focus on the severely ill, played a role [DE3, p. 1]. He further noted that his MoH predecessor (until 2002) knew the Anglo-Saxon debates (and the developments in the GDR) very well [DE3, p. 1]. He described the 1998-2001 Health Minister Andrea Fischer (Green) as very interested in international developments, owing in part to her experience as research assistant in the EU parliament, which stimulated the debate [DE3, p. 1]. Likewise, a researcher and co-author of a 2001 DMP expertise said that only literature was used as a source of expertise to identify the evidence about interventions improving care and mentioned the example of the CCM by Ed Wagner. Thus, German experiences were not included, since evaluations, for example on the Saxony experience, were published only later, and most of the literature cited originated in the US (Lauterbach, 2001). As a further input to the work, the researcher described phone conferences with international experts from the network surrounding Karl Lauterbach [DE2, p. 2].

Second, it seems that the contrast with certain characteristics of the US system has reinforced in some cases the deliberate choice *not* to resort to a US model, in the sense of "inverse inspiration". For example, the researcher explained that a fundamental difference with the USA was that American DM was operated by third-party vendors who collected data directly without access to physician data. She said that external data collection would have been difficult, which is why the joint data collection of KBV and SHI was established. In addition, she argued that there was no will to use an external actor because "*this would have disturbed acceptance with GPs*" and because experience from the pilots showed that patients generally prefer to see their GP. Finally, she said that an opt-in solution was set up because of the importance of patient choice and data protection, and that care directives such as those seen in managed care would have been "*unthinkable*" in Germany [DE2, p. 4]. This seems to be congruent with an analysis of Zentner and Busse of debates about the 2003 SHI reform act. They came to the conclusion that most actors consider the German system unique to the point

that foreign experiences are generally considered as barely transferable (Zentner and Busse, 2004).

Finally, a particularity of German DMPs is the scale of their implementation, given that the regulations of the actual RSA-DMP did not provide for a test phase. With respect to this phenomenon, a researcher described a "*split in the scientific sphere*" between those demanding a scientific, study-based implementation approach and those in favour of a nationwide introduction since the benefit was considered very likely. Overall, the implementation was criticised because it "*was whipped through rapidly in a top-down approach*" [DE2, p. 3]. She suggested that positive experience with the Saxony models, anticipating DMP content such as the linkage of care and quality goals, was probably a reason why politicians did not deem preliminary evaluation necessary and opted for direct nationwide roll-out [DE2, p. 2]. Further, she noted that DMPs were established to "*improve coordination and quality of chronic care*" without reference to cost or efficiency goals. This contrasted with the US, where programmes focused on "*high risk groups*", allowing for cost savings. In Germany, a "*broad population-based approach*" was chosen, focusing on secondary prevention and "*nationwide improvement of chronic care*", based on the SVR report [DE2, p. 1]. Suggesting a pattern, a former SHI and CC actor said that the approach of German health policy is "*to switch the lever from one day to the other and gratify the system with a nationwide innovation*", adding that this *a priori* precludes adequate evaluation [DE4, p. 5].

5.1.3 Experts and expertise: consensus-building around a rationalisation mindset

While the previous section described the role of individual actors in relaying ideas, a particular role was played by SVR. Explaining the mindset preceding the RSA-DMP reform, a former MoH actor stated that a main reason for the introduction of DMPs was the variance in the treatment of major chronic diseases that could not be entirely explained by medical and epidemiological factors. In this context, he describes discussions about EBM and guidelines, with a "*spill-over*" from England to Germany and "*wild debates*" within the physician community about the "*bad word cookbook-medicine going around*" [DE3, p. 1]. For him, the unfavourable comparison to other countries in terms of complication rates, etc. was clear, but "*this alone does not suffice to induce political change*". He maintained that this triggered the idea of SVR, pushed by Lauterbach, to survey all actors. He said that the basis of the "*monumental 2001 report*" was basically a systematic review of positions of all system actors: savant societies, chambers,

sickness funds, patient groups, etc. He noted that "*it hit like a bomb*", with critics claiming there were "*only socialists in SVR*" and SVR replying that they only reflected what all others said. According to him, SVR was a "*buffer*", with the "*medical soul in motion*" and politicians having the possibility to argue that they only drew conclusions from what the community voiced [DE3, p. 3-4].

Such an enthusiastic perspective on the role of SVR is supported by external analysts, such as Weckert; she noted that indeed with the SVR report the "*varying practice of care suffered a loss of legitimacy*" and highlighted the preeminent role of the report, pointing out that such discussions were held relatively late in Germany compared to other countries such as France (Weckert, 2013), which has been characterised as "catching-up modernisation" in the field of public health beginning in the 1990s (Rosenbrock, 1995). Likewise, a researcher argued that the 2001 SVR report was an important reform trigger and mentioned DM as one possibility for addressing issues including quality deficits, poor coordination and poor respect of guidelines. She did so in similar terms to the MoH actor, which supports the idea of common references to the SVR report and the fact that the actors' institutions were involved in its elaboration[93]. The former MoH actor further indicates the "*famous IOM report*", elaborated during the same time span and extensively referenced in the SVR report. Interestingly, several main ideas are shared in both reports, and the SVR authors note that the Institute of Medicine (IOM[94]) report was much more oriented towards values and goals than towards "*singular problem solving*" compared to earlier American documents. Such shared ideas include the move from acute towards continuous care, the role of evidence, the coordination of care and the "activation" of the patient (Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen, 2001). This indicates how the SVR report with its consensus-building methodology as well as the concomitant IOM report may have indeed contributed to fostering shared cognitive schemata among different actors, most certainly representing a solid building block in achieving the reform.[95]

[93] In the case of the former MoH actor through his previous role as SHI representative, and in the case of the researcher through her employment with one of the SVR authors.
[94] The National Academy of Medicine, formerly called the Institute of Medicine (IOM), is an American non-profit, non-governmental organisation.
[95] In this context, it should be noted again how these events took place within a tight timeframe, with the final SVR report published in August 2001 and the RSA-DMP act adopted in November 2001. Necessarily, the work on the SVR report and the RSA act proceeded in parallel, and the former MoH actor confirmed that the involved actors indeed knew each other well [DE3, p. 1].

5.1.4 Interim conclusion

In sum, in does not seem possible nor useful do explore in detail how each component of the German DMP process was influenced by national vs. international experience; the preceding sections have, however, attempted to identify some broader themes. An additional layer of complexity in this task results from the overlapping temporalities with other reform ideas and projects: a former MoH actor argued that, when foreign ideas are used, they "*cannot be applied in pure form but must be transduced into the German system of self-administration*". He said that the debates about DMPs were closely related to those around the self-regulating institutions, with the CC at the centre of the discussion.

> *"All this was also linked with guideline-based care and the later IQWIG, transporting the thoughts of NICE and NIH." [DE3 p.2]*

In this context he again emphasised the relevance of Lauterbach, "*who brought these international things to Germany*", which were then modified in the debate for use in Germany [DE3, p. 2].

This leads to two conclusions that can be drawn through the prism of the two main actors, Sawicki and Lauterbach. First, one could show that, in broad terms, bottom-up *and* top-down elements contributed in parallel to the introduction of DMPs as they are in place now. While the "branding" of DMPs as an innovative instrument borrowed from the USA was a domain of the "high road", most of the actual DMP content and structure was the fruit of national experience and considerations. Second, the analysis could confirm but somehow nuance the idea that the German health system represents a "consensus democracy": while indeed the negotiation forum CC and the consensus tool SVR played eminent roles, the individual actors Sawicki and Lauterbach had at least comparable leverage. Both were tightly integrated in the consensus structures, but each of them kept a personal profile which resulted in them being termed, in turn, "public enemy number one". This "blame game" may have allowed the medical profession to externalise part of its ambivalence, thereby overcoming their internal resistance.

5.2 Translation and implementation in France

"A public health, IT and human adventure." [FR4 p.6]

In France, SHI opted for a commercial-based programme operated in part by a private US provider, since they "*wanted to be coached by a US company with longstanding DM experience*". At the end of 2007, they selected Health Dialog, a Boston-based company that provided a population stratification model. Many adaptations were necessary on the macro and micro levels, constituting "*a major job*" [FR4, p. 2]]. We outlined the integration of GPs and the opt-in patient enrolment as macro modifications. With respect to GPs, who are neither an integral part of the original programme nor of most other DMPs in the USA, their implication in Sophia *de facto* had remained limited: they receive a notification by SHI when a patient enrols and are then requested to perform check-up exams for which a financial incentive has been set up. By far, the main initiative and control lies with SHI. The role of GPs can therefore only be considered as a focussed "add-on" to the main intervention, which is patient counselling via a call centre.

Concerning patient enrolment, an SHI actor emphasised her institution's strong will to show that Sophia is voluntary, free and has no consequences on reimbursement, underscoring the notion of choice [FR4, p. 2]. In practice, patients must sign and return an enrolment document and can leave the programme at any time. Conversely, in the US model, patients insured under certain health plans can benefit from DMPs without a specific enrolment procedure: the subscription is presumed, but patients may choose to opt-out. It is likely that patient organisations had a strong influence on this point, with a representative stating that is was central to patients that Sophia be free allowing one to enter and leave the programme without consequences. He linked this repeatedly to concerns about patient "*monitoring*" (*flicage*), ensuring that Sophia would have no impact on full reimbursement in the scope of the ALD scheme. To avoid the perception of "*monitoring*", the patient representative insisted that call centre staff should see themselves as coaches rather than as care professionals, which he described as a "*complicated*" process. For patients, it was important not to think of Sophia as a "*programme*". Instead,

> *"We always wanted it to be real personal exchange. People need to have confidence in the person at the other end of the line." [FR10, p. 4]*

This suggests that the de-professionalisation of nurses in the context of Sophia may be a converging point of somehow similar, yet distinct interests of patients and SHI. For the former, it seemed important that coaches did not represent the health system as such; for the latter, transforming the role of nurses was a challenge in terms of human resource management; for both patients and SHI, Sophia apparently was viewed as a fair complement to physician care.

5.2.1 Adaptations on the micro level: simplifying the original model

"All 'American' ways to address someone had to be 'francised'". [FR12 p.7]

We will now more closely examine adaptations on the micro level, in particular how communications between the call centre and patients were established, before examining how such technical processes were experienced as a cultural challenge by SHI staff. First, a senior SHI actor explained that in the "*American model*" there was an incoming-call component, including for emergencies. Although reportedly representing added value in the US system, in France GPs and the continuity of care system were already in charge of this and thus the component was discarded [FR12, p. 6]. Second, the US provider provided proposed outgoing calls via an interactive voice server[96], which SHI chose not to implement although in the US patients reportedly increasingly requested such services. Another actor said that SHI wanted "*human beings to talk to human beings*", arguing that the French do not have "*the same relation with their health*" as Americans:

> *"If a robot called to tell me I had not had my breast cancer screening, I would not answer." [FR4, p. 4]*

Further, the senior actor described a fundamental technical function of DMPs: the pyramidal risk-stratification algorithm to determine the frequency of calls. To that end, the provider used an econometric scoring model, and SHI travelled to the US and London to use SHI data for simulations. The model was based on the programme objectives. While 80% of the US objectives are economic, SHI adapted the model to include 50% economic objectives (delay in hospitalisations and complications) and 50% quality objectives. However, the actor said that it was difficult for SHI to determine the exact properties of the algorithm, in other words, defining on the basis of the score who should be called, who not, at what rhythm, etc. Finally,

[96] A technology that allows a computer to interact with humans through the use of voice and DTMF tones input via keypad: https://en.wikipedia.org/wiki/Interactive_voice_response

SHI opted for thematic campaigns instead, in which all patients without an eye examination or check-ups of their renal function would be called or specifically supporting smoking cessation [FR12, p. 7-8]. Another actor explained that, with respect to the dialling algorithm, staff had to advance "*at rapid pace*" because "*we had to prove quickly that we were successful*" because of political resistance. In addition, American partners reportedly "*plugged*" their IT system to the French one, posing complex issues with the SHI database that contains individual claims data, requiring data protection procedures [FR4, p. 2-3]. However, the senior actor said that the learning process about stratification was important, because at some point SHI would need the tools to stratify services and care delivery.

> *"If we wanted to pay physicians based on their patient population, we would somehow need an idea of the fact that the more severely ill need more care; so in both ways we know that these are tools (which PMSI[97] is, too), all these things show internationally this system equipment which finally is technocratic and very engineering-like, with the development of IT systems it has effectively become possible to have models that predict us what the likelihood of hospitalisation and high cost is." [FR12, p .7-8]*

Finally, there were intense discussions about evaluation, because the indicators of success were very important for the private US provider since they were to be paid based on the results [FR12, p. 7].

5.2.2 Cultural implications: cowboys in Moscow

In very clear terms, the SHI actor responsible for the operational implementation of Sophia described the entire adaptation of the IT system as "*extremely complex*", owing to cultures of development and programming in the US and France that have "*nothing in common*". She said that "*at SHI we write [functional specifications] and once everything is validated, after six months, we develop*". In case of failure, the cycle starts at the very beginning, adding another six months. Conversely, in the US "*people are more into an agile method, […], you do, you develop, you say what you want to do, you develop*", and in case of failure the cycle re-starts at a later point, adding only three weeks. She said it was a "*major cultural shock*" that American partners failed to understand that SHI needed to write everything up, compounded

[97] The French national hospital information system

by the fact that few of the SHI IT staff spoke English [FR4 p.4]. So translations were necessary at each step, with significant tensions between the teams and the US team claiming:

> *"You are in Moscow in 1964; IT does not work like that anymore". [FR4 p.5]*

This actor described as another "*cultural issue*" with respect to the call centre staff the fact that French nurses were very different from their US counterparts. She said that in France "*they obey doctors, you tell them what to do, there is little autonomy*". Conversely, she ascribes more autonomy and "empowerment" of nurses towards doctors in the USA. Further complicating this difference, the Health Dialog trainers for the French nurses were American nurses who spoke very poor French. The training regarding interview techniques for French nurses was described as a slow and ongoing complex process:

> *"To train the French about interview techniques including barriers and facilitators, motivational aspects, doubts etc., you really need to understand French culture to do that. And an American can't do that." [FR4 p.5-6]*

She maintained that both language and culture were responsible, underscoring that this process was a major component of DM in France which was not anticipated: "*You cannot improvise multi-cultural teams, […], we thought just because we put them together they will work together, but no*". She highlights that she had worked in international organisations before, but that most of SHI staff was in an uncomfortable position due to the language [FR4 p.5-6]. Finally, there was a physical notion to the process:

> *"When there were Americans in the SHI offices, I was enthusiastic but it was complicated for the teams. They were the American way, type 'winner, cowboy', and we were the small people from social security, you have to realise, it is not only about IT, about buying intelligence or expertise, concretely it was a true cultural shock". [FR4 p.6]*

Adding a layer to the cultural complexity, the provider Health Dialog had called on staff from Germany, where it had operated a DM programme in conjunction with the consulting firm Accenture. The German staff helped adapt the system to the French context, with the initial effect that in the software interface for nurses, error reports appeared in German language. The actor said "*it was horrible*" [FR4, p. 6].

5.3 Ambivalence towards the model: what does the USA stand for?

This account and the one by the SFD president presented earlier reflect an underlying ambivalence towards the influence of ideas originating in the USA, revealing a mixture of admiration and refusal. On the one hand, it seems accepted and recognised that "ideas from abroad" are widely used in France; on the other hand, it is perceived as something negative, as a proof and confession of a lack of genuine French innovation. Exemplifying this, the French SHI actor said that Sophia was a new experience that "*opened many doors to foreign initiatives*", so that now "*SHI is different*", "*it is an imprint*" [FR4, p. 6]. At the same time, her senior colleague expressed some doubt about the transfer by noting that "*the USA are not always a model you want to follow*" [FR12, p. 5]. In fact, interview partners (one in favour and one opposing the introduction of Sophia) used vocabulary from an almost colonial or imperialistic repertoire when they associate France with a "*province*" and perceive American collaborators as "*cowboys*". Intrinsically, the ambivalence could be linked to an underlying tension, revealing that SHI found itself in a paradox and asymmetrical situation: although SHI was *de facto* a proactive buyer and creator of services, the foreign expertise seems to have taken an almost physical dimension, expressed by a terminology of confrontation and conquest, qualified by notions of self-infliction (lack of language skills) and constraint (time-pressure).

Adding to these concrete circumstances, there may, however, be historical factors that structure and amplify the noted ambivalence. In their contribution to a 1986 seminal book about the relationship between France and the USA, the authors Guy Sorman and Marie-France Toinet note two important points that contribute to understanding of the "special relationship" between the two countries, set between the poles of pro- and anti-Americanism. First, Sorman holds that both nations, at their revolutionary origins, are based on a social contract. Instead of ethnic roots, citizens "become" French or American by culture, education and the shared will to form a nation. Thus, each country constitutes an ideological system and feels positioned to "teach lessons to the rest of the world", eventually leading to a certain kind of rivalry (Sorman, 1986). In a clarification in the chapter by Toinet, we can appreciate why this rivalry can lead to strong emotional reactions: both countries hold their values as universal and superior to those of others, implicating an "*eminently moral auto-perception of the national state*" (Toinet, 1986). In French literature, consequently, Americans are depicted as

individualists and materialists, with a mass culture inferior to the richness and sophistication of European culture (Sorman, 1986).

Second, the end of the Second World War marked an historical event with lasting consequences. The liberation of France by US troops was followed by the Gaullist era, characterised by a neutralist foreign policy that sought the equidistance between the USA and the USSR. The surprising absence of gratitude towards the USA was based on the two "foundation myths" of Gaullist Liberation: first, the "auto-liberation" of France, prolonging conflicts and misunderstandings between de Gaulle, Roosevelt and Eisenhower; second, the "myth of Yalta", where de Gaulle felt excluded from the Soviet-American split-up of Europe on the initiative of the American president. The motives around these ideas have been described by the American Michael Harrison as a mostly reactive phenomenon. He maintains that French anti-Americanism was and is an expression of frustration and rancour due to its proper geopolitical and economic decline (Harrison, 1986).

Despite these elements, the USA has always been perceived in France as a "*social-economic and ideological laboratory of the future*", dating back to Tocqueville[98]. Although Sorman makes clear that the USA rarely constituted a political model due to marked differences such as federalism and the presidential system, the French perception generally oscillated between fascination and rejection. For example, while post-war French economists initially considered American capitalism as a deterrent example, the economic up-turn under president Reagan lead to an "*idealisation of success*" (Sorman, 1986), eventually setting the ground for neo-liberal reforms not only in France but across Europe. In the past two decades, the duality of aversion and proximity continued over the strongly diverging attitudes over the Iraq war, the re-integration of France into NATO in 2009[99] and the renewed "friendship" under the Obama and Hollande presidencies (Seelow, 2013). The French attitude towards the USA can thus be clearly qualified as "special", based on multiple layers of experience and perceptions. Although there seems to be a recent tendency towards more proximity, the most striking feature of this relationship is its wide amplitude, with sometimes concomitant feelings on the positive and negative ends of the spectrum, strongly dependent on circumstances. This

[98] Creating a parallel to our case study, Tocqueville is also credited to have initiated the archetype of the "journey to America", followed by many writers and journalists.
[99] Pursued by president Sarkozy, after president de Gaulle's retraction from NATO in 1966

pattern seems to hold in the case of Sophia. In the best tradition of Tocqueville, senior SHI members ventured to the USA in order to "*uncover the signs of their own future*" (Sorman, 1986). In a context of managerial transformation at SHI, they chose to almost entirely transpose an existing programme, in spite of the awareness of cultural differences that eventually led to significant challenges.

The German case represents a significant contrast to the situation in France. While clearly "special" in the sense that the perception of America in Germany is heterogenic, its roots and inherent ideas differ. To begin with, the USA and Germany have no "common history" and subsequent rivalry in the sense that, by the time the USA became a strongly value-based nation, the various territories of the German-speaking sphere were still in the process of shaping a common identity. In contrast to France, Germany was one of the main originators of American immigration in the 19th century[100], built upon perceptions of economic promise as well as religious and political freedom. In the following years, America became a projection canvas for the discourse about the pros and cons of modernisation in Germany.

The defeat and the American occupation after the Second World War then started an era in which, in common perception, "Americanisation" and "democratisation" of the German society went hand in hand, based on a relationship of "friendly patronage" according to the analysis of Frank Becker in his book "Myth USA" (Becker, 2006). Yet, Becker underscores the important role that social construction has played in defining what is American. For example, while acknowledging that the USA was a model for instituting values such as individual freedom, civil courage or participation, Becker and other researchers highlight that the post-war constitution, as a cornerpiece of change, was mainly based on the model of the Weimar Republic, with little American influence (Becker, 2006; Fait, 2001). Likewise, while much of the formally displayed "Americanism" was supposedly pragmatic and selective, related and supporting concepts such as "Anticommunism" are reported to have been genuinely shared throughout influential groups of society, such as the media and the church (Sauer, 1999).

Finally, the representation of German-American relations is characterised by strong symbols, such as the famous Kennedy quote "*Ich bin ein Berliner*" in his 1963 Berlin speech. According to Becker, not even the strong dissent over the 2003 Iraq intervention can hold as a sign for

[100] Between 1850 and 1930, about 5 million Germans migrated to the United States, according to https://en.wikipedia.org/wiki/History_of_immigration_to_the_United_States

change in German-American relations. Instead, the conflict can be seen as symptom of a deeper crisis, namely, the lack of a common enemy for the Western military block and the concomitant significant shift in geopolitical constellations. In sum, the example of DM in Germany and the concept of the “mythical” USA seem to blend into a coherent picture. In contrast to the wide amplitude that the Franco-American relations seem to offer, the utilisation of the USA as a vector to negotiate domestic issues in Germany seems to be a pragmatic cultural routine. Part of this routine, as illustrated with the role of Lauterbach in the introduction of DM, is to “brand” an entity as American despite its diverse origins and representations.

5.4 Continuation and extension of national Disease Management Programmes

While the analytical focus of this thesis is on the introduction of DMPs, it is also necessary to appreciate some aspects of continued implementation and outcomes. Some evidence in this section is based on the results of the European project DISMEVAL, which provided comparative analyses on the approaches to chronic disease care and its evaluation in several countries including Germany and France.[101]

In Germany, between 2003 and 2006, DMPs were introduced for six conditions: breast cancer; type 1 and type 2 diabetes; coronary heart disease; asthma and COPD. A special module for chronic heart failure was added in 2009 to the DMP for coronary heart disease[102]. Since each sickness fund offers its own range of DMPs and each DMP has to be accredited by the BVA, there are many DMPs in Germany as a whole. At the end of 2015 there were about 10,000 DMPs, between 1,500 and 1,800 for each of the six conditions. However, as content and organisational structures of DMPs are regulated at the national level, they are very similar (Erler et al., 2015). Following their introduction in 2002, the number of enrolled patients increased steadily, with a slow-down after 2009. By the end of 2015, a total of 6.6 million insured had enrolled in one or more DMP[103]. The number of participating physicians is estimated at 65% of family physicians acting as coordinating physician in type 2 diabetes DMPs and 57% in coronary heart disease DMPs (Erler et al., 2015). After initial, widespread concerns about excessive bureaucracy linked to DMPs (Rheinisches Ärzteblatt, 2003), these figures suggest a wide and growing acceptance of the programme.

In terms of the reform context created by the need for a risk compensation scheme between sickness funds, the situation has changed. The introduction of DMPs was linked to the RSA by giving sickness funds a financial incentive for each patient joining a DMP. This incentive was abolished in 2009 with the introduction of the morbidity-adjusted risk compensation scheme, and compensation is now based on the morbidity profile of the insured. Subsequently, the payment to cover programme operating costs for patients joining a DMP is lower than before, decreasing from €180 in 2009 to €148 in 2013. Whether sickness funds continue to benefit

[101] The author of this thesis conducted the policy analyses of the French part of the DISMEVAL project, under the supervision of I. Durand-Zaleski and K. Chevreul. See also www.dismeval.eu
[102] http://www.bundesversicherungsamt.de/weiteres/disease-management-programme.html
[103] Ibid.

from offering DMPs now mostly depends on whether DMPs can reduce health care costs for the individual fund (Erler et al., 2015).

Several SHI funds commissioned independent scientific evaluations of DMPs' effectiveness, in particular of DMPs for type 2 diabetes (Miksch et al., 2010). Evidence from these studies suggest improved outcomes including quality of life (Ose et al., 2009) and mortality (Miksch et al., 2010; Stock et al., 2010) as well as reduced costs (Stock et al., 2010). However, some authors question whether improved survival can indeed be attributed to the diabetes DMP (Miksch et al., 2010; Schäfer et al., 2010), while other studies fail to provide evidence of improved outcomes (Fuchs et al., 2014; Linder et al., 2011). Overall, the debate over clinical outcomes of DMPs remains lively (Mengersen, 2015). Many related scientific publications and discussions take place in the joint medical journal of KBV and BÄK[104] and are largely authored by physicians. In the latest scientific evaluation in 2015, the authors [105] analysed the association between DMP enrolment and the delivery of care according to guidelines. Interestingly, they found that, at the beginning of the study in 2006, guideline care and DMP enrolment were positively associated. However, five years later, the association was no longer significant. The authors suggest this may be due to a spill-over effect, meaning that "*with the implementation of DMPs and corresponding physician education requirements, physicians started to apply the adopted standards to all treated patients*", and not only to DMP patients (Laxy et al., 2015). These elements clearly seem to support the position of those regarding DMPs as an "implemented guideline".

In France, the Sophia programme was initially implemented in several pilot regions. By November 2010, 62,000 patients had signed up to the programme and it was rolled out nationwide in 2013. In August 2015, a total of 620,000 patients were enrolled (CNAMTS, 2015). Based on the model of the Sophia diabetes programme, SHI launched its asthma programme in early 2014, which is currently being implemented in pilot sites in 19 departments and contains similar key components as the Sophia diabetes programme. SHI has commissioned two external evaluations of process, outcome and economic indicators. All evaluations suggest a moderate improvement in process (for example, percentage of ophthalmological check-ups and Hb1Ac controls). An in-house evaluation by SHI suggests minor improvements

[104] Deutsches Ärzteblatt: https://www.aerzteblatt.de/
[105] Health economists who did *not* publish in the aforementioned Ärzteblatt

in intermediate outcomes (Hb1Ac) in patients with poor glycaemic control (CNAMTS, 2013). The latest evaluation, published in 2015, shows no impact of Sophia on health expenditure (CNAMTS, 2015).

