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RESEARCH HANDBOOK ON
Health Care Policy

Edited by
Martin Powell • Tuba I. Agartan • Daniel Béland

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RESEARCH HANDBOOK ON HEALTH CARE POLICY

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1. Introduction: ideas, interests and institutions in health care policy

Martin Powell, Tuba I. Agartan and Daniel Béland

The overarching aim of this *Research Handbook on Health Care Policy* stems from the idea that students of health care need to take policy more seriously. It should be noted that the focus is on the narrower 'health care policy' rather than wider 'health policy' as it could be argued that *all* policy (such as unemployment, poverty, housing, education, pollution, climate change) affects health, as suggested by the term 'Health in all policies' (HiAP). According to the WHO (2014: 2), 'Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity … It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.'

The idea of taking policy more seriously translates into two main points. First, analysts of health care policy need to draw on conceptual models of the policy process. There are a large number of possible approaches (see below) but we focus on the 'stages model' and the '3Is' model of ideas, interests and institutions. As we show below, this brings us closer to the scholarship on the policy process compared to many texts on health care policy. Second, we apply these concepts to a wider range of countries than are often considered. Until recently, most of the analytical tools, such as theoretical frameworks and typologies, used in the broader public policy literature have remained focused on national dynamics and policy interactions within the global North, comprising of higher income countries. Health care policy questions in the global South, however, were seen in the context of an international development paradigm, with greater interest in transnational policy processes and the role of international actors. This Handbook contributes to the growing literature that aims to bridge these divides.

Moran (2000: 135–136) noted that the literature on health care policy was often semi-detached from the wider literature on the welfare state, being immersed instead in its own specialist controversies; conversely, writings on the welfare state often seemed to marginalize health care policy, and that the purpose of his article was to redress this semi-detached condition. We believe this is still the case and we note two more detachments. First, the literature between health care policy and public policy tends to be semi-detached. Much public policy literature does not say much about health care policy, while some health care policy studies tend to draw on health care approaches rather than wider public policy approaches (Powell and Mannion, 2023). There are two possible routes to close this gap. The first is that studies of health care policy should draw on approaches from the mainstream public policy literature such as the 3Is model. The second is based on the idea that health care is distinctive, and requires its own approaches. As we suggest below (see also Powell and Mannion, 2023), while health care policy texts tend to feature the 3Is model, many articles on the health care policy process tend to be based on the 'health policy triangle' (Walt and Gilson, 1994; see also Buse et al., 2023). Moreover, it might be argued that some features of health care tend to be different from other sectors of public policy, and so require increased focus on issues such as professional power (e.g., 'Actors' in the health policy triangle, or medical interest groups or 'structural interest groups' in 'interests').

Scholars have responded in different ways to the question of whether studies of health care policy should be based on 'home grown' approaches developed within health care or developed in mainstream studies of public policy. Parkhurst (2023) argues for deeper engagement with the broader public policy scholarship, as making an argument for 'home grown' efforts requires constructing a difficult case for health policy exceptionalism that appears unjustified. He continues that while some political features of the health sector which appear fairly specific may exist, such as the importance of clinicians' epistemic power, or the oligopolistic influence of pharmaceutical companies, it is difficult to argue that health policy-making is inherently different from other social policy sectors. Similarly, Peckham (2023) writes that health policy analysts should draw more on general policy theory. While it is possible to identify specific elements about health in terms of medical care, different actors and the roles of different actors; similar arguments may also be made about other complex areas of public policy such as education or planning. However, he argues that a more useful approach would be to combine such approaches within governance and systems analyses that provide useful frames for employing robust public policy theory models that are situated within a health context. Finally, Sheaff (2023) considers that the answer to the question of whether we should analyse health policy processes in the same way as other policy processes (a 'One Size Fits All' approach) or use more health-specific explanatory models: 'Horses for Courses' is 'Both, of course.' He supports a bricolage (patch-work assembly) to combine models, bringing in actors, 'content,' processes and more. In particular, he suggests that a stages model, as an empirical (not normative) model of the policy process, offers a framework for combining the models. He concludes that at a high level of generality 'one size fits all' policy processes include health. However, that general model then has to be qualified (not replaced) with additional explanations of how and why policy processes in a particular polity are distinct special cases of that general model; and then how and why the health policy process is a still more special case within that: a 'horses for courses' approach. This *Handbook* is based on the first route suggested by Powell and Mannion (2023) that studies of health care policy should draw on approaches from the mainstream public policy literature such as the 3Is model.

The second detachment involves the literature on global health, which does not systematically engage with the broader public policy scholarship. Many of these studies prioritize technical and administrative aspects of health systems over political and social dimensions (Ho et al., 2022; Lee, 2015), thus overlooking the contribution of the policy perspective. These studies have been criticized for their weak theoretical foundations (Gore and Parker, 2019) as well as their inability to develop these foundations that could explain health issues in different contexts (Kleinman, 2010). Some efforts to address this detachment are centred within the field of Health Policy and Systems Research (HPSR) that 'explicitly identifies the interconnections between policy and systems and highlights the social and political nature of the field' (Sheikh et al., 2011: 1). Just like most global health scholarship, earlier studies have focused on low- and middle-income countries (LMICs) and used some of the key frameworks of the public policy scholarship to analyse 'underlying power structures, interests and interdependencies' to balance the emphasis on 'hardware of health systems' (Sheikh et al., 2011: 4).

Considered together, these detachments help us make sense of another divide between the global North and global South, especially in the country case studies. While the earlier work on health systems in the advanced industrial countries (which are included in the category of global North) engaged in the welfare state debates and shared its emphasis on national policy dynamics, case studies focusing on low- and middle-income countries in the global South remained analytically separate with greater acknowledgement of global policy dynamics.

The remainder of this chapter consists of four sections. First, we review the main public policy and health care policy texts to illustrate the wide variety of existing approaches. While most of both the public policy and health policy texts cover some material on ‘policy stages’ and thematic material such as the 3Is of ideas, institutions and interests, many health care policy articles draw on the ‘health policy triangle’ (see Powell and Manion, 2023). We follow the texts in setting out our main conceptual bases in terms of policy stages and the 3Is. Second, we explore the health and policy nexus through a discussion of policy stages and the 3Is. Third, we stress the importance of turning to transnational actors and processes in the study of health care policy in both the global North and the global South. Finally, we provide a brief overview of the *Handbook* and its structure.

LEARNING FROM EXISTING TEXTS

There are many excellent texts on public policy, which have been well cited and/or appeared in multiple editions. They tend to show a wide variety of approaches, suggesting that there is no widely agreed route to introducing public policy.

Some are largely based on the ‘policy stages’ or the ‘policy cycle’ approach. There is a great deal of variation in the number and terminology of the stages. For example, Hogwood and Gunn (1984, 3334 Google Scholar citations) contains: analysing public policy; the policy orientation; models of policy making; while their section on ‘analysis in the policy process’ broadly follows a version of the stages model, with issue search; issue filtration; issue definition; forecasting; objectives and priorities; options analysis; implementation; evaluation; policy succession and policy termination. Howlett et al. (2009, 6227 GS): theoretical approaches; the policy context; the five stages of the policy cycle – agenda-setting; policy formulation: policy instruments and policy design; decision-making; implementation; evaluation; and patterns of policy change. Knill and Tosun (2012, 695 GS): the nature of public policies; the context for policy-making; central institutions and actors; theoretical approaches to policy-making; problem definition and agenda-setting; decision-making; implementation; evaluation; governance; public policies beyond the nation state; policy change and policy convergence.

The classic text on theories of the policy process is Sabatier (1999, later Weible 2023, 2014 edn, 4924 GS). This examines some theories that include those associated with stages or their equivalent, but also models such as innovation and diffusion models. Some texts examine both stages and themes. For example, John (1998, 1276 GS, 2nd) explores the study of public policy; stages; institutions; groups and networks; exogeneous determinants; rational actors; ideas; a synthesis. Cairney (2020, 1242 GS, 2nd) discusses theories and issues; what is policy and policy making?; power and public policy; institutions; rationality and incrementalism; structural explanations; rational choice theory; multi-level governance and multi-centric policy making; punctuated equilibrium; the advocacy coalition ideas; ideas and multiple streams analysis; policy learning and transfer. Parsons (1995, 3850 GS) covers a great deal of ground in a text of four parts and over 400 pages. Some of the most cited and multiple editions are US texts. For example, it is claimed that Dunn (2015, 6th edn) is 'the most widely cited book on the subject' (5828 GS). Birkland (2019, 4th edn, 3092 GS) explores the policy process through theories, concepts and models of the public policy making. Dye (2013, 14th edn, 8693) focuses on the 'policy challenges confronting the Obama administration' including 'a close up look at the American healthcare system'.

Some comparative public policy texts include material on health care. For example, Dodds (2018, 2nd, 146 GS) 'combines coverage of public policies in different countries with the conceptual and methodological frameworks for analysing them'. She discusses policy instruments, ideas, institutions and interests, with a chapter on health policy. Heidenheimer et al. (1990, 1335 GS) discuss health within 'the politics of social choice in America, Europe, and Japan'.

There are also some excellent texts on health care policy. Walt (1994, 1274 GS) provides 'an introduction to process and power'. Alaszewski and Brown (2011, 72 GS) presents two parts: 'rationality in policy making' and 'the limits to rationality', and focuses mainly on the nature of health policy making in the UK. Baggott (2015, 99 GS 2nd) discusses processes and institutions that make health policy such as government, party politics, the media, and policy networks. Although it explores the role of regional and international institutions, it is mainly focused on the UK.

The most recent text in this group is the third edition of Buse et al. (2023, 2012, 1284 GS)'s *Making Health Policy* which builds on Walt (1994). It is a comprehensive introduction to the study of health policy, its political nature and its processes. In contrast to many other health policy texts, it takes one of its starting points as the 'policy triangle' which has content, context, and process at the apexes of the triangle with actors placed at the centre (Walt and Gilson, 1994). Buse et al. (2023) state that the chapters are organised partly according to the broad contours of the health policy 'triangle' and partly according to the device of breaking the policy process into 'stages'. However, they are linked in the sense that the most common approach to understanding policy processes draws on the 'stages model' and explores agenda setting, implementation and evaluation. The third edition includes chapters on globalising health policy and on the relationships among national, regional and global health policy making. This edition also incorporates additional theoretical perspectives and empirical studies from researchers who originate from, and work outside of, North America and Europe.

There are some texts on comparative health policy. For example, Leichter (1979, 406 GS) examines four countries. Blank et al. (2017, 629 GS, 5th) presents material on the provision, funding and governance of health care across a variety of systems, with additional material on low/middle income countries. Finally, there are also a number of articles that explore health care policy in 'developing countries' (e.g., Walt and Gilson, 1994, 1679 GS) and, later, LMIC (e.g., Gilson and Raphaely, 2008, 498 GS; see below).

We have now briefly outlined the range of approaches taken by both public policy and health care policy scholars. First, it can be seen that there is a large variety of approaches, with little consensus or agreed approach. As John (1998) put it, researchers use a bewildering array of labels to try to explain and understand policy-making, and there is little agreement on what constitutes a 'model of the policy process'. However, many of the policy texts include at least some material relating to stages (e.g., Hogwood and Gunn, 1984; Howlett et al. 2009; John, 2012; Knill and Tosun, 2012; Parsons, 1995) and at least some of the '3Is' of interests, institutions and ideas (e.g., Cairney, 2012; John, 2012; Knill and Tosun, 2012; Parsons, 1995). It can be argued that there seems to be some differences between texts and articles on health care policy. As noted above, health care policy texts tend to draw on a mixture of stagist and thematic approaches, with the dominant theme being the 3I approach (but, see Buse et al., 2023). However, the most commonly used overarching framework in health care policy articles is the 'Health policy triangle' (Gilson and Raphaely, 2008; Powell and Mannion, 2023). We follow the public policy texts and health care policy texts, rather than the health care policy articles, in a broad approach that draws on stages and on the 3Is of interests, institutions and ideas. This makes studies of health care policy less detached from the mainstream public policy texts. The next section discusses our main conceptual bases of the stages approach and the 3Is model in more detail.

EXPLORING THE HEALTH AND POLICY NEXUS: STAGES AND THE 3IS

The stagist framework, the 'policy cycle', or the 'stages heuristic' appears to be a 'zombie' approach in that while many scholars have tried to banish it, it always seems to return. A defence by Peter de Leon in the first edition of Sabatier's (1999) classic text of models of the policy process seemed to be its last stand, as it was banished from the second edition (Sabatier, 2007). De Leon's defence was perhaps not over-spirited as he claimed that we 'need to make sure, first, that it really does warrant a place in the dustbin of abandoned paradigms' (in Sabatier, 1999: 29).

As Sabatier (2007: 6–7) explains, the most influential framework for understanding the policy process until the mid-1980s, particularly among American scholars, was the 'stages heuristic'. 'Beginning in the late 1980s, however, the stages heuristic was subjected to some devastating criticisms'. He continues that: 'The conclusion seems inescapable: The stages heuristic has outlived its usefulness and needs to be replaced with better theoretical frameworks'. Sabatier was clearly unsure that the 'stages heuristic' should have been included in the first edition of his text, but 'I have spent so much time criticizing the stages heuristic that simple fairness required me to provide a forum for its defence'. Peter deLeon, one of the earliest proponents of the heuristic, volunteered to be the spokesperson (deLeon 1999: 8). Some scholars tend to agree in largely rejecting the model. For example, John (1998: 18) argues that 'researchers should explore more wide-ranging approaches or theories as substitutes for, rather than additions to, stages models'. He later states that the 'stages idea confuses more than it illuminates', but concedes that 'the stages model can still be used as a heuristic device. Analysts should be wary of rejecting it entirely' (p. 28).

However, while many scholars point to many criticisms, they are less clear on what should replace it, and tend to focus on individual stages, even if they have concerns over the model as a whole. For example, Parsons (1995: 80) discusses criticisms of policy cycle, and then declares that 'to imagine that public policy can be reduced to such over-simplified stages has more methodological holes than a sack-load of Swiss cheese', but the stagist framework is not without its advantages, should not be abandoned lightly and the book adheres to the stagist approach (p. 80). Hogwood and Gunn (1984: 4) state that 'like many other analysts, we find it useful to analyse the policy process in terms of a number of stages through which an issue may pass'. Cairney (2012: 32) states that 'the policy cycle is the best known way to organize the study of policy making' (and the best way to introduce a discussion of policy theories). He continues that 'while the use of the cycle as a framework for policy studies has diminished, many of the terms used to describe its stages are integral to tie discipline – and this book – because they command their own literature' (p. 33). Howlett et al. (2009) are clear that while the model has both advantages and disadvantages it is 'one of the most popular means of simplifying public-policy making for analytical purposes' (p. 10) and that it 'will be used throughout the book and forms the basis for separate chapters on each stage' (p. 12). According to Knill and Tosun (2012), the policy cycle is the 'most common approach' (p. 9). While 'it is not surprising that the idea of a cyclical model based on a sequence of policy stages has been criticized' it is 'employed as a standard approach' but their book departs from the classical cycle approach by not assuming a sequential model of the policy process and they 'consider it more useful to conceive of the different stages as potential analytical lenses on the policy-making process' (pp. 9–10). For the health care policy texts, Baggott (2015) briefly discusses the 'stagist' model, but argues that while it is a 'useful' way of thinking about policy, it over-simplifies the policy process. Buse et al. (2023) present 'frameworks for health policy analysis' (Chapter 1) focusing mainly on the health policy triangle, with the 'stagist' model discussed under 'process' which is regarded as a 'useful but simple' framework (p. 15).

The phrase 'ideas, interests, and institutions' is widely used in health care research but also in political and policy analysis more generally. In contrast to the 'health policy triangle', the '3Is' do not necessarily point to a specific theoretical framework. Instead, it points to three broad aspects of the economic, social, and political world that scholars can pay attention to in their research about public policy. In this context, the 3Is are a way to map factors that might shape the policy process and that researchers should pay attention to. Some of the texts discussed above feature one or more of the 3Is. Parsons (1995) discusses 'institutional approaches' (section 3.6; and see bureaucracy/organizations) ideas (pp. 168–75), and 'interest groups' at a number of points. John (1998) includes chapters on 'institutions' and 'ideas'. Knill and Tosun (2012) discuss 'institution-based models' and 'interest-based models'. Cairney (2012) has chapters on 'institutions and new institutionalism' and 'the role of ideas'. The health care policy texts seem to have less focus on the 3Is. Alaszewski and Brown (2012) discuss 'interests' at a number of points. Baggott (2015) briefly covers institutions and interest or pressure groups. Buse et al. (2023) cover institutions within a chapter on 'government and the state' (Chapter 3) and focus on 'interest groups' (Chapter 4) with respect to 'actors' within the 'policy triangle' model.

Still, what do we mean by each of these '3Is'? One way to define them is to turn to the work of Craig Parsons (2017) on *How to Map Arguments in Political Science*, which is helpful far beyond that discipline, including for health care research. In his book, he distinguishes between four types of explanations: structural, institutional, ideational, and psychological factors. This typology is discussed in detail in the Agartan and Béland contribution to the present *Handbook*, so, in this Introduction it is suffice to say that ideational factors (the 'ideas' in the 3Is) belong to a logic of interpretation according to which we can account for specific behaviour and decisions by looking at how actors see the world and their position within it. Within the logic of position, Parsons (2007) distinguishes ideas from hard-wired psychological processes but this dichotomy is perhaps less central to health care research, as psychological explanations are not prevalent in that literature. Still, understanding that the 'ideas' in the 3Is are historically constructed rather than the product of hardwired processes is an important point, in general and for health care scholars.

If, for Parsons (2007), 'ideas' are synonymous with ideational factors, institutional factors point to how institutions as historically constructed and embedded rules and forms can shape the behaviour of political actors (see also Béland, 2019; Campbell, 2004). For Parsons (2007), like structural (material) factors, institutions belong to a logic-of-position according to which it is the location of actors within social and political order that account for their behaviour rather than the ways in which they understand and give meaning to their surroundings (logic-of-interpretation). The advantage of Parsons's approach is that it allows scholars to draw a strict analytical line between 'ideas' and 'institutions', which help us disentangle these two types of explanation in a rigorous manner, both theoretically and empirically (Parsons, 2007).

Interestingly, Parsons (2007) rejects the concept of 'interest' because he finds it too ambiguous, he sees it as located in an ambiguous zone between the logic-of-interpretation (actors have subjective and intersubjective preferences) and the logic-of-position (actors are nudged by the institutional and structural forces surrounding them). Yet, for scholars who see interests as objective realities belonging to the logic-of-position, these interests are simply structural (material) explanations. When moving away from this materialist conception of interests, however, this concept becomes fuzzier and more closely linked to ideas and/or institutions (Béland, 2019). For instance, if interests are described simply as subjective preferences, they are simply ideas (Hay, 2011), which means that they belong squarely to the logic-of-interpretation. Conversely, interests can be seen as shaped by existing political and policy institutions (Skocpol, 1992), which is about the logic-of-position but not necessarily structural (material) factors. In the end, regardless of what one thinks of the added value of the typology Parsons (2007) put forward, what matters is that scholars who use the phrase 'ideas, interests and institutions' define clearly what each of these three terms means, and how they might relate to one another, both analytically and in the real world.

When we talk about ideas, interests and institutions, another key point that emerges from the literature is that scholars should break down these broad categories to study their more concrete expressions, which are extremely diverse internally (Béland and Waddan, 2015). For instance, interests might differ depending on whether we study individual actors or collective actors, or whether we are interested in economic interests or political interests. Health scholars could also distinguish between the subjective (interpretation) and objective (position) sides of interests.

At the same time, it is clear from the literature that there are many types of ideas and of institutions. For instance, ideas can take the form of policy programmes, framing processes, policy paradigms and public sentiments (Campbell, 2004). These four types of ideas do not even give us the full picture of ideational processes, as they do not include important things like problem definitions (Mehta, 2011) and political ideologies (Béland, 2009).

As for institutions and institutional processes, they can take the form of veto points and policy legacies, among many others. Using the contrast between veto points and policy legacies as they appear in the health care literature is particularly helpful to illustrate the internal diversity of 'institutions' (and each of the 3Is) more generally.

The concept of veto points refers to how concrete institutional configurations can empower certain policy actors by giving the possibility of blocking the enactment of reform proposals they oppose (Bonoli, 2001; Immergut, 1992; Kay, 1999). In the field of health care research, for example, Ellen Immergut (1992) explains how political institution physicians in one country may have more veto power than their counterparts in other jurisdictions because the institutional configuration of their polity gives them a veto point within the health care policy reform process (Immergut, 1992).

As for policy legacies and the related concept of policy feedback, which is about how policies shape politics over time (Béland, Campbell and Weaver, 2022; Pierson, 1993), they point to how existing health care policies can become strongly embedded over time in ways that might create obstacles and/or opportunities to reform the policies already in place. These feedback effects from existing policy legacies can be self-reinforcing, in the sense that they can make transformative reform less likely over time, a situation that leads to the path dependent reproduction of existing health care systems (Hacker, 1998; 2002). Yet, self-undermining policy feedback is also a possibility, when policies become weaker and more vulnerable over time because of the ways in which their initial policy design interacts with changing economic, social, and political circumstances (Jacobs and Weaver, 2015).

Veto points and policy legacies are two different types of institutional process that illustrate the internal diversity of 'institutions' and their effects. This is the case partly because veto points refer mainly to formal political institutions while policy legacies are about policies as embedded institutional rules and norms (Immergut, 1992; Pierson, 1993). This distinction between political institutions and public policies has long been central to institutionalist scholarship about health care and social policy (Skocpol, 1992).

Another aspect of the contrast between veto points and policy legacies is that, as Alan Jacobs (Jacobs, 2016: 341) suggests, the former points to the synchronic (short-term) effects of institutions as the 'rules of the game' while the latter points to their diachronic (long-term) effects, which take place over long periods of time. Beyond institutions, the distinction between synchronic and diachronic effects is helpful to map how the 3Is are used in the health care literature which features and sometimes combines both perspectives, for example, when scholars study both veto points and policy legacies as part of the same study (Béland, 2010).

LOOKING BEYOND THE DIVIDES AND NATIONAL POLICY FRAMEWORKS

Despite greater acknowledgement of the transnational factors on the policy process, there is still a clear divide between the literatures that focus on health systems in the global North and global South. As reviewed in the previous sections, the broader welfare state literature, developed in the context of 'advanced industrialized countries' or the countries in the 'global North', often prioritizes national policy dynamics, ignoring the possibility of influence from international organizations (IOs), even under the dire conditions of the COVID-19 pandemic. Comparative studies that examine the policy developments in various countries expand this narrow focus to some extent, especially in cases where they analyse cross-border learning (see, for example, Orenstein, 2008; Weyland, 2004). Another important exception is the scholarship that explores the implications of regional integration projects (such as the European Union), and analyses of International Labour Organization (ILO)'s role in the evolution of social security systems (Gorsky and Sirrs, 2020; Kott and Droux, 2013). When extended to the global South, this literature has engaged in a sophisticated analysis of the interplay between the global and national policy dynamics with a close attention to global actors and cross-border movement of policy ideas (Adesina, 2011; Deacon et al., 2008; Huber and Stephens, 2012; Noy, 2018). However, scholars interested in developments outside the 'advanced capitalist countries' often complain about the limited nature of the conceptual tools of the traditional welfare states when applied to global South contexts (Schmitt, 2020: 3).

Since the 1990s, determined to go beyond the limits of methodological nationalism (Campbell, 2004; Deacon et al., 2010; Orenstein, 2008; Stone, 2008), a growing number of scholars with diverse disciplinary backgrounds have explored cross-cutting institutions, actors and mechanisms of a global social system that interact with regional and national policies in diverse ways (see Yeates and Surender (2021) for a recent analysis in the health field). With its emphasis on the role of international organizations as policy actors as well as the interaction among policy scales (Stubbs and Kaasch, 2014) – transnational, regional, national and local – this scholarship has important contributions to bridge the North–South divide in social policy.

Some of the reasons for Moran's description of semi-detached status of health care policy research in relation to welfare state and broader public policy research are beyond the dynamics of the welfare state literature: they pertain to the development of different fields of inquiry on health systems, building on diverse disciplinary backgrounds. For the majority of the 20th century, the evolution of health systems in the global South was seen in the context of an international development paradigm, and hence was envisioned almost entirely separately than the Northern path. The field of international health (later renamed global health) developed in universities, research centres and philanthropic foundations in the United States and Western Europe during the 20th century, using principles of public health and administration, to understand and solve health problems (including infectious diseases, sanitation, malnutrition, child and maternal health) in low- and middle-income countries (Merson, Black and Mills, 2006; Packard, 2016). While providing clear evidence of the mechanisms and processes of change in health systems, global health scholarship has been criticised for the predominance of 'biomedical approaches in public health' (Lee, 2015; Shiffman, 2014) which partly explains the tendency to overlook the distribution of power (Gilson and Raphaely, 2008) and other dynamics of the policy process, such as the role of ideas and normative premises that shape global health efforts in important ways (Ooms, 2014).

Recent debates on decolonizing global health have taken these criticisms further, highlighting the legacy of former colonial relationships on current research and funding practices (Erondu et al., 2021), medical education and global health curricula (Atuire and Bull, 2022; Eichbaum et al., 2021), development of metrics and collaborations among organizations and researchers from the global North and global South. These deep-seated legacies perpetuate power imbalances across geopolitical divides and shape relationships within countries and organisztions based in low- and middle-income countries (Khan et al., 2021). Disparate experiences of populations across the world with the COVID-19 pandemic and practices of high-income countries that prioritized their own populations and undermined the multilateral health initiatives, have further exposed the systemic inequalities (Atuire and Bull, 2022).

There is now a significant body of interdisciplinary work that critically analyses the political context, including ideas, interests and institutions, and systematically embeds the policy analysis in global health literature (some examples include Buse et al., 2023; Gilson et al., 2018; McInnes et al., 2019; Shawar and Shiffman, 2017; Walt and Gilson, 1994). Health Policy and Systems Research (HPSR) aims to systematize this interdisciplinary literature in its endeavour to overcome the secondary status of policy analysis in relation to primary scientific-technical approaches within global health (Bennett et al., 2011; Sheikh et al., 2011). This *Handbook* aims to contribute to these efforts to bridge the divides among literatures with its sections on the policy process, key health system functions and developments in selected countries.

Despite this critical body of work and recent debates on decolonizing global health, many policymakers – and some academics – in the global North still believe that its core mission does not involve their own countries; nor is the advice of international organizations, such as the WHO, appropriate for their own concerns. So, the divide remains for now, as demonstrated by the COVID-19 pandemic.

ORGANIZATION OF THE *HANDBOOK*

The structure of the remainder of this *Handbook* is as follows. First, there are a series of chapters focusing on stages of the policy process: agenda-setting, policy formulation, policy implementation, and policy evaluation. This is followed by chapters exploring the 3Is: ideas, interests, and institutions. The following chapters examine key topics such as providing, financing and regulating health care, delivery, governance, health and health care inequalities, long-term care and responses to COVID-19. The focus then moves to the transnational policy scale with chapters on global health policy and international organizations, and on international comparisons. The remaining chapters explore health care policy in a variety of countries from the global North and the global South. Regarding the global North, we selected countries that are widely studied and illustrative of the diversity of health care systems in advanced industrial countries: Japan, Australia, Canada, the United States, the United Kingdom, France, Germany, and Sweden. Concerning the global South, we decided to include the five BRICS countries: Brazil, Russia, India, China, and South Africa, which are particularly large and well-researched. To the list of cases, we added Turkey because this case illustrates very well the contemporary global push for Universal Health Coverage (UHC). In addition to the description of the key features of these health care systems in terms of financing, provision and regulation of services, the country chapters examine how ideas, interests, and institutions are historically constructed and relate to one another in their specific contexts. For instance, the Japanese financing model is built on the unstated norm that patients were expected to pay according to their ability (Chapter 17) whereas in Turkey the use of universal health coverage as a guiding principle implies limiting out-of-pocket costs, at least in theory (Chapter 26).

In terms of institutions, we notice diverse expressions across countries as Béland and Waddan (2015) point out: institutional legacies such as archaic and complex governance structures in China's hospital sector limit public reform (Chapter 18) while the disparities in health outcomes and social indicators in India can only be understood if we study the implications of the federal system, increasing privatization and co-existence of multiple systems of medicine (Chapter 19). The conceptualization of interests similarly ranges from collective actors to economic and political interests. As Chapter 23 demonstrates, the success of coordination efforts in Brazil depends on harmonizing financial incentives and managing diverse interests of politicians, managers and providers. Russia seems to experience a familiar trend with the rise of patient-consumers, but particular features of the system such as deep mistrust towards the state and health care providers shape their behaviours. Chapter 25 traces the development of complex trends where patients use not only their money, but also their cultural and social capital to successfully navigate the health system. Hence, the perception of their interests simultaneously shapes and are shaped by the marketization trends in the Russian health care system.

Overall, this *Handbook* shows that scholars and practitioners interested in health care should take policy very seriously. The study of health care *policy* leads to a broader engagement with public policy research in comparative perspective, a core reality illustrated in the above chapters.

