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T01P03 Public Policies Beyond Borders: International Cooperation, Transfers and Translations

Is Daniel Carpenter right (again)? Why policy transfer in health is different from other domains

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Introduction

Health issues can stir political systems to an extent which seems comparable only to large scale military conflicts, entailing the shutdown of entire sectorial of economic life and severe restrictions of individual liberties – this is what the current Covid-19 pandemic has just suggested in an implacable manner. Yet, academic health policy and politics research is a relatively new field, and the conceptual foundations of a distinctive role of health as a policy domain are far from widely established. The most prominent work in this regard has been undertaken by Daniel Carpenter who has conceptionalised why health politics is different from other domains, highlighting the notion of a right to equality in health care access, the importance of health in identity, and the key role of technology and expertise (Carpenter, 2012).

Without doubt, all of these notions intuitively appeal to observers of the current pandemic and health issues in general. However, they seem to miss at least one point that not only characterizes this latest pandemic but also earlier health policy issues: the global "travel" of ideas, tools and discourses and many other elements that structure health policy making. Indeed, parallel to the virus' planetary spread, recent policy debates in many countries have seen vivid and often erratic comparisons with other health policies and systems. Likewise, yet more hidden from public observation, many major health reforms in the past decades are, often to significant extent, the result of transfer of diffusion processes. Examples include the introduction of market elements in health systems (Freeman, 1999) or the global spread of diagnosis-related groups (DRGs) as a dominant hospital payment method (Kimberly et al., 2008).

To these policy examples, we may add structural factors to explain transfer phenomena, such as the increasing scale of global funding streams. The global volume of developmental aid for health, for example, has risen from $7.8 billion in 1990 to $41 billion in 2019, representing more than a five-fold increase.[2] These international developments are fueled by the emergence of notions such as Global Health and One Health, and are characterized by a shift of influence in favor of globally acting private

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[2] http://www.healthdata.org/data-visualization/financing-global-health

organizations such as the Gates Foundation, with less weight for traditional actors such as WHO. Hence, the stakes for the health sector are increasing. This generates economic and social momentum which, coupled to the institutional specifics as we will attempt to show, has a direct impact on policy transfer activities.[3]

This analytical essay sets out to assess and potentially complement the validity of Carpenter's notions in the context of health policy transfer processes between 2010 and 2020. Our aim is hence twofold. First, we strive to update the work of Carpenter in a rapidly changing policy domain and lay out why health policy and politics is distinct from other policy domains. Second, our analysis is meant to test the applicability of his work in a newly emerging academic field: the specific role of transfer, translation and diffusion phenomena in the policy process. In other words: before establishing what is specific about health policy transfer, we will point out and update the specifics of health policy and politics in general. To this end, the following section will re-visit and re-contextualize Carpenter's legacy in the light of health policy transfer phenomena. We will then illustrate our conceptual points with empirical examples from France, Germany and England, based on interview and literature data.

A) Carpenter's key notions, seen today with a policy transfer lens

The following section provides a brief discussion of Carpenter's three main distinctive notions, because they still provide fundamental insight as of today.

1) The notion of a right to equality in health care access

Carpenter's first point relates to the fact that nations generally tend to grant access to health services and to aim for equality of access even where other inequalities (for example access to loans or capital) are tolerated. Thus, health is being treated differently from other areas of social policy, and, according to Carpenter, this is "*in part due to health's status as a constitutive expression and measure of well-being*" (Carpenter, 2012). This unique status has important implications for public policy, including the provision of health insurance, the funding of global health initiatives and the different forms of safety and quality regulation. Carpenter argues that these shared values (more equal access to health services) are, contrary to other domains, reflected by a global convergence of several structural factors. These include the reduction of out-of-pocket payments; the reduction of the variation of government spending on health; and the increase of public spending for health overall (Carpenter, 2012; Dewan & Ettlinger, 2009).

We can complement this stance, from today's perspective, by confirming the continued rise in health spending: between 2000 and 2018, health spending as a share of GDP has continued to increase in most countries, averaging about 1% worldwide (WHO, 2020); for example, health spending as a share of GDP currently amounts to 11% in France and 17% in the USA (OECD, 2020). Even during the period of reinforced fiscal pressure after the 2008 financial crisis, health expenditure was "protected"[4] in most countries worldwide (WHO, 2020), meaning that other sectors suffered from higher financing cuts. The status of the health sector in political systems thus keeps on changing. This change, preceding and now paralleling the Covid-19 pandemic, implies a growing attention and importance for health issues in most countries.

[3] Note in this context for example the emergence of health policy elite in France, who have increasingly gained authority in particular for health insurance policies vis-à-vis the Ministry of Finance (Genieys & Hassenteufel, 2015).

[4] A term coined particularly in reference to the British National Health Service (The King's Fund, 2009)

2) The importance of health in identity

For Carpenter, the identities generated by issues of health and illness do not match the frequently observed divides in politics – along the lines of wealth and poverty, or capital and labor, for example. According to him, "*there is no clear line between those who are more healthy and less, nor between those who provide health services and those who employ them*" (Carpenter, 2012). We add that national borders are yet another divide which is transcended by health-related identities. This is, once again, clearly illustrated by the Covid-19 pandemic which globally creates the group identities of those who are, for example, vaccinated or not. Besides other pandemics in human history (H5N1, Spanish flu, etc.), this phenomenon also extends to non-infection related topics. One example are rare diseases, which are increasingly generating strong transnational ties between patients, carers and providers in order to facilitate (by increasing scale via transnational registries or centers of expertise) the diagnosis and treatment of these conditions.[5]

Rare diseases are hence one the many examples of how "*illness creates identities and political organizations (latent and explicit) that would not otherwise arrange themselves along the same lines of cleavage*" (Carpenter, 2012). These identities and the related politics shape scientific concepts and methods – in order to develop this argument, Carpenter uses the example of the global AIDS crisis (Lieberman, 2009) which, again, highlights the international and transnational dimension of health issues and, concomitantly, their receptiveness to transfer phenomena. Indeed, strikingly, AIDS is precisely the domain where there has been the highest growth in the international flow of developmental aid for health in the past two decades – from $380 million in 1990 to $9.5 billion in 2019, representing more than a twenty-fold increase.[6]