While we have noted the "indifference" of providers, in particular GPs, in the above sections, acceptance by physicians appears to remain an issue for the Sophia program. In a 2013 issue of the physician daily *Le Quotidien du Médecin*, the president of MG France, Claude Leicher, stated that "*DMPs have not proven their effectiveness, but since in France was lagging behind in terms of patient care and follow-up, any organisation put in place by SHI would have improved the indicators*". Going further in his critical stance, the author reports on GPs who display signs in their private practices dissuading their patients from enrolment with Sophia (Le Quotidien du Médecin, 2013). The ambivalence of providers is also demonstrated by a 2014 satisfaction poll published by SHI. While two-thirds of GPs have "*a positive opinion of the service Sophia*", only 40% of physicians talk to their patients about the programme and tend to motivate them to participate (CNAMTS, 2015). Addressing some of these issues, SHI plans certain changes to Sophia, including more focused recruitment and follow-up campaigns for patients with poorly controlled diabetes and the possibility of the GP to choose a "priority theme" to be addressed by the call-centre coaches (CNAMTS, 2015).

Taken together, evaluations on the effectiveness of DMPs in both countries appear to be consistent with most evidence from the scientific literature on DM: there are some significant, but mainly modest improvements of indicators reflecting process and, to a much lesser extent, outcome indicators. In terms of acceptance with providers, as seen in the previous sections, it appears that German DMPs are more widely accepted than the French Sophia programme.

5.5 Conclusions on the introduction of national Disease Management Programmes

In introducing a national DMP, France opted for copying a specific foreign programme and adapting it, while Germany chose and combined several components in the sense of selective borrowing. It seems likely that such differences in process are linked to the care system structure and the degree to which concepts such as EBM are prevalent and accepted by key actors of the adopting system. Diane Stone (2004) argued that "soft" forms of transfer, in which non-state actors play a more prominent role, are a necessary complement to the "hard" transfer of policy tools, structures and practices (Stone, 2004).

Over the course of this first case study, it became clear that such notions of transfer are strongly complemented by other aspects that seem crucial to our comparison. These aspects allow us to view DMPs in both countries as a negotiation ground for high-stake issues such as the power relation between SHI and health professionals, linked to the particular role of GPs and overall policies to strengthen their place in the system. This is interrelated with institutional transformations (SHI in France, the CC in Germany) and the "performance" of programmatic actors such as Karl Lauterbach or Frédéric Van Roekeghem[106]. Last but not least, ways of generating and using expertise (for instance, SVR in Germany vs. more technocratic traditions in France) as well as cognitive schemes determining the perception of foreign experience appear to be crucial variables on both sides.

In order to provide additional context for our conclusions, we have consulted the literature on the diffusion of complex innovations in health care, grounded in organisational theory. According to Denis and colleagues, negotiation of the meaning of an innovation in general takes place at its periphery rather than at the core (Denis et al., 2002). Indeed, the adaptations undertaken in France concerned the structural elements rather than the conceptual "heart" of the DMP. Likewise, assuming the "branding" of German DM to be a form of "purposeful

[106] On a more conceptual level, this case study suggests that both Lauterbach and Van Roekeghem are true *programmatic actors* in the sense that they fulfil a creative and constructive role by "*selecting, translating, recombining, and, most important, imposing ideas*" (Hassenteufel et al., 2010). This is distinct from *policy entrepreneurs* in the sense of Kingdon, seen as "*advocates who are willing to invest their resources - time, energy, reputation, money - to promote a position in return for anticipated future gain in the form of material, purposive or solidary benefits*" (Kingdon, 1984).

conceptual borrowing", we can defend the position that the addition of GPs represents a modification outside the mainstream of a prototypical DMP in the USA.

If we further asked the question whether the DM reforms in both countries were a political success (which is not *per se* the aim of this study), risks and benefits could be assessed against the following postulate by Denis et al.:

> "*The presence of a strong pro-adoption coalition of interests combined with high need for learning can lead to compressed learning that may be costly (for patients).*" (Denis et al., 2002)

This statement seems to be particularly relevant for Sophia in France, where the overall impression prevails that the rapid introduction of a ready-made programme came at high cost in terms of lively and lasting reservations by physicians in a context of increasing cleavage and tensions between providers and SHI. The hypothesis could also be applied to DMPs in Germany: although stretched over a slightly wider timespan than the introduction of Sophia, the great complexity of the German diabetes DMP makes the overall effort in relation the available experience and resources comparable. Yet, it seems that it came at a slightly lower cost, providing some benefit for most actors. The following case study can help elucidate whether similar patterns can be found for the introduction of P4P elements in the two health systems.

Second part: pay-for-performance

Comparing the introduction of P4P elements into the French and German health systems is probably even more challenging than the comparison of DM approaches, since payment schemes can apply both to the ambulatory and the hospital sector. Therefore, the present study will focus on the ambulatory sector for the period from 2007 onwards and will only briefly describe the hospital context. Overall, the objects of comparison differ in the two countries, with a clearly delineated, national bonus payment scheme in France and a still ongoing process in Germany with pilot initiatives and a vivid proxy-discussion about quality indicators.

The structure will be similar to the previous part: 1) the general context and the proponents of P4P reforms in both countries will be examined; 2) the more critical (and less prominent) actors and the related interactions will be discussed; 3) the ideas inside and outside the systems that have influenced the processes will be highlighted before conclusions are put forward.

6 Context and reform coalitions

As a guide to the interpretation of the following sections, we advance two main arguments. First, development of P4P in both countries is intrinsically linked to the preceding DM policies as instruments prolonging the larger, long-term system transformations: the growing role of the State and SHI in parallel to a fragmentation of the medical profession. It was embodied in France by the 2004 reform redefining the mission of SHI. In Germany, in addition, we have emphasised the growing role of competition elements since the 1990s.

This leads to our second argument: the prolongation of the long-term transformations did not lead to the same results in France and in Germany. In fact, P4P has seen a rapid uptake in France, facilitated by a relatively strong and proactive coalition led by SHI, which suggested that the reform be set within a coherent line of measures and ideas. As with DMPs in Germany, arguments of de-professionalisation and ethics played a role in the ensuing discussions, with the majority of individual practitioners ultimately opting for P4P in balancing cognitive and material implications. However, in the case of Germany, the picture is less clear, with many providers remaining reserved towards the idea of P4P and key actors still uncertain about the net political gains. One major initiative for P4P in ambulatory care came from the physician representatives of KBV in a move to regain regulatory edge. Yet, it was rejected by its base over concerns about de-professionalisation and the allocation of funds.

6.1 Context in France: a joint initiative

In the ambulatory care sector, French physicians are predominantly paid on a fee-for-service basis, the terms of which are defined in collective agreements between doctors' unions and SHI. In July 2007, SHI published its annual report with propositions for the advancement of the health system. Under the heading "containment of drug spending", putting forward the poor comparison with other European countries, it suggested experimenting with individual contracts with ambulatory care health professionals so as to pay them based on performance indicators (CNAMTS, 2007).

In general, there is agreement with DSS of MoH concerning the propositions included in the annual SHI report [FR7, p. 7], and thus in September 2007 the proposal for individual P4P contracts figured in the MoH draft for the 2008 Social Security Financing Act, alongside measures such as multidisciplinary health centres and cross-professional financing pilot projects [FR5 p. 2]. In parallel, in June 2008, IGAS published a report on the use of P4P in the UK and USA, drawing conclusions for a potential introduction in France (Bras and Duhamel, 2008). Finally, a decree in April 2009 set forth the model contract between local SHI funds and GPs (UNCAM, 2009), and the first CAPI (*Contrat d'Amélioration des Pratiques Individuelles*) went into effect in July 2009. Fourteen months later, 14,800 contracts were signed, representing one third of eligible GPs (CNAMTS, 2010).

CAPI were signed on a voluntary basis for a three-year period and could be broken at any time on the GP's demand. The additional payment took into account the size of the population and the achievements for a number of indicators (clinical care, prevention, generic prescription), for which final as well as intermediate targets were defined. Depending on the baseline measures for the GP's practice, either final or intermediate targets were considered in determining the level of remuneration. There were no penalties for GPs who did not achieve the targets (Chevreul et al., 2010). With effect in 2012, CAPI were renamed ROSP (*Rémunération sur Objectifs de Santé Publique*) and incorporated into the collective agreements between doctors and SHI, with an expanded list of objectives and an extension to specialties such as cardiology.

6.2 The reform coalition in France: "the time was right"

There were three main institutions that developed what was later termed CAPI: SHI, DSS and IGAS. Starting with SHI, which had the most prominent role, we will examine in greater detail how and why this work was carried out.

6.2.1 SHI: finding the means to assume a new role in the health system

The key transformations of SHI were described in the previous part. In brief, an important element in the leading role of SHI was its director Frédéric Van Roekeghem, who served in that role from 2004 until 2014. Just before assuming this role, he was head of cabinet of the Minister of Health and became a leading figure in the negotiations of the 2004 SHI reform (Hassenteufel, 2009). In 2005, SHI underwent a major audit that led to the creation of a dedicated strategy department within the directorate for strategy, expertise and statistics (DSES). In the words of an SHI member, SHI wanted "*not to be seen as a simple payer anymore but as a true insurer, not limiting its role to reimbursements but accompanying the insured*" [FR3, p. 1]. Further, Van Roekeghem reportedly implemented international benchmark logic, as well as yearly study trips abroad.

Despite these measures, which appear deliberate and coherent, some SHI interviewees described the conceptualisation of P4P as an incremental, almost random process. One explained that SHI had used its own quality indicators for some time and wanted to use a national objective to reward those exceeding them. At some point, this concept became "*linked up*" with lessons from international sources, with the UK Quality and Outcomes Framework (QOF) as the major source of inspiration, despite a clear choice to implement it differently [FR 12, p. 9]. Another former SHI actor said that "*the moment was right*" when P4P emerged in other countries and SHI was prepared to increase GP payment by increasing the basic consultation rate ("C"). This had last been done in 2009, but there was already the perceived need to find new remuneration modes after implementing the "referring doctor" scheme in 1998 and the ALD scheme in 2004. However, there were doubts about the impact of P4P on clinical practice, which is why the proven but potentially debatable impact of QOF on clinical practice was perceived to be relevant. DSES, the SHI medical department, but also IGAS relied upon a common knowledge base in the form of articles about QOF [FR7, p. 3-4]. Amid these accounts indicating relatively moderate policy learning, an SHI member monitoring innovations in other countries used stronger words:

> *"The introduction of P4P was first of all the conviction that it's a trend all health systems started to follow, because even if there are questions about the principle, we think still that it is an effective tool to change practice, and obviously you have to follow, […]." [FR3, p. 1]*

Taken together, the reports of all current and former SHI interviewees consistently suggest that the leadership of the new SHI director was crucial in setting the groundwork for P4P, by dedicating significant staff resources and promoting a benchmarking logic across departments. Many SHI interviewees expressed strikingly similar themes, suggesting a high common adherence to the ideas and resulting in an almost pedagogic notion with respect to physicians. This is exemplified by the account of one senior SHI member (a physician by training):

> *"They have individual relationships, but tools like IT allow them to re-orient towards all patients in a risk-management logic. […] They are sceptical when confronted with their individual feedback, […], but convinced when you present them comparative local or national data, they gain conscience of the gaps." [FR13, p. 2]*[107]

6.2.2 DSS: cost containment and "fresh ideas"

In contrast to SHI, the work on P4P at the MoH was carried out within a more confined space by a significantly smaller workforce. The key actor within DSS was the deputy head of the sub-directorate for health system financing (Bras and Duhamel, 2008). She described having been charged with "*finding means to save money so as to contain costs*" in the form of financing and savings for the Social Security Financing Act in conjunction with SHI [FR5, p. 1]. This mission statement is coupled with assumptions about the health system that reveal the overarching perceived need for change: for example, this actor felt that the solo, "*isolated*" private practice approach belonged to the "*1960s*" and that France had not yet made the transition that other countries have made but wanted to do so by the next generation, including development of group practice for which fee-for-service payment represents a barrier [FR5, p. 2-3]. She portrayed French GPs as the lowest paid in Europe, often required to do work for which they were overqualified, and said that there was a dominant "*retro-conservatism*", with highly qualified researchers at hospitals but no benchmark culture in the ambulatory or even the hospital sector [FR5, p. 4]. The actor contrasted this with her own training in a hospital and her preference for team work, explaining that she was the first public

[107] At an earlier point of the interview, noting that fee-for-service is deeply rooted in the payment system, she states that the objective of CAPI was to „*change mentalities.*" [FR13, p. 1]

health physician with a background in research to hold a DSS position generally reserved for administrative elites, thus representing the first generation of gap-closers between academia and administration. According to her, this facilitated the notion that "*the ideas could pass*", because of the interaction of several persons [FR5, p. 4]. These elements of professional identity overlapped with aspects of her biography and comparative approach: in her previous work on group practice and remuneration, this actor had closely monitored the UK system, which she perceived as well performing, with very satisfied users [FR5, p. 4] and doctors and patients who more readily accept changes in prescription practice based upon evidence and cost arguments [FR5, p. 9]. She described herself as having a natural benchmark logic due to her training, which was new at MoH, where international developments were not a priority: there was a department for international affairs in charge of legislative aspects and an ineffective network of social advisors in French embassies [FR5, p. 3]. She explained that study trips are not part of French central administration culture and noted that she herself had no time to travel or use her network and, instead, based her work on CAPI on the literature [FR5, p. 13-14]. In sum, while this does not purport to be representative of DSS or even MoH, it highlights (based on the account of one person) the apparent combination of several cognitive threads: the importance of fiscal pressure, the perception that change was needed to the existing provider landscape and finally the idea that comparison to others may be beneficial.

After the Social Security Financing Act passed in late 2007, SHI was in charge of CAPI design and development indicators, because SHI operated the relevant databases. According to the former DSS actor, DSS let SHI "*take over*" so that they could fully understand the topic and manage the negotiations [FR5, p. 12]. Yet, she described what happened then at SHI as a "*black box*" because, despite regular meetings, few details were communicated, in particular regarding the calculations of bonus levels [FR5, p. 10].

6.2.3 IGAS: independent expertise and "open minds"

At IGAS, the initiative for theP4P report in 2008 came from the two authors themselves, who put the subject on the internal IGAS work plan, which was then discussed and validated by MoH. The two have authored several IGAS publications together, among them the 2006 report on foreign experiences with DM (Bras et al., 2006).

In their report, the authors put forward three drivers for their analysis: first, increasing experiences with P4P in chronic care delivery systems reported by foreign countries; second, a trend

towards "individualised remuneration" as a means of modernising administration; third, the need to re-stimulate the stalled debate about physician payment[108] (Bras and Duhamel, 2008). The main analysis was based on two joint study trips between IGAS and SHI that included the two authors and two SHI collaborators. A first trip was to the UK to explore the P4P actors' attitudes against the backdrop of advantages and drawbacks described in the growing body of literature; the second trip was to a P4P conference in Los Angeles, California. A former SHI actor noted that the participants viewed the situation in the USA as "*more complicated*" because the connection between doctor and patient is less clear-cut, which, in addition to the existence of multiple insurers, makes it difficult to set objectives. Somewhat frustrated by the USA experience, the French delegation saw the UK experience as more useful, which is why the QOF became the more important source of inspiration [FR7, p. 3].

In terms of influence on other actors, the IGAS report had little impact on DSS, as the Social Security Financing Act was drafted in 2007 and the report published in 2008. Likewise, the influence of IGAS on SHI appears to have been relatively small: of the 17 indicators proposed by the IGAS report, only two (flu vaccination and breast cancer screening) figured among the 16 CAPI indicators ultimately established by SHI (see table in section 8.1.3).

In sum, it appears that there was no linear flow of ideas or information among the main architects of P4P in France. Instead, the interview data suggest that the cognitive and material work on P4P started almost concomitantly in the three institutions: the dedicated strategy and medical departments at SHI; a lead actor at DSS who was open to experiences from the UK; and finally, two senior IGAS experts who almost routinely practice "horizon scanning". While each of the actors had distinct motives to examine P4P, it appears that the idea gained momentum in a similar manner and a level time horizon, which one actor described as "*some kind of convergence, […], the time was right*" [FR5, p. 9]. Finally, although the three institutions made explicit use of foreign experiences and literature, in particular with reference to the QOF in the UK, this does not reveal the degree to which they were actually used to frame the meaning of P4P in the French context and to design the actual policy. After examining the situation in Germany, this point will be addressed in greater detail in section 8.1.

[108] Note that, in the French academic sphere, the discussion about financial incentives in medical care was only cautiously led, with authors emphasising the need for a wider evidence base. See for instance (Chaix-Couturier et al., 2000).

6.3 Context in Germany: multiple measures

In contrast to France, ambulatory care physicians in Germany are paid by the sickness funds via the regional associations of SHI physicians (KVs) based upon an overall morbidity-adjusted capitation budget, which is then distributed to their members according to the volume of services provided, with various adjustments (Busse and Blümel, 2014). This remuneration scheme has been subject to constant debates over its complexity, the most recent in 2014, when the TK sickness fund proposed a reform that would introduce a simplified and generalised fee-for-service system (IGES Institut, 2014). The proposal has not yet entered the political agenda. In terms of the quality of ambulatory care, structural requirements are part of the Federal Framework Contract (*Bundesmantelvertrag*) [109]; if there are structural shortcomings, the KV can refuse the right to bill for certain services. Further, DMPs *de facto* add to physicians' remuneration mix, since adhering physicians are paid a fee per enrolee and per documentation unit (see previous part). In addition, sickness funds may pay bonuses for referrals or certain examinations.

The context for the introduction of P4P in Germany was also marked by integrated care provisions included in the SHI Reform Act of 2000. They aimed to improve cooperation between ambulatory physicians and hospitals via selective contracts (SC) between sickness funds and individual providers or groups of providers from different health care sectors (Busse and Blümel, 2014). Endorsed by the SHI Modernisation Act of 2004 and the Act to Strengthen Competition in SHI of 2007, such SCs represent the primary means sickness funds currently have to grant financial incentives to providers for achieving agreed performance goals.

There are several SCs, but little is known about them because not all are public. The P4P component in such contracts is not a generalised concept, but rather individual and mostly concerns penalty payments if there are complications. A former MoH actor explained that SCs may be difficult to expand outside of the classical surgical domains because of issues such as risk selection [DE3, p. 7], and an SHI actor maintained that they have not had the intended impact: "*the only thing happening is to link hip surgery and rehabilitation*" [DE5, p. 1]. This opinion is shared by a senior researcher, who said that politicians and most sickness funds wanted to expand SCs since they "*bring competition, which may increase efficiency*"; however, she thinks most SCs are "*integrated care light*" [DE2, p. 6-7]. An SHI actor added that the most

[109] Concluded directly between KBV and GKV-SV, meaning there is no state involvement.

important existing quality-based payment rule is the DRG-linkage in the event of early re-hospitalisation, deliberately designed as a quality incentive [DE5, p. 1].

In 2007, the influential Advisory Council for the Assessment of Developments in the Health Care System (SVR) published its white paper on "*cooperation and responsibility – conditions for target-oriented health care*". In a chapter on "*accountability and competition*", it reviewed the international literature and noted that P4P was rooted both in the concept of EBM and economic theory. The SVR experts concluded that most studies show a positive effect of P4P but raised concerns about negative impacts on physician motivation and equity, finally recommending a "*stepwise introduction of P4P elements with pilots and intensive evaluation*" (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen, 2007). This cautious recommendation was interpreted by a former MoH actor as "*we do not recommend a wide roll-out*" [DE3, p. 6], reflecting a certain reservation with regard to P4P.

In 2012, MoH commissioned a dedicated analysis of P4P by the Federal Office for Quality Assurance (BQS). Based on a systematic literature review, a survey and workshops with experts and stakeholders, the authors concluded that there was insufficient "*convincing evidence*" for the effectiveness of P4P, although most stakeholders considered that P4P would play a greater role in the future. They recommend that other quality instruments, such as feedback and public reporting, be implemented before adding a P4P component, highlighting the need for operationalised quality indicators and political commitment (Veit et al., 2012). A senior researcher interpreted these conclusions as describing in a hesitant manner "*what is theoretically feasible, but eventually not feasible because things are complicated*" [DE1, p. 3]. The lead author of the analysis stressed its role as a communication tool:

> *"For payers and providers, it is something that is still being read. I think that is one thing that the expert report has caused; it provides a factual platform on the basis of which one can talk with each other calmly." [DE9, p. 3]*

Indeed, in addition to searches of the literature, surveys and interviews, the authors held a workshop with a broad set of actors before formulating their recommendations (Veit et al., 2012).

With respect to the *status quo* of P4P in Germany, the expert report found that overall there were few initiatives in place, mostly based on SC. An overview of the findings is presented in Table 8.

Table 8: Overview of P4P projects as of 2012, adapted from (Veit et al., 2012)

Project name and description	Quality dimension/measure	Type of project	Contractual basis and participants
SWEET = improved metabolic control of children and adolescents with diabetes: development of reference centres	Structure	Pay-for-Competence*	Coordination by paediatric hospital, association status since 2011, 10 European countries included
Network for Mental Health	Hospital referral	Elements of P4P	SC of the TK sickness fund
SC headache**	Ability to work	Elements pf P4P	SC of the TK sickness fund
SC back pain	Ability to work	Elements pf P4P	SC of the TK sickness fund
QuE-Network Nuremberg	Structure, process, outcome	Elements of P4P	SC of AOK Bavaria sickness fund
Integrated care for hip- and knee-replacement	Outcome	P4P	SC of AOK Hessen sickness fund
GP-contracts AOK Lowe-Saxony sickness fund	Prescription behaviour	Gainsharing, potential for further elements	Contract for GP-centred care (see part on DM)
Diabetic foot syndrome in Berlin	Outcome	Pay-for-competence	SC AOK Northeast sickness fund
AnyCare ProMed care management	Outcome and patient surveys	P4P of the company AnyCare	Individual contracts between AnyCare and payers
DMP contracts with defined quality parameters	Process	Pay-for-transparency***	KV Thüringen
Phlebologicum: venous diseases	Structure, Process, Outcome	P4P	Pilot for SC
Diabetic food syndrome in Cologne-Leverkusen	Outcome	Pay-for-competence	SC
"Excellent patient care" (see also box below)	Structure	Pay-for-competence	KV Bavaria

**Pay-for-competence, according to the authors, measures and rewards the spatial, technical, procedural or personal competency to deliver quality. **SC = selective contracts. ***Pay-for-transparency rewards the measure and display of quality.*

In 2013, the coalition agreement between the centre-right and centre-left parties, CDU/CSU and SPD, provided for the introduction of risk-adjusted bonus and penalty payments for hospitals. With respect to indicators, the agreement foresaw the foundation of a dedicated institute for the measurement of both ambulatory and hospital care quality (CDU, CSU, SPD, 2013). Legally established in 2014, the new body was called IQTIG (Institute for Quality and Transparency in Health Care) and began recruiting staff in January 2015.

6.4 The reform coalition in Germany – is there one?

Although "reform coalition" is useful to broadly categorise actors, overall there were no clear alliances supporting a move towards a broader introduction of P4P in ambulatory care. Instead, owing to the specificities of the German system – federalism, clear sectorial borders, self-regulation of providers and insurers – there were initiatives of individual actors, particularly the physician organisations and SHI.

The following sub-section introduces the ideas and interests of importance to these actors and elaborates on some of their concrete initiatives. Next, attention is focussed on those whose role may be qualified as less prominent, namely MoH and the academic sphere.

6.4.1 Federal Association of SHI Physicians

The most proactive player with respect to P4P was the Federal Association of SHI Physicians (KBV). According to its former head, KBV gave the "*impulse*" for the P4P section in the 2007 SVR white paper, noting that SVR was often forward thinking, and its report had a significant effect on actors [DE6, p. 3]. Further, he described the perceived need in the KBV directorate for new steering tools, particularly for chronic disease management, as opposed to those that "*come to an end*" (i.e., fee-for-service and capitation components) [DE6, p. 1].

Finally, a more empiric reason for KBV to look into quality improvement and P4P was to close a gap within the hospital sector, especially in terms of process of care, since thus far the focus in ambulatory care had been on volume of service delivery. This led KBV to start an indicator definition process which, although not specifically tied to P4P, was meant to be a steering tool that ultimately would require a payment component. The details of this project (AQUIK), which in the end failed, are presented in section 7.2.1.

These elements illustrate the relevance of internal concepts about payment and regulatory schemes, but also underscore the competition with other actors of the self-regulated structures for financing and delivery of SHI benefits, namely hospitals.

"Excellent patient care" in Bavaria

Local and/or regional quality improvement initiatives with P4P components were often driven by the individuals championing them. This was the case for the "Excellent patient care" program of KV Bavaria, initiated by its president Axel Munte, who headed the institution from 2001 until 2010. Via individual or collective contracts between physicians and sickness funds, doctors could receive bonus payments in 14 disease areas. For rheumatoid arthritis, for example, the conditions for payment were minimum standards for equipment, participation in continuing training in rheumatology and prescription targets.

Axel Munte explicitly saw P4P as a steering tool for controlling volume, costs and patient flow in ambulatory medical care (Munte, 2010). "Excellent patient care" became a registered brand in 2008[110] but was ended in 2011 after a change of KV directorate and strategy. Although the quality initiatives were continued, the new leaders announced that their reasoning for abandoning the brand was "*our quality idea, which says that all ambulatory care physicians and psychotherapists in Bavaria deliver excellent care*".[111]

6.4.2 SHI: a proactive competitor, looking in a similar direction

In a 2014 position paper on "quality-oriented steering of care and remuneration", SHI clarified that P4P should "*start now*" with a clear emphasis on the hospital sector (aerzteblatt.de, 2014a). While one reason may be that the handling of data in the hospital sector was easier, this was also driven by discussions about a wider hospital reform, which represented an opportunity for change. According to a senior SHI actor, savings through prescriptions did not play a role in putting P4P on the agenda; he said that prescription behaviour was one of the main drivers of specific GP contracts because they do not appear to affect health outcomes [DE5, p. 7]. Currently, GKV-SV is positioning itself by managing the quality indicator database QUINTH, a thesaurus that collects and assesses available indicators for use in different sectors[112].

