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Panel T05P04: Combining Instruments in Formulating Policies: Why and How Decision-makers Set up Policy Instruments' Mixes
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Breaking new ground or adhering to 'what works'? Comparing Policy Instrument Choice to Overcome Regional Shortages in the Supply of Medical Care in Germany and France

Abstract

Since the early 2000s, the problem of regional shortages in the supply of outpatient medical care has emerged on the health policy agenda in several Western European states. Shortly afterwards, France and Germany were amongst the countries to seek to overcome this policy problem by the adoption of particular policies. In this context, French policy-makers – besides selecting traditional instruments – could select a range of new (regulative) instruments like a re-regulation of medical studies or regulations to re-organize the provision of medical services finally leading to an innovative mix of instruments of the regulation of medical care. German policy-makers, in contrast, essentially adhered to traditional instruments in this field of recurrent regulation, namely the creation of material incentives for health professionals, i.e., first and foremost, physicians.

The paper is concerned about the driving factors influencing the selection of policy instruments in fields of recurrent regulation. It takes the instance of varied instrument selection in two institutionally similar Bismarckian welfare states, Germany and France, faced with the similar problem of regional shortages in medical supply as an empirical example in order to comparatively analyse the framework conditions and drivers of policy instrument choice in such fields. The paper particularly sheds light on the significance of the framing and definition of the policy problem in question so as to understand the selection and mix of policy instruments in the two countries compared.

The paper argues that, in fields of recurrent regulation, the framing and definition of policy problems often is not a subject of controversy. The selection and mix of policy instruments thus tends to be based on customary agency-related as well as structural factors like policy-makers' experience ('what works') or traditional assumptions about the appropriateness of certain instruments seen from the perspective of core

stakeholders of political and functional interests. Under such conditions, given instruments will be adapted to new challenges. However, when politicization of a well-known policy problem occurs (e.g. due to new information about the framework condition leading to the problem at stake or due to a changed constellation of political stakeholders and the formulation of interests), this often leads to a reframing of the problem at stake. As a consequence, the selection of policy-instruments might as well be concerned as policy-makers are confronted with new expectations by (new) stakeholders of interest, with emerging public expectations and/or with new regulatory ideas.

1. Introduction

In modern mature welfare states, public policymaking is in large parts a 'routinized endeavour'. Many policy items to be decided on are not new, but recur from time to time (True, Jones and Baumgartner 2007, 155; Hassenteufel 2011, 51). This does not mean that each time a topic re-appears on the policy-makers' 'problem radar' or re-attracts policy-makers attention exactly the same instruments are being applied in order to deal with it. Rather, policy-making often is about the recasting of well-known instruments the effects of which have proven to be unsatisfactory notably when seen from the perspective of a changed situational context (Peters 2002). As a consequence, the selection of policy instruments in fields of recurrent regulation seldom is marked by pure repetition and "inertia" (Capano and Lippi 2017, 283). However, it tends to be marked by path dependency and incremental changes (ibidem.) with 'instrument paths' being rarely interrupted by greater changes.

In this article, we focus on policymaking and notably instrument selection as regards recurrent policy problems and fields of recurrent regulation. We are interested in when, how and under what conditions or why the particular policy mix to deal with a recurrent topic or solve a recurrent problem is being changed more radically. In order to develop an answer, we comparatively analyse instrument choice in the field of health policy-making regarding the regulation of the supply of outpatient medical care in the cases of Germany and France.

The comprehensive provision of outpatient medical care has traditionally been a subject of recurrent political regulation in all developed health care systems. The need for regulation arises because of at least two interrelated framework conditions. On the one hand, adequate access to medical care in general and outpatient care in particular is a fundamental promise of health policy in the modern welfare state (Moran 2000). Access to care is not only a social right of citizens in the nationally organized welfare state, but, at the same time, it is a humanitarian obligation that the state has towards all persons in its territory. On the other hand, the actual warranty of this fundamental promise is subject to great fluctuations in many welfare states. The supply of and demand for medical services rarely correspond completely. Periods of oversupply have alternated with undersupply phases in the past, regional supply fluctuations often occur and in many cases there are differences in specialist care compared to primary care, which can have a negative impact on the overall care situation.

In the recent past, the fulfillment of the welfare states' guarantee of adequate outpatient medical care has become precarious in many developed welfare states, especially in the Western European ones. Structural transformations such as demographic change and its highly divergent regional impact, the actual epidemiological evolution of populations, and changes in the attractiveness of the profession of general practitioner (GP) leading to an overall shortage of professionals have contributed to the evolution of regional shortcomings in terms of access to outpatient medical care, notably GP care or primary care, irrespective of a comparatively high density of doctors in many

countries (OECD 2017). Regional imbalances in the supply of outpatient care and in access to care have thus become a central health policy problem in recent years, especially in Western European countries (Sundmacher and Busse 2014; Siegel et al. 2016).

The described paradox manifests itself i.e. in Germany and France. Both countries, due to the institutional framework of policy-making in relation to outpatient medical care of the population and due to their traditions of the organization of outpatient care, can be described as most similar cases. In both countries, the total number of doctors has been rising steadily for years; nevertheless, from around the beginning to the mid-2000s, the problem of a "lack of doctors ("Ärztemangel") (SVR 2014; Klose und Rehbein 2016) or of the existence of "medical deserts" ("déserts médicaux") (Véran 2013; Vergier et al. 2017) has become a topic of public and political discourse on health policy.

To address the recurrent problem of ensuring adequate access of the population to outpatient medical care, health policy can traditionally resort to a wide range of policy instruments (Ono, Schoenstein and Buchan 2014; EPF 2016). When comparing the policies adopted by the two countries in order to regulate the supply of outpatient medical care during the past two decades, we find a pattern of "routinized" (Capano and Lippi 2017, 282f.) instrument selection in the case of Germany, whereas, in the case of France, significant change in instrument selection and an expansion of the traditional selection of instruments becomes apparent.

This statement of differences forms the starting point of this article. We ask which instruments have been selected to regulate outpatient medical care in Germany and France since 2000, which changes in instrument selection have come along with the choice and what explains (more or less radical) change in the selection of instruments in each country respectively and in a comparative perspective?

