Panel T17P09 - Public Policy and Payment for Performance Programs (P4P/PBF) in Health: in High-, Middle- and Low-Income Countries

Pay-for-performance in French and German health reforms: similar instruments, distinct trajectories

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Introduction

Not only since the latest financial crisis, health systems worldwide are facing increasing health expenditures and a parallel increase in public debt, with policy makers framing problems and answers centred on more effective and efficient care. Henri Bergeron and Patrick Castel (2015) have conceptualised these developments and contend that the growing role of market and competition logic between individual and collective actors is marked by four broad policy directions, including more patient choice in National Health Services; increasing competition for coverage; competition between providers; the growing evaluation of 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. First, in terms of governance, measures redistribute responsibilities and reorganise relations between actors in charge of care, support, financing and patients. Second, most health systems have adopted measures to control their budgets. Ceilings were introduced, and payments designed to be "prospective" instead of "passive" reimbursements. Third, measures for quality control and improvement are structured around the dimensions of patient safety; comparisons of performance including potential incentives; and standards for clinical practice (Bergeron and Castel, 2015).

In this context, as an almost prototypical "solution", pay-for-performance (P4P) has been proposed as an 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 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 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 base on P4P suggests overall limited quality gains (Scott et al., 2011).

While P4P is now in place in many countries, (with clear inspiration drawn from the experiences in the US and the UK[1]), the models in place and their uptake vary significantly, contrasting with the idea of supposed convergence of welfare state policies and objectives (Caminada et al., 2010; Clavier, 2013). This article is structured around the initially intriguing observation that in the two largest EU health systems (France and Germany), while sharing a common Bismarckian history, the role and nature of P4P varies substantially: in France, P4P is widely disseminated via a national top-down program in

[1] For a discussion of the role of transfer and translation in this process, see (Brunn, 2017).

ambulatory care, while in Germany it is still largely under discussion. Paradoxically, French GPs, generally opposed to payment reform, have rapidly signed direct P4P contracts with statutory health insurance (SHI). Conversely, German doctors, already equipped with IT and accounting systems that would largely facilitate an add-on P4P component, were reluctant to do so.

The existing comparative literature on the introduction of health policy instruments is limited and includes 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). Yet, we currently lack analyses that demonstrate in detail how the introduction of such instruments relates to the power structure within the system and its actors, in particular in countries of corporatist tradition where the interaction between the state and professions seems to be a key issue. Therefore, in a first section, this paper sets out its theoretical angle, which is to consider P4P as a policy instrument in the hands of programmatic actors. In a second section, we will outline the main features of the French and German health systems, so as to have a basis for comparison. The third section will then present and discuss the empirical data.

I. Public policy instruments and programmatic actors

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 Christopher Hood, who takes an explicit perspective in looking at government activities as the application of a set of tools or instruments (Hood, 1983). Pierre Lascoumes and Patrick Le Galès have proposed the following definitions: *"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."* (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 a large body of literature exploring numerous variables to explain instrument choice and their mode of application. These approaches, in the 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). In fact, the instrument becomes a dependent variable, and 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 turns 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"[2]. It is centred upon the dynamics of permanent construction and appropriation by actors in less formal, symbolic, and cognitive dimensions. In this body of literature, three dimensions seem of particular importance. 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[3] and others, instruments are closely related to the imposition of power. Second, the authors 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. 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, characterised by technical and at the same time emotionally loaded issues. Third, 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 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).

To address the question of actors more specifically, we further resort to the programmatic action framework (PAF), based on the observation that, in France and Germany, increasing similarities on the institutional meso-level of SHI regulation seems 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. The PAF also emphasizes that these actors appear as 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; Hornung and Bandelow, 2018). In France, these programmatic actors are mostly constituted by an elite of senior civil servants

[2] 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.

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

in within key bodies of the health system: the Ministry of Health (MoH), the Inspector of Health and Social Affairs (IGAS), and SHI. They share a common mindset and similar training in the central administration and use budget constraints as a resource to increase power (Genieys and Smyrl, 2008). In Germany, three types of actors comprising an SHI expert group have been described, the first being political, the second senior civil servants, and third members of parliament. Overall, in both countries these programmatic actors are specialised and politicised, and complemented by other decision makers and operational implementers. The effectiveness of these arrangements for the implementation of 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).