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2. Agenda-setting in health care policy

Martin Powell

INTRODUCTION

Agenda-setting is generally regarded as the first stage of the policy process in the accounts based on the ‘stages model’ or the ‘policy cycle’ (e.g., Howlett et al., 2009; Knill and Tosun, 2020). Although a number of studies covered how issues reached the agenda, the term ‘agenda’ did not appear in the policy sciences literature until the 1970s (below). Moreover, the study of agendas has been divided into three main approaches with limited communication between them: media agenda-setting, public agenda-setting, and policy agenda-setting. The media agenda is generally examined by a content analysis of the news media. The public agenda tends to be explored through public opinion surveys. The policy agenda is measured by policy actions such as the introduction of Parliamentary Debates, laws, and budgets (Dearing and Rogers, 1996; Soroka, 2002).

We focus on the policy agenda, which is more difficult to measure than the public or media agendas. Moreover, unlike opinion polls or content analysis of news media, which is more ‘universal’, much empirical agenda-setting work is based on the US system, and examples do not always travel easily into other political systems (Soroka, 2002).

As noted above, the term ‘agenda’ did not appear in policy sciences literature until an article, and then a book, by Cobb and Elder (1971, 1972) focused on the ‘politics of agenda-building’. Zahariadis (2016) claims that Cobb and Elder (1971) ‘single-handedly [created] a new field of the study of pre-decision processes’. Similarly, Jones (2016) noted the term ‘agenda-setting’ or ‘agenda-building’ was not used by previous scholars, and that Cobb and Elder’s (1972) tour de force was the first systematic scholarly assessment of the pre-decisional components of the policy process.

Agenda-setting is generally regarded as the first stage of the policy process in the accounts based on the ‘stages model’ or the ‘policy cycle’. However, as we shall see, there is little agreement on content or approach, with different terms used and discussed together with, or separately from, issues such as ‘problem definition’ and ‘framing’. We will first explore this in general public policy texts. For example, Hogwood and Gunn (1984) do not provide a chapter on agenda setting, but on ‘issue search’, ‘issue filtration’ and ‘issue definition’. They discuss ‘deciding to decide’ (issue search or agenda setting) and ‘deciding how to decide’ (issue filtration). Howlett et al. (2009: Chapter 4) regard agenda-setting as ‘the first and perhaps the most critical stage of the policy cycle’ (p. 92). They discuss policy problems, moving from ‘the objective construction of policy problems: the role of social conditions and structures’ to ‘the subjective construction of policy problems: the role of policy actors and paradigms’. They then consider ‘combining ideas, actors and structures in multi-variable models of agenda-setting’, including the issue-attention cycle (Downs, 1972), modes of agenda-setting (Cobb and Elder, 1972; Cobb et al., 1976), and ‘linking agenda-setting modes to content: policy windows and policy monopolies’ (e.g., Kingdon, 2011). Knill and Tosun (2020) discuss problem definition and agenda-setting (Chapter 5), noting that although they are closely related, they are discussed separately for analytical purposes. They regard problem definition as ‘the path to agenda-setting’, and point out that problems need to be ‘framed’. They discuss different types of agenda-setting models: the process perspective (e.g., Cobb et al., 1976); the power distribution perspective (e.g., Schattschneider, 1960); the institution-based perspective (e.g., Baumgarther and Jones, 2009); and the contingency perspective (e.g., Kingdon, 2011). They focus on actors and interests in the agenda-setting process (elected public officials and judges; bureaucracy; mass media; interest groups; and international organizations). Weible and Sabatier (2018) do not have a chapter on agenda-setting, but on Kingdon’s MSF, as well as other chapters on Advocacy Coalition Framework (ACF) and Punctuated Equilibrium Theory (PET).

Turning to texts on health policy, there are references to ‘agenda’ scattered throughout the text of Baggott (2015). There is no reference to Kingdon (2011), but only passing references to Cobb and Elder (1972) and Downs (1972). There is a chapter on government influence over the media; pressure groups and corporate interests. Agendas are not in the index of Alaszewski and Brown (2012), but there is a brief discussion of Kingdon (2011) in identifying policy problems. The most comprehensive treatment may be found in Buse et al. (2012: Chapter 4). They point out that there are a number of theoretical models of agenda setting, with two of the most prominent being Hall et al. (1975) and Kingdon (2011). They apply these two models to a case study. They also explore ‘non-decision making’ and ask who sets the agenda, examining the Government and the mass media as agenda-setters. In short, health policy texts do not appear to cover agenda-setting in much detail.

This chapter explores agenda-setting in health care. As we have seen, there is a significant variety in terms of content and approaches. It focuses on agenda-setting rather than problem definition or framing (but see Koon et al., 2016; Shpaizman, 2020). It does not consider approaches such as the Advocacy Coalition Framework (ACF) since this is focused more on policy change and the wider policy process rather than agenda-setting per se (see e.g., Cairney and Heikkila, 2018; Weible and Sabatier, 2018). It examines the main agenda-setting models in roughly chronological order, together with related studies in health care, before aiming to draw the threads together to sum up the ‘state of the art’.

AGENDA-SETTING MODELS

This section examines the main agenda-setting models, introduced in broadly chronological order, with examples of health care applications.

The Politics of Agenda-building (Cobb and Elder, 1971, 1972)

In an article and then in a book, Cobb and Elder (1971, 1972) focused on the ‘politics of agenda-building’. They noted that ‘in its most elementary form, we are raising the basic question of where public-policy issues come from’, such as how is an agenda built, and who participates in building it? (p. 905). However, they pointed out that there are different meanings of the term ‘agenda’. The ‘institutional agenda’ is a set of concrete items scheduled for active and serious consideration by a particular institutional decision-making body (e.g., legislative calendars or the docket of a court). On the other hand, the systemic agenda will always be more abstract, more general, and broader in scope and domain than any given institutional agenda.

They argued that the relation between the two types of agendas was of 'primary concern', and that due to inertia, institutional agendas will always lag to some extent behind the more general systemic agenda.

They then discuss sources of bias in the institutional agenda. First, decision-makers tend to give priority to 'older items'. Second, there are the decision makers themselves. For an issue to attain agenda status, it must command the support of at least some key decision makers, for they are the ultimate guardians of the formal agenda.

They then turn to sources of bias in the systemic agenda. They point out that the problem confronted by any newly-formed or newly-mobilized group is often more that of legitimizing the group and the interest it represents than that of legitimizing a particular issue position. They then move to discussing cultural constraints, giving the example that federal aid to education was seen to be an inappropriate or illegimate area for federal action (c.f., Hall et al., 1975, below).

Cobb and Elder (1972) identified three steps in the agenda-building process: issue creation, issue expansion, and agenda entrance, and five characteristics that stood to impact the relative position of an issue on the legislative agenda: specificity; social significance; temporal relevance; complexity; and categorical precedence. They discussed the links between steps and characteristics. For example, there is a greater probability that an issue will be expanded to a larger population where definition is more ambiguous, social significance is greater, temporal relevance is extended, and any clear precedent is less available. They stressed the importance of a policy 'initiator' (c.f., the policy entrepreneur of Kingdon (2011)): 'a link must be made between a grievance … and an initiator who converts the problem into an issue' (p. 85).

Cobb et al. (1976) set out four phases in the life of an issue: initiation, specification, expansion, and entrance. Initiation is the articulation of a grievance in very general terms by a group outside the formal government structure. Specification involves general grievances being translated into specific demands in a variety of ways. Expansion notes that in order to be successful in getting on the formal agenda, outside groups need to create sufficient pressure or interest to attract the attention of decision makers. Entrance represents movement from the public agenda to the formal agenda, where serious consideration of the issue by decision makers can take place. They identify three different models of agenda building depending on variation in these phases (see Howlett et al., 2009: 101–103). The 'outside initiative model' accounts for the process through which issues arise in nongovernmental groups and are then expanded sufficiently to reach, first, the public agenda and, finally, the formal agenda. The 'mobilization model' considers issues which are initiated inside government and consequently achieve formal agenda status almost automatically. The 'inside initiative model' describes issues which arise within the governmental sphere and whose supporters do not try to expand them to the mass public. They claim that a more detailed discussion of these models in terms of the four phases will provide a framework for cross-cultural investigation of these important variations in the policy-making processes.

Although many studies still cite this work, it is largely due to the definitions of the 'institutional' and 'systematic' agenda, rather than the discussions of models, steps or phases, or issue characteristics. There do not appear to be many sources that apply these approaches to health care. However, Lockett (1984) draws on Cobb et al. (1976) to explore setting the Federal Agenda for Health Research in the case of the National Institute on Aging. She argued that the NIA corresponded to 'the outside initiative model', and discussed the process in terms of initiation (the push from the private sector); specification (demands for support of aging research); expansion (creating interest and pressures); and entrance onto the formal agenda.

The Issue-attention Cycle (Downs, 1972)

Downs (1972) drew attention to the cyclical nature of public attention to domestic issues in the United States. He divided the cycle into five stages:

1. The pre-problem state;
2. Alarmed discovery and euphoric enthusiasm;
3. Realizing the costs of significant progress;
4. Gradual decline of public interest; and
5. The post-problem state.

Downs (1972) argues that a systematic ‘issue-attention cycle’ influenced public attitudes and behaviour concerning most key domestic problems. The pre-problem stage was when some highly undesirable social condition existed, but had not captured much public attention, even though some interest groups or experts were aware of it. The public become aware of the problem in the ‘Alarmed discovery and euphoric enthusiasm’ stage, which brings calls for the government to ‘do something’. The third stage of ‘Realizing the cost of significant progress’ involves recognition of the costs and benefits attached to possible solutions. A ‘Gradual decline of intense public interest’ results when people realize how difficult and costly solutions might be. Finally, the ‘Post-problem stage’ arrives when attention moves to a new problem, but new institutions, programmes and policies have been created to address the problem.

Although the model focuses on ‘public’ or ‘issue’ attention, Gupta and Jenkins-Smith, (2015) argue that Downs, in a ‘most implicit set of propositions’, explored the complex relationship between media attention, public attention, and governmental attention. They discuss several articles that test the existence of attention cycles in three different, yet interconnected, realms of public attention, media attention, and government attention, concluding that it is clear that Downs’s model of the issue-attention cycle has fared positively. Moreover, the model illustrates a number of important issues. First, not all issues or conditions move onto the government agenda. It seems to stress ‘pluralism’ in the shape of public opinion over interest groups, as interest or expert groups may be aware of issues, but it seems to require public attention to move them onto the agenda. Furthermore, it seems to assume that calls for the government to ‘do something’ are broadly responded to. It considers the costs and benefits of possible solutions (cf. Kingdon’s policy stream, below).

Drawing on Downs (1972), Arendt and Scherr (2019) investigate the chronology of media attention, public attention, and actual vaccinations during a recent measles outbreak in Austria. They show that peaks in media attention and public interest were followed by a substantial increase in the number of vaccinations. They conclude that evidence indicated issue–attention–action cycles in the health domain. However, their main focus is on a time-series analysis to capture the interplay between media attention, public attention, and vaccinations, rather than focusing on the stages themselves.

The Ingredients Model (Hall et al., 1975)

Hall et al. (1975) set out their ‘ingredients model’, which suggested that issues reached the agenda when they were high in terms of legitimacy, feasibility and support. Legitimacy is regarded as when governments believe they should be concerned and in which they have a right or even obligation to intervene. Feasibility is related to the potential for implementing the policy. It is defined by prevailing technical and theoretical knowledge, resources, availability of skilled staff, administrative capability and existence of the necessary infrastructure of government. There may be technological, financial or workforce limitations that suggest that a particular policy may be impossible to implement, regardless of how legitimate it is seen to be. Finally, support refers to the elusive but important issue of public support for government, at least in relation to the issue in question.

The model suggests that issues tend to reach the agenda when they are ‘high’ on all three ingredients: high legitimacy (government is seen as having the right to intervene), high feasibility (there are sufficient resources, personnel, infrastructure) and high support (the most important interest groups are supportive – or, at least, not obstructive). It is a simple ‘additive’ model, which seems to assume equal weighting of elements. However, it is not clear if the three elements are fully independent, as it is difficult to see an issue that is supported, but not legitimate. Moreover, it is unclear whether ‘very high’ support might outweigh low feasibility.

Buse et al. (2012) apply the Hall model to the case of getting essential drugs onto the policy agenda after a military coup in Bangladesh in 1982. They argue that the policy had legitimacy because President Ershad’s government was new and new policies were both expected and allowed. It was feasible to introduce radical change because it could be done by passing an Ordinance from the President: it did not require a long parliamentary process. However, support was more difficult as there was considerable resistance from health professionals, from multinational pharmaceutical firms, and initially from national drug companies. They note that, as a dictator, Ershad was able to ignore initial opposition since he did not need parliamentary support for his policy to be enacted. Moreover, popular support for the policy grew, as it became clear that prices were lowered.

The Multiple Streams Framework (Kingdon, 1984, 2011)

John Kingdon’s *Agendas, Alternatives and Public Policies*, first published in 1984 (Kingdon, 2011) is one of the most frequently applied approaches to study the policy process (Zohlnhöfer et al., 2022). Kingdon argued that an issue reaches the agenda when the policy window opens (sometimes through a policy entrepreneur) to allow the coupling of three independent streams: policy, problem, and politics. Jones et al. (2016) point out that these ‘multiple streams’ have been referred to as a framework (MSF), an approach (MSA), a model, and a theory.

Most accounts focus on MSF’s five main components: the three streams, the policy window and the policy entrepreneur, with each of these having sub-components. The problem stream is concerned with issues that policy-makers consider to be problems. It includes sub-components of ‘indicators’, ‘focusing events’, ‘load’ and ‘feedback’. The political stream involves the cultural and institutional context, and has three sub-components: ‘national mood’, political ‘party ideology’ and ‘balance of interests’. The policy stream consists of solutions, which float around in the ‘policy primeval soup’ and are narrowed down to a subset of feasible options by a process akin to ‘natural selection’. The sub-components that influence the survival of a policy idea are 'value acceptability', 'technical feasibility', 'resource adequacy'. 'policy communities' and 'network integration'.

Kingdon argues that these three streams flow independently most of the time, but occasionally there is a point of confluence where they come together. Two streams coming together results in a 'partial coupling', but it is only when all streams come together in a 'full coupling' that the policy window opens. The sub-components of the policy window are: 'coupling logic', the logic or arguments used to couple streams; and 'decision style', the amount of information needed or the number of people who accept the feasibility of a solution before a decision can be made. Policy windows can open in the political stream, as a result of elections or changes in government, or in the problem stream.

Kingdon points to the importance of agency in the shape of a 'policy entrepreneur', who invests time and effort to push their favoured policy through the policy window. They can be inside and outside the formal governmental system, but those inside, holding elected positions, stand the best chance of achieving policy implementation. Kingdon (2011: 180–181) argues that three qualities contribute to the success of policy entrepreneurs: some claim to a hearing (expertise, an ability to speak for others and an authoritative position); political connections or negotiating skills; and 'probably most important', persistency. Jones et al. (2016) regard three factors as critical to entrepreneurial success: resources (e.g., time and money), access to a critical decision maker; and entrepreneurial strategies.

The three streams have some similarities to the three ingredients of Hall et al. (1975), but Kingdon (2011) introduces the additional elements of the policy windows, and the agency of policy entrepreneurs. According to Jones et al. (2016), MSF has a robust, active, but also disturbingly incoherent research programme. They report that, of the 311 coded documents, 273 (88 percent) were coded as qualitative, with only 13 quantitative applications, suggesting that the strong preference for qualitative methodology among MSA scholars may be linked with MSF being difficult to operationalize in terms of measurable variables. Cairney and Heikkila (2018) claim that the vast majority of MSF contributions are qualitative case studies. Zohlnhöfer et al. (2022) consider that too many empirical MSF studies lack a conceptual and methodological foundation that would allow assessing the framework's explanatory potential. Ridde (2009) points out that the framework has been criticized as it cannot be contested because of its limited, or even non-existent, explanatory capacity, with falsification very difficult. Jones et al. (2016) point out that only about one-third of their 311 studies used all five major components, with none employing all sub-components. The most explored sub-components were 'Indicators' (69 percent of applications), 'Focusing events' (27 percent), 'Policy Community (24 percent), and 'National Mood' (20 percent). Sub-components were used 'sparingly' for the policy window and policy entrepreneurs (Jones et al., 2016). Engler and Herweg (2017) explore three challenges: the choice of dependent variables and case selection; operationalization and measurement of the framework's (predominantly figurative) key concepts; and choice of a method that corresponds with the framework's research questions.

MSF is clearly the most used model of agenda setting in studies of health care. In contrast with the other models, there is no shortage of examples of studies that have applied MSF to health care. Kingdon (2011) included case studies of health care. Jones et al. (2016) point out that the most popular policy domain explored was health (28 percent of their studies). As noted, Kingdon focuses on how issues reached the agenda at Federal level in the USA for health and transport. However, studies have since extended to a wide range of areas of public policy, different nations, different levels of government and to other parts of the policy process.

Exworthy and Powell (2004) draw on Kingdon to examine the implementation of health inequalities policy in the UK at both central and local levels. They pull Kingdon 'off the Hill' (that is, Capitol Hill) and examine the 'little windows' at local levels as well as the 'big' windows at national level. They explore the policy stream in the context of wider models of policy success, arguing that a successful policy is likely to have clear objectives, mechanisms that achieve these objectives, and resources to fund them. Successful implementation is more likely to occur when the three policy streams are aligned across the three dimensions of the (traditional) vertical (central-local) dimension, and the horizontal dimensions of both central-central (joined-up government at the centre) and local-local (joined-up governance at the periphery).

Ridde (2009) explores the transferability of MSF to the study of public policy implementation at the local level and in a low-income country, focusing on the case of the Bamako Initiative (BI) health policy in Burkina Faso in West Africa. He analyses the five main elements, reporting an implementation gap resulting from the lack of coupling between the solution and problem streams. He advances three main explanations: the exclusion of the indigent is not perceived as a public problem; existing windows of opportunity have not been seized; and there are no policy entrepreneurs who favour equity. He stresses that the importance of policy entrepreneurs was highlighted, though negatively, something which is relatively rare in applications of the framework.

Blankenau (2001) uses the Multiple Stream lens to explore why Canada eventually adopted national health insurance in the 1960s, compared with the most recent attempt at adopting national health insurance in the United States in 1993–94 by the Clinton administration. He points out that a major criticism of MSF is its inadequate attention to institutions, and so his study refined MSF by paying particular attention to political structure. He sets out a new hypothesis that political structure affects how long and large a window of opportunity is necessary for policy change. He compares success in Canada (Defining a Problem; An Acceptable Solution; Changing Political Conditions; and Spillover and Opening a Policy Window) with the failure in the USA (A Divided Problem Stream; An Unacceptable Solution; A Shallow Political Stream; and Limited Spillover and a Closed Window?). He provides a Table that compares problem, policy, and political streams in terms of indicators; focusing event; policy feedback (problem); technical feasibility cost; value acceptability (policy) and national mood; interest group activity; turnover/ policy entrepreneurship (political). While he does explore sub-components, and many later studies have not, he only examines three of the five main components (exploring policy entrepreneur under the political stream) and does not explore the full range of subcomponents (cf. Jones et al., 2016). The summarization of each variable within the three streams is based upon a crudely specified scale: strong, medium, and weak. He reports US: strong; medium; weak, with all three sub-components in the policy stream regarded as weak, and Canada: strong; and medium. This seems to present some face validity, accounting for health reform being adopted in Canada, but not in the US. However, it also illustrates the problem of defining the agenda, as health reform in the US was arguably on the agenda in the sense of reforms being debated, but they did not become legislation and lead to policy change.

Bandelow et al. (2019) analyse major reforms in our Bismarckian health systems (Austria, Belgium, France and Germany) by combining the Multiple Streams Framework (MSF) and the

Advocacy Coalition Framework (ACF). They conclude that learning is a necessary condition for major policy change. A major reform only happens as a result of learning processes, either combined with a negotiated agreement, which presents a pure ACF related configuration, or combined with a window of opportunity opening in the problem stream. The latter configuration thus confirms the need for integrating a condition from the MSF into the ACF to explain major policy change. However, again, this study seems to conflate being ‘on the agenda’ as in being given ‘serious attention’ with policy change. Moreover, it perhaps sacrifices depth for breadth, in that there is no discussion of the sub-components on MSF.

Summing up, it seems that health care examples of MSF broadly reflect the verdict of Zohlnhöfer et al. (2022) that many MSF (case) studies to date lack falsifiable hypotheses, a shared understanding of the main concepts, rigorous operationalization, and systematic empirical assessment of theoretical expectations.

Punctuated Equilibrium Theory (Baumgartner and Jones, 1991, 1993)

Punctuated Equilibrium Theory (PET) was introduced in an article (Baumgartner and Jones, 1991) and text (Baumgartner and Jones, 1993), and has been developed by these and other authors into one of the most cited models in public policy (see Baumgartner et al., 2018; Heikkla and Cairney, 2018; Kuhlmann and van der Heijden, 2018).

However, it is not clear if PET is a theory of agenda setting, wider policy change or policy dynamics. While the titles of both the original article and text include the word ‘agenda’, PET seems to focus mainly on ‘stability and change in public policymaking’. While most policy models explain either stability or change, PET encompasses both. It emphasizes two related elements of the policy process – issue definition and agenda setting – and draws on foundations of political institutions, boundedly rational decision making, policy images, policy venues and policy feedback (Baumgartner et al., 2018; cf. Eissker et al., 2016; Kuhlmann and van der Heijden, 2018). In short, PET claims that a single process, involving the interaction of beliefs and values concerning a particular policy (policy image) with the existing set of political institutions (the venues of policy action) explains both periods of extreme stability and short bursts of rapid change (Baumgartner and Jones, 1991).

In contrast with most agenda-setting models, many early PET studies tend to be quantitative with dependent variables being congressional hearings, media attention or budgets. For example, studies of budgets focused on the degree of kurtosis in a distribution. Where continuous, dynamic adjustments were the primary decision mechanism, a normal (or Gaussian) distribution would be expected. However, if budgets generally change very little but occasionally change a great deal, annual budget changes would be distributed leptokurtically, with a large, slender central peak, weak shoulders and big tails. Baumgartner et al. (2018) give the example of annual percentage change in U.S budgeting for each of 60 programmatic budget subfunctions between 1947 and 2012. They point out that the distribution is clearly leptokurtic and positively skewed, with a very strong central peak (indicating the great number of very small changes), weak shoulders (indicating fewer than normal moderate changes) and big tails (indicating more than normal radical departures from the previous year’s budget).

Eissler et al. (2016) claim that PET began as a theory to study agenda change in the USA, but has since evolved into a focus on the wider policy process and policy change worldwide. They discuss ‘A Prequel to PET’, ‘PET origins: agenda setting’, ‘PET evolves: attention and framing', 'PET further evolves: information processing' and 'PET moving forward: diffusion across institutions'.

Kuhlmann and van der Heijden (2018) explore the evolution of PET through a series of texts and articles. They first discuss how mechanisms of feedback are related to policy change, with negative feedback generally linked to stability, and positive feedback normally associated with policy change. They set four PET core concepts related to policy change: policy image (how a policy is understood and discussed); institutional venues (institutions or groups that have the authority to make decisions); attention allocation; and forces of resistance. They provide the results of a structured review of 86 empirical, high-quality articles, not written by Baumgartner and Jones, that were explicitly analysing policy change. First, they investigate if the concept of feedback (positive, negative, or both) has been addressed as the core mechanism contributing to policy change. They note that it is striking to see that more than half of the articles do not deal with feedback processes at all, and that 28 percent of the articles only analyse positive or negative feedback processes. Then they examine to what extent the factors that are considered to explain policy change (policy image, policy venue, attention allocation, and rules for making binding decisions) have been addressed. They report that 14 (16 percent) studies examined one factor; 22 (26 percent) examined two; 7 (8 percent) examined 3; 16 (19 percent) examined all four factors, with 27 (31 percent) not examining any factors. They consider that the factors to explain policy change are selectively applied. Moreover, they find that studies with a focus on the USA are still dominant, accounting for some 59 percent of articles. In terms of methodology, 41 (48 percent) were quantitative; 36 (42 percent) were qualitative; with 9 (10 percent) mixed methods. PET is also often combined with other established theories of the policy process, with one cluster of papers (18 percent) that combines PET with the MSF, or single concepts from it such as policy entrepreneurs or policy windows. Finally, 8 (9 percent) focused on the area of health, with tobacco policy (7 percent), being the topic of six articles.

We now explore examples of a few PET health studies. Green-Pedersen and Wilkerson (2006) compare health care attention and policy developments in Denmark and the US over 50 years. They draw on the Policy Agendas Project, which uses expert coders to categorize political activities into mutually exclusive topic areas. 'Health' is one of 19 major topic areas, which is further distinguished into 20 subcategories (e.g., insurance access, health care facilities, medical procedures, etc.). They compare political activity over a 50-year time period, drawing on nearly 500,000 events. They conclude that the proportion of overall agenda space that each national legislature has devoted to health care issues has tripled or quadrupled since the early 1960s.

Other studies seem to show significant controversy in applying PET to topics in health care. For example, according to Givel (2017), an academic controversy exists regarding whether US tobacco control policy has been punctuated and rapid. He argues that two widely different scholarly conclusions have emerged. A group of scholars, mostly supportive of the punctuated equilibrium theory in public policy, have concluded that US federal policy outputs and outcomes in tandem with state and local tobacco control policy outputs and outcomes from 1964 to 2013 have led to dramatic change and effective new tobacco control policies that have improved public health. However, another set of scholars claim that tobacco control policy did not change at all and that individual levels of government have not been particularly dramatic or effective but rather incremental or piecemeal. On the basis of a survey of the evidence, he concludes that the rapidity of the adoption of federal tobacco control policy outputs has, with two exceptions including youth enforcement and tobacco product safety regulation, been non-dramatic, non-explosive, and non-punctuated.

Finally, the significance of a policy punctuation is not fully clear. For example, John and Bevan (2012) identify punctuations from the content of Acts of the UK Parliament between 1911 and 2008 from the UK Policy Agendas Project (http://www.policyagendas.org.uk). They point out that Acts are only one measure of attention, and more commonly budgets or executive speeches have been taken to represent punctuations. They point to 48 punctuations, including 26 high-salience punctuations, identified from 1862 observations. There are only two high-salience punctuations in the 'health' category: Public health reforms (1935) and a series of related health service reforms (2005). They are clear that their method does not replicate what standard histories of British politics do, which is to write about what are considered to be defining pieces of legislation and to see them as symbolizing and structuring politics and policy afterwards. Rather, it examines the expansion of attention to a major policy topic and its prioritization at particular moments of time. As they point out, a critic could ask where is the National Health Service Act 1948 that established comprehensive health care. They respond that the approach of the contemporary historian is different to the student of public policy: the former tends to focus on groundbreaking pieces of legislation, which may not take up a large amount of legislative time in any one year, whereas the latter is interested in the attention policymakers pay to a particular topic. However, it seems strange to stress 'policy punctuations' that would puzzle and bemuse most students of British health policy.

Framework for Analysing the Determinants of Political Priority for Global Health Initiatives (Shiffman and Smith, 2007)

In an article that has been highly cited within health policy, Shiffman and Smith (2007) ask why some global health initiatives receive priority from international and national political leaders whereas others receive little attention? They propose a framework consisting of four categories: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and the characteristics of the issue itself. They apply this framework to the global safe motherhood initiative, which was launched in 1987 to reduce levels of maternal mortality.

They note that a central concern in collective action research is the role of power: the power of actors connected with the issue; the power of the ideas used to define and describe the issue; the power of political contexts to inhibit or enhance political support; and the power of some characteristics of the issue, such as the number of deaths a particular disease causes, to inspire action. They claim that these four elements form the foundation of their framework for the determinants of political priority for global initiatives, with initiatives more likely to attract political support if they share specific features in all categories. They explored the global safe motherhood initiative through process-tracing, with data including 23 interviews, and 70 documents covering the history of the initiative. They concluded that the safe motherhood initiative has had many difficulties, and it remains in a state of infancy even after 20 years.

Walt and Gilson (2014) aim to apply an existing framework in extracting and synthesizing data from a set of papers. They select the Shiffman and Smith (2007) framework because it remains the most developed and comprehensive-related health policy framework. However, this seems a rather narrow view, as it could be argued that the most important criterion should be the quality or utility of the framework rather than its origins, or whether it was developed by health policy scholars. They finally select 22 papers from a literature search for health policy analysis in low- and middle-income countries for the period 1994–2007. They add an additional element of 'outcome' in order to see whether the issue under discussion was being taken seriously by policymakers, was represented by an authoritative decision, or had resources allocated to it. They consider that while adding one column on outcome to the template was helpful in judging the position of the issue on the policy agenda over time, it did not entirely resolve the question of where agenda setting ends and policy formulation begins. They conclude that the Shiffman and Smith (2007) framework offers huge value in guiding cross-national as well as cross-policy research and analysis in a field that has been neglected and under-developed, and that it would be enhanced by a few adjustments and conceptual refinements.