In the following section 2 we present the conceptual framework of our empirical study. Firstly, after having defined the concept of "change" with regard to the selection of policy instruments, we develop a concept to explain the change of policy-based instrument choice, drawing on insights from punctuated-equilibrium theory and from theoretical considerations on the instrumentation of public policies, and secondly we formulate basic assumptions about the conditions of a change in the selection of policy instruments. As well, we explain the methods applied in our comparative analysis. Section 3 sums up the political framing of the recurrent health policy problem of regulating outpatient medical care in Germany and France since the year 2000. Furthermore, the mixes of instruments selected since then in both countries to deal with the problem as well as the changes in instrument selection are mapped. In section 4, starting with our assumptions, we comparatively discuss what explains more radical or rather path dependent change in the two cases. In section 5, we summarize, formulate conclusions in relation to the comparative study, and discuss overarching theoretical implications of the case comparison for the key issue of the drivers of policy instrument selection.

2. The selection of policy instruments in fields of recurrent regulation: conceptual background

2.1 Selection of policy instruments – insights from punctuated equilibrium theory

In the modern state, which operates on a large number of complex regulatory areas, numerous regulatory tasks, issues and policy issues regularly recur. Policy-making is delegated to policy subsystems as far as possible, where – depending on the matter – essentially the same actors (specialist administrators, policy experts, stakeholders of interest, consultants) interact in relatively stable policy-professional communities and are involved in routine processes of problem definition, target selection and instrument discussion (Pierson 2000; Howlett and Rayner 2006; True, Jones and Baumgartner 2007; Mahoney 2000). In the system thus organized, the political process in the different policy fields runs continuously over long periods of time, often outside the public debate, and is characterized by "stability and incrementalism" (True, Jones and Baumgartner 2007, 155). Sometimes, however, the "equilibrium" of the policy process is interrupted and fundamental policy change takes place (Hall 1993; True, Jones and Baumgartner 2007; Sabatier and Weible 2007; Kingdon 1995).

The path to policy change (and more or less explicitly of policy instruments) has been addressed and described in various theories of the policy process (Sabatier and Weible 2007; Kingdon 1995; True, Jones and Baumgartner 2007). However, these theories cannot provide a convincing answer to the question of why certain policy instruments are selected at all, and, consequently, why instrument choices sometimes may change radically. In many cases, instrumental change is assumed to be an automatic process in the context of policy change, which – overall – includes changes in ideas and goals, possibly procedural changes, changes in the actor constellation, etc. This raises an explanatory gap (Capano and Lippi 2019), which is particularly interesting with regard to recurrent regulatory tasks, as the structural and institutional resistance to change is particularly high in such contexts (Pierson 2000). To help bridge this gap, we combine insights from the punctuated equilibrium theory (True, Jones and Baumgartner 2007) with reflections drawn from the literature on the instrumentation of public policies (Linder and Peters 1984, 240; Lascoumes and Le Galès 2004).

First of all, it is necessary to define "change" in terms of the choice of policy instruments. In this context, Capano and Lippi assume that there are four forms of change in the choice of policy instruments. While adjusting the level of individual instruments (e.g. increasing or decreasing a tax) or changing the range of the given mix by adapting individual instruments means less radical change – Capano and Lippi speak of "routinization" and "contamination" (2017, 282-284) –, the introduction of a new dominant instrument that differs in content from the instruments of the traditional mix, or the rebalancing of the instrument composition such as creating a 'new layer'

of instruments - Capano and Lippi speak of "hybridization" and "stratification" (2017, 284-286) – stand for a radical change in instrument selection.

It is important to emphasize that "change" in instrument selection implies a more or less fundamental adaptation of the traditional instrument mix in the respective policy context (Capano and Lippi 2017, 282-286). In the modern welfare and regulatory state, political issues are usually not dealt with by specific individual instruments, rather, a set or mix of instruments are created and used (in combination) (Lascoumes and Le Galès 2004, 12). This is especially the case in traditional policy areas with recurring regulatory needs and their own 'policy history'. Here, over time, a differentiated mix of instruments usually develops and several long-proven instruments exist. In addition, the focus is on the use of certain types of instruments as a characteristic of traditional policy areas (social policy with its sub-fields as a supposedly redistributive policy or environmental policy as, above all, a regulatory policy are considered as examples; Majone 1997; Lees 2007). Against this background, our premise is that "change" of instrument choice also implies a rebalancing between the predominant types of instruments[1], notably in fields with recurring regulatory needs (Klenk and Reiter 2012).

The punctuated equilibrium theory (PET) (True, Jones and Baumgartner 2007) offers a model for understanding policy change in policy areas with recurring regulatory needs. The starting point for PET is the assumption that radical change of an inherently stable policy process is due to the change in the attention of the relevant policy actors to fundamental ideas shaping the perception or interpretation of a policy as a whole ("policy images") (True, Jones and Baumgartner 2007, 161-162). Change – here PET corresponds to other approaches (e.g. Hall 1993: ideas and "paradigms", Sabatier and Jenkins-Smith 1993: "beliefs", Fischer 2003: "frames") – can always take place when a traditional policy with its problem interpretations and objectives is successfully being based on a new policy image or is successfully connected to a changed "framing" (Fischer 2003) of the initial problem. If this happens – so the argument goes – the starting point of all actors involved in the policy process (i.e. the actors of the policy subsystem and the actual decision-makers at the macro-political level) for the definition of policy problems, policy objectives and the selection of political goals and measures or tools may change as well (True, Jones and Baumgartner 2007, 162-163). While the issue of policy selection is an integral part of the policy process, it is not

[1] Different approaches to classify policy instruments (e.g. Lascoumes and Le Galès 2004; Howlett 2011, 23f.) distinguish between at least four basic instrument types: regulatory instruments (based on authoritative measures, command and proscription), fiscal and economic instruments (based on the use of money as taxes or financial incentive instruments), procedural instruments (these include the regulation of decision-making processes by subordinate actors, e.g. local authorities, self-government, such as by allocation of participation rights or decision-making powers) and informational instruments (these include the approach of influencing the actions of actors through the provision of information). Occasionally, the fulfilment of public tasks by the state itself is included in the typology of instruments; it implies that the state may take the place of private or non-profit actors, and may itself carry out public functions in facilities operated by itself (for example hospitals), which integrally includes the regulation of such action.

explicitly addressed by PET (and other theories of the policy process). However, it is implicitly assumed that the choice of instruments must change so that a change in policy objectives, ideas or patterns of interpretation ("images", "ideas", "frames") actually results in a different policy (Hall 1993).

A key difficulty, now, is to overcome the routines of the policy process. Especially in fields with recurring regulatory matters – as indicated by PET – such routines are available. Here the political process and also the choice of policy instruments are, as it were, institutionalized (Lascoumes and Le Galès 2004, 14-15). In this case – PET argues – the policy subsystem which prepares political decision-making in particular triggers a braking or blocking effect with regard to the possibility of policy change ("negative feedback"; True, Jones and Baumgartner 2007, 162 Beyer, Boushey and Breunig 2015, 356f.). This – so our starting assumption goes – is especially true with regard to the pre-selection of policy instruments (appearing e.g. in draft legislation) which is made at the level of the policy subsystem by preparatory communities docking with the ministerial administration.