II. France and Germany: commonalities and differences

The comparison of France and Germany, close to a *most similar systems design* (Anckar, 2008; Bandelow and Hassenteufel, 2006) is characterized by major commonalities due to common Bismarckian origins as well as some distinct differences. The commonalities include the financing of health risk via social contributions, 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. Germany's differences when compared to France include greater diversity and decentralisation of sickness funds with higher autonomy, an income threshold above which SHI contribution is voluntary, the greater role of collective negotiation between sickness funds and doctors and hospitals as well as a federal system with delegation of competences to *Länder*[4].

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. In terms of the role of the medical profession, the main differences lie within its collective organisation. In France, the dominant conception is that of the self-employed, independent physician ("liberal medicine", 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 with professional societies and associations (*ordres*) having relatively little power, in Germany chambers (*Kammern;* with 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

[4] Germany is a federal republic consisting of sixteen federal states, the *Länder* (singular: *Land*)

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. In contrast, Germany's representation of doctors is institutionally and legally integrated in the welfare state (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. Overall, 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). In analysing the relation between the state and SHI systems in France and Germany, *de facto* state-related institutions are gaining power in both countries. Indeed, there is a strong implication of the state in sickness funds in France, with SHI contribution rates fixed by MoH, the director of SHI nominated by the government, the budget controlled by ministries and collective conventions being approved by MoH. 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. State control in France 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). In Germany, the stronger role of state has become apparent in particular through the unique health fund introduced in 2009 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). In France, the "Alert Committee" was created in 2004, 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 (DSS) under the joint auspices of MoH and the Ministry of Finance is then required to take measures to reduce expenditure. Further, agencies were created, notably the National Authority for Health (HAS) in 2004, similar to the Institute for Quality and Efficiency in Health Care (IQWIG) in Germany. Overall, there was an increase of measures such as audit and benchmarking. Harnessing of

the interaction of non-state actors by the state became a *leitmotif* of public health policy in both countries.

Hence, 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 instruments such as 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. To address this, we have conducted a comparative case study of the introduction of P4P in France and in Germany, in the ambulatory sector for the period from 2007 until 2017. It is based on a literature review and semi-structured interviews of 23 actors between August 2013 and July 2015. Groups of actors are heuristically termed "coalitions" in the sense of Lascoumes and Le Galès[5], structured around a first group of actors in favour of the introduction of P4P, termed the reform coalition. A second group of actors is termed the professional coalition and includes mostly health professionals.

III. P4P in France and Germany: similar, but different

Reform coalitions

Two main arguments structure this section. First, development of P4P in both countries is intrinsically linked to the preceding 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, there is the growing role of competition and agencies. Second, 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. Arguments of de-professionalization 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 physician representatives of in a move to regain regulatory edge. Yet, it was rejected by its base over concerns about de-professionalization and the allocation of funds.

[5] In this definition, heterogeneous actors are grouped around certain questions (Lascoumes and Le Galès, 2005). 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).

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, and thus in September 2007 the proposal for individual P4P contracts figured in the MoH draft for the 2008 Social Security Financing Act. In parallel, in June 2008, IGAS published a report on the use of P4P in the UK and US, 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. 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 (Brunn, 2017).

"The time was right"

There were three main institutions that developed what was later termed CAPI: SHI, DSS and IGAS. 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 position, he was head of cabinet of MoH and became a leading figure in the negotiations of the 2004 SHI reform (Hassenteufel, 2009). As part of other key transformations, 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*". 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 as the major source of inspiration, despite a clear choice to implement it differently. 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. This had last been done in 2009, but there was already the perceived need to find new remuneration modes after implementing the ALD scheme in 2004 (exempting those with long-term conditions from co-payments).

Overall, 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."*

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). Her interview highlights 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. 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.

At IGAS, the initiative for the P4P report in 2008 came from the two authors themselves. The two have authored several IGAS publications together, among them a 2006 report on foreign experiences with disease management. 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[6] (Bras and Duhamel, 2008).

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*".

Germany: heterogeneous landscape

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 entered the political agenda. In terms of the quality of ambulatory care, structural requirements are part of the Federal Framework Contract (*Bundesmantelvertrag*)[7]; if there are structural shortcomings, the KV can refuse the right to bill for certain services. Further, disease management programs add to the remuneration mix, since adhering physicians are paid a fee per enrolee and per documentation unit.

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.

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*

[6] 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 (Chaix-Couturier et al., 2000).
[7] Concluded directly between KBV and GKV-SV, meaning there is no state involvement.

health care". 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*", 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. With respect to the *status quo* of P4P in Germany, the report found that overall there were few initiatives in place, mostly based on SC. It recommends 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*". 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."*

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).

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.

KBV

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. 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). 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 the following main section. 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.