However, the Shiffman and Smith (2007) framework seems to consist of four (or five) categories or discussion under four (or five) sub-headings. These four elements seem to rise inductively from empirical literature, rather than deductively, and the framework appears to be very loosely connected to the wider agenda-setting literature. For example, Kingdon (2011) is only mentioned in passing as part of a group of studies by Shiffman and Smith (2007). However, there are some similarities to wider literature, such as 'ideas' (e.g., Beland, 2016) and 'issue characteristics' (e.g., Cobb and Elder, 1972). It is difficult to see how the concepts are operationalized, or how they are weighted or fit together (cf. Hall et al.'s (1975) Ingredients Model).

DISCUSSION

There have been many studies on agenda-setting in health care. For example, 'Agenda-setting health care policy' yields over 149,000 hits in Google Scholar (and about 183 million hits in Google) (June 2023). However, it can be argued that we do not know a great deal about agenda-setting. This may be explained by focusing on issues of breadth and depth.

In terms of breadth, the study of agenda-setting in health care has tended to be fairly narrow, with many studies drawing on Kingdon's MSF, but (as noted above) relatively few studies drawing on other approaches or other issues within agenda-setting. Even the definition of the 'agenda' is not fully clear. Hogwood and Gunn (1984: 67) point out that there are different types and levels of agendas. As Dearing and Rogers (1996: 18) put it, 'measures of the policy agenda vary from study to study much more than do measures of the media agenda and the public agenda which are fairly standard … Defining and measuring the political agenda is the trickiest choice to be made by political agenda setting students …. There is no such thing as the political agenda but only an archipelago of different loosely associated political agendas.'

Cobb and Elder (1972) differentiated the systemic (or informal) public or discussion agenda from the institutional (or formal) state or action agenda (see Howlett et al., 2009; Knill and Tosun, 2020). Similarly, Kingdon (2011) differentiates the governmental agenda, which contains the list of subjects that are getting attention, from the decision agenda, which seems to contain subjects that are getting '*serious* attention' or are 'up for an active decision' (p. 4) or for 'actual action' (p. 20).

Knill and Tosun (2020) state that the institutional agenda is the action agenda, which is more specific and concrete than the systemic agenda, and contains a set of problems that are up for serious consideration by decision makers. Following Kingdon, they differentiate the 'drafting' (governmental) agenda and the decision agenda. The government needs to take a basic decision that a certain policy problem needs to be addressed and start drafting measures that relate to the problem, with those issues for which a decision has been taken constituting the drafting agenda. By contrast, the decision agenda is based on those issues for which a government has agreed on a draft proposal and has decided to put the issue on the agenda of the responsible decision-making body (usually the legislative), which has to take the final decision as to whether or not to adopt the policy. These broad concepts need to be turned into measures. For example, Soroka (2002) examines five different measures of the Canadian policy agenda: government spending, committee activities, legislative initiatives, Throne Speech content, and Question Period discussion. However, his 'primary measure of the policy agenda' is a content analysis of House debates on each issue from 1985 to 1995.

To borrow a term from above, how set in concrete do agenda items have to be? In concrete terms (for the UK), what is the tipping point between agendas (e.g., government announcement; acceptance of inquiry recommendation; inclusion in Green or White Paper or Parliamentary Bill)? What does 'on the agenda' mean in terms of definitions and operationalization? Can issues stay on the long list for long periods, missing multiple possible policy windows, but rarely getting the 'serious attention' of the short list?

Powell and Hall (2020) examine ideas in government green papers, and the government appointed commissions on Long Term Care funding since 1997, concluding that the policy window, ajar for over 20 years, had not fully opened. The words of the Health Secretary in 1997 that 'the present situation cannot go on much longer' has resonated for over 20 years, meaning that the entitlement of older people 'to security and dignity in their old age' represents an idea whose time has not yet come. With discussions dominated by cost and affordability, ideas were on the agenda – but not *seriously* on the agenda – for over 20 years.

The focus on Kingdon's (2011) MSF has led to less attention on issues identified earlier, such as steps or phases in the agenda-building process and characteristics that stood to impact the relative position of an issue on the legislative agenda (e.g., Cobb and Elder, 1972; Cobb et al., 1976). Studies on Kingdon's (2011) MSF model tend to focus attention on 'coupling' when the streams join, with less attention directed to the phases (e.g., issue initiation, specification, expansion and entrance, Cobb et al. (1976) or steps (e.g., issue creation, issue expansion, and agenda entrance, Cobb and Elder (1972)). Similarly, there is little discussion of different models such as the 'outside initiative model', the 'mobilization model' and the 'inside initiative model' (Cobb et al., 1976; Howlett et al., 2009: 101–103).

Similarly, the focus on 'coupling' has meant less attention on the content and flow of the streams over time before coupling. For example, it is unclear how issue characteristics such as specificity; social significance; temporal relevance; complexity; and categorical precedence (Cobb and Elder, 1972) or crisis; particularity; emotive aspect; wide impact; power and legitimacy; fashion (Hogwood and Gunn, 1984: 67–68) relate to Kingdon's streams.

While MSF has an advantage over some other models such as the 'Ingredients model' as it introduces an element of 'agency' in the form of the policy entrepreneur, this may have distracted attention away from other actors. Kingdon (2011: 16) argues 'we want to know something about the game itself. So aside from the participants, we are interested in the processes by which agendas are set and alternatives specified.' However, perhaps there has been too much attention on the game itself rather than the players or participants. Some other accounts directed more focus to agenda-setters in addition to agenda-setting (e.g., Buse et al., 2012; Knill and Tosun, 2020).

Buse et al. (2012) examine how the main actors in the policy process, particularly the government and the media, put issues on the policy agenda. They consider governments as agenda-setters and the mass media as agenda-setters, and later, examine the business community, the medical profession and other interest groups (their Chapters 5 and 6). Similarly, Knill and Tosun (2020: Chapter 5) explore 'actors and interests in the agenda-setting process': elected public officials and judges, bureaucracy, mass media; interest groups; and international organizations. In short, MSF studies on health care may exhibit a degree of 'tunnel vision', missing key insights from other models and elsewhere, such as actors and issue characteristics. Moreover, MSF may place all of its agency eggs in the policy entrepreneur basket.

Moreover, many studies of Kingdon's MSF tend to lack depth. Many studies discuss some of the five major structural elements, but only about one-third of studies in the review by Jones et al. (2016) used all five major components, with none employing all sub-components. Many of the general critiques of studies drawing on MSF (e.g., Cairney and Heikkila, 2018; Engler and Herweg, 2017; Ridde, 2009) also apply to studies of health care. There seems to be limited cumulative knowledge about MSF in health care: for example, do the three streams always need to come together in 'full coupling' or can 'partial coupling' of two streams lead to an issue reaching the agenda? Similarly, can the three streams achieve full coupling without a policy entrepreneur? Even less is known about sub-components. For example, are there dominant sub-components within each stream?

Some studies have explored extending MSF into other parts of the policy process (Herweg et al., 2015; Howlett et al., 2015), but there do not appear to be any studies of health care. There are some health care studies that combine MSF with other models. For example, Bandelow et al. (2019) combine conditions from ACF and MSF to emphasize the added value of merging them to explain major policy change. Kusi-Ampofo (2021) explores tobacco control policies in Mauritius from 1980 to 2019, drawing on MSF, historical institutionalism, and ideational perspectives. However, while both approaches add 'breadth' they necessarily risk reducing depth. While breadth and depth may be achieved in a book length study, the word limit of most academic articles mean that there is limited space for details such as sub-components of MSF. This is not to argue against incorporating other perspectives into MSF. For example, following a lead from Kingdon (2011: 17) that 'we will forsake the usual political science preoccupation with pressure and influence, and instead take excursions into the world of ideas', Béland (2016) demonstrates the value of ideational perspectives in MSF. Powell and Hall (2020) explore ideas in government green papers, and the government appointed commissions on Long Term Care funding since 1997 through the lens of the agenda-setting model of the MSF.

CONCLUSIONS

While there has been no shortage of studies on agenda-setting in health care, it can be argued that we do not know a great deal about the topic, because of issues associated with both the breadth and depth of the literature. First, much of the breadth of the literature has largely been ignored in favour of a focus on Kingdon's (2011) MSF. Second, many studies of Kingdon's MSF tend to lack depth, with little attention to his major structural components, and sub-components. Moreover, many studies in health care tend to focus on individual case studies, and the marginal benefits of applying MSF to different issues and nations in individual case studies, without much attempt to build these results into any cumulative knowledge, is perhaps very limited (but see Béland and Howlett, 2016). For example, we do not know whether all three streams, with or without a policy entrepreneur, must be fully coupled to open the policy window. Nor do we know if this varies in different contexts, such as different political systems. In other words, the most urgent research task is not for more empirical studies, but for some synthesis of existing studies. However, any future empirical studies should attempt to examine sub-components, not just the main structural elements (cf. Jones et al., 2016). Similarly, rather than simply looking at single case studies of successful openings of the policy windows, there should be more comparative case studies and studies where the policy window did not open (see, e.g., Béland and Howlett, 2016).

To draw on the evolutionary biology metaphor of Kingdon (2011), MSF has become the dominant idea in agenda-setting in terms of the 'survival of the fittest'. However, this may be because its low 'barriers to entry' mean that it is the 'survival of the easiest to apply', with the valuable insights of earlier frameworks being largely forgotten. A research agenda for agenda-setting research suggests that future studies should address concerns of both limited depth (examining the sub-components of Kingdon's model) and breadth (linking Kingdon with other agenda-setting models; consolidating individual studies into broader conclusions).

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3. Decision making and policy formulation: the case of health care coverage

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INTRODUCTION

Health care policy makers across the world face levels of demand for services that frequently outstrip what they are willing or able to provide, therefore requiring them to find ways to stem the flow of expenditure and resources. This chapter introduces the study of policy formulation, drawing on the example of health coverage policy. The term 'health coverage' here refers to the setting of limits to what is provided (or 'covered') by a given health care system, thereby determining which treatments and services are made available and which are either curtailed or excluded. A characteristic feature of coverage policy is the frequent attempt by government actors to deflect responsibility for the details of policy formulation onto other parts of the system. This is partly because rationing processes in health care are often antagonistic and there is a high probability that those associated with such policies will be blamed for negative effects. The frequent delegation of responsibility for health care coverage policy formulation makes it a productive case study through which to examine such dynamics. The chapter starts with the rational (or design) approach to policy, describing its main tenets and limitations. Counter models, informed for example by notions of incrementalism and pluralism, are then introduced and critiqued, which leads to discussion of the mediating role of institutions, ideas and interests. These models and concepts are then used to examine the case example of health coverage policy, which is shown to reflect elements of each. On this basis, the chapter concludes by arguing for the ongoing relevance of examining the difference between rational and 'non-rational' influences, and the presence of these in policy formulation processes.

STUDYING POLICY FORMULATION

Policy formulation here refers to 'the development of proposed courses of action to help resolve a public problem' (Kraft and Furlong, 2019, 80). When framed within a linear model of policy processes, formulation comes after *agenda setting*, and concerns what happens once there is acceptance of the need to address a policy problem (Sidney, 2017). It is generally depicted as being followed by *implementation* of the agreed policy. However, policy formulation is less well understood than these prior and subsequent stages of the policy process and the distinction between them is often blurred, meaning it can also be tricky to identify the moment at which policy formulation actually occurs. For example, some analysts incorporate elements of policy formulation, such as deliberation and decision making, into their conception of agenda setting (e.g., Kingdon, 1995). Similarly, Majone and Wildavsky (1984, 177) note that 'when we act to implement a policy, we change it', so that formulation and implementation are also often hard to disentangle.

Like all aspects of the policy process, it is tempting to imagine there are discrete activities and actors associated with formulation. The reality is invariably more diffuse and complicated, due to the number and range of actors that seek to influence the content of policies. As well as the backstage work of 'hidden' participants (Kingdon, 1995), there are numerous settings where multiple actors might become involved, including: parliament, legislative committees, local and national government bureaucracies, interest group offices, special commissions, think tanks, political party conventions, task forces, working groups, and various other mechanisms for bureaucratic and interest group involvement.

This complexity – whereby policy stages overlap and the authors of policy are sometimes difficult to discern – poses challenges for those seeking to analyse formulation processes, or to put forward plausible recommendations for good practice. Most analysts agree that policy formulation typically involves generating policy options, and can be presented as culminating in, or as a precursor to, policy *decision making*, whereby a course of action is selected from among pre-identified options. Policy formulation invariably involves some combination of *appraisal* (e.g., of data and information), *dialogue* between actors involved, *formulation* whereby options are weighed and proposals drafted, and *consolidation* where feedback is incorporated (Howlett et al., 2009). Based on a review of the literature, Berland et al. (2014) extend this to include: generation of policy alternatives, deliberation and consultation, advocacy of/lobbying for specific policy alternatives, negotiation over policy content, drafting/enacting legislation and guiding implementation.

There are numerous strands in the policy studies literature that are of relevance to the study of policy formulation. Some analysts and commentators start with the substance or *content* of policies, that is the 'blueprints, architecture, discourses, and aesthetics of policy in both its instrumental and symbolic form' (Schneider and Ingram, 1997, 2). By contrast, the policy *tools* tradition studies the techniques through which policies are constructed, such as forecasting, option appraisal and framing, and seeks to locate these within complex governance processes and settings (Turnpenny et al., 2015). More broadly, a rich tradition of scholarship has sought to categorize the approaches or 'instruments' adopted by governments (see, for example, Hood, 1983), including: information and exhortation, performance management, commissions and inquiries, regulation, grants, subsidies and financial incentives, direct provision, marketization, reconfiguration, and more (Howlett et al., 2009).

Overall, the literature on approaches to policy formulation can be separated into those which focus on policy as *noun* (the properties of a given policy) and those which focus on policy as *verb* (the process of creating policy). The approach adopted in this chapter focuses on the latter through an examination of policy *decision making*, i.e., the act of selecting a course of action from among alternatives (including 'do nothing'). This is because decision making is clearly an integral component of the policy formulation process, and one that is more obviously distinct from the agenda setting and implementation phases, thereby allowing us to retain a focus on 'the bit in the middle' of these two more studied aspects of the policy process (Berland et al., 2014). By examining how decisions are made between policy options we can understand the interplay of values, tools, relationships and institutions, and assess their influence on policy outcomes. Several 'ideal type' models for explaining or conducting policy decision making have been put forward and critiqued (Hogwood and Gunn, 1984). This chapter presents some of these as they apply to formulation of health coverage policy both in the UK and internationally.

THEORIES OF POLICY DECISION MAKING

Criticisms of the tendency in health coverage towards policy inaction and/or deflection – and the alternative emphasis on explicit approaches to policy formulation – are redolent of the *rational model* of how policy decisions ought to be taken. The pervasiveness of this model is illustrated by the embedding of its basic assumptions into definitions of policy formulation itself (e.g., see Howlett, 2011; Jann and Wegrich, 2007; and Kraft and Furlong, 2019, cited above). Its exposition is often credited to Herbert Simon who argued that in order to be rational, decision making should fundamentally involve taking policy choices that are 'conducive to the achievement of goals or objectives' (Simon, 2013). This has also been termed the 'utilitarian' or 'design' approach to policy formulation, which Chindarkar et al. (2017, 3) describe as 'the deliberate and conscious attempt to define policy goals and connect them in an instrumental fashion to instruments or tools expected to realize those objectives.' Within this idealized model of policy formulation, the task for policy analysts and actors is to identify and align the various parts of the decision puzzle including goals, target populations, actors, implementation channels, and so on. The role of knowledge in the rational model is therefore primarily mechanistic, i.e., the problem is defined, the knowledge required to solve the problem is sought and applied to the problem, and the correct policy change is made. This is underpinned by a commitment to *technocracy* and the pursuit of rule by scientific rationality, towards optimal decision making (Parsons, 1995).

Despite its intuitive appeal, it is not hard to see how the highly idealized rational model might diverge from the messier reality of decision making. Policy makers undoubtedly face major substantive and procedural constraints on what they can achieve, whereas rationality requires high levels of decision maker autonomy. Simon himself, despite accusations of naivety, was aware of the need to create a less idealized version of the rational model for real-world decision making, and he documented many of these constraints, including limits in the evidence available, unknown consequences of decisions, cognitive limitations and constraints of people, organizational context (Simon, 1957). He subsequently proposed a descriptive model of 'bounded rationality' to better understand decision making in practice. In this model, the range and number of decision options is narrowed, decision making criteria are augmented with 'rules of thumb', and optimizing/maximizing is replaced with satisficing. Simon's concern, particularly with the limitations to human cognition, was subsequently taken up in the pursuit of more advanced techniques for improving policy design (e.g., Linder and Peters, 1984). These again typically rest on the assumption that finding ways to inculcate increased levels of rationality – for example through expanded policy options and higher analytical thresholds – would result in better policy decisions and programmes.

However, the concept of bounded rationality has itself been subject to critique for its relative failure to theorize the role of multiplicity and disagreement in policy decision making, and for its continued valorization of a narrow rationalist ideal. Many have expressed serious doubts that policy could ever be 'designed' in the way that proponents of rational approaches advocate and reject the narrow value-based reasoning it adopts (deLeon, 1988). For example, in his notion of 'incrementalism', Charles Lindblom (1959) argued that policy decision making's primary characteristic is the presence of bargaining and negotiation between policy actors with often diverging values, agendas and goals. He cited the constraining effects of policy legacies, prior commitments and other temporal factors, which limit the exercise of decision-making autonomy and therefore sought to elucidate how policy choices proceed through successive limited comparisons, and the 'simultaneous analysis of facts and values, means and ends' (Hill, 2005, 148). The importance of pluralism in this process is shown by the requirement for 'partisan mutual adjustment' between policy actors, which precludes the pursuit of optimal policy outcomes (Lindblom, 1968). Lindblom therefore agreed with Simon's observation of the dominance of satisficing over optimizing. However, Lindblom also saw this 'muddling through' as a *preferable* state of affairs and he was notably less enamoured than Simon with developments in the scientific management of policy decision making. For Lindblom, the status of evidence and analysis was always secondary, with experts 'on tap', but never 'on top' in the decision-making process. Incrementalism therefore shifted emphasis from goal attainment towards small, consensus-based policy adjustments. Lindblom argued this approach was likely to be more cost effective (i.e., avoiding numerous elaborate processes of option appraisal) and would also lessen the risk of serious policy mistakes.

Incrementalism, as both an explanation and prescription for decision making, has itself not escaped criticism. For example, Dror (1964) was critical of incrementalism as an *aspiration* for policy formulation, noting for example that 'muddling through' is hardly desirable in circumstances where current policy is manifestly deficient, or where received policy responses are inadequate to deal with a new policy challenge. To give a recent example, it would be hard to justify an incrementalist health policy response to the challenges posed by the initial outbreak of COVID-19. Critics such as Dror therefore accused Lindblom of fostering, whether deliberately or otherwise, a policy conservatism, and of excusing policy *inertia*, rather than promoting pluralistic formulation processes. Despite its advantages over rationalism as a descriptive framework, the efficacy of incrementalism as an explanation for the realities of policy formulation has also been questioned. This includes its apparent inability to explain the occasional presence of major policy shifts and its latent tendency to assume 'good faith' on behalf of policy actors. Dror (1964) and others argue that Lindblom's apparently benign view of policy actors is inconsistent with observed behaviours, which can often be self-serving and at times unscrupulous. A desire to protect institutional interests, pursue personal advancement and/or political favour, maximize commercial interests and so on, have all been found to be present in policy formulation processes (McCollum et al., 2018). In their work on health policy, Buse et al. (2012) note variation across systems in terms of the role of interest groups but argue that these non-government actors have become more common, including in low-income settings.

Lindblom came to acknowledge the failure of classic incrementalism to account for the less savoury objectives and values which may be driving such behaviours (Lindblom, 1977). In response he refined the normative and explanatory applications of incrementalism, acknowledging that whilst the *theory* of incremental politics remains laudable (and preferable to the design approach), the *reality* is marked by asymmetries of power, and structural factors that determine who can participate in and influence the formulation of policy. Interestingly, Lindblom's later writings also support a greater role for policy *analysis* in the formulation process, in an apparent concession to the normative ideal of rational decision making.

In recognition of the incrementalist tendency towards a 'piece-meal, plodding, and anti-synoptic' vision of policy, scholars have been reluctant to jettison the rational model entirely (Pal et al., 2011). Those working broadly within the policy design tradition, for example, have sought to clarify the features that distinguish it from other formulation/decision making processes, and to develop understanding of their 'frequency and likelihood of occurrence' in complex, multi-level policy systems (Howlett and Mukherjee, 2014, 58). From this perspective, evidence remains important to policy formulation whilst also being inherently contextual, recognizing that the application of policy tools will not produce the same effects under differing conditions. Here, the study of policy formulation overlaps with the analysis of implementation, and specifically how tools intended to put policies into practice (e.g., 'sticks', 'carrots' and 'sermons') succeed or fail, and the factors behind these outcomes (Vedung, 1998). Another attempt to find an accommodation between Simon and Lindblom was put forward by Etzioni (1967). His 'mixed scanning' model was intended to harness the transforming potential of rationalism whilst tempering this with the realism of the incrementalist school. Etzioni argued that whilst some resources and attention should be expended on the full range of potential policy options (especially where major decisions are being made), more detailed scanning is required of those options that are most likely to be adopted. It has been noted, however, that beneath these broad principles, Etzioni's model lacks sufficient detail to be codified into an actual decision-making aid (Hogwood and Gunn, 1984).

Other schools have sought to address the dimensions of structure and power that Lindblom acknowledged as being beyond the capacity of classic incrementalism to explain, seeking thereby to incorporate a broader range of influences on policy choices than is afforded by either the rational/design or incremental/pluralist models. For example, the 3I framework divides these variables into 'ideas', 'interests' and 'institutions' (Hall, 1997). This framework has been applied to the understanding of various policy stages including formulation (e.g. Dickinson and Buse, 2008; Patay et al., 2022).

Here, 'ideas' refers to knowledge and beliefs that can be both normative (i.e., referring to how things should be) or descriptive (i.e., about how things are). Ideas have been shown to be critical to the defining of policy problems and the prescribing of subsequent policy actions, and to articulating the underlying value mission. By paying attention to the role of ideas, we can seek to understand how competing policy frames might be brought to bear on decision making, and how these change over time. The 3I framework also acknowledges the apparent inevitably of *interest* group contestation and negotiation as a feature of policy decision making. In particular, it assumes that decisions are influenced, in differing ways and to differing extents, by relationships between stakeholders and decision makers (Peters, 2002, 553). The third and final category of influencing factors is 'institutions' and this is where the 3I framework moves beyond rational and incremental models. Whilst definitions of what is meant by institution vary considerably, the common concern is to understand how wider organizational and structural arrangements can shape how decision makers act, think and behave. These institutional factors can manifest in formal mandates and governance arrangements, or in less formal networks and practices (Lecours, 2005).

The following sections of this chapter return to the specific policy domain of health coverage, before going on to examine the extent to which it exhibits elements of the models and theories of policy formulation introduced so far.

HEALTH COVERAGE POLICY

Some of the drivers of the imbalance in demand and supply in health care – such as rising patient expectations, ageing populations, and expensive new treatment options – are common to many health systems across the world. However, policy responses to these problems are constrained by local factors. For example, there is huge variation in the levels of resource available to governments to fund health care systems and services (Hopkins, 2010). Policy options are also circumscribed by the prevailing model of revenue generation, which may include combinations of taxation, insurance (both social and private), and out of pocket payments (Robinson, 2016). Further constraints on the autonomy of decision makers can be imposed by supra-national bodies, especially in lower- and middle-income settings, where NGOs can, for example, distort spending priorities (Abimbola et al., 2017). Furthermore, the allocation of resources to health care services often takes place against a backdrop of intense media scrutiny, and deeply embedded (and contested) norms and expectations about what health services are for (Williams, 2015).

These factors can drive differences in policy responses to resource pressures, and shape what is available to the would-be policy maker (Blank and Burau, 2017). There is further variation in where policy responsibility lies. For example, the traditional strength of local councils in Sweden has led to a decentralized approach to health policy decision making, whereas the opposite is true in, for example, Israel where a national 'basket' of approved services has been in place for many years (Sabik and Lie, 2008). These constraints can also be temporal, with prior histories and commitment to policy approaches circumscribing the range of available approaches. However, it is important to also note that these arrangements change and evolve, thereby opening up the possibility of new policy actors and the availability of new policy tools and levers (Torgerson, 1985). In some systems, the coverage role is partially performed by market actors (e.g., private health insurance providers). More often than not, however, policy is set by government bodies or by intermediaries acting on their behalf. It is perhaps not surprising that, as already noted, governments seek to shield themselves from their adverse consequences. Health ministries have, for example, sought to *devolve* responsibility to local system actors who, in turn, have developed methods for withholding the flow of resources. Examples of such strategies include introducing treatment delays, diluting the quality of services (e.g., through random 'salami-slicing' of budgets), and deflecting demand to other parts of the system (e.g., from health to social care and vice versa) (Klein, 2010; Williams et al., 2019).

In recent times, these 'implicit' ways of managing resource scarcity have come under increasing fire, leading governments to seek more explicit approaches. One of the earliest examples is the now familiar story of the US state of Oregon, whose legislature sought to develop a list of core services to be funded through Medicaid but saw ongoing political revisions to the plan to the extent that the original objective of rationalizing the process of coverage policy became largely lost (Jacobs et al., 1998). In England and Wales, the National Institute for Health and Care Excellence (NICE) is responsible for some health coverage policies via its mandatory guidance on new treatments and interventions. NICE exemplifies the trend towards *delegation* of health coverage policy making responsibility, in this case to non-majoritarian 'expert' bodies (Landwehr and Böhm, 2011; Williams, 2013). This trend has been alternately lauded for de-politicizing decision making and criticized as a manifestation of blame avoidance and democratic deficit (Löblová et al., 2020; Majone, 1999).

Whichever side one takes in these arguments, it is clear that bodies such as NICE have not fully succeeded in taking the 'politics' out of resource allocation, and that no system or organization has successfully solved the conundrum of how to make policy formulation both explicit and politically palatable (Smith et al., 2014).

APPLYING THE RATIONAL MODEL

These developments make health coverage policy an interesting test case for how far the rational model of policy can be taken in practice. As we have noted, the rational model is *goals oriented*, and therefore requires a clear articulation of what decision makers are seeking to achieve through their policy choices. However, it has been noted that such explicit objectives are often not present in practice, with the aims of health coverage policy so far escaping simple codification. Some have sought to condense these goals into the *maximization of overall population health* (see for example Williams, 1996). In this approach, the classical economic notion of 'utility' is reinterpreted as 'health', and health maximization is installed as the guiding principle by which the success of policy should be measured (Alaszewski and Brown, 2012). However, there is a widespread recognition that this excludes other principles that should influence coverage policy decision making, such as: equity and distributive justice (Barra, 2020); respect for human dignity (Sandman et al., 2018); and the 'rule of rescue' (whereby life-saving treatments are granted additional weight over more routine interventions) (Charlton, 2022). This links to a second limitation of the rational model, that is the implicit assumption that policy makers can separate facts from values. Health care coverage provides a classic example of how the pursuit of policy goals is inevitably informed by contested social value considerations about the purpose and ethics of health systems. Box 3.1 lists some of the many goals that have been advanced in the literature on health care priority setting.

BOX 3.1 ETHICAL PRINCIPLES AND PERSPECTIVES IN HEALTH COVERAGE POLICY

Utilitarianism: The injunction to bring about the maximum level of utility (for example overall health gain)
Egalitarianism: The ethical foregrounding of collective responsibility for fair distribution of resources
Libertarianism: The ethical foregrounding of individual choice and reward, whereby patients are understood as consumers with rights and choices
Communitarianism: The injunction to allocate resources according to collectively agreed citizen values
Efficiency: The concern to maximize outcomes from within a limited resource
Equity: The principle that equal people should be given equal treatment – and in some cases that those worse off should receive extra resources
Desert: The principle that individuals should be held responsible for their behaviour and that this should influence access to scarce resources
Rule of rescue: The imperative to save human life wherever possible
Fair innings: The principle that resources should be distributed so as to distribute healthy years most evenly across a population
Disease severity: The principle that resources should be weighted towards those in greatest need or with the most severe conditions

Source: Williams and Robinson, 2012

At the very least then, the goals by which health coverage policy might be judged are not universally agreed and are likely to contain multiple elements. This makes it difficult to achieve another aspiration of the rational model: optimization. Selecting the optimal policy course becomes more challenging when this requires complex trade-offs between multiple goals. The rational model of policy is therefore highly 'data hungry', requiring 'full or at least adequate knowledge about the nature of social problems, the possible responses to such problems, and the probable outcomes of these responses' (Alaszewski and Brown, 2012, 35). During a period seconded to the UK Ministry of Health, the health economist Alan Williams sought to encourage an optimization approach in health policy, such that resources would be allocated to aximizes population health benefits (Williams, 1997). The associated study of health state valuation eventually produced measures intended to be applied to such policy making, including the quality-adjusted life year (QALY) (Drummond et al., 2015). The promise of the QALY was to enable allocation decisions to be made consistently across a range of treatment areas, and to facilitate the selection of options with the greatest promise of optimizing population health. However, QALY analyses must compete with other legitimate decision goals and principles. Alongside the development of summary outcome measures such as the QALY have been analytical techniques associated with 'health technology assessment' (HTA). HTAs combine information on efficacy, safety, and costs of health care interventions, and have become a feature of resource allocation policy in countries across the world (Draborg et al., 2005).

