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11 Health policy in a comparative perspective

Abstract: The regulation, financing and provision of health services is one of the main tasks for contemporary welfare states. There is a great amount of scholarship that deals with different aspects of health policymaking. This chapter introduces the reader to this literature in three steps. Firstly, it defines the scope of health policy by distinguishing health care policies, which aim at curing diseases, from public health policies that focus on preventing the outbreak of sickness. Secondly, the chapter presents different typologies of health care systems and discusses how they have evolved over time and how various countries differ regarding their expenditure for health. After that, the paper explores whether the type of health care system has consequences for the capacity of the country to put into place preventative health policies. Thirdly, the chapter introduces readers to the topic of health inequalities and elaborates some of the most recent findings from this literature.

Keywords: Health care, public health, prevention, health insurance, health expenditure, health inequalities

11.1 Introduction

The provision of health care for the sick and the protection of the population from health hazards is an important policy challenge and a major issue of concern for decisionmakers. Health and health policy have for a long time been a central welfare state issue. In developed democracies, policymakers have historically faced the challenge to create comprehensive health policies that include a variety of policy measures, such as financing health care services, regulating medicines but also providing vaccines and food safety regulations. More recently, policymakers have begun to face additional policy challenges related to health, such as rising health care costs due to fiscal pressures and new technologies that improve treatments. Furthermore, decisionmakers are confronted with rising cases of non-communicable diseases due to lifestyle habits and ageing populations as well as new infectious diseases, such as pandemics.

Against this backdrop, this chapter has two goals. Firstly, it aims to introduce the reader to the field of health policy and provides an overview of different policies that are part of this policy field. Secondly, the chapter intends to give an overview of how different countries provide health care and deal with some of the problems that go beyond the medical dimension of health policy, notably health inequalities.

Therefore, the chapter poses three related research questions. The next section asks how we can distinguish different elements of health policy, pointing notably to the distinction between health policy understood as public health on the one hand, as

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well as health care on the other. The section demonstrates how public health can be defined as disease prevention and needs to be distinguished from health care, which focuses primarily on disease treatment. Section three poses the question how health systems are different and similar between countries, how they have evolved over time, and how health systems organise health policies, focusing on the financing of health care services as well as the ability to protect the entire population from health hazards. The fourth section of the chapter analyses how health inequalities as well as inequalities in access to health care have persisted in different countries and to what extent policymakers in various health systems have succeeded in dealing with these problems.

11.2 Different health policies

Which elements are part of health policy and how can we organise and compare different health policies? This section proposes a comparative analysis of different health policies, in distinguishing public policies that provide health care services for the sick from measures that aim at protecting those individuals, groups and the population from health hazards. Typically, scholars broadly define health policy as the regulation, financing and provision of services that aim at curing those who suffer from disease and preventing the healthy from getting sick (Blank, Burau, and Kuhlmann 2017; Böhm et al. 2013; Trein 2018). Health policy is different from other types of welfare policy, such as pensions and unemployment insurance, because an important part entails the provision of services and not only transfer payments. This implies that traditionally health policy comprises not only of the financing but also of the regulation and organisation of all kinds of health services (Barr 2020). As a consequence, health professions and industrial-scientific interest groups and firms that are relevant to health service provision have an important political influence in health policy (Immergut 1992; Rothgang et al. 2010).

Table 11.1: Health policy according to timing of intervention and target

	Illness-focused	**Health-hazard-focused**
Individual-focus	Medical treatments for individuals (e.g., pharmaceutical intervention, operations)	Services and treatments related to early diagnosis (e.g., cancer screening, counselling regarding health behaviour)
Population-focus	Treatment of groups or populations (e.g., measles, influenza, COVID-19)	Regulations of health protection (e.g., food safety, occupational safety, regulations to contain infections), vaccination, mass diagnosis

Note: based on Trein 2017, 749.