This is relevant for our context because such aid often comes with specific ideas (on the donor side) and, thus, the potential transfer of health care programs.[7] One example for a specific program that has been increasingly diffused via these channels is pay-for-performance (P4P), a payment method that most often rewards providers for attaining certain objectives. Despite mixed scientific evidence on its effects, several international organizations (multilateral and bilateral donors, and NGOs) have significantly invested in P4P such as the World Bank and USAID. Experimenting with P4P in Sub-Saharan Africa, for example, has involved a lot of technical assistance, P4P training across countries, and learning lessons from other P4P pilot schemes. These financial, technical, and social investments have led to wide implementation. While in 2006, there were only four out of 46 countries in Sub-Saharan Africa that piloted P4P (8.7%), in 2017 this figure had jumped to 32 countries (71.7%). Therefore, in less than ten years, P4P spread across more than two thirds of the region, whether as pilot program or nation-wide policy (Brunn, 2021; Gautier et al., 2018).[8]

3) The prominent role of technology and expertise in health care

Carpenter's third point creates a particularly strong link to transfer phenomena and the related (emerging) literature. Chiefly, Carpenter insists on the observation that health care is generally not only delivered but also often regulated by experts belonging to the health professions, in co-

[5] https://ec.europa.eu/info/research-and-innovation/research-area/health-research-and-innovation/rare-diseases_en

[6] http://www.healthdata.org/data-visualization/financing-global-health

[7] On the notion of coercion in this context, see for example (Brunn, 2021) or (Dodd et al., 2009)

[8] On a cognitive level, these instruments are rooted in a growing role of economic reasoning in health reform. This was and is facilitated by the institutional context of international organisations and via "cognitive technologies" (standards, recommendations, classifications, indicators, etc.) that they elaborate and which influence the way problems and solutions are conceptualized (Bergeron & Castel, 2015). This provides the frame for an epistemic community with shared reform ideas and leverage for diffusion (Serre & Pierru, 2001).

organization with state power. Further, according to Carpenter, technology has a special place in this arrangement since it creates new fields of expertise which, in a circular process, generate new forms of technology. This process then, in addition to experts and state actors, creates the highly regulated industry characteristic of the health sector (Carpenter, 2012): Carpenter mentions the pharma biotechnical and medical device research enterprises, and we will add the new technologies further below. For Carpenter, the "*discretionary administrative gatekeepers*" (in other words, regulatory agencies) that separate the consumer from the product are highly distinctive and far less present in other sectors, for example financial products.

Carpenter has based these arguments in part on his own work in the sector of drug regulation (Carpenter, 2014). The importance of these institutions for the phenomena of transfer and diffusion becomes obvious when Carpenter holds that "*drugs and other medical products pass through, and are governed by, a set of institutions and procedures that display remarkable similarity worldwide*". He further argues that this standardization reflects "*the reputational force and the various regulatory powers of the American FDA* [Food and Drug Administration]*, whose rules, concepts, and practices have been copied — sometimes in faith, sometimes ceremonially, and often with partial or full resistance — the world over*" (Carpenter, 2012).

These statements call for several comments. First, the "reputational force" of the American regulatory agency calls to mind other examples of the – increasingly disputed – cognitive hegemony of the USA, linked to the wider Anglo-Saxon sphere, in the health sector. One example is the abovementioned and globally diffused P4P, rooted in experiences in the USA and subsequently in the United Kingdom (Brunn, 2020). Another example are disease management programs, equally developed in the USA, which aim at providing structured care for chronic conditions such as diabetes. Their recent introduction in Germany and France is an illustration of how reputational forces can take quite distinct shapes, which we will present in detail in our empirical section. Second, it is important to note that the political and academic focus of drug regulation has increasing shifted from the question of access and safety (dealt with by the FDA) to issues of pricing and evaluation (Benoît, 2016). We will illustrate this shift and the equally – if not increasing – importance of transfer phenomena in this field in our empirical section on evidence-based health agencies in Europe. Further, we should add to the abovementioned industry sectors (pharma, biotechnology) the burgeoning field of new health technologies, including e-health, mobile devices, big data and artificial intelligence. Indeed, many of these innovations, for example in the field of artificial intelligence, are developed and marketed by major global firms (notably, the so-called GAFA), in collaboration with internationally acting scientific experts at the nexus of software engineering and health (Brunn et al., 2020). Alike the "tradition" sectors yet with probably distinct mechanisms, we can expect this process to entail a significant degree of transfer and diffusion phenomena.

Finally, it is necessary to return to the initial point of this sub-section about expertise and health professions in order to introduce the concept of evidence based medicine (EBM). EBM is a prime illustration of the types of knowledge and actors that are mobilized in the nexus of professions and the state and, beyond that, the global diffusion processes at play. Indeed, EBM has led to a wide and enduring transformation of the health system landscape and led to the development of clinical guidelines (Weisz et al., 2007) and health technology assessment (HTA). The movement of EBM started among North American academics (physicians, epidemiologists, statisticians) in the 1970s, who aimed to use the best available scientific data to inform clinical decision making. Based on statistical methods, they promoted controlled clinical trials and the critical appraisal of scientific evidence (Sackett et al., 1996). While the origins of the movement can be traced back easily, it is however important to note that often EBM has been introduced in a context where it matched existing patterns in the recipient

country. This is illustrated in France by Christine Rolland and François Sicot in a critical analysis of the history of EBM and clinical guidelines as their operational form (Rolland & Sicot, 2012). According to Rolland and Sicot, the diffusion of EBM coincided with growing concerns by French state and statutory health insurance who were increasingly regarding health expenditure and how medical practice could be regulated. By including physicians in these efforts, the Agency for the development of medical evaluation (ANDEM) was founded in 1989 as a first "*institutionalisation of EBM in France*", tasked with the diffusion of guidelines of learned societies. The latter viewed guidelines also as a mean to legitimise certain practices that were not in line with the regulator's goal of budget control. Over time, state control over health expenditure tightened, and the Agency (renamed ANAES after gaining competencies for accreditation) fell under more direct ministerial control. Concomitantly, mandatory clinical guidelines were issued, making it possible to sanction physicians if scientific criteria are not respected. After strong resistance by the profession and a decision by the Council of state, these were abolished in 1999. A new and less ministry-controlled agency, HAS, was founded in 2004 with a mission that extended to economic evaluation, thereby adding the issue of efficiency to that of effectiveness (Brunn, 2021; Rolland & Sicot, 2012).