HTAs and QALYs are typical of analytical techniques designed to 'help evaluate current or past practices and aid decision-making by clarifying or eliminating some of the many possible alternative courses of action mooted as policies are formulated' (Howlett et al., 2014, 272). These include option appraisal, forecasting, scenario analysis, and framing (Turnpenny et al., 2015). The rational model implies that these analytical policy tools – produced internally by government departments or commissioned from private and other non-governmental actors – should be at the heart of the policy process. However, studies suggest that the types of policy tools in common usage across government are far more likely to be process-related (e.g., brain-storming and consultation) rather than 'substantive' content-related technical tools (such as option appraisal), which typically require greater levels of formal analytical training and expertise (Howlett et al., 2014).

In health coverage policy formulation, it is often assumed that the typical government and civil service machinery is unlikely to contain adequate expertise to provide the sorts of complex analysis required (Löblová, 2018). Research suggests that many policy decisions still fall significantly short of the 'comprehensive analysis' standard. For example, there are deficiencies in the extent to which decision makers receive timely, relevant evidence and can call upon the necessary expertise to apply this to the decision (Williams and Bryan, 2015). In summary, the experience suggests persistent knowledge limits and underlines the impossibility of considering all options to achieve perfect information. The rational model's emphasis on measurement and maximization raises additional complexities. For example, whereas from an instrumentalist perspective health care is only viewed as valuable when it demonstrates positive outcomes, as Donaldson and Shackley (1997) note, other concerns such as 'process utility' may be important. This is particularly the case in health care where 'patients, professionals and managers … value intermediate outcomes or aspects of process as much as final clinical outcomes' (Calnan and Ferlie, 2003, 186).

PLURALISM AND INCREMENTALISM IN HEALTH COVERAGE DECISION MAKING

As noted, the ‘rationalism versus incrementalism’ debate has become a cornerstone of the classic policy formulation literature, and one which has an echo in arguments over how health coverage policy proceeds. These were debated in a conference plenary session in 2000 between Alan Williams (again) and political scientist Rudolf Klein (Klein and Williams, 2000). In his opening gambit, Williams declared his commitment to the rationalist doctrine:

> What is required is a major shift of thinking and resources towards the kind of outcome measurement required for strategic priority setting … If half the resources that have been devoted to institutional reform had been devoted to this task instead, priority setting would now have a much better evidence base than it actually has (Klein and Williams, 2000, 19–20).

By contrast, Klein’s response presumes the essential pluralism and incrementalism of policy formulation processes:

> There is no one value or principle from which we can derive our health care priorities … the problems of policy making do not stem primarily from a lack of information but from a lack of consensus about how to use and interpret it … unless we strengthen our institutional capacity to analyse evidence, to clarify policy choices and to promote informed debate, generating more information is more likely to compound confusion than to lead to better decision making (Klein and Williams, 2000, 21–25).

In an echo of Lindblom’s later work, Klein notably retains a role for evidence and its application to decisions but is at pains to promote consensus and debate as pre-requisites. This position receives some endorsement from the wider literature which suggests that tools such as HTA have not de-politicized policy formulation, and that many HTA bodies such as NICE can best be understood as one element of a broader process of pluralistic bargaining over resource allocation (Williams, 2016). However, in comparison to the evidential requirements, the pluralistic elements of decision making often remain informal and somewhat opaque. Holm (1998, 1001) articulates the risks that this poses:

> If our priorities cannot be directly legitimised as the rational results of following rational rules, what should we then do? We have to make decisions in some way, and we also have to be able to defend them publicly.

In the area of health care coverage, responses to this challenge have centred on codifying the *procedural* and *participative* domains of decision making. For example, Daniels and Sabin (1998) argue that coverage policies should be judged by the extent to which they meet conditions of procedural justice such as: transparency, revision, and ‘appeals to rationales that all can accept as relevant’ (Daniels, 2000, 1300). They convert these elements of reasonableness into four tests that decision making processes should pass: publicity, relevance, appeals and enforcement, with enforcement relating to mechanisms for ensuring the first three conditions are met. At the heart of their ‘accountability for reasonableness’ framework is the requirement to incorporate deliberation and debate – as well as information and evidence – into decision making.

HEALTH CARE COVERAGE AND THE 3IS

As we have seen, incrementalism has also been guilty at times of naivety in its characterization of deliberation between policy actors. Unequal relationships of power have been recognized throughout the study of policy formulation processes, which are often weighted in favour of specific groups. As a result, design elements of policy processes can be 'crowded out' by bargaining and 'log-rolling', or else may themselves be used to pursue partisan interests and agendas. Alongside the complex normative debates in policy formulation, there is therefore a requirement to account for the *realpolitik* of decision making and how this is subject to power, partisanship and even coercion. Here it is important to bring insights from the wider policy literature on how interest groups form into coalitions, networks, and policy communities and subsequently shape policy outcomes (Shearer et al., 2016). These may vary across policy subsystems which can themselves develop semi-autonomous processes and cultures which in turn impact upon the outcomes of policy formulation activities (Sabatier, 1988). For example, Alford (1975) draws on the familiar policy studies concept of 'interests' to map distribution of power in health policy formulation. He categorizes the interests of senior medical professionals as being 'dominant' due to their monopoly on definitions of health and disease. By contrast, advocates of rational policy tools such as government civil servants, health service managers and academic specialists in population health, are characterized as 'challenging' interests, whose agenda involves imposition of restraint and control over the activities of the dominant group. Finally, the interests of external actors on behalf of patients and the public are 'repressed', lacking significant influence over policy beyond shoring up dominant professional interests against the 'corporate rationalizer' group. The extent to which such imbalances of policy influence – which Alford was at pains to state were a heuristic simplification – still pertain is a matter for ongoing empirical inquiry. However, it is useful in pointing to the relationships of power and influence that confound any benign pluralism in accounts of the health policy formulation process. In health coverage policy this has been explored by Harrison et al. (1992) who found that there were 'dominant players' – e.g., the medical profession – and that there was little by way of 'mutual adjustment' taking place in respect to subordinate interests.

The 3Is framework reminds us that ideas also play a role in the relationships between actors in the decision-making process. Within resource allocation decision making, these are manifest in disputes between managerial frames which adopt various forms of cost benefit ideas, with more medical frames which prioritize immediate clinical considerations (Tenbensel, 2000). Participants in health coverage policy have also been portrayed as belonging to 'epistemic communities' (Haas, 1992; Löblová, 2018). Examples of these 'networks of the like-minded' include: the clinical fraternity; the community of health economists; and NHS senior management. External commercial actors such as those operating in the pharmaceutical industry can also seek to shape coverage policy towards their own ends, albeit with varying levels of success (Rickard and Ozieranski, 2021). Indeed, Lindblom in his later work developed an analysis of how businesses and markets constrain policy formulation (Lindblom, 1977). Overall, these critiques highlight the role played by ideas within such professionalized networks of interest groups, creating 'knowledge elites', and countering naive portrayals of technocratic policy design (Fischer, 2000).

In these ways, an incrementalist explanation overlooks the role of ideology, which Lindblom came to recognize. Coverage policy options are circumscribed by assumptions that many would argue are themselves ideological, rather than self-evident – i.e., that resources are scarce, that some level of rationing is inevitable, and that there therefore should be 'winners and losers' in service delivery. Light and Hughes (2004) argue that these are rhetorical constructions that serve particular interests and agendas – for example those of budget holders and system leaders – over others, including patients and service providers. Recognition of power asymmetry in health coverage policy formulation has led to calls for a fundamental reorientation towards minority players (McCollum et al., 2018; Razavi et al., 2020). This, in turn, echoes calls in the policy literature for attention to marginalized voices and re-balancing of power between experts and citizens (Fischer, 2000). If policy processes serve primarily to maintain 'systems of privilege, domination, and quiescence among those who are the most oppressed' (Schneider and Ingram, 1997, 53), part of the criteria for evaluating coverage policy ought to be 'the degree to which they advance democratic citizenship – that is, inspire political participation and remedy social division' (Sidney, 2017, 83). To this end, for example, Gibson et al. (2005) propose that 'empowerment' be added to Daniels and Sabin's criteria for procedurally defensible decision making.

In a study of NICE and its adherence to a rational mode of policy formulation, Williams (2013) shows how the 'democratic deficit' of unelected policy bodies can create a demand for decision rules informed by objective criteria and thresholds. In the case of NICE, this was intensified by the mandatory status of their decisions and the resulting high levels of external scrutiny and interest group contestation. NICE's apparent adoption of a rational model was further supported by the formal separation of policy *formulation* (NICE's responsibility) from *implementation* concerns, which were designated as beyond its remit. This meant that those involved with NICE were incentivized by the institutional context to adopt a design-based approach that was neither possible nor desirable at local levels of coverage decision making. Williams concludes:

> It is important to understand the goals and aims that call technology coverage bodies into being. It is equally important to track the adjustments subsequently made in response to pressures from the wider institutional environment and how formal goals are adapted in light of these (Williams, 2013, 226).

Landwehr and Böhm (2011, 667) extend this analysis to identify criteria to understand 'central aspects of delegation' affecting decision making in health care coverage:

- *Positive and negative defaults:* this refers to whether the limits to what health services are provided is expressed in a positive or negative list, with the latter considered more contentious and therefore more likely to be subject to blame avoidance in institutional design arrangements (Thatcher and Sweet, 2002).
- *Degree of independence and delegation*: bodies can be advisory, produce explicit recommendations that are subject to government consent, or can be commissioned to make immediately binding decisions (as with the NICE Technology Appraisals Programme). Further indicators include extent of independence from government ministries and departments, and how committee make up is determined.
- *Degree of inclusiveness:* this refers primarily to composition of the appointed body, and how narrowly/widely membership is conceived. As Landwehr and Böhm (2011, 670) describe, 'maximally inclusive bodies would be large, involving not only all potential stakeholders, such as representatives of manufacturers, patient advocates, clerics, representatives of minorities, and different regions, but also lay citizens'. And as we have seen,

how this involvement is enabled also has implications for whether more marginal groups merely provide a sheen of legitimacy or are actually granted power of decision veto.

- *Degree of publicity and transparency:* in an echo of Daniels and Sabin, this criterion concerns the extent to which 'meetings and proceedings, relevant documents, and reports are accessible to outsiders' (Landwehr and Bohm, 2011, 671).

It is not entirely surprising that coverage policy formulation is subject to the 'structuring effects' of such institutional arrangements, and that it will therefore adapt to changes in the task environment (Hill and Hupe, 2021; March and Olsen, 1996). The influence of institutional forms on policy decision making has been explored in other policy domains, and institutional analysis takes in not just formal organizational boundaries and procedures but also includes organizational cultures, values and ways of thinking (Hall, 1993; Peters, 1999). These can come together to create a 'logic of appropriateness' which circumscribes individual and group behaviours (March and Olsen, 1996).

SYNTHESIS AND CONCLUSIONS

This analysis of health care coverage suggests that it is an example of policy formulation that is more amenable than most to a rational approach, and that advocacy of design models has penetrated the heart of policy communities (referred to by Klein (2010) as the 'technocratic chastity belt'). As well as the development of many analytical policy tools, the rational approach is arguably embodied in the delegation of responsibility for decision making to specially designed bodies (albeit with varying levels of ascribed independence and authority). Despite these developments, the experience to date also suggests that there remains much to be applied from policy frameworks that emphasize plurality, procedure, politics, ideas and institutions. Coverage policy is not insulated from the interplay of actors, power and incentives structures, and what represents a 'good' prioritization of scarce resources is still a far from settled question. Frameworks such as the 3Is can help provide the conceptual tools to make sense of these complex inter-dependencies and how these play out in different contexts. More broadly, it is also important to remember that formal coverage policy accounts for only a small fraction of the typical spend on health care, and that most spending is determined by previous legislation and routine expenditures (Cairney, 2019).

Other themes from the policy literature remain somewhat under-explored in relation to health care coverage policy. For example, in the shift towards focusing on the role played by networks of non-state actors it is important not to overcompensate and neglect the influence of internal actors. For example, there has been little examination so far of bureaucrats (taken to include the range of governmental and civil service roles), and the extent to which they might also seek to maximize their own interests by, for example, increasing their budgets and resources, and by improving their profile and status (Niskanen and Houghton, 1973). A focus of the future empirical literature in health coverage policy could be to investigate the idea of the self-interested bureaucrat, given the growing appreciation of how institutional configurations shape and constrain policy decision making in direct and indirect ways. For example, it might be instructive to map the identities and behaviours exhibited in case studies of coverage decision making to a typology of bureaucratic forms, such as Downs' (1967) categories of 'climbers', 'conservers', 'zealots', 'advocates' and 'statesmen'. Similarly, there has been little direct exploration of the relationship between coverage decisions and the electoral calculations of governments and government agents. The 'median voter' theory has proven to have some validity in predicting policy decisions in other domains, albeit within the constraints on policy maker autonomy illustrated throughout this discussion (Ahmed and Greene, 2000; Goddard et al., 2006).

However, whilst potentially fruitful, it seems unlikely that pursuit of these neglected subthemes in health coverage literature will dislodge the dominant and recurring explanations presented in this chapter. Health care 'rationing' is highly emotive and subject to high levels of evasion, delegation and blame avoidance. Although in some ways typical of policy formulation more generally, this is perhaps one of its most consistent and distinguishing characteristics and one which threatens to elude satisfactory resolution. The normative pursuit of fair decision making will doubtless lead to ever more elaborate prescriptive models, and reheated disputes between advocates of technocracy on the one hand and democracy on the other. Indeed, the ever-complex policy realities will no doubt stubbornly resist simple explanation. In this situation, the task of the analyst is to continue to track the relative presence and influence of the myriad ideas, interests, institutions and other influences on policy outcomes.

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4. How to study the implementation of health policy interventions with integrative frameworks?

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INTRODUCTION

While the effectiveness of health interventions has monopolized scientific attention for decades, the state of knowledge on the analysis of their implementation is beginning to develop and catch up, even if it is very unevenly, across the world. Implementation can be defined simply as the process of organizing activities within a setting or organization, with some suggesting that the choice of these actions be based on evidence or sound theory (Damschroder et al., 2009), thus "getting science into practice and policy" (Fixsen et al., 2011).

In this chapter, we will not revisit the history of the study of policy implementation, which essentially shows that the field is still under construction. There is a large body of literature on this subject since, and well before, the famous book *Implementation* by Pressman and Wildavsky (1984), which has significantly influenced the field. In addition, Saetren's reviews (2005; 2014) and Hill and Hupe's (2021) book are very informative about the historical development of policy implementation research.

First, Saetren confirms the expansion of this field, especially outside the writings of its original discipline, political science. From 1933 to 2003, the health sector ranked second (15%), after education (38%), in the number of studies on implementation, with nearly 1100 articles, book chapters, or doctoral dissertations. However, many of these studies were conducted in the United States or Canada (69%) and only 4% in Africa (Saetren, 2005). This chapter will show how research conducted outside of the North American continent and the Western context can be inspiring for health researchers interested in policy implementation. We wish to move away from what Saetren (2005) calls the "ethnocentric bias in implementation studies".

Second, while the concept of implementation seems relatively well established, Saetren's reviews confirm that "we are not even close to a well-developed theory of policy implementation" (Saetren, 2005, p. 573). This highlights the importance of theoretical development, or even theoretical tinkering, to speak in the words of Denzin and Lincon (2018). For example, a review of health policy analyses in Africa from 2000 and 2017 (Jones et al., 2021) shows that a third of the articles took a theoretical bricolage approach, i.e., a heuristic mix of different theories and concepts, to better understand policy implementation (for more details on the bricolage approach, please read the next pages). Thus, "the theoretical basis for implementation is relatively new and needs to be tested and operationalized in real-world settings" (Franks and Schroeder, 2013 p. 12). According to Winter (2011), despite much work, we are in a situation of "too little theory accumulation. Implementation is too complex to be accounted for by one theory."

Another vital lesson from Saetren's reviews is that he suggests the existence of three generations of implementation analysis. The first generation, in the 1970s, used single-intervention focused approaches, rather qualitative and exploratory methods without any specific theoretical approach. For instance, Hogwood and Gunn (1984) established a list of eight a-theoretical "prerequisites for perfect implementation". The second generation, in the 1980s, borrowed more conceptual frameworks and theories, and the studies became more empirical with more use of statistical techniques of analysis (Saetren, 2005). According to Saetren (2014), the third generation would be about rigorous research designs, applying multiple, clearly defined variables, a willingness to test hypotheses from theoretical propositions using mixed method research, and in a more comparative and longitudinal perspective, from five to ten years.

Most importantly, Saetren shows a gradual shift amongst scholars, from the classic dichotomy between top-down and bottom-up analytical and theoretical frameworks towards "integrative and synthesizing" frameworks, as a key feature of third-generation policy implementation research. Here, we briefly review the core components of the debate.

Several policy analysts considered those above "perfect implementation" model as being a top-down, prescriptive and normative model (Palfrey, 1999). For example, in England, a study in the 2000s based on Gunn's perfect implementation proposals highlighted the challenges associated with implementing top-down guidance in health sector policies (Checkland and Harrison, 2004). In reaction, some suggested "bottom-up" models – Lipsky's "street-level bureaucrats" being the most well-known of these models looking into the (potential) influence of lower-level actors in the implementation process, e.g., teachers, nurses, and social workers (Lipsky, 1980). For example, in France, a study carried out in the 2000s using the street-level bureaucrat's approach showed how the consideration given by welfare officers to their beneficiaries partly reflects the way in which poverty is understood and considered by the welfare state (Dubois, 2005). The "bottom-up" model thus enables the investigation of the consultation or negotiation process that takes place between those who design policies (situated at the top) and those who implement them. This proposal is coherent with Pawson's perspective (2013), who argued that implementation success will come if social actors, through their reasoning and subsequent actions, decide to support it. In other words, what has been planned before the implementation stage does not necessarily come to fruition when the new policy encounters key actors and contexts.

Yet, let us go beyond the classic stakeholder analysis, which is too often the only tool used by certain researchers to analyse the implementation of policies from the perspective of street-level bureaucrats. We are thinking particularly of the cognitive analysis of public policies and the role of ideas or even the ideologies of actors. Their influence is not limited to the emergence but the implementation of policies. This ideological influence has been shown, for example, for the suppression of the policy instrument of direct payment for care and payment by performance in Africa (Béland and Ridde, 2016; Gautier et al., 2018). Since Lipsky's (2010) proposals on the role of street-level bureaucrats and their ideas, it seems that they have rarely been applied to the analysis of the implementation of policy interventions aimed at reducing social inequalities in health. Yet, equity is a central value in our societies, and it deserves attention in the study of health and public policies, especially in low-income countries (Ostlin et al., 2011). Some neoliberal ideas, for example, lead to the sidelining of the need for more equity and social justice when implementing health policies in Africa (Ridde et al., 2018).

As it turned out, neither the top-down model nor the bottom-up model, captured "the full complexity of the implementation process" (Palfrey, 1999, p. 49, citing Elmore, 1978). Studying the factors that influence policy implementation is indeed a worthy, yet complex endeavor (de Leeuw et al., 2014; Durlak and DuPre, 2008; Franks, and Schroeder, 2013). We can rather speak of two sides of the implementation coin: challenges in the field (*implementation failure*), and challenges in designing the implementation (*intervention failure*). What Saetren and Winter call "integrative and synthesizing" frameworks are relevant illustrations of that metaphor: they would simultaneously address the two sides of the implementation coin (Winter, 2012). Matland's framework (1995) provides a useful analytical lens, but it predominantly features Western-centered characteristics (e.g., public administration culture, democratic institutions, sovereign citizenry, rule of law culture, etc.). Since we adopt a global outlook to policy implementation, it would be challenging to apply Matland's framework – all the more so in the context of power issues involved in official development assistance funding. Such power dynamics largely influence the formulation and implementation of health policies (Gautier and Ridde, 2017). Similarly, in Pulzi and Treib's (2006) analysis of theories for the study of policy implementation, what they call "hybrid approaches" also reflect the interface between the top-down and bottom-up approaches. They can thus also be called integrative or comprehensive to follow Hill and Hupe (2021). All cases reviewed in this chapter provide concrete illustrations of applying diverse integrative theoretical and conceptual frameworks globally.

Integrative frameworks may involve a *bricolage*, i.e., "do-it-yourself" strategy in which existing theories and conceptual frameworks are combined. Qualitativist authors describe *bricolage* as combining various elements (interpretations, theories, concepts, tools) to tackle the complexity associated with social phenomena (Denzin and Lincoln, 2011). To Jones et al. (2021, p. 1208), "multiple theories used together provide an overarching frame with more explanatory power for the policy processes in a given context". The conclusion of a recent book promoted the *bricolage* approach, calling for a need to move "beyond the tendency towards theoretical monomania", notably through acknowledging the added value of "flexible" identification and combinations of theoretical models of the policy process (de Leeuw, Cassola and Fafard, 2022, p. 332). In fact, the *bricolage* strategy aligns well with what Winter (2012, p. 265) suggested ten years ago, i.e., that policy implementation research should be "accepting theoretical diversity rather than looking for one common theoretical framework". Indeed "the theoretical base for implementation is relatively new and needs to be tested and operationalized in real-world settings" (Franks and Schroeder, 2013, p. 12). Some of the cases reviewed in the present chapter indeed feature the *bricolage* approach (e.g., case 2).

Saetren's 2014 review provides a last important constitutive argument for our chapter on third-generation policy implementation – his calls for doing more single and multiple case study research. First, Saetren acknowledged the value of *critical* single case studies for demonstrating the relevance of specific theories or conceptual frameworks. Single case studies also allow for in-depth investigations of complex social policies that can be useful to policy-makers. Second, Saetren encouraged the use of multiple case studies, which allow for comparisons across cases. Saetren (2014, p. 92) argues that "the comparative research design is an important defining feature of the third-generation research paradigm" in policy implementation. Building from Saetren's research method reflections, the cases reviewed in the present chapter reflect single and multiple issues.

THE SELECTED CASES

In this chapter, we reviewed empirical studies that reflected the defining features of third-generation policy implementation research according to Saetren, and from the global health perspective. Cases were thus selected based on the following criteria: a) to represent the global geographical diversity and contexts where health policy implementation studies remain rare (i.e., Francophone countries and West African countries), b) to feature original research applying a diversity of integrative frameworks, and c) to reflect diverse case study methods.

A Global Health Reflective Approach

We wish to position our reflection on a global scale by proposing empirical examples of health policy implementation from several countries on different continents, in a global health perspective transcending national borders. We are thus part of the contemporary call for more reflexivity on the methods used to analyse implementation (Tremblay and Parent, 2014). In this chapter, the authors reflected *a posteriori* on their mobilization of specific theories and frameworks. Our goal is twofold: i) to provide the readership with empirical examples of how integrative theoretical and conceptual frameworks have been mobilized empirically, and ii) to share lessons about the challenges of using them.

Diverse Integrative Frameworks

Implementation studies still need to be made available in Africa. This chapter is an opportunity to show how the mobilization of three integrative conceptual frameworks for analysing policy implementation that are widely used in (and coming from) North America have been applied to the study of health policy implementation in Mali and Senegal. The Quality Implementation Framework (QIF), with its 14 steps grouped into four phases based on a synthesis of 25 analytical frameworks, has yet to be applied in Africa (Eboreime et al., 2019; Meyers et al., 2012) (see Case 1). The first and second phases, i.e., 'initial considerations regarding the host setting' and 'structural features for implementation' reflect both bottom-up and top-down policy implementation issues. Similarly, the Consolidated Framework for Implementation Research (CFIR), a "meta-theoretical framework" for policy implementation studies and its 39 constructs organized around five domains (Damschroder et al., 2009), is in widespread use now (see Case 5). Four domains, i.e., intervention characteristics, inner setting, outer setting, and characteristics of individuals, provide useful assessment criteria for analysing not only policy implementation but also policy design. Third, one of our cases (Case 6) featured an application in Mali of Durlak and Dupré's (2008) "ecological framework for successful implementation" of 23 factors that influence policy implementation. While this approach focuses on a list of factors to be considered, it is based on an interdisciplinary synthesis of nearly 600 empirical studies of implementation, both quantitative and qualitative. The ecological framework for understanding the effectiveness of intervention implementation is based on five main areas of influence that cover both bottom-up and top-down processes: innovations, providers, communities, delivery system and the support system (see also Case 6). This chapter featured the issue of policy coherence from the perspectives of both policy designers and policy implementers through the analytical lens of OECD's *Policy Coherence for Sustainable Development Framework* (see Case 3).

Finally, without entering the old critical analyses of *stagists*, we thought it was important to show how it is sometimes necessary to go beyond studies of implementation that do not sufficiently consider the "big picture'" including the inherent complexity and the effectiveness of policy interventions. A systemic and complex approach to health policy deserves particular attention here. Two reasonably new approaches should be highlighted. First is the realist approach (see Case 7), which stresses the central role of various theories in the implementation analysis, but also that of social actors and the concept of mechanism in explaining the functioning of policy interventions (Pawson, 2013; Ridde, 2016). Second, the theoretical proposals of process tracing (Beach and Pedersen, 2019) aim to understand better the impacts (or lack thereof) of policy intervention. This can be done by uncovering how the policy intervention was organized based on hypotheses of the causal mechanism to be tested. The process tracing approach has not been widely applied in Africa. The example of Burkina Faso (Case 4) showed its heuristic power but also its challenges.

Single- and Multiple-case Study Research Designs

Our last criterion was to review cases adopting either a single-case or a multiple-case study research design. Multiple cases reflected either various policies, or implementation in numerous geographical locations.

Thus, each of the seven case studies presented allow us to understand the context and objective of the study, the choice of the integrative approach/framework (and its key components), the research strategy used, the main results, and above all, the lessons learnt process we offer. Because methodological issues are central to the competencies of policy implementation researchers (Schultes et al., 2021), the focus will be on showing what worked well methodologically, how it could have been done differently and, finally, critical lessons learned that may help improve policy implementation analysis.

1. Single case studies in health policy implementation

Case 1: Using the Quality Implementation Framework (QIF) to analyse the implementation of the national response to SARS-CoV-2 in Senegal

STUDY SETTING

Senegal had experience in fighting infectious diseases. As such, the country was early to respond to the COVID-19 pandemic, well before the first case appeared on March 2, 2020. Technical committees planned the national response, and state measures were quickly taken. However, these were soon suspended after widespread protests in the context of an outbreak that remained low in lethality. The government launched an economic and social resilience plan with a projected budget of 1 trillion CFA francs, financed mainly by international aid.

Study objective

A mixed-methods study was conducted in March and April 2021 with a qualitative component aimed at understanding the national response's design and implementation.

Integrative framework

Quality Implementation Framework (QIF) and factors that support or constrain implementation are used to determine quality lessons learned (Patton, 2001). The four areas of QIF (initial consideration, creating the structure of implementation, implementation support, improving future application) allow an integrative view of public policy processes without focusing solely on implementation and street-level workers agency. QIF also provides for the study of design, decision and capacity-building elements. Moreover, while QIF is originally an integrative framework, the reflection on step 14 concerning lessons learned to improve future implementation should be combined with Patton's conceptual and pragmatic proposals for further clarification (2001).

Research strategy

The implementation study used a case study strategy in eight of the country's 14 regions, including the capital (for design and implementation). The analysis was based on the QIF framework. Data was collected by researchers in Dakar and research assistants in the regions after training and with daily follow-up. A total of 189 interviews were conducted with key stakeholders at the national, regional and local levels (decision-makers and implementors).

Summary of results

The implementation of the response was facilitated by good preparation, the ability to adapt, the responsiveness of stakeholders, and the commitment of political and religious authorities. It was confronted with a coercive approach, challenges in the coordination of actors, and the absence of an intersectoral response. The response remained highly politicized, centralized, directive, and limited civil society involvement.

What worked well

It was essential to adapt the design of the original 14 generic steps of the QIF to the context of the study in Senegal. The complementarity and sequencing of the dimensions used were fruitful. Prior reflections on the dimensions of implementation quality, enabling and constraining factors allowed the interviewees to reflect on the lessons learned. These lessons were also discussed and validated during a national workshop with key officials at the central level.

What we would do differently

Conduct a national survey with a limited budget and during an ongoing pandemic, researchers could not cover every region in-person. The use of research assistants at different levels (national, regional and local) may have reduced the ability to have in-depth data on some dimensions. It may have led to differences in interpretation between the assistants. The QIF and Patton's lessons-learned approach remain very pragmatic and helpful for managers, but the results remain relatively limited in theoretical and conceptual scope. The discussion of our analysis allowed for some ex-post generalization about the role of ideas, actors, and policy instruments to go beyond this overly pragmatic but useful vision for national leaders.