To describe different aspects of health policy, I use a simple two by two table that combines the level of the policy's target group with the timing of the health policy intervention in relation to disease progress. Specifically, I distinguish whether health policies focus rather on individuals, or if they tend to address a population or sub-group of the population at the same time. Furthermore, I separate whether health policies mainly address the moment once a disease is present, i.e., can be diagnosed clinically, or whether health policy action mainly addresses health hazards (Trein 2017, 2018).

Table 11.1 shows how this distinction offers the possibility of comparing different health policy interventions. Firstly, there are health policies that address medically diagnosed sickness and focus only on the individual level. Such policies regulate medicines, diagnosis techniques and skills, finance health care services, for example through health insurance, and organise the provision of services. Secondly, health policies focus on the individual level only, but address health hazards, i.e., the moment prior to the arrival of a disease. These are health policies that regulate, finance and provide preventive diagnostic services, for example screening regarding non-communicable diseases and health counselling. Thirdly, there are health policies that focus on the treatment once a sickness is medically diagnosed but extend this to the level of groups or populations. Examples for these types of health policies are measures dealing with the coordinated treatment of groups suffering from the same disease, such as COVID-19. Fourth, Table 11.1 distinguishes health policies that focus on health hazards at the population level. On the one hand, these are policies aiming at preventing the spread of a highly infectious disease through testing and vaccination, such as in the case of the COVID-19 virus. On the other hand, these are regulatory public health policies, for example food and occupational safety regulations or tobacco control policies, such as smoking bans. These policies extend beyond the policies that are at the core of health care policy.

These different types of health policies overlap considerably between institutions and organisations of health policies. Especially the first three types of health policies are often integrated in one law, such as the national health insurance laws, as well as in the same organisations and practitioners who are responsible for service provision, such as hospital or medical practices of independent doctors (Blank, Burau, and Kuhlmann 2017). Other policies, such as health regulations and policies to counteract the pandemic are more decoupled from health policies that are at the core of the health system and are part of health regulations (Bell, Salmon, and McNaughton 2011). In recent years policymakers have begun to propose health policies that integrate different aspects of health policies into other policies, such as those related to employment, environmental protection and transportation, which aims at combining as many of the fields mentioned in Table 11.1 as possible (Kickbusch and Buckett 2010).

The various elements of health policy differ according to their budgetary importance. In normal times, governments spend the largest part of their budget on health for services aiming at the cure of sick individuals and only a very small part on the preventative efforts (Trein 2018, 66). Expenditures in other fields of social policy, such

as education, unemployment insurance and social assistance also have health impacts as they contribute to preventing sickness (Mackenbach 2019). Different health policies also vary concerning the political feedback effects (i.e., electoral rewards, support by interest groups), they produce for politicians. Health care policies that pay and provide cure for sicknesses, for example through extending health care coverage, are likely to create political support by politicians and interest groups (Hacker 2019; Jacobs, Mettler, and Zhu 2021). Contrariwise, it is much more difficult to create political support amongst the population and interest groups for preventative health policies. The reason for this is that public health and prevention address problems which individuals do not yet experience, and therefore are unlikely to prioritise in elections. At the same time, these policies often produce negative effects for influential interest groups, such as the tobacco or food industry, and these actors oppose public health policy through lobbying or in courts (Cairney and Denny 2020; Gailmard and Patty 2019; Healy and Malhotra 2009).

11.3 Health expenditure and health protection in different health care systems

An important part of research on health policy is the distinction of different health care systems. In most rich countries, governments have developed policies aiming at the development of universal health care services, which cover (in principle) the entire population. Nevertheless, there are important differences between countries regarding how to achieve such universality. In order to take into account the diversity in health policy, authors have put forward various comparative analyses of how countries regulate, finance and organise the provision of health care (Böhm et al. 2013; Reibling, Ariaans, and Wendt 2019; Rothgang et al. 2010; Saltmann, Busse, and Figueira 2004; Wendt, Frisina, and Rothgang 2009). An important insight from this research is that health care systems do not overlap particularly well with different welfare state systems, notably the distinction between liberal and small welfare states on the one hand, and continental European and Nordic welfare states on the other. Specifically, countries with a rather liberal welfare state (Emmenegger et al. 2015), such as Australia, Canada, and the UK have a largely publicly financed comprehensive health care system (Bambra 2005; Rothgang et al. 2010).

