Renegotiating the role of the state in governing medical performance: non-linear change, institutions and the introduction of clinical guidelines in Germany

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draft, comments are welcome

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This paper is part of an international research project on ‘Governing Doctors: A Comparative Analysis of Pathways of Change’, funded by the Danish Social Science Research Council. The aim of the project is to identify and explain the country specific pathways of change in the governing of doctors in four countries: Denmark, Germany, Italy and the UK. For further information on the project see www.ps.au.dk/governing_doctors. I would like Mette Nørgaard Andersen (University of Aarhus) for research assistance with the literature search, Ellen Kuhlmann (University of Bremen) for invaluable help with identifying and approaching policy experts, and interview partners at federal and state levels for making time available to share their insights into health policy making in Germany. Laura Fenton (York University), Vincenzo Giorgino (University of Turin), Ellen Kuhlmann, Brian Salter (University of East Anglia), Willem Tousijn (University of Turin), Karsten Vrangbæk (University of Copenhagen) and Claus Wendt (University of Mannheim) also commented on earlier versions of this paper. I am grateful to the colleagues at my Department and especially Mette Kjær for commenting on the conceptual part of the paper.
In the literature the notion of governance is closely related to shifts in how governments seek to govern in functionally highly differentiated societies, which do not necessarily respond to formal, top-down steering (cf. Brevir and Rhodes, 2003; Kooiman, 2000). Governance highlights variety, in terms of the arenas and the relationships involved in governing and importantly also emphasises governing beyond the state (Pierre and Peters, 2000; Rhodes, 2000). More specifically, the literature points to the rise of networks as a third ‘logic of co-ordination’, which is distinct from both markets and hierarchies (cf. Kooiman 2003; Kickert 1993; Rhodes 1997; Mayntz 1993). In terms of the dynamics of change there is often an implicit assumption about a linear move away from hierarchy and towards other, network-based forms of governance.

As Newman (2001: 17) observes, this reflects the breadth of the notion of governance and more specifically an often over simplified view of both past and present/future governing arrangements. Instead, change tends to be incomplete and the relationship between old and new forms of governing remains ambivalent. Even Rhodes (1997) acknowledges this: while he characterises network-based governance as ‘governing without the state’, he admits that relations between government and networks are asymmetric. Recent empirical studies underline the non-linear nature of change and suggest that network-based governing is closely intertwined with vertical power relations and steering opportunities of the state. On the basis of their study of old age care policies in Sweden Johansson and Borrel (1998), for example, suggest that central government has a variety of control and steering mechanisms at its disposal. Government control has not disappeared but taken on different forms. Similarly, Bach’s (2000) study of urban generation in the UK highlights that government itself can be a pivotal actor in policy networks.
In response, recent contributions to the literature try to capture the non-linear nature of change by defining governance as the interplay between different forms of governing. For example, Newman (2001) and Jørgensen and Vrangbæk (2004) distinguish between four ideal typical associated forms of governance: hierarchy, the rational goal/market model, the open systems/network model, and the self-governance/clan model (based on professional self-regulation). Jørgensen and Vrangbæk (2004) define change as the changing nature both of individual forms of governance and of the relationships between different forms of governance. This builds on an understanding of individual forms of governance as dynamic and non-exclusive. More specifically, the authors look for: changes within individual forms of governance; the changing balance of power between different forms of governance; and the existence of hybrid forms of governance. In contrast, Newman treats individual forms of governance as static and exclusive. Individual forms of governance consist of a distinct set of definitions of problems and assumptions about the nature of change. When combined, as is typical of contemporary policies, this leads to tensions that cannot be resolved easily. Governance is thus characterised by multiple and conflicting forms of governance that pull into different directions. As such, Newman (2001) goes beyond the description of hybrids as more or less unproblematic combinations of different forms of governing and instead focuses on the interactions and especially tensions between different forms of governance. Change therefore emerges as a process concerned with balancing competing pressures and addressing a variety of dilemmas.

The focus on conflict resonates with Newman’s explicit concern with power relations within and underlying governing arrangements. This is an important contribution to a literature on governance as issues of power are often a blind spot in the literature that primarily focuses on change as a move towards self-steering networks (see for example Kjær 2004). Newman suggests analysing power
relations as part of a contingent relationship between organisations and their environments. Here, she adopts a neo-institutionalist approach and defines change as process of organisational isomorphism driven by a logic of appropriateness and embedded in discourses of change. This helps to account for the existence of non-linear dynamics of change in governance, but it is less clear how *specifically* such non-linear changes come to emerge and why non-linear change in governance takes the *specific* form it does.

The analysis presented in this paper therefore takes a step backward and looks at the processes of negotiating change in governance and how institutions shape this process. Institutions are an important reference point for understanding such processes of negotiation: institutions embody both past experiences with and past decisions about governance as well as associated power relations. Indeed institutions can be seen as the consolidation of bias. In terms of conceptualising the institutional contexts of such processes of negotiation Pierre and Peters (2005) for example suggest focusing on the adaptive capacity of political institutions. Adaptive capacity depends on two factors, the authority of the state and the capacity of the state to gather and process information. This echoes Weiss’ (1998) concept of transformative capacity. Importantly, she emphasises that the transformative capacity of the state is not a generic force, but varies among policy issues: ‘Speaking of state capacity in the abstract is of little use for understanding substantive issues. Whether or not state capacity exists in a given context can only be determined on the basis of specific issues that interest us’ (1998: 17). This is an important point considering the broad nature of both the notion of governance and associated claims about the dynamics of change discussed above.
The aim of the present analysis is two-fold: first to map out the emergence of non-linear change in governance and second to analyse how sector-specific institutions and underlying power relations shape the process of negotiating change in governance. The analysis uses changes in the governance of medical performance as a case study and more specifically focuses on the introduction of clinical guidelines in Germany. Governing doctors and their practice has traditionally been based on different forms of professional self-regulation, while recent years have seen the introduction of new forms of governing based on the logic of hierarchy (sometimes in conjunction with the market). Interestingly, old and new forms of governing often co-exist in the context of individual policies (cf. Allsop and Mulcahy 1996, Dent 2004, Gray and Harrison 2004). As such, the case of the governance of medical performance provides critical insights into the complexity and tensions typical of contemporary governance. This also applies to the institutional embeddedness of change in governance. The governance of medical performance is concerned with redistributive policies, which with their focus on distributional conflicts continue to be strongly shaped by institutionally created developmental pathways (Reich 2000).