LESSONS LEARNED FOR ANALYSING THE POLICY IMPLEMENTATION

- The QIF, based on the synthesis of 25 frameworks, is sufficiently broad and generic to address all the elements useful for the analysis of implementation in different types of contexts and by considering the interrelationships (not the steps) between design and implementation.
- QIF is simple and didactic enough to be used in a collaborative research approach with field research assistants who may need to gain interdisciplinary training and experience in using integrative frameworks.
- Challenges associated with testing and adapting questions from the QIF to the specific context of the study and to avoid a dichotomous analysis between a top-down vs bottom-up approach.
- Combining the QIF with more theoretical approaches ex-ante or ex-post analysis would provide interesting avenues for future implementation science research.

Case 2: Applying a bricolage framework to explore whether and how the French COVID-19 centre considered social inequalities in health when implementing testing and vaccination

STUDY SETTING

In France, Seine-Saint-Denis' district bore the burden of social inequalities in health (SIH) during the COVID-19 pandemic, particularly affected by the health crisis and its impacts. Several testing and vaccination centres were set up within the territory's healthcare facilities to reduce SIH in response to the pandemic. The aim was to promote the accessibility, availability, and acceptability of these interventions for the population. Our research was conducted in one of these centres, located within a public hospital.

STUDY OBJECTIVE

The study aimed to analyse the centre's implementation of testing and vaccination, focusing on considering SIH in this process.

INTEGRATIVE FRAMEWORK

Initially, the Reflex-ISS tool – a health promotion tool designed to encourage the consideration of SIH at each stage of intersectoral and public health interventions (planning, implementation, evaluation, empowerment, sustainability) – was identified as the conceptual framework to guide data collection and analysis. Since the Reflex-ISS tool covered each stage of public health interventions, it allowed us to focus on the implementation and design-related challenges faced by the actors regarding SIH consideration. As per a methodological bricolage, the use of Reflex-ISS was progressively combined with a more ethnographic method of inquiry. This approach enabled us to investigate in-depth both the top-down and bottom-up processes in the center, and to emphasize the centre's workers' experience with SIH consideration.

RESEARCH STRATEGY

The result of this bricolage is a qualitative survey combining a deductive approach to the consideration of SIH with an inductive approach to produce a monograph of the centre, studying the implementation processes, the work of the agents, their socio-professional trajectory, and their relationship to the function they perform.

SUMMARY OF FINDINGS

Consideration for SIH in the implementation of testing and vaccination interventions is a complex subject to grasp. Various actors, including the centre's agents, frontline public service actors, determine how SIH are considered. Most of the young professionals in the centre's team have little professional experience in the health field and occupy a marginalized position in the hospital and social hierarchy. They face structural and situational inequalities influencing their understanding of SIH. Moreover, they are confronted with multiple administrative and organizational complexities that hinder specific approaches to reducing SIH. The latter sometimes leads to unintended results, such as the confiscation of many vaccination slots by wealthy and non-local populations at the centre, at the beginning of the vaccination campaign.

WHAT WORKED WELL

The qualitative survey allowed us to understand the drivers and determinants of the centre's agents' views and consideration of SIH. The implementation of an ethnographic research method detached from the Reflex-ISS framework resulted in the emergence of results anchored in a complex context (societal, hospital, individual), favoured by the relationship of trust gradually established between the respondents and the researcher. The observations carried out in different spaces allowed for an in-depth and finely contextualized understanding of these phenomena around the ideas and conceptions of SIH by the actors. The ethnographic research method allowed to increase our epistemic scope as we bypassed the descriptive perspective induced by Reflex-ISS used as an investigative tool. The analyses of this investigation were shared and validated by diverse hospital actors. The links established during this research led to new collaborations.

WHAT WE WOULD DO DIFFERENTLY

Over the course of the research, we experienced some challenges in applying the Reflex-ISS tool on the field, which resulted in a shift in the study from deductive to inductive, accompanied by the gradual abandonment of Reflex-ISS as a data collection tool. These challenges could have been anticipated, as the Reflex-ISS tool appeared difficult to mobilize in a context as singular as the centre's. Specifically, the structuring of the bricolage model along the Reflex-ISS dimensions did not resonate with the study participants' experience on the field. In practice, this issue led to a negative perspective upon analysis of the collected data. It would have been advisable, instead, to favour a predominantly ethnographic approach from the very beginning of the survey, thus avoiding the progressive methodological shift, which was a source of questioning for the respondents. The latter, who had been presented with the survey as dealing with the consideration of SIH in response to COVID-19, questioned the purpose of the researcher's prolonged presence at the centre, and long-term observation of implementation processes, particularly in spaces where the topic of SIH was not explicitly addressed. If the research requires addressing specific elements, the experience of this survey suggests that a reverse methodological shift – from the ethnographic approach to the deductive approach, or the less specific to the more specific – would be more comfortable for the respondents and the researchers. It would allow time for each party to understand the other outside of any conceptual framework. At the same time, a relationship of mutual trust is established, before explicitly tackling the more specific elements of interest for the researcher (which are not necessarily those on which the respondents wish to dwell).

LESSONS LEARNED FOR ANALYSING POLICY IMPLEMENTATION

- The use of the Reflex-ISS integrative framework allowed investigators to explore the different dimensions of the intervention implementation. This approach appeared highly relevant in the health crisis context in which all stages of the intervention were blurred, actors multiplicated, and traditional implementation processes disrupted.
- A better anticipation of the challenges of interdisciplinary research practice and integrative framework (i.e., theoretical bricolage, in our specific case) could have smoothed the empirical research work. This could be achieved by intensifying a dialogue between researchers from different disciplines to stabilize consensual methodological choices before launching the survey.

Case 3: Using the Policy Coherence for Sustainable Development Framework to analyse the implementation of the Health in All Policies approach in Kenya

STUDY SETTING

Kenya is one of the few Sub-Saharan African countries adopting Health in All Policies (HiAP). Kenya's sixth policy objective in the national Health Policy for 2014–2030 aims to "strengthen collaboration with private and other sectors that have an impact on health" and explicitly addresses various social determinants of health through HiAP.

STUDY OBJECTIVE

This single, qualitative case study aimed to assess how the HiAP approach was implemented alongside the Sustainable Development Goals (SDGs) agenda.

INTEGRATIVE FRAMEWORK

To reflect the complexity associated with HiAP policy implementation in a low- and middle-income country such as Kenya, we chose the Organization for Economic Co-operation and Development (OECD)'s Policy Coherence for Sustainable Development (PCSD) Framework (OECD, 2016, 2018). The PCSD framework was initiated as the agenda of the SDGs was gaining momentum. It provided a roadmap for ensuring the congruence of national policies with the SDG agenda. The framework features five components: (a) political commitment, (b) inclusion (stakeholders' engagement, involvement of all juridical levels including subnational and local levels), (c) policy coherence (coordination, integration, and effects), (d) long-term planning, and (e) monitoring and reporting. These key components emphasize intersectoral collaboration, multistakeholder engagement (i.e., from designers, funders, to implementers), and accountability, i.e., core "success factors" of successful health policy implementation.

RESEARCH STRATEGY

We conducted an exploratory single case study. Individual interviews were conducted using a purposeful sampling approach with 24 key informants, including government, development partners, NGO employees, and independent consultants. The PCSD framework guided the policy implementation analysis.

SUMMARY OF FINDINGS

HiAP and SDGs implementation coherence primarily relied on policy coordination and mapping of stakeholders' engagement, as they allowed to strengthen both horizontal and vertical coordination. The study also highlighted the need for more appropriate coordination mechanisms to allow ministries and other key stakeholders at lower levels (e.g., street-level bureaucrats in public sector agencies) to share information, define and distribute responsibilities, allocate resources, and monitor progress more efficiently. Relying on existing local structures could prove a critical leverage for overseeing the implementation of both SDG and HiAP policies (e.g., through county-level oversight bodies).

WHAT WORKED WELL

This work was one of the first of its kind to apply the OECD framework for scientific research (Mauti et al., 2022). The integrative framework approach enabled the reflection of complex policy implementation processes involving actors at the various levels, particularly through the dimensions of inclusion (stakeholders' engagement at all juridical levels) and policy coherence (coordination, integration, and effects).

WHAT WOULD WE DO DIFFERENTLY

Two of the framework's components (i.e., subnational and local involvement; policy coordination) highlighted the importance of assigning responsibilities at all juridical levels. Our analyses could not feature the county level as time and resource constraints prevented us from interviewing informants at the county level.

LESSONS LEARNED FOR ANALYSING POLICY IMPLEMENTATION

- The PCSD framework offers a flexible, user-friendly guide for documenting policy implementation in diverse governance contexts, reflecting both the perspective of policy designers and policy implementers at subnational and local levels.
- The PCSD Framework principles proved useful to assess the implementation of HiAP from the perspectives of both policy-makers (i.e., those who designed the HiAP policy) and implementers (i.e., those who participated in policy implementation) through the lens of policy coherence analysis. Specifically, the framework enabled us to focus on coordination mechanisms in implementing the HiAP approach, which led us to examine the linkages between decisions and actions across different governance levels, from international to national and local levels (i.e., "vertical coherence").
- In addition, the framework featured sustainability as a guiding principle in two ways. First, long-term sustainability lies at the framework's core in the long-term planning horizons component. HiAP implementation was portrayed as benefitting from the long-term planning horizons of the SDGs, which were able to move past the quick turnover of political cycles effectively. Second, the PCSD framework's specificity lies in its integrated evaluative component "monitoring and reporting" (i.e., to systematically track progress as the implementation progresses). Informing this component is often a blind spot of implementation frameworks.

Case 4: Using process tracing to explain why performance-based financing in Burkina Faso failed to achieve the intended equity effects

STUDY SETTING

Performance-based Financing (PBF) has been extensively tested as a way of reforming provider payment to improve access to and quality of care in low- and middle-income countries over the past 20 years. Addressing criticism that PBF might benefit the best-offs and damage the worst-offs, PBF has also been tested in conjunction with demand-side interventions to enhance access to healthcare among the ultra-poor. One of these pilot interventions took place in Burkina Faso between 2014 and 2018. An impact evaluation showed that the specific equity measures did not produce the intended effects.

STUDY OBJECTIVE

We used a process tracing approach to understand the reasons for the lack of impact produced by the equity measures.

INTEGRATIVE APPROACH

At the time we conducted the study, a wealth of knowledge on the intervention and its impacts had already been generated. What was lacking, however, was an understanding of how the logic of the intervention design was aligned with local needs, expectations, and capabilities, and therefore capable of producing the intended change through the implementation of specific actions. *Process tracing* was instrumental in this regard because it allows mapping implementation realities against the underlying design construct. The wealth of data and evidence already available on the intervention enabled us to adopt process tracing. Had we not had access to such a wealth of data ex-ante, the method might have been out of reach, albeit perfect to confront design intentions with implementation realities, given that mapping the details of the mechanism chain is inevitably very data-demanding.

RESEARCH STRATEGY

Process tracing is a qualitative method originating in political science. Process tracing aims to establish confidence in how and why something occurred through formulating and testing detailed hypotheses to specify the assumed causal mechanisms of an intervention in a single-case, uncontrolled design. The development of a clear understanding of implementation context, successes, and failures is an inherent component of the method. We reconstructed the theory of change of the equity measures through implementation documents, stakeholder feedback, and our own knowledge of the intervention and its context. We then supported or invalidated the reconstructed theory of change elements with published evidence, secondary data, and a qualitative study. While process tracing is usually employed to understand how and why an intervention produced an effect, we instead employed the method to understand the known lack of impact by investigating where and how the theory of change failed to play out as planned.

SUMMARY OF FINDINGS

Our study revealed that the logic of the intervention was not always aligned with its implementation's needs, expectations, and capabilities. This allowed only limited change to take place insofar as the equity measures embedded within the PBF programme were concerned. We could look at how incentive payments intended to motivate providers to privilege care for the ultra-poor failed to do so, not because the logic underpinning the mechanism of action was *per se* faulty, but because payment levels did not meet needs and expectations of healthcare providers to cover basic healthcare costs. Similarly, the rationale of targeting the ultra-poor and enabling prompt identification in the healthcare system was not *per se* faulty at the design stage. Still, the actual process of targeting and distributing cards faced several challenges impeding the expected mechanism to work out as planned in promoting change. These examples illustrate how the intervention design interacted with implementation challenges to partially impede the theory of change from translating into practice. This explains why the equity measures failed to produce the anticipated effect of enhancing healthcare utilization among the ultra-poor.

What worked well

Our study is one of the first attempts to translate the process tracing method to evaluate complex health interventions. We were therefore faced with few "precedent cases" to learn from. This proved challenging but also gave us flexibility in adapting the approach to the realities of complex intervention research in global health. We found the approach extremely helpful in decomposing the theory of change and systematically understanding shortfalls. With a view towards the practical value of the research, our findings are easily accessible to implementation stakeholders, clearly showing critical elements and their influence on the success of the intervention.

What would we do differently

First, we identified process tracing as a potentially helpful methodological approach relatively late along the path of our overall evaluation of PBF in Burkina Faso. We applied the method rigorously, but we inevitably missed the opportunity to plan ex-ante for data collection activities geared specifically at generating evidence for our process tracing. Hence, we sometimes struggled to identify sufficient evidence to elucidate a given mechanism and had to use existing data sources falling somewhat short of meeting our expectations. Second, we recognize that process tracing entails reducing a complex reality to a simplified series of sequential steps. On one side, we found this helpful process since it forced us to think through what elements were essential for the success of the intervention. On the other side, given the complexity of the intervention, tapping into multiple health system dimensions on both the demand- and the supply-side, we often questioned our decisions. Third, even though we reduced the intervention to a minimum of sequential steps, we struggled to identify a strategy to communicate findings concisely, comprehensibly, and meaningfully for both policy and academic audiences. We felt we had more data than we could handle in a single study. Fourth and last, we struggled to decide the extent to which a mechanism having played out only partially or only weakly represented a problem for the overall realization of the intervention. While the method is set to validate or invalidate working hypotheses on how a mechanism plays out to produce a given effect, the reality is rarely set around such a strict dichotomy. In practice, we had to rely on our extensive knowledge of the intervention to gauge the role that a given part of the theory of change played in relation to its achievements or shortcomings.

Lessons learned for analysing the policy implementation

- Process tracing can successfully be used in global health studies to map the design of a policy against its implementation, capturing different dimensions of action in detail.

- Given the wealth of data needed, it is best to plan for it ahead of starting an evaluation to ensure adequate primary data collection and access to reliable secondary data sources/evidence.
- "It takes a village" to lead a process tracing evaluation towards a successful end, so it is best to engage several experienced researchers on the project, along with all phases from theory development to evidence appraisal.

2. Multiple case studies in health policy implementation

Case 5: Using the Consolidated Framework for Implementation Research to analyse the implementation of Performance-Based Financing in Mali

Study setting

This research focuses on the implementation of the pilot of a health system strengthening intervention – performance-based financing (PBF) – in district hospitals (DH) in the Koulikoro region of Mali. PBF aims to increase the productivity and quality of healthcare delivery to populations by paying health centres based on their performance, measured by the quantity and quality of services provided.

Study objective

This research was conducted from December 2016 to January 2017, focusing on stakeholder perceptions and the context of PBF implementation in DHs. The aims were to understand the issues related to the design of the PBF intervention model, the influence of the local context and to show the specificities of local norms and values when implementing PBF in DHs.

Integrative framework

The Consolidated Framework for Implementation Research (CFIR) with its different taxonomies, dimensions, and constructs (Damschroder et al., 2009) was used. There are five main dimensions to understanding policy implementation: the characteristics of the intervention, the external context, the internal context, the characteristics of the individuals, and the implementation process. In the case of PBF in Mali, two dimensions of the CFIR (i.e., characteristics of the intervention and the external context) helped to address the design challenges of the PBF intervention. In contrast, the other helped to inform the implementation of the intervention for stakeholders.

Research strategy

We adopted a qualitative approach based on a multiple case study design. The cases are three among the 10 DHs in the Koulikoro region. We conducted 36 interviews, 24 non-participant observation sessions, 16 informal interviews and used a literature review.

Summary of findings

The findings showed that most health workers were committed to the PBF policy intervention. However, except for the key implementation actors, and those from one district who had already experienced a pilot PBF project, respondents needed more knowledge of the intervention. Stakeholders perceived the PBF pilot as a vertical intervention, externally driven, and focused on reproductive health. In addition, local stakeholders were not involved in the design of the PBF model. Several challenges to the quality of its design and implementation were highlighted: the intervention was too short (eight months), the choice and number of indicators were insufficient for the donor (The World Bank) priority, and the model could not be modified during implementation. Only respondents from one district with prior PBF experience provided some insights on implementation success.

What worked well

The choice of the different taxonomies, dimensions, and constructs of the CFIR was made by several researchers from different disciplines (anthropology, public health, and psychology). A prior discussion of the CFIR conceptual framework within the research team allowed us to retain certain constructs and remove those that did not apply to the context of PBF implementation in Mali. We used the French version of the CFIR, which allowed us to create a table that included the different constructs retained and their descriptions, the constructs not retained, and the justification for why they were not kept. In addition, the multiple case study approach allowed for reporting on contrasted findings across the three implementation locations.

What we would do differently

We believe that the results of using the CFIR during the implementation of an intervention should be used to inform implementers and decision-makers about adaptations to the intervention during its implementation, scale-up, or termination.

Lessons learned for analysing the policy implementation

- The CFIR provided evidence on the design and implementation challenges of PBF in Mali.
- The evidence produced was summarized and transferred to the implementing agency, and the donor helped to improve the design of the new PBF project, taking into account the design and implementation challenges of the previous project.
- The CFIR did not allow for the identification of causal links (between the different components/implementation process/internal and external context on the one hand, and the effects on the other).
- A longitudinal study was initially planned to enable us to see the evolution of PBF implementation over time. However, due to significant delays in implementation, we had to conduct a cross-sectional study, covering only the eight-month implementation time of the PBF pilot project.

Case 6: Applying Durlak and Dupré's 23 influencing factors for analysing the implementation of a method for targeting vulnerable households in two Northern Mali communities

Study setting

Identifying and selecting individuals or households to benefit from social interventions remains a challenge in Africa. Several methods for targeting these people exist. Inspired by the experiences of Niger and Burkina Faso, in 2014, six international NGOs funded by the European Commission Humanitarian Office launched a pilot project in the Gao and Timbuktu regions. Through a cash transfer intervention, its objective was to mitigate the consequences of food and nutrition insecurity during the pastoral and agricultural lean seasons for the most vulnerable households. The Household Economy Approach (HEA) targeting method was the preferred method used by two NGOs to select households eligible for receiving the cash transfer. The pilot project was implemented in northern Mali between June 2016 and October 2017.

Study objective

To understand how the HEA method is implemented by two NGOs, in two different villages (a pastoral and an agricultural village) and how the context shapes the intervention, and to identify factors that constrained or facilitated the HEA method's implementation.

Integrative framework

The Durlak and Dupré (2008) framework used to identify and classify factors was developed following an analysis of 542 health promotion and prevention programmes. From this analysis, the authors extracted 23 factors identified in at least five studies. The 23 factors were grouped into five categories reflecting bottom-up and top-down processes: 1) community-level factors, 2) provider characteristics, 3) characteristics of the innovation, 4) prevention delivery system: organizational capacity, and 5) prevention support system: training and technical assistance.

Research strategy

This was an exploratory qualitative multiple case study reflecting various implementation sites. Two villages in an agricultural community and two fraction locations in a pastoral community were selected as implementation sites. Data collection (48 interviews and 15 documents) was conducted between April and November 2016. Data analysis was carried out based on the 23 factors that influence implementation.

Summary of findings

The results showed that household identification was based primarily on geographic and community targeting. The factors that influenced the targeting process were the low knowledge of the HEA method, the lack of enthusiasm and low motivation of the people involved, the top-down management, and the need for more transparency in the decision-making processes. We have also identified logics of domination and power relations within communities, as well as issues relating to funding and hegemonic relations in the humanitarian aid and official development assistance sectors. The context of insecurity in the pastoral community (vs. the other agricultural community) contributed to impeding communication between implementation actors, which had some negative impacts on the implementation.

What worked well

The researcher's introduction to the field by people with prior knowledge of the context and the participants' collaboration (openness and transparency) was beneficial to the study. The prior development of the interview guide based on Durlak and Dupré's (2008) conceptual framework facilitated the identification of factors that influence implementation.

What we would do differently

Insecurity in northern Mali limited access to the field as some sites had to be removed from the geographic sample. Insecurity hurt matching time and resources (human and financial) for data collection. The difficulty in recruiting professional and accredited interpreters was an issue. Better reporting of results to stakeholders would have enriched this research. The late analysis and publication of the research results (in 2019 when the intervention occurred in late 2016) prevented process improvement.

Lessons learned for analysing the policy implementation

Given the complexity associated with the different levels of analysis (institutional, organizational/community, and individual) and the diversity of actors involved in the process of implementing an intervention, researchers are increasingly encouraged to explore and use combinations of concepts, theoretical approaches, or methodological approaches in order to best capture the real-world conditions in which an intervention takes place. In this case study, process analysis combined with Durlak and Dupré's (2008) framework allowed for the identification of factors that influenced the implementation of the HEA targeting method in two distinct communities: one agricultural, one pastoral – with some variations mainly due to a different political context. While context shaped the intervention, we also noted that adaptation takes time and depends on the original intervention's design flexibility. We strongly recommend that time be secured for adapting to the context of the mechanisms inherent in an intervention's design. This time should be planned in advance, factored into the timeline, and protected.

Case 7: Realist evaluation and integrative framework for collaborative governance to understand the contribution of WHO in supporting health policy dialogue

Study setting

WHO supports several countries worldwide in their efforts to achieve universal health coverage (UHC), including through the Universal Health Coverage Partnership. This Partnership aims to support policy dialogue, a collaborative governance instrument placed under the leadership of ministries of health. Policy dialogue initiatives can address different topics related to UHC: health financing, health planning, coordination of health stakeholders, etc.

Study objective

The objective was to understand how the Partnership was working, in what context(s), particularly in African countries, and identify its outcomes on collaboration dynamics.

Integrative framework

The research drew on Emerson and colleagues' (2012) integrative framework of collaborative governance, to understand the role of the Partnership and the policy dialogue dynamics. This framework is integrative because it draws on concepts and knowledge from a variety of disciplines; it exposes the multiple relationships between system contexts, actors' roles and behaviours, process outcomes and long-term impact; and it allows for the study of various interventions or phenomena affecting or contributing to collaborative governance, as part of the collaborative governance process.

Research strategy

To consider the diversity of contexts in which the Partnership was implemented and the variety of topics policy dialogue initiatives may address, we conducted a realist evaluation using a multiple case study design in six African countries. We used qualitative research methods, including interviews, observations, and document analysis.

Summary of findings

Two implementation modalities strongly influenced outcomes: the modalities for deploying the Partnership in-country (one expert in-country; multiple experts in-country; one expert available for several countries); and the leadership, expertise, and collaborative know-how of Partnership experts. Context also strongly influenced the ability of Partnership experts to initiate and support policy dialogue, such as the level of involvement of ministries of health, the transparency of policy dialogue processes, and stakeholders' sense of meaningful contribution to policy dialogue.

What worked well

Developing the intervention theory of the Partnership and its intended outcomes helped identify the accountability threshold of the Partnership. It also helped to distinguish the Partnership outcomes from the effects of policy dialogue. The use of qualitative methods (interviews, observations, document analysis) combined with the investigation of several cases provided a wealth of data that facilitated a realistic transversal analysis (Pawson, 2013). Finally, the emphasis on actors' roles, behaviours, and attitudes – through the mechanism concept – contributed to the identification of complex causal relationships that are particularly enlightening for understanding the sequence of events that led to more or less fruitful policy dialogue initiatives. A research strategy rooted in realistic evaluation allows researchers to go beyond the simple statement of factors that facilitate or hinder the implementation of an intervention or influence its outcomes.

Methodological challenges

The main methodological challenge was the diversity of the cases and the strong influence of context, both on implementing the Partnership and policy dialogue. It was indeed challenging to identify standard levers for action that may also be relevant at the local level. That is why it required a sufficiently high level of abstraction to draw cross-cutting lessons. Such a challenge is inherent to the realist evaluation of highly context-dependent interventions. Emerson's integrative framework was instrumental in supporting this abstraction process.

Lessons learned for analysing implementation

Integrative theoretical frameworks can prove valuable for implementation science. However, they can also be empty shells when no epistemological grounding allows researchers to use them "integratively". Thus, researchers whose reasoning relies on linear causation can hardly use such frameworks to their full potential. Our research showed the relevance of combining realist evaluation and Emerson's integrative framework. Connecting the framework's components through reasoning based on generative causation has made it possible to generate robust knowledge. In addition, it became possible to produce knowledge beyond the organizational, logistical, and financial arrangements on which many implementation evaluations usually focus, by highlighting contextual influences, the importance of collaborative relationships, and their interactions. The challenge is not to get lost in the variety of interactions and to refocus on the most critical implementation issues, particularly those that will interest decision-makers or sponsors of the evaluation.

CONCLUSION

This chapter provided a helicopter view of third-generation policy implementation studies mobilizing conceptual and theoretical approaches in diverse contexts. We reviewed seven case studies illustrating the application of diverse integrative frameworks to analyse policy implementation methods, frameworks, and approaches. Among the critical dimensions of third-generation implementation studies as stated in Saetren's 2014 review, we emphasized authors' ability to apply an integrative approach. Our chapter and reviewed policy implementation cases also reflected another key dimension of third-generation implementation studies, i.e., a diversity of case study approaches – using both single and multiple case studies, thus allowing for comparative work, which proved relevant for highlighting contrasted implementation experiences (see Case 5 in particular). In addition, one case (Case 1) also featured mixed-method research – which, according to Saetren, should become more mainstream in policy implementation studies. However, we could not integrate each third-generation dimension. Missing dimensions included the ability to carry-out analyses over time. Indeed, in a context of scarce resources for implementation science, both in the North and the South, it is never easy to maintain a longitudinal research plan, even if the research proposal includes such a longitudinal approach (Ridde et al., 2014). Moreover, the high turnover of decision-makers and implementers, as well as the socio-economic vulnerability of academic actors (especially in the South) does not always make this approach easy. For example, we had planned a multiple and longitudinal case study to study the implementation of a health financing policy in Burkina Faso. Despite the proposal's publication (Ridde et al., 2014), we could not carry out all the planned phases due to the lack of availability of certain researchers, who were challenging to mobilize over the long term. This will certainly be one of the following major challenges for students of health policy implementation.

Our chapter also featured policy implementation scholars' capacity to apply *bricolage* approaches, combining existing theories and conceptual frameworks (see Cases 1, 2, and 7). This aspect reflects a broader trend in health policy and systems research, which typically involves scholars with diverse backgrounds and disciplinary traditions (Jones et al., 2021); a movement that can also be found in public policy scholarship (e.g., de Leeuw, Cassola and Fafard, 2022; Jones et al., 2016; Pierce et al., 2017). Despite sometimes conflicting epistemological and conceptual approaches (see Case 2, for instance), the *bricolage* strategy thus may indicate a promising avenue for policy implementation research.

Our chapter provided the opportunity to cover a primarily overlooked region for health policy implementation scholars – Francophone sub-Saharan Africa. Indeed, most reviewed case studies were carried out in that region, where this type of research is still under-represented in the field of healthcare policy research. This characteristic highlights how much public policy scholars investigating and/or based in that geographical region can innovate in policy implementation, applying unexplored or overlooked theories and frameworks and building new, adapted ones, thereby making the public policy research field strive.

On a related note, the chapter was a clear reminder that policy implementation primarily investigates a policy's capacity for adaptation – adaptation to complex local, organizational, and sociocultural contexts. It is a central element in contexts where official development assistance is important and often influences decision-making, the choice of policy instruments and the implementation of health policies and interventions. One cannot look at policy implementation without considering the "big picture," i.e. the broader ecosystem in which said policy is being introduced. The current, interrelated health and climate crises should also urge public policy researchers to embrace ambitious implementation science approaches because they allow for a flexible study design that can be continuously adapted to account for structural and temporary shocks affecting the interventions studied and the research process.

Many of these policy implementation approaches can guide us through a much-needed space for reflexivity. The reflective process may be undertaken both by public policy scholars and policy implementers separately or, more remarkably, in a joint effort (Jones et al., 2021; Tremblay and Parent, 2014). The reflective process can thus be continuous to reflect the feedback loop between implementers and researchers, what this interaction meant for both categories and what tangible impacts it may have had on a given policy's routine adaptations.

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5. Health policy evaluation

Nicholas Mays and Alec Fraser

INTRODUCTION: DEFINITION AND ORIGINS

Policy 'evaluation' has been defined in a number of different ways over the years. Here is one widely used definition:

> … making a comparative assessment of the value of the … [policy] intervention, using systematically collected and analysed data, in order to decide how to act. (Øvretveit, 1998, 9)

'Evaluation' is thus a form of research, albeit carried out in the context not of 'blue skies' science but of given or contemplated interventions or policies and their processes of implementation.