11.3.1 Diversity of health system typologies

In the following, the chapter contrasts two recently published typologies of health care systems that reveal the complexity that students and researcher face in the analysis of health systems. One typology by Böhm et al. (2013) distinguishes four groups of

health care systems, according to how three dimensions – a) regulation, b) financing, and c) provision – of health care are coordinated, based on the governance literature (Benz 2004). Notably, each dimension can either be governed by the state, by interest groups, or by the market. The first group of health care systems are *National Health Service* systems where the state dominates the regulation, financing and provision of health care (e.g., Denmark, Finland, Sweden, Norway, Portugal, Spain, UK). The second group of countries are a *National Health Insurance* type and combine state regulation and financing with largely private provision (e.g., Australia, Canada, Ireland, New Zealand, Italy). The third group are countries representing *Social Health Insurance* systems, in which interest groups (peak associations) have an important degree of autonomy regarding the regulation and financing of health care whereas service provision is private (e.g., Austria, Germany, Luxembourg, Switzerland). The fourth group is called *Etatist Social Health Insurance* systems that combine state control of regulation, interest group control of financing and private provision (e.g., Belgium, Estonia, France, Czech Republic, Hungary, Netherlands, Poland, Slovakia, Israel, Japan, Korea). The U. S. is an outlier in this typology where private actors have a dominant role in health care governance and provision (Böhm et al. 2013, 263).

Table 11.2: Two typologies of health systems

Theoretically driven typology (Böhm et al. 2013)		**Empirically driven typology (Reibling, Ariaans, and Wendt 2019)**	
System type	Countries	System type	Countries
National Health Service	Denmark, Finland, Sweden, Norway, Portugal, Spain, UK	*Supply-and choice oriented public systems*	Australia, Austria, Belgium, Czech Republic, Germany, France, Ireland, Luxembourg
National Health Insurance	Australia, Canada, Ireland, New Zealand, Italy	*Performance- and primary-care oriented public systems*	Finland, Japan, South Korea, Norway, New Zealand, Portugal, Sweden
National Health Insurance	Austria, Germany, Luxembourg, Switzerland	*Regulation-oriented public systems*	Canada, Denmark, Spain, Italy, Netherlands, UK
Etatist Social Health Insurance	Belgium, Estonia, France, Czech Republic, Hungary, Netherlands, Poland, Slovakia, Israel, Japan, Korea	*Low-supply and low performance mixed systems*	Estonia, Hungary, Poland, Slovakia
Private Health System	U. S.	*Supply- and performance-oriented private systems*	Switzerland, U. S.

Another and more recently published typology uses an empirical approach to classify health care systems. Therein, the authors combine information on the supply of health care services (practitioners and expenditure), public–private mix, access regulation, primary care orientation, and performance (alcohol and tobacco consumption). In using cluster analysis, the authors visualise five clusters of health care systems that can be separated into two pairs respectively, as well as a fifth cluster that is not connected to the other two systems. The first cluster is named *Supply-and choice oriented public systems* amongst which are countries such as Australia, Austria and Germany. The second cluster, which is closely connected to the first one, is named *Performance- and primary-care oriented public systems* (e.g., Finland, Japan, New Zealand, and Portugal). A third cluster of countries is more distant from the first two and is entitled *Regulation-oriented public systems*. Notably, Canada, Denmark, Italy and the UK are part of this group. The fourth cluster, closely connected to the third one, is named *Low-supply and low performance mixed systems* (e.g., Estonia, Hungary and Poland). Finally, Switzerland and the U. S. are combined in a cluster named *Supply- and performance-oriented private systems* and are disconnected from the other four clusters (Reibling, Ariaans, and Wendt 2019, 615–617).