This suggests that SHI, like KBV, aimed to be proactive in a sector where it currently saw its largest margin to manoeuvre, because P4P was perceived to be a means of seizing efficiency potential, in both the hospital and ambulatory sectors. The sickness fund AOK launched their indicator project QISA, which started in parallel to AQUIK. Developed in conjunction with

[110] https://de.wikipedia.org/wiki/Ausgezeichnete_Patientenversorgung
[111] Letter „Beendigung der Dachmarke ‚Ausgezeichnete Patientenversorgung'", KV Bavaria, 22.11.2011
[112] https://quinth.gkv-spitzenverband.de/content/index.php

AQUA, it was aimed at ambulatory care physicians and distributed easy-to-use tools that allowed practitioners to use quality indicators via SC. AOK explicitly suggested on its homepage how QISA as a "beginner's kit" could help indicators become a permanent part in physician practice:

> *"Finally, those who have made good experiences with quality indicators can more openly think about further-reaching forms of using indicators, such as external benchmarking or the definition of quality-based remuneration components".*[113]

6.4.3 MoH: wait and see

As discussed in the context section, there has been little clear political commitment for P4P since the 2007 SVR white paper other than the option for a quality payment component in hospitals. Other than occasional conferences, MoH has taken a "wait and see" attitude with regard to the indicators to be elaborated by IQTIG. One explanation was given by a leading SHI actor, who stated that the position of MoH was indecisive because P4P was linked to competition, and attitudes towards competition diverged significantly within MoH [DE5, p. 6]. From a party perspective, the health minister was a member of the smaller liberal coalition party FDP between 2009 and 2013. In keeping with FDP's economic angle, the 2009 party program provided that all health providers had "*a right to be paid based on performance and transparency criteria*" (FDP, 2009), and these ideas were discussed at the MoH level until the agreement of the following coalition in 2013 restricted the notion to the hospital sector (CDU, CSU, SPD, 2013). Indeed, while P4P has been discussed in the context of the hospital reform act (see *section 7.3 on hospitals* below), there has been no state-driven initiative concerning P4P in ambulatory care, which has given other actors the opportunity to do so. Illustrating how consensus is viewed as a key element of the system, a MoH actor noted that "*you cannot push a concept against opposition*", and that the role of MoH was to "*provide requirements and legal frameworks that have to be 'distilled' by the self-regulating bodies*" [DE7, p. 2]. Finally, with the considerable costs anticipated for the announced hospital reform and the many concessions made to various stakeholders, fiscal constraints did not seem to be a major concern in the German context, at least not as substantial driver of the introduction of P4P elements in ambulatory care.

[113] http://www.aok-gesundheitspartner.de/bund/qisa/ueber_qisa/index.html

6.4.4 Academia: the background actors

Although not statutory actors, we give particular consideration to the role of researchers because their influence on the discussion surrounding P4P appears to be relevant. Senior professors of medicine, health sciences and health economics are the constituting members of SVR (discussed above). Its reports are based on consensus-seeking with a large array of stakeholders, and its propositions have regularly become legislation (Bundesministerium für Gesundheit, 2015). Further, the statutory institutes relevant to quality and efficiency have directors with strong research backgrounds, including the Institute for Quality and Efficiency in Health Care (IQWIG)[114], the Centre for Quality in Medicine (ÄZQ)[115] and the Institute for Applied Quality Improvement and Research in Health Care (AQUA)[116]. This suggests the role of research, or at least of a research mindset, within the health reform decision making process.

In the case of the 2012 P4P expert report, two professors for health economics and health services research were consulted, each of whom had several years of training and research experience in the USA and the UK. One of them published his own papers on P4P in 1998 and 2000, in which he maintained that it was too early to be relevant for international policy because no one had implemented it at the time. With respect to the current debate, he argued that health services researchers were rather open-minded concerning P4P but overemphasised problems of risk adjustment, creating a perception of coalition between them and DKG[117] against P4P [DE1, p. 4].

The second researcher did not favour nationwide introduction of P4P at the GP level, preferring that it be applied to specific situations, such as pharmaceutical care or disease management. She mentioned QOF and maintained that its decreased effectiveness was linked to QOF's broad roll-out. She added that the background for P4P was an effort to impose greater rationalisation in SHI through increased competition, with the idea that P4P could rectify quality losses experienced when competition was introduced, as with DRGs in the context of "bloody discharge" [DE2, p. 5]. She said that KBV is the actual guarantor of high level of care

[114] Prof. Dr. med. Jürgen Windeler, professor of biometry and epidemiology
[115] Prof. Dr. rer. nat. Dr. med. Günter Ollenschläger, professor of internal medicine (director until 2014)
[116] Prof. Dr. med. Joachim Szecsenyi, professor of general medicine and health services research
[117] The German Hospital Federation of national and state associations of hospital owners, representative organ of all German hospitals in the GBA

in Germany and that their mandate was to ensure coverage of care, noting that the level of care and productivity is better in Germany than in other countries [DE2, p. 7].

These elements suggest that evidence about foreign experience with P4P was most likely channelled through researchers in parallel to the international literature available to all actors. However, no clear thread of action or coalition guiding the discussion or action around P4P was evident. Actors seemed to have been concerned with aspects related to their turf and the respective sectorial competencies designated by the self-regulating structures of the German system. Yet, with respect to the institution of KBV and its place in the system, there seems to be more at stake with P4P than for others: it may be linked to its claim for legitimacy and represent a means to act as "designer of the system". Finally, according to several interview partners, patient organisations did not play a role in the discussions around P4P.

6.4.5 Interim conclusion

In comparing the P4P initiatives of France and Germany, one initially sees little in common in their trajectories. While SHI in France was able to exert a lot of initiative and independence in a resource-intensive project with a certain degree of backing by MoH, the initiatives in Germany were more disparate, featuring projects driven by physician leaders, who were concerned with creating tools that would legitimise their competencies as self-regulators. The same is true for SHI in Germany, which has launched projects that, for the time being, focus on the hospital sector. In the meantime, MoH apparently remains true to its role as legal steward in a consensus-based system by not explicitly taking sides.

However, there appear to be similarities between the cases of France and Germany. They each concern a cast of experts (IGAS in France and BQS/researchers in Germany) who have laid a cognitive foundation upon which part of the negotiations and common representations could be based. In both countries, public reports were used that were based upon interviews with many stakeholders and experts. Likewise, in both cases, this expertise made extensive use of literature and personal experiences from the Anglo-Saxon sphere.

Following this first assessment of the key proponents, the next section will explore how other actors positioned themselves with respect to the reform stream and how this was interrelated with the reform coalition.

7 Professional coalitions

The interaction between the medical profession and the promoters of P4P programs is an essential factor of this study, because it constitutes a unique variable that seems both dependent and explanatory. It is dependent because some of the relations result from longer-standing lines of dissent; it is explanatory because these long-standing conflicts have inspired instruments (such as P4P) that imply a re-configuration of the social relations of the actors. In this respect, the relationship between the reform and professional actors highlights the complexities and multiple temporalities at play.

A key pattern is a growing disconnect between physician representatives and their bases in both countries. In France, SHI, employing significant human and material resources, proposed P4P contracts directly to GPs, thereby bypassing opposed union leaders. In Germany, an important potential P4P project was initiated by physician representatives, but rejected by their bases. In both cases, monetary considerations played a double-role. On the one hand, expected gains certainly weighed in favour of French GPs signing CAPI, while a powerful share of German physicians anticipated losses with a P4P payment component. On the other hand, the concern that external financial motivation may be an unethical disruptor of physician autonomy was a significant issue in both countries. Nonetheless, discontent with the dominant fee-for-service system in France most likely was a factor that led many practitioners to embrace CAPI.

Finally, the conflicts were (and remain) largely related to highly technical issues. In France, CAPI and the related performance measurements were also designed as means of driving the "digitalisation" of physician offices. In order to attract a sufficient number of GPs who would be eligible for bonuses, complex and lengthy simulations were made at "black box" SHI. In Germany, many inter-sectoral technical issues with quality measurement have been delayed because they are closely related to the conflictual question of data authority. These issues have not been resolved within the joint self-governing bodies, and thus the State has now stepped in as additional actor.

High technicity is an element that evokes path dependence. Technical instruments are more likely to be conceived by institutions that have the necessary resources to do so. Moreover, experience with such an instrument will increase the likelihood that other technically similar instruments follow. Such is the case in France with the extension of Sophia to other diseases,

the incorporation of CAPI into the collective agreements and the extension to other physician groups, such as cardiologists. Similar extensions may also occur in Germany under the newly founded agency IQTIG.

Ultimately, P4P was adopted in the hospital sector in both countries. Yet, while German DMPs were a means of strengthening competition between sickness funds, P4P elements in hospital payment are explicitly considered instrumental to fostering competition between hospitals to achieve “structural cleaning”.

7.1 The interaction with others shaping the action of the main actors in France

We have already established the high degree of discretion that SHI had in implementing its P4P initiative. However, they were not operating in a power vacuum: on the contrary, anticipation of the reactions of potential opponents played a very important role in their course of action. The following sub-section will briefly explore the instrumental role of indicator design in this process before considering the role of supporting parties.

7.1.1 Opposition at first

Initially, the efforts to introduce P4P were met with formal opposition from the medical profession. All GP unions were opposed, with varying degrees of opposition and differing arguments. The conservative[118] Federation of Medical Unions (FMF) expressed their resistance to the individual aspect of the contracts and their wish to continue collective bargaining on all issues concerning quality and continuity of care in exchange for an increase in the basic consultation fee for GPs (Chevreul et al., 2010). MG France, the major left-wing union of GPs, was not completely hostile to the objectives of CAPI, but they were concerned that such results-based contracting might encourage patient selection, arguing that doctors would have fewer incentives to work in low-income zones where health outcomes are worse. The Confederation of Medical Unions in France (CSMF), the right wing union, was opposed to the principle of controlling "medical practice" implied by CAPI and called on their members to refuse to sign CAPI (Chevreul et al., 2010) on the basis that CAPI meant "*the end of the freedom of prescription*" (Bras, 2011b). The former CSMF leader Michel Chassang, who at the time held a prominent position in media coverage and collective negotiations with SHI (Guichard, 2014), played a particular role. He interpreted CAPI as a "*proper SHI initiative backed by government*". He insisted that their aim was to save money and to bypass collective agreements with individual contracts, and that his opinion had little weight within SHI [FR6, p.1-2]. Yet, a former DSS actor suggested that the SHI director negotiated directly with Chassang, although there was no formal role for CSMF in the CAPI decision process [FR5, p.12].

Likewise, the National Council of the Physicians' Association (CNOM) sent strong messages describing CAPI as non-deontological and called for its withdrawal (Chevreul et al., 2010). The former CSMF leader said that savant societies were opposed as well. He maintained that

[118] In the sense that the defense of "liberal medicine" is a major mission

CNOM had reservations because with CAPI physicians had a vested interest in their own prescription practices, although he personally believed that CAPI had no effect on the doctor-patient relationship. He explained that doctors received extra money and patients were not concerned since CAPI only included efficiency indicators [FR6, p. 2], contrary to a 2009 CSMF leaflet that evoked a conflict of interest in the doctor-patient relationship (CSMF, 2009). Later, CSMF re-positioned itself by backing the introduction of P4P into the collective agreements in 2012, which also extended the program to specialists. According to the former CSMF head, they "*wanted something close to the UK system*", an "*improved version*" with medical as well as organisational indicators concerning IT infrastructure [FR6, p. 1-2]. CSMF reportedly advocated the indicators from the IGAS report, which were received very well by its membership [FR6, p. 1]. They also took a close look at the QOF indicators, which were perceived as archaic but rewarding in monetary terms [FR6, p. 2].

Despite multiple public statements signaling formal disapproval, the medical profession's resistance did not appear to be homogenous and rock-solid. Indeed, it seems as if the opposition leaders had anticipated that union members and non-members alike might ultimately "vote with their feet". This was confirmed by a former SHI actor, who said that there was no fundamental opposition by the CSMF leader or MG France as long as CAPI was part of the collective agreements. He added that if there had been actual opposition, "*there would have been blockage, but it was not the case*" [FR7, p. 6].

An interesting facet of the opposition to CAPI involved workers' unions, according to a senior SHI member. She said that workers' and doctors' unions appeared to collude from the outside. Yet, workers' unions believe that doctors are paid too much and that they should be salaried instead of being paid on a fee-for-service base, which they regard as a tool to increase income. Reportedly, debates on the SHI board on this subject were recurrent, with one union conceding that it was a good idea to diversify payment modes. However, the unions were opposed to the idea that "*doctors are paid for the work they should do anyways*" [FR12, p. 11], a concern shared by an MG France member, who reportedly was "*shocked to receive €5000 for working normally*" [FR5, p. 13-14]. Not surprisingly, these issues were also discussed by the advocates of P4P. An IGAS actor stated that it may be against the fundamental principles of health professionals to say "*when you work you will be paid more*", all the more so when efficiency indicators are used and it is not clear why certain diseases are targeted and others

not [FR2, p.4-5]; a former SHI actor framed it as the only serious counterargument: "*you don't work to be paid, but you do the best for your patient*" [FR7, p. 7].

Thus, SHI was well aware that external motivation could have a negative effect on intrinsic motivation as well as of the international discussions surrounding this issue. Yet, its logic was that increased remuneration for doctors should be treated as for anyone else, and they preferred to diversify the payment method instead of increasing the consultation tariff. Likewise, a former DSS actor said that in times of financial crisis the population would not like to see doctors receiving windfall benefits, but that from a management perspective payment should be increased if there is a "*win-win*" [FR5, p. 13-14], despite the fact that there may be a conflict between bonuses for prescriptions and patient interest [FR5, p. 8]. Although these concerns have not led to a wider public debate, it seems likely that they were largely shared by proponents and opponents of P4P and contributed to setting the level of bonus payments at a level deemed "socially acceptable".

Physicians' attitudes with respect to CAPI were explored by Saint-Lary et al. in a sample of 14 GPs. They held two focus group interviews with physicians who had (group 1) or not (group 2) signed CAPIs. The research focus was on ethical tensions, and the authors found that for all participants conflicts of interest were an issue in the sense that a potential resurgence of doctor's dirigisme could be detrimental to a patient's autonomy. GPs who did not sign CAPIs believed that the scheme would lead to patient selection, while those who signed CAPIs did not. The bonus level was considered low by all GPs and considered an offense by non-participating GPs. For participating GPs, the low bonus level minimised the risk of patient selection. Interestingly, the authors also found that "*for the majority of GPs in both groups, the dominant fee-for-service system of payment in France was judged unsatisfactory as it induced GPs to spend less time with complicated patients and was judged as being unfair*" (Saint-Lary et al., 2012). This suggests that, despite the small sample size, CAPI may indeed have been perceived as a necessary innovation in payment mode. This may also be linked to a generational effect in the sense that younger physicians are more amenable to such innovations. Indeed, a phone survey in 2013 found that 51% of doctors younger than 45 years are in favour of P4P, compared to only 29% of those above 60 years (Dupuis, 2013).

Finally, a controversial position was taken by HAS. In a 2009 speech its president, a professor of clinical hematology, acknowledged foreign experiences with P4P (but not CAPI), while

underscoring that quality indicators in France should either serve decision making for medical professionals or public health (Degos, 2009). This was reinforced by an SHI actor who noted that by the time HAS expressed opposition to the use of indicators for external regulation[119], "*luckily SHI worked without them*" [FR3, p. 3-4]. Likewise, another SHI actor reported subsequent opposition by HAS was due to the fact that they were not consulted in the CAPI process and felt that SHI "*improvised"* quality indicators[120], with HAS feeling "*that's not how you do it*" [FR12, p. 10]. Without any apparent link to CAPI, a seminar was organised at HAS in February 2008 in conjunction with the research project COMPAQH on "payment for quality" (Compaqh, 2008). Following an initiative by the seminar leader, a pilot for P4P in hospital settings was undertaken by COMPAQH and evaluated, and MoH has assessed the project indicators for use in wider settings (Projet Compaq-hpst, 2015). More details on the hospital indicator project are provided in section 7.3.

It is indeed surprising that an institution in charge of the regulation of healthcare quality was not more closely involved in the design of the CAPI indicators. While part of the explanation may be due to HAS' reluctance to couple quality indicators with financial incentives, another factor appears to be SHI's desire to be a nearly solitary actor in the introduction of CAPI, after initial collaboration and back-up by DSS. The following sub-section explores that in greater detail, in light of the role of the actors described above.

7.1.2 A solitary strategy

Opposition by doctors' unions was anticipated by SHI regardless of CAPI's content, because CAPI were individual contracts that represented a threat to collective agreements. In this context, early significant design choices were described as having been made unilaterally by SHI, resulting in other actors' perception that "*SHI always does everything alone and never teams up*", according to a senior SHI member [FR12, p. 9]. In addition, SHI was aware of opposition by doctors' unions to the top-down approach to data collection [FR12, p. 15-16], which indeed decreased transparency and control by other parties. With respect to such an independent approach, another SHI actor said that it was necessary to "*force*" CAPI, while noting that since CAPI was transformed into ROSP in 2012 SHI has worked systematically with

[119] A detailed account of the way quality indicators were seen at HAS (i.e., initially as a means of professional auto-regulation) is provided in (Bertillot, 2014).

[120] This is however contradicted by a statement of SHI authors in a joint OECD/Observatory book on P4P practice: "*The quality indicators were submitted to HAS, which validated them*." (Cashin et al., 2014)

doctors [FR3, p. 4]. Likewise, an analysis by one of the authors of the IGAS report on P4P concludes that SHI used CAPI to "*force*" the evolution of payment modes in France (Bras, 2011b).

As with the transformation of SHI since 2004 described earlier, it appears that the principal responsibility for these choices lay with the SHI director. A former SHI actor explained that Van Roekeghem not only led the CAPI initiative but also made the tactical decision to start with individual contracts, with the intention of including it in collective agreements at a later point [FR7, p. 1]. This approach was reportedly backed by DSS [FR7, p. 1] and ensured that union leaders would later support ROSP [FR12, p. 11]. This course of action was described as "*politically intelligent*" by an IGAS actor, since returning to the logic of collective agreement meant maintaining the "*balance of powers*" [FR2, p. 4].

These accounts are nuanced by interviewees who explained that there was a certain friction between SHI and MoH. According to one SHI actor, MoH almost refused the secondary integration into collective agreements because they supported the wedge in collective bargaining created by CAPI. SHI counter-argued that with exclusively individual contracts the participation rate would not exceed 40% [FR12, p. 11]. Moreover, a former DSS member explained that while SHI negotiates with unions it does not collaborate with them [FR5, p. 5-6], describing the SHI director's concerns during the initial discussions regarding strong resistance by CSMF, which finally gave in to political pressure [FR5, p. 2]. Finally, Bertillot, in his thesis on the evolution of quality indicators in France, concluded that MoH and SHI were in competition over who would be the first to introduce P4P: SHI as part of its remit for ambulatory care or MoH in its stewardship over the hospital sector (Bertillot, 2014).

Within SHI, there was nonetheless high approval for the CAPI approach. As one actor stated, the isolated development was a source of resistance but allowed it to be quite prepared from the start, doing a "*first bet, try to sell it*". He maintained that if it had been done in a cooperative manner, ROSP would not exist today [FR3, p. 3]. Another actor described CAPI as a vast and resource-intensive project with statisticians, lawyers and marketing experts, and the SHI team celebrated the milestones of 5,000 and 10,000 signatures [FR8, p. 6]. The team was reportedly enthusiastic, despite facing an uncertain outcome [FR8, p. 10-11]. Another SHI actor described the uncertainty regarding the evidence for policy tools, especially in designing them for maximum effectiveness [FR12, p. 13]. She said that there was a shared opinion at

SHI that the QOF led to a "*small acceleration on an already positive trend, but not for all indicators*" [FR12, p. 16]. The actor added that there was awareness that quality indicators may not always be entirely meaningful, although there was not much debate describing CAPI as "*cookbook medicine*" [FR12, p. 11].

7.1.3 With high investment in technical design

The independent action by SHI is illustrated by the manner in which CAPI's core indicators were designed. According to one senior actor, there was no precedent for the efficiency indicators, which were set unilaterally based on international prescription practice data and benchmarks such as Germany [FR12, p. 11]; prevention and clinical care indicators were developed by the SHI medical department using several references from the 2004 Public Health Act [FR12, p. 12]. Other sources included the international literature, such as AHRQ and other US organisations that had adopted indicators [FR3, p.3]. A former SHI actor said that the indicators were chosen if possible based on clinical recommendations and applicable to as many patients as possible so as to increase doctors' buy-in [FR8, p.10].

At the same time, a former DSS actor explained that there were discussions between DSS and SHI about the idea that the initial SHI indicators were not sufficiently medical [FR5 p.6], making sense to managers but not to doctors [FR5 p. 7]. She said that the indicator design was based on the desire to have a return on investment [FR5 p. 7]. She said that initially there were two or three self-declared public health indicators, in order to satisfy CNOM, but SHI refused them out of concern over the reliability of self-declaration in light of the experience with QOF. At the same time, she conceded that doctors could not be asked to document indicators without the necessary IT infrastructure [FR5 p. 7]. In line with this reasoning, an SHI actor explained that the initial plans included an indicator section on "office IT & organisation" which was postponed due to concerns about doctors' opposition. Such indicators were perceived as a lever for desired change towards the "*digitalisation*" of doctors' practices and patient records, given that France lagged in this regard compared to other countries [FR12, p. 14-15]. Finally, an IGAS actor clarified that IGAS' indicator propositions were on a system level, while SHI focused on GPs, feasibility and their own interests: IT infrastructure and generics policy [FR2, p.5].

In addition to the definition of indicators, thresholds had to be set to determine the size of the bonus payment. According to a former SHI actor, this happened in an incremental manner

using "*political and statistical criteria*" during month-long simulations, estimating payments in relation to actual GP data. He explained that the yearly bonus at the individual level should be significant, not only cosmetic [FR8, p. 10]. Likewise, his colleague described that, unlike QOF, CAPI had intermediary as well as final targets, so that the contract was "*attractive for everyone*", a feature that was rare in the literature and considered "*a technical, but important point*" [FR9, p.10]. At the same time, the absence of negotiations between doctors' unions and SHI led to the definition of tougher targets than in the UK, since on average 45% of objectives were reached (and a third of French GPs did not receive any bonus) while UK doctors reached on average 90% of available points (Bras, 2011b; CNAMTS, 2010). These apparently contrasting perspectives may actually confirm an overarching theme: that SHI engaged significant means and left nothing to chance to ensure that a balance was struck between investments, appeal to doctors, savings and payoff.

7.1.4 And support from other parties

Although not officially involved in the discussions around P4P, the head of an organisation for patients with diabetes said that his organisation backed SHI, in part due to good personal relations with the SHI director, following a fruitful collaboration on the diabetes disease management program Sophia. This suggests that there was a certain continuity between Sophia and CAPI starting as early as 2007. In the view of the patient organisation head, a fee-for-service payment system does not allow for the care pathways diabetics patients need, while P4P could help doctors find a new role and competencies around patient-centred care [FR10, p. 3-4].

A former DSS actor said that CAPI passed with little resistance from the legislative bodies. She said this was due to the framing as "*win-win*" program, using only bonuses and anticipating large savings through the reduction of prescriptions and the increased use of generics [FR5, p.8, p. 13]. However, she said that initially there was resistance in the Council of State, which argued that it was contrary to patients' interests to "*reward doctors for prescribing less*". She said that the opponents were won over by the public health implications of improved prescription behavior, for example in the case of antibiotics, where France lagged behind other countries [FR5, p. 8].

At the National Assembly public hearing on 26 Oct 2007, Jean-Marie Le Guen, a Socialist Party (PS) member and physician by training, called CAPI a "*pragmatic exit from collective*

agreements", despite awareness within the party (Jérôme Cahuzac) about the independent leading role of SHI and MoH. Not surprisingly, the right-wing Union for a Popular Movement (UMP) rapporteur of the Act, Yves Bur, reminded the body that during the past five years, doctors' unions had "*not supported*" SHI in its medically based cost containment efforts. Finally, the discussion in the Assembly was dominated by disputes over the gatekeeping system that has been in place since 2004, with PS arguing that P4P was a way by which UMP tried to re-install a logic that had been introduced as part of the referring doctor scheme in 1998 under a PS health minister. Likewise, there was no significant resistance at the Senate public hearing on 14 Nov 2007. Amendments by physician and UMP member Paul Blanc to have the contracts negotiated collectively and eliminate language regarding prescriptions were rejected, as well as an UMP amendment requiring consultation with professional organisations not officially recognised as representative and pharmaceutical companies[121]. Physician and PS member Bernard Cazeau welcomed the fact that CAPI was a step away from the fee-for-service principle. Citing a newspaper headline that "*health professionals live on the principles of 'liberal' medicine put forward in 1927*", he emphasised the negative impact of medical procedures and prescriptions on public finances, receiving applause from the Senate left wing[122].

Overall, the public debates suggest that there was a conjunction of the government initiative and a tendency in PS against the fee-for-service scheme. The importance of the gatekeeping concept and the references to medically-based cost containment underscore how P4P was perceived as being rooted in long-standing issues within the French system, reflected in the convictions put forward by the CAPI proponents. Interestingly, the deontological notion of conflict of interest, a key argument of doctors' representatives, was neither part of public debate nor advanced by a patient organisation with ties to SHI. These elements show that, despite the anticipated resistance by doctors' unions, many factors were favourable for the independent CAPI initiative pursued by SHI, including a shared understanding among influential politicians and patient organisations about the necessity to move away from the fee-for-service system.

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[121] Unsurprisingly, drug companies in France were not in favour of CAPI, asserting it would "*reduce doctors' liberty to prescribe and would put a brake on innovation, all in the name of improving public health*", according to M. Senior, *Europharmatoday*, cited in (Cashin et al., 2014).

[122] In a 2012 Dordogne budget report he wrote that « *la médecine libérale classique est à bout de souffle* » ("*classic liberal medicine is out of breath*")

Finally, another plausible aspect was advanced by the former CSMF head, who maintained that mutual insurance companies were in favor of CAPI as well, since the expected savings would also affect them [FR6, p. 3]. This completes a picture in which doctors' representatives appear almost isolated in their initial protest, which may explain why they changed their position soon after the CAPI introduction, allowing them ultimately to benefit from the momentum generated by CAPI. With the high rate of signing GPs, the inclusion of its successor ROSP in the 2012 collective agreements and the extension to medical specialists and pharmacists, P4P in France may emerge as a "dominant policy design". This term, used to describe the role of the DRG system after its introduction in the USA, describes a policy that balances stakeholders' interests and contains basic features that future innovations must embrace (Kimberly et al., 2008). Although the general media coverage describing P4P as a "*cultural revolution*" would seem to point in the same direction (Le Monde.fr, 2015), it may still be too early to draw final conclusions on this hypothesis.