SHI: a proactive competitor

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, 2014). 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. SHI positioned itself by managing the quality indicator database QUINTH, a thesaurus that collects and assesses available indicators for use in different sectors[8]. 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. 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".*[9]

MoH: wait and see

As discussed above, 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

[8] https://quinth.gkv-spitzenverband.de/content/index.php
[9] http://www.aok-gesundheitspartner.de/bund/qisa/ueber_qisa/index.html

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. 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, 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*". 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.

Academia: the background actors

Although not statutory actors, the role of researchers appears to be relevant in the discussions surrounding P4P. Senior professors of medicine, health sciences and health economics are the constituting members of SVR (see above). Its reports are based on consensus-seeking with a large array of stakeholders, and its propositions have regularly become legislation. Further, the statutory institutes relevant to quality and efficiency have directors with strong research backgrounds, including IQWIG[10], the Centre for Quality in Medicine (ÄZQ)[11] and the Institute for Applied Quality Improvement and Research in Health Care (AQUA)[12], suggesting a role 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 abroad. One argued that researchers were rather open-minded concerning P4P but overemphasised problems of risk adjustment, creating a perception of coalition between them and DKG[13] against P4P. The second researcher did not favour nationwide introduction of P4P at the GP level, preferring that it be applied to specific situations. She added that the background for P4P was an effort to impose greater rationalisation through increased competition, with the idea that P4P could rectify quality losses.

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

These elements suggest that no clear thread of action or coalition guiding the discussion 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.

Overall, in comparing the P4P proponents in France and Germany, one initially sees little in common. 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 also appear to be similarities. 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 abroad. The next section will explore how other actors positioned themselves with respect to the reform stream.

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 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.

France: anticipating the opposition

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.

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[14] 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. 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. 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, 2011). The emblematic former CSMF leader Michel Chassang 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. Yet, a former DSS actor suggested that the SHI director negotiated directly with Chassang, although without a formal role.

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 CNOM had reservations because

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

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, contrary to a 2009 CSMF leaflet that evoked a conflict of interest in the doctor-patient relationship. 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. Hence, 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*".

An interesting facet of the opposition to CAPI involved workers' unions. According to a senior SHI member, 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*". 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. Thus, SHI was well aware that external motivation could have a negative effect on intrinsic motivation. 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*". 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 in a sample of 14 GPs who had (group 1) or not (group 2) signed CAPIs. The study 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. The authors also note 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 CAPI may indeed have been perceived as a necessary innovation in payment mode, which 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).

A solitary strategy by SHI

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. In addition, SHI was aware of opposition by doctors' unions to the top-down approach to data collection, 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 doctors. 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, 2011). As one SHI actor stated, the isolated development was a source of resistance but allowed it to be quite prepared from the start. He maintained that if it had been done in a cooperative manner, ROSP would not exist today.

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. This approach was reportedly backed by DSS and ensured that union leaders would later support ROSP. 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*". These accounts are nuanced by interviewees who explained that there was a certain friction between SHI and MoH. Bertillot, in his study 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).

In this context, and in its interaction with the medical corps, SHI was able to rely on its considerable workforce including medical representatives who perform individual visits to physician practices. A former SHI actor stated that they were actually inspired by pharmaceutical representatives but what they were marketing was SHI risk management. At the time of the introduction of CAPI, these representatives with a workforce of around 1000 were also backed by SHI-employed physicians, with

a workforce of about 2000. The high impact of this targeted approach is illustrated by the fact that, in 2009, 89% of GPs subscribing to CAPI stated that their signature followed a visit by a SHI representative (Bras, 2011). An SHI 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.

Finally, 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; prevention and clinical care indicators were developed by the SHI medical department. Another 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*". The initial plans included an indicator section on 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.

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 and following a fruitful collaboration on a diabetes disease management program. In his view, 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.

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. 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.

Overall, the public debates suggest that there was a conjunction of the government initiative and a tendency in the left-wing party PS against the fee-for-service scheme. 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.

In this picture, 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", balancing stakeholders' interests and containing basic features that future innovations must embrace (Kimberly et al., 2008), reinforced by general media coverage describing P4P as a "*cultural revolution*" (Le Monde.fr, 2015).

Conflicting actors in Germany

Since P4P as a national program is currently not 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*".

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 (US/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. Finally, 48 indicators were operationalised and tested for practical feasibility. 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. While this may indeed have reinforced the directors' ambitions, the constituting members of KBV (KVs) 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*".