The study

In terms of mapping out non-linear changes in the governance of medical performance the analysis uses hierarchy, market, network and (professional) self-regulation as four ideal typical forms of governance. Each form is characterised by a distinct logics in terms of defining the problems governance is supposed to address and in terms of defining the approaches to change. This makes for tensions and conflicts between different forms of governance, which in turn form the basis of change in governance. More specifically, Newman (2001) describes change in governance as a process of balancing competing pressures and addressing a range of dilemmas. Table 1 below
illustrates what the individual forms of governance mean in relation to the governance of medical performance and points to the tensions between them.

Table 1
Different forms of medical governance

<table>
<thead>
<tr>
<th>professional self-regulation</th>
<th>network</th>
</tr>
</thead>
<tbody>
<tr>
<td>based on expert authority</td>
<td>based on interdependent flows of power</td>
</tr>
<tr>
<td>for example, codes of practice and clinical guidelines set by professional bodies, monitoring through peer review</td>
<td>for example, negotiations among purchaser, provider and professional organisations of quality standards/monitoring</td>
</tr>
<tr>
<td><em>towards professional control over practice</em></td>
<td><em>towards adaptation and flexibility</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>hierarchy</th>
<th>market</th>
</tr>
</thead>
<tbody>
<tr>
<td>based on formal authority</td>
<td>based on managerial power</td>
</tr>
<tr>
<td>for example, centralised system of standard setting and auditing, earmarked funding, professional regulation as part of bureaucracy</td>
<td>for example, performance related payment, competition for contracts, public ranking based on benchmarking</td>
</tr>
<tr>
<td><em>towards control, standardisation and accountability</em></td>
<td><em>towards maximising cost efficiency and effectiveness</em></td>
</tr>
</tbody>
</table>

Newman (2001) suggests that tensions are particularly strong between the diagonally opposite forms of governance. Governance based professional self-regulation pulls into the direction of professional control over practice. Typical forms of governance are codes of practice and clinical standards set by professional bodies and monitoring through peer review. The authority of (medical) experts is the basis of power. This stands in stark contrast with market-based forms of medical governance, which rest on managerial power. Here, the focus of governance is on maximising cost efficiency and effectiveness. Examples of this type of governance include performance related payments of providers (such as Diagnosis Related Groups), competition for service contracts in
public quasi markets, and the public ranking of provider organisation based on benchmarking. As Newman (2001) suggests, in reality, market and hierarchy-based forms of governing are often closely connected. Examples of this form of governance include centralised system of standard setting and auditing, the use of earmarked funding and embedding professional regulation in the regular public administration of health care. This is markedly different in relation to network-based forms of governance, which are rooted in flows of power among interdependent actors. Examples include joint negotiations of quality standards and monitoring among purchaser, provider and professional organisations. This type of governance pulls into the direction of adaptation and flexibility, in the context of ongoing negotiations that include processes of feedback and learning.

In terms of the contexts that shape the negotiation of change in the governance of medical performance the analysis focuses on three sector-specific institutions. First, the analysis uses Moran’s (1999) concept of the health care, which captures a set of regulative institutions related to central areas of governing health care: consumption, provision and technology. The first two are particularly relevant in the context of analysing the governance of doctors. The institutions related to the consumption of health care are concerned with: the mechanisms to decide on the total volume of resources allocated to the financing of health care (such as governing through public management and setting regulatory frameworks); and with the mechanisms by which individual patients have access to services (such as social citizenship and earned insurance entitlements). In contrast, the institutions related to the provision of health care are related to: the mechanisms for governing hospital care (such as the style and amount of public regulation, and the mix of differently owned hospitals) and the governing of doctors (especially different forms of private interest government). This reflects the centrality of hospitals and doctors for the politics of health care provision.
Second, the analysis includes the relative decentralisation of governance in health care states as another regulative institution. The concept of the health care state stresses the embeddedness of the institutions of health care in the institutions of the state, but the state seems to emerge as a unitary organisational entity. This is problematic: reflecting the features of the broader polity states are embedded in or/and recent reforms that have decentralised different aspects of health governance the relative degree of (de)centralisation is an important characteristic of health care states. At the same time, the relative (de)centralisation of the state in relation to health care is an important factor constraining/facilitating change in governance.

Third, the analysis considers normative institutions related to perceptions of professional authority; formal education and professional networks help to define and sustain such norms and values. The concept of the health care state captures the regulative element of institutions and directs the attention to explicit regulative processes, rule setting and monitoring. In terms of the private interest government of doctors the focus is on the relationship with other institutions of health governance and the extent to which hierarchy-based forms of governing circumscribe private interest government. However, considering the many normative aspects associated with medical governance, the (normative aspects of) institutions of private interest government need to be further unpacked (more generally on this point see Burau 2005). The normative elements of institutions are about norms and values; that is conceptions about desirable goals and legitimate means to achieve these goals (March and Olsen 1989, Scott 2005).

The study of how sector-specific institutions shape the process of negotiating change in (and the substance of) the governance of medical performance is a study of path dependence and how institutions sustain and reproduce themselves and make for developmental paths. The literature on
historical institutionalism (for an overview see Mahoney 2000, Thelen 1999, Thelen and Steinmo 1992) identifies feedback mechanisms as central to understanding such processes and more specifically distinguishes between two types of feedback mechanisms: first, ‘co-ordination effects’, whereby actors adapt their strategies to existing institutions; second, ‘distributional effects’, whereby institutions distribute power among actors in a specific and often uneven way. In the literature, feedback mechanisms tend to be associated with the study of policy stability. However, as Thelen (1999) suggests, the study of change and stability are in effect closely intertwined: understanding political change is inseparable from (and even rests on) analysing the foundations of political stability; understanding the ideational and material foundations of institutions is a precondition for understanding how such institutions can become undone. This resonates the insights of the literature on governance as well as studies of medical reform, which, as discussed above, emphasise the non-linear nature of policy change and the co-existence of old and new forms of governing.

The following analysis focuses on Germany, where in addition to professional self-regulation, medical governance has traditionally involved doctors in hierarchical and network-based forms of governing. This reflects the key role of the joint self-administration of doctors and insurance funds, which is at the heart of a corporatist health care state. This potentially makes change difficult and as such Germany provides a good test case for assessing the interplay between old and new forms of governance and its institutionally embedded nature. More specifically, the case study analyses the introduction of clinical standards as part of Disease Management Programmes for chronic illnesses and how feedback mechanisms have shaped the process of negotiating the reform. The reform is interesting as it set out to address a range of policy pressures underpinning the governance of medical performance. These are generally concerned with issues around control, especially
strengthening public accountability. In the specific case of Germany, institutional tensions arise from the relative autonomy of statutory organisations and this frames public accountability as a question of controlling funding (and quality).