The connection of Carpenter's work with the policy transfer concept

We have seen in the previous sections that Carpenter's arguments are up to date. In addition, they inherently address key issues related to the global dimension of health policies and politics. These connective points can be summarized and addressed as follows.

First, health policy and politics is increasingly characterized by intertwined and overlapping networks of expertise and norms (for example, WHO and OECD), regulation (international networks and regulatory initiatives at the supranational level, for example in the case of health technology assessment in the EU[9]) and commercial activity of health innovation, by an increasingly globalized (pharma and digital) industry: "*much more than other global players (WHO, for instance) global health companies bring serious capital and resources to the table*" (Carpenter, 2012), as indicated by the unprecedented increase in scale of global funding outlined above.[10]

Second, in parallel, there is a *specific* and diverse set of multiple actors that identify, process and spread what is deemed current "best practice". An illustration is the literature on "best clinical practice and evidence based policies" and the concept of knowledge translation, promoted amongst others by the Canadian Institutes of Health Research[11] to address the gap between research knowledge and its application in clinical practice (Khoddam et al., 2014). Targeting the daily work and education of practitioners, Ian Graham and colleagues have conceptualized knowledge transfer and the "Knowledge-to-Action Cycle" as a means to encompass the processes of both knowledge creation and knowledge application (Graham et al., 2006).

Beyond these 'first order' actors who lay the foundations and fill the virtual bookshelf of policy options from which other actors of the network will serve themselves, there are several 'second order' actors in the health sectors whose aim and core activity is to carry out policy transfer in a proactive manner. Examples include, in the public and academic sector, the European Observatory on Health Systems and Policies which is hosted by the WHO Regional Office for Europe. The Observatory "*generates and shares the evidence in print, in 'person' and on-line – acting as a knowledge broker and bridging the*

[9] https://www.consilium.europa.eu/en/policies/health-technology-assessment-post-2020/

[10] The globalization process of the pharma industry is paralleled and illustrated by its concentration process: over the last three decades, 110 companies have consolidated to about 30; see https://www.pharmasalmanac.com/articles/ma-fundamental-to-pharma-industry-growth

[11] http://www.cihr-irsc.gc.ca/e/40618.html

gap between academia and practice" [12]. It has lately been one leader of the European Union funded research project TO-REACH (Transfer of Organizational innovations for Resilient, Effective, equitable, Accessible, sustainable and Comprehensive Health services and systems) which identified 1) key topics for learning across systems and 2) ways for better transferring service and policy innovation (Nolte & Groenewegen, 2021). In the private sector, besides the well-known generalist and global consultancy firms with a health branch amongst others (Stone et al., 2021), there are now specialized health policy transfer operators. One example is Health Dialog which provides (sells) population management tools (like phone coaching for patients with diabetes) to insurers or larger care providers[13]. Other companies such as Dialog Health work on the demand side and propose commercial study trips to healthcare executives on the search for inspiration from abroad[14] (Brunn, 2021).

The following paragraphs will argue why it is worthwhile to connect these key notions to the emerging field of policy transfer and translation research. Why is it a necessary field of work, and which tendencies warrant its development?

In brief, one rationale for the need to look at health transfer phenomena with a social sciences or public policy perspective is the normative dominance in the currently available studies, which are – besides the communication venues around actors such as WHO and OECD, and commercial activities – often published in the health services, management and systems research community. As alluded above, such analyses looking at health reforms with a certain degree of inspiration from elsewhere often make the assumption – implicit or explicit – that such transfer is desirable (Enthoven, 1985; Lauterbach & Stock, 2001; Pérez-Ferrer et al., 2010). This perspective may however lead to a neglect of, amongst others, the political dimensions at play and thereby provide an only partial picture. Further, from a policy evaluation perspective, the "capture" of transfer phenomena by the health services, management and systems literature can lead to a misrepresentation of outcomes. Indeed, if mostly "positive" examples or elements of health policy learning are reported, this may induce biased expectations by practitioners and policy makers. The authors of this literature are not seldom health professionals, who are themselves part of transfer networks.[15]

In addition, fittingly, it is known that policy makers, usually operating under time pressure, tend to look for overseas evidence that supports rather than challenges the decisions on the table (Ettelt et al., 2012). This constellation of supply and demand for evidence on (potential) transfer objects highlights that expertise is "socially embedded" in authority relations, which warrants dedicated consideration for the complex nature of the science-policy nexus at play (Strassheim & Kettunen, 2014). The particularity of health policy transfer phenomena, in this nexus, is thus to draw concomitantly on three potential sources of legitimacy: science, in its larger epistemic sense; medicine, in its professional (and mostly social) sense; and international reference, in its reputational sense (Brunn, forthcoming).[16]

[12] https://eurohealthobservatory.who.int/about-us/overview

[13] www.healthdialog.com

[14] www.dialog-health.com

[15] See for example (Brunn, forthcoming).