The important point to retain is that the literature on comparative health systems has a tradition of separating different health systems with quite different results (Table 11.2). The main reason for this divergence is that scholars have either taken a deductive approach that is theory-driven and based on different modes of governance, such as hierarchy (state), networks (interest groups) and markets (Böhm et al. 2013). Other researchers have used a much more empirically driven approach, which comes to a considerably different result regarding the separation of health care systems (Reibling, Ariaans, and Wendt 2019). Both health system typologies reveal important insights for the understanding of health care policy. On the one hand, they show how the internal governance logic of health systems works. On the other, the empirical approach builds on the policy outputs and outcomes that these health systems produce.

11.3.2 Similarities between countries in their development over time

Another strand in the literature on health policy and health care focuses on temporal dynamics in health and the changes in health systems over time. Such reforms were also part of health policy, notably the health care sector. For example, in many countries policymakers reformed hospital payment systems to make the delivery of health care more efficient. Notably, governments began to introduce Diagnosis Related Groups (DRGs), Disease Staging and Patient Management Categories. These are classification systems aiming at making the health care sector more cost-efficient by changing the billing structure for hospitals. Despite the differences between their health care systems, countries around the world adopted these management tools in their

health care sector (Gilardi, Füglister, and Luyet 2009). These reforms are part of a general dynamic that aimed at increasing the role of market elements within health care financing and provision. In the UK, a variety of different NHS (National Health Service) reforms increased the role of market elements within national health policy (Greener 2002). Up to now, the impact of marketisation reforms in the health care sector probably have not been very well researched. A recent paper systematically analysed the usage of market instruments in hospitals in Madrid and showed that the cost-effectiveness of these types of reforms is limited (Alonso, Clifton, and Díaz-Fuentes 2015).

Another type of reform in the health care sector during the last three decades entails the decentralisation of health services to lower levels of government. The rationale behind this decision was to get the organisation of services closer to citizens and to take into account that regional governments are better placed for the organisation of services and the adaption of needs to local situations (Costa-Font and Greer 2016). For example, in Italy, regional governments received important competences in the organisation and financing of health care, in order to make health policy more cost efficient (Terlizzi 2019). In addition to decentralisation and the usage of market elements in health care governance, austerity was a third element of health care reform, especially in some European countries. Notably, in the wake of the global financial and economic crisis after 2007 many European governments aimed at reducing public expenditure, which also touched health policy, for example in Greece and Italy but also in the UK (McKee et al. 2012).

To illustrate some of these dynamics, I will now turn to a descriptive analysis of health expenditure against the background of the discussed insights from the literature. Therefore, I compare the relationship of the mean health expenditure per capita and mean out-of-pocket expenditure per capita in different OECD countries from 2000–2009 and 2010–2019. The data are in USD and weighed for purchasing power parity. First, the results suggest that there are differences in the patterns of expenditure between different countries that correspond only partially to the above discussed patterns of health care governance. Only Switzerland and the U. S. are clear outliers. Secondly, the comparison of the two decades indicates that health expenditure augmented considerably, but this increase varies between countries. Some Southern and Eastern European countries augmented their health expenditure at a much lower level compared to other countries in the sample. Furthermore, out-of-pocket health expenditure augmented, i.e., the share of health care cost that private households must cover themselves and that is not taken on by health insurance (Figure 11.1). Although these figures need to be interpreted in the context of a growing economy, they outline a common trend towards an increase in health expenditure as well as a growing share of health cost that needs to be covered by private households. This is a problem especially for low-income households, which tend to avoid investing in medical examinations if they have to cover them out of their own pocket (Agarwal, Mazurenko, and Menachemi 2017). The chapter further points to this problem below in the section on inequalities related to health outcomes and access to health care.