The institutional context of health care and pathways of governing medical performance

Germany can be characterised as a corporatist health care state. In many countries across Europe the state has a more or less highly influential role in the governance of the consumption and provision of health care. In contrast, the (federal) state in Germany only has a regulatory role and instead statutory organisations of insurance funds and doctors, and more specifically Associations of Insurance Fund Doctors (*Kassenärztliche Vereinigungen*), are dominant (for an overview see Busse and Riesberg 2004, Deppe 2000, Rosenbrock and Gerlinger 2004). Formal negotiations (at federal and state level) are a central feature of the health care state, but crucially these explicitly involve doctors. This reflects the fact that the private interest government of doctors extends beyond professional regulation and includes the allocation of funding. The private interest government of doctors is therefore more extensive, but this comes with a closer integration in health care governance and corresponding constraints. In terms of the associated normative institutions this makes for highly institutionalised medical authority, but that is also characterised by strong elements of private practice. Here, the perceived failure of the statutory organisations, especially in terms of containing costs, provides an important leverage for change.

In relation to the governance of medical performance this means there are strong elements of network-like governing in form of formal negotiations, which are combined with governing based on hierarchy and professional self-regulation. The governance of medical performance rests on two,
closely related pillars. As in other countries, statutory organisations of professional self-regulation are responsible for setting professional and ethical standards. The state-level Chambers of Doctors (Ärztekammern) set standards directly through general codes of good practice and more indirectly through their responsibility for secondary training and continuing education as well as through dealing with cases of malpractice. This is complemented by voluntary clinical guidelines developed by specialist societies. Over the last decade, this has been complemented by more direct approaches in form of professionally-led quality management. In 1997 for example, the Federal Chamber of Doctors (Bundesärztekammer) and the Federal Association of Insurance Fund Doctors (Kassenärztliche Bundesvereinigung) issued ‘guidelines’ for clinical guidelines. In 1999 this culminated in the creation (together with the insurance funds) of a clearing house for clinical guidelines as part of the Medical Centre for Quality (Ärztliches Zentrum für Qualität in der Medizin), a non-statutory organisation for medical quality created several organisations of doctors in the early 1990s (Clade, 1999; Wigge, 2000).

In addition to that, doctors are also part of another, statutory regime of governance, the joint self-administration of insurance funds and doctors. This statutory part of the governance regime consists of (substantive and procedural) legislation regulating the statutory health insurance and the collective (and often statutory) agreements by joint self-administration and more specifically the Federal Committee of Doctors and Insurance Funds (Bundesausschuss der Ärzte und Krankenkassen). The committee includes the statutory Federal Association of Insurance Fund Doctors and the federal associations of the different insurance funds. Here, the governance of medical performance often takes the form of financial incentives. Financial incentives are especially powerful when combined with definitions of the range of services covered, as in relation to
ambulatory care and pharmaceuticals, because this allows for the de facto exclusion of services (for an overview see Busse and Riesberg, 2004: 164).

The last aspect has provided a springboard for change, and as a result the governance of medical performance has become both more formalised and fine tuned (for an overview see Igl, 2002; Hess, 2005; Sauerland, 2001). For example, the inclusion of services follows a more explicit approach. The basis for evaluating medical treatments and procedure was extended to include ‘benefit’ and ‘efficiency’ in addition to ‘medical necessity’, making for a broader as well as more formal assessment process (Busse, 1999: 78). In addition, the assessment process is now closely tied to the notion of ‘evidence-based medicine’ and has been complemented by procedures of ‘quality assessment’ (Schmacke, 2001). For example, the extended responsibilities of the Federal Committee include defining (evidence-based) guidelines for medical treatment and compulsory quality assurance (for an overview see Sauerland, 2001).

The mainstreaming of ‘clinical guidelines’ is framed as a new way of defining quality for treatment and diagnosis within the statutory health insurance, and this has helped to widen the debate about clinical guidelines beyond expert circles (Schmacke, 2002b). In this respect it has also been important that ‘quality turn’ has been part and parcel of wider organisational reforms. For example, in 2000 the Federal Committee was extended to include a sub-committee on co-ordination, charged with, among others, defining treatment guidelines for inter-sectoral care. In conjunction with the development of new, more flexible forms of contracting, clinical guidelines also gain further ‘operational meaning’ (Müller de Cornejo, 2005).
The context of negotiating Disease Management Programmes

The Disease Management Programmes introduced in ambulatory care in 2002 build on the developmental pathway outlined above, but also include elements of change (Bundesministerium für Gesundheit 2001). With the Disease Management Programmes the joint self-administration of doctors and insurance funds has become involved in the setting clinical standards. Compared to the earlier initiatives of the specialist medical societies, the evidence base of clinical standards has moved more firmly towards randomised controlled clinical studies and the Disease Management Programmes also include procedures for monitoring clinical standards. Finally, coupling clinical standards to the Risk Equalising Mechanism means that as a governing mechanism clinical standards are now embedded in hierarchical forms of governing. At the same time, there is considerable policy continuity. Even in relation to the Disease Management Programmes doctors continue to play a key role in the definition of clinical standards, as one of the parties to the joint self-administration and as experts in different medical specialities. Also as part of the Disease Management Programmes, clinical standards continue to be advisory. Procedures for evaluating clinical standards remain loosely defined and mainly rely on different forms of organisational self and peer control. Significantly, sanctions continue to be absent.

The following analysis specifically looks at the Programme on Diabetes II, which was one of the first ones of its kind and where the negotiation of new governing arrangements therefore was centre stage. Negotiations of clinical standards can relate to either, the building of relevant institutions (such as the setting up of procedures and agencies), or the operationalisation of processes of standard setting, monitoring, evaluation and sanctioning. In the case of the Disease Management Programme on Diabetes II both types of negotiations are closely intertwined. The negotiations in
several phases, although the corporatist style negotiations at federal level are clearly centre stage (also see Müller de Cornejo and van Lente 2003). For an overview see Table 2 below.

Table 2
The process of negotiating Disease Management Programmes

<table>
<thead>
<tr>
<th>I</th>
<th>II corporatist negotiations in Co-ordination Committee</th>
<th>III contractual negotiations at state level</th>
</tr>
</thead>
<tbody>
<tr>
<td>federal policy making</td>
<td>legislative reforming Risk Equalising Mechanism passed</td>
<td>federal ministry approves recommendations of Co-ordination Committee</td>
</tr>
</tbody>
</table>

First, at federal level, Disease Management Programmes emerge as the frame for governing medical performance notably as part of the policy process leading to the reform of the Risk Equalising Mechanism. This is a mechanism to redistribute funds among the insurance funds to compensate for the unequal distribution of bad risks. The federal government created the Co-ordination Committee (Koordinierungsausschuss) as a sub committee of the Federal Joint Committee and charged the Committee, in a first step, with identifying for which chronic illnesses Disease Management Programmes should be set up, and, in a second step, with setting clinical standards and specifying the organisation of Disease Management Programmes.