The actors within the policy subsystem often choose a course that could be termed a "what works"-strategy: they seek to avoid major changes in the choice of instruments in order to avoid the need for increased adjustment costs, for the processing of new information or for increased coordination effort as a result of changed expectations of the actors. As well, they search to circumvent the increased need of the political decision makers, e.g. in Parliament, for policy explanation combined with increased political control (March and Olsen 1989, 54ff.; Pierson 2000). The "what works"-strategy – as suggested by Principal Agent Theory and Implementation Research – is difficult to overcome despite a supposedly greater willingness on the part of decision-makers at the macro-political level to actively and sometimes radically change a policy ("positive feedback", True, Jones and Baumgartner 2007, 163; Beyer, Boushey and Breunig 2015, 357). The reason for this is that the actors in the decision-preparing policy subsystem usually have a higher level of technical-content knowledge as well as a knowledge advantage with regard to the technical feasibility of certain political solutions (Kingdon 1995) and their implementability. At the same time, the limitations of policy actors' temporal and cognitive ("bounded rationality") resources are more important at the macro-political level of decision-making than at the level of the policy subsystem as politicians on the macro-level are normally more exposed to competing policy issues and problems than actors on the level of the subsystem (True, Jones and Baumgartner 2007, 164, Walgrave and Dejaeghere 2017).

PET – as well as other theories of the political process (Sabatier and Jenkins-Smith 1993, Sabatier and Weible 2007, Kingdon 1995) – points out that structural factors in particular can explain a more or less sudden change in the policy process – "external shocks" or catastrophes or the election-related exchange of the political leaders and thus – depending on the political system – also of the staff at the technical level are common explanatory factors of change (True, Jones and Baumgartner 2007, 165-166). However, the reference to structural factors is only partially convincing. First, there

are numerous examples of non-change following an external shock or a catastrophic event (for example, the reluctant response in energy policy-making in Western countries to the Chernobyl disaster in 1986, or the political reactions in Europe and the US to the international financial crisis from 2008). On the other hand, the reference to structural factors also remains superficial. So, the factor "crisis" or "catastrophe" is less predictable and anticipatable as an influencing factor on the policy process than the factor of elections and party political change. Moreover, further possible explanatory factors specific to the selection of policy instruments and instrumental change that interact with structural framework conditions (Capano and Lippi 2017) remain underexposed – this applies in particular to the factor "institutions".

Based on considerations from the literature on the instrumentation of public policies (Linder and Peters 1984; Lascoumes and Le Galès 2004), we propose an addition to the PET model. We argue that change in the selection of policy instruments takes place in particular under three conditions, which must be relevant both at the policy subsystem-level and at the macro-political level of decision-taking (see True, Jones and Baumgartner 2007, 166-167):

- First, if *doubts about the effectiveness* (Lascoumes and Le Galès 2004, 30; Mehta 2011, 31) of given policy instruments are identified at both levels and recognized as such. The effectiveness of certain policy instruments is not a purely technical issue, but one that concerns the legitimacy of policies and thus the legitimacy of politicians (ibidem.). Therefore, the determination of the effectiveness problems of existing instruments can develop political relevance, which first and foremost becomes effective at the macro-political level. Under these conditions, the pressure on the level of the political subsystem to change instruments can rise;
- Second, if the existence of *instrument alternatives* (Linder and Peters 1984, 240; Kingdon 1995; Mehta 2011, 26) is perceived notably at the subsystem level. Many policy problems can be handled with different tools. Yet, the range of possible alternatives is not always known to the actors preparing policies. The opportunity to perceive alternatives can be facilitated by the existence of an "instrument constituency", i.e. a network of different actors (politicians, experts, administrators, stakeholders, consultants, etc.) (often across levels and countries) that are involved in the design of policy instruments ("instrument infrastructure") independent of the existence of a concrete problem (Béland and Howlett 2011). The purpose of such constituencies, in which both actors of policy subsystems and the political decision-makers can be involved, is the renewal or further development of policy instruments; it is not the definition of policy problems or the politically motivated selection of policy-alternatives (ibidem., 398). Especially in the case of recurring problems or regulatory tasks, policy constituencies' 'offer' of viable instrument-alternatives can be attractive both for the actors of the policy subsystem as well as for political decision-

makers who, often, resort to the instrument solutions proposed by the actors of the policy-subsystem (Walgrave and Dejaeghere 2017).

- Third, when the *compatibility* of existing instruments *with general norms* of the political and social system is questioned especially at the macro-level of policymaking (Lascoumes and Le Galès 2004, 25). Violation of generally recognized social or political norms is a frequent motive in the context of the selection of policy problems (ibidem; Mehta 2011, 34). This consideration can be transferred to instrument-selection. So, instruments can be perceived as illegitimate under certain conditions, even if their compatibility with social and/or political norms was not previously in question. In this situation, the pressure on politics to use other instruments increases.

In analyzing the impact of these factors on policy instrument selection, it is important to take into account both the institutional embeddedness of the policy process and, above all, the capacity of the macro-political level to effectively control and govern the actors of the policy-subsystem. In particular, the relevant specialist administrations and the stakeholders of interests or core interest groups are in the focus (Mayntz and Scharpf 1995, 40ff., 54ff.).

2.2 Design and methods

Based on these conceptual considerations, we will examine below the choice of policy instruments in the case of the recurrent public health problem of ensuring an adequate supply of the population with outpatient medical care. In line with the results of an international research project to ensure outpatient care in disadvantaged areas[2], we focus on the examples of Germany and France. These were chosen because of the combination of structural as well as institutional similarities and differences, which both countries exhibit, amongst other things, in the healthcare system and in the political system in general.

Thus, Germany and France are similar in terms of the prevailing structural framework conditions (population, demographic development, economic development, EU membership) and the relevance of the initial problem of regional undersupply with outpatient medical care (see introduction). In addition, both countries have similar health systems (social health insurance system; regulation of ambulatory based on a system of health self-governance) (Schölkopf and Pressel 2017), which, especially in the field of outpatient care, are characterized by a traditional dominance of the medical profession as a central interest group and a central political veto-player.