Policy evaluation generally tries to answer the following questions:

- Has the policy achieved its goals?
- How does the policy compare to alternatives in terms of effectiveness and cost?
- Has it produced any unintended positive or negative consequences?
- How and why has the policy achieved or not achieved its intended goals?

All the findings are intended, at least in principle, to be applied to decisions about the design and subsequent revision of policies and their related programmes. The findings can be applied before, during or after initial policy implementation. The relevant policies can exist in prototype and/or experimental form when evaluated, or, much more commonly, they can be the product of governments' commitment to act, for example, contained in election manifestos and party programmes (Ettelt et al., 2015a). The former situation generally increases the odds that researchers are able to undertake experimental or quasi-experimental evaluations, while in the latter case, researchers have to adopt a more naturalistic approach, following the ins and outs of the policy implementation process with little or no ability to shape it in their favour since the policy will not have been made with a view to facilitating and simplifying its evaluation (Fraser and Davies, 2019). In both cases, policy evaluation is generally associated with a broadly rationalist approach (Simon, 1957) to policy making and implementation. Most obviously, it comprises one of the major steps in the rationalist 'stages heuristic' (Hogwood and Gunn, 1984) used to conceptualise the policy process. From this perspective, the role of evaluation is straightforwardly to ascertain whether a policy has succeeded or not in meeting any targets set or outcomes expected.

Globally, starting mainly in western Europe and North America, advocacy of the value and, indeed, claims of the necessity, of evaluation of policies and the programmes that they generate can be seen to have grown fairly consistently since the 1960s and 1970s (Weiss, 1979). Thenceforward, evaluation began to take place in more and more fields of public policy such as education, housing, social security, transport, etc. However, it is in health and health services, perhaps more than any other area of policy, that evaluation has been promoted, debated, developed and practised (Boaz et al., 2019). The profile of evaluation in the health field was given its most important boost in the shape of the 'evidence-based medicine' movement that took off in the mid-1980s, initiated by a group of clinical epidemiologists congregated around McMaster University in Canada, whose messages were then taken up and strongly supported by a growing cadre of health economists. Whereas the clinical epidemiologists emphasised the importance of evaluating the effectiveness of health care interventions, the economists went further, arguing for widespread analysis of cost-effectiveness, particularly of new drugs, devices and procedures. Both built their thinking and advocacy on a foundation of ideas laid more than a decade earlier by the British epidemiologist, Archie Cochrane, who had championed the application of scientific methods, especially randomised controlled trials (RCTs), to clinical medicine and health care. Cochrane (1972) argued that there was little or no evidence to support the effectiveness of most medical interventions, that clinicians preferred to follow their beliefs and prejudices to the detriment of their patients, that health care would be greatly improved if new and existing treatments were tested using RCTs and that only validated procedures should be paid for from public funds. All these propositions fed into the 'evidence-based medicine' movement which, in turn, stimulated similar thinking applied to the management, organisation, staffing and resourcing of health systems, that these too could, and should, be subjected to careful evaluation and become 'evidence-based'. The 'evidence-based medicine' movement also raised the profile of evaluation in other fields of public policy such as education that had arguably led the way in the 1960s in terms of the application of evaluation by educational psychologists (Boaz et al., 2019).

The commitment to undertaking policy evaluation is now widespread globally, but especially in the English-speaking world where it has become normative. How, why and where policy evaluation takes place, and how it relates to the policy process varies by country, most obviously because of the governance structure. For example, in the highly centralised United Kingdom, the Treasury's so called Green and Magenta Books give authoritative, regularly updated guidance to spending departments on, respectively, the underlying economic principles of policy and programme appraisal, and details of the methods to be used (HM Treasury, 2020a, 2020b). Since the UK's public health care system is general tax funded, the Treasury can require the evaluation of major spending proposals. By contrast, in the federal US, evaluation at national level is enabled by the use of legislative waivers to allow new policies to be introduced experimentally for a defined period of time (Haynes et al., 2013). In addition, such federal systems offer more of a 'policy laboratory' since states are free to pursue different policies that can be compared. The challenge then is how to apply the learning from evaluations of policies between largely autonomous states.

There have been moves internationally to establish more effective evidence ecosystems or national infrastructures to encourage evaluation and evidence use in policy. For instance, there has been a proliferation of evidence 'Clearinghouses' in the US. In Scandinavia, we see the Nordic Cochrane Centre based in Denmark and the Swedish Agency for Health Technology Assessment and Assessment of Social Services (Boaz et al., 2019). The 2012 Civil Service Reform Plan in the UK led to the expansion of a set of What Works Centres to encourage better evidence to policy links within and across policy domains (HM Government, 2013).

THE CHALLENGE OF POLICY EVALUATION

The evaluation of public policies in the health field, in contrast to the evaluation of interventions such as pharmaceuticals and surgical procedures through clinical trials and related cost-effectiveness analyses, clearly poses considerably more practical, epistemological and methodological challenges that may have been underestimated by the early advocates of evaluation in medicine and health care. As a result, in public policy, advocates of (more and better) evaluation have in recent years tended to refer to the importance of 'evidence-*informed* policy' rather than 'evidence-*based* policy' (Boaz et al., 2019). There are a number of reasons for this terminological shift. Most obviously, such policies rarely have a single unequivocal goal, therefore they tend not to sit comfortably within a purely positivist epistemology. Multiple, potentially conflicting, aspirational objectives are the norm and different stakeholders (including political opponents) can use different criteria to judge 'success' such that policy 'success' is intrinsically contested comprising both tangible goal achievement and subjective appeal (Marsh, 2010; Marsh and McConnell, 2010). Policy evaluations therefore require greater inclusivity in relation to the types of knowledge that can inform understandings of such policies. The 'interventions' of policy makers are usually multi-faceted, not always well described or bounded, operate at different levels within systems affecting multiple actors, can change over time in the implementation, and have contextually-specific justifications and effects. Those involved, such as politicians, policy advisers, civil servants, managers tasked with implementation, staff providing a service, service users, the media, voters, the public and evaluators themselves, may have quite different goals and perspectives (Best and Holmes, 2010). Policy makers may perceive an urgent need to respond to a policy problem that is inconsistent with the timescale of rigorous evaluation. As a result, the effects of policies may only become apparent long after decisions have already been taken to extend, modify or terminate them.

Two further features of policy and thus policy evaluation provide important context to differentiate *clinical* from *policy* evaluations in the health field: first, public policies affecting health and health services tend to be introduced simultaneously across an entire jurisdiction; and, second, elected governments invest considerable political capital in their policies in contrast with evaluators who are usually relatively indifferent to whether a policy 'works' or not. The first contextual feature greatly reduces the scope for experimental or even quasi-experimental approaches to establish causality in which an 'exposed' population is compared with an 'intervention' group (see below) despite the wishes of champions of an experimental approach such as Haynes et al. (2012).

The second feature reduces governments' commitment to evaluation in practice as against their commitment in principle (e.g. 'we will be guided by the science'). Despite the pro-evidence, pro-evaluation rhetoric of 1990s technocratic political turn represented by UK New Labour's famous 1997 manifesto mantra 'what matters is what works', elected politicians – especially in more ideologically polarised times – rarely approach a policy problem and solution in the clinical trialist's state of 'equipoise', uncertain as to how to proceed and willing to experiment with a range of responses, including doing nothing. Indeed, voters would be surprised and disconcerted if they did.

As the great proponent of rigorous evaluation of policy, Donald Campbell, put it: 'If the political and administrative system has committed itself in advance to the correctness and efficacy of its reforms, it cannot tolerate learning of failure. … This predicament, abetted by public apathy and by deliberate corruption, may prove in the long run to permanently preclude a truly experimental approach to social amelioration' (Campbell, 1969, 410). Arguably, policy evaluation continues to grapple with this predicament.

While evaluation at the clinical level embraces questions other than 'efficacy' (under optimal trial conditions) to include real-world effectiveness in 'usual practice', the range of questions to which policy makers require answers is typically wider. Policy makers are often interested in questions beyond real-world effectiveness such as those relating to:

- Fidelity – can and is the policy being delivered as intended?
- Adaptation – how far can it be altered to suit different contexts while remaining effective?
- Acceptability – do implementers and recipients support the policy?
- Reach and access – does the policy reach the intended recipients and to what extent?

The balance between fidelity and adaptation may be important for effective implementation and, if captured in evaluations, provides the basis for feedback to policy makers as to whether more or less flexibility is necessary for effective implementation (Durlak and Du Pre, 2008). Others argue that for the evaluation of more complex interventions what matters is fidelity of function, not form – ensuring that the policy intervention achieves all the steps in a theory of change by locally appropriate means (Hawe et al., 2004).

Policy makers are also likely to want to know how the effects of policies are moderated or accentuated by different settings and the characteristics of different (sub)populations (e.g. ethnic groups, occupations, gender, religion, education, socioeconomic status, etc.), especially whether a policy consistently benefits some groups over others and thus what might be done to mitigate this or conversely whether it reduces inequalities (Evans and Brown, 2003). This clearly has implications for making a judgement about whether a policy is broadly equitable or not, which often shapes its acceptability to the public. Because of the political repercussions, elected policy makers are likely to be especially concerned to learn about any harm or unintended consequences associated with their policies. Since these can be distal and, by definition, are unplanned, they can be difficult to identify a priori and subsequently assess.

Finally, assuming that the new policy is overall superior to its predecessor, where a policy intervention has not been implemented universally, policy makers will want some indication of the extent to which the policy is generalisable and transferable to other places or populations (Burchett et al., 2020). Likewise, if introduced on a limited basis, there will be an appetite for information relevant to the scalability and sustainability of the policy intervention. These concerns will be challenging on the basis of a single evaluation undertaken over a limited period of time (Skivington et al., 2021).

The rest of this chapter will discuss how policy is evaluated (evaluation *of* policy) and the role of evaluation *in* policy (evaluation as an instrument of policy). The chapter does not go into detail in terms of the design and methods of policy evaluation since there are many other sources available (e.g. Drummond et al., 2005; Øvretveit, 1998, 2014; Raine et al., 2016; Tsang and Cromwell, 2016). However, it does briefly describe the main types and approaches to evaluation that have been used in the health field to inform policy, their strengths and weaknesses, and where they are most applicable.

DIFFERENT TYPES OF, AND APPROACHES TO, POLICY EVALUATION

Health policy evaluation typically employs a range of mostly social research methods such as surveys, interviews and analyses of routine data. It uses theory and insights from a wide range of disciplines, especially epidemiology, statistics, economics, sociology, anthropology, psychology, management and organisation studies, political science, and policy analysis. It will also require access to clinical and biomedical knowledge where the policy in question has a significant technical and scientific component.

As a form of applied research strongly informed by the social sciences, the evaluation of policy has been influenced by the wider evolution of social theory, trends in the conceptualisation of knowledge and changes in fashion in the social sciences since World War II. As a result, the different social research traditions from positivist to post-modern, and from experimental to participative (i.e. 'co-produced' evaluations shaped by service users and communities as much as by researchers), are present in the field, though the influence of medicine, biomedical science, health psychology and health economics on the field has historically prioritised positivist and experimental approaches over others (Boaz et al., 2019). This is also reflected in the orientation of the funders of policy and programme evaluation in the health field.

A notable development in the last 30 years has been the increased use of both qualitative and quantitative methods of data collection within the same evaluation (Skivington et al., 2021). So called, 'mixed method' evaluations are now commonplace though the extent to which the conduct, interpretation and presentation of findings from qualitative and quantitative components of evaluation studies are fully integrated varies greatly (Pope and Mays, 2009). The 'paradigm wars' continue, albeit in a lower key and more sporadic way than in the past. Since public policies typically have multiple goals, there is a recognition that evaluations need to tackle issues other than effectiveness such as the feasibility, fidelity and acceptability of policies from the perspectives of implementers and recipients in different contexts, and that such issues can be illuminated by qualitative research such as observations of meetings of decision makers and patient/client-staff interactions (Boaz et al., 2019).

Despite this, there is a tendency in the health field to preach the existence of a so called 'hierarchy of evidence' with quantitative experiments at the top and anecdotes at the bottom, failing to appreciate that different questions are suited to different methods of data collection and that not all evaluation questions relate to comparative effectiveness. For example, the perceived fairness of a policy and its actual distributional consequences (equity) are usually a deep concern of politicians and the public, and as important for policy sustainability as its effectiveness and efficiency. Petticrew and Roberts (2003) argue that the 'hierarchy of evidence' approach is poorly suited to broader questions of public policy – instead, different types of evidence derived from different methods are more useful to guide such complex questions.

In terms of how evaluation relates to the stages of the policy process, the main distinctions in health policy evaluation lie between *ex ante* evaluation (designed to inform policy decisions and programme development) and *ex post* evaluation which focuses both on helping shape policy implementation (*process evaluation*) and identifying whether or not a policy has had its intended outcomes and at what cost (*summative evaluation*). In the health field, outcomes are usually measured in terms of changes in patient or client symptoms, function, health status or health-related quality of life. Summative evaluations are primarily focused on identifying whether a policy is on average, all other things equal, more effective or cost-effective than the alternative which could be no intervention or a previous approach to a policy problem. Thus, summative evaluations generally require some sort of control or comparison group so as to identify whether the outcomes associated with the policy of interest are genuinely a result of the policy. Summative evaluations also need to be sufficiently large to have enough statistical power to detect real effects and rule out chance associations between the policy of interest and outcomes.

Both process and summative approaches to data collection can contribute to *formative* evaluations. The distinctive feature of formative evaluation is its commitment to attempting to shape and guide policy as it is implemented. Thus, formative evaluation, whether it prioritises process or outcome analysis, engages directly and continuously with those who are responsible for originating and implementing policy. It tends to be focused on policies that are regarded in some way as innovative or immature. The key questions for formative evaluation are not ‘Does it work?’ and ‘How and why does it work?’ but rather ‘How can it be improved?’ Such evaluations typically make extensive, but not exclusive, use of qualitative inquiry and may engage key participants (e.g., policy implementers, professionals delivering a service and the intended beneficiaries) directly in shaping, doing and interpreting the evaluation – so-called participatory and/or ‘action-research’ in which all or most stages in the research are ‘co-produced’ between the researchers and the main groups involved in the policy. Whereas summative evaluation tends to be undertaken with an emphasis on the independence and objectivity of the evaluators who remain at arm’s length from the implementation process, the various types of formative evaluation emphasise the depth of engagement of the researchers in the policy milieu (Lorne, 2021).

Whereas ex post evaluations can be undertaken by the agencies themselves that are directly responsible for policy development and its implementation, as well as by external researchers in the independent sector, management consultancy and academia, ex ante evaluations are typically conducted in-house, for instance, by analytically trained public servants, in which case the findings tend not to be published. Think tanks can also contribute to both ex ante and ex post evaluative activity. Ex ante evaluations rely on interrogating the available evidence, including systematic reviews, analysis of administrative and other routinely available data, consulting experts, patient representatives and other interest groups, and building a variety of statistical models either to attempt to predict the results of different hypothetical policies or to identify a range of plausible trajectories with different likelihoods. Ex post evaluations usually involve a considerable amount of primary data collection alongside analysis of administrative data to capture policy processes and impacts that are not included in routine information systems (e.g., surveying groups of patients to ascertain their experiences of different approaches to innovations in service delivery).

Each of the main evaluation study designs embodies a different relationship between the evaluator, policy makers and those charged with policy implementation. The more experimental the approach to evaluation, the more it depends on the evaluator being given the ability to determine the way that the policy is introduced and implemented. The more naturalistic the approach, the less the evaluator influences what they are able to observe and measure but the closer the findings may be to ‘routine’ practice.

MAIN DESIGNS FOR SUMMATIVE EVALUATION OF POLICY EFFECTIVENESS

The overarching challenge in attempting summative evaluations of policies is to establish with reasonable confidence that the trends and associations observed have some causal link to the policy being evaluated. This is often challenging since evaluators typically have limited or no influence over the way that policies are specified and implemented.

'Before and After'

This is the simplest design and requires the least alteration of the policy process to accommodate the considerations of evaluation. A good example of the strengths and weaknesses of this design is Bevan and Hood's (2006) work that explored the role of targets in relation to performance in English NHS hospitals. They looked at hospital performance data before a 'star rating system' for three key targets was introduced and compared this to performance after the star rating system had been introduced. Performance appeared to have improved in targeted areas but there was also evidence of manipulation of reported data.

This approach tends to be used when there is no obvious comparison population available or where it would be impractical or unethical to implement a policy at random. Apart from data on the consequences (e.g., for patients) before and after the introduction of a policy or a policy change, the only requirement is clarity as to when precisely the policy started to be implemented. As so often in policy analysis, this seemingly simple question can be difficult to answer unequivocally in practice. For example, some parts of a jurisdiction may anticipate the 'on' date and/or make preparations that affect the results of the previous policy, thereby reducing the extent of recorded impact of the new policy. However, the principal drawback of the simple 'before and after' design without a 'control' group is its vulnerability to 'regression to the mean'. When a variable is sampled and found to be out of the ordinary, the odds of the same variable appearing closer to the mean are greater the next time it is measured. In an evaluation, this phenomenon would suggest that a policy intervention was having an effect when none was present. In such circumstances, it is much better to use an interrupted time series design.

Interrupted Time Series

Interrupted time series is a more robust form of before and after study design in that it compares the time trend after the introduction or change of a policy with the trend that would have been expected based on the time trend in the period before the introduction or change in policy. Ideally, the evaluator needs access to five to seven years of pre-intervention and as much as possible post-intervention data as possible, as well as sufficient knowledge of the field in question to be able to exclude rival explanations for the trends observed.

A good example is provided by Grijalva et al. (2007) who evaluated the impact of the introduction of routine childhood pneumococcal vaccination nationally in the US on rates of hospital admission for pneumonia. The evaluators compared monthly admission rates estimated for years after the introduction of the vaccination (2001–2004) with the expected rates calculated from the period before the introduction of the vaccine (1997–1999). The year of vaccine introduction (2000) was excluded. Unrelated admission rates for dehydration for children under two years were also studied in case the effect seen in pneumonia hospital admissions was a function of a change in health care coverage rather than an effect of the vaccination programme. Dehydration admissions were unchanged over the study period but admissions for pneumonia reduced by 65% on average.

Interrupted time series is also widely used in the evaluation of other types of public health policies such as screening programmes, regulation (e.g., alcohol licensing) and educational campaigns (e.g., to improve health literacy).

‘Additionality’ Evaluation

This approach can be seen as a largely qualitative alternative to an interrupted time series analysis, again in the absence of an obvious comparator. Here, the evaluator attempts to ascertain from a range of sources such as plans, performance indicators, interviews and observations of behaviour whether the (new) policy is ‘adding value’ in the desired way (Hind, 2010; Mohr, 1999). This approach was used to evaluate the impact of the Public Health Responsibility Deal in England, a public-private partnership between government and industry in which ‘pledges’ were made by businesses to introduce changes positive for public health. Evaluation of the food industry pledges showed that many had already been underway before the Responsibility Deal began, thus their effects could not be attributed to the Deal (Knai et al., 2015).

The evaluation designs for effectiveness studies described so far, though valuable when there is no scope for policy experimentation and where a policy is rolled out simultaneously across an entire jurisdiction, suffer the disadvantage that there is no direct way to see what would have happened in the absence of the new or changed policy being evaluated. In other words, they do not enable a ‘counter-factual’ analysis to be undertaken. The next two evaluation designs attempt to remedy this weakness by identifying a number of different types of comparison between the policy of interest and the status quo while falling short of an experimental or quasi-experimental approach (see below).

Regression Discontinuity

This approach is applicable where eligibility criteria for a policy intervention are clearly measurable such that there is a defined cut-off between those who will receive the intervention and those who will not. This can be assessed at individual, group or area levels. In these circumstances, the comparison is between those people or areas that were eligible and those who narrowly ‘missed the cut’. This assumes that the distribution of factors that could confound the comparison is the same in both groups. The extent to which this is true can be tested before analysing and presenting the data.

Regression discontinuity designs have been used especially in situations where eligibility is determined according to criteria such as age or income where it is relatively easy to recruit a highly similar comparison group. For example, where people’s incomes determine their eligibility for health or care services, comparing those whose incomes are slightly too high with those with incomes just below the threshold. A good example of this is a study that examined health services use and health outcomes of children in families just above and just below income eligibility thresholds for US Medicaid (De La Mata, 2012).

This design relies on the assumption of a linear relationship between a person’s or area’s need (i.e., eligibility) and the outcomes of the policy or service. The approach has the advantage for policy evaluation that none of the members of the eligible group necessarily need to be excluded or delayed in receiving the policy intervention that is being evaluated. This is particularly valuable when there is political pressure to be seen to be ‘doing something’ about an issue. However, the most robust estimate of the effect of the policy can only be made by comparing two groups at or near the threshold (discontinuity) of eligibility. The further from the cut-off both group members are, the greater the risk of making an unlike comparison.

Natural Experiments

Another form of policy evaluation that is attractive when policies are introduced or amended with little or no consideration of evaluation is the natural experiment and also where it would be either unethical or impractical to undertake a controlled experiment such as a RCT. In health policy, a typical opportunity for a natural experiment arises when otherwise similar jurisdictions with similar health system goals choose to adopt different policies; for example, when states in a federal system pursue different means to achieve similar goals. This provides an opportunity to use a regression discontinuity design (see above), for example, comparing populations living close to either side of state boundaries (Sood et al., 2012). Other types of natural experiment can be undertaken when a new policy is implemented at different times within the same health system so that, at least for a period of time, there are places that can act as comparators until they too join the intervention group. For example, different acute hospitals in the English NHS adopted a new system of activity-based payment in phases. In addition, different specialties were moved onto the new system over time (Farrar et al., 2009).

Another form of natural experiment occurs when the same policy is implemented in a different way in different places. A good example was the introduction of hyper-acute stroke services in the NHS in London and Manchester. The approach to service delivery in Manchester was significantly more complex than in London with not as good clinical outcomes (Fulop et al., 2013).

Other natural experiments can be exploited for evaluation when the intensity of implementation of a policy varies across a system, for example, because different places have access to different levels of resources, expertise and experience. A final opportunity for evaluative learning via a natural experiment arises when different areas are exposed to the policy in question to varying degrees because of their circumstances. Again, this form of evaluation is particularly useful when a policy is introduced at the same time throughout a jurisdiction or health system but it is important to find out how well the policy is working in different settings. A notable example was an econometric evaluation using difference-in-difference (see below) of the impact of introducing competition between NHS acute hospitals in England that took advantage of the likelihood that the policy would have differential impact in places with a higher or lower density of hospitals (Cooper et al., 2011). In a similar vein, evaluators compared the impact of a set of complex organisational changes in the English NHS on different specialties, hypothesising that services that relied on coordination across organisational boundaries would be more disrupted than those that could be delivered by a single organisation (Hammond et al., 2019).

Quasi-experimental \Evaluations

a. Controlled before and after evaluations

This is a non-randomised but controlled form of evaluation in which an intervention setting or population (e.g., a clinic or a group of patients) is compared before and after introduction of a policy or policy change with a similar setting or population. Since there may be some differences between the two groups despite striving for as much similarity as possible, the comparison of outcomes is adjusted for baseline differences in factors (such as gender, ethnicity, socio-economic status, health, etc.). For example, the Healthy School and Drugs project was a whole school intervention to reduce student drug use that compared students in schools participating in the programme with similar schools not involved. The intervention showed a reduction in alcohol use but it was not possible to rule out the possibility that some of this was the related to baseline differences in unmeasured factors such as prior academic achievement between the two groups of schools and students (Cuijpers et al., 2002).

Clearly, it is inadequate simply to compare individuals who choose to participate in a programme and those that do not as a way around this limitation, since they are likely to differ in terms of ability, motivation, support for the programme, etc. The main response is carefully to match settings and individual participants between intervention and control groups. There is a range of methods to do this with varying degrees of sophistication. All require the evaluator to select the variables to match on a priori and collect data accordingly. The most widely known approach is propensity score matching, which is based on assessing individuals' average likelihood of achieving the policy outcome (e.g., health improvement) based on their characteristics known from previous research to be associated with the outcome.

b. Difference-in-differences

An alternative to matching is to compare the intervention and control groups before the policy change to estimate the unaffected or 'normal' difference between the two and then to compare this difference with the difference between the two groups after the policy change has been applied to the intervention group. The difference between the post-intervention difference and the pre-intervention difference is the average effect of the intervention. This design usually relies on there being routine data available since it requires trends before as well as after the policy change to be established. Critically, difference-in-differences is only valid if it can be established that the outcomes of interest were on a parallel trend in the period before the policy change. While difference-in-differences is still exposed to the risk that unobserved confounders change over time, it is a relatively robust design as long as the parallel trends assumption holds. Examples were given in the section on natural experiments, above.

c. Synthetic control method

This design was developed to offset the limitations of difference-in-differences. It still relies on being able to identify places and people 'exposed' to a policy and those not, but it also aims to create a synthetic comparison group as similar as possible to the intervention group. The method proceeds as follows: possible confounders of the comparison of outcomes are identified based on previous research and a priori reasoning to be used to reweight outcomes in the control group with highly predictive pre-intervention characteristics being given greater weight; the pre-intervention outcomes of the control group are then reweighted to minimise discrepancies between its outcomes and those of the intervention group thereby creating a control group, which is the weighted average of the outcomes in the control units (i.e., areas, organisations or individuals); then the post-intervention outcomes for the adjusted control group are estimated and compared with the actual outcomes in the intervention group.

Abadie et al. (2010) applied the approach to study the effects of California's Proposition 99, a large-scale tobacco control programme, and were able to show that smoking reduced markedly in California relative to a comparable synthetic control region and that the effects were larger than previously estimated using less sophisticated statistical methods.

Experimental Evaluation Designs

This approach to summative evaluation is identified with RCTs. Economic evaluations are often built into RCTs to assess the relative efficiency of the different interventions being trialled. The aim of the RCT is to establish a secure causal link between the policy of interest and a pre-defined outcome or set of outcomes. In a RCT, the policy or programme of interest is allocated randomly, for example, between areas, to try to ensure that any extraneous factors likely to affect the outcome of the policy or programme are equally likely to be present in the intervention and control populations (Haynes et al., 2012). Policy RCTs are generally more difficult to undertake than clinical trials since it is not possible to blind the participants, the interventions are usually multi-faceted and may be implemented differently in different settings for good contextual reasons. As well as requiring that the needs of the evaluators are built into the policy design so that populations, service providers or areas are allocated at random between an 'intervention' policy and a 'control' (e.g. the previously prevailing policy regime), experimental evaluations work best where both intervention and control policy settings are clearly defined, stable and separable from one another. Such evaluations also require sufficient statistical power. This is more taxing in experimental policy evaluations since they typically randomise areas or organisations rather than individuals (so called cluster RCTs).

Finally, successfully undertaking randomised trials of policies requires an unusually high and sustained alignment of incentives and tolerance of uncertainty among all the actors involved – executive, legislators, the health professions, managers and other implementers, front-line staff, patients/clients and the public. As a result, experimental policy evaluation beyond small scale pilot or prototype schemes is rare, though there are some notable exceptions such as Mexico's *Seguro Popular*. By law, the scheme had to be independently evaluated every two years and it was introduced in stages to facilitate rigorous evaluation. The first evaluation in 2005–2006 was in the form of a RCT of 118,569 households in seven states (King et al., 2009). Despite substantial achievements, *Seguro Popular* was replaced in 2020 by el Instituto Nacional de Salud para el Bienestar (el INSABI) without piloting or a staged roll out (Agren, 2020) demonstrating that the values and preferences of politicians count for at least as much as evidence in shaping policy decisions.

Though difficult to incorporate into policy processes, RCTs can be extremely valuable since policies can have negative consequences that would not necessarily be predicted from common sense. For example, driver education programmes for young people below the legal age to learn to drive are advocated to improve skills and reduce accidents. RCTs show to the contrary that they lead to higher crash and injury rates. This can be explained because graduates from these programmes pass their driving tests at younger ages than non-participants, and younger age is strongly related to higher accident rates (Roberts and Kwan, 2001). This evidence has not necessarily reduced their popularity among policy makers.

The stepped wedge RCT has been developed to take into account the enthusiasm of policy makers to see their untested innovations implemented. It can also be useful when some potential sites refuse to be randomised. In this approach, intervention sites join from the control group at intervals until all the sites involved in the trial have entered the intervention group or the trial has been stopped on the grounds that the intervention has been shown to be unequivocally superior or inferior to the comparison.