> *"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."*

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. In fact, P4P would actually entail a re-distribution of funds, which was of concern to those well-off in the current system. According to the former KBV head, there was no political support either. On the contrary, they anticipated resistance at the federal and geographical levels because allocations per insured vary depending on the *Land*, and this would have implications for a uniform P4P scheme, resulting in opposition by currently well-off *Länder* such as conservative Bavaria. Finally, the KBV actor claimed that no other actors were truly opposed to P4P and that partisan policy did not play a role. 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.

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. It ultimately was rejected in the face of vivid criticisms concerning professionalism and the technical aspects of allocation of funds. In this respect, P4P as policy instrument restructuring social configurations did not have its place and time in the complexly balanced German health system.

Quality assurance across sectors: high technical complexity

Another example of the challenges surrounding indicators and a proxy-debate for P4P 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. The AQUA Institute was commissioned in 2009. The work process proved to be very slow, and physician organisations entitled to provide input regularly criticised the methods proposed by AQUA via public statements[15]. AQUA was not familiar with quality assurance measures across sectors, which is why many methodological issues had to be clarified. According 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, so that "*one occupies himself with expertise, methods …*". A senior researcher explained: *"If each indicator has to be reliable and valid and manipulation-proof […], then they can never advance […]; of course not only AQUA is to blame but also the commissioners."*

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. He expanded on his position by adding that KBV wanted to keep their activities outside of GBA's control, to the point that KBV had "*tried everything*" to block quality assurance measures across sectors by blurring the discussion over indicator development, so that "*not a single procedure currently exists*", although he conceded that there was minor progress. Under his explanatory model, physicians dislike P4P because it represents an external assessment, concluding that for SQG, the "*monopoly of KBV needs to be broken*", which would be an unpopular measure under an FDP-government[16], 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. A similar point was defended by IQTIG's director[17]: *"With the steering instruments P4P and indicators relevant to planning, it will be a sovereign [hoheitlich] affair that you cannot delegate to someone."*

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 suggested that it is an irreconcilable conflict, in which control of data has strong implications that lead to immediate sanctions by other parties. This is illustrated by the case of the sickness fund AOK, sued

[15] See http://www.kbv.de/html/themen_2854.php

[16] 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.

[17] Christof Veit, physician by training, formerly head of BQS and lead author of its 2012 P4P report.

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 issue is: "W*ho holds the data, holds the power* […] *everything failed because of this question.*" Indeed, the generation of data within the self-regulating bodies would shift the power distribution among SHI, doctors and hospitals. This would explain the move by GBA and the government to task a new institute with the delicate issue of SQG. As for the overall debate over P4P, consistently, a researcher asserted the reasons for the slow discussion thus far was that neither KBV nor SHI would endorse or even push it. Indeed, it would appear logical that the KBV directors would now align with the reservations that their members had expressed about P4P, and some actors certainly have lost courage after the initial efforts, as prompted by headlines of the lead medical magazine *Deutsches Ärzteblatt*, ranging from "*implementation still far away*"[18] to "*P4P – yesterday's discussion*"[19].

Conclusions

The present analysis has attempted to demonstrate how the introduction of a supposedly clear-cut policy instrument with similar models – P4P in health care – is distinctly shaped by the intertwined configuration of institutional architecture and the policy program of key system actors. Such "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) is part of a long-term process of SHI regulation in France and Germany. Important aspects of convergence (shared focus on expenditure control, implementation of other instruments such as HTA agencies, role of programmatic actors linked to the state) are constrained by limits of convergence, including the nature of programmatic actors (senior civil servants in France; links to SHI and KBV 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).

Yet, these supposedly independent variables – institutional architecture and key actors, and in particular the interface state-physicians – are subject to dynamic change in both countries. Again, this change can be understood as a continuation of long-term transformations, most importantly the increasingly direct influence of the state and a weakening of the representation of the medical profession, as well as an internal fragmentation of the latter. This trend is qualified for instance by the emergence of "medical entrepreneurs": individual actors from the medical profession promoting innovations in the primary care system and being able to find administrative and political allies to

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

support some of their ideas (Gerlinger et al., 2017). In this cycle of change, the highly technical policy instrument P4P, which we have introduced as a depend variable, now has its own place and will, in turn, influence and interact with existing institutions and actors. Evoking path dependence, technical instruments are also more likely to be conceived by institutions that have the necessary resources to do so, and experience will increase the likelihood that similar instruments follow. Such is the case in France with the incorporation of CAPI into the collective agreements and the extension to other physician groups. Similar extensions may also occur in Germany under the newly founded agency IQTIG. It remains to the be elucidated whether these conclusions can be transferred to other policy domains, countries or instruments.

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