7.2 Interaction between conflicting actors in Germany

Since P4P as a national program is not yet implemented in Germany, the debate about quality indicators represents a proxy-debate for the potential implications of a P4P-component, illustrating the lines of conflict around which the actors position themselves. As discussed above and argued by most actors, quality indicators constitute the necessary basis for P4P. Without them, in the words of a researcher, "*acceptance will be lacking and the project is dead*" [DE2, p. 6].

7.2.1 The KBV project Ambulatory Quality Indicators and Measures (AQUIK)

An initial example of this debate is revealed through a quality indicator set developed by KBV, which led to conflicts and revealed tensions among self-regulating SHI physicians. At the end of 2006, the KBV directors decided to launch the project Ambulatory Quality Indicators and Measures (AQUIK), which started in 2007 and aimed to test the "*measurement, reporting and steering of the quality of ambulatory care*" (Kassenärztliche Bundesvereinigung, 2009). Ultimately, KBV leaders planned for it to include P4P components. A first step was to collect internationally used quality indicators, an effort initiated with the help of RAND Health (USA/UK), discussed with health economists and collected in a database. In a second phase, the indicators were checked for usability in ambulatory care via expert panels and a method defined by RAND, before other expert panels discussed them by medical specialty. Finally, 48 indicators were operationalised and tested for practical feasibility (Kassenärztliche Bundesvereinigung, 2009). Describing this process as time- and money-consuming [DE6, p. 5], the KBV directors reportedly felt that, if no considerable preparatory work had been made, the project would have had no chance to survive the immediate fundamental discussions. Instead, according to its former head, KBV wanted to demonstrate feasibility first, to the point of its implementation in office software and payment modalities [DE6, p. 1]. He added that this helped KBV members overcome their early doubts, and the foreign experience was also helpful. Further scepticism concerned risk adjustment, the statistical feasibility of which could be proven because KBV could test it in its database with 11 million insured [DE6, p. 6].

With respect to facilitators and resistors, the former KBV head argued that his belief in using incentives conflicted with basic principles of care organisation. This ambivalence and uncertainty could, however, be moderated through the use of experiences from abroad. He said that foreign experts were very helpful by saying "*don't worry, that was not different in our*

experience" [DE6, p. 5]. While this may indeed have reinforced the directors' ambitions, the constituting members of KBV (KVs, the regional associations of SHI physicians) were not in favour. In the words of a physician journal, they cast a "*destructive verdict*", with the KV North-Rhine asserting its "*unproven effectiveness*" and the KV Baden-Württemberg arguing that it changed the medical professions into a "*performance within the scope of a target-oriented contract*" (Staeck, 2012). In addition, some of the panel experts and other physicians felt "*deceived*" because they had not been informed that AQUIK would ultimately form the basis of a P4P scheme (aerzteblatt.de, 2009). Finally, a group of family physicians argued that indicators and guidelines from other countries were not directly transferable because Germany lacked the gatekeeping-component frequently observed abroad (Rieser, 2009).

Ultimately, AQUIK was rejected, and the resistance suggests a link to fundamental assumptions about professional identity. The former KBV actor indeed stated the opposition revealed the resistance to breaking the hierarchical model of school-medicine which is closely linked to a generational effect. Unlike a traditional split between GP versus specialists within KBV, division over AQUIK reportedly was between junior and senior doctors, as was the case in France. Doctors born after 1960 accepted to have their performance displayed while senior doctors, still in solo practices, whose careers developed under the hierarchical model and who sat on the decisional bodies, opposed it: "*they were decisive for the resistance*" [DE6, p.2].

> *"We went in the discussion with the basis to see if this is wanted at all, with the claims that looked surprisingly clear to me: 'we do not want that'. […] It was clear from the beginning, if you do not do this preparatory work and collect arguments that you have no chance at all, according to the motto: 'how shall that work? My medical practice cannot be measured.' These were the discussions, and we do come from a very paternalistic physician image. In Germany, there is still is this school-thinking, holders of chairs, there are these enormous hierarchies with us in medicine, P4P breaks with this old hierarchy model in school-medicine." [DE6, p.1]*

A further factor behind the resistance reflects a certain overlap with the generational effect but exhibits some dimensions of the technical complexity inherent in the self-regulated physician payment: who would benefit. The former KBV head explained that P4P would actually entail a re-distribution of funds, which was of concern to those well-off in the current system [DE6, p. 3], and this view was shared by a senior researcher [DE1, p. 6]. According to the former KBV head, it would have been different if additional funds had been available, but SHI had

refused [DE6, p. 2]. Likewise, he stated there was no political support either. Indeed, they anticipated resistance at the federal and geographical levels because allocations per insured vary from 320-390€ depending on the *Land*, and this would have implications for a uniform P4P scheme, resulting in opposition by currently well-off *Länder* such as Bavaria (represented by CSU) [DE6, p. 3].

Finally, the KBV actor claimed that no other actors were truly opposed to P4P [DE6, p. 4] and that partisan policy did not play a role, although he conceded that there had been more impetus for reform under the Schmidt-led MoH than under the current coalition [DE6, p. 5]. Likewise, an SHI actor said there were only a few frontiers of partisan politics with left-wing *Die Linke* opposed, potential proponents for economic incentives found in the centre-right CDU and the centre-left SPD sometimes assuming the view of trade unions (Verdi) [DE5, p.6].

In sum, AQUIK appears to have been a move by KBV to maintain its legitimacy as a self-regulating body, amidst growing claims that the remuneration system in place was incomprehensible and insufficient (IGES Institut, 2014). This may have triggered a relatively early initiative that lacked clear alliances outside KBV and suffered from insufficiently transparent internal communications and that ultimately was rejected in the face of vivid criticisms concerning professionalism and the technical aspects of allocation of funds.

7.2.2 Quality assurance measures across sectors: high technical complexity and an increase in State influence

Another example of the challenges surrounding quality indicators are the cross-sectorial quality indicators (SQG) and the long delay in their methodological design. In 2007, the Act to Strengthen Competition in SHI mandated that GBA commission an institute to provide technical support in developing SQG. After an EU-wide tendering process, the AQUA Institute was commissioned in 2009 (Busse and Blümel, 2014). The work process proved to be very slow, and physician organisations that were entitled to provide input (KBV and BÄK) regularly criticised the methods proposed by AQUA via public statements[123]. AQUA was not familiar with quality assurance measures across sectors, because their previous experience mainly involved hospital data, which is why many methodological issues had to be clarified. According

[123] See http://www.kbv.de/html/themen_2854.php and http://www.bundesaerztekammer.de/politik/stellungnahmen-zu-aqua/thematische-uebersicht-zu-aqua-papieren/

to a KBV actor, this was linked to a characteristic of self-regulation: "*discuss until the subject is dead*". He claimed that the technical pre-conditions for a wide roll-out of SQG were lacking (such as unique patient identifier), so that "*one occupies himself with expertise, methods …*" [DE6, p. 4]. While this partly self-critical account of KBV indeed suggests that neither side accelerated the process, a senior researcher explained that the technical specifications impeded rapid advancement:

> *"If each indicator has to be reliable and valid and manipulation-proof and and and …, then they can never advance […]; of course not only AQUA is to blame but also the commissioners." [DE1, p. 4]*

A more pointed interpretation was put forward by a senior SHI actor, who argued that the stalling SQG process was mirrored by a "*split republic, two worlds*". On the one hand, AQUA focussed on the hospital sector with a public quality report partly steered by GBA; on the other hand, ambulatory care was under the remit of a "*KBV-monopoly*", with a quality report beyond GBA influence that lacked transparency and patient participation [DE5, p. 1]. He expanded on his position by adding that KBV wanted to keep their activities outside of GBA's control, invoking SHI regulations from 1930 and their confirmation in 1950 [DE5, p. 4]. He said that KBV had "*tried everything*" to block quality assurance measures across sectors by blurring the discussion over indicator development, so that after the Act in 2007 "*not a single procedure currently exists*" [DE5, p. 3], although he conceded that there was minor progress in terms of structural requirements and quality measurement [DE5, p. 3]. Under his explanatory model, physicians dislike P4P because it represents an external assessment and their world view is different: poor quality is rare and doctors should deal with it among themselves [DE5, p. 6]. He concluded that for SQG, the "*monopoly of KBV needs to be broken*", which would be an unpopular measure under an FDP-government[124], and thus the process was slowed on the technical level and waived by parliament. He said that development of IQTIG may be a move to re-implicate parliament in the process, and to stop KBV's delay tactics [DE5, p. 3]. A similar point was defended by IQTIG's director[125], who noted:

[124] During the 2009-2013 period, the two ministers of health in office were both members of the liberal party FDP which has a strong physician electorate.

[125] Christof Veit, physician by training, formerly head of BQS and lead author oft its 2012 P4P report.
He reports good networking relations with the USA (Commonwealth Fund, Brooklyn Institute) and the UK including regular meetings and visits.

> *"With the steering instruments P4P and indicators relevant to planning, it will be a sovereign [hoheitlich] affair that you cannot delegate to someone." [DE9, p. 1]*

These examples illustrate, particularly with respect to the KBV and SHI actors, that there was a significant divide between the parties of the self-regulating bodies. The intensity of the accounts, not prompted by specific questions by the interviewer, suggested that it is an irreconcilable conflict. Because we are dealing with institutions, we assume that there may be deeper-rooted system elements that explain part of the dispute. Asserting a hypothesis that something may be hidden under the tip of the iceberg, a senior researcher stated that the *quality improvement* put forward by many actors may only be a sham argument:

> "*The improvement of care or quality is being used in the discussion, but I do not actually really believe most actors.*" [DE1, p. 6]

In any case, control of data has strong implications that lead to immediate sanctions by other parties, as illustrated by the case of the sickness fund AOK. It was sued by two hospitals for displaying in an online-navigator comparative hospital data based in part on insurer claims data (Brandt, 2013). Within this line of reasoning, a KBV actor said that the key question is:

> "W*ho holds the data, holds the power* […] *everything failed because of this question.*" [DE6, p. 4]

Indeed, the generation of data within the self-regulating bodies would shift the power distribution among SHI, doctors and hospitals. With respect to SQG, these arguments appear very plausible and would explain the move by GBA and the government to task a new institute with the delicate issue.

As for the overall debate over P4P, a researcher said the reasons for the slow discussion and small progress thus far was due to the fact that neither KBV nor SHI would endorse or even push it [DE2, p. 6], which is consistent with the discussion above. Indeed, it would appear logical that the KBV directors would align with the reservations that their members had expressed about P4P. Moreover, if bonus payment only represented 5-10% as set forth in the BQS 2012 report, it is possible that physicians would prefer resort to private patients as additional source of income and dismiss P4P. Finally, another researcher argued that the current P4P-discussion was not forward-oriented, and some actors lost courage after the initial efforts

[DE1, p. 3]. This picture is confirmed by the headlines of the lead medical magazine *Deutsches Ärzteblatt*, ranging from "*implementation still far away*" [126] to "*P4P – yesterday's discussion*"[127].

With this in mind, the next section will briefly outline the perspectives for a P4P component outside of ambulatory care.

[126] Umsetzung noch in weiter Ferne. Deutsches Ärzteblatt, 3. Oktober 2014.
[127] Pay für performance: Diskussion von gestern? Deutsches Ärzteblatt, 15. Mai 2014.

7.3 Hospitals: the current path of pursuit

The aforementioned Hospital Reform Act (*Krankenhausstrukturgesetz*, KHSG[128]) became effective in January 2016. Its main component is a structural fund at the national level designed to overcome insufficient funding at the *Länder* level. It also includes a provision and financing to increase the number of nurses in hospitals. Of significance to this study, quality criteria are being introduced as part of capacity planning: additional or reduced payments will be made for some performance areas depending on quality. GBA is charged with the development of quality targets and indicators and has tasked IQTIG with delivering a proposal, which is scheduled for mid-2017[129].

In the discussions preceding the act, the Federal Association of Sickness Funds (GKV-SV) staked out a clear position. To increase the comparability of hospitals, a score should be developed for patients and sickness funds, and low achieving hospitals should transfer funds to the top performers. In this way, SHI would not be seen as saving money with poor performing hospitals (aerzteblatt.de, 2014a). An SHI actor described this as marketing problem: "*there should be no budget savings through bad care*" [DE5, p. 2]. In this respect, P4P is linked to the notion of competition, with one goal of GKV-SV being the exclusion of poor performing hospitals from the market.[130] Likewise, for the health minister in office, Hermann Gröhe, with KHSG "*we help the Länder with reducing costly over-capacities*"[131] via a process termed "structural cleaning"[132].

In terms of the assumptions and means at hand for the actors at play, a former MoH actor said that, based on the US experience, incentives should target groups and reward improvement, not thresholds. Hospitals are seen as better targets than doctors because ambulatory care by individual physicians is hard to measure [DE3, p. 6]. This notion, shared by many actors, may have added to the difficulties with SQG and other delays, and underlies the context within which the P4P initiatives for the hospital sector have evolved in Germany.

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[128] Gesetz zur Reform der Strukturen der Krankenhausversorgung (Krankenhausstrukturgesetz - KHSG), 2016

[129] https://iqtig.org/startseite/

[130] However, the senior SHI actor conceded that P4P based on outcome indicators is not an adequate tool for meeting this goal because confidence intervals made it difficult to identify a "significantly poor" hospital [DE5, p. 2].

[131] https://www.bundesgesundheitsministerium.de/themen/krankenversicherung/krankenhausstrukturgesetz/khsg.html

[132] *Strukturbereinigung*. See, for example, (Leber and Schmedders, 2014)

Nonetheless, other key assumptions and influences appear to be highly relevant. The senior actor in charge of hospital policy at SHI, an economist by training, described a longstanding professional relationship with the professor of quality management at TU Berlin, Thomas Mansky, who previously held a position at the private hospital group Helios after working on the introduction of DRGs with 3M Health Information Systems [DE5, p. 6]. He said that the DRG system was made possible through a coalition that encompassed the sickness fund AOK, private hospitals hoping to improve their position and private substitutive insurers.

> *"This partnership has continued I think in a quality initiative, under Qualitätskliniken.de, there is a whole scene where private hospitals have realised: it is their weak point if they publicly have a bad reputation."*[133] *[DE5, p.6]*

Arguing they are the only ones publishing mortality data, he framed the development of indicators by private hospitals for publication and internal steering as a "*transparency offensive*" and "*quality as marketing*". Mentioning an SC with AOK, he maintained that "*private hospital chains have actually proven the most sustainably reliant partners for P4P*" [DE5, p. 6]. This apparently clear positioning by a leading SHI representative in favour of private hospitals seems surprising at first glance. Yet, the idea of P4P as a client-binding marketing measure is very plausible and substantiated by the official opposition of DKG to P4P (aerzteblatt.de, 2014b), which is likely explained by the preponderance of public/private non-profit hospitals over private hospitals in Germany. Interestingly, the lawsuit against AOK was made by one public and one private non-profit hospital (Ärzte Zeitung, 2014), suggesting that public hospitals did indeed anticipate a marketing disadvantage.

Finally, the SHI actor described its proposal for a P4P component in developing the KHSG that would evaluate indicators for certain DRG clusters, potentially based on standardised mortality rates [DE5, p. 2] and scored for a hospital department[134]. He made clear that the US, with its hospital value-based purchasing program introduced in 2013, is "*one step ahead*" [DE5, p. 4]. He explained that the potential for transfer of US indicators has decreased because "*five years*" will be needed due to the slow institutional process [DE5, p. 3]. Yet, he defines his

[133] As a consequence, local authorities may not sell them public hospitals anymore.

[134] He further argues that such a "take what you have" approach allows starting right away; the rest of the hospital may wait.

work-process for P4P as chance-driven, having been done without study trips or benchmarking unlike others (and younger colleagues) at SHI [DE5, p. 5].

This circumscribed account of the hospital sector seems to diverge in its logic from the previous sections. Indeed, the strong references to notions of marketing, competition and the role of private providers suggest that recent experiences from the US may have colluded with similar, pre-existing concepts around (neo)-liberal market logic. The particular role of Thomas Mansky in this regard was qualified by a recent PhD thesis on financial incentives in the hospital sector, which was supervised by Mansky. The author highlighted a book that was influential in the debate in Germany, "Creating Value-based Competition on Results", which advocated transferring the concept of competition to the health care market (Gesche Seeger, 2013). Whilst this approach is not new to health reformers, the above elements exemplify how the presence of a "transfer agent" and a recent model policy in the US may have amplified their respective impact on the reform discussion in Germany.[135]

The French case seems to reveal a similar drawing of inspiration from the US, yet without the notion of market logic. As mentioned in section 7.1.1, the French hospital quality indicator project COMPAQH initially led to the establishment of official hospital league tables in 2006/2007, based on the idea of informing patient choice and, according to the head of COMPAQH, to "*reduce information asymmetry between payer and regulator and the producer, the hospital*" [FR14, p.1]. Hospital payment in France is based on the DRG system (as in Germany), which holds little intrinsic incentives for quality improvement. As a complementary payment mode, the IFAQ project (*Incitation Financière à l'Amélioration de la Qualité*) used 81 indicators for bonus payments to reward the top 30% of participating hospitals from 2012-2015; the initiative was expanded nationwide in 2016.

> "*How did we proceed: we did a lot of literature search, a lot North-American value-based purchasing, because they are very advanced, and then we started to create a model that we proposed to MoH and HAS, adapted to the French context …*" [FR14, p. 2][136]

As in the German case, the differential impact on public versus private hospitals was an issue. While the first round of the experiment revealed a disadvantage for university hospitals with

[135] In the meantime, the evidence base for P4P in an inpatient setting remains poor, as reported in the latest 2016 review of experiences in OECD-countries (Milstein and Schreyoegg, 2016).
[136] For a full account of the foreign references, see (Jiang et al., 2012)

a large case-mix compared to private hospitals with specialised activity, the following rounds of analyses will examine whether adjustment for this bias is possible. With respect to competition, the political framework for the hospital landscape, however, differs strongly from Germany, with P4P advocated as an instrument for egalitarian policy goals:

> "*We are in a [statutory] health insurance system in France, where quality must be the same everywhere. So if an evaluation shows a gap, the policy must mean to reduce that gap.*" [FR 14, p. 7]

Despite the briefness of this account, the French case with its consecutive steps from COMPAQH to IFAQ and a nationwide implementation gives the impression of a surprisingly smooth and linear process. While the reality is certainly more complex than that, the fact that the COMPAQ research was undertaken by a long-standing group of researchers and experts operating in cooperation with regulators and hospitals in an "applied research" mode facilitated the process. For Bertillot, describing the process as a form of "soft rationalisation", success was driven by framing the instrumentation so that it would align the meaning of the indicators with the different expectations and objectives of the institutional actors involved (Bertillot, 2015).

7.4 Interim conclusion

This exploration of the hospital sector reveals that P4P initiatives are gaining ground in both France and Germany, with the specifics still being developed in Germany. From both country cases, we can begin to appreciate that there are not only frictions along the traditional conflict lines (state/insurers versus providers), but also an additional sectorial dimension. Indeed, the respective actors seem to view P4P as an instrument for increasing their regulatory power, mediated largely through access to and control over data. This seems to be particularly relevant In Germany, because SHI has a significant remit over hospital data (as well as ambulatory care data), while in France, a dedicated state agency (ATIH[137]) processes hospital data. Another key difference in this respect is the proactive role of German private hospitals in a context of explicit competition between hospitals, as opposed to a hospital policy with a stronger focus on equality of care in France.

[137] *Agence Technique de l'Information sur l'Hospitalisation* (Agency for Information on Hospital Care), under the remit of MoH

8 Interplay between domestic and foreign policy streams

The following section will examine the more cognitive factors and developments in and outside of the system that have shaped the reform debates.

In the case of France there appears to be a shared and strong narrative, centred on transformations of cost containment as well as physician practice and remuneration. In this storyline, the idea of a concrete "model" for P4P in the UK is indeed present; yet it appears as more of a means to allow the key actors to reflect and contrast their own assumptions and intentions. It is likely that this concise narrative indeed laid the basis for the introduction of P4P[138] and contributed to the high impact of P4P in France. It fits the characteristics of causal stories in policy agendas as set out by Deborah Stone, as having "*a strong normative component that links suffering with an identifiable agent, and so they can be critical of existing social conditions and relationships. They implicitly call for a redistribution of power by demanding that causal agents cease producing harm and by suggesting the types of people who should be entrusted with reform"* (Stone, 1989).

Conversely, our data on Germany does not suggest a strong narrative, and certainly none that would be shared among the actors. Instead, it appears that there has been a rather long-term exposure to the subject P4P, with resource-intense evaluations such as the one by MoH. The different actors attached distinct meanings and interpretations of the P4P experience from abroad, ranging from approval and legitimacy to refusal and denial.

[138] However, some of the discourse may also be adapted to fit the events, in the sense of a post-hoc bias.

8.1 National challenges as precursors and drivers of adaptation in France

In the international literature that preceded the introduction of CAPI in France, there was no elaborate or uniform definition of P4P. While the IOM views it as "*the systematic and deliberate use of payment incentives that recognise and reward high levels of quality and quality improvement*" (Institute Of Medicine, 2007), the authors of a decision guide for the US Agency for Healthcare Research and Quality simply state that it includes "*any type of performance-based provider payment arrangements including those that target performance on cost measures*" (Dudley and Rosenthal, 2006). The straightforward nature of these concepts may seem almost banal today, and one could wonder whether the fundamental idea of providing financial incentives for performance were already in France before the introduction of CAPI. Such conceptual foundations are indeed suggested by our data and can be distinguished by four broader dimensions: 1), "medically based cost containment", linked to audit and feedback; 2), the perceived need for change in physician payment; 3), the promotion of data flow and IT structure; 4), the notion of gatekeeping. The following two sub-sections will examine these dimensions in greater detail. The last sub-section of the French case will then take a closer look at how CAPI relates to the QOF in the UK.

8.1.1 Medically based cost containment, academic detailing and the perceived need for new remuneration schemes

The notion of medically-based cost containment has become increasingly important in French health policy since the 1990s, following a long period of cost containment efforts that focussed on controlling the volume and prices of goods and services. As the head of the SHI medical department has explained, medically-based cost containment can conciliate both cost control and the demand for quality (Allemand and Prieur, 2009). This has been operationalised through continuing medical education, the development of practice guidelines by national agencies and the introduction of good practice commitments within professionals' collective agreements (Chevreul et al., 2010). The latter are in the remit of SHI, and the former head of its DSES described the development of CAPI as a more stringent step within a series of measures taken by SHI. For her, the 2005 collective agreements renewed the idea of medically-based cost containment, because there were medical objectives and the agreement to use more generics. However, those objectives were collective and rather perceived as good intentions. However, she noted the positive role of physician profiles delivered by SHI medical representatives (DAM) pursuant to the good practice commitments. The DAM, intensively

recruited since 2005, perform individual visits to physician practices presenting generic prescription statistics in comparison to local colleagues. Their impact on prescription behaviour was marked, but only had a short-term effect. For the former DSES head, the concept is linked to "*international rationalisation*", ideas of audit and feedback which were tested and reported by the Cochrane Collaboration as means of changing physician behaviour, leading to the emergence of multiple methods around "*academic detailing*"[139] [FR12, p. 8-9].

[139] Defined as the "*theory and practice of methods to improve physicians' clinical decision making to enhance the quality and cost-effectiveness of care*", as "*Principles of Educational Outreach ('Academic Detailing')*" in (Soumerai, 1990)

DAM ("Délégué de l'Assurance Maladie"): a powerful asset

DAMs usually receive two years of tertiary training in commerce or sciences before following dedicated training at SHI[140]; there were approximately 1000 DAMs in 2009 (Allemand and Prieur, 2009). While they have been described in the literature as being created in 2003 to counteract the influence of pharmaceutical representatives (Chevreul et al., 2010), a former SHI actor stated that DAMs were actually inspired by pharmaceutical representatives but what they were marketing was SHI risk management [FR7, p. 5]. A similar interpretation was given by the former head of a doctors' union, who described the role of DAMs in the promotion of CAPI as "*individual advertisement based on the analysis of individual practices*", noting that only GPs with "*interesting profiles*" were visited [FR6, p. 2]. The high impact of this targeted approach is reinforced by the fact that, in 2009, 89% of GPs subscribing to CAPI stated that their signature followed a visit by a DAM (Bras, 2011b). At the time of the introduction of CAPI, DAMs were also backed by SHI-employed physicians (*médecins conseil*), with a workforce of about 2000 [FR13, p. 2].

According to the former head of DSES at SHI, there was a subsequent idea to individualise the objectives that were formerly part of the collective agreements, which was also driven by the fact that there are ample physician-level data. This would allow proposing "*something ambitious*" to physicians who were far from reaching certain objectives and to compensate those making great efforts [FR12, p. 9]. This reasoning is almost identical to the framing used by the Minister of Health, who stated that the collective agreements contained only minimal objectives and that CAPI allowed physicians who wanted to commit to go "*further than that*"; for the Minister, CAPI was supposed to "*individualise the collective commitments of medically based cost containment*" (Roselyne Bachelot-Narquin at the Senate public hearing on 14 Nov 2007).

This public framing was complemented by the views of a DSS actor with regard to physician practice. She said that doctors are aware that resources must be saved, but they are not well informed in their individual, isolated offices. If they received information on their prescription behaviour, they were "*the first to change*" and indeed they were receptive to medically-based cost containment if a medical benefit was put forward [FR5 p. 1]. At the same time, she said

[140] http://www.lassurance-maladie-recrute.com/nos-metiers/zoom-metier/metier/delegue-de-lassurance-maladie/famille/gestion-du-risque.html

that the argument of cost to society was not a decisive argument in French medical decision making, noting that doctors often argue in payment debates that the individual interest supersedes the collective interest (for example, with respect to chemotherapy).