Realist Evaluation

From the perspective of policy analysis, probably the most interesting development in the last 20 years is the emergence of so-called 'realist' or 'realistic' evaluation that sprang from a path-breaking book by Pawson and Tilley (1997), which critiqued the limitations of RCTs and other traditional approaches to policy evaluation in the face of the reality of public policy and its implementation. Observing that the seemingly similar (or the same) policy had different effects in different contexts, they argued that rather than trying to compare fixed 'intervention' and 'control' groups with the emphasis on maximising internal validity in order to identify the average effect of a given intervention compared to a control, the task of policy evaluation is to tease out which mechanisms underlying particular policies work best in which contexts. Thus, the archetypical question for the realist evaluator is: what works, for whom, in which contexts and to what extent? Evaluators should develop a priori theories about how, for whom and under what conditions interventions will work and then use observational data to examine how context and intervention mechanism interact to generate the outcomes observed.

In later work, looking closely at the nature of the policy process, Pawson (2013) argued that policies and their programmes are not fixed 'interventions' that can and should be evaluated and then replicated if found to 'work', since they are constantly evolving and interacting with other contemporaneous policies. As recognised in earlier studies of policy implementation, policies are constantly being changed in their implementation; they are implemented in multi-level systems by multiple actors; and the contexts of intervention and control groups are in constant flux. Thus, 'It is not [policies and] programmes that work but the endless interpretations of their endless stakeholders that generate their effects' (Pawson, 2013).

Rather than generating a toolkit of methods or an ideal research design, realist evaluation provides a set of guiding principles and insights:

- Stakeholder involvement and engagement should occur throughout the evaluation.
- Policy 'mechanisms' should be considered as theories, which are based on a hypothesis or proposition that postulates that if a programme is delivered and managed in a particular way, then it will bring about some improved outcome, contingent on a supportive context.
- The tasks of evaluation are the development and testing of context, mechanism, and outcome (CMO) configurations (i.e., hypotheses/propositions) – initial configurations being conjectured CMOs, which are then refined through the evaluation process to generate explanation about what works, for whom, how, and in what circumstances.
- Evaluation should focus on the underlying social and psychological factors that shape the thinking and behaviour of those involved in implementing a policy (referred to as a 'gen-

erative' conception of causality) in order to understand how and why a policy produces its outcomes.

- Evaluation should aim for cumulation of knowledge about a dynamic policy rather than replication of relatively fixed interventions.

The theory-based nature of realist evaluation has stimulated wider interest in developing and testing the 'theories of change' inherent in policies, not just in realist evaluations. Many policy evaluators now try to identify ex ante and then study the 'active ingredients' or mechanisms of action of policies. They also try to identify which components of policies contribute to their effectiveness and how. This may be very difficult to identify in the case of complex interventions , but it is sometimes possible (Gardner et al., 2006). Qualitative research is often undertaken to tease out the more complex or unanticipated causal pathways by which a policy has its effect (Bonell et al., 2010).

The challenge posed by realist evaluation thinking to traditional experimental evaluation design has also produced a response from evaluators in the experimental and quasi-experimental tradition. Bonell and colleagues (2012) accepted that evaluation needs to examine how, why and for whom interventions work; to give more attention to context; and to focus on the elaboration and validation of programme theory. They agreed that RCTs often fail to explain how intervention components and mechanisms have their effects and that RCTs generally do not examine how complex interventions interact with the context in which they are implemented and received. However, they argued that counter-factual designs are still needed precisely because of the complexity of causality underpinning social and policy interventions and proposed a 'realist RCT'. This would emphasise understanding the effects of intervention components separately as well as in combination; examine mechanisms of change; take a more strategic, coordinated approach to testing the effects of interventions and their components in different contexts using consistent measures where possible; allow for an interchange between qualitative and quantitative findings; and thus build and validate the programme theories underlying interventions. While desirable, it would be likely to be expensive and time consuming to assess how different intervention components play out in different sites, and possibly therefore of limited value to policymakers.

In response, realist evaluators contend that 'realist RCTs' as proposed take insufficient account of important aspects of policy complexity such as non-linearity, feedback loops and path dependence that create significant problems for the utility of policy RCTs (Marshal et al., 2013). Irrespective of the merits of these arguments (Bonell et al., 2013), it is clear that the challenge of realist evaluation has highlighted the importance of theory-informed policy evaluation and reinforced the case for qualitative research to be undertaken within quantitative experimental evaluations (Skivington et al., 2021).

EVALUATION AS A POLICY TOOL

There is a tendency in health policy to discuss evaluation either in order to assess the appropriateness, strength and weaknesses of different evaluation designs (see above), or within the wider debate about the use and non-use of evidence in policy making (see below). Yet, the presence of an evaluation can alter the policy process because of the way it is interpreted by different participants. For example, particularly in the health field, this tends to be seen, especially by evaluators themselves, as a sign that a policy is in some broad sense still 'experimental' or at the least open to modification in light of the findings of research. However, the commitment to evaluation can be seen quite differently among politicians and managers as an indication that a policy direction is justified and thus legitimate. Alternatively, the commitment to evaluation can be used by policy makers performatively to enhance their position and pre-empt criticism by borrowing from the authority of science, as seen in reiterations during COVID-19 of misleading statements from politicians such as 'we are following the science'.

The different interests at play when policies are evaluated identify different purposes for evaluations (Ettelt et al., 2015b). The fate of policy 'pilots' shows this process at work. The roll-out or replacement of pilots before their evaluations have been completed is superficially puzzling since policy pilots are generally justified publicly on the basis that policies should be 'tried out' on a smaller scale before being extended, as long as they can be shown to 'work', as part of a process of evidence-informed policy making. Ettelt et al. (2015a) explain this phenomenon by identifying the following distinct purposes of pilots held by different groups:

- to learn 'what works best' in the spirit of 'trying it out' (evaluators from a positivist, epidemiological and economics tradition);
- to support better implementation of a given policy
  - early implementation for (local) innovation – to stimulate diversity in implementation (local managers);
  - 'pathfinder' or 'trailblazer' – to identify the best route to implementation (policy advisers and politicians);
  - 'demonstration' – a means for experts to show others how best to implement the policy.

There is clearly scope for conflict and confusion between those who approach a pilot as a 'what works' experiment versus those who wish to emphasise learning for subsequent (better) policy implementation (Ettelt et al., 2022). Ansell and Bartenberger (2016) argue that all of these purposes are distinct forms of experimentation:

- 'controlled', of which the RCT is a paradigmatic example, focused on establishing causality;
- 'Darwinian', in which as many different approaches as possible are pursued in a process of 'trial and error' learning to see which prove useful and which less so; and
- 'generative', described as 'a process of generating and iteratively refining a solution concept (an idea, innovation, design, policy, programme, etc.) based on continuous feedback'.

Different Decisions May Require Different Levels of Proof

Whereas evaluators tend to emphasise the need for the most rigorous evaluation designs to support policy decisions, not all decisions in all contexts require this (Habicht et al., 1999). For example, if an intervention has a very large, immediate measurable impact that coincides with its implementation, there may be very little value in trying to undertake an experimental or quasi-experimental evaluation. Indeed, it may be impossible to recruit a control group. Likewise, rigorous evidence of effects will be less important if an intervention is cheap, easy to deliver, uncontroversial and has little anticipated potential for harm (Ross et al., 2006).

Similarly, some evaluations (trials) are stopped early when it becomes clear that one intervention is superior to the others being assessed (e.g., some of the drug trials for COVID-19).

The policy context also makes a difference such as 'business as usual' or a crisis. During the first wave of the COVID-19 pandemic in the first half of 2020, there was a vigorous debate, notably in the UK, between public health experts on the wisdom of encouraging or requiring the public to wear face masks indoors and in crowded spaces. Sceptics of the value of face masks argued that there was no RCT evidence to justify their public use whereas proponents argued that face masks could plausibly reduce transmission of infection at little or no burden to the public and that the evidence available, although limited, was thus sufficient to advise mask wearing as a precaution (Greenhalgh et al., 2020; Martin et al., 2020).

Indeed, COVID-19 shone a light upon the limitations, as well as the enduring importance, of health policy evaluation, as well as the impossibility of disentangling the ever-present influence of politics in debates over evidence, effectiveness and best practice. Research knowledge generated through evaluation is prized by actors involved in policy and politics because it confers a degree of legitimacy on a venture – embodying a claim to truth and, with it, power (Boaz et al., 2019).

CONCLUSION

As health and health care costs rise both as a share of national income in many countries and especially as a share of public or collective spending, it is likely that evaluation *of* health policy will continue to be promoted as an important underpinning of health policy decision making. Although experimental and quasi-experimental approaches to effectiveness evaluation are still highly prized in health policy, the field of health policy evaluation has continued to expand and diversify, especially with the emergence of more theoretically driven approaches such as realist evaluation.

However, evaluation should also be seen as a policy instrument in itself (evaluation *in* policy), enabling policy makers to portray their decisions as 'rational' and evidence-informed (if not, even evidence-based) rather than informed by ideology. From this perspective, investing in policy evaluation is a price worth paying even if, from time to time, evaluators produce disappointing or politically uncomfortable findings.

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6. Ideas, transfer, and diffusion in health care policy[1]

Tuba I. Agartan and Daniel Béland

INTRODUCTION

Much has been written in recent decades about the role of ideas in politics and public policy, a trend that is also present in the more specific field of health care research. This is the case because the assumptions of policy actors and the ways in which they frame the issues at hand have a direct impact on patterns of policy stability and change in health care (Béland, 2010). Such an attention to the role of ideas is ever present in the literature focusing on the impact of transnational processes in health care policy. In this chapter, we connect the scholarship on the impact of domestic ideas with the literature on transnational processes in health care. The result is a critical review of the key concepts and claims associated with the study of ideas it relates to both domestic and transnational processes.

The first main part of the chapter focuses on the broader literature on the role of ideas in politics and public policy before stressing how ideational processes shape health care reform at the domestic level. The second main part of the chapter explores the role of transnational ideas and the actors carrying them in health care reform by reviewing three main literatures, which are respectively centred on policy diffusion, policy transfer, and critical analysis of the role of ideas in health care. Although these literatures are not necessarily centred on the role of ideas, the analysis suggests they contribute to the study of ideational processes at the transnational level. The shorter Conclusion section formulates an agenda for future research about the role of ideas in both domestic and transnational health policy processes.

BRINGING IDEAS IN

In recent decades, much has been written about the role of ideas in public policy, including health care reform. This literature is interdisciplinary in nature and it features the work of political scientists, sociologists, and interdisciplinary health and public policy scholars (e.g., Béland and Cox, 2011; Béland and Hacker, 2004; Berman, 2013; Blyth, 2002; Boothe, 2015; Campbell, 2004; Cox, 2001; Hall, 1993; Genieys and Smyrl, 2008; Jacobs, 2009; Jenson, 1989; Mehta, 2011; Schmidt, 2008; Somers and Block, 2005; Walsh, 2000). The objective of this section is not to review the entirety of this sprawling literature but simply to illustrate how paying close and systematic attention to ideas can help scholars seeking to account for policy stability and change in health care policy. The discussion is anchored in the broader literature on the role of ideas in public policy while providing concrete examples from the health care literature.

An appropriate first step in the study of the role of ideas in health care, and in public policy more generally, is to outline their potential analytical power in relationship to other types of explanation in social science research. According to Craig Parsons (2007), ideational analysis can be defined in contrast to three other major types of explanation: structural, institutional, and psychological explanations. First, both structural and institutional explanations feature a logic-of-position that details "the landscape around someone to show how an obstacle course of material or man-made constraints and incentives channels her to certain actions" (Parsons, 2007: 13). Second, both ideational and psychological explanations feature a logic-of-interpretation that shows "that someone arrives at an action only through one interpretation of what is possible and/or desirable" (Parsons, 2007: 13). For Parsons (2007), the main difference between ideational and psychological factors is that, while the former are human-made and historically constructed, the later are grounded in the hard-wired brain functions. Considering these remarks, we can say that ideas are contingent, historically created meanings through which individual and collective actors make sense of their economic, social, and political environment. More generally, all four types of explanation identified by Parsons (2007) can be combined, something that becomes appropriate when one type of explanation alone is unable to solve a particular empirical puzzle.

Just like institutions, psychological processes, and structural forces, ideas come in different shapes and forms and the individual and collective actors who carry shape and reshape them are also very diverse (Campbell, 2004). One way to map these types of ideas and the actors associated with them is to go over the five main components of what is known as the policy cycle: agenda-setting, policy formulation, decision-making, policy implementation, and policy evaluation (Howlett, Ramesh and Perl, 2009). The policy cycle approach does not capture the complexity and the messiness of the policy processes authors like John W. Kingdon (1984) have rightly emphasized, but it does offer a straightforward template to map the different types of ideas that might play a direct role in policy processes.

First, as far as agenda-setting is concerned, ideas as problem definitions shape debates about policy reform (Kingdon, 1984; Mehta, 2011; Stone, 2002). Among other things, such problem definitions are the product of media stories produced by journalists, collective mobilization on the part of social movements seeking to draw attention on specific issues, and experts who gather within specialized "epistemic communities" (Haas, 1992) devoted to the study of particular policy topics. Problem definition is a discursive process in which the terminology used, and the stories told about how the world works, are essential in shaping expert and public perceptions alike (Stone, 2002). There are different ways to define the same issue as a problem worthy of government attention, and multiple problems and the actors associated with them compete for the attention of policymakers, which is why problem definition is so directly related to agenda setting (Baumgartner and Jones, 2005; Kingdon, 1984).

In health care, ideas as problem definitions can play a crucial role, something illustrated by the work of Sandra J. Tanenbaum (2013) on "geographic variation in the use and cost of health care" as a policy problem in the United States. As she suggests, "Public opinion did not turn against variation, nor did it appear on an interest group's agenda or in a politician's family's medical history. Variation is a statistic, inferentially ripe, but arguably more a window on other problems, including high cost and low quality, than a problem in and of itself" (Tanenbaum, 2013: 7). Because of its technical nature, this problem became a central issue for a particular set of actors who are especially interested in statistical variation: "epidemiologists, economists, and engineers and, perhaps more importantly, (...) the many members of the health policy community who have been educated and influenced by these three disciplines" (Tanenbaum, 2013: 15). In her analysis, Tanenbaum (2013) illustrates the complex and ambiguous definition of a policy problem in health care while stressing the role of concrete policy actors within problem definition. This work also points to the potential impact of framing processes, which are discussed below.

Second, ideas also play a central role in policy formulation, a process through which potential policy solutions are formulated and assessed (Mehta, 2011). A particularly useful ideational concept used in the study of policy formulation is the one of policy paradigm as formulated by Peter Hall (1993), which borrows from the work of Thomas Kuhn on scientific revolutions to formulate a framework to understand policy change. According to Hall (1993), policy paradigms underpin policy formulation, which features debates about the choice of policy instruments and their settings. For Hall (1993), policy paradigms are clusters of policy assumptions that are relatively stable over time and that typically guide the policy learning process. Yet, from time to time, following a punctuated equilibrium logic, the dominant policy paradigm is called into question because of the accumulation of a growing number of "anomalies" that lead a growing number of actors to consider alternative paradigms. If one of these triumphs, a paradigm shift takes place. Importantly, a paradigm shift is primarily a change in the dominant policy ideas of the day within a particular policy area. This means that, to demonstrate that a paradigm shift has taken place, scholars must show that the core assumptions have changed and that this process is driving policy development on the ground (Daigneault, 2014).

A striking example of paradigm shift that has directly impacted heath care policy is the transformation of dominant social policy ideas in China that began in 2002–2003 in the context of a leadership change in the country (Ngok and Huang, 2014). Adopted in reaction against the SARS outbreak, as well as the increasingly obvious flaws of the pro-market social policy paradigm that became dominant during the economic liberalization period, the new paradigm reaffirmed "the responsibility of the government in welfare provision," "strengthened its role in providing welfare services" and, finally, articulated an emerging "conception of social citizenship" leading to a reassessment of both the urban–rural divide and the situation of migrant workers (Ngok and Huang, 2014: 255–256). This paradigm shift impacted health care reform, as it helped bring about, in 2003, a "New type of rural cooperative medical system for rural residents" and, in 2011, a "Contributory health insurance for urban residents" (Ngok and Huang, 2014: 255). This example from China is especially useful for two reasons: it suggests paradigm shifts can take place in authoritarian regimes, and it shows that a broad paradigm shift about the dominant approach to economic and social governance can directly shape health care reform on the ground.

Third, as far as decision-making is concerned, ideas can become powerful framing devices in the hands of policy actors who seek to justify the adoption of specific reforms and policy instruments (Béland, 2010; Campbell, 2004; Schön and Rein, 1994). Appearing "in the public pronouncements of policy makers and their aides" (Campbell, 1998: 394), discursive frames are associated with social movements and other social constituencies seeking to influence policy debates (Benford and Snow, 2000; Ferree, 2003). In the context of these debates, frames are especially crucial when the time comes to participate in what Robert Henry Cox (2001) refers to as the "social construction of the need to reform." More generally, framing processes are about the public discourses that help persuade the public and/or particular interest groups to support certain policy reforms (Schmidt, 2008).

Regarding health care, Vandna Bhatia and William D. Coleman (2003) study the role of discursive framing processes in the politics of health care reform in Canada and Germany. What these authors try to explain is why these two federal countries, which faced similar structural pressures, adopted two different paths in the 1990s, with path-departing health care reform taking place in Germany but not in Canada. According to Bhatia and Coleman (2003), the main ideational factor behind the advent of health care reform in Germany was the capacity of Social Democrats to articulate a compelling discourse on solidarity that justified reform in the firm place. In contrast, for Bhatia and Coleman (2003), in Canada supporters of pro-market health care reform simply failed to come up with a politically compelling discourse to justify large-scale health care privatization in the country while undermining public support for the existing public system (Bhatia and Coleman, 2003: 732–733). This comparative study of framing processes points to the role of public opinion in health care reform (Jacobs, 1993), which is also a central issue for ideational analysis, which studies how framing processes can shape public sentiments, and vice versa (Campbell, 2004).

Fourth, policy implementation concerns the operationalization of previously enacted policy provisions and instruments (Béland and Ridde, 2016: 10). Implementation is a crucial moment of the policy cycle because the adoption of legislation or executive orders is not the end of the reform process and that many factors on the ground can complicate its operationalization (Derthick, 1972; Patashnik, 2008; Pressman and Wildavsky, 1984). Here, civil servants and professional groups in charge of delivering benefits and services typically play a major role in policy implementation. This is particularly the case of street-level bureaucrats, who interact directly with users in the provision of public benefits and services (Lipsky, 2010). In this context, the embedded cultural, economic, social, and political beliefs of these actors on the ground are highly significant, as they are likely to shape how they perceive and act upon the new policies they are tasked to implement (Béland and Ridde, 2016). Simultaneously, the perceptions of the population targeted by these new policies can also impact their implementation, as the perceptions of citizens and their level of confidence towards the state and the potential intermediaries involved in delivering the benefits and services can determine whether they will facilitate or resist implementation (on public sentiments as a type of ideas see Campbell, 2004). In other words, ideas as embedded beliefs and public sentiments are meaningful factors. Students of policy implementation should pay close attention to public sentiments and the embedded beliefs of street-level bureaucrats is consistent with the work on the impact of cultural categories and values in policy development (Pfau-Effinger, 2005; Steensland, 2008).

In the field of health care reform, the perceptions of health care workers can become a crucial aspect of the politics of policy implementation. For instance, in the work on the gradual advent of free health care in sub-Saharan Africa, Daniel Béland and Valéry Ridde (2016) explore how the widely shared belief of physicians on the ground that people who pay for health services are more likely to value the care they receive creates a negative predisposition against free health care on the part of these street-level bureaucrats, who tend to support user fees. Another key belief they widely share is their lack of trust in the capacity of the state to reimburse them for the health services they render. These negative perceptions of physicians on the ground is likely to pose a challenge when the time comes to lift user fees physicians believe in (Béland and Ridde, 2016).

Finally, policy evaluation, which is about drawing lessons from existing reforms and their implementation, is directly connected to the role of ideas. This is the case because major policy activities closely related to policy evaluation such as policy learning (Hall, 1993; Heclo, 1974) and lesson drawing (Rose, 2004) are explicitly ideational in nature, as they involve assessing what has been done to guide policy change and, ultimately, improve future policies. The actors involved in policy learning are often the same as the ones central to policy formulation, especially experts working for government, universities, and think tanks. Yet, regarding both policy formulation and policy evaluation, their expertise is shaped by existing institutional factors that empower some types of experts over others. Cross-national variation in institutional economic and political factors lead to the formation of what John L. Campbell and Ove K. Pedersen (2014) call "knowledge regimes." For instance, France's knowledge regime is far more statist than the United States' welfare regime, in which private experts and think tanks play a much more prominent role in both policymaking and policy evaluation (Campbell and Pedersen, 2014). Beyond these national knowledge regimes, which shape the construction of expertise, policy evaluation is closely linked to transnational lesson drawing, a process through which actors look at policies implemented in other countries for lessons about how to reform their domestic policies (Rose, 2004; Marmor, Freeman and Okma, 2005).

The widely cited article by Jan-Kees Helderman et al. (2005) on market-oriented health care reforms in the Netherlands illustrates the role of domestic policy learning in the country's gradual shift from corporatist to market-driven health policy. Through this process, Dutch political and policy actors learned strategic lessons about the failure of key reform initiatives, a situation that led them to adopt an incremental approach to health policy change in the country. Simultaneously, the process of decentralization central to Dutch incrementalism led to new opportunities for policy learning among multiple actors: "By allowing individual providers and insurers more autonomy in exchange for risk bearing, the locus of power in Dutch health care has shifted from the national associations toward individual health care providers and health insurers. Individual providers, health insurers, and the government are now in the process of learning about the pitfalls and opportunities of social entrepreneurship in health care" (Helderman et al., 2005: 207). These remarks suggest two things. First, far from being purely technical in nature, policy learning as a process is inherently political (Béland, 2006). Second, policy change itself can alter the nature of learning processes by empowering or disempowering key actors involved in policy formulation and/or implementation. This point goes back to the idea that expertise is an institutional construction in which the production of knowledge is structured in different ways across time and between countries (Campbell and Petersen, 2014). Yet, as Helderman et al. (2005) suggest in their article through a discussion of the influence of the European Union on Dutch health care policy, policy evaluation has a transnational component that scholars would ignore at their peril. More generally, paying close attention to how ideas travel across geographical and temporal boundaries is essential to grasp the role of ideas in contemporary health care policy around the world, in both the global North and the global South. This is why the second main part of this chapter discusses the interaction between ideational analysis and both transnational actors and processes in health care reform all over the world.

THE ROLE OF IDEAS IN HEALTH CARE DIFFUSION AND TRANSFER

Policy scholarship has long been interested in why actors look beyond national borders in search of ideas and how these ideas travel. Yet, since the 1990s, determined to go beyond the limits of methodological nationalism (Campbell, 2004; Orenstein, 2008; Stone, 2008; Yeates and Deacon, 2010), a growing number of scholars with diverse disciplinary backgrounds have begun to explore cross-cutting institutions, actors, connections and mechanisms of a global social system that interact with national policies in diverse ways. There are several ways to review this literature that draws on many disciplines and subfields (see Graham et al., 2013; Porto de Olivera, 2021), but for the purposes of this chapter, we identify three literatures based on their methodological and epistemological assumptions: policy diffusion, policy transfer, and critical analysis of the role of ideas and policy mobility. We should also note the recent interest in developing theoretical foundations of policy diffusion processes (Blatter et al., 2021; Gilardi and Wasserfallen, 2019). For instance, Blatter and colleagues (2021) strive to combine all three literatures in their alternative typology, which focuses on motivational mechanisms.

The first stream focuses on choices of governments to adopt a policy and strives to identify whether these choices were shaped by policy ideas in another context. Studies in this stream are generally grounded in political science, developed within subfields such as American politics, comparative politics, and international relations, to capture the causal mechanisms of diffusion of ideas among governments, mostly through quantitative studies (Kuhlmann, 2021). Despite some small disagreements, diffusion scholars describe primary mechanisms of diffusion in terms of coercion, learning, competition, emulation, or socialization (Graham et al., 2013; Shipan and Volden, 2012). The earlier focus on geographic proximity as the key dimension of diffusion was later expanded to include the spread of policies and their features across any connected network, using methodologies such as event-history analysis, dyadic approach, and network approaches. However, there are some limitations in the conceptualization and unevenness in the operationalization of key mechanisms as we will briefly discuss below (Kuhlmann, 2021).

The first mechanism, coercion – defined as the use of force, threats, or other incentives, such as grants or loans, by one government to affect the policy decisions of another – involves multiple soft and hard policy tools. While these tools are somewhat easier to identify, their diverse political dynamics deem further critical examination. With regard to the second mechanism –learning – Graham and colleagues explain that some diffusion scholars label "the enhanced spread of successful policies as learning, largely because policy success is not necessarily central to competition, coercion or socialization," thus demonstrating the need for better operationalization: the diffusion of successful policies is not "a direct measure of learning itself" (2013: 694). In addition, there is no distinction between "learning about" and "learning from," the latter indicating some sort of interpretation of what has been learned and translating to local circumstances (Klein, 1997). The third mechanism – competition – builds on a rational conception of policy actors who engage in strategic interactions with short-term effects (Simmons et al., 2006). And yet, most studies still lack sufficient recognition of the learning processes that could be taking place as part of the competitive dynamic: there has to be some element of learning to be able to know what is going on in another policy context and evaluate the effectiveness of these policies before adopting them as part of the competitive process.

Conceptualization and operationalization of the fourth mechanism – emulation – and the closely related concept of socialization, present both challenges and pathways to consider the role of ideas in policy diffusion. In contrast to other mechanisms, emulation does not view diffusion as a rational search for the best policies and recognizes the social construction of policy ideas (Gillardi and Wasserfallen, 2019). Highlighting the role of ideas, some scholars have demonstrated that actors emulate others with similar ideological preferences, especially when the effects of novel policies are not well known (Givens and Mistur, 2021; Obinger et al., 2013). These scholars pay particular attention to the ways in which policymakers conform to norms and rules (Finnemore and Sikkink, 1998; Meyer et al., 1992) and explore how interactions among policy networks, epistemic communities (Haas, 1992), or policy entrepreneurs (Mintrom, 1997) change the preferences of policy actors. Despite these major differences with studies focusing on other mechanisms, scholarship on emulation does not still explicitly focus on political dynamics of diffusion (Gillardi and Wasserfallen, 2019). Nor do they explore possible overlaps and relationships among these mechanisms: rather than independent processes, these mechanisms may indeed be "complements" which might have "interdependent effects" (Graham et al., 2013: 695).

Our recent experience with the COVID-19 pandemic has provided a rare opportunity to examine mechanisms of diffusion as policy actors looked across the national borders to frame problems and develop solutions in diverse policy areas such as public health and health care systems, social policy interventions, economic policy, and political strategy. While some studies highlighted the role of epistemic communities consisting of researchers (Basrur and Kliem, 2021), staff working at the World Health Organization (WHO) and other international organizations, and civil society organizations in the exchange of data and experiences to control the spread of the virus and its effects (Harman, 2020), others identified specific mechanisms of diffusion among national governments. For instance, Givens and Mistur (2021) demonstrate how countries that adopt a nationalist ideology are more likely to emulate COVID-19 policies of similarly nationalist regimes, even after controlling (for geographic proximity), trade, linguistic connections, political systems or domestic policy conditions. Nationalist regimes in countries such as Brazil, the United States, Hungary, and the Philippines used a combination of strategies including downplaying the problem, appealing to exceptionalism with a claim of unique protection from the virus, promoting scientifically dubious and even dangerous treatments, and blaming outgroups including migrants, other countries, and international organizations such as the WHO (Givens and Mistur, 2021: 217). In their analysis of COVID-19 policies of OECD countries, Sebhatu and colleagues similarly find mimicry or emulation as a major factor in explaining why very different countries adopted the same 19 policies within a span of two weeks in the early months of the pandemic. A quantitative analysis of these COVID-19 policies also revealed the importance of level of democracy: countries with strong electoral democracy being slower in adopting COVID-19 policies but demonstrating more susceptibility to "the diffusion pressure of many proximate countries adopting such policies" (Sebhatu et al., 2020: 21207).

Considered as a whole, diffusion studies tend to focus almost entirely on the policy adoption stage, thus ignoring policy actions that take place in other stages, including implementation and evaluation (Graham et al., 2013). As our experience with the COVID-19 pandemic illustrates, this narrow focus on legislative or executive adoption results in failure to systematically analyse key policy dynamics relating to implementation such as systematic enforcement (as in the case of mask mandates), or major shifts in decision making such as rescinding COVID-19 interventions (school closures), or their readoption (social distancing, remote working options, mask mandates, etc.) in the face of new waves of COVID-19. Recent studies have proposed to overcome this limitation by expanding the analysis of diffusion across the policy cycle (Gillardi and Wasserfallen, 2019) and exploring implications for the scope of policy change (Campbell, 2004).