[16] The normative dominance in the currently available studies is also mirrored by the significant underrepresentation of health topics in public policy and political science until recently. As an illustration, one may note that, to date, there is no working group on health policy in the French Political Science Association (https://www.afsp.info/activites/groupes-de-projet/). The American Political Science Association, by contrast, does have a Health Politics and Policy section since 2008 (https://www.apsanet.org/section39). Yet, the importance of the section seems to be reflected by its rank in the section numbers, ordered chronologically (by foundation year) from 1 to 52. Health has the section number 39, which ranks after Politics, Literature, and Film (section 30), for example. There is thus a historical lack of consolidated approaches to address the phenomena

In sum, there seem be two antagonistic dimensions that explain well the distinctiveness of policy transfer in health. One is the assumption, widely made, that certain programs, techniques and other innovations in health must be universal – after all, one shall think, physiological and other basic health related principles including those of care delivery should apply virtually anywhere around the globe. The antagonistic dimension is the subjectivity of health and the very distinct arrangements surrounding it, including the organization of expertise, health professions and the political system, which turn health policy transfer into a particularly complex and challenging undertaking.

Policy transfer as an emerging field

Within public policy research, itself at an intersection of political science, sociology and economics, the literature on policy transfer, diffusion and translation is emerging (for an overview, see (Porto de Oliveira, 2021)). In a nutshell, policy transfers have occurred throughout political history. However, it was only more recently with the development of disciplines such as political science, public policy analysis, and international relations that this phenomenon gained attention and started to be studied more meticulously. In public policy analysis, the roots of policy diffusion analysis in contemporary political science can be found in pioneering investigations such as Jack Walker's study of the adoption of innovations in the context of the United States intra-federalism (Walker, 1969), as well as Everett Rogers' seminal work on the diffusion of innovations (Rogers, 2003).

In political science, policy transfer processes generally refer to the travel of policy ideas, models and institutions across different political levels, political systems and policy fields. One of the most quoted definitions of policy transfer is by Dolowitz and Marsh (Dolowitz & Marsh, 2000) who understand it a process by which "*knowledge about policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in development of policies, administrative arrangements, institutions and ideas in another political setting*". Globalization has accelerated these processes. Recent scholarship in the field has proposed the notion of translation, first used in human sciences, as a complementary relational and constructivist approach to the understanding of policy transfer processes (Hassenteufel & Zeigermann, 2021).

The strength of applying the inclusive policy transfer approach to the health sector lies with its inherent ability to 1) deconstruct the abovementioned normative aspects at play; and 2) put the analytical focus on the agency within health policy transfer (Hassenteufel & Zeigermann, 2021). As Carpenter has argued for the health sector at large, and as we have argued respectively with our policy transfer lens: the changes we observe appear to be the result of mostly endogenous processes, often driven by health sector actors using their specific knowledge. The following main section will illustrate these arguments.

B) The case of policy transfer: empirical comparative findings from Europe

The previous sections have established that health remains a policy domain that is distinct from others and, consequently, deserves "models and understandings" (Carpenter, 2012) that account for its particularities. The remainder of this article attempts a first step towards this goal. We will use examples from three European countries in order to examine why policy transfer is distinct in the health domain, in light of the elements discussed above. In other words, we will empirically study the

discussed so far. We should however add that more recent organizations such as IPPA regularly propose health policy venues, and that the Covid-19 pandemic has obviously increased public and scientific interest in health policy and politics.

implications of health's distinctiveness in the emerging field of policy transfer, translation and diffusion. Particular attention will be paid to the notions of context; timing (the sequence of transfer steps, including elements of both "soft" and "hard" transfer (Stone, 2004)), instruments (in our examples, the transferred programs); agents; and scale.

1) Expertise generation, statism and corporatism: the case of disease management programs in Germany and France

This case study analyses the introduction of disease management programs (DMPs) in Germany and France to deliver more structured care for patients with diabetes, set within a wider transformation of the health insurance landscape (Brunn, forthcoming). This was in part facilitated by support from international organizations or firms, and study trips or other forms of exchange with Anglo-Saxon countries. In the case of France, the DMP was modelled on a pre-existing program in the USA, developed and operated by a commercial provider. Its introduction represents both the copy of an existing program, conserving virtually all elements of the original, and a blend with certain existing health system components such as some contact with general practitioners (GPs). This program, called Sophia, continued to be supported in France by its original provider and the transfer also included human and physical assets, such as senior managers moving from the USA to France, technology and the training of the French staff (Bupa World, 2010).

One salient issue in this transfer process is the distinct ways by which references to foreign DMPs were used. In Germany, references to the USA where used as a strong source of legitimacy which is illustrated by the choice to keep the English term *disease management*. In France, in contrast, there has been a much higher ambivalence towards the originator country of the DMP. This went hand in hand with a branding strategy in Germany (high display of foreign influence) and the inverse picture in France (high degree of actual inspiration). Such distinct "routines of inspiration" have to be understood in the context of a (now) globalized arena for DMPs and many other policy problems and solutions (Brunn, 2021; Stone, 2004). This case study thus examines how the distinct use of inspiration is embedded in the wider policy making process and the systems' respective institutional architecture.

The policy context: disease management and globalized health reform in the 2000s

Disease management first emerged as a concept in the USA in the 1980s and was initially used mainly by pharmaceutical firms offering educational programs to promote medication adherence and behavior change among patients with chronic conditions (Bodenheimer, 1999; Nolte & McKee, 2008). In 2005, two-thirds of employers with 200 or more employees offered DMPs through their health insurance plans (Geyman, 2007). Further, the US federal government and individual states have developed and implemented DMPs. Payers have thus widely embraced DMPs in the USA and, later, in many other regions including Europe (Brunn, forthcoming). In parallel to programs such as DMPs, broader frameworks developed that have sought to guide the delivery of effective healthcare to people with chronic conditions. One influential framework has been the Chronic Care Model developed by Edward Wagner and colleagues in the USA, drawing on a synthesis of the evidence of effectiveness of various disease management interventions (Wagner, 1998). Beyond the USA, the model has been influential in informing chronic care policies in countries including Australia, Canada and England (Nolte & McKee, 2008). Both DMPs and frameworks such as the Chronic Care Model are, then, set in a wider array of problem definitions and proposed solutions which have been widely diffused in Western democracies in the 2000s, catalyzed and normalized by organizations such as the OECD (Brunn, 2021; Stone, 2004). Core themes within this diffusion process include governance, control of health expenditure, and quality control and improvement (Bergeron & Castel, 2015).