On the other hand, Germany and France exhibit significant differences in the design of their political systems in general (parliamentary democracy in Germany vs. semi-presidential democracy in France), the structure of state-administration (decentralized

[2] The paper has been developed within the framework of the international research project REGMEDPROV funded by the German Research Foundation (DFG) and the French Research Agency (ANR). It ran from 2015 to 2018 and was jointly directed by Thomas Gerlinger, Patrick Hassenteufel and Renate Reiter.

federal structure in Germany vs. centralist structure in France) (see Klenk and Reiter 2012). As well, the some elements in the design of the policy-specific governance structure in the field of health differ as well. So, in the case of Germany, the actors of health self-governance (i.e. the National association of panel doctors, *Kassenärztliche Bundesvereinigung*, KBV, and the national association of the German sickness funds) via the Federal Common Board of Actors (*Gemeinsamer Bundesausschuss*) exert far reaching influence on the process of health policy-making notably in terms of the regulation of ambulatory care ("health corporatism"). Notably the KBV is a major player in this context as it is vested with the legal mandate to ensure the outpatient medical care (§ 75 SGB V). In contrast, the federal states' health bureaucracy in the federal Health Ministry defines its role as that of an instance of framework regulation. In contrast, in the case of France, the state, i.e. the bureaucratic elites within the national Health ministry and the agencies controlled by it, exert a strong control on policy development and actively intervene in the policy process.
Methodologically, we conducted a systematic analysis of secondary studies and documents[3] and used the information from 23 semi-structured expert interviews carried out in both countries during the period 2016-2018.

In the following section, we record the processes of problem framing and political instrument selection in relation to the recurrent health policy problem of regulating outpatient medical care in Germany and France since 2000. Thereafter, in section 4, we examine the reasons for instrument selection in the course of recent national legislation on outpatient medical supply in both country cases.

3. The area-wide supply of outpatient medical care – policy framing and instrument-selection in Germany and France

3.1 Frames and instruments

In principle, health policy actors have access to a wide range of policy instruments for the recurrent regulatory task of establishing adequate access to outpatient medical care services. The idea of adequate access to healthcare not only relates to the goal of tackling shortages of supply, but also implies the regulation of possible oversupply in the sense of the overarching requirement for the economic management of public health resources (Rosenbrock and Gerlinger 2014, 129-131; Schölkopf and Pressel 2017). The range of available instruments ranges from regulatory measures, such as the legal obligation of service providers (physicians) to provide care, to various incentives for the establishment of physicians or prospective physicians in underserved regions, to changes in the organization of health services and strengthening the

[3] In total, we analysed 181 documents (77 in the case of Germany, 104 in the case of France) using specialized word selection software (MaxQDA) in order to capture the attributes the attributes used by actors on each level characterizing the situation of outpatient medical supply as well as the policies to be subjected.

autonomous participation rights of non-medical health care providers up to changes in patient information on care access and opportunities (Ono, Schoenstein and Buchan 2014, EPF 2016) (the list below is far from complete and is not conclusive). Alongside instruments, the recurring initial problem of the public health regulatory system – the creation of favourable conditions for an adequate access of individuals to outpatient medical care – can be defined or framed differently (Fischer 2003) (table 1).

Table 1: Area-wide supply of outpatient medical care and available policy instruments

Problem framing	Policy instruments
Deficits in medical training	- Strengthening general medicine within the study of medicine - Opening up the study of medicine for future students of health, allowing for better access to the study of medicine - …
(Problematic) financial situation of health professionals	- Special financing rules (price supplements) - Exemption from mass limits - Financial guarantees - Provision of immobile goods (e.g. practice rooms) - Low priced credits, aid to investment - Study credits for students of medicine - …
Limited role of local/ regional actors	- Reform of supply planning - Creation of new local/ regional institutions - Extension of competences of local/ regional actors - Political strengthening of local/ regional level of regulation - …
Deficient organization of medical provision, including the division of labour amongst health professionals	- Authorization of ambulatory care in hospitals - Removal of age limitations for physicians - Mobile service offer - New bearers of care-offerings - Tele-Medicine, eHealth - Recruitment of foreign medical practitioners - New competences for non-physician health professionals - Special programmes of advanced vocational training - …

Source: Gerlinger, Hassenteufel and Reiter 2014.

To comparatively assess the processes of policy instrument selection (with regard to the recurring problem of adequate outpatient medical care in Germany and France, it is necessary, first of all, to shed light on changes in the underlying "policy image" as well as the framing of the initial problem and the mix of policy instruments. In this context – starting from our initial assumption formulated above –, we assume that a particular "framing" is associated with the preference for certain types of policy instruments.

3.2 Problem-framing and instrument-selection in Germany and France since 2000

Both in Germany and in France the issue of regional shortages in the supply of outpatient medical care has become a core concern in health policies during the last fifteen years. In both countries the re-appearance of this topic which has a continual

position on the national health policy agenda since the early 20th century is related to signs of a change in the supply of medical professionals notably physicians, and – here – general practitioners (GPs), at the turn of the 21st century. This change was brought forward as a recurring health policy topic by different health political actors in Germany and France at the beginning of the 2000s.

In Germany (West), the discourse on the conditions of an adequate supply of outpatient medical care, not only within the profession and among professionals, but also in public, goes back to the 1960s (Rosenberg 1972; SPIEGEL 1972, 131). The debate was initially characterized in the late 1960s and early 1970s by the findings of both qualitative and quantitative supply shortages (Rosenberg 1972, 34). However, against the backdrop of a growing number and density of doctors, public attention and political pressure on the subject began to decline in the late 1970s. Since then, the question of an adequate supply of outpatient has again been addressed, above all, by health professionals or within the health policy subsystem. Here, the various administrative and political actors, experts and stakeholders of interest have been leading the discourse since the 1980s under the heading of "medical glut" (Herder-Dornreich 1985). With this term, concerns about the consequences of high numbers of doctors were expressed. From a medical point of view, these consisted above all in a competition problem, from a health economic and health policy perspective, the fear of rising health costs due to a more demand-oriented supply of services was in the foreground (Herder-Dorneich 1985).

This problem interpretation was influential for the health supply policy in Germany until the turn of the millennium. Measures such as a tightening of study conditions or professional admission conditions or the statutory regulation of the establishment of doctors through the requirements planning system introduced by the 1993 Health Structures Act were seen as appropriate instruments notably by actors of the health policy subsystem. For a long time, these instruments were not called into question at the macro-political level of decision-making because the cost argument was ultimately central (KomPart 2012, 15-19).