The second stream, often called the policy transfer literature, shares the interest in exploring the motivation of actors and mechanisms of diffusion, but expands this analysis with an inquiry into the object and degree of transfer, role of information and expertise, as well as impact of policy mobility on success and failure (Dolowitz and Marsh, 2000; Graham et al., 2013; Simmons et al., 2006). Using case studies and other qualitative research methods, scholars in this stream have identified mechanisms, similar to those discussed by the diffusion scholarship, such as voluntary processes and coercion (Dolowitz and Marsh, 2000; Kuhlmann, 2021). Although some of the earlier reviews placed this stream within the diffusion literature associated with international relations and comparative politics literatures (Graham et al., 2013), we consider these studies methodologically and epistemologically distinct: grounded in public policy tradition this stream uses qualitative case studies and pays close attention to domestic political dynamics, institutional characteristics, key actors and how they connect to transnational policy processes. Another distinctive feature has been investigation into the diffusion of ideologies, partisan values, norms, attitudes, and negative lessons (Dolowitz, 1997; Rose, 1991; Stone, 2008).

Given its global scale, waves of infection with emergence of new virus strains, and the severity of the ensuing public health, economic, and social crises, the COVID-19 pandemic created an unprecedented context for policy learning and transfer. While systematic analyses of transfer need more time and further accumulation of evidence, an initial wave of blog articles and opinion pieces criticized policy actors for failing to engage in policy transfer as they searched for effective pandemic control measures, treatment protocols and social, economic and fiscal policies aimed at mitigating its negative impacts (Ham, 2021; Hantrais and MacGregor, 2021). Some of these analyses of failure of policy learning explain this gap with differences in demographic dynamics or absence of clear success stories (Hantrais and MacGregor, 2021). Others discussed urgency, uncertainty, and severity of the crisis as opposed to "normal" times, the pressure on policymakers to act quickly, limitations in the scientific evidence base regarding the novel virus, communication issues, and reaching populations across political divides (Capano et al., 2020; Weible et al., 2020) as barriers that may inhibit collaboration and learning policy lessons across borders. Still, others attributed this gap, specifically in the UK context, to an exceptionalist mindset, characterized by a "lack of curiosity about the experience of other countries and a willingness to learn from them" hence leading to a "willful blindness" (Ham, 2021: 1). Another key theme was the failure, specifically in the context of Europe and North America, to learn from experiences with past or similar diseases that could have provided some guidance in terms of effectiveness and acceptability of various public health interventions (Boin et al., 2016). In their review of the literature on COVID-19 that discusses lesson drawing and policy transfer, Powell and King-Hill (2021: 28–29) found more emphasis placed on specific results in one or more countries and limited discussion of applicability of these lessons in other contexts and specific characteristics of the adopting countries such as political climate, institutions, and availability of resources that could influence transferability of the lessons.

In addition to policy interactions among countries, the transfer stream has been growing steadily with further attention to the transnational dynamics of policy learning and transfer as part of the regional integration projects in Europe (Radaelli, 2008) and Latin America (Riggirozzi, 2014). Recent studies also brought this literature into conversation with development studies, examining dynamics of the movement of ideas among countries in the global South as well as from global South to global North. Given the focus of the studies in the first two literatures on the interactions among the Organization of Economic Cooperation and Development (OECD) countries, and diffusion from states and international organizations

(IOs) from the global North to global South, this opens up an exploration of "continuous, transnational, multi-scalar, and multi-stakeholder circulations" (Stone et al., 2020: 4) of policy ideas within different policy spaces such as the Sustainable Development Goals (SDGs) at the global level or new forms of South-South Cooperation (SSC) networks. This conversation also presents an important opportunity in health policy as it opens the possibility of bringing separate fields of global health, development studies and comparative health policy together (Agartan, 2020).

Since the early days of the pandemic, the role of regional organizations in developing policy responses to COVID-19, particularly in ensuring effective communication, policy harmonization and learning among member countries, has been discussed in the media, blogs and opinion pieces (Hantrais and MacGregor, 2021). The assessment of the European Union's performance in this regard has underlined gaps and largely ineffective initiatives. For instance, in their analysis of external travel restrictions in Europe, Rausis and Hoffmeyer-Zlotnik (2021) found little evidence that the European Union (EU) shaped the adoption of similar policies across member states during the first wave of the pandemic in 2020. Although the European Commission issued guidelines, many observers described them as "a mere reaction to justify ex post the actions that some Member States had already taken, rather than an instance of the Commission taking things in its own hand" (Rausis and Hoffmeyer-Zlotnik, 2021: 286). Similarly, Basrur and Kliem (2021: 7) described how the EU and the Association of Southeast Asian Nations (ASEAN)'s responses have been "constrained by outbreaks of nationalism and unilateral knee-jerk reactions." However, the discussion on regional policy activism and learning differed significantly in the case of the African Union and the Africa Centers for Disease Control (Africa CDC). Patterson and Balogun (2021: 146) described Africa CDC's agency during the pandemic as rooted in "solidarity, norms of cooperation, and epistemic communities" alongside "lessons learned about health messaging and community mobilization from previous health crises." Building on their pre-pandemic relations, Africa CDC and the specialized health organization of the Economic Community of West African States (ECOWAS), collaborated with the WHO, the West African Health Organization (WAHO), and other development partners in Europe and the US. In its efforts to harmonize the response and coordinate policy steps, Africa CDC developed a COVID-19 Joint Continental Strategy and collaborated with the WHO to deploy common technology platforms to improve public trust in testing (PACT). While representing important steps in regional cooperation and policy development, we need in-depth studies that trace how these processes shaped policy developments in member countries and how (harmonious and conflictual) political dynamics influenced their adaptation and implementation in national and subnational contexts.

Before moving to the third stream, we should highlight one important difference between policy transfer studies and diffusion studies. Unlike diffusion scholars, some policy transfer scholars highlighted the extent to which transfer studies paid attention to the stages of the policy cycle beyond agenda setting. For instance, Mossberger and Wolman (2003) discussed: 1) how the perceived success of a programme – hence its implementation and evaluation – impacts its adoption by others, and 2) whether it has been implemented in other countries with important similarities while being adapted to local dynamics. We see recent examples of this emphasis on implementation and adaptation/translation in the discussions around the spread of the Universal Health Coverage (UHC) agenda and its implementation in various contexts. Placing a new emphasis on learning and the role of epistemic communities, some studies (Kiendrébéogo et al., 2021; Meessen et al., 2019) draw attention to the role of "communities of practice" in relation to implementation of the UHC. The African Collaborative for Health Financing Solutions (ACS) is a good example of such a community of practice that brought some of the key stakeholders together to co-produce relevant knowledge and provide support for combining two resource tracking methodologies – the System of Health Accounts and the National AIDS Spending Assessment – to streamline more efficient allocation of resources in Namibia. Kiendrébéogo and colleagues (2021) describe how the ACS exercise was then adopted in Botswana and policymakers in other countries, such as Kenya, indicated interest in the method. A distinctive feature of these studies is the acknowledgement of power dynamics among the development actors – donors versus recipients, global North versus global South – that have long been characterized by top-down approaches of the donors, involving fly-in/fly-out development support by policy experts from the global North (Kiendrébéogo et al., 2021). The top-down type of policy transfer, even when the policy actors pay attention to domestic political dynamics, often failed to build research and implementation capacity within recipient countries and limited country ownership. Therefore, initiatives like the ACS aim to reverse these earlier models of technical assistance and unidirectional policy transfers by developing consultative approaches that include stakeholders across all policy scales and contexts (global North, global South, local, regional, national, global, etc.) in a way that prioritizes understanding of local needs and builds local and regional institutions.

The third stream includes a diverse body of work building on various disciplinary traditions. What they have in common is a criticism of key assumptions embedded in the diffusion and transfer literatures regarding the motivation of actors, problem definitions and policy solutions, the role of values, norms and ideologies, the process of movement and what happens to policy ideas as they travel. The first criticism centres on the motivation of policy actors including policy entrepreneurs. Diffusion and transfer studies assume that actors choose to learn ideas across borders as a rational response to a perceived problem, viewing the movement of policy ideas as a technocratic exercise (Campbell, 2004; Freeman, 2009; Klein, 1997). This implies common perception of problems and their solutions regardless of the role of ideas, values, norms, and ideologies. The second criticism also relates to this conception of diffusion, described by John Campbell in terms of a "mindless mechanical transfer of information from one place to another" (2004: 78), but focuses more on the conception and implications of mobility. These two criticisms shape the key debates in the current literature and are useful to highlight the contribution of the third stream.

The methodology of tracing the diffusion of policy ideas comes with a perception of them as fixed and technocratic, which often obstructs the analysis of political dynamics of such process. As discussed in the previous section, critical attention to the role of ideas and framing processes opens a window into the complex political dynamics and allows us to see how discursive tools are used in all aspects of the policy cycle to shape perception of problems and definition of solutions, to help persuade the public and/or particular interest groups to support certain policy packages and hence legitimize the actions of policy actors. Shiri Noy's critical examination of World Bank's mandates to access loans and technical assistance in the health sector across Peru, Argentina, and Costa Rica, demonstrates how the content of World Bank recommendations and implementation of coercive mechanisms varied substantially depending on "the historical institutional arrangements and countries' broader political economies" (2018: 180). Noy's close attention to framing of ideas around targeting and the implementation of policies opens up opportunities to understand specific political dynamics, different policy outcomes, and patterns of health reform.

Several studies in comparative health policy demonstrate how selective assessment of information, factual errors or misunderstandings about other contexts, and the intentions of policy actors, shape the movement of policy ideas in important ways (Marmor et al., 2005; Okma, 2008). Indeed, as Daniel Béland explains, ideas, ideological commitments and interests of actors influence their perception of both the "object" of policy transfer and lessons drawn (2006: 563). Policy actors often use cross-national ideas as "ammunition" to "inspire either emulation or repudiation" (Klein, 1997: 1270) in domestic battles and hence may be interested in "victory, not illumination" (Marmor et al., 2005: 334). Ideational scholars further provide in-depth analysis of the social construction of policy diffusion, translation, and role of success stories (Agartan, 2021; Béland, 2006; Béland et al., 2022; Orenstein, 2008). Actors often use the policy ideas from other countries to push for certain problem definitions, promote some solutions over others to the public, build political support for their agendas, and enhance their "leverage with domestic opponents or hesitant political leaders" (Weyland, 2005).

A diverse body of scholarship has emerged that developed the second criticism arguing that the story does not end when a policy "arrives at an organization's doorsteps" (Campbell, 2004: 78); nor do they remain unaltered. Here we can identify two concepts, grounded in different disciplinary traditions, that make critical contributions on the process and implications of mobility: 1) the circulation idea that is associated with French scholarship on the ideational aspects of public policy, and building on ethnography, sociology and philosophy, and 2) policy translation that has been developed within the historical institutionalist scholarship as well as from within the mobilities literature that involves critical policy studies, urban studies, geography, ethnography, and anthropology.

The notion of "circulation" places emphasis on the complex dynamics of the movement itself, arguing that it is not direct or linear, as assumed by the scholarship on diffusion and transfer (Hassenteufel et al., 2017). Indeed, circulation implies movement that could be forwards or backwards and consist of pauses, stops or reversals (Porto de Olivera and Pimenta de Faria, 2017). These complex dynamics also recognize transformation in the object of transfer – idea, policy instrument, measurement tools, etc. – as they move across space and time. Hassenteufel and colleagues explain this change in terms of "translation" which involves "the negotiations and conflicts between different policy actors with different kinds and amount of resources" (2017: 82). The notion of translation allows the researchers to examine not only the shifts in the meaning and use of policy ideas, but also, how and why actors engage in appropriation and translation, thus allowing us to identify the role of values, norms, ideologies, and dominant paradigms. Some scholars called for ethnography to trace the micro-dynamics of policy mobility, demonstrating the complex interactions among actors, sites, and networks (McCann and Ward, 2011; Mukhtarov, 2017; Peck and Theodore, 2015). In the context of health policy, Agartan (2021) examines how global frameworks such as the Universal Health Coverage (UHC) spread to countries such as Turkey, while paying particular attention to the national political dynamics. Her analysis of Turkey's major health reform initiative shows how political leaders framed their Health Transformation Project as a UHC success story – although their reforms predated the UHC framing – to build domestic legitimacy and craft a new global role (2021: 293). Tracing the movement of the UHC idea across borders and political dynamics in countries, regions, and local political contexts provides a good opportunity to examine processes of learning, adaptation, and translation.

Critical policy studies, with their roots in urban studies, geography, and anthropology, similarly criticize diffusion and travel approaches with their linear and static conception of policy ideas as they cross boundaries. From this perspective, distortion or misunderstandings are expected because mobility is always mediated through political processes (Clarke et al., 2015; Lendvai and Stubbs, 2015: 447; Peck and Theodore, 2015). John Clarke uses the concept of "assemblages" to explain the interaction of "multiple and potentially contradictory forces, pressures and tendencies" (2004: 25) in any policy context. Resulting new policy arrangements are translated in relation to the specific historical-geographical characteristics (McCann and Ward, 2011; Robinson, 2021), interpreted and implemented. Policy actors are often aware of the heterogeneity and try to stabilize specific assemblages, which implicate alignment of particular positions and power (Clarke et al., 2015).

CONCLUSION

This chapter provided an overview of the literature on the role of ideas and of the analytical tools it features that can contribute to the study of health care politics and policy at the domestic level as well as at the intersection of local, national, regional, and global policy dynamics. Given its enduring connections to welfare state studies, global health, and international development as fields of study, health policy scholarship has been at the forefront of the debates on policy reform, innovation, and change, with a particular attention to how actors interact with each other and with often overlapping local, national, regional, and global institutional contexts. Thus, it is not surprising to see keen interest within the interdisciplinary health policy scholarship on ideas and their mobility across temporal, institutional, and geographical boundaries.

Various studies rooted in global social policy, international relations, comparative policy, global public policy, and critical policy studies have examined policy learning processes that combine domestic and transnational political dynamics in complex ways: they explore how ideas diffuse, how international norms and goals are interpreted and implemented in specific contexts, and how policies are translated and combined with locally available practices. However, as clearly demonstrated by our review of these studies, the interactions among the different literatures are very limited. This is partly due to different epistemological and methodological priorities that are rooted in certain disciplinary traditions. There are also separate academic networks based in various professional organizations and conferences, often with limited participation of the scholars, practitioners, and activists from the global South.

Despite calls for searching for a "holistic approach to policy transfer" that explores complementary aspects (Porto de Oliveira, 2021), or to decolonize academic fields of study, important tasks remain for future research. First, there is the need to develop analytical frameworks that break some of the silos between literatures centred on different – yet related – concepts such as "diffusion" and "transfer" or "policy paradigms" and "lesson drawing". Second, building on the calls to decolonize, we need to pay more attention to power dynamics and representation within research partnerships, conferences, and other forms of academic collaborations. This also implies recognizing colonial and historical legacies that shape research questions around the direction of policy learning, who should follow policy recommendations of international organizations such as the World Health Organization or World Bank, and dynamics of translation and assemblage. In particular, the global COVID-19 pandemic experience, which demolished prior expectations of success and failure, provides new opportunities to challenge power asymmetries in the production of knowledge and identify mechanisms whereby prior experiences with infectious diseases in the global South can inform policy decisions in regional and global organizations and can diffuse to high-income countries. Third, expanding the narrow focus on agenda setting and policy adoption towards the entire policy cycle and exploring the interactions across the cycle will enrich our understanding of the policy process. As described in the second section of this chapter, ideational scholarship is uniquely positioned to develop these connections and bring politics to the centre of this analysis. Fourth, more empirical work is needed to compare ideational explanations with other types of explanation (Parsons, 2007) in a systematic manner. This is the case, in part, because ideational explanations are not always considered by many students of health care policy and politics, to be a situation that is detrimental to this field of research (Béland, 2010). We hope this chapter will draw greater attention to the role of ideas in health care politics and policy and that it will encourage more scholars to explore these processes at the local, national, and transnational levels.

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7. Institutions, interests and ideas: framing and explaining entrepreneurial policy change in the UK health system

Stephen Peckham, Simon Bailey and Daniel Huggins

INTRODUCTION

National health policy is shaped by many factors and policy analysts have sought to explain how these factors interact to shape policies and policy outcomes. This chapter discusses the value of using the 3Is framework as a way of understanding policy change over time and the advantages of drawing on an approach that brings together three core concepts applied in policy analysis – namely institutions, interests and ideas. In order to explore the interaction between these conceptual frames for analysing the policy process, we apply the framework to changes in English health policy over a 30-year time frame. Over this period, health policy in the UK has been particularly marked by numerous policy changes and developments, especially in England. Since the 1980s, UK health policy has been characterised by significant policy shifts that have reframed how services are co-ordinated and organised, therefore, providing a valuable way to explore the application of the 3Is framework.

These changes have been explored through a number of policy lenses but most focus has been on the understanding of specific policy shifts such as the development of the internal market (Baggott, 1997), purchasing (Salter, 1993), foundation hospital trusts (Allen et al., 2012) and most recently the response to the COVID-19 pandemic (Vindrola-Padros et al., 2020). Weible and Schlager (2016) argue that policy analysis should, however, move beyond case studies of single policies to analyse and interpret broader policy areas. Compton and 't Hart (2019) have highlighted the importance of examining the temporal aspects of policy change. They argue for incorporating a temporal dimension which can account for the contextual changes that may affect ongoing policy implementation, but this is also important when considering policy development. Drawing on the 3Is framework: Institutions, Interests and Ideas (Palier and Surel, 2005; Walt, 1994), provides a way of taking a longer view of policy change.

In this chapter we examine a longer term-perspective of the development of a new institutional policy actor – NHS England (NHSE), which was established by the Health and Social Care Act 2012 – and how it has influenced English health policy, exploring the intersection of institutions, interests and ideas as a framework for policy analysis. NHSE is selected as the focus because its organisation and operation as a statutory body offers insight into the ways each of the 3Is and the relations between them have changed over time. The establishment of NHSE as an 'arms-length' body removed political interference and control but provided the space for NHSE to become a powerful political actor in its own right, promoting new policy ideas. Thinking in terms of the 3Is, it is clear that NHS England have successfully engineered institutional 'disruption' (Lawrence et al., 2011). Among the changes introduced in the 2022

Act is the reinstatement of the Secretary of State's power to intervene, which suggests the 'creation' of a new kind of institutional settlement between the state and the entrepreneurial policy actor. The emergence of NHSE may also represent a classic example of dominant interests representing, in accordance with Alford's theory of interests (Alford, 1975), the dominance of managerial or bureaucratic interests. These are among the issues which will feature in our discussion, which we begin by introducing the 3Is framework, setting out how interests relate to ideas and institutions, subsequently applying this framework in order to situate the creation of NHS England historically, and then showing how the framework helps us to understand the unfolding policy trajectory and their influence upon it.

POLICY FRAMEWORKS IN HEALTH POLICY ANALYSIS

Paton (2016) has described NHS policy since 1990 as '… subject to short-termist change … yet also increasingly directed by the assumptions of neo-liberalism and neo-classical, economics' (p. 152). This suggests that policy evolves with each change, building on or attempting to counter, previous policy developments, but also that changes can be understood according to a more enduring underlying 'logic' (Friedland and Alford, 1991). Approaches that focus on single policy shifts will not, therefore, grasp the broader sweep of policy change, and in so doing will often obscure the symbolic and ideological character of change. As discussed in other chapters, the apparent linear progression of a policy 'evolution' has also been widely called into question, leading to the development of a number of non-rational frameworks that provide ways of analysing the 'messiness' of health care policy in different contexts including: Muddling Through, or incremental policy making (Lindblom, 1959); the Garbage Can Theory (Cohen et al., 1972); Punctuated Equilibrium Theory (PET) (Baumgartner et al., 2014); Complexity Theory (Geyer and Rihani, 2010); Advocacy-Coalition Framework and theories (Jenkins-Smith et al., 2014); Multiple Streams Approach (MSA) (Kingdon, 1984; Zahariadis, 2007); and Policy Paradigms (Hall, 1993). Such approaches frame decision-making as contingent and context-dependent, with actors that can only enjoy a partial view of their worlds (i.e. bounded rationality: Simon, 1984). However, their derivation in one or other part of the framework means that each of these frameworks might miss interactions between one or more of the 3Is. For example, paradigms might be helpful to explain the shift to more market mechanisms for co-ordination of health care but might miss important institutional factors (Peckham et al., 2012).

The Multiple Streams Approach (MSA: see Powell, this volume) does encourage some focus upon the interaction between the 3Is and is a useful foundation for thinking about short-term change – perhaps change that occurs within a specific political cycle. The interplay of interests within MSA helps clarify the role of different interests and actors – especially when illuminated through an advocacy coalition lens (ACF). However, MSA must itself be situated in a broader, longitudinal framework to consider more fundamental shifts in ideology that shape the developments identified in the MSA. The 3Is, therefore, provides a set of meta-categories with which to bring together the insights that can be gained by combining existing frameworks. Examples of attempts to do so include exploring developments prior to 1990 shift to the internal market linking directly to MSA and providing a valuable insight (Powell, 2019). However, the shift to the 2012 Health and Social Care Act (HSCA) is a much messier situation than the 1980s. In part because the mid-1970s saw the first major structural transformation of the NHS, but subsequently reorganisation has become a much more frequent occurrence. This has led to a fragmentation of institutional structures, with deeply embedded contradictions, such as between competition and cooperation, which over time have created both 'salient' and 'latent' paradoxes (Pierides et al., 2021) and signified the need to move beyond structurally-bound conceptions of institutions and interests. Alongside this increasing normalisation of transition and transformation has come a lack of a clearly articulated problem that the new policy is meant to address, or, indeed, a coherent design for how it is meant to address it (Allen et al., 2021, Harrison and Wood, 1999). Attempting to map this dynamic complexity from pre-1990 through to 2022's structural changes is not possible with the use of single models and theories. The 3Is provides an overarching framework with which to consider adapting and combining multiple approaches.

Gestel et al. (2018) have argued for a broader interpretation of this combined MSA and Advocacy Coalition Framework approach. They set out the importance of an institutional theory approach (ITA) arguing that actors make choices within an institutional context of well-established social structures – rules, values, and cognitions – that guide their perceptions and behaviour (Ostrom, 2011; Scott, 2008). But as Tuohy (2018) has observed, it is important to recognise the way that new institutional entrepreneurs can also shape policy, creating the moments for policy 'windows' to open, or 'puncture the equilibrium' and create paradigm shifts (see also; Exworthy and Powell, 2004; Oborn et al., 2011). The importance of Tuohy's analysis is signified by the development of NHS England – originally established as the operational arm of the NHS, but which within five years had started to drive policy around funding and integration through the *Five Year Forward View*, then the NHS Long-term Plan (NHSE 2019) and subsequently the framing of the most recent White Paper *Integration and Innovation: Working Together to Improve Health and Social Care For All.* To explain the development of NHSE as a significant policy actor and its impact on health policy requires adopting a temporal aspect and a broader framework than can be provided by simply drawing on different policy analytical approaches.

The shortcomings of analysis that draws on theories and models as discrete approaches has been highlighted by Schlager (1997) who noted that the study of policy analysis has been characterised by 'mountain islands of theoretical structure, intermingled with and occasionally attached together by foothills of shared methods and concepts, and empirical work, all of which is surrounded by oceans of descriptive work not attached to any mountain of theory' (Schlager, 1997: 14). She highlights the value of drawing on different but complementary analytical lenses to examine unfolding policy. Such an approach has been echoed by Cairney (2013a) who has highlighted the potential of combining PET and MSA given the explicit clarity of each approach. Cairney and others (Cairney, 2013a, 2013b;Cairney and Jones, 2016; Rawat and Morris, 2016) also point to MSA and PET as important contributors to the study of institutionalism and ideas. Studies have also highlighted the important relationship of MSA with Hall's (1993) Policies Paradigms framework. As Baumgartner (2014) has argued, ideas are important whether they are paradigms or not. Ideas can be found at all levels in the policy process and are linked to political actors and those actors who are framing policy problems and solutions. This highlights the role of policy actors (Walt, 1994) and the role of policy entrepreneurs (Kingdon, 2011).

THE 3IS FRAMEWORK: INSTITUTIONS, INTERESTS AND IDEAS

The 3Is framework draws these different approaches together into a single analytical framework with three key elements, or explanatory variables: institutions (processes, context); interests (actors, power) and ideas (content, evidence, values), known as the '3Is' (Palier and Surel, 2005; Walt, 1994). Lavis and others have argued that the '3I' framework offers a comprehensive set of variables to consider in the analysis of policy change (Lavis, 2004; Lavis et al., 2002; Palier and Surel, 2005; Waddell et al., 2005). North (1990) argued that institutions are the 'rules of the game' that structure policymaking in ways that favour some outcomes over others. Institutions include policies, structures and embedded practices that shape policy change primarily through the ways in which they create and distribute incentives and learning (Hall and Taylor, 1996; Ostrom, 2005; Pierson, 1993). Institutions may be formal such as constitutions and laws enforced by the state, and 'informal' constraints such as 'codes of conduct, norms of behavior, and conventions' (North, 1990: 3). But, as Immergut (1992) and others have noted, how can such rule following lead to significant policy change? In fact, institutions, by definition, imply permanence and stability, and one of their key characteristics is that they are resistant to change (Strang and Sine, 2002). Traditionally this has led to a focus within political institutionalism on the rarity of policy change, in which change is often attributed to external events that alter institutional rules – so-called 'exogeneous shocks' – providing opportunities for other policy actors. Over time the question of how and why institutions do change and evolve has become an increasing preoccupation for institutional theorists (e.g., Greenwood and Hinings, 1996). A number of approaches have emerged as a result. For example, retaining a structural focus, the institutional 'logics' framework (Thornton et al., 2012) provides tools to think through change as these logics can 'segment', 'conflict' and 'combine' into new 'constellations' (Bailey et al., 2020; McDonald et al., 2013; Reay and Hinings, 2009). At the micro level, the concept of 'institutional work' (Lawrence et al., 2011) provides a framework to think through individual actors who are able to strategically 'create', 'maintain' and 'disrupt' institutionalised positions. A key concept which derives from a combination of both macro and micro lenses is the concept of 'institutional entrepreneurship' (Garud et al., 2007), in which well-placed institutional actors are able to take strategic advantage of ongoing contradiction and flux. This aligns with Kingdon's description of policy entrepreneurs, and building upon his framework, attention has been paid to the behavioural role of the policy actors themselves as engendering change and their ability to shift the 'rules of the game' (Knoepfel et al., 2007; Tuohy, 2018).

Within a highly institutionalised space such as health care policy in the UK, institutional structures are an important and enduring source of power. Within this context, institutions can be considered the primary operators within the 3Is framework. However, as noted above, institutions can and do change, and Interests and Ideas offer two ways into thinking about how and why. Recent analyses of policy responses to COVID-19 have shown the key role of NHSE as an institutional actor rather than policy actor, as policy leadership on health care shifted from NHSE to political decision-makers reminding us that power in the policy process is often fluid (Weible and Cairney, 2021). However, throughout this, NHSE has maintained a clear policy lead over the shape and delivery of health care, ultimately shaping Government policy, and can be seen as a key actor representing a managerial interest, with the ability to influence change further up the hierarchy, as well as down.

Interests describe the preferences and power embedded in policy actors. Behavioural schools of policy change assume policy outcomes are largely determined by actor interests and behaviours (Hall and Taylor, 1996). The ability of actors to attain and exercise their interests depends on the distribution of resources and power in a policy domain, as well as individual capacity and skills, which are constantly in flux (Richardson, 2000). However, the degree of autonomy of these actors is bound by structural constraints but also the articulation of more stable interests. Richardson noted that, in general, policy communities are not continuously stable with long-term organised interests. However, through a case study of successive reforms to the health systems within New York in the 1960s and 1970s, Alford (1975) explored how structured interests within the institutional framework of health care can generate stable long-term interest groups. To elucidate his study's observations around the interactions between clinicians, managers and 'the community', Alford outlined the theory of 'structural interests', and in his analysis and discussion, concluded that the interactions between, and power of, 'strategically structured interests' (ibid) held the key to health care decision making, and therefore reform.

Alford argued that the sub-surface interplays of these 'structural interests' defined how decision making, and health care politics more widely, are undertaken and governed. Set out in *Health Care Politics: Ideological and Interest Group Barriers to Reform*, Alford argues health policy is characterised by three key structural interests: 1) the *professional monopolisers*, namely the medical profession; 2) the *corporate rationalisers*, primarily hospital administrators and managers; and 3) repressed interests, or *the community*, typified by its lack of influence in decision making.

The theory of structural interests provides a succinct representation of the key stakeholders within the health policy making landscape and establishes a structurally embedded conflict at its heart. Alford's theory of structural interests argues that an inherent conflict between interest groups exists, which often manifests as clinicians wishing to maintain or even extend their positions of authority, opposed to those wishing to bureaucratise health care or in any way reduce clinical dominance. To comprehensively understand Interests, Alford's structural interest will be concisely set out here.

In Alford's theory, the dominant structural interests are unsurprisingly exemplified by clinicians, and these professional monopolisers are seen as a group maintained by existing political, economic, and social structures and institutions. The medical profession retains the authority to define diseases, and their power is reflected in both legislation and practice, with the aim of preserving professional autonomy paramount. The challenging structural interest, the corporate rationalisers, are those health care administrators and managers, who broadly seek to bureaucratise the administration of health care, therein reducing clinical autonomy. The third group, is that