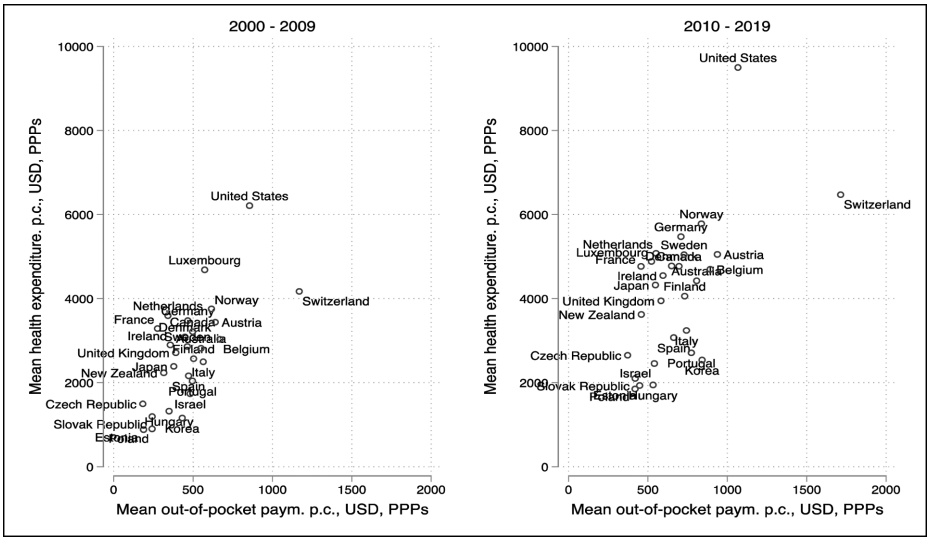

Figure 11.1: Health expenditure and out-of-pocket payments in OECD countries

This data suggests that there are some important elements of convergence between different health systems across developed democracies towards more marketisation and an increasing investment into health care services. Nevertheless, another dynamic of convergence also goes towards an increase in health care coverage through publicly regulated health insurance programmes. In 1996, Switzerland introduced a national health insurance law that extended coverage to all inhabitants, as regionally and locally organised health insurance models did not work anymore (Uhlmann and Braun 2011). In 2010, the U. S. Congress approved a national health insurance law that offered the possibility of obtaining health care coverage for those that could not afford health insurance (Affordable Care Act) (Rosenbaum 2011).

11.3.3 Do health care systems affect the capacity to make preventative policy?

In this section, the chapter turns to the analysis of preventative and protective health policy. The above-discussed comparisons of health systems do not take into account the capacity to make preventative health policies, although some of the texts account for tobacco consumption as a measure of health system performance (Reibling, Ariaans, and Wendt 2019). Nevertheless, different strands of literature have shown that there are differences between countries regarding their capacity to put into place health policies that prevent health hazards and that include non-medical policies.

This finding can be illustrated using the example of tobacco control policy. Researchers and international organisations have compared how different countries

vary in their adoption of measures aiming at the prevention of non-communicable diseases, for example through tobacco control policy (Anderson, Becher, and Winkler 2016; Studlar, Christensen, and Sitasari 2011). In this context, scholars have also assessed which factors explain why countries adopt measures such as tobacco control policy. For example, researchers have held that corporatist institutions tend to explain a delay in the implementation of tobacco control policy as interest groups and firms, such the tobacco industry have more influence on public policy (Cairney, Studlar, and Mamudu 2011). Another explanation points out that if governments finance their health care systems through taxes, they will implement preventative health policies, for example tobacco control, as this will reduce the health care cost they have to cover through taxes (Trein 2017). Nevertheless, more research needs to be done to determine what explains the capacity of different countries to put into place preventative health policies.