The negotiations of the Co-ordination Committee are concerned both with defining overall procedures relating to clinical standards and with operationalising such procedures. The Committee is therefore at the centre of the negotiations of clinical standards as part of the Disease Management Programme on Diabetes II and the work of the Committee is the focal point of the following analysis. In many ways the Committee is an extension of existing agencies of the joint self-
administration and consists of representatives of both insurance funds and provider organisations. At the same time, the Committee is specific in a number of respects: it includes representatives of providers of both ambulatory and hospital care; the substantive remit of the Committee is unusually specific; and the final decisions of the Committee only has the status of recommendations to the federal ministry. The last two aspects point to the presence of strong elements of hierarchical steering.

Finally, the contracts concerning specific Disease Management Programmes at state level together with the accreditation of such contracts by the Federal Insurance Office in principle further contribute to the operationalisation of procedures related to clinical standards. State level organisations of insurance funds and associations of insurance fund doctors agree on the contracts and this particularly includes agreeing on procedures for monitoring clinical standards. The Federal Insurance Office for its parts has to approve the agreements as part of the initial accreditation of individual Disease Managements Programmes. In practice, this, among other factors, has meant that the state level negotiations have not used the existing leeway and are therefore less important for understanding the negotiation of clinical standards.

The dynamics of the joint self-administration: negotiating and setting standards

The negotiations of the Co-ordination Committee are highly formalised and institutionalised and this also makes for highly closed negotiations, which exclusively involve the members of the joint self-administration. There are only two types of points of opening: informally as part of the process of negotiations, which moves between the extremes of having to find a consensus and using threats of exit; formally, but much less importantly, as part of hearings subsequent to the completion of the
negotiations and the recommendations of the Co-ordination Committee. Table 3 below gives an overview of the different phases of negotiations of the Co-ordination Committee and associated alliances and conflicts.

**Table 3**

*Alliances and conflicts in the negotiations of the Co-ordination Committee*

<table>
<thead>
<tr>
<th>Alliance</th>
<th>Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) ministry &amp; association of General Regional Insurance Funds</td>
<td>(5) insurance funds &amp; association of insurance fund doctors/Federal Chamber</td>
</tr>
<tr>
<td>(2) insurance funds &amp; association of insurance fund doctors</td>
<td></td>
</tr>
<tr>
<td>(3) among medical experts</td>
<td></td>
</tr>
<tr>
<td>(4) Federal Chamber &amp; rest of joint self-administration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase</th>
<th>Alliances</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Initial phase</td>
<td>negotiating clinical standards</td>
</tr>
<tr>
<td>II</td>
<td>negotiating the organisation of DMPs</td>
</tr>
<tr>
<td>III</td>
<td>negotiating procedures for documentation</td>
</tr>
</tbody>
</table>

**Initial alliances and salient conflicts**

The negotiations of the Co-ordination Committee are highly politicised, notably in two ways: on the one hand the government has a strong interest in the speedy and successful implementation of Disease Management Programmes; on the other hand, the Disease Management Programmes are highly sensitive for both doctors and insurance funds. The coupling with the Risk Equalising Mechanism means that any decision has very real financial consequences for either side. For the medical profession the involvement of the joint self-administration and the focus on evidence-based practice are additional points of controversy. Taken together, this set the scene for the alliances and conflicts in the initial phase of the negotiations. For an overview of the interests of the different actors involved in the negotiations of the Co-ordination Committee see Table 4 below (also Erler 2002).
Table 4
The interests of actors in the Co-ordination Committee

| **Federal Ministry of Health** | • reforming the Risk Equalising Mechanism  
|                              | • strengthening the integration of health care provision  
|                              | (through evidence based practice and focus on quality)  
|                              | • demonstrating ability to reform health care  

| **insurance funds** | • strengthening the integration of health care provision  
|                    | (through evidence based practice and focus on quality)  
|                    | • demonstrating the ability of the joint self-administration to act  
|                    | *structurally weak insurance funds*  
|                    | • reforming the Risk Equalising Mechanism  
|                    | *structurally stronger insurance funds*  
|                    | • keeping the existing Risk Equalising Mechanism  

| **Federal Association of Insurance Fund Doctors** | • maintaining professional control over setting standards  
|                                                 | • separating issues of standards/quality from issues of funding  
|                                                 | • demonstrating the ability of the joint self-administration to act  

| **Federal Chamber of Doctors** | • maintaining professional control over setting standards  
|                                | • separating issues of standards/quality from issues of funding  

For the Federal Ministry the Disease Management Programmes are a central measure of health reform, in terms of both adapting the Risk Equalising Mechanism and addressing imbalances in the provision of health services. As such and in conjunction with the more general political pressure for health reform the Federal Ministry has a strong interest in Disease Management Programmes and in ensuring that the Programmes are to happen. Not surprisingly, the legislation is very specific in relation to both the substantive focus and procedural aspects of the negotiations of the Co-ordination Committee. In relation to the latter the legislation includes a tight time table together with threats of unilateral ministerial decisions in case of delays.

The insurance funds are generally supportive of the general thrust of the reform to strengthen the integration of health service and to put measures of quality assurance on a firmer footing. Yet, the insurance funds are more divided concerning the coupling with the Risk Equalising Mechanism. As
one of the structurally weaker funds the General Regional Insurance Funds (Allgemeine Ortskrankenkassen) are likely to receive additional funding and the Federal Association of the General Regional Insurance Funds becomes a very active promoter of the introduction of Disease Management Programmes. This contrasts with the structurally stronger funds such as the Substitute Funds (Ersatzkassen) and the Company-based Insurance Funds who fear a loss of funding (Schönbach 2001).

The divided position of the insurance funds gives rise to a more or less open alliance between the Federal Ministry and the Federal Association of the General Regional Insurance Funds. Here, it is indicative that the imminent shift of arena of decision making to the joint self-administration is not least also marked by the fact that even before Co-ordination Committee begins, its work the Federal Association of the General Regional Insurance Funds is very proactive in developing the organisational framework of Disease Management Programmes. In collaboration with Peter Sawicki, one of the leading medical experts within the specialist field of diabetes who promotes the use of evidence-based guidelines, the Federal Association prepares an expertise (also see Schmacke 2002a). Indeed, the expertise becomes an important reference point for the negotiations, especially for two reasons.

The expertise takes the other parties to the negotiations in the Co-ordination Committee by surprise. In relation to the medical profession, the expertise also fills a vacuum in that the existing initiatives do not necessarily conform to the standards of evidence-based guidelines; a fact that even a representative of the Federal Chamber of Doctors openly acknowledges. At the same time, existing initiatives are seen as too partisan to provide a basis for the negotiations. This particularly applies to the Ärzliches Zentrum für Qualität, a joint initiative of among others the Federal Chamber of
Doctors as one of fiercest critics of the Disease Management Programmes, as a representative of the Federal Insurance Office highlights. The other insurance funds have also been less pro-active and therefore are taken aback by the proposals developed as part of the expertise and, especially initially, adopt a more reactive stance.