> *"The 'liberal profession', well these for me are extraordinary principles, […] but wanting to remain great idealists I think there is great problem of maintaining the system […]." [FR5, p. 9]*

Overlapping with the logic of "*renewed medically-based cost containment*" at SHI and MoH, there was the conviction at SHI that "*physician remuneration had to evolve anyways*", but that SHI wanted "*something in exchange*" [FR3, p. 1-2], ideally obtained through efficiency margins [FR12, p. 10]. SHI supported the idea that "*everyone has a margin of improvement*", noting that it was certainly the case for generic prescription at that time [FR12, p. 10]. Further, by using individual contracts, the possibility of freeloading inherent to collective agreements would be reduced [FR3, p. 1-2]. Similarly, a DSS actor expressed concern about the dichotomy between doctors' unions, characterised by low overall membership rates, and their bases which is why DSS wanted to address those bases with individual contracts [FR5 p. 1].

Finally, SHI and DSS held similar views that impacted the technical dimensions of individual contracts for GPs. More concerned with budgets and efficiency in the first place, a DSS actor explained how prescriptions hold a greater potential for savings than consultation tariffs, the latter being fairly well controlled. She said that in the prescription budget even small changes have significant impact, while doctors and patients are insensitive to drug prices, resulting in unnecessary and non-indicated prescriptions [FR5 p. 8]. At the same time, the head of the SHI medical department was described as an advocate of medical and public health objectives in the collective agreements. He defended CAPI as a major public health tool, since small individual improvements on physician level may lead to large scale public health outcomes because of the large target population [FR12, p. 12]. Indeed, unlike QOF and most other foreign examples, CAPI included population-focussed indicators targeting prevention and clinical care. Actually, the domain with the highest number of indicators is efficiency (generic prescription, see Table 9 below). This illustrates how long-standing yet distinct themes (budget control and public health) in both institutions contributed to the framing of CAPI as the logical continuation of medically-based cost containment; or as a former SHI actor put it, "*all arguments converged*" [FR7, p. 7].

8.1.2 Strategic issues and the aim of "cultural transformation": data, IT infrastructure and gatekeeping

Another key factor advanced by SHI for the genesis of CAPI was the strategic interest of implicating physicians in the delivery of data, with the aim of using more physician-level data in the long run. The modernisation of the physician IT infrastructure was set out as an explicit goal, potentially allowing inclusion of patients for whom no claims data is available (such as for individuals with diabetes treated by diet only for whom there are no prescription data in the SHI database). According to a senior SHI actor, the first step was to provide data feedback at the population level before a second step in which doctors would produce their own data and develop the habit of checking their results. Ultimately, SHI aimed for a mix of claims and physician-level data with P4P as a means of transparency, able to address "*many things about the system*" [FR12, p. 15-16]. A DSS actor reinforced how important it is that doctors generate structured patient follow-up data, explaining that previously there were no clear and uniform requirements at the time funding was provided to physician offices for IT infrastructure [FR5, p. 7]. The point was underscored by Van Roekeghem in a foreword to a joint publication by OECD and the European Observatory on Health Systems and Policies in 2014:

> "*Beyond its direct results, P4P may have positive collateral impacts: the development of a culture of performance measurement and monitoring among health professionals, the strengthening of a public health approach enhancing population-based outcomes. In France, P4P also gave strong impetus to the development of electronic medical records in primary care practice. These dynamics may contribute to quality improvement outside of the range of traditional 'performance indicators', but little is known about them. Finally, P4P is a lever to develop strategic purchasing and to enrich the dialogue between purchasers of care and the medical profession, and in that sense it may be an element of a strategy for change*." (Cashin et al., 2014)

Before the introduction of CAPI, physician-level data were neither available nor feasible. A former SHI actor described visiting a UK GP office with burdensome data management and thinking that "*French GPs could not handle this*" [FR7, p. 4], which is why SHI opted for a top-down approach to data collection: of 16 indicators, only one (blood pressure) was self-declared by physicians. The simplistic impression that SHI only used its data because it was short of alternatives was nuanced by the same actor who maintained that, while foreign inspiration played a role in the introduction of P4P, another reason was the fact that "*the information*

systems allowed for it": SHI was able to identify patients, their diseases, trends, etc. He said that, despite the potential critique about data, France does indeed have significantly more data than other countries [FR7 p. 5], a fact that was quantified by another SHI actor:

> *"We have one of the biggest databases in Europe, even in the world almost in terms of exhaustivity." [FR3, p. 3]*

Regardless of the respective weight of these arguments in the process leading to CAPI ("we need more data" versus "we have the data") they clearly challenged the hypothesis of QOF as a direct model. The first argument, under which doctors should generate data in order to look at their results, is consistent with the academic paradigm presented above. In addition, the generation of physician data may also present an additional means of regulatory control over the medical profession. The second argument, concerning the strategic opportunity presented by the ample SHI database, stands in direct contrast to QOF because in the UK all data are generated by health centres, processed by NHS and then audited (Boyle, 2011). Thus, data and IT infrastructure may be characterised as "internal elements" that may have been re-interpreted in light of foreign experiences.

Finally, the way in which these strategic elements were put forward conveyed a sense of cultural transformation, reflected by a comment by a senior SHI actor, who said that CAPI would "*change things, advance the way we think about things*" [FR12, p. 14]. This appears to have particular relevance to another issue recurrent since the 1990s: the role of the GP with respect to the gatekeeping function. A senior SHI actor explained that the individualistic doctor-patient relationship is typical for France, but that doctors should be responsible for the overall population enrolled in his or her practice and not only for the patients visiting the physician's office. It is important to note in this regard that CAPI results are calculated by reference to the population enrolled with their gatekeeping physician (*médecin traitant*) as denominator. According to the SHI actor, it is "*culturally positive*" to sensitise doctors via feedback to the fact that, contrary to their own perceptions, many of their patients are not vaccinated or screened for breast cancer [FR12, p. 14]. Evoking this public health perspective in a similar manner, the Minister of Health stated in a parliamentary debate that CAPI "*completes the gatekeeping scheme*" introduced in 2004 (Roselyne Bachelot-Narquin at the National Assembly public hearing on 26 Oct 2007).

8.1.3 Differences CAPI – QOF and indicator design: a strong in-house component

Against the backdrop of the development of P4P in France, it is important to highlight key differences between CAPI and QOF (see Table 9) to better understand how certain design choices were made.

Table 9: Overview of the indicators used to measure performance in the UK (QOF) and France (CAPI), based on (Boyle, 2011; Chevreul et al., 2010)

	QOF	CAPI
Number indicators	**134**	**16**
Clinical care	**86 indicators** covering 20 clinical areas including coronary heart disease, stroke, hypertension, diabetes, chronic obstructive pulmonary disease, epilepsy, cancer, mental health, hypothyroidism and asthma	**5 indicators**: - diabetic patients: proportion treated in line with current recommendations (eye examinations, glycated haemoglobin tests, co-prescriptions of statins and aspirin); - normalisation of high blood pressure
Prevention	**9 indicators** covering four service areas including cervical screening, child health, maternity and contraceptive services	**4 indicators**: flu immunisations, breast cancer screening, reduction of the prescription of vasodilators and benzodiazepine with long half-life
Generic prescription	-	**7 indicators**: antibiotics, proton pump inhibitors, statins, antihypertensive drugs, angiotensin-converting enzyme inhibitors, aspirin
Organisation	**36 indicators** covering records and information for and about patients, education and training, practice and medicines management	-
Patient experience	**3 indicators** covering the services provided, how they are provided and patient involvement in service development plans	-

The health system financing context constitutes a major difference in that QOF was not set within a cost containment logic, which was addressed elsewhere in the UK system (Walley et al., 2005). Generic prescription, for example, had been previously promoted in the UK, leading to relatively high generic prescription levels compared to the European average (Duerden and Hughes, 2010). Instead, QOF was part of a new collective GP contract negotiated in 2004 (GMS) that represented a major investment in primary care by the NHS. Accordingly, the mean net income of a GP in the UK increased by approximately 60% to 140,000€ between 2003 and 2006 (Bras and Duhamel, 2008). In contrast, the introduction of CAPI in France was set within

a context of growing SHI deficits and the imposition of expenditure ceilings. GPs signing CAPI contracts could earn a bonus of approximately 5,000€/year, representing about 90% of the mean net revenue per month of a GP at the time of introduction (Saint-Lary et al., 2012). This relatively low additional income compared to the UK stems from the principle that the contract was designed to be theoretically "*neutral*": if all quality and efficiency objectives were met, the system would be self-financed [FR12, p. 10]. In other words, SHI anticipated that the implementation cost would be balanced by savings resulting from improved prescription practice (Bras, 2011b; Saint-Lary et al., 2012).

Another key element concerns the treatment of outliers: in contrast to QOF, CAPI does not allow exception reporting. This means that doctors cannot exclude patients from CAPI on the grounds that their characteristics do not fit the P4P scheme. According to a senior SHI actor, this matter was and still is a subject of public debate. She described strong internal opposition to exception reporting by the head of the SHI medical department who did not want physicians to say "*I can do nothing for these patients*" [FR12, p. 12]. This choice may be linked to the distinction between "individual practice" and the "public health approach" addressed above, reflecting the goal of increasing doctors' responsibility for their entire patient population. Likewise, the preclusion of exception reporting prevents patient selection, in other words physicians choosing or refusing patients based on whether they may generate additional income. Neither CAPI nor QOF used risk adjustment, although capitation, the main remuneration component in the UK, is risk-adjusted (Bras, 2011b) in contrast to the fee-for-service remuneration in France. Risk adjustment could have compensated the absence of exception reporting, but a senior SHI actor noted that "*frankly, no one does it*". She explained that the SHI deliberately set non-ambitious thresholds so that physicians would have discretion over some patients, but could not say "*we exclude them*" [FR12, p. 12]. A former SHI actor illustrated this using the case of generic prescription, where targets of 100% or even 90% would be difficult for some GPs with mostly older patients. He said that indicators were chosen that made sense without risk adjustment: for example, the number of blood tests per year for glycated haemoglobin should normally be valid for all patients with diabetes [FR7, p. 11]. Another senior SHI actor summarised the procedure for the indicator design:

> "*With claims data, we chose to start with real-life data. […]. We tried to come up with 'intelligent' indicators […], we tested on the data of the previous year, this has allowed us to calibrate obviously a distribution, […] that allowed to calibrate target objectives, […] it's not perfect medicine, but we looked what we could expect from the recommendations, […] in-house at CNAMTS.*" [FR13, p. 2]

Finally, the NHS differs from France with respect to the organisation of the health care system: GPs are exclusively set in relatively large group practices, including non-medical staff, and the QOF is calculated at that level. Further, patients are generally enrolled with a fixed GP (Boyle, 2011), in contrast to the "soft gatekeeping" practiced in France via financial incentives for patients (Chevreul et al., 2010). A former SHI actor participating in the study trip to the UK highlighted the differences between the two countries, stating that P4P "*was a second layer on a first one that differed indeed*". Beyond differences in terms of service delivery, awareness about differences also concerned system objectives:

> *"Each system, behind it rests on an incentive system, a lot of Julian Le Grand*[141] *and all that, finally it is very British the idea that public service is good but one must better direct incentives. What we have well seen is that incentives need to be well directed towards the objectives of the program on so what you could imagine as needs and deficiencies of the system. […] So we did not come home by saying 'we will duplicate QOF and P4P'". [FR7, p. 3-4]*

These explicit statements suggest that the QOF may have been less a *model*[142] for CAPI than a *case study* allowing the key actors to reflect and contrast their own assumptions and intentions. A former SHI actor added the notion that the literature around the international experiences represented a facilitator vis-à-vis the French health professionals, conceding it was difficult to "*sell*" CAPI as an individual initiative while QOF was collective [FR7, p. 6].

[141] Sir Julian Le Grand, professor of social policy at the London School of Economics, senior policy advisor to former Prime Minister Tony Blair, defends policies aimed at promoting choice and competition within the NHS: "*So if we cannot rely on performance management or voice to reform public services, what can we do? The answer lies in choice and competition and the key elements are: user choice; money following the choice; and new forms of providers*" (Le Grand, 2006).

[142] IGAS members Pierre-Louis Bras and Gilles Duhamel raised this question in "The English Health System, a model for France?" and concluded that this should not be the case because, despite many interesting system characteristics, the outcomes of the NHS were still inferior to those in France (Bras and Duhamel, 2010).

8.2 The use (or not) of foreign experience in Germany

With respect to the MoH and its attitude regarding change with respect to P4P, a former senior MoH actor[143] gave an account of his exposure to the idea over several years (2001-2009), which led him to think that there was growing scepticism despite the high interest in the international developments. He argued that key MoH actors were well aware that there are no "*reform big-bangs*" but rather "*direction settings*" that may exert their effect at a later stage. He said that the last "megatrend" in health policy was the system change from acute to chronic care, starting with the Bundestags-Enquete-Commission on the Structural Reform of SHI in 1990. While such processes appear to emanate from the system as part of a deliberate evolution, he added that there were other important factors to open "*new horizons*". They included personalities such as Karl Lauterbach[144], the contact with the EBM movement and the 2001 Institute of Medicine report[145], which he describes as "*famous*" [DE3, p. 7-8]. Issued by the health branch of the US National Academy of Sciences, the report set out performance expectations for the US health care system and identified current practices impeding quality care.

Thus, the US system apparently played an inspirational role in addition to intrinsic processes. This inspiration was further triggered by an employee of the Bertelsmann Foundation[146] who was seconded to MoH. She was in charge of drafting articles for the Health Policy Monitor[147] and organised several MoH meetings at Harvard University with the P4P expert Meredith Rosenthal. In addition, MoH participated regularly in the so-called Four Country Conference of Health Care Policies and Health Care Reforms. These conferences included scientists, civil servants and practitioners, lasted five days and treated themes such as disease management and P4P. The former MoH actor described them as a "*unique way of exchange*" that stopped at some point [DE3, p. 8].

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[143] Head of a directorate from 2003-2009

[144] Member of parliament (SPD), former Director of the institute of health economics at the University of Cologne, adjunct professor at the Harvard School of Public Health; he had major implications for the introduction of disease management in Germany in 2000 (see related case study)

[145] Institute of Medicine, Crossing the Quality Chasm: A New Health System for the Twenty-first Century (Washington: National Academy Press, 2001).

[146] According to Wikipedia, The Bertelsmann Foundation is the largest private operating non-profit foundation in Germany, supporting neoliberal ideas and holding 77.4 percent of the German multinational mass media corporation Bertelsmann (http://en.wikipedia.org/wiki/Bertelsmann_Foundation)

[147] Initiated by the Bertelsmann Foundation, the Health Policy Monitor (http://hpm.org) was part of an international network for exchange on health reform activities, operated through meetings and articles. In 2011, it merged under the auspices of the European Observatory on Health Systems and Policies.

While he argued that there was initial enthusiasm over P4P, it was followed by a "*sobering up*" when MoH realised that the direction of P4P's effects were not clear from the experiences in the US. The perceived difficulty in attributing performance to distinct actors seemed to be an obstacle, particularly for the German system, which is characterised by a strict separation of care sectors. He added that similar lessons were drawn from the experience of QOF, ultimately leading to significant reservations regarding legislator efforts [DE3, p. 6]. While this suggests that US and UK experiences played an actual role MoH's positioning, it was nuanced by the actor, who said that "*many people do not see the use of international experience evaluation*", adding that "*transferring a concept is at least as much work as developing a new concept*" [DE3, p. 9]. This account suggests that personal contacts and networks played an important role in MoH's positioning; that significant resources had been invested to gather evidence and that, finally, a deliberate decision was taken to "non-act".

Conversely, the former head of KBV appears to have been far more inclined to implement experiences made in other countries. Arguing that there are many indicators in the international literature that are suitable for quality measurement, he believed that pay-for-transparency should be introduced before P4P so as to create incentives for IT-infrastructure in physicians' offices [DE6, p. 2]. Since KBV is concerned with ambulatory care, its former head had a clear focus on experiences in the UK, as well as reports from the US, Scandinavia and HMOs in Switzerland. Although no study trips were organised, existing contacts with the NHS, the WHO Observatory and health economists from Germany[148] and the US[149] allowed expert meetings to be organised in Germany. He said these events helped to convince the participants, noting that they were in any case "*the generation you do not need to convince*" [DE6, p. 2].

While evidence from abroad regarding the usefulness of P4P had mostly positive reactions at MoH and KBV, other actors applied it for a contrary purpose. Although difficult to demonstrate through public statements, a senior researcher described a "*dominant coalition*" with the mindset that "*P4P is a good idea in principle, but everything is so difficult, and also experiences elsewhere show it does not work*" [DE1, p. 4). In this way, "*misused arguments*" on how P4P does not work in other countries were used to stall the debate [DE1, p. 6-7]. One example of

[148] Prof. Dr. med. Reinhard Busse, Technische Universität Berlin; Prof. Dr. rer. pol. Eberhard Wille, Universität Mannheim
[149] Pr. Dr. Uwe Reinhardt, Princeton University

this may be the attitude towards P4P expressed by Josef Hecken, head of the principal decision-making body within the system of joint self-government, the Federal Joint Committee (GBA). It consists of representatives of the federal associations of providers and payers and as well as several neutral members including its head (Busse and Blümel, 2014). Although GBA did not publish a clear position concerning P4P, Josef Hecken stated during a 2014 conference that P4P was a "*magic word*" for which no one knows the meaning, adding the unsupported claim that P4P in the UK had been stopped after two years (Köhler, 2014). In April 2015 he reiterated this opinion, stating that "*worldwide there is no model in which P4P works in a collective contract*" (aerzteblatt.de, 2015), which is contradicted (in part) by the QOF experience.

Finally, a distinct view of the impact of other countries on P4P in Germany is to dismiss it; an SHI actor argued that quality indicators were a "*German product*", unlike DRGs which entailed "*international tourism*" to the US. He said quality indicators "*follow the payment scheme*". In other words, where payments were first differentiated in the scope of DRGs, the first quality assurance procedures were established. He emphasised that "*in this respect, other countries played no role*" [DE5, p. 3].

8.3 Conclusions on the introduction of pay-for-performance

Interpreting P4P as a policy instrument in power politics, the introduction of CAPI in France appears to have been linked to the increasingly dominant regulatory role of SHI since 2004. A clear leadership role was assumed by its director, applying an almost military tactic by starting with CAPI as individual contracts and then later integrating P4P "generously" in the collective agreements, using the "secret weapon" DAM [150] as a means of bypassing unions and "marketing" CAPI directly to GPs. The cognitive focus was on cost containment via generic prescription[151], with SHI's strategic goal of fostering IT in physician offices. Its backbone was a well-staffed strategy department scanning foreign experience.

At the same time, the leader of KBV in Germany tried to improve the doctors' position in relation to SHI and hospitals, including in terms of the new role and increasing competencies of GBA. He may have aimed for a tactical advantage by supporting an early initiative for P4P, hoping also to gain control over data or at least over data collection methods. The P4P pilot in ambulatory care led by KBV failed and was followed by long technical debates about quality indicators that may be seen as delay tactics. The current debate concerns issues over data and the balance of power among the self-regulating partners at GBA (physicians, SHI, hospitals). A P4P component will be introduced for hospital payment soon and is likely to yield advantages for SHI and private hospitals.

Besides the politics of power, there are less tangible aspects at play, notably the influence of experiences with the QOF as remuneration component in the UK. Preparatory work on CAPI in France and AQUIK in Germany started concomitantly in 2007. This suggests a common external impulse, probably triggered by the first landmark evaluation of the QOF published in 2007 in the widely read New England Journal of Medicine[152].

We have examined interview data and other sources in order to establish exactly how experiences and ideas have impacted our case studies; in both countries, it is apparent that

[150] This is reflected in the terminology used e.g. by a senior SHI member, stating that SHI has convinced thanks to its "*striking force, the [SHI] physicians in the field*" [FR13].

[151] However, an analyst points out the inconsistency in political goals: DSS and SHI opted for P4P to increase generic prescription; at the same time MOH did not promote reference-class based drug pricing; hence, pharma sales representatives financed through drug prices oppose CAPI incentives financed by SHI (Bras, 2011b). A similar argument was put forward at the National Assembly public hearing on 26 Oct 2007, highlighting the contradiction between financial margins for industry (€200 Mio) but incentives for generic prescription through CAPI (Jérôme Cahuzac).

[152] Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. *Quality of primary care in England with the introduction of pay for performance*. N Engl J Med 2007;357:181-90.

processes were far more complex than they appeared from the outside. The following and final sections will build upon these aspects and draw conclusions within the wider policy context as well as current debates.

Conclusions

9 The changing health systems in France and Germany seen through the lens of disease management and pay-for-performance

While the preceding parts of this thesis have been dedicated to the presentation and discussion of our data, the following sections will address the overarching themes from both case studies and seek to determine whether a generalisation of these themes is possible or appropriate.

This conclusion is structured in three sections. The first will examine the role of physician autonomy and representatives, patient organisations, expertise and partisan politics as key features of change. The second section will link our data to the theoretical framework we introduced and examine the link with other concepts such as Europeanisation. The third section will revisit the growing role of SHI and the State, which has been a central theme throughout our analysis and assess the possibilities for future study.

9.1 Key features of change

9.1.1 Physician autonomy: a key motive, subject to timing and system configuration

One of the most striking features of the case studies on P4P is the apparent paradox of the union leaders' position and the reaction of the targeted physicians. In France, leaders of doctors' unions opposed P4P but were bypassed by their members, while in Germany the reverse was seen: KBV leaders were in favour of P4P and implemented a pilot, which was then rejected by its members. In other words, in France, GPs rejected the union leaders' call for resistance by signing up for P4P; in Germany, doctors rejected their leaders' initiative by rejecting P4P.

Both cases reveal an underlying divide between physicians' representatives and their memberships, and a closer look at the motives for opposition may explain the paradox. In fact, two discursive categories can be identified that were used by physicians in both countries: the first centres on their professional concerns and the second relates to the material aspects. With respect to the professional concerns of doctors, almost all actors in France addressed the conflict of internal versus external motivation and the ethics of "paying what a doctor should do anyways", but this was only a minor issue in the public debate. The latter was characterised by the announcements and leaflets of union leaders on the grounds that "liberal medicine" was in danger. In Germany, conversely, the core conflict was more linked to doctors' professional identity and the shift from "autonomy towards transparency". As for material aspects, French doctors' unions' prime concern was the fact that individual contracts bypassed their legitimacy as negotiators and representatives. In Germany, the methodology of the regional fund allocation and concerns that well-off doctors may have material losses represented key barriers.

The most important conclusion to be drawn from this probably relates to the dynamic in physicians' attitudes towards their professional identity. In France, the process may be interpreted as "silent admittance" that a move away from "liberal medicine" towards new remuneration schemes was necessary, in light of its backing by politicians and patients in our case study, and *de facto* was already taking place[153]. In this respect, French doctors may appear more as "price takers" rather than actors co-designing the agenda. In Germany, the

[153] For instance, through a flat payment per patient enrolled in the ALD chronic care scheme.

rejection of the KBV initiative for P4P represented a move perceived as self-congruent by physicians 1) to manifest they were not willing or ready to give up part of their autonomy and 2) to express a growing but moderate discontent with the effectiveness of their self-regulating system.

It is important to note that a major transition away from professional autonomy had already taken place with the introduction of DM in Germany in 2002: in exchange for financial incentives, doctors follow treatment guidelines for certain diseases, backed by legislation and regulated via GBA. Thus, physicians may already be "saturated" by the 2002 DM reform that has been interpreted as significant by many analysts and that has been met with growing acceptance. Conversely, there has been no comparable major specific policy in France preceding the advent of CAPI: besides a certainly growing influence of clinical guidelines, DM (via the SHI program Sophia) has not had a significant impact on physician behaviour, and the gatekeeping scheme currently has greater implications for patients and specialists than for GPs. This might be one reason for the rapid uptake of CAPI, in addition to more obviously favourable factors such as an increase in income without the risk of penalties.

This seeming contradiction may also help to explain why the reactions of physicians to P4P in both countries were not consistent with their positions vis-à-vis the respective earlier reforms[154]. In fact, by heralding the principle of "liberal medicine", doctors in France showed clear resistance to measures such as budgetary sanctions in the scope of the Juppé reforms in 1996. Meanwhile, in Germany, physicians were tightly integrated in the regulation of their own profession, in the German corporatist tradition (Hassenteufel and Davesne, 2013). To address this paradox further, the following section will examine the role of physician representatives in this context.

9.1.2 Physician representatives in a context of diminished influence

As mediators of diverging meanings and interests, physician representatives have a particular role characterised by great ambiguity. On the one hand, a chief occupation of physician representatives is to advocate the interests and opinions of their profession, as it is for union

[154] This account emphasises the importance of timing for our conclusions and for comparative study in general. Cognitive and social processes can be cyclical in nature, and therefore even small shifts in the temporal horizon of analysis may lead to seemingly paradoxical results of comparison. In this regard, Pierson has clarified that "*placing politics in time and systematically situating particular moments (including the present) in a temporal sequence of events and processes can greatly enrich our understanding of complex social dynamics*" (Pierson, 2000c). See also (Jensen and Wagoner, 2009) for a proposed broader cyclical model of social change.

leaders across professional groups (Andolfatto and Labbé, 2006). On the other hand, our data suggest a relatively high degree of cognitive proximity with state/SHI actors, expressed through technical vocabulary and notions such as regulation and economics[155] – a bit more in Germany but also seen in France[156].

These distinct roles have been emphasised by Bandelow and Hassenteufel (Bandelow and Hassenteufel, 2006) with their motives of "consensus democracy" (Germany) and "conflict democracy" (France). Consistently so, the self-regulating nature of physicians in Germany confers on KBV representatives a particular "buffer" status that results in continuous negotiation between its roles as regulator and representative. Unlike the unions in France, KBV not only represents doctors but also is in charge of distributing payments that SHI allocates based on morbidity characteristics of patients. Through this delegation to self-regulating bodies, government actors can blame them in the event of failure[157]. In France, in the case of P4P, the motive of "conflict democracy" did not prove effective for the unions, since neither a critical mass of physicians, nor public opinion could be mobilised. The primary reasons for this were presented in section 7.1, among which are the "direct marketing" of CAPI at physician level via DAM and SHI medical representatives and the full support of patients of the SHI policy.