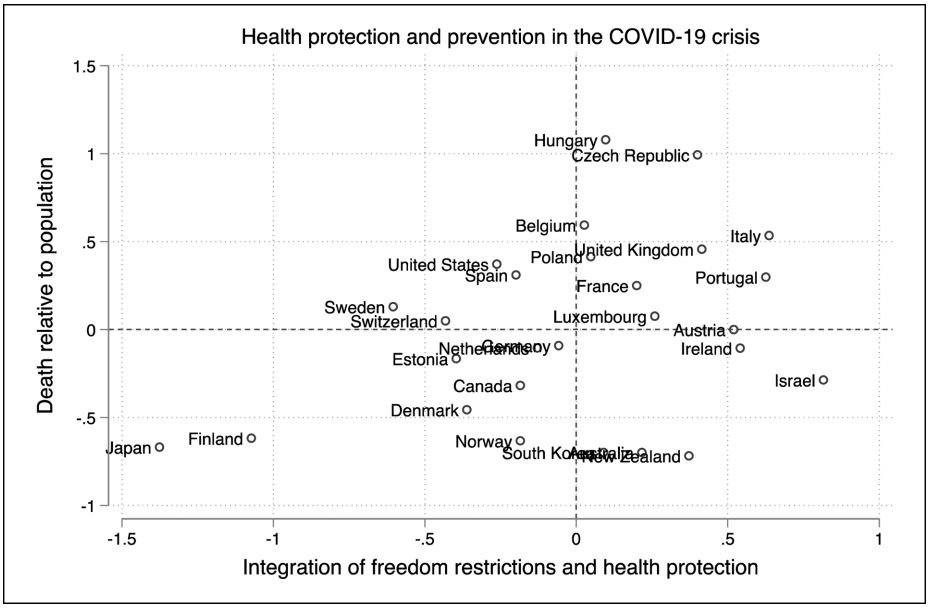

Figure 11.2: Variations in public health policy

The COVID-19 pandemic has brought to the fore the question of how and why countries differ in their capacity to put into place policies that aim at addressing an infectious disease at the population level. This instance is different from the problem of non-communicable diseases because governments face the challenges of combatting an epidemic. The arrival of COVID-19 and its massive impact on societies has sparked many research efforts, which also cover the capacity of countries to respond to the pandemic by "locking down" societies as well as the capacity of governments to create measures that protect the population, for example through testing and vaccination

measures. The *COVID-19 Government Response Tracker* provides an index that combines the capacity of governments to restrict individuals' freedoms, for example through school closures or curfews with measures that protect the population on a rather voluntary basis, such as testing, contact tracing and vaccination (Hale et al. 2021).

To analyse this data, I combine the maximum value of the government containment index in the period of measurement (12/2019–05/2021) with the number of reported deaths related to COVID-19. To simplify the interpretation of the variables, I standardised them around their mean (Figure 11.2). The results show that there are important differences between countries. Some countries, such as Austria, Hungary, Italy, Israel and New Zealand managed to achieve a high level of integration between measures that severely restrict individual liberties with health protection measures. Other countries, such as Sweden, Switzerland, Japan or Finland did not pursue a high intensity response that integrated different types of public health policies. Importantly, there is a considerable variance regarding the impact of the pandemic between the countries that display a high response capacity. For example, New Zealand shows a high degree of integration between health protection and restrictions of freedom combined with little impact of the pandemic whereas the Czech Republic and Hungary have also high level of integration between different policy measures but in combination with a high level of crisis impact. When it comes to dealing with public health challenges, such as pandemic, not only the response capacity matters to achieve better health outcomes but also the timing, i.e., the ability to respond quickly (Oliu-Barton et al. 2021). Furthermore, different types of health care systems and worlds of welfare capitalism do not seem to be clearly correlated with the response capacity and outcomes related to public health (Figure 11.2).

11.4 Health inequalities and inequalities to health care access

The third research question that is important in relation to health policy in different countries relates to health inequalities as well as inequalities in access to health care services. For example, scholars have asked the question how different countries perform concerning the combat between health inequalities and if there is a difference between health systems regarding their ability to address health inequalities. Health inequalities are an important topic as they link health care back to other dimensions of welfare state research, such as pension and unemployment policy.