DMPs and the transformation of health insurance

In Germany, the first DMPs for diabetes enrolled patients in 2003. They are funded and operated by individual sickness funds that in turn contract with regular healthcare providers. All DMPs comply with a regulatory and financial framework set out for diabetic patients in 2002, based on a program structure proposed by a technical committee to the Ministry of Health (MoH). Sickness funds receive a financial incentive to enroll patients in their DMPs via a risk compensation scheme between funds (Busse, 2004). Further, while DMP ownership in the USA is generally commercial, Germany opted for a regulatory framework to stimulate the broad introduction of national, "public" DMPs. Participation in a DMP is voluntary for both patients and providers. It is centered on the GP who coordinates care according to guidelines provided by sickness funds. Patient eligibility and enrolment are determined by the physician. Patients then typically receive regular follow-up visits and benefit from educational workshops held by the physician or more likely a practice nurse auxiliary. By signing up for a DMP, physicians commit to transmitting patient follow-up data to sickness funds in exchange for practice feedback and a financial incentive.

In France, the DMP Sophia for diabetic patients was introduced in 2008, following the recommendation in an Inspector of Health and Social Affairs report (Bras et al., 2006) and implementation by statutory health insurance (SHI). It is financed and operated as a single national program by SHI, which has contracted with a private provider for support services. The main intervention is carried out by health coaches (trained nurses) who counsel patients via a call-center. The frequency and content of the calls are based on a software algorithm. They include nutritional information, advice on self-management, reminders and linkage with healthcare providers. The main adaptation of the original DMP concerned the involvement of GPs, who were not an integral part of the original program and whose involvement has remained limited (Jourdain-Menninger et al., 2012). The main initiative and control lie, largely, with SHI. Patient participation is voluntary after reception of an enrolment dossier directly from SHI that the patient must return (opt-in).

In sum, the DMPs in both countries differ greatly on two key points. First, in terms of service delivery, the German DMPs are integrated into the usual care structure (via the GP and practice staff), whereas the French DMP adds a new feature to the healthcare system by setting up a call-center with dedicated professionals. Second, in terms of clinical information and decision support, German DMPs rely on guidelines developed by self-governing bodies, while French Sophia guides health coaches by stratifying patient profiles within SHI's exhaustive claims database. These differences reflect the fundamental transformation of the role and configuration of SHI in both countries. Because SHI in both nations relies heavily on wage-based contributions, increasing contributions to cover rising costs represents a threat to national economic competitiveness. As a result, budget control has become a paramount concern, leading to a stronger role of the state. Yet, this quest for fiscal discipline translated into distinct patterns in Germany and France, owing to different configurations in SHI setup.

In Germany, SHI has traditionally been constituted by hundreds of different sickness funds, historically linked to certain professional groups. Following measures to facilitate competition between them, these funds have undergone a strong concentration process. Thus, the German system was more fertile ground than the French for the introduction of market elements. This idea of competition structures actors and processes, and DMPs were seen as a nuanced tool within the highly complex landscape of funds, self-governing bodies, federal and regional power levels. DMPs facilitated competition between funds, mostly because the latter received a dedicated allocation for DMP patients which helped balancing the uneven distribution of morbidity (and thus, cost). At the same time, DMPs introduced clinical guidelines into daily practice while otherwise maintaining the prerogatives of the medical profession in care delivery. In France, there is no competition between

funds. Rather, there is a single SHI scheme per employment category (for example, salaried workers) and a national federation which represents SHI in negotiations with providers. There also is a strong implication of the state, with SHI contribution rates fixed by MoH, the director of SHI nominated by the government, the budget controlled by ministries and negotiations with providers being approved by MoH. Hence, in the absence of competition elements as seen in the German system, efforts by the French state to contain expenditure focus on budget control and measures within the care delivery system. SHI's emblematic shift "from payer to player" is set within this logic, emphasizing the notion of risk management, of which the DMP Sophia is a practical application. The process was facilitated by the unique power position of SHI and closely linked to the persona of its 2004-2014 director. Further, Sophia is shaped by a large in-house database, salaried nurses, and an external contractor to train them.

Interplay with international inputs

Germany: high use of national experience, high display of foreign influence

While institutions and individuals in both countries perceived DMPs within a spectrum that can be heuristically defined by the extremes of "national" and "foreign", over time, there was a shift in the actors' minds along that spectrum: a change in meaning that qualifies as translation. In Germany, most features of the final DMPs were based on previous national and regional experience. In a "branding" process, these features were however reframed (and thus translated) in the context of international experience, as a source of legitimacy at higher levels. In this process, expert groups had a particular role in building consensus and legitimacy for action.

Overall, reflections on foreign experience had an impact on the design of the German DMPs in at least two ways. First, in what could be termed "linear inspiration", senior MoH staff "*looked over the Atlantic*" and monitored the US system, where DMPs had been developed [interview]. Second, it seems that the German contrast with certain characteristics of the US system reinforced in some cases a deliberate choice *not* to resort to a US model, in the sense of "inverse inspiration". For example, a fundamental difference with the USA was that American DMPs were operated by third-party vendors who collected data directly from patients without access to physician data. Such direct data collection would have been difficult in Germany, which is why the joint data collection of physician organizations and SHI was established (Brunn, forthcoming).