However, these system features are also set within a wider transformation of physician representation. In France, medical unions are facing a significant reduction in their degree of representation, reflected by election participation rates that have dropped from 59% in 1994 to 45% in 2010. This is strongly linked to a process of internal fragmentation based on the key issues of "liberal medicine" and vested interests of subgroups of medical specialties, including GPs. Although the institutional landscape differs in Germany and SHI physicians are *de jure* represented by KBV, there also have been significant signs of fragmentation. The most important have been the creation of a separate organisation to represent GPs and the

[155] In both countries, SHI has been able to position itself better in the playing field in which P4P is set: it is characterised by logic of data and economics, which are areas of expertise of insurers.

[156] A senior SHI member expressed how the SHI negotiation partners were aware of this: according to her, during negotiations, the interlocutors "*share some notions of economics, but are not always representative of the base*" [FR13, p. 2].

[157] This blame avoidance is also seen as one the factors explaining why the joint self-administration in Germany gains competencies despite (and concomitantly with) the strengthening of the State. With the political aim of expenditure control and increased competition, the institutions of self-governance face a lower risk of de-legitimisation than politicians or parties, in part because they do rarely act in the public arena (Gerlinger and Schmucker, 2009).

foundation in 1999 of MEDI-organisations[158] which have tried to establish themselves as alternatives to the "system-integrated" KV-system (Hassenteufel and Davesne, 2013). The basis for this "erosion" was laid by increasing dissent over the distribution of funds, in a context in which the growth of the overall remuneration budget did not match the increase in the numbers of ambulatory care physicians (Gerlinger and Schmucker, 2009).

Overall, our data show that the DM and P4P reforms implemented to date represent a higher benefit for GPs than for specialist physicians. Although slightly neglected in the early phase of Sophia, GPs were the explicit target of CAPI in France. In Germany, GPs have *the* key role in running DMPs, but have not yet been targeted by national P4P components[159]. SHI and the State in both countries have interests in strengthening the role of family medicine: if the GP has a greater role in the coordination of patient trajectories, SHI can exert influence through the definition of pathways and the related incentives[160]. Interestingly, SHI in both countries resorted to a similar tool: selective contracting with individual or groups of physicians, which resulted in a weakening of physician organisations. Since 2000, this has been in place for family physicians Germany; in France, they were used for CAPI in 2009, before P4P became subject to collective agreements with ROSP[161]. In contrast to GPs, we have seen that specialists (in this case, diabetologists) in both countries held conflictual positions when DM was introduced. In the case of P4P, specialists have been included in the ROSP scheme since 2012 in France, but have not staked out a particular position in the discussion in Germany.

Overall, DM and P4P in both countries were most likely not causally linked to the decline that physician representatives have experienced. Instead, the conflict appears to be a symptom of the overarching threads exposed above: decreased representation, increased fragmentation and growing influence of SHI. The true challenge seems to be the positioning of physician representatives in highly technical domains, which indicator-based payment systems clearly

[158] By choosing the legal status of an association, MEDI did not fall under the remit of the self-regulatory bodies. According to MEDI, this facilitated alternative forms of contracting or care delivery, such as integrated care, GP-centred care and multidisciplinary medial homes: http://www.medi-verbund.de/was_ist_medi2.html.

[159] It is also interesting to note that the model for P4P – the NHS in the UK – has a very strong primary care system, while GPs in France and Germany (still) have a low professional profile.

[160] See section 4.3

[161] Consequently, the following conclusion by Gerlinger and Schmucker on the growing ability of German individual actors to shape healthcare and payment arrangements can be applied to both France and Germany: *"[…] an overwhelming proportion of care continues to be regulated by collective agreements with the associations of statutory health insurance physicians. But the trend towards further erosion of arrangements made 'uniformly and jointly' is obvious"* (Gerlinger and Schmucker, 2009).

are. If union leaders understand the opportunity and aim for discursive and tactical ownership (of P4P, in this case), they should adopt mind-sets that are be viewed as "technocratic" or "quantitative" in the eyes of their memberships, which would lead to a loss of support. The importance of the argumentation in this regard is further detailed in section 9.3.

9.1.3 Patient organisations: a growing role in both systems

We have noted the significant difference in the roles of patient organisations in the introduction of DM and P4P. While an organisation representing patients with diabetes was an important ally to SHI for Sophia (and to a lesser extend for CAPI), in Germany the role of patient organisations was only marginal and even viewed as "pharma-contaminated". Which factors account for these differences?

By applying the concept of political opportunity[162], Bergeron and Castel suggest that the impact of patient movements strongly depends on the institutional and political context. In a prototypical case, the high dynamics of patient movements in the USA are linked to decentralised administration, a relatively weak executive, a lively legislative branch and a horizontal fragmentation of federal authorities. Conversely, the British NHS, with its centralised character, has features that favour more cooperative interactions with civil society, and indeed there appears to be a more consensus-based relationship among public authorities, patient organisations and physician representatives. Bergeron and Castel see France as a case characterised by a centralised State, where pubic decision making is largely isolated from the requests of social actors and movements. In this context, the authors suggest that regulations such as the 2002 act (see below) were shouldered by a "*small number of individuals, enjoying strong proximity to places of public decision making*" (Bergeron and Castel, 2015). This is consistent with our data and is substantiated by a recent assessment by IGAS of "health democracy" following the 2002 Patients' Rights and Quality of Care Act[163], which defined in particular the rights and duties of patients and health professionals. The author of that report concluded that "*the functioning of the administration and also of the associative movement is considered as non-satisfactory since it rests on a 'top down' and not on a 'bottom up' model*" (Mauss, 2016). Indeed, we have discussed that the relationship between the individual leaders

[162] Doug McAdam, John D. McCarthy, Mayer N. Zald (1996). *Comparative perspectives on social movements: political opportunities, mobilizing structures, and cultural framings*. New York: Cambridge University Press. In (Bergeron and Castel, 2015).
[163] Act no. 2002-303 of 4 March 2002; *loi relative aux droits des malades et à la qualité du système de santé.*

of SHI and the patient organisation was important and potentially facilitated by social affinities. In addition, our data suggests a role for framing (changing the mode of medical practice as a "boundary object"[164]) and complementary resources (potentially material benefits for the patient organisation and legitimacy/publicity for SHI[165]). Finally, the internal tensions that resulted for the head of the patient organisation[166] illustrate the conflicts of interest inherent to such alliances.

It must be noted that these characterisations carry the risk of generalisations, since there is a great diversity within the spectrum of patient organisations, most often due the disease focus and its trajectory within the system. For example, the French association of haemophiles (AFH[167]) underwent a significant shift in its relationship with the medical profession[168], in part due to the "contaminated blood crisis" of 1991[169].

In contrast to France, there is no shared narrative for the role of patient organisations or its transition. Yet, as in France and other countries, the participation of patients in the health system has been increasingly institutionalised. Since 2004, patient representatives have participated in GBA's negotiations, although they do not have the right to vote. The recurrent theme of corporatism and consensus in the German health decision making can, apparently, also be applied to patient organisations. Indeed, a 2014 position paper by the four leading federations[170] concludes on the *status quo* of patient participation:

> *"The in part difficult decisions have gained credibility and acceptance through the participation and partly consenting, partly critical vote of patient representatives. At the same time, patient representatives have proven to be reliable and competent partners when it came to defend controversial decisions to the outside, if they were made*

[164] For Star and Griesemer, boundary objects are plastic enough to adapt to the local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They have different meanings in different social worlds but their structure is sufficiently common in more than one world to make them recognisable, a means of translation (Star and Griesemer, 1989).

[165] The president of AFD figured on the cover page of Sophia's newsletter: *Sophia et vous*, Journal N°23 - Été 2014. https://www.ameli-sophia.fr/diabete/nos-publications/journaux-sophia-et-vous.html

[166] See section 3.5

[167] https://www.afh.asso.fr/

[168] As noted in (Bergeron and Castel, 2015), from an almost complete delegation of scientific affairs to physicians and the defence of a paternalistic doctor-patient relationship (Carricaburu, 2000) towards greater scientific independence and the promotion of greater patient autonomy (Fillion, 2009).

[169] For an overview on „*l'affaire du sang contaminé*" and its impact, see (Carricaburu and Ménoret, 2004), pages 121 – 136.

[170] These four organisations have been accredited to represent patients with GBA, with criteria set out by law.

in the interest of the community of patients and insured." (Verbraucherzentrale Bundesverband et al., 2014)

However, naturally, the federations of patient organisations are seeking greater participation, for example in the new IQTIG or on the *Länder* level.

Despite this perceived constructive collaboration, the relationship the pharmaceutical industry has with patient organisations remained a conflictual theme in Germany (in addition to the issues around the diabetes DMP discussed earlier), as well as within the patient community. This is illustrated by a position paper by *Deutsche Krebshilfe* (Action against Cancer) from 2016. The authors "*increasingly perceive*" that pharmaceutical companies aim for increased integration of patient interests in drug policy and suggest that politics "*seek to promote this desired proximity between private firms and patient representatives"*. Consequently, they argue that the work of patient organisations should be independent from industry (Deutsche Krebshilfe, 2016).

In sum, the sub-system structuring the representation of patients in both countries seems to follow similar patterns to those observed in the overall system. This features a relatively strong role for individuals and vertical power relations in France, while in Germany more horizontal and cooperative processes are at play. The formal role of patients is growing in both systems, leading to a more complex set of actors. This seems to have played in favour of State and SHI interests in France, while our data allows no firm conclusions for this development in Germany.

9.1.4 Expertise: different approaches, different traditions

In the highly technical reform fields addressed here, actors have made extensive use of expertise (or were indeed experts themselves, as in the case of Karl Lauterbach). Beyond the actual need for information, expertise can be a means of external validation when there is uncertainty. Further, referring to an expert often is a source of legitimacy and therefore power.

In our case studies, we note that none of the French actors reported influence by other institutions such as the High Council for the Future of Health Insurance (HCAAM) or French academic expertise. In addition, the expertise of IGAS did not have an impact as such but was rather revelatory of a co-occurrence of ideas across institutions. Instead, expertise was mostly in-house at SHI, in part based on newly recruited senior health system experts such as Dominique

Polton[171] and in part through long-standing senior employees. They have diverse backgrounds in traditional elite institutions, economy, statistics, but also public health. In Germany, our data suggests a different "tradition": we have highlighted the role of the "independent" institution SVR, comprised of researchers, on the policy process, as well as the 2012 BQS report on P4P. Likewise, both KBV and SHI reported on the extensive reliance on external and mostly academic expertise, suggesting a certain profile of intermediate actors in charge of transfer and translation: university professors, trained as physicians with a specialisation in health economics and extensive experience in the USA, using a similar terminology and participating in international networks (Reinhard Busse, Stephanie Stock, Thomas Mansky, Karl Lauterbach).

The role of expertise appears to be consistent with previous accounts about health reform actors in Germany, such as Bandelow and Hassenteufel's description of the prominent role of expert committees during the 1990s and to a lesser extent after 2003 (Bandelow and Hassenteufel, 2006). Conversely, the authors underscore the role of specialised civil servants with high influence in the French central administration. This is confirmed in our case studies in the role of Frédéric Van Roekeghem (appointed SHI director in 2004 while he was still head of cabinet of the Minister of Health), Pierre-Louis Bras and Gilles Duhamel at IGAS, as well as, more recently, a growing specialised workforce in the ministerial statistics department (DREES). Despite the risk of oversimplification, such differences must be considered against the backdrop of the more general traits of the political system. Comparing pluralistic and centralistic in France and federal and corporatist in Germany (Bandelow and Hassenteufel, 2006), these traits appear coherent with the way in which expertise was conveyed in the cited examples. Telling illustrations of these distinct patterns are reflected in the use of eponyms: while in France reforms are typically associated with a minister's name (the Juppé Plan, the Bachelot Act, etc.), some of the major social policy reforms in Germany have been permanently associated with the name of expert commission leaders, the most prominent example being the common use of "Hartz IV"[172] in designating the basic social benefit package.

[171] Mathematician and economist by training and alumna of the ENSAE statistics school, Dominique Polton was director of the IRDES institute for research and information in health economics before joining the SHI.
[172] Named after Peter Hartz, senior manager at *Volkswagen AG*; in extension, the verb "*hartzen*" has also gained traction in informal language.

9.1.5 Partisan politics: differing arenas of discourse

The year 2017 will see elections in both France and in Germany, which raises the important question of the impact of partisan politics on past and future health reform.

At the time of submission of this manuscript, health issues were not on the political agenda in Germany. With the KHSG in effect, the subsequent technical preparations are under way for the future use of indicators, which is of marginal interest to the general public. Instead, geopolitical topics and the impact of the "refugee crisis" dominate the discussions. On the SPD website, health is not even mentioned under the 14 "viewpoint" topics for which the party provides information[173]. Indeed, under continued economic stability, a dominant idea conveyed under the grand coalition (CDU/CSU and SPD since 2013) is that *"Germany is doing well"*. Accordingly, there (still) is no fiscal pressure to fuel health reform debates[174]. This contrasts with periods of intense public discussions, such as the 2005 election campaign, when the concepts of *Bürgerversicherung* ("citizen's insurance", defended by SPD[175]), and *Kopfpauschale* (per capita premium, defended by CDU[176]) confronted each other. Over time, these topics have received diminishing attention, but are still part of the respective party platforms.

In the context of the rather technical reform topic P4P, we see that partisan positions appear to have played a more important role in Germany than in France. The liberal party FDP had highlighted P4P in its party manifesto, and the CDU expert committee on health recently published a detailed position paper on how to implement inpatient P4P that goes beyond the KHSG[177]. In France, the 2012 PS manifesto devotes only one sentence in its 27 pages to

[173] *Gute Arbeit, Gute Bildung, Starke Familien, Starke Wirtschaft, Soziale Sicherheit, Weltoffene Gesellschaft, Lebendige Städte und Gemeinden, Frieden und Verständigung, Gleichstellung, Saubere Umwelt, Freiheit in Sicherheit, Digitalleben, Europa*; https://www.spd.de/standpunkte

[174] Deutschland steht gut da! Erfolgskurs in Deutschland und Europa fortsetzen! Positionspapier CDU, 26.3.2014, https://www.cdu.de/politik-a-z/gesundheit-und-pflege

[175] Ideas: expand the mandatory health insurance requirement to additional population groups, eliminate the upper wage threshold beyond which employees can currently opt out of the SHI system, increase the SHI wage base, extend the SHI financing base to include other forms of income such as rents and interest (Busse and Blümel, 2014).

[176] Community-rated per capita premium combined with a fixed employer contribution based on employee's gross wages. People unable to afford the premium receive subsidies financed through general taxation (Busse and Blümel, 2014).

[177] 24. Oktober 2016: CDU will Kliniken nach Qualität bezahlen. http://www.rp-online.de/politik/deutschland/gesundheitsversorgung-cdu-will-kliniken-nach-qualitaet-bezahlen-aid-1.6345357

physician payment and refers to capitation[178]. In the UMP manifesto, no mention of payment was made at all[179]. Meanwhile, the upcoming 2017 presidential election has seen vivid discussions of health system reforms, most prominently concerning the plans of the Republican candidate Francois Fillon. He had initially proposed to "*focus universal public coverage on severe illness or chronic disease and private insurance on the rest*"[180], and is determined to reverse the recently enacted generalisation of third-party payment[181].

One element in these differences may be the differing arenas of discourse. Indeed, a factor in favouring the role of political parties and parliamentary factions in Germany is the visibility of their spokespersons. Perfectly exemplified by Karl Lauterbach (SPD), these individuals have become crystallisation points in many ongoing debates.[182] Likewise, the key reforms of earlier decades were negotiated among the respective experts of the main parties and factions in 1992 and 2003 (Bandelow and Hassenteufel, 2006). Since 1990, many social policy decisions have been made with considerable consensus among the major parties, as highlighted in an analysis by Karen Anderson. Although this is certainly linked to two recurrent grand coalitions (2005-2009 and 2013-2017), she emphasised the fact that parallel majorities in both chambers of parliament (*Bundesrat* and *Bundestag*) have never been the norm. Hence, "*bicameralism creates strong incentives for the major parties to compromise on social policy reforms, even when they express different social policy preferences in their electoral strategies*" (Anderson, 2015). In France, instead, we have seen that much of the debate and expertise were kept in-house (mainly, SHI). This is consistent with findings by Bandelow and Hassenteufel on the way

[178] « *Nous introduirons le paiement au forfait, autrement dit, dans le cas de patients qui ont besoin de se rendre souvent chez leur médecin, celui-ci recevra de la sécurité sociale un montant global pour le suivi de ce patient*. » (Parti socialiste, 2012)

[179] Except the idea to increase accountability ("*responsabiliser*") for patients and prescribers: (Union pour un mouvement populaire, 2012)

[180] Since the initial propositions, his discourse has become less explicit: https://www.publicsenat.fr/article/politique/reforme-de-l-assurance-maladie-exercice-d-equilibriste-pour-fillon-51628

It should be noted how Fillon has used the distinctions "big risk vs. small risk" (*gros risque et petit risque*) to denote the idea that severe and chronic disease should be covered by SHI while less severe disease coverage should be shifted to VHI. These terms have been frantically re-used in the media and political discussions. It represents, to a certain extent, the introduction of the "risk-discourse" into a wider public arena. We have seen examples of this discourse at the outset of this thesis in a technical domain ("morbidity as currency") and with risk-management as a recurrent and rising concept in the institutional transformation of SHI in France.

[181] In a third-party payment arrangement, some or all costs of health services or drugs are paid directly by a third party (in general statutory or private health insurance), and not the patient, to the provider.

[182] For an illustration of this idea in the case of *Bürgerversicherung* vs. *Kopfpauschale*, see (Leiber et al., 2010).

in which major reforms were orchestrated among programmatic actors inside the ministerial bureaucracy and critics in the civil society (Bandelow and Hassenteufel, 2006).

9.2 Implications for theory

9.2.1 Transfer versus translation

At the outset of this study, we framed the introduction of DM and P4P in France and Germany as policy transfer, implying there was a decision making dynamic to use foreign experiences in a national context. Although our analysis *a priori* confirms this assumption and the framework by Dolowitz and Marsh appears helpful in structuring information around a policy, it seems less appropriate as a means of fully accounting for the complexity of processes at play, particularly with respect to the examples of DM in Germany and P4P in France. Besides the fact that in both countries there was full awareness that P4P was no "magic bullet", the French P4P case in particular seems to confirm that the process leading to CAPI was not linear and did not follow a rationalist logic of "import-export". Instead, our data points towards a collusion of similar ideas in different institutions, which nonetheless can be linked to key reports on the QOF experience. At the same time, the situation was characterised by high fiscal pressure and discontent about collective agreements on medically-based cost containment, which led to a diversity of "home-grown" solutions.

These overlaps and the fact that terms such as interests and context seemed sometimes imprecise in our case studies (is discontent over remuneration schemes in Germany context or has it become an issue in light of new options such as P4P?) are reflected in critiques about transfer studies. For example, Dumoulin and Saurugger note that the rational vision of transfer may not allow and accounting of the hesitant and floating processes sometimes at play (Dumoulin and Saurugger, 2010). Likewise, Stone voices doubts about the "*mechanistic assumptions*" and the model of "*linear messaging from A to B*" (Stone, 2012). In this respect, a recently emerging body of literature around the sociology of translation adds valuable perspective (Hassenteufel and de Maillard, 2013). Referencing Bruno Latour, the proponents of a sociological view of translation emphasise the "*fluid and dynamic nature of policy, where meanings are constantly transformed, translated, distorted and modified*" (Lendvai and Stubbs, 2007), which appears to be reflected in significant notions captured by our data. A particularly interesting concept of translation is the "*contact zone*", described as a kind of "*in-between space which is never fixed but always becoming, characterised by forces and directions rather than forms or dimensions*" (Lendvai and Stubbs, 2007).

Such a contact zone appears to be an appropriate metaphor to account for the interaction between internal elements (attributed as national trajectories) and external elements (attributed as foreign experience), with the notions of internal and external being necessary to the policy transfer approach. The internal elements centre on the notions of medically based cost-containment and "liberal medicine" in France and the notions of self-regulation, sectorial borders and competition in Germany. They seem to reflect the broader history of the systems as well as ideas and concepts that have emerged over recent decades. Our study suggests that they determine how evidence is received, interpreted and re-negotiated, ultimately blurring the notions of what is internal and external. Thus, the sociology of translation appears to be a fitting complement to the rationalist and linear approach of transfer, which challenges the common perception that "P4P has been introduced".

In this context, it is worth highlighting that the experiences of DM in Europe have come to be of interest to health policy makers across the Atlantic[183]. This is illustrated by a case study on the German DMP, requested by the think-tank The Commonwealth Fund based in New York (Stock et al., 2011). This also implies how, at least in part, concepts such as DM have entered the era of the globalisation of ideas. Similar to the concept of "Hollywood movies"[184], rooted in the US decades ago, DM has become a set of ideas and instruments that are now widely spread across the planet. Consistent with Stone's stance (Stone, 2012), this development has been fuelled by the growing importance of international organisations and networks. Many of these have been cited in our analysis, and the relevance of their discourse will be addressed in section 9.3. With respect to theory, the next section examines the notion of convergence.

9.2.2 Divergent convergence

This study has explored how DM and P4P instruments were introduced in distinctive manners in two different health systems. This contrasts *a priori* with the recurrent argument that we

[183] Seizing the notion of a "contact zone" again, we note that the case study on DM has presented some contact between France and Germany, and there is evidence for exchange of ideas at the European Union level in expert groups or health minister meetings (Steffen, 2010a). Yet, none of the interviewees or any other source suggested that there was a bilateral information exchange with respect to P4P. Similar features such as the changing professional identity within a Bismarckian system would make it logical to seek further inspiration from close neighbours. Indeed, "in bilateral exchange there is the reflection about one's own system, and the wheel does not need to be re-invented" [DE3, p. 9]. Thus, a greater flow of information between France and Germany would appear to be a rational goal. Yet, an in-depth analysis of barriers (beyond the obvious linguistic one) and perspectives is beyond the scope of this study.

[184] An elaboration on this idea is given in (Becker, 2006).

have used that several actors in both France and Germany have referenced similar models (DM in America, P4P in the UK) and used language that refers to shared concepts, such as medical practice based on standards, quality gaps and benchmarking. Consequently, one could expect that the application of DM and P4P would lead to comparable phenotypes, which we have found is not the case. Instead, there is a nuanced set of motives, narratives, actors and instrument components that both resemble each other and yet do not seem to be truly comparable.

A starting point for a conceptual reflexion on this phenomenon is the point made by Theodore Marmor et al. that "*there is as much evidence of continued difference (or divergence) in national arrangements for the finance, delivery and regulation of health care as there is of increasing similarity*" (Marmor et al., 2009). The authors make the point that convergence alone has only limited utility in studying health reforms, because a reduction of variation has been neither the intention nor the effect of health reforms over the past decades. David Levi-Faur and Jacint Jordana attempted an explanation by proposing that transferred or diffused policies are not necessarily well-adapted to the existing institutional context, due in part to the irrationality at play. Instead, Levi-Faur and Jordana suggest that as "policy irritants", they can produce new and unexpected effects. As a result, an object of policy diffusion will not have the same meaning and will not serve the same functions and interests in different systems. The authors propose the term "divergent convergence" for "*a notion of change that includes both convergence and divergence as important dimensions of the new order"* (Levi-Faur and Jordana, 2005). Although this approach bears the limitations of the policy diffusion and transfer concepts (namely, the supposed linearity), it seems a useful option if a reduction of analytical complexity is desired[185].

The idea of divergent convergence is substantiated for the health sector by Hassenteufel in his comparative analysis of changes in SHI regulation in France and Germany. While pointing out important aspects of convergence (for instance, shared focus on expenditure control, implementation of policy instruments such as HTA agencies, role of programmatic actors linked to the State), he concomitantly stressed the limits of convergence. These include the

[185] For example, it allows visualising a heuristic that leads to a 2x2 table, in which 1) similar causes (the same diffused innovations) can lead to different outcomes (in different sectors or countries), or 2) different causes lead to similar outcomes, or 3) similar causes lead to similar outcomes, or 4) different causes lead to different outcomes (Levi-Faur and Jordana, 2005).

nature of programmatic actors (senior civil servants in France; links to SHI in Germany), which is closely related to the institutional organisation of the respective SHI systems, as well as differences in implementation (centralised but more easily affected by opposition in France; more negotiated and with a higher integration of key actors in Germany) (Hassenteufel, 2011).

Each of these aspects is very closely linked to the data in the present study. Most importantly, we have demonstrated how the institutional configurations in the respective countries affect actors and their interactions. For example, the particularity of the German corporatist system is the close integration of physician representatives in the joint self-regulating bodies, with decision power over funding modes and volumes, among other areas. Following this logic, some physician leaders backed DM, with the further incentive of potential financial gains and the goal of preserving their role as legitimate co-regulators. At the same time, critics were able to identify with the more "conservative" Federal Physicians' Chamber, who ultimately withdrew from the negotiations, or to externalise their ambivalence via a "blame figure", an expert physician for clinical guidelines. By contrast, the inclusion of French physicians in regulatory decision-making is far less institutionalised. The guiding theme structuring the relationship between ambulatory care physicians and SHI is the principle of "liberal medicine", in which the dyad doctor-patient is subject to limited interference by third-party payers. Collective agreements between doctors' unions and SHI are often conflictual, and fragmentation among the unions has led to varying constellations between partnership and conflictual opposition with SHI. As a result, the major union MG France did not even position itself publicly regarding DM in France, while its competitor UNOF-CSMF became a (temporary) ally of SHI. Moreover, the DMP Sophia received upfront and strong backing by patients, reducing the margin for challenge (by physicians).

Thus, this thesis supports the idea of divergent convergence in the transformation of both health systems. Contrasting findings in the literature include the idea that, linked to the convergence of per-capita income and health care expenditure in European countries, overall convergence of health policy would follow as "*plausible hypothesis*" (Leidl, 2001). This relates to a body of literature in which reduced sets of indicators are examined and conclusions are drawn in the sense of convergence, for example in the case of health care spending and health outcomes (Nixon, 2000). Conversely, Monika Steffen finds in her 2010 assessment of the French health system signs suggestive of very limited convergence. She holds that the system

has "*taken little from the international repertoire of reforms: neither privatisation nor competition nor resolutely managerial methods*" (Steffen, 2010b). Although we agree that competition is not a key feature of the French health system, there are indirect and growing signs of privatisation, for example via the shift of coverage to private insurers operating in a market. Most importantly, however, our data supports the view that there is indeed an increase in managerial methods, notably in the case of P4P which is linked to the narrative of medically-based cost containment and the related concepts of accountability, academic detailing, audit and feedback. These distinct conclusions are likely due, in part at least, to differences in the timeframe of the respective analyses (2010 versus 2017).