The important role played by the expertise reflects not only favourable timing, but also the closeness of the expertise to the legislation introducing the Disease Management Programmes. The fact that the interests of the two parties coincide forms the basis of an alliance, while various contacts in the run up to the legislation and during the negotiations themselves further strengthen this alliance. A representative of the Federal Association of the General Regional Insurance Funds describes the relationship as follows.

We were in very close contact with the Federal Ministry of Health and from the very beginning we put the issue [of Disease Management Programmes] very high on our agenda. […] The Federal Ministry greatly supported the General Regional Insurance Funds, because it was glad that there was an insurance fund, which was prepared to invest considerable effort and which had a strong interest in advancing this [the development of Disease Management Programmes].

(representative of the Federal Association of the General Regional Insurance Funds)

In contrast, for the medical profession the introduction of clinical standards is problematic, in some respects highly so, for a number of reasons. Clinical standards are first and foremost about medical practice. Clinical standards are therefore a potentially powerful tool of governance but one which is closely tied to (and even relies on) medical expertise. As discussed above, individual medical societies together with the Federal Chamber of Doctors have set up a variety of initiatives to formulate clinical standards as well as standards for clinical standards. Nevertheless the Disease Management Programmes mark a radical departure. First, with the Disease Management Programmes the formulation of clinical standards moves from the exclusive arena of voluntary professional development within the medical profession to the joint self-administration as an arena,
which is not only more inclusive but which is also closely tied to the hierarchical governing by the state.

I feel that many [doctors] interpreted the intervention in the self-regulation of the medical profession as an intervention in their autonomy. […] The crucial difference [compared to existing approaches] was, that the state had asked a committee, which included both insurance funds and doctors, to formulate these aims [of Disease Management Programmes] using evidence-based criteria and to identify appropriate structures of collaboration [among service providers] within a broader context of cost-efficiency. […] The rest is psychology, that the medical profession felt that the criticism ‘Your practice is inappropriate. […]’ put them under attack.

( representative of Federal Committee who sat on the Co-ordination Committee as a representative of the insurance funds)

As such, the Disease Management Programmes also openly challenge the entrenched position of the specialist medical societies, which are particularly influential in the German context. Similarly, in the long-term this also means that the insurance funds can potentially expand their role from being a payer to being a player in relation to medical practice. Second, the introduction of clinical standards as part of Disease Management Programmes also raises fundamental questions about the nature of such standards and more specifically promotes randomised control trials as the most desirable form of evidence for the formulation of clinical standards. As a representative of the Federal Association of General Practitioners who sat on the Co-ordination Committee as a representative of the insurance funds suggests, this challenged existing traditions.

And that it was possible: that insurance funds together with a group of experts formulate a clinical guideline; that this was in fact not just a guideline, but a clinical recommendation, which was based on external evidence; and that this evidence in part was counter to expert opinion; that was completely new. […] From a medical point of view that was a revolution. […] This also broke with existing traditions, a fact, which has not been completed digested even today.

( representative of the Federal Association of General Practitioners who sat on the Co-ordination Committee as a representative of the insurance funds)

Third, Disease Management Programmes put the clinical standards on a much firmer institutional footing and within the medical profession this is controversial for a number of reasons. The coupling of clinical standards with funding through the Risk Equalising Mechanism means that
clinical standards have concrete (and even measurable) consequences for individual doctors and as such also have a potentially directive nature (cf. Hartmannbund 2001, 2002; Rüter 2001). Finally, the Federal Association of Insurance Fund Doctors in particular is also critical of the fact that Disease Management Programmes are separate from the collective contract, potentially undermining the sphere of influence of the associations of insurance fund doctors at state level (cf. Korzilius 2001).

In sum, the very beginning of the negotiations is characterised by a close, more or less open alliance between the Federal Ministry and the Federal Association of General Regional Insurance funds. In conjunction with favourable timing this means that the expertise of the Federal Association in fact kick-starts the negotiations of the Co-ordination Committee. Further, this first phase is characterised by two sets of salient conflicts: first, between the structurally weak and the structurally strong insurance funds, and second, between the insurance funds and the Federal Ministry on the one hand and the representatives of the medical profession on the other.

Hierarchical framing through procedural steering

The subsequent process of negotiations occurs in the shadow of hierarchy. This takes the form of procedural steering and is closely related to two elements of the initial federal legislation, a tight time table together and threats of unilateral ministerial decisions in case of delays. This means steering at a distance, but not necessarily less powerful steering.

The Federal Ministry takes part in the negotiations of the Co-ordination Committee as an observer and very closely follows the course of the negotiations. Keeping the time table and ensuring that the
recommendations of the Committee conform to existing legislation are the main concerns of the Federal Ministry. In relation to the last aspect it is indicative, as the representative of the Federal Association of Company-based Insurance Funds points out, that the recommendations could largely be incorporated into the legal provisions without any significant changes. Several interviewees across the broad suggest that the time pressures in effect helped to focus the negotiations and to come to an agreement. The fact that it does is closely related to the parallel threat of a unilateral decision by the Ministry in case of a lack of agreement. The following quote illustrates the underlying dynamics at play here.

I feel that this [time] pressure also lead to a pressure to come to an agreement, because it was clear that the Federal Ministry would [otherwise] take a unilateral decision. And this is what nobody wanted.

(Representative of the Federal Association of General Practitioners who sat on the Co-ordination Committee as a representative of the insurance funds)

This [the time pressure] was also constructive. […] Not least to push forward these radical recommendations [of the Co-ordination Committee in relation to the Disease Management Programmes]. […] The time pressure helped to move things on. Otherwise many issues would simply have turned round and round and many [parties to the negotiations] would have retreated to their [original] positions.

(Representative of the Federal Association of Company-based Insurance Funds)

The substance of the threat is two-fold: in the short-term, the exclusion from a decision central to the governance of medical performance, and, in the long-term, the weakening of the role of the joint self-administration as the ‘small legislator’. The possibility of unilateral ministerial decisions (ministerielle Ersatzvornahme) has existed for some years, although its importance as a means of hierarchical governing is unclear. In the present context, the possibility of a unilateral ministerial decision seems to have been a powerful resource for ‘steering at a distance’. To some extent the possibility of such a decision is ‘real’, as a representative of the Federal Insurance Office explains.