There is burgeoning literature that analyses health inequalities and the differences between countries, for example differences in health status and behaviour according to income and education (Bambra 2019). Researchers have pointed out that there is a paradox of public health. Although there is increasing investment in welfare

state and health care policies, health inequalities have persisted throughout developed democracies (Bambra and Eikemo 2009; Lynch 2020; Mackenbach 2019). Notably, the literature has shown that socio-economic inequalities in mortality are a universal and substantial element of modern societies. In the European context, such inequalities are smaller in poorer Southern European countries but larger in wealthier Northern European countries. Furthermore, socioeconomic inequalities in mortality are widening and do not respond to policies that aim at reducing these goals. Lifestyle factors play an important role to explain these health inequalities. Oftentimes, the robustness of an individual's socioeconomic position is a fundamental cause for the mortality risk compared to other groups (Mackenbach 2019). Contrariwise, higher expenditure for health care reduces mortality across European countries. Thereby the gap in mortality rates between different education cohorts becomes smaller the more a country spends on (public) health care plans (Mackenbach et al. 2017, 1116).

In a recently published book, Julia Lynch assesses the question why health inequalities persist in different welfare states. Therefore, she conducted a comparative analysis of the politics of health inequalities in Finland, France and the UK. Lynch argues that despite their differences in terms of the welfare state, in none of these countries have decisionmakers acted to fundamentally address the causes of health inequalities. Rather than using more traditional options of statecraft, such as taxation, redistribution and labour market regulation, decisionmakers medicalised health inequalities, i.e., government policy documents essentially frame action against health inequalities through the professional lens of primary care and health promotion. Such a policy frame avoids addressing some of the more substantial causes, which would entail pushing back against neoliberal ideas of a small state with a limited redistribution capacity (Lynch 2017, 2020).

These persistent inequalities in health outcomes are mirrored by equally persisting inequalities in access to health care. It is well known that in the United States access to health care differs between poor and rich parts of the population. Poorer groups, amongst them often African Americans, remain in many cases excluded from health care services, even after the federal government extended coverage in the wake of the Affordable Care Act (Dickman, Himmelstein, and Woolhandler 2017). In Europe, there are considerable differences between countries regarding access to health care services. A recent report that compares expert reports from 35 countries points to the following key findings: (1) There are large differences between countries in Europe concerning how much they spend for health care services. (2) Countries with underfunded health care systems also have a bad performance regarding equality in access to health care. (3) In some countries, a substantive part of the population (up to 20 percent) has no public health care coverage. (4) High and increasing out-of-pocket payments are a cause for concern in many countries. (5) Inequalities in access are not linked to the model of the health care system. (6) Shortage of health care personnel is a problem in many European countries. (7) Waiting lists for treatments are a major problem in many European countries. (8) Experts warn that voluntary and occupa-

tional health insurance might increase inequalities in access to health care. (9) Disadvantaged groups, such as those with lower income as well as ethnic minorities, often face inequalities regarding access to healthcare (Baeten et al. 2018).

11.5 Conclusion

This chapter has analysed health policy in advanced democracies by taking a broad and comparative perspective. In a first step, the chapter has distinguished different realms of health policy by pointing out that health policy entails measures aiming at healing sick individuals but also policies to prevent diseases at the population level. In a second step, the chapter has demonstrated how researchers have distinguished different health systems, how health systems have evolved, and how they are linked to policy outputs. Specifically, the second section shows that researchers have conceived comparative analyses of health systems by either taking a deductive or an inductive approach, with quite different results. Then the second section also discusses how different health systems have evolved and how health expenditure has developed in different countries. Eventually, the second section of the chapter has pointed out how countries differ in their ability to respond to a pandemic. The third section of the chapter has drawn attention to health inequalities as well inequalities in access to health care. The chapter holds that researchers have found health inequalities to be persisting across countries and different institutions of health governance. Furthermore, the chapter has demonstrated that recent scholarship found that different governments have not addressed the fundamental causes of health inequalities as well as access to inequalities in health care.

Overall, this chapter introduces different themes in health policy. Furthermore, the text offers readers information on important frontiers for research in health policy. Notably, these are questions related to the evolution of the private share in health expenditure as well as the persistence of health inequalities in different developed democracies.

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