In the early 2000s, the discourse on health supply policy shifted again. The renewed discourse shift initially went out of the medical associations, notably the National Association of Statutory Health Insurance Physicians (KBV) with their regional subdivisions, the KVn, and the Federal Medical Association (BÄK). Already in the early 2000s, these stakeholders of interest warned of a looming shortage of doctors (BÄK 2004, 2005). The health insurances as a financing carrier rejected this generalized warning already a short time after their publication, pointing to regional differences in healthcare and arguing for the introduction of specific tools to specifically address regional supply deficits (e.g. better integration of outpatient and inpatient care) (Klose and Rehbein 2016). Nonetheless, with the dramatizing public warning of the medical profession about supply shortages, a new theme for the political discourse about healthcare provision was born.

At first, politics reacted reluctantly to this return to the supply challenge. In fact, the Health Reform Act passed in 2000 by the Red-Green Federal Government did not yet contain any instruments that would have involved direct state intervention e.g. in favour of increasing physician numbers or improving the conditions of physician care. On the other hand, informational instruments were central. For example, the Council of Experts on Health Care Development (*Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen; SVR*) as the highest advisory body on public health issues established in 1985 received the mandate to report on the actual forms and degree of supply shortages as well as other deficits of outpatient medical care. In 2001to present different types of deficits by 2001 Supply, namely under-, over- and misuse, to report.

The findings of the SVR report presented in 2001 were quite explosive (different forms of under-, over- and misuse of healthcare were explained in the report). However, the subject of an impending supply shortage with outpatient medical services in Germany initially remained one that was discussed on the professional level and the level of professional policy, but less in the general public. It was in particular medical interest groups, the KBV and the BÄK, who took up the supply-related findings of the SVR report and in this context warned against an imminent "shortage of physicians" ("*Ärztemangel*") (BÄK 2004, 19). Under this heading, KBV, BÄK and other medical groups since the first half of the 2000s consistently frame the basic problem in the same sense. This is: regardless of the growing number of doctors, there are signs of a shortage of doctors. In eastern Germany in particular, and especially in rural and economically weak outskirts, the shortage of physicians will soon be dramatic, as a wave of pensions among the established physicians is pending and many practices will be orphaned in the near future. Especially among the general practitioners in East Germany, this development is expected in a short time, so that there is a very high pressure for policy action. The argument goes on to say that the key to solving the problem lies with current and future physicians. For them, the profession as a whole must be made more attractive again and, above all, incentives must be created to settle in underserved or underprivileged regions (BÄK 2004, 2005; Kopetsch 2010, 144; Klose and Rehbein 2016).

This problem interpretation has increasingly been reflected in a public discourse on health care in Germany since the end of the 2000s. Since then, the press coverage on the topic of "medical shortage" has increased and the number of scientific publications has also increased (Web of Sciences 2019). Other possible interpretations of the initial problem (cf. Table 1), like the existence of deficits in the organization of care and the role of health professionals other than physicians was at best discussed only in specialist circles and here.

The policy measures taken since the mid-2000s hardly deviated from the routine choice of instruments in the context of the traditional supply policy. Thus, for example, the Reform of the Compulsory Medical Law (*Vertragsarztrecht*), which entered into force in 2007, allows doctors to continue practicing beyond the legal age limit of 68 if

they do not find a successor for their practice (KomPart 2012, 68). And the two central laws on the supply of outpatient medical care passed in 2011 and 2015, the Health Supply Structure Act and the Health Supply Reinforcement Act, with their instruments, are aimed primarily at creating better conditions for the establishment of doctors. Thus, they take up the traditionally dominant concern of German health policy in the field of outpatient care, i.e. the conditions of action of the medical profession (Rosewitz and Webber 1990). Related to this concern, they provide in particular financial incentives in favour of doctors. In addition, the traditional regulatory instrument of health care needs planning is being reformed (SVR 2014, 367) (see Table 2).

In France, too, the discourse on the supply of outpatient medical care for the population has been characterized by a return to the issue of supply shortages since the beginning of the 2000s.

Here, gaps in the supply of healthcare especially in the inpatient sector were first discussed in the 1950s, leading to a wave of public investment in public hospital infrastructure (Klenk and Reiter 2012). However, as in Germany, this interpretation of the problem lost public and political attention in the mid-1970s at the latest. On the other hand, the concern about excessive spending in the health sector was also the focus of attention, especially among those involved in the health subsystem since the 1970s. Like in Germany, this change in France was associated with the fear of an "abundance" of medical care ("medical plethora", Bungener 1984). A health policy response to the "abundance" problem was the regulation of medical studies by introducing the numerus clausus in 1971 (Déplaude 2015). At the time, the creation of this regulative instrument was not least due to the massive lobbying of the French medical profession, in particular the Federation of Doctors of France (ibidem, Hassenteufel et al., 2019).

As in Germany, the interpretation of the initial problem of health care policy changed again in France from the beginning of the 2000s. Here, too, concern about a supply shortage replaced the hitherto dominant notion of supply overflow. The repeated discourse change in the case of France - unlike in Germany - was not primarily due to the medical profession. On the contrary, two reports commissioned by the Ministry of Health, published in 2002 and 2005 (Lebas 2002, Berland, Gausseron, 2002), for the first time pointed to impending supply gaps, highlighting in particular two emerging problems: first, the problem of a generalized declining of the number of doctors, especially general practitioners; and second, the problem of a regionally very different occurrence of deficits (ibidem.). The authors of the reports identified a north-south divide, pointing out that rural areas in central and northern France and suburban areas, e.g. around Paris, especially at risk (ibidem.). Unlike in the German case, the issue of inadequate care, especially in rural and neglected (pre-) urban areas in France, attracted from the outset not only the attention of relevant stakeholders, but also the wider public. In the media debate, the topic was discussed in the early 2000s in the

context of the out-of-hours reform, which was adopted in 2003 following a strike by GPs and which released the established free-practicing physicians of the legal duty to offer fixed presence times or times of availability to their patients (Hassenteufel et al., 2019). And in the discourse of stakeholders of interest the National Medical Order used the catchy term "medical deserts" ("déserts médicaux") early to point to areas with a particular risk of supply (Lucas 2001).

In France – as in Germany – health politics first responded reluctant to the well-received supply problem. So, in the early 2000 new institutional structures independent of stakeholders in the sector were created to improve the future monitoring of the development of the medical care provision. Thus, in 2003, the Ministry of Health established the National Observatory on the Demography of Health Professions (ONDPS), creating a semi-autonomous agency to regularly produce statistics and studies on the evolution of the care situation. Since then, the ONDPS, which since then regularly publishes figures and data on the situation of medical care in France, has been acting as a neutral entity alongside the key players in health care, medical interest organizations (e.g. the National Medical Order) and the statutory health insurances (e.g. CNAMTS), which – as in Germany – dispute the interpretation of the problem of care (Hassenteufel et al., 2019, Mauss and Piquemal 2015, Vergier et al., 2017).