The Federal Ministry had increasingly made use of this resource over recent years, even in areas that strictly speaking lay outside the formal remit of the Federal Ministry. The Federal Ministry also has access to the relevant (medical) expertise, either through its own staff or through the Advisory
Board of the Federal Insurance Office. The expertise by the Federal Association of the General Regional Insurance Funds potentially also provides a blueprint for such a decision. At the same time, the fact that the involvement of the Co-ordination Committee had been a concession of the joint self-administration also puts the latter under considerable pressure to succeed. This resonates with the fact that long standing concerns about cost containment and the ability to agree on reforms have put the joint self-administration under considerable pressure to demonstrate its ability to act. However, as a representative of the Federal Association of the General Regional Insurance Funds suggests, the threat of a unilateral decision is perhaps more real in relation to the organisational aspects of the Programmes, such as the transfer of data on medical performance, rather than the definition of clinical guidelines itself. This reflects the fact that unilateral decisions enjoy less legitimacy and this underlines the importance of the Co-ordination Committee as an arena for securing legitimacy for the introduction of a set of highly controversial new means to govern medical performance.

In sum, the procedural steering by the Federal Ministry affects the negotiations in both direct and indirect ways. The direct effects are related to keeping the time table and ensuring the recommendations conform with the legislation. The indirect effects are based on the threat of unilateral decisions in the case of a lack of agreement. In terms of the negotiations of the Co-ordination Committee this means that the insurance funds and the Federal Association of Insurance Fund Doctors put their salient conflicts to one side and instead form an alliance. A representative of the Federal Association of General Regional Insurance Funds characterises the short-term rationale underpinning this alliance as follows.

Of course, the insurance funds and the Associations of Insurance Fund Doctors knew: ‘If we do not come to an agreement, the Federal Ministry of Health can decide on something on its own. In relation to this, we have even less influence compared to the consensus-based negotiations as part of the Co-ordination Committee. [The fact] [t]hat there could be a unilateral decision put
considerable pressure on the negotiations and also made the parties [to the negotiations] look very seriously for a solution of their own
(representative of the Federal Association of General Regional Insurance Funds)

In this respect it is also indicative, as a representative of the Federal Chamber of Doctors highlights, that the insurance funds and the Federal Association of Insurance Fund Doctors use the threats of the Federal Ministry as a lever to push for agreement.

Beyond the immediate threat of a unilateral decision by the Federal Ministry, the alliance is motivated by a joint interest in safeguarding the continued existence and centrality of the joint self-administration in the governance of health care in Germany, as the following quote by a representative of the Federal Association of General Regional Insurance Funds illustrates.

From time to time, the joint self-administration certainly has to prove that it is an important governing body, which continues to enjoy influence. [...] In part, they [the parties to the joint self-administration] have very different interests, but the one thing which unites them is that they prefer to come to a solution themselves and together with each other, and that they dislike the idea that the Federal Ministry of Health decides everything.
(representative of the Federal Association of General Regional Insurance Funds)

The corresponding strategies are about demonstrating the ability of the joint self-administration to act and to come to an agreement, specifically by containing conflict and by securing legitimacy. A first set of strategies is concerned with defining the negotiation of the substance of clinical guidelines as an issue for medical specialists and with allowing the parties to the joint self-administration to choose the experts. The second set of strategies is about forming a division of labour with the Federal Chamber of Doctors that allows expressing both critical and moderate views.
The joint self-administration I: defining the substance of clinical guidelines

As part of the policy process at federal level there was considerable controversy concerning the operating procedures of the Committee as well as the medical membership of the Committee. This reflects not least the highly sensitive nature of the Disease Management Programmes that mark a change in terms of both the substance and the process of setting clinical standards. The challenge for the negotiations is therefore two-fold: to contain conflict and to secure the legitimacy vis-à-vis both, the parties involved in the negotiations and the medical community at large. In this respect, the Co-ordination Committee decides on two specific procedures for negotiation. First, the negotiations fall into two distinctive parts and the definition of clinical standards is separate from the definition of the organisation of the Programmes. The former was the prerogative of the medical experts, who, importantly and second, the different parties to the joint self-administration nominate (also see Brommer 2003, Müller de Carnejo 2005). This helps not only to contain conflict, but, by acknowledging the substantive complexity of the issue at hand (and the need for medical expertise), also provides a means to strengthen the legitimacy of the recommendations of the Committee and importantly on both sides. Through the medical experts the Committee also includes representatives of the relevant specialist medical societies and this increases the legitimacy of the Committee especially for the representatives of the medical profession. Similarly, the fact that the insurance funds nominate their own medical experts in their eyes helps to avoid medical bias as representative of the Federal Association of General Regional Insurance Funds explains.

In relation to diabetes we never had any concerns [about the economic consequences of the Disease Management Programmes]. [This is because] we managed to include experts [in the Co-ordination Committee], who were very important from our perspective, because they were not guided by alien interests, but who were instead highly committed to an evidence-based approach.
(representative of the Federal Association of General Regional Insurance Funds)
At the same time, securing legitimacy is not limited to establishing certain procedures for the negotiations; but these procedures also have to be upheld and partly adjusted throughout the entire negotiating process. This requires balancing out partisanship and more specifically minimising the involvement of additional actors whose position is seen to be clearly biased. An example is the more explicit use of the material developed by the Ärztliches Zentrum für Qualität, a joint initiative of among others the Federal Chamber of Doctors as one of fiercest critics of the Disease Management Programmes. Further, as a representative of the Federal Association of Company-based Insurance Funds highlights, this also means that the insurance funds keep a low profile throughout the first phase of the negotiations. The only exceptions are the definition of criteria of access to the Programmes, which have clear financial consequences for the insurance funds.

Negotiating the substance of clinical guidelines (that is defining diagnoses and identifying best treatment) is marred by conflict, but the exclusive involvement of medical experts and the clear time constraints help to contain the conflict. The conflict centres not only on different approaches to treating diabetes II but also on the nature of clinical evidence. In this last respect, two schools exist: one defines evidence broadly to also include the experience of senior medical practitioners; the other defines evidence more narrowly as knowledge based on clinical studies using randomised control. Among the medical profession in Germany the first, so-called ‘eminence-based’ approach to clinical evidence appears to still have been dominant at the time of the introduction of Disease Management Programmes and the Programmes therefore mark a significant change of track as a representative of the Federal Association of Company-based Insurance Funds observes.