Besides these direct ways of dealing with international stimulus, there were also slower and more nuanced processes, which highlights the role of temporalities. A particular mediating role in structuring ideas was played by the influential Advisory Council for the Assessment of Developments in the Healthcare System (SVR), which acts as a "cognitive blender" in the German system. A main reason for the introduction of DMPs was the variance in the treatment of major chronic diseases, which could not be entirely explained by medical and epidemiological factors. The ensuing controversial discussions about guidelines prompted the idea that SVR should survey the positions of all system actors, resulting in a very detailed document reflecting the range of opinions about various issues including quality deficits, poor coordination and poor respect of guidelines. This 2001 SVR report was an important reform trigger that mentioned DMPs as one possibility for addressing these issues. It is important to note also the US Institute of Medicine report, issued around the same time and extensively referenced in the SVR report. The former set out performance expectations for the health system and identified current practices impeding quality care (Institute of Medicine, 2001). Several main ideas are shared in both reports and include the move from acute towards continuous care, the role of evidence, the coordination of care and the "activation" of the patient, all of which concern DPMs (SVR, 2001). The SVR report with its consensus-building methodology, as well as the concomitant Institute of Medicine

report, may have contributed to fostering shared cognitive patterns among different actors, and most certainly represented a solid building block for achieving the reform.

Besides the SVR report, the SVR member Karl Lauterbach, physician, professor and politician with personal ties to the health minister,[17] had drafted a white paper on DMPs on behalf of sickness fund federations (Lauterbach, 2001). This expertise played only a limited role for the actual design of DMPs within the self-governing bodies. Its "*continuous and lengthy reference to the USA*" were however considered important for the political decision and to convince MoH and parliament. Most literature cited originated in the USA and German experiences were not included because evaluations on regional experience were published only later. Indeed, there were regional precursors to national DMPs, including projects at the regional sickness fund AOK Saxony-Anhalt, as well as experiences with structured diabetes care in Saxony. Yet, for many, it was Lauterbach "*who brought these international things to Germany*", which were then modified in the debate for use in Germany [interview]. This account suggests a legitimating role of US references in the German political sphere, which has also been analyzed in a book entitled "Myth USA" (Becker, 2006). For the authors, this dates back to the period of significant German emigration in the 19th century, built upon perceptions of economic promise as well as religious and political freedom in the USA. The utilization of US experience as a vector to negotiate domestic issues is thus part of a pragmatic cultural routine, and coincided with the presence of a prominent "spokesman" (Lauterbach) in the case of DMPs.

France: high use of foreign influence, limited translation

While the previous section has illustrated the multi-layered and multi-directional process in Germany, conversely, in France, DMP-meanings were translated in a single direction – from "foreign" to "national". There has been a relatively high degree of conceptual and technical transfer, linked to the fact that the DMP was de facto purchased from abroad and that US staff were involved on the ground at many steps of the implementation process. Issues of negotiation mostly concerned differences in professional culture and training. Finally, the translation process was characterized by a fair degree of ambivalence towards the DMP model, interacting with ideas about its originator country.

The actual trigger for the program was "*some sort of international stimulus*" with two parts: a joint mission to three countries and a sustained collaboration with a sickness fund in Germany. First, in 2006, SHI joined a one-week mission to the USA, England and Germany. The team was composed of two statutory health insurance members along with three Inspector of Health and Social Affairs civil servants who organized and led the mission. One of the participants reported: "*We asked ourselves all the questions based on what we saw in the USA … all began with that one-week study trip*" [interview]. The notion of a collective cognitive process is substantiated by an actor who joined SHI in 2007 and described how the involved core actors worked on Sophia in a prolonged process of SHI's "*progressive transformation*" when they "*travelled and reflected together*" [interview].

The US experience and model, in turn, finally convinced the critical mass of French decision makers. The SHI director was looking for something with a "*good return on investment*" (in practice: a decrease of hospitalizations), and for diseases like diabetes they concluded that the evidence from US DMPs was sufficient [interview]. SHI's argumentation justifies Sophia based on its elements of foreign legitimacy and a "unique added value". Referencing the Chronic Care Model, Sophia was seen

[17] Physician by training, member of parliament since 2005, director of the institute of health economics at the University of Cologne and adjunct professor at the Harvard School of Public Health. He was health policy spokesman of the social democrats (SPD) from 2009-2013. From 2013-2019, he has held the position of vice chairman of the SPD parliamentary group. He is part of a programmatic elite that has been shaping health policy in Germany since the 1990s (Hornung & Bandelow, 2018).

essentially as the only formal initiative in France that fostered self-management support. The dialogue with patients via Sophia was conceptualized as distinct from the doctor-patient relationship: it was "coaching", and while doctors could do it, they were not trained to do so. Finally, Sophia was framed as serving the doctors and helping them through increased compliance and self-management. The idea that Sophia was a way "*not to put everything in the hands of doctors*" [interview] was endorsed by patient representatives: "*chronic care is too severe to be left to doctors*". For patients, it was central that Sophia be free, allowing one to enter and leave the program without consequences or charges. Concerning the term "coaching" (*accompagnement*), an article by SHI actors reported that a direct translation of *disease management* into French would have been "*opaque and little attractive*", which is why coaching was chosen, being closer to the "*basic concept*" (Lemaire & Lennep, 2009). It could be argued that the use of the word coaching served two purposes: first, to distinguish the program semantically from other existing areas of care; second, to avoid associations with the term *management*.[18]

In sum, this case appears to be a limpid illustration of the interplay between expertise (foreign and local), the state and corporatists structures (here: around the medical professions) in health policy transfer. It highlights, via the persona of Lauterbach, the unique role of reputation and expertise (medical, political, international) in the health sector and in the transfer process. At the same time, the case reveals a partial counter-point to Carpenter's argument of structural conversion. In contrast to converging levels of public spending and others he mentions, the institutional architecture of national health systems does not *per se* converge via transfer phenomena. The opposite seems to be shown in our case, because DMPs undergo significant changes when introduced in their respective national context.