Since the second half of the 2000s, however, the range of instruments for ensuring adequate outpatient medical care has gradually changed (cf. Table 2). While the initial selection of instruments, e.g. in the context of the 2004 health reform adopted under the Gaullist president Jacques Chirac and his prime minister, Jean-Pierre Raffarin, was still "routine" and can be interpreted as a political illustration of the physician's dominance of care, which – like in Germany – has traditionally influenced supply policy in France (de Pouvourville 1997), subsequent laws, such as the Loi HPST (Hospitals, Patients, Health and Territory Act) of 2009, the pacte territoire santé of 2012 or the Health Modernization Act of 2016, recognize a change in the instrument that goes far beyond routine or hybridization (Capano and Lippi 2017).

The 2009 HPST-Act created so-called regional health agencies (Agences régionales de santé, ARS), i.e. semi-autonomous structures at the regional level controlled by the Health Ministry and which shall improve the state's ability to control local health policy. In addition, the role of health departments in the French Départements (county level) has been upgraded; the Départments with their public health services are traditionally responsible for the care of certain vulnerable groups (infants, toddlers and their mothers). The 2012 territorial health pact was a concerted action by the French Ministry of Health, together with local medical and health organizations and the ARS. It was launched on the initiative of President Hollande (PS) and is set to start with a package of state commitments in order to contribute to the strengthening of the supply situation, especially in rural areas (Ministère des Affaires des Sociales et de la Santé 2014). And the 2016 healthcare system is developing a new type of professional health: the clinical nurse (IPA), who – based on more intensive qualification compared to 'normal' nurses – acts in greater autonomy from the physician (Art. 51 Loi 2009-

879 [HPST]) and may – under certain circumstances – substitute the physicians' intervention.

The listed instruments are more likely to find their role models in countries with national health systems than in countries with a social security system. With this selection of instruments, the supply policy in France recently deviates clearly from its long-dominant instrument path, which – as in the German case – put the doctor at the center and used financial incentives for physicians and the regulation of medical training as essential tools. Of late further ideas questioning the established logic of the SHI-based healthcare system and favouring system-relevant changes (e.g. reorganizing primary care or improving the procedural conditions of coordination among health professionals) ranked prominently in public and political discourse on health policy and have become a key focus of French reports (Larrivé and Boussereau 2015; Casteigne and Lasnier 2017).

Table 2: Main instruments to tackle the issue of medically underserved territories

France	Germany
2004: first financial incentives for doctors working in underserved areas (created by the sickness fund organization) 2005: beginning of the raise of the numerus clausus for medical students 2009: Hospital, Patient, Health and Territory Act (HPST) creating the regional health agencies (ARS) and allowing the creation of multi-professional primary care practices (*maisons de santé pluri-professionelles)*. The constraining measures concerning physician's settlement were withdrawn in 2011 without being implemented. 2011: national agreement between the sickness funds and ambulatory doctor's associations including financial incentives to settle down in underserved areas 2012: Health territory pact (ministerial decree) 2016: Health modernization law and national agreement between the sickness funds and ambulatory doctor's associations changing the financial incentives to settle down in underserved areas and creating territorial health professional communities; creation of the "clinical nurse" (infirmier en pratique avancé, IPA) as new type of health professional, entitled to partly substitute the physician's intervention in strictly defined cases 2017: Reinforcement of territorial access to healthcare pact (ministerial decree)	2007: First legal measures to overcome regional shortages: As a consequence of the Act to Change the Law of Panel Doctors, physicians in underserved areas do no longer have to return their admission as a panel doctor when having reached the age limit of 68 years 2011: the Health Supply Structuring Act (GKV-VStG) aiming at securing the supply of medical care at the regional level and to strengthen the quality and efficiency of medical supply by strengthening competition introduces a number of new financial incentives to doctors practicing in underserved areas as well as changes in the modalities to be admitted to the status of 'panel doctor' 2015: the Health Supply Strengthening Act (GVK-VSG) introduces structural measures like e.g. a structural fund to be administered by the association of panel doctors in order to create financial incentives for their members to settle in underserved areas or the legal right of municipalities to open up multidisciplinary medical treatment centers (*Medizinische Versorgungszentren*, MVZ)

Source: Hassenteufel et al. 2019.

The described developments point to stasis (of the dominant problem frame) and routine (in terms of instrument selection) in the case of Germany whereas a change of the dominating problem frame and the mix of policy instruments is characteristic of the case of France as well as to developing differences in. How can we explain this diverging development in terms of the selection of policy instruments to tackle the recurrent problem of the welfare state (Moran 2000) to guarantee adequate access to outpatient medical care? Starting from the conceptual considerations formulated above, we discuss this question in the following section.

4. Securing access to outpatient medical care in Germany and France: What explains diverging instrument-selection?

In Section 2, following on from the punctuated-equilibrium theory, which has been supplemented with considerations on the instrumentation of public policies, we have formulated three prerequisites for the selection of policy instruments or a more fundamental change in the selection in fields with recurring regulatory tasks: shared concerns about the *effectiveness* of instruments within the policy subsystem and at macroeconomic level; a shared perception of instrument *alternatives* at both levels; and doubts shared at both levels about the *compatibility* of given instruments with widely acknowledged social *norms*. At the same time, we pointed out the importance of institutional embedding of the policy process.

Applying these considerations to the two cases of Germany and France, the following picture emerges as to the question of what explains the different development in instrument selection in terms of the recurrent problem of the welfare state to guarantee adequate access to outpatient medical care.

Effectiveness of given instruments

Both in Germany and in France new information about the basic problem of medical care of the population in the regions emerged already at the beginning of the 2000s (SVR 2001; Klose and Rehbein 2016; Lucas 2001). In both countries, this would cast doubt on the effectiveness of the existing regulatory instruments – like e.g. the regulation of requirements planning; sanctions and incentives for physicians in connection with the establishment and operation of a practice; regulation of medical studies.