Such conflicts [about the substance of clinical guidelines] also have to be seen against the background that in the past, quoting a high profile researcher in the field was enough to define something as given. And this has changed. Here [as part of the negotiations of the Co-ordination Committee] every statement had to be substantiated with a study, which also had to be presented. And this [the evidence base of studies] was also double checked. (representative of the Federal Association of Company-based Insurance Funds)
The representative of the Federal Insurance Authority also suggests that this is especially true for the specialist field of diabetes, where many studies exist, but where few of those studies use randomised control. Beyond the specific issues of conflict this also points the more general point that agreeing evidence-based clinical guidelines is very much unchartered and therefore sensitive territory. As a representative of the Federal Association of Insurance Fund Doctors points out this requires to first agreeing ‘standards for clinical standards’. Here it is also indicative that a lot of the clinical evidence available at that point of time in effect originates from studies conducted a broad, sparking further controversies concerning the transferability of evidence, as an interviewee who took part in the negotiations of the Co-ordination Committee as a representative of the insurance funds suggests. Taken together this also underlines the importance of procedures for securing legitimacy discussed above.

**The joint self-administration II: the division of labour with the Federal Chamber of Doctors**

The other strategy the joint self-administration uses to secure agreement and thereby to demonstrate its ability to act is to form a division of labour with the Federal Chamber of Doctors, which allows expressing both highly critical and more moderate views. As such, the joint self-administration can maintain legitimacy vis-à-vis both the Federal Ministry and the grassroots of the medical profession.

The involvement of the Federal Chamber had been a point of controversy in the policy process leading up to the legislation. The Federal Chamber is usually not one of the parties to the joint self-administration, but especially in relation clinical standards the Federal Chamber seems to be an obvious party to include. As an organisation the Federal Chamber has a clear focus on medical
practice and has also worked with clinical guidelines. Importantly, the Federal Chamber also has close connections to the ‘hinterland’ of specialist medical societies. Considering the sensitive nature of the process the inclusion of the Federal Chamber also promises increasing the legitimacy of the negotiations. In the course of the negotiations, however, the highly critical stance of the Federal Chamber (for a summary see Bundesärztekammer 20002) increasingly comes to the fore, culminating in the withdrawal from the negotiations.

A representative of the Federal Chamber of Doctors characterises the relationship with the Federal Association of Insurance Fund Doctors as a division of labour, whereby the former is mainly concerned with the substance of medical practice and whereby the latter focuses on issues of contracts and fees. Yet, in the context of the Disease Management Programmes issues of medical practice and issues of fees are closely intertwined and are decided in a forum where the Federal Chamber is a new comer. This turns out to be a problematic combination: while the Federal Chamber is highly critical of both the involvement of the joint self-administration and especially the coupling with the Risk Equalising Mechanism, the Federal Chamber itself is part of the Co-ordination Committee and as such also has to engage with the Committee in one way or the other. The following quote of a representative of the Federal Chamber of Doctors poignantly illustrates this dilemma.

And the biggest point of conflict [was] the coupling with the Risk Equalising Mechanism. From then on it was crystal clear that it [the Disease Management Programmes] would be misused to redistribute financial debts among the insurance funds. From my view this, if I may be frank, completely spoiled the issue [of Disease Management Programmes]. […] [W]e and more specifically our representatives [on the Co-ordination Committee] felt that we were used to support decisions, which ran absolutely counter to our views. This relates not only to substantive medical issues, but also to the way in which this was put into practice. (representative of the Federal Chamber of Doctors)

Interestingly, the fact that the position of the Federal Chamber of Doctors proves to be untenable in effect helps to strengthen the legitimacy of the joint self-administration. That way, the Federal
Chamber becomes the host for expressing views, which are highly critical of the Disease Management Programmes, while this allows the Federal Association of Insurance Fund Doctors to demonstrate its moderate and constructive stance. As a representative of the Federal Association emphasises the Association has a genuine interest in the Disease Management Programmes as a means to continue some earlier contractual experiments, but also hopes its involvement helps to safeguard the collective contract.

Our main point of criticism of the reform of the Risk Equalising Mechanism was the following: ‘We are against a Risk Equalising Mechanism which is related to medical performance. Nevertheless we are against the fact that the Disease Management Programmes put a question mark behind the collective contract.’ (representative of the Federal Association of Insurance Fund Doctors)

Throughout the negotiations the Federal Association adopts a moderate stance, trying to make the best out a situation the Federal Association considers to be less than ideal, as a representative of the Federal Association of Insurance Fund Doctors emphasises. As suggested earlier the insurance funds share the concern about the threat to the joint self-administration and in addition both actors agree on the broad terms on Disease Management Programmes, as a representative of the Federal Joint Committee who sat on the Co-ordination Committee as a representative of the Insurance Funds explains. This provides a basis for an alliance between the Insurance Funds and the Federal Association of Insurance Fund Doctors.

The ménage-à-trois among the joint self-administration only becomes apart in the relation to the very final phase of the negotiations concerned with the issue of documentation, where the Federal Association of Insurance Fund Doctors joins the Federal Chamber in its opposition to the transfer of patient data (also see Gerst and Jachertz 2002, Kassenärztliche Bundesvereinigung 2002). At one level the controversy is about questions about data protection and more specifically how to protect the confidentiality of the relationship between doctor and patient.
In the end, the main point of conflict was, I feel, the question of access to data on medical diagnoses. At this point the medical profession altogether as well as the hospitals simply refused to continue. They all said ‘It is not on that the insurance funds gets to know who is a smoker and who is not, who is overweight and who is not. [...] From our point of view this should not be the responsibility of the insurance funds. That was the end, I feel, the main point of conflict, but where the Federal Chamber of Doctors, the Federal Association of Insurance Fund Doctors and the hospitals again shared the same opinion.

(Representative of the Federal Association of Insurance Fund Doctors)

However, what is also at stake is the relative transparency of medical practice and the opportunities for control this would give to insurance funds. As a representative of the Federal Association of Insurance Fund Doctors explains this goes back to the fact that the insurance funds and the medical stakeholders also have different ideas about the nature of quality controls, with the insurance funds favouring individual controls and the medical side preferring collective controls.

The idea, which the Federal Association of Insurance Fund Doctors pursued, was a different one. The Federal Association said: ‘We identify the criteria, which offer relevant information and which are appropriate for retrospectively evaluating a patient and a doctor through collective comparisons.’ In contrast, the insurance always insisted on the principle of individual quality assessment. The insurance funds always imagined: ‘We look at every single data set for every single patient, and if there is any provision the doctor does not follow, then he [the doctors] will be reprimanded.’

(Representative of the Federal Association of Insurance Fund Doctors)

For the insurance funds, as a representative of the Federal Association of Company-based Insurance Funds explains, the availability of patient data is also central for ensuring that the transfer of funds conforms to the provisions set out in the legislation.

We attached great importance to this [the quality of data], because every written record of the inclusion [in a Disease Management Programme] also has financial consequences. And in this respect we wanted to ensure, that the transfer of funds correctly (and not wrongly) follows existing provisions. In this respect written records can be helpful, at least in part.