Taken together, the contribution of the present study is its comparative analysis of two policies in two countries, revealing the interactions of various actors so as to understand the translation process at play. In this analytic process, we have blended the theoretical approaches of policy transfer, policy instruments and programmatic actors. This allowed overcoming the notion of supposed verticality in transfer or translation processes. Instead of assuming that a policy innovation is "being implemented" from a supra-national level on downwards, our analytical angle was able to also take into account inverse effects. For example, the "branding" of regional experiences with diabetes care in Germany with the American label DM constitutes a reconfiguration of meanings that includes bottom-up and top-down elements. This thesis underscores how, in turn, programmatic actors such as Karl Lauterbach have played a pivotal role in this process.

The particularity of the instrument approach is to see *ad hoc* coalitions around a policy instrument as stable enough to allow for implementation, without assuming a shared belief system between the actors in a group. This notion was exemplified in the French case through the support of the patient organisation for Sophia: although the SHI director and the patient representative did not seem to share core values, the instrument (Sophia) was able to confer sufficient common ground, structured around the idea of "changing medical practice". However, such a coalition is possibly limited in duration, which leads to the issue of temporalities. Our method used cross-sectional interviews, which carry the risk of recall bias and selective perception. One way to address such bias is triangulation with data from other actors and written sources, which was applied here whenever possible. However, more valid conclusions on the interlaced temporalities could be drawn if actors were interviewed at

multiple points in time. This would allow assessing, for example, how interactions between actors change over time, and the extent to which "adherence" to an instrument can induce changes in belief systems.

9.2.3 The growing role of the European Union

A necessary addition to the notion of divergent convergence and the layers of administration considered so far (international, national, and regional) is the question to what extent the European Union (EU) as an institution represents an additional and useful level of analysis. In fact, we have established that the US and the UK have supplied important models for the introduction of DM and P4P in France and Germany. Yet, our data did not provide clear evidence of influence from the EU level.

In terms of theory, it is important to distinguish Europeanisation from convergence. The former has been conceptualised by Claudio Radaelli as "*processes of (a) construction (b) diffusion and (c) institutionalisation of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and shared beliefs and norms which are first defined and consolidated in the making of EU public policy and politics and then incorporated in the logic of domestic discourse, identities, political structures and public policies*" (Radaelli, 2002). Thus, in this linear and vertical conceptualisation[186], Europeanisation *can* lead to convergence, but is a distinct process.

We must consider the means by which the EU can exert influence on national health policy. In Europe, questions of heath care and institutional reform are, as a rule, treated as national affairs. In this context, the Open Method of Coordination provides a mode of soft regulation within the multi-level European system and is being increasing applied to the area of health policy (Urban, 2003). In a first phase during the 1990s, the EU and other international organisations such as the OECD promoted ideas of "organised competition" and "quasi-markets" in healthcare [187], mainly referencing the 1990 NHS and Community Care Act in the UK (Hassenteufel et al., 2001) and entailing increased pressure on Member States to curb cost expansion (Urban, 2003). Overall, this is set in the context of a union that is, at its core, an

[186] For a critique of the concept (which has some proximity to the notion of policy transfer), see for example (Hassenteufel and de Maillard, 2013).
[187] Note that due to the existing competitive elements of the French and German systems (free choice of doctors and hospitals by patients), these reform orientations were not a primary subject of debate.

economic project. As a consequence of European integration and competition among Member States, efforts have been made to minimise the financial burden on employers, including health insurance cost (Gerlinger, 2009). Another, more direct means of EU influence is through court rulings and directives, which have increasing importance for the health sector. The most prominent domain of action in this regard is the strengthening of patient rights (specifically, cross-border mobility), most recently via a 2011 directive[188]. Finally, powers over economic and budgetary issues have recently been enhanced and reinforce the European Commission's capacity to weigh in on national welfare state reforms from a budgetary angle. New rules adopted in 2010 include the European Semester, Six-Pack and Fiscal Compact [189] (de la Porte and Heins, 2015).

The most important recent phenomenon that links the question of Europeanisation to our data is the financial and economic crisis that started in 2008.[190] Our key argument here is that, *a priori*, the crisis represented across Europe a convergence of constraints to health systems, mostly through additional pressure on the health budget. Consequently, this reinforced and prolonged the long-term transformations (and their justifications) discussed throughout this study. Indeed, in the case of France, actions taken since the onset of the crisis constituted a continuation of the incremental cost containment measures undertaken since the late 1990s. Most importantly, these measures included a reduction in the scope and depth of SHI coverage, an increasing the role for user charges and VHI and supply side measures such as drug price reductions (Brunn et al., 2015).[191] This occurred in a context in which the economic crisis had substantially impacted France's public finances, even though overall France was less

[188] http://ec.europa.eu/health/cross_border_care/policy_en

[189] The European Semester, introduced in 2010, sets out that Member States discuss their budgetary and economic plans with their EU partners at specific times throughout the year (http://europa.eu/rapid/press-release_MEMO-13-318_en.htm). The reinforced Stability and Growth Pact (SGP) entered into force in 2011 with a new set of rules for economic and fiscal surveillance. These new measures, the so-called "Six-Pack", are made of five regulations and one directive proposed by the European Commission (http://europa.eu/rapid/press-release_MEMO-11-898_en.htm). The Treaty on Stability, Coordination and Governance in the Economic and Monetary Union (TSCG) entered into force in 2013. The main provision of this Treaty is the requirement to have a balanced budget rule in domestic legal orders, the Fiscal Compact (https://ec.europa.eu/info/publications/fiscal-compact-taking-stock_en).

[190] For an overview, see De La Porte, C. and Heins, E.: *The Sovereign Debt Crisis, the EU and Welfare State Reform*. Palgrave Macmillan, Basingstoke, 2016.

[191] With regard to the mid-term impact on determinants of health in France, the authors stress the steady increase in unemployment and household debt since 2008 concomitant with the decreasing personal health budget. The most significant and burdensome element was the exacerbating effect of the crisis on health and social inequalities as reflected, for example, by an increasing percentage of low-income health system users foregoing care (Brunn et al., 2015).

affected than other Member States. Due to the automatic stabilisers and discretionary fiscal stimulus, the public deficit rose from 3.4% of GDP in 2008 to 7.1% in 2010. Meanwhile, SHI's deficit of grew from €10.2 billion in 2008 to €23.9 billion in 2010. As a result, the French government had to negotiate with the European Commission to put into place a stability programme with the goal of reducing the deficit to 3% by 2013 and a balanced budget by 2017. One of the pillars of this strategy was the reduction of the social security deficit. According to Hassenteufel and Palier, under these acute financial conditions, French actors have been more willing to listen to the EU, in part because they may need its support, should refinancing become difficult, as well as because the EU can help to reassure lenders about France's capacity to repay. French authorities have (re)-discovered the EU's two means of pressure: first, in the explicit integration of the need for deficit reduction into French political speeches and policies and, second, the EU's right to demand evidence of reform (Hassenteufel and Palier, 2015).[192]

Nonetheless, the argument of converging constraints does not hold in the case of Germany. Although real per capita GDP in Germany declined in 2009, the country otherwise was largely unaffected by the crisis. Ten-year bond rates dropped and are among the lowest in Europe, and unemployment has been decreasing since 2008, reaching 5.9% in 2011. Despite these positive indicators, the federal government reduced the SHI contribution rate from 15.5% to 14.9% of wages from mid-2009 to the end of 2010, with the difference funded from the federal government budget. The contribution rate returned to 15.5% at the beginning of 2011. In terms of user charges, in 2012 the quarterly co-payment of €10 for GP and specialist visits were abolished because of the large surpluses accumulated by the SHI system (Henke and Quentin, 2015).

The idea of increasing direct EU influence is summarised by Scott Greer, who claimed that the financial crisis has given the EU a "third face" (in addition to soft regulation and court rulings),

[192] Despite this plausible link, there is no direct reference linking the crisis and the measures taken in the health sector. This is similar to the political discourse and content surrounding recent French pension reforms, in which French authorities denied that they acted "because of Europe". However, Hassenteufel and Palier see clear indirect indicators, such as the fact that pension reforms were not announced during the 2007 or 2012 electoral campaigns as part of the policy programme of the winning candidates. However, both Sarkozy and Hollande implemented pension reforms when the EU placed France under the Excessive Deficit Procedure (Hassenteufel and Palier, 2015).

a "*newly rigorous and intimate fiscal governance model in which member state policies and budgets will be under continuous review, and countries in extreme trouble will face elaborate loan conditions affecting health care in detail*" (Greer, 2014). Although it seems too early to conclude on the long-term implications for France and Germany, it seems possible that the steps taken so far have created a cognitive breech that will serve as basis for the influence of the EU to further increase. Overall, if we consider Europeanisation as factor leading to convergence, we could argue that the EU's growing influence would reinforce most of the similar national policy and cognitive streams we have discussed for France and Germany, particularly the role of health expenditure control. Yet, the consequences of the economic crisis seem to show that, with the distinctive (macro-) economic contexts of France and Germany, there is at least an equal share of divergence in the mix.

9.3 Continued strengthening of SHI and the State, mediated through discourse

Despite several differences, the case studies from both countries are set within the development of increasingly dominant regulatory roles of SHI and the State. In both countries, reforms since 1990 have introduced a widening of coverage with a higher share of the population falling under the remit of SHI and bringing it closer to universal coverage. Moreover, France saw an increasing role played by taxes instead of social contributions[193]. Institutional changes for both countries included new State agencies, with the notable case of the recently founded IQTIG in Germany, and delivery system reforms, such as the strengthening of the role of GPs through gatekeeping. At the same time, the level of SHI reimbursement has gone down both in France and in Germany.

In this context, it is very important to highlight that the strengthening of SHI in France was set in a deliberate political context: the notion of risk-assessment, frequently discussed in this study, has been expressly set out in legislation in close cooperation with MoH. Interestingly, a 2014 Senate report on collective agreements with physicians noted that the insufficiency of the legal framework since 2004 has "*left SHI with wide leverage for risk management*".[194] This suggests that tighter State control (of SHI) is politically desired and illustrates the ambiguity that the delegation of power ("remote governance") entails.[195] In Germany, the loss of power for the self-regulating parties has been embodied by a shift in the role of GBA. Government exercises legal supervision over GBA's decisions, whose directives are submitted to MoH, which has two months to object. If GBA fails to issue a directive on time, MoH can issue it itself. For Gerlinger and Schmucker, there have been four key developments illustrating a reduction in the influence of the collective bodies representing sickness funds and doctors in GBA. The first was an increasingly restrictive financial framework, with the decision in 2007

[193] As opposed to Germany, where the share of tax-based funding has fallen from 10.8% in 1996 to 4.8% in 2012 (Busse and Blümel, 2014).

[194] RAPPORT D´INFORMATION au nom de la commission des affaires sociales sur l'enquête de la Cour des comptes sur les relations conventionnelles entre l'assurance maladie et les professions libérales de santé, par M. Yves DAUDIGNY, Sénateur. Paris, 8 juillet 2014.

[195] The view of physicians is, once again, given by the former CSMF head. The SHI logic is described to "*force the conservatism of the medical corps, and try by all means to bypass it*"; it also is to diversify payment modes by rewarding quality and not quantity. He claims there is the intention to push for "*more rapid*" advancement, so that the concerned actors do not have the time for "*appropriation of all these tools*". He argues there is the risk of an "*overdose*", since it is not as easy as that to "*overthrow*" habits of medical practice [FR6, p. 4].

abolishing the right of sickness funds to set their own contribution rates and transferring this prerogative fully to the State. The second was the establishment of IQWIG in 2004, which added external scientific expertise to evaluate the benefit and efficiency of diagnosis and treatment methods. A third occurred in 2007, when the three impartial members of GBA became its full-time employees[196]. The fourth measure was the 2007 Health Reform that gave MoH the right to request additional statements and information when scrutinising GBA directives (Gerlinger and Schmucker, 2009).

Thus, the overall reform trajectories seem to be clear, and they seem to follow what we have described as paths leading to the DM and P4P reforms. However, we must also consider the cognitive processes to which they are linked. First, we noted that both DM and P4P continue to be set within the dominant logic of rationalisation. Second, in Germany, P4P in hospitals represents the continuation of liberalisation reforms, with the previous key reform steps including competition between sickness funds and the introduction of the health fund meant to facilitate competition through better risk adjustment. In France, liberalisation is taking place via the shift of coverage from the statutory to the voluntary (and thus, private) insurance sector. A third concept is NPM[197], an explicit goal of which is the modernisation of the physician IT infrastructure in order to collect data, and it is relevant on several points (Bezes, 2005). It allows the institution to display (to the public or the electorate) measurable aims and results. Indeed, CAPI, with its multiple efficiency goals clearly bears the traits of an accountant and accountability logic. In this respect, SHI could gain "remote" control via the multiple contractual arrangements that it "enforces" by sending representatives who perform face-to-face benchmarking.[198]

The influence of international institutions in this respect is exemplified by language used in a book by the European Observatory and OECD: apart from the "*passive role*" that payers can

[196] In addition, since 2012, MoH and/or parliament have been empowered to block the nomination of the impartial members, who have the right to vote in GBA.
[197] See section 1.1.2
[198] At this point we must caution against an over-simplified criticism of neo-liberalism. Le Galès recently noted that "*quantifying approaches go well beyond neoliberalism and it can be difficult to distinguish between the different logics at work*". In fact, the rationalisation of activities such as performance measurement has a long history, and Le Galès mentions the "scientific approach" to government via indicators central to communist regimes such as the USSR. Further factors that have influenced instrumentation of the logic of rationalisation may be the development of new technologies such as computers or telecommunications. Finally, quantitative instruments have been developed by social movements, such as health service users prompting the development of league tables (Le Galès, 2016).

have, P4P can contribute to a "*more productive dialogue between health purchasers and providers*". The authors further note that "*improved generation and use of data is possibly the most important positive spillover effect of the P4P programmes*" (Cashin et al., 2014). Again, in its introduction and problem framing, the authors refer to the "quality gap" and other key concepts set out in the 2001 IOM report, pointing towards a strongly shared mindset with actors in our case studies[199]. This relates to Bandelow and Hassenteufel, who explained how think-tanks and the like favour similar problem definitions and solutions in France and Germany. It also raises the issue of a "closed-loop" of ideas between policy makers, insurers and international organisations. This is substantiated by the way in which key actors move between institutions, as the former director of SHI did in France. Two prominent examples include Marine Jeantet (interviewed as MoH expert by the authors of the IGAS report on P4P): after starting her career at a smaller SHI scheme (MSA), she moved into a position as deputy head of unit at MoH, before being appointed program director at IGAS and, ultimately, becoming head of department at the main SHI scheme (CNAMTS). Likewise, Franck Von Lennep (interviewed as SHI expert by the authors of the IGAS report on DM) was the head of SHI's strategy department by the time Sophia was introduced. Before, he worked for the National Statistics Institute (INSEE), and after his position at SHI he became an advisor to two successive Ministers of Budget before being appointed to his current position as head of the statistics department at MoH (DREES).

Overall, the discourse over highly technical issues has been dominated by a certain set of actors, and the mastery of discourse seems to have provided a clear strategic advantage to which others must "buy in". Moreover, high technicity requires significant assets for those designing the instruments as well as for those who interact with them, such as institutions trying to understand them or developing their own (counter-) experience. When these assets are not available and there is no mastery of the relevant discursive elements, high complexity/technicity can potentially lead to frustration and retrenchment in reflexive protest positions.

At present, incremental reforms in Germany continue to impose restrictions on the physician self-regulation: in order to decrease waiting times for specialists, KVs were obliged to set up

[199] As mentioned before, the foreword to the book was written by the director of French SHI.

phone-based "consultation service centres"[200] in 2016, where patients can find out which provider is available for a consultation. In France, the 2016 health system modernisation act[201] introduced generalised third-party payments for ambulatory care, along with the extension of the "soft gatekeeping" scheme, the reinforcement of the public hospital sector and the strengthening of regional health agencies. As expected, there was strong criticism by the main unions concerning third-party payments, on the grounds that payments were not "*guaranteed*" any longer[202]. While these measures clearly represent a further blow to "liberal medicine", there are signs that certain compensation has been provided. Indeed, in August 2016, collective agreements between SHI and physicians were finalised for the next five-year period, providing an estimated additional €1.3 billion in remuneration[203]. They key components were a €2 increase in the basic GP consultation tariff (then €23) and the specialist tariff (then €28). In addition, a flat payment incentive is foreseen in exchange for investment in practice IT infrastructure[204]. Beyond that, the new agreement implies no structural changes, which has led many younger-generation doctors to criticise the "*obsolete model of medical practice*"[205].

This view is representative of the perceived standstill and frustration with respect to the adaptation of the care delivery system to changes in demography and case-mix in France. Reconsidering the prescriptive manner of regulatory tools such as P4P (CAPI and ROSP), such effects may well be linked to the small margin of manoeuvre that physicians have in these settings (in the sense of the work of Michel Crozier[206]): they are essentially reduced to accepting or refusing participation in the programme. In addition, the State has given diminishing attention to alternative "playing fields" of proactive initiatives such as local provider networks[207]. If providers perceive a reduced sense of control, they might retrench (even

[200] *Terminservicestellen* : http://www.kbv.de/html/terminservicestellen.php
[201] *Loi de modernisation de notre système de santé du 26 janvier 2016.*
[202] http://www.mgfrance.org/index.php/presse/communiques/1490-mg-france-toujours-oppose-a-l-obligation-du-tiers-payant-appelle-les-medecins-au-boycott-du-tiers-payant-complementaire
[203] On the physician side, it was signed by Le Bloc, MG France and FMF, representing 53% of physicians. The biggest union, CSMF, refused the agreement.
[204] https://www.mutualite.fr/actualites/convention-medicale-principales-mesures/
[205] Négociations Conventionnelles : le fossé intergénérationnel se creuse. Intersyndicale Nationale Autonome Représentative des Internes de Médecine Générale. https://www.isnar-img.com/negociations-conventionnelles-fosse-intergenerationnel-se-creuse/
[206] Crozier, M. *Le Phénomène bureaucratique*, Paris, Le Seuil, 1963.
[207] In 2002, a financing mechanism for provider networks was introduced via two funds (FAQSV and DRDR/DNDR). Both funds could be used to finance networks, while the DNDR could also finance new services. These budgets were replaced, in 2008, by the quality and coordination of care funds (FIQCS). The FIQCS budget

further) into conservative fall-back positions (structured around "liberal medicine"). It would seem an option that future reforms seize the potential of more collaborative and inclusive policies that may "empower" providers in the positive sense of the word[208].

On the other side of the Rhine, issues include the principles that govern the system. In 2002, Gerlinger underscored the "shift in the hierarchy in values" induced by growing stimulus for competition between sickness funds in Germany. This shift is illustrated by the reluctance of sickness funds with "better risks" to expand the variables within RSA to provide for a fairer redistribution of money between funds. Conversely, according to Gerlinger, funds with "bad risks" who claimed more solidarity only did so after realising that they would be among the losers in the increased competition within SHI (Gerlinger, 2002). Another example for the effects of marketisation is the growing offer and demand for individual out-of-pocket health services (*Individuelle Gesundheitsleistungen*, IGEL) in ambulatory care. Every physician may offer these services, which are not reimbursed by SHI and tend to be supported by little evidence (for example, certain check-ups, medical-cosmetic measures, screening tests). Although not a subject of debate, IGEL are common: in 2010, they were proposed to half of the insured population, three-quarters of whom accepted such offers, representing a market of nearly €1.5 billion (Krüger-Brand, 2011). There are at least two ethical issues with IGEL. First, cancer screening tests provided as IGEL are potentially harmful, while their benefit is either not clear or contested (Koch et al., 2014). Second, IGEL may induce conflicts of interest for doctors who are in the position to trade-off "medical" versus "IGEL" time.

was not exclusively dedicated to provider networks, but also funded initiatives such as health IT projects and multidisciplinary and multi-professional care centres. In 2012, FIQCS was merged into a regional intervention fund (FIR) to accommodate among other things the budgets for hospital modernisation and the continuity of care system. As a result, funding of provider networks has become less secure (Chevreul et al., 2015).

[208] Note the potential bias of the thesis author, who has been trained as a physician in the German system, but also has worked as a health services researcher in the French system for a number of years. He does not prefer one system over the other.

9.3.1 Perspectives for further analysis

From the outset of this study, we have raised a series of critical questions about the health system transformations that are embodied in tools such as DM and P4P. In these transformations towards more liberalisation, rationalisation and state control, the frontiers between what is internal and external to the system are blurred. In fact, several key actors seem to operate concomitantly within multiple cognitive reference systems. In other words, they may reason in terms of national policy goals and, at the same time, interpret data according to a global/European set of attitudes and ideas. With regard to the "chaos" that translation represents, the order that the title[209] of this study suggests could potentially be inversed: as seen, for example, in the German cases, regional or national ideas were used (and later re-framed) to address the (perceived) global challenge of chronic disease and not the other way round.

While the utilisation of indicators for payment clearly serves the strategic goals of the reform coalitions, it is linked to what Bertillot has termed "soft rationalisation" in "evidence-based bureaucracies", with the distinction that the evidence base for performance-related payment systems remains poor. The normative potential of the used tools is high: DM in both countries continues to be expanded, as does the use of indicators for payment. While, for example, CAPI has been framed by its founders as a means to "transform medical practice", it now has developed its own dynamic[210] and will serve as a reference for other ideas and instruments[211]. In this respect, future research could examine three resulting lines of thought:

1) On a macro level, analyses about cases in other countries would be of high interest, as well as a deeper understanding of the processes at play inside (international) organisations that "broker" ideas.

[209] Global ideas, national challenges

[210] In the sense of path dependence, see (Pierson, 2000a)

[211] See for example the case of the hospital discharge programme PRADO (*Programme d'Accompagnement du Retour à Domicile*) that SHI launched in 2010 (first for maternity care, then for surgery, heart failure and chronic lung disease). The aim is to achieve a better coordination of discharge and to avoid further hospitalisations. This includes nurse visits for patient education at home and consultations with the GP and specialists. In designing PRADO, SHI used evidence from a similar programme with the German sickness fund AOK. This knowledge transfer was facilitated through the international consulting firm McKinsey [FR1, p. 2]. A matter that has sparked criticism by physicians is the fact that follow-up consultations are coordinated by a discharge manager who is employed by SHI (https://www.conseil-national.medecin.fr/article/programme-d-accompagnement-du-retour-domicile-prado-apres-hospitalisation-1175).

2) On a micro level, few studies have elucidated how the advent of indicators and other tools has actually affected the doctor-patient relationship, which is often seen as inviolable by physicians. While research often focusses on the implications for organisations and providers, little is known on how individual system users perceive the described reform tools and how they may structure attitude and behaviour.
3) On a meta level, parts of our data have suggested a role for institutional culture in the reform processes, notably in the case of DM in France and its sometimes turbulent translation efforts. Indeed, the notion of culture is recurrent in comparative analysis, with, for example, Marmor et al. noting that "*lessons from abroad often meet strong cultural resistance*" (Marmor et al., 2009), echoed by Hall and Lamont in their book on the impact of culture and institutions on population health (Hall and Lamont, 2009). Other authors have stressed the idea that the exporting and the receiving systems of an innovation ideally should match in values (Denis et al., 2002), indicating the proximity of the notions of culture, values and institutions. Such proximity sparks scholarly debate, and indeed the term culture and its relation to social sciences has been the subject of lively debate in France. For example, it opposes the tenants of culturalism and those of organisation theory over the role of a "national culture" versus the idea that organisations are not only weaved into culture but also its "producers" (D'Iribarne, 1989; Friedberg, 2005). This distinction is far from trivial and is highly relevant to the question of how and which policy instruments with references from other cultures are constructed and received. Although reforms are negotiated by institutions, they most often affect a wider (patient) population. A clarification of these conceptual boundaries is needed, especially in the culturally sensitive domain that is health and illness.

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Appendix II: Overview of policy instruments based on the typology by Christopher Hood

Type of instrument	Type of political relations	Type of legitimacy
Legislative and regulatory	Social guardian state	Imposition of a general interest by mandated elected representatives
Economic and fiscal	Wealth producer state and redistributive state	Seeks benefit to the community, social and economic efficiency
Agreement-based and incentive-based	Mobilising state	Seeks direct involvement
Information-based and communication-based	Audience democracy	Explanation of decisions and accountability of actors
Performance indicators, standards, best practices	Adjustments within civil society, competitive mechanisms	Mixed: Scientific/Technical, democratically negotiated and/or competition, pressure of market mechanisms

Source: (Le Galès, 2016)

Appendix III: Interview guide for IGAS auditor, France

Merci de préciser votre formation, votre position actuelle et vos responsabilités.

Motivation/contenu

D'après vous, pourquoi était-il important d'introduire DM et P4P en France ? [Volonté politique forte ? Un retard avec d'autres pays à combler ? Un besoin absolu de ces réformes ?]

Quel était le degré de détail quand la mission a été définie ?

En dehors de la littérature et les voyages, y-avait-il une "source d'inspiration" pour votre travail sur le DM et P4P ? [HCAAM, think tanks]

Quel rôle a joué votre formation (en distinction avec des collègues à l'IGAS) ?

Comment avez-vous choisi votre méthode ? Disposiez-vous des réseaux de connaissance dans les autres pays ? Lesquels ? Pourquoi l'Allemagne pour le DM ?

Y avait-t-il un lien entre le DM et les CAPI ? Si ou, lequel ? [Même initiateurs, même pensée, …] Diriez-vous qu'il y avait une continuité, un apprentissage ? Si oui, lequel ?]

Acteurs

Quels étaient les autres acteurs principaux et à quel moment, et quel étaient leur positionnement et influence ?

Y avait-il un personnage-clef ?

Qui devrais-je rencontrer impérativement ?

Quels problèmes/résistances avez-vous rencontrés ?

Divers

Dans le rapport P4P, pourquoi vous ne proposiez-vous vas les indicateurs classiques (HBA1C), page 49 ?

Pour le rapport DM, vous avez consulté les patients, la CNAMTS, etc. mais pas les médecins; pourquoi?

Dans le rapport DM, vous dessinez des contours relativement précis d'un potentiel dispositif en France. Quel était le rôle de la CNAMTS (ex) dans la définition de ces détails ?