2) Evidence based health agencies in England, France and Germany

In this case we study the transfer and translation of the model of the English National Institute for Clinical Excellence (NICE), created in 1999, to other European countries (Hassenteufel et al., 2017). It can be characterized as an "evidence based bureaucracy" in order to insist on two main analytical traits: (1) the use of evidence is highly structured by standards and protocols, which gives a bureaucratic flavor (Benamouzig & Besançon, 2005; Yesilkagit, 2004); (2) a high level of openness to non-state actors, like experts, citizens or interest groups, gives them meanwhile an inclusive and deliberative aspect (Moffitt, 2010). Therefore, it was a powerful source of inspiration for similar new institutions across Western Europe, not least because of the creation of "NICE international" in order to diffuse the methods and practices of the new agency. In France, the creation of the *Haute Autorité de Santé* in 2004 was certainly, even if not always explicitly, an attempt to mimic the way health technology assessment had been implemented in the United Kingdom (Robelet & Minonzio, 2015). In Germany, the creation of the IQWIG the same year (2004) refers more directly to the NICE and was build up as an attempt to develop the use of health technology assessment in Germany.

We will focus here on two aspects of the NICE that were diffused: its centralized institutional model and the systematic use of cost-benefit assessment based on Bayesian statistical methods (Benoît, 2016) so as the definition of cost-effectiveness ratio and thresholds. The use of the translation framework gives some evidence for the understanding of two apparent paradoxes: the reference to the NICE was more direct and explicit in Germany than in France, but the French HAS is more centralized and powerful than the German IQWIG; the use of cost-benefit assessment was defined as a new duty for the IQWIG in Germany, not for the HAS, but it is nowadays used in France, not in

[18] The direct translation of *management* into French would be *gestion*, a term which (far more than its American counterpart) relates to technical and impersonal aspects.

Germany. The translation process is analyzed in a long term period (from the 1990's to nowadays), showing its partial character in Germany (the agency is embedded in the existing institutional framework and cost-effective assessment tools still play a marginal role) and its incremental character in France (progressive shaping of a State narrow agency and increasing use of economic assessment).

Actor's oppositions to transfer and partial translation in Germany

The creation of the German Institute for Quality and Efficiency in Healthcare (IQWiG), institutionally corresponding to the agency model (a public institution based on expertise and with some degree of autonomy from the State), can be related to two main factors. The first one is the intertwined diffusion of Evidence Based Medicine (EBM) and Health Technology Assessment (HTA) in Germany (Perleth et al., 2009) corresponding to an international circulation process. It started at the end of the 1980's in the academic sphere and was in the mid-1990's sustained by the Health Ministry who financed a first feasibility study on the assessment of medical treatment and technologies (Bitzer et al., 1998). The second explanatory factor was the public debate on the efficiency of the German health care system after the publication of the WHO report in 2000 ranking different health systems. The relatively bad performance of Germany (ranked 25st for its global results) gave rise to a public debate and to an interest for the English system, especially the NICE which was praised by the WHO and the European Commission (Bußmann, 2012). The debate was also fostered by the 2001 report of the expert commission on health insisting on the quality and efficiency flaws of the German system. This helps to explain that in 2002 a report from the Frederich Ebert Stiftung, written by experts close to the SPD, proposed the creation of an institute based on the model of the NICE. This proposal was included in the SPD electoral manifesto for the 2002 elections (Weckert, 2014). Therefore, it was not a surprise to find the creation a new institute linked to the State, especially in charge of the assessment of pharmaceuticals, in the governmental law proposal formulated in June 2003. But, it was strongly opposed by Doctor's associations and the pharmaceutical industry, sustained by the Christian-Democratic party defending the "self-administration" of the health insurance system against the strengthening of the Health Ministry (Bußmann, 2012).

These oppositions explain that the IQWiG's was finally put under the supervision of the Federal Joint Committee which decides (so as the Federal Health Ministry) what diagnosis and treatment it is allowed to assess (Gerlinger & Schmucker, 2009). The new institute was thereby embedded in the institutional world of self-administration, more controlled by the Federal State. The other important point is that neither the possibility to realize cost-benefit assessment of pharmaceuticals, nor the role of crafting evidence-based guidelines aimed to guarantee quality, were given to the IQWIG, contrary to the initial plans of the policy reformers (among them professor Karl Lauterbach, close adviser of the Health Minister Ulla Schmidt and one of the main promoter of HTA in Germany) facing the opposition of doctor's an the pharmaceutical industry sustained by the right-wing opposition (which had the majority in the *Bundesrat*, the second Chamber, at that time).

The most important fact to stress is that the cost-benefit assessment of drugs and medical interventions which was discussed in 2003 and finally introduced in the 2007 law was not implemented because of strong oppositions and debates on the methods used. The Heath Economics Department of the IQWIG, which was created after the passing of the 2007 law, promoted the Efficiency Frontier method, refusing the British QUALY approach (for mainly ethical reasons). This reformulation of cost-effectiveness assessment in a "German way" was highly contested by academic health economics (Caro et al., 2010). The compulsory character of cost-benefit assessment was withdrawn in the 2010 law on the Reform of the Market for Medical Products (AMNOG) under a right-wing government (coalition between Christian-Democrats and Liberals). In Germany a less powerful evidence-based bureaucracy than its British counterpart (Chalkidou et al., 2009) was created without systematically

using economic knowledge, despite strong international references in the public and expert debates (Zentner & Busse, 2004). On the contrary, in France, where NICE was not directly mentioned as a model, a centralized evidence-based bureaucracy using the same cost-benefit assessment tools as the NICE (QUALYS) was incrementally institutionalized in the long term (from the 1990's up to today).

Transfer under the cover and incremental long-term translation in France

Indeed, the French "*Haute Autorité de Santé*" (HAS) was created in 2004 by the health insurance reform law (LAM) as an autonomous scientific body dedicated to the assessment of health products. But neither the Health ministry, the Social Security Direction nor the sickness funds succeeded in their attempt to introduce economic assessment in the new agency's tasks because of the opposition of physicians and of the CEPS directed by senior civil servants (Benoît, 2016).