In the German case, the new information on the basic problem in supply policy was first discussed at the policy level of the policy-subsystem. Here, in turn, the actors did not address the question of the effectiveness of the given instruments of supply policy, in particular the regulatory instrument of requirements planning. In this context, the influence of organized groups of physicians, above all the National Association of Statutory Health Insurance Physicians (KBV) as the central representation of the German panel doctors and central actor of health self-governance with the legal

mandate to ensure the outpatient medical care (§ 75 SGB V), was particularly important. The medical profession advocated a political solution to the (pending) problem of supply shortages, which aimed at making the establishment of physicians in underserved areas more attractive (BÄK 2004, 2005; Kopetsch 2010, 144; Klose and Rehbein 2016). Specific branch-targeted incentive tools, such as those originally created by the Supply Structure Act 2011, e.g. the establishment of a structural fund managed by the KBV and intended to invest in projects to solve the supply problem, for this reason were welcomed by the German doctors' (Marburger Bund 2014). In particular, the family doctors demanded more political and inner-professional attention and criticized the KBV for an unbalanced consideration of the different groups of physicians, especially family doctors, in the distribution of additional financial resources (Deutsches Hausärzteverband 2014).

In the 2000s, German doctors' organizations succeeded in transporting their central concern for improving the working conditions of physicians via different channels into the health-political decision-making system. Thus, from the beginning of the 2000s onward, they pointed to various reports that presented the problem of (imminent) undersupply of outpatient care (Klose and Rehbein 2011: 17) in specialist discourses, but also towards the broader public. At the same time, the KV's as regional branches of the KBV successfully used the institutional conditions of a federalist decision-making system and of health corporatism to push their "pet" (Kingdon 1995) problem frame and their favored solutions onto the political agenda. In this context, the doctors' associations found powerful allies the German federal states (notably in those most affected by undersupply, i.e. four of five East German countries in particular, WiDo 2016). They, for the first time in 2010, pushed forward the problem via the Federal Council (upper house of the German parliament and chamber of the federal states) and the states' Health Ministers' Conference (GMK 2011). Moreover, the KBV successfully managed to be recognized by the German Ministry of Health and to push the topic on the ministry's agenda (KBV 2007; Interview G-3 BMG 2016). Against this bundle of activities a discussion on the effectiveness of given policy instruments in the supply policy did not emerge. Within the policy sub-system, doctors' organizations already occupied the topic of appropriate instruments at a very early stage, and in the public and at the macro-political level, where the topic of "medical shortages" was increasingly discussed from the end of the 2000s, this framing also had a significant impact. What is more, from 2009 on, the medical interest strategy was favoured by a change in the national government from a grand coalition (conservatives and social democrats) to a conservative-liberal coalition. The liberal Minister of Health, known for his proximity to the medical profession, launched the Supply Structure Act of 2011 during this period, which has shaped the consecutive path of the instrument selection (Interview G-3 BMG 2016).

In France, the topic of (pending) undersupply with services of outpatient medical care and of regional supply differences – like in Germany – was already discussed at the beginning of the 2000s; yet, right from the start it was raised not only in professional

circles and amongst policy experts, but it also became a subject of a broader public discourse. Such a broader perception was already favoured by the fact that the supply issues' return to the health policy agenda was based on the publishing two parliamentary reports in 2002. The question of the effectiveness of existing regulatory instruments was initially not discussed – as in Germany. Thus, the health reforms adopted under President Jacques Chirac and Prime Minister Jean-Pierre Raffarin, e.g. the out-of-hours reform of 2003, with their instruments in the field of care supply policy still largely reflect the dominant idea of the physician's primacy in matters of healthcare and primary care. However, since the election of Nicolas Sarkozy as President of the French Republic in 2007 at the latest, politics on the marco-level has been ready to question given instruments in the field of supply policy, such as additional gratuities for doctors, and to adopt decisions challenging against the will of the organized medical profession (Prieur 2009). The early discourse on the effectiveness of instruments of supply policy in France also relates to the development of a disagreement within the medical profession. The French medical profession, like the German one, is a key factor influencing national health policymaking. Especially new GP organizations as well as young doctors' organizations already in the 2000s started to use the issue of regional shortages strategically to promote new primary care organization models (especially multi-professional primary care practices) (Vézinat 2017). In this context, financial incentives and other given instruments were presented as partly not matching the actual expectations of the medical profession which now tend to be more oriented towards the goal organizing working conditions and care services differently (Hassenteufel et al., 2019).

Instrument-alternatives

The policy problem of regional imbalances in the supply of haelthcare notably primary care has been discussed by health policy experts on the international level since the 1990s. The World Health Organization (WHO), the OECD and also European organizations such as The European Patient's Forum (EPF) published health care surveys comparing various countries around the world, which included in particular a discussion on policy solutions as well as proposals for policy instruments to address health supply imbalances (Simoens and Hurst 2006; Dolea et al 2010; Ono, Schoenstein and Buchan 2014; EPF 2016). In addition, from the late 2000s onwards, the policy problem of outpatient medical care also became the subject of an international scientific debate, which, as well, included the question of policy instruments (Sundmacher and Busse 2014; Corallo et al. 2014). Thus, an international instrument constituency developed, which in particular used well-known instruments from countries with a national health system to further develop the mix of policy-instruments of supply policy apt to deal with the problem of supply shortages (e.g. changes in the organization of the provision of outpatient medical services, revaluation of non-medical professions and better integration of medical care and non-medical social activity; Dolea et al. 2010).

In Germany, this international discourse was almost never received at the level of the health policy sub-system (Interview G-3, BMG 2016; Interview G-2, KBV 2016). Here, a tight-knit community of officials from the Federal Ministry of Health and of actors of health self-governance (the KBV and the Central Association of the Statutory Health Insurance), not only monopolized the interpretation and framing of the basic problem of supply policy-making at the sub-system level, but it also dominated the pre-selection of policy instruments. Given the high stability of this pre-decision-making community, even approaches by actors who were directly affected by the problem of regional shortages of the supply of outpatient medical care initially did not manage to be heard with of their own policy suggestions (Interview G-3 BMG 2016; Interview G-5 DStLT 2017). For example, the municipalities, bringing forward through their umbrella organizations ideas on the instrumentation of health supply policy such as the strengthening and expansion of tasks of the municipal public health service remained widely unheard at first (cf. Deutscher Landkreistag 2012, 3). This "routinized" selection of policy instruments, which can be identified in particular regarding the Health Supply Structure Act of 2011, still was backed up at regional and local levels generating their own policy instruments. For example, some of the particularly affected federal states in the East of Germany are trying to lure medical offspring by facilitating the access to medical studies for students who come from the respective federal state (dpa/aerzteblatt 2016); or municipalities provide practice rooms to make the office attractive (Schnack 2014).