Quels sont les projets antérieurs/actuels que vous qualifierez de "transfert" ?

Merci beaucoup. Auriez-vous des choses à ajouter ?

Appendix IV: Interview guide for senior SHI actor, France

Merci de préciser votre formation, votre position actuelle et vos responsabilités.

Motivation/contenu

D'après vous, pourquoi était-il important d'introduire DM et P4P en France ? [Volonté politique forte ? Un retard avec d'autres pays à combler ? Un besoin absolu de ces réformes ?]

En dehors de la littérature scientifique, les rapports et les voyages, y-avait-il une "source d'inspiration" pour votre travail sur le DM et P4P ? [HCAAM, think tanks]

Comment avez-vous choisi votre méthode ? Disposiez-vous des réseaux de connaissance dans les autres pays ? Lesquels ?

Acteurs

Quels étaient les autres acteurs principaux et à quel moment, et quel étaient leur positionnement et influence ?

Quels problèmes/résistances avez-vous rencontrés ?

Adaptation

Quelles raisons pour les adaptations Sophia, et par qui ?

[Fiche à remplir par GP, Données ALD, Serveur vocal interactif, Implication des généralistes, 'opt out' -> 'opt-in', Données sur la stratification du risque mis à jour annuellement (et non mensuellement)]

Quelles raisons pour les adaptations P4P, et par qui ?

- Seuils fixes
- Pas d'ajustement de risque

Perspectives

Y avait-t-il un lien entre le DM et les CAPI ? Si ou, lequel ? [Même initiateurs, même pensée, …] Diriez-vous qu'il y avait une continuité, un apprentissage ? Si oui, lequel ?

Quels sont les projets antérieurs/actuels que vous qualifierez de "transfert" ? -> Continuité ?

Quel sera son rôle dans l'avenir ?

Merci beaucoup. Auriez-vous des choses à ajouter ?

Appendix V: Interview guide for professor of health management, Germany

Können sie bitte kurz ihre Ausbildung, aktuelle Position und Verantwortung darlegen.

Motivation/Inhalt

Weswegen war es wichtig DM und P4P in Deutschland einzuführen? [starker politischer Wille? Aufholbedarf im Vergleich zu anderen Ländern? Absoluter Reformbedarf?]

Gab es außerhalb der Literatur andere Inspirationsquellen für die Arbeit an DM und P4P? [think tanks]

Wie wurde die Arbeitsmethode festgelegt? Gab es Netzwerke in anderen Ländern? Welche?

Akteure

Welches waren die Hauptakteure, zu welchem Zeitpunkt? Was war ihre Position und ihr Einfluss?

Gab es eine Schlüsselperson?

Wen muss ich unbedingt treffen?

Welche Probleme und Widerstände gab es?

Adaptation

Warum wurde DM an den deutschen Kontext angepasst, und von wem? [Rolle der Allgemeinmediziner, „öffentliches“ DMP]

Warum wurde P4P angepasst, und von wem? [Selektivvertrag, Verschreibung]

Perspektiven

Gab es eine Verbindung zwischen DM und P4P? Wenn ja, welche? [dieselben Initiatoren, dieselben Ideen, …] Würden sie sagen es gab eine Kontinuität, einen Lernprozess? Wenn ja, welchen?

Gibt es ältere/aktuelle Projekte die sie als « Transfer » qualifizieren würden? → Kontinuität?

Was wird seine Rolle in der Zukunft sein?

Vielen Dank. Haben sie etwas hinzuzufügen?

Appendix VI: Interview guide for senior SHI actor, Germany

Was ist ihre Ausbildung und aktuelle Stellung?

Positionspapier GKV im September 2014:

Weswegen ist es wichtig P4P in Deutschland einzuführen? [starker politischer Wille? Aufholbedarf im Vergleich zu anderen Ländern? Absoluter Reformbedarf?]

- P4P ambulant und stationär, aber Schwerpunkt scheint auf stationär zu liegen?
- Wieso Nutzung aggregierter Scores?
- Habe ich dies richtig verstanden: Sie sind für Boni, und für Nicht-Abrechnung statt Mali?
- Schnelle Einführung, auch ohne IQTIG?
- Einordnung der Arbeit AQUA an SQG?

Was sind ihre Inspirationsquellen für die Arbeit an P4P? [Think tanks; Initiativen in DE?]

Wie wurde die Arbeitsmethode festgelegt? Gab es Netzwerke in anderen Ländern? Welche?

Akteure

Welches sind die Hauptakteure, zu welchem Zeitpunkt? Was ist ihre Position und ihr Einfluss?

Gibt es eine Schlüsselperson?

Welche Probleme und Widerstände gibt es?

DM

1996 bis 1997 waren Sie „Projektleiter des AOK-Hausarztmodells in Frankfurt und arbeiteten in den Bereichen Disease Management sowie Arztnetzwerke“.

- Welche Programme/Modellprojekte gab es damals?
- Was war der konzeptionelle Nährboden?
- Welche Rolle der internationalen Erfahrung?
- Welchen Einfluss auf die RSA-DMPs?

Vielen Dank. Haben sie etwas hinzuzufügen?

Appendix VII: The Framework Method

The main stages of the Framework Method as suggested by Gale and colleagues (2013), and as applied in this study for the analysis of literature and interview data.

Note that the first two stages only applied to interviews.

Stage 1 and 2: Transcription and familiarisation with the interview

An audio recording and a verbatim transcription of the interview were done. Then, contextual or reflective notes that were recorded during the interview were used to complete the verbal information.

Stage 3: Coding

The document or transcript was then read line by line, applying a paraphrase or label (a 'code') describing what was interpreted in the passage as important. Using an inductive approach, coding was 'open' and included anything potentially relevant, from as many different perspectives as possible. Coding allowed classifying all data so as to render it comparable with other parts of the dataset.

Stage 4 and 5: Developing and applying a working analytical framework

After open coding the first four transcripts, an 'operational' set of codes was elaborated. Where appropriate, codes were grouped together into categories. This working analytical framework was then applied by indexing subsequent transcripts using the existing categories and codes.

Stage 6: Charting data into the framework matrix

A spreadsheet was used to generate a matrix and the data were 'charted' into the matrix, involving summarising the data by category from each transcript.

Stage 7: Interpreting the data

Characteristics of and differences between the data were identified, and connections between categories were mapped in order to explore relationships and/or causality.

Appendix VIII: Timeline of major system events and key measures of DM and P4P, 2000-2015

Year	France		Germany	
	Reforms and elections	**DM and P4P**	**Reforms and elections**	**DM and P4P**
2000			SHI Reform Act: Provisions for integrated care through individual contracts	Coordinating Committee (CC) created, steering the auto-regulation of providers and SHI
2001			Act to Reform the Risk Structure Compensation Scheme (RSA)	Act defining the process for the introduction of DMPs
2002	Jacques Chirac (UMP) re-elected president		Re-election of Social Democratic-Green government	
2004	Health Insurance Act: gatekeeping in ambulatory care, creation of National Authority for Health (HAS), responsible for the development of guidelines; Public Health Act: five major health plans and 100 public health priorities for the period 2005–2009		DRGs implemented in hospitals	
2005			Grand coalition of CDU/CSU and SPD	
2006		IGAS report "lessons on foreign experiences with disease management"		
2007	National public health plan for those with chronic illness Nikolas Sarkozy (UMP) elected president	Social Security Financing Act authorises that SHI puts in place chronic care programmes; SHI annual report proposes P4P pilots; suggestion for P4P in MoH draft for the 2008 Social Security Financing Act		Advisory Council for the Assessment of Developments in the Health Care System (SVR) expertise carefully recommends P4P pilots
2008	DRGs implemented in hospitals	Launch of regional DMP pilots (Sophia); IGAS report "paying doctors by performance: lessons from foreign experiences"		

2009		Decree for model contract between local SHI funds and GPs; Launch of P4P pilots (CAPI)	Centre-right/liberal coalition of CDU/CSU and FDP	
2010		14.800 CAPI contracts signed		
2012	Francois Hollande (PS) elected president			Expertise on P4P by the Federal Office for Quality Assurance (BQS)
2013			Grand coalition of CDU/CSU and SPD	Coalition agreement sets out introduction of risk-adjusted bonus and penalty payments for hospitals and foundation of a dedicated institute for the measurement of ambulatory and hospital care quality
2015			IQTIG (Institute for Quality and Transparency in Health Care) starts recruiting staff	

Appendix IX: Résumé en Français

Dans de nombreux états providences, les systèmes de santé subissent, de nos jours, d'importantes transformations en réponse aux pressions budgétaires, qui sont caractérisées par le rôle croissant du marché et des mesures de rationalisation. C'est dans ce contexte que la France et l'Allemagne ont mis en place des programmes de *Disease Management* (DM) dans le but de fournir des soins plus structurés et de paiement à la performance (P4P).

Ces deux systèmes présentent des ressemblances en ce qui concerne, d'un côté, le rôle de l'Etat et la profession médicale, et de l'autre, les choix apparemment similaires qui ont été faits concernant l'introduction des programmes de DM et de P4P. Cependant, la nature, l'étendue et le calendrier de ces mesures diffèrent à bien des égards, ce qui semble être lié à la différence dans la configuration des institutions et des acteurs clés.

D'un point de vue analytique, la perspective des instruments d'action publique (*public policy instruments*) semble être particulièrement appropriée pour montrer quels sont les processus cognitifs en jeu et la restructuration potentielle des relations sociales. Le concept de transfert de politiques (*policy transfer)* est utilisé comme une hypothèse pragmatique (parmi d'autres) pour expliquer l'influence potentielle qui vient d'autres pays ou systèmes. Enfin, l'approche des acteurs programmatiques (*programmatic actors)* met en lien et complète ces deux concepts en se concentrant sur le rôle et les motivations des acteurs.

Cette étude est guidée par les questions de recherche suivantes :

- Qui sont les principaux groupes d'acteurs responsables et concernés par l'introduction du DM et de P4P en France et en Allemagne ? Comment est-ce que les groupes interagissent entre eux et dans quelle mesure (délibérée ou non) est-ce que ces outils peuvent modifier leurs relations ?
- Dans quelle mesure est-ce que ces instruments peuvent être liés aux transformations sur le long terme voire aux conflits au sein du système de santé ?
- Quels sont les facteurs cognitifs, historiques et institutionnels qui structurent la mise en place et/ou la traduction de ces outils ?

Le plan pour ce travail est un modèle d'étude de cas comparatifs avec quatre perspectives : l'introduction du DM pour les patients diabétiques en France en 2008 et en Allemagne en 2002 ainsi que l'introduction du P4P dans les soins ambulatoires en 2009 en France et peut-être prochainement en Allemagne.

Les données ont été obtenues grâce à une revue documentaire et à des interviews semi-structurés. La première se base sur une documentation scientifique et grise, soit des écrits administratifs, des sites internet de parties prenantes, des communiqués de presse ainsi que des travaux universitaires primaires et secondaires. Les personnes interrogées ont été choisies en utilisant les méthodes d'échantillonnage raisonné et en boule de neige. Nous avons recueilli les données par des entretiens approfondis avec des acteurs impliqués dans la prise de décision et la mise en œuvre des processus (membres d'administration, assureurs, représentants de prestataires et des patients, universitaires et experts). Quatorze acteurs ont été interviewés en France et neuf acteurs en Allemagne entre août 2013 et juillet 2015.

Disease Management (DM)

La clé de lecture des éléments qui sont liés au changement en Allemagne et en France est la transformation fondamentale du rôle et de la configuration de l'assurance maladie. Malgré les différences de calendriers, les origines de cette transformation reposent dans la nature bismarckienne des deux systèmes. Etant donné que ces derniers s'appuient fortement sur les contributions salariales, les accroître représenterait une menace pour la compétitivité économique nationale. Par conséquent, le contrôle budgétaire est devenu une préoccupation primordiale et un moyen d'encadrer les changements du système de santé. Ainsi, le processus s'est suivi d'un rôle plus important de l'État. Néanmoins, cela s'est traduit par des modèles distincts en Allemagne et en France, en raison des différences dans la configuration de l'assurance maladie. En Allemagne, l'assurance maladie est traditionnellement constituée de centaines de caisses d'assurance maladie qui sont historiquement liées à certains groupes professionnels. Ces caisses ont subi un fort processus de concentration, accéléré par des mesures visant à faciliter leur concurrence. À cet égard, le système allemand était un terrain plus fertile pour accueillir des éléments de marketing et de privatisation. C'est cette idée de la concurrence qui structure les acteurs et les processus, et le DM a été considéré par beaucoup (mais pas tous) comme un bon outil au sein du contexte très complexe des caisses d'assurance maladie, de l'autorégulation des médecins et des niveaux de pouvoir fédéraux et

régionaux. En France, il n'y a pas de concurrence entre les caisses. Au lieu de cela, les efforts déployés par l'État central pour contenir les dépenses se sont axés sur le contrôle budgétaire et les mesures visant à saisir l'efficacité et les marges de paiement dans le système de prestation des soins (appelé *maîtrise médicalisée*). C'est dans cette logique que le changement emblématique de l'assurance maladie « du payeur à l'acteur » a été mis en place, en mettant l'accent sur la notion de gestion des risques dont le programme de DM Sophia est l'application pratique. La position de pouvoir unique de l'assurance maladie, étroitement liée à la personne de son nouveau directeur, a facilité les alliances (dans ce cas avec les associations de patients), mais a également suscité un scepticisme par son tuteur (Ministère de la Santé) et par les agences thématiquement proches (Haute Autorité de la Santé).

Les changements dans les deux pays modifient le rôle des professionnels de santé. La question clé, relativement similaire dans les deux pays, est celle de savoir comment la profession médicale doit se positionner par rapport à l'intrusion croissante de l'Etat et de l'assurance maladie au sein de l'autorité de réglementation des médecins. Une renégociation des règles sociales paraît dans le changement profond de gouvernance quasi inévitable. Traditionnellement, les arrangements se caractérisent par une autorégulation qui permet aux médecins une autonomie considérable dans leur travail. En revanche, les nouveaux outils de gouvernance renforcent la comptabilité publique et se basent sur une logique de hiérarchie.

C'est dans ce contexte que les arrangements observés en Allemagne et en France diffèrent de manière substantielle et ce en raison des différences sous-jacentes dans leurs structures corporatistes. Par conséquent, en Allemagne nous pouvons noter une scission au sein des groupes de médecins et leurs représentants avec au départ l'expression d'un fort scepticisme. Ce débat a été particulièrement tendu et souvent sensible car le DM était à ce moment étroitement lié à des conflits plus généraux dans la profession médicale, soit des questions des recommandations de bonnes pratiques qui se sont « institutionnalisées » (et ainsi plus contraignantes) via le DM. Cependant, la particularité du système corporatif allemand est la forte intégration des représentants de médecins au sein des organes d'autorégulation entre les caisses, les hôpitaux et les médecins de ville. Ces organes disposent d'un pouvoir de direction sur les modes et les volumes de financement entre autres. En suivant cette logique, les dirigeants des fédérations de médecins ont soutenu les DM, basé sur des incitations financières et dans le but de préserver leur rôle en tant que co-régulateur légitime. En même

temps, les critiques ont pu, d'un côté, s'identifier avec l'ordre national des médecins qui s'est finalement retiré des négociations. De l'autre, les critiques ont pu externaliser leur ambivalence via un médecin expert qui avait travaillé sur les recommandations de bonnes pratiques.

En revanche, l'inscription des médecins français dans la régulation du système de soins est beaucoup moins institutionnalisée. Le thème directeur qui structure la relation entre les médecins de ville et l'assurance maladie est le principe de la « médecine libérale », dans le sens où l'assurance maladie interfère peu au sein du couple patient-docteur. Les accords collectifs entre les syndicats de médecins et l'assurance maladie sont souvent conflictuels et la fragmentation au sein des représentants est importante. En conséquence, le syndicat principal MG France n'a pas eu à se positionner publiquement face à Sophia alors que son conçurent UNOF-CSMF est devenu un allié (temporaire) de l'assurance maladie. Cette fenêtre d'opportunité a été également renforcée par le fait que les discussions importantes sur les recommandations de bonnes pratiques ont déjà eu lieu (et en fait Sophia contenait peu d'éléments de *médecine fondée sur les preuves*), de sortes que Sophia n'a pas été perçue comme sujet à conflits. Par ailleurs, le programme Sophia a reçu un soutien fort de la part des patients, réduisant ainsi les difficultés. Le prix à payer, tel qu'il est suggéré ici, est une diminution globale dans la cohésion au sein de la profession médicale dans les deux pays.

De manière heuristique, il est possible de définir la perception de DM, qu'ont les institutions et les particuliers dans les deux pays, par les notions extrêmes que sont « national » et « étranger ». Pourtant, au fil du temps, il y eu un changement dans les esprits des acteurs, ce qui représente un processus de *traduction*. En réalité, en Allemagne, le DM a évolué du sens de « national » à celui de « étranger ». En même temps, en France, ces perceptions ont clairement progressé dans la direction opposée, soit de « étranger » à celui de « national ». En effet, la traduction et la mise en œuvre du concept de DM en Allemagne a été opéré de manière concomitante à différents niveaux et avec des temporalités distinctes. Alors que l'expérience internationale a été principalement utilisée en tant que source de légitimité à des niveaux supérieurs, la mise en œuvre s'est basée sur l'expérience nationale passée. Cela a contrasté avec les modèles étrangers et a mené vers un processus de « *branding* ». C'est là que les groupes d'experts ont eu un rôle particulier dans la construction du consensus et de la légitimité pour agir. A l'inverse, en France, il y a eu un degré relativement élevé de transfert

conceptuel et technique qui est lié au fait que Sophia soit un programme *de facto* étranger et que l'équipe américaine ait été impliquée sur le terrain de nombreuses fois lors du processus de mise en place. Les conséquences des négociations ont concerné avant tout les différences culturelles et la formation professionnelle, par exemple des programmeurs de logiciels et des infirmiers. Enfin, le processus de traduction a été caractérisé par un certain niveau d'ambivalence envers le modèle de DM, tout en interaction avec les idées sur son pays d'origine.

Paiement à la performance (P4P)

Le développement du P4P dans les deux pays est intrinsèquement lié aux politiques précédentes de DM en tant qu'outils pour prolonger les larges transformations du système à long terme, soit le rôle croissant de l'Etat et de l'assurance maladie en parallèle à la fragmentation de la profession médicale. Cela a été incarné en France par la réforme de 2004 qui redéfinissait la mission de l'assurance maladie. En revanche, en Allemagne, nous avons souligné le rôle croissant des éléments de concurrence depuis les années 90. Cela mène à un autre argument, celui de la prolongation des transformations à long terme qui n'ont pas mené au même résultat en France et en Allemagne. En réalité, le P4P a connu une diffusion rapide en France, facilité par une coalition relativement forte et proactive menée par l'assurance maladie qui a proposé que la réforme soit placée au sein d'une ligne cohérente de mesures et d'idées. De la même manière que pour le DM en Allemagne, les arguments de déprofessionnalisation et d'éthique ont joué un rôle dans les discussions qui ont suivi, avec la majorité des praticiens individuels qui ont finalement opté pour le P4P afin d'équilibrer les implications cognitives et matérielles. Cependant, dans le cas de l'Allemagne, la vue d'ensemble est moins claire avec une pléthore de fournisseurs qui demeure réservée quant à l'idée du P4P et les acteurs clés encore incertains sur les gains politiques. Une initiative majeure pour le P4P dans les soins ambulatoires est venue des représentants des médecins dans le but de reprendre un contrôle réglementaire. Pourtant, il a été rejeté par la base des médecins en raison de préoccupations concernant la déprofessionnalisation et l'allocation de fonds.

L'interaction entre la profession médicale et les promoteurs des programmes P4P est un facteur essentiel pour cette étude, car elle constitue une variable unique qui semble dépendante et explicative. Dépendante car certaines relations résultent de longues lignes de dissidence, et explicative car ces conflits de longue date ont inspiré des outils (tels que P4P) qui

impliquent une reconfiguration des relations sociales des acteurs. À cet égard, la relation entre la réforme et les acteurs professionnels souligne les complexités et les temporalités multiples qui sont à l'œuvre. Un phénomène clé est la déconnexion croissante entre les représentants des médecins et leurs bases dans les deux pays. En France, l'assurance maladie, qui emploie d'importantes ressources humaines et matérielles, a proposé des contrats de P4P directement aux médecins généralistes, pour ainsi contourner les dirigeants syndicaux opposés. En Allemagne, un important projet de P4P potentiel a été lancé par des représentants de médecins, mais rejeté par leurs bases. Dans les deux cas, les considérations monétaires ont joué un double rôle. D'une part, les gains attendus ont certainement pesé en faveur des médecins français qui ont signé les contrats de P4P, alors qu'une puissante part des médecins allemands prévoyait des pertes avec un composant de paiement P4P. En revanche, la préoccupation, selon laquelle la motivation financière externe peut être un perturbateur contraire à l'éthique de l'autonomie des médecins, était une question importante dans les deux pays. Néanmoins, le mécontentement du système dominant de rémunération à l'acte en France a probablement été un facteur qui a amené de nombreux praticiens à adopter le P4P.

Enfin, les conflits étaient (et restent) largement liés à des problèmes hautement techniques. En France, le P4P et les mesures de performance connexes ont également été conçus comme moyen de conduire la « numérisation » des cabinets médicaux. Afin d'attirer un nombre suffisant de médecins généralistes qui seraient admissibles à des bonus, des simulations complexes et longues ont été faites au sein de l'assurance maladie. En Allemagne, de nombreuses questions techniques intersectorielles avec la mesure de la qualité ont été retardées car elles sont étroitement liées à la question de l'autorité sur les données qui demeure conflictuelle. Ces problèmes n'ont pas été résolus au sein des organes d'autorégulation entre les caisses, les hôpitaux et les médecins de ville, ce qui a mené à l'intervention de l'Etat. La haute technicité est un élément qui évoque l'interdépendance du processus. Les outils techniques sont plus susceptibles d'être conçus par des institutions qui disposent des ressources nécessaires pour le faire. En outre, le fait d'utiliser un tel outil augmentera la probabilité que d'autres instruments techniquement similaires suivent. Tel est le cas en France avec l'extension de Sophia à d'autres maladies, l'incorporation du P4P dans les conventions collectives ainsi que l'extension à d'autres groupes de médecins, comme les cardiologues. Des extensions similaires peuvent également se produire en Allemagne dans le cadre de l'agence publique nouvellement créée pour la création d'indicateurs. En fin de compte, le P4P a été

adopté dans le secteur hospitalier dans les deux pays. En Allemagne, contrairement à la France, ces éléments de P4P dans le secteur hospitalier sont explicitement considérés comme essentiels pour favoriser la concurrence entre les hôpitaux dans le but d'atteindre un « nettoyage structurel ».

En ce qui concerne les facteurs cognitifs et les développements qui ont façonné les débats de la réforme du P4P, dans le cas de la France, il semble y avoir un récit partagé et fort qui se concentre sur les transformations de la maîtrise des coûts ainsi que sur la pratique et la rémunération des médecins. Dans cette histoire, l'idée d'un « modèle » concret pour le P4P au Royaume-Uni est effectivement présente. Cependant, il apparaît comme un moyen pour permettre aux acteurs clés de réfléchir et de contraster leurs propres hypothèses et leurs intentions. Il est probable que ce récit concis ait bien servi de base à l'introduction du P4P et ait contribué à l'impact élevé de P4P en France. À l'inverse, nos données sur l'Allemagne ne suggèrent pas un récit fort. Au lieu de cela, il semble qu'il y ait eu une exposition à long terme au sujet P4P, avec des évaluations intenses en ressources. Les différents acteurs ont attaché des significations et des interprétations distinctes à l'expérience de P4P à l'étranger, allant de l'approbation et de la légitimité au refus et à la négation.

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Titre : Idées globalisées, défis nationaux : l'introduction du Disease Management et du paiement à la performance en France et en Allemagne

Mots clés : Politiques de santé, comparaison internationale, instruments d'action politique, profession médicale

Dans de nombreux états providences, les systèmes de santé subissent de nos jours d'importantes transformations en réponse aux pressions budgétaires et caractérisées par le rôle croissant du marché et des mesures de rationalisation. C'est dans ce contexte que la France et l'Allemagne ont mis en place des programmes de Disease Management (DM) dans le but de fournir des soins plus structurés et de paiement à la performance (P4P) pour inciter financièrement les fournisseurs à répondre à certains objectifs.

Ces réformes, qui reflètent le rôle croissant de l'Etat dans les deux systèmes d'assurance maladie, se sont inspirées des modèles anglo-saxons mais se concrétisent de manière distincte en fonction des caractéristiques des systèmes des deux pays. En Allemagne, DM et P4P se sont basés sur la concurrence croissante entre les caisses d'assurance maladies et entre les hôpitaux tandis qu'en France, ces réformes ont reflété un changement du rôle de l'assurance maladie « de payeur à acteur ».

Le positionnement de la profession médicale vis-à-vis de ces nouveaux instruments de gouvernance, qui sont de nature hiérarchique et qui imposent une logique comptable, est une question clef en France et en Allemagne. Dans les deux pays, les processus de négociations ont été lié à un écart grandissant entre les représentants des médecins et leurs membres, et ce malgré les différences dans la manière dont les médecins sont traditionnellement intégrés dans la régulation des systèmes de santé respectifs.

Title: Global ideas, national challenges: the introduction of disease management and pay-for-performance in France and Germany

Keywords: Health policy, international comparison, policy instruments, medical profession

Health systems in many welfare states are undergoing important transformations, triggered by increasing budgetary pressures and characterized by the growing role of market and rationalization measures. In this context, France and Germany have introduced disease management (DM) programs to deliver more structured patient care and pay-for-performance (P4P) measures to provide financial incentives for providers meeting certain objectives.

These reforms, which reflect the increasing role of the State in both statutory health insurance systems, were inspired by Anglo-Saxon models but translated in distinct ways, owing to differences in the two countries' systems. In Germany, DM and P4P were based on increasing competition between sickness funds and between hospitals, while in France these reforms reflected a shift by its central insurance system "from payer to player".

The positioning of the medical profession vis-a-vis these new instruments of governance, which are hierarchical in nature and impose stronger public accountability, was a key issue in both France and Germany. The negotiation processes were accompanied by a growing disconnect between physician representatives and their memberships in both countries, despite significant differences in the way physicians are traditionally integrated into health system regulation.