The HAS is run by an executive body, "*le Collège*", a small body of eight persons which collegially managed this institution and jointly assumed the formulated recommendations. In 2006, a health economic academic, Lise Rochaix, was appointed as a HAS College member. She was the only woman and the only non-physician member of the *Collège,* most of them being professors of medicine. Just after her nomination she launched a working group called "Serc", for "*Service rendu à la collectivité*" ("Community helpfulness") that aimed at harmonising reflexions driven in the different HAS commissions in order to take into account collective and societal dimensions in the evaluation process. The working group also aims at enlarging "Public Health Interest" to take into account non-medical dimensions, as a part of a global Health technology assessment strategy (Robelet & Minonzio, 2015). Therefore, it played an important translator role with the reformulation of the introduction of non-medical dimensions in health technology assessment (especially pharmaceuticals), less focused on cost-benefit than in the UK and in Germany.

Whereas government expectations towards cost-benefit assessment became more pressing, this working group appeared as an inadequate institutional response. In order to strengthen the HAS function in "medico-economic" evaluation, the budgetary Law of Social Security for 2008 established a new commission inside HAS, the *Economic Evaluation and Health Policy Commission (CEESP)*, chaired by Lise Rochaix. The creation of this dedicated commission results from a joint lobbying action driven by economists and the Social Security Direction of the Health and Social Affairs Department who wanted to create a "French NICE" (Benoît, 2016).

Even if the economists seemed to have obtained "their" commission in 2008, they advanced under cover inside the HAS, anticipating the oppositions to the introduction of economic evaluation, coming particularly from physicians by the promotion of a "societal" dimension in health technology assessment. The hallmark of their action was to answer to the imperative of the evaluation of "collective outcomes" of healthcare (public health strategies as well as individual medical practices), which are not taken into account through the classical methods of medical evaluation. The members of the commission organized conferences and roundtables to raise awareness of actors inside and outside the HAS about what should be an extension of the missions of the HAS on economic assessment. The concept of "collective outcome" was vague enough to not frighten the clinicians but specific enough to justify the development of first a dedicated working group and further a dedicated department, specific methods and practices. By doing so, they progressively constructed a niche of expertise inside the HAS on the non-medical dimensions of the evaluation, including social, ethical and political dimensions. The definition of such a jurisdiction requires the expertise of other social sciences like sociology, philosophy, political science or geography, which were progressively introduced in the CEESP. They gained autonomy inside the HAS, especially from the other commissions (run by clinicians) and from the departments dealing with the production of medical guidelines. The CEESP also launched

a coalition with some members of the College (first of all with the President of the HAS), reassured that the economic evaluation will not lead to barriers in access to care. The college was very keen to preserve the reputation of the HAS to protect the population from bad medical practices or products and from health inequalities.

These experts build a discursive coalition with actors and institutions outside the agency (health economic academics, representatives of the ministry of Health and of the national health insurance organization), launching exchanges of resources with them. They gained their support by involving them in the debates on the definition of the content of non-medical dimensions of evaluation. This explains that two major French institutional bodies in charge of Health policy, the Accountability Court (Cour des Comptes) and the General Inspection of Social Affairs (Inspection générale des affaires sociales – Igas), claimed for a strengthening of economic evaluation in decision-making. They also claimed for the strengthening of the regulatory status of the CEESP, which was endorsed by the Social Security Law for 2012. The CEESP became a regulatory entity like the Transparency Commission. The recommendations of each of both commissions have now the same enforceable value. This law also introduced a systematic economic evaluation for new drugs that are registered for the first time on the Health Insurance reimbursement list.

This objective alliance helped to encode in the law the concepts and practices of economic evaluation defined by this group of entrepreneurial experts acting as translators, who was more successful than his German counterparts facing a stronger coalition of opponents at different levels: at the political level (opposition between political parties), at the policy level (opposition of the medical profession) and at the expertise level (opposition of academic health economists).

C) Conclusions

Just as health policy and politics is different from other domains, health policy transfer extends this distinctiveness into the emerging field of policy transfer, diffusion and translation analysis. Therefore, just as with health policies at large, specific methods are needed in order to sufficiently account for the distinctive traits we have discussed. Without being exhaustive, we suggest further research in this area explore the following conceptual avenues, which appear both suitable and complementary:

1) The role of "programmatic actors", a term that has been proposed and applied to the health sector in an analysis of the introduction of quasi-market mechanisms in France, Germany, the UK and Spain. The authors conclude that small, closely integrated groups of policy professionals, motivated by a desire to wield authority through the promotion of programmatic ideas, rather than by material or careerist interests, act both as importers and translators of ideas and as architects of policy (Hassenteufel et al., 2010).[19]

2) Similarly, as applied in our second case study, a recently emerging body of literature around the sociology of translation adds valuable perspective and can be linked to the role of actors (Hassenteufel & de Maillard, 2013; Hassenteufel & Zeigermann, 2021). The latter is a key feature of the sociological approaches to translation, mainly rooted in the sociology of sciences and prominently represented by actor-network theory. Its proponent Michel Callon analyzed the knowledge transfer from one scientific world to another and proposed an analytical translation framework, based on the distinction between and transition among four intertwined "moments": the reformulation of a problem; the negotiation

[19] This presumption of proactivity with respect to actors is distinct from, for example, policy entrepreneurs in the sense of Kingdon, seen as "*advocates who are willing to invest their resources - time, energy, reputation, money - to promote a position in return for anticipated future gain in the form of material, purposive or solidary benefits*" (Kingdon, 1984).

between the different actors; the assignment of different roles to these actors; and the mobilization of actors that allows the achievement of the action (Callon, 1984).

3) Finally, the notion of translation has a natural proximity to the literature on public policy instruments, defined as "*technical and social devices that organize specific social relationships between public power and its addressees depending on the representations and meanings they convey*" (Lascoumes & Le Galès, 2005). Among the various examples of transferred programs that we have mentioned (addressing AIDS, provider payment, chronic disease), both their technical and agency-related nature is obvious, which highlights the relevance of the instrument approach for further research in this area.

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