In France, on the other hand, following an initial routine response at the policy sub-system levels, notably within the French Ministry of Health, in the early 2000s, the international discourse on healthcare and healthcare supply policy soon became part of the formulation of solutions and instrument proposals at this level. The French Ministry of Health, for example, actively tied up to proposals from the international instrument debate by the end of the 2000s (Hassenteufel et al., 2019). This can be related to a distinct openness of the health bureaucratic elites as regards scientifically supported policy proposals (Genieys and Hassenteufel 2015). The commitment to internationally discussed instruments, which was reflected in the territorial health pact of 2012, for example, was reinforced from three sides. First, the goal of an adequate supply of the French population with outpatient medical care did not lack in any of the national presidential election campaigns since 2007 (Hassenteufel et al. 2019); the political pressure to solve the problem and to search for effective instruments thus was high. Second, part of the medical profession itself actively advocated a reorganization of care. And third, there was also pressure from below, from the municipalities bringing forward via their umbrella organizations numerous legislative proposals through the Senate (as the upper chamber of the French parliament and the subnational territories' chamber) and obtained numerous reports on the topic of supply shortages (ibidem.).

Compatibility with basic norms

Both in Germany and in France, regional differences in outpatient medical care have been perceived as a normative problem by politicians at the macro-level of the policymaking system since the beginning of the 2010s at the latest.

In Germany, the constitutional conditions of policymaking, notably the specific form of federalism, prompting the norm of an "equivalence of living conditions" everywhere in the country as provided by the German constitution (Art. 72 German Basic Law, GG) stood out as an important factor benefitting the public politicisation of the problem frame of 'physician shortages'. This norm contrasts with economic and social differences as well as variability related to the citizens' sense of well-being that has been prevalent between the German federal states (*Bundesländer*) in the Western and the Eastern parts of Germany since reunification in 1990 (BMVBS 2009). However, the discourse was not linked to doubts about the instruments of healthcare supply policy. On the contrary, it is precisely the federal states that are most affected or threatened by health care problems that essentially shared the problem assessment disseminated by the medical professional organizations. Based on this perception, the states, amongst others, advocated then idea of improving access to medical studies (e.g. by creating special incentives for students) and suggested to establish research funds in the field of health services research (GMK 2011).

In France, since the late 2000s by the latest, all political parties took up the issue of regional differences in outpatient medical care as a policy problem directly relating to the Republican quest for equality of rights for all citizens as enshrined in the French Constitution. Against this background, the issue of "medical deserts" not only has become one of the main topics of the health policy programs since 2007 (Hassenteufel et al., 2019). What is more, it was also linked to the questioning of the given instruments of healthcare supply policies in France (Véran 2013). Local politicians (especially the mayors of municipalities directly concerned by a lack of physicians) since then have denounced the increase of "medical deserts". Their claims have been supported by the influential national associations of the subnational territories (especially the French Mayor Association, AMF), and the Senate, the upper chamber of the French parliament and high-level parliamentary representation of local authorities, which published several parliamentary reports and made law proposals (Hassenteufel et al., 2019). All in all, the perception of a breach of the constitutional norm of equality on the macro-level of health policymaking raised doubts about the legitimacy of policies simply drawing on traditional instruments to guarantee citizens' access to medical. Against this background, political pressure to clearly change the pre-selection of policy instruments at the level of the health policy sub-system increased.

5. Conclusion

The adequate provision of outpatient medical services is a central task of the modern welfare state. Based on this core function as well as phenomena of medical over- and

undersupply, a veritable supply policy has developed in various countries in the 20th century as an integral part of national health policy. More recently, since the beginning of the 2000s, this policy has faced the recurring problem of regional shortages in different countries. The article takes as its starting point this empirical observation and raises the question of the reasons for selecting policy instruments and changing the instrumentation of policies in fields with recurring regulatory needs.

To get closer to the problem, we use the punctuated equilibrium theory and propose supplementing the theory with theoretical considerations on the instrumentation of public policies. We identify three actor-related factors that could help break the "routinized" selection of policy instruments particularly characteristic of fields with recurring regulatory needs, and which – according to PET – has its origin in the propensity of the actors of the respective policy subsystem to respond to new policy challenges with proven solutions ("what works"-strategy). The three factors are: shared *concerns about the effectiveness* of instruments within the policy subsystem and at macro-level of the policymaking system; a perception of *instrument-alternatives* notably at the subsystem-level; and doubts about the compatibility of given instruments with widely acknowledged social norms especially at the macro-level of policymaking. In order to understand the impact of these factors on the selection of policy instruments as an integral part of the policy process, the institutional embedding of this process and the dynamics of interaction between the levels of the policy sub-system, where decisions are normally being prepared, and the macro-level of policy decision-making must be taken into account.

In our article, we analyze the explanatory power of the three factors using the example of the selection of policy instruments in the field of healthcare supply policy in Germany and France. Both countries are suitable as comparative cases because of their specific similarities and differences with regard to the structural conditions, the constellations of actors and the institutional embedding of the policy process in the field of health policy.

We argue that change in the selection of policy instruments is "fundamental" if it implies a shift in the weighting of the basic types of instruments that may shape a policy. Furthermore, relating to PET (just like other theorie of the policy process), we argue that a change of basic policy ideas ("images") or problem frames ("frames") is a prerequisite for fundamental change in the policy- and instrument mix.

The juxtaposition of the two cases of comparison has first shown that in France, since the beginning of the 2000s, such a change in the framing of the basic problem of healthcare supply policy has come both at the level of the policy sub-system and at the macro-political level. The traditional idea of the centrality of the physician for the proper functioning of outpatient care was supplemented by the idea that to ensure care it is not only necessary, to take into account the conditions of the medical practice, but also the organization of the provision services and the division of labor between doctors and other medical professionals. In the case of Germany, in contrast, the conventional physician-centeredness of healthcare supply policy has survived.

In France, the fundamental change in the instrumentation of supply policy in the sense of a now stronger focus on procedural instruments, can be explained mainly by two factors: First, the existence of instrumental alternatives stemming from an international instrument constituency was important to the gradual opening up the actors of the policy sub-system for new instruments. Pressure from above, from the macro-political level, also played an important role in accelerating change. Early on, French politicians from all political camps in particular expressed doubts about the compatibility of the traditional instruments with the basic norm of equality; the given instruments alone were no longer considered an effective response to the questions of healthcare supply policy. In the case of Germany, the actors of the policy sub-system have adhered to traditional instruments of healthcare supply policy. In recent years, they have even expanded the corresponding mix of instruments under the influence of the medical interest organizations in particular. Here, the supply issue was perceived comparatively later than in France by the wider public and at the macro level of political decision-making, with doubts about the effectiveness and legitimacy of the traditional instrument mix not yet associated with this perception. The necessary political pressure to change the instrument therefore did not materialize.

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