(Representative of the Federal Association of Company-based Insurance Funds)

In relation to the issue of the transfer of data the salient tensions between the Federal Association and its rank and file also come to the fore, and the Federal Association has to backtrack from its until then constructive stance, as a representative of the Federal Association of General Regional Insurance Funds points out.
Here, the state representatives of the Federal Association of Insurance Fund Doctors ordered its executive board back, and required putting considerable limits on the transfer of data to the insurance funds. This demonstrated that the negotiating power of the Federal Association of Insurance Fund Doctors is always a little problematic, because the Federal Association has to secure the support of the Associations of Insurance Fund Doctors at state level. […] This highlights the divisions in the medical profession and the fact that although we [the insurance funds] could work together with the Federal Association of Insurance Fund Doctors in a constructive manner, the tensions remained salient.

(Representative of the Federal Association of General Regional Insurance Funds)

In short, the negotiations of the co-ordination committee end in a stalemate in relation to the issues of the transfer of clinical data. However, time constraints mean that the agreement on the issues is postponed until after the publication of the final legal provisions by the Federal Ministry.

**Feedback mechanisms as a springboard for non-linear change in medical governance**

As suggested earlier, the governance of medical performance through clinical standards as part of Disease Management Programmes is an example of non-linear change and combines old and new forms of governance. In what ways do sector-specific institutions shape the negotiations leading to the Disease Management Programmes and thereby help to explain the existence and specific form of non-linear change in the governance of medical performance. The analysis suggests two things. On the one hand, there are feedback mechanisms at work, which limit the involvement of actors to the usual parties to the joint self-administration and which mean that the strategies of actors largely correspond to the standard operating procedures of the joint self-administration. This puts limits on the extent of change in governance and makes for either path dependent change or continuity. Here it is indicative that the procedures for evaluating clinical standards remain ill defined (and largely rely on peer and organisational self-control) and that doctors continue to have a highly influential role. In part, this lies in the nature of clinical standards as governing mechanisms which rely on medical expertise, but the very extensive involvement of doctors is specific to the joint self-
administration. On the other hand, in combination and together with additional conjunctural factors, the same distribution and co-ordination effects also provide a springboard for change in governance, which marks a move away from existing development pathways. This includes the involvement of the joint self-administration in defining clinical standards and the stronger external evidence base of clinical standards.

The conjunctural factors are two-fold. First, the persistently high unemployment over recent years has reduced the income of the social health insurance and thereby makes it more difficult to fund existing levels service provision. As contributions are paid directly as a percentage on income, this makes for a highly visible policy pressure. This has tended to be coupled with the perception of low government authority and capacity in health care, as reflected in characterisation of health policy as ‘continuous reform’ and ‘reform blockades’ (cf. Rosewitz and Webber 1992, Webber 1991). Secondly and more specifically, the perceived failure of Reform Act in 2000 (cf. Burkhardt 2002) and the upcoming general election in 2002 put the government under further pressure to act. However, the time frame to do so, is limited, as is the substantive room for manoeuvre. The majority of the Federal Chamber of States (Bundesrat) is in the hands of the opposition party of the Christian Democrats and the relations with doctors’ organisations are still tense after the controversies (and public protests) in connection with the Reform Act in 2000 (Gellner and Schön 2002).

In relation to the strategies actors use (‘co-ordination effects’), it is significant that the actors tend to adapt their strategies to the operating procedures of the joint self-administration, but importantly with a twist. For example, the Federal Ministry delegates the specification of the Disease Management Programmes to the joint self-administration. At the same time, the ministry engages
heavily in procedural steering at a distance. The specification of the substance and the time table of
the negotiations as well as the threat of a unilateral decision are all strategies, which are fall under
the repertoire defined by the institution of the joint self-administration. However, in combination
with the other strategies discussed below and together with the conjunctural factors outlined above
this helps the negotiations to succeed and the parties to come to an agreement within the substantive
framework set by the Ministry. Similarly, the insurance funds and the Federal Association of
Insurance Funds Doctors pursue their interests through strategies which strengthen the legitimacy of
the joint self-administration and which help contain conflict. One consequence is that the influence
of medical interests is strong throughout the negotiations and it does not come as a surprise that the
definition of procedures for evaluating clinical standards is weak and largely relies on peer and
organisational self control. At the same time, the strategies of procedural steering used by the
ministry in effect limit the strategies available to medical interests (and thereby the extent to which
they can pursue different kinds of interests). For the Federal Association of Insurance Fund Doctors
adopting a strategy of total opposition is not an option as this may jeopardise the continued short
and medium term involvement of the Federal Association in health governance, not least also
through the collective contract. Instead, the Federal Association uses a strategy of constructive
collaboration and selective opposition and it is only the issue of the transfer of patient data at the
very end of the negotiations, which the Federal Association completely rejects. Similarly, for the
Federal Chamber of Doctors with its highly critical stance towards Disease Management
Programmes, pursuing insider strategies proves to be impossible under the given circumstances.
Instead, the Federal Chamber has to switch to outsider strategies and as such inadvertently
strengthens the strategy of constructive collaboration adopted by the Federal Association of
Insurance Fund Doctors.
In terms of the relationship between institutions and the distribution of power among actors (‘distributional effects’), it is indicative that the Federal Ministry delegates the specification of the Disease Management Programmes to the joint self-administration. This makes the federal associations of insurance funds, insurance fund doctors together with the Federal Chamber of Doctors the key actors, whereas the Federal Ministry of Health takes a back seat. At the same time, this does not prevent the ministry from adopting a more indirect but no less influential role of ‘procedural steering at a distance’. Indeed, the joint self-administration has proved to be a highly flexible form of governing: it includes elements of both hierarchy and network and the balance between the two has oscillated over time (cf. Döhler, 1995; Döhler and Manow, 1997). As the discussion of the strategies of actors above illustrates, this co-existence is full of conflict and the dynamics of the negotiations are concerned with carefully, but often only temporarily channelling conflict. Similarly, as the original parties to the joint self-administration the insurance funds and the Federal Association of the Insurance Fund Doctors are the key actors and enjoy considerable influence. Yet, the detailed substantive specifications as part of the federal legislation of the reform of the Risk Equalising Mechanism and the tight time table for the negotiations put some limits onto the extent to which they key actors can indeed exert their influence. Similar limitations exist in relation to the involvement of medical experts and the Federal Chamber of Doctors. Both are new parties to the joint self-administration, but their involvement strengthens the influence of medical interests as well as the legitimacy of the joint self-administration as a whole. However, the possibilities of the two new actors to translate their critical views on Disease Management Programmes into practical influence are limited, not least by the interest of the original parties to the joint self-administration to demonstrate their ability to act. Here it is indicative that the influence of the medical experts is confined to defining the substance of clinical standards, whereas the Federal Chamber is pushed into a position of a critical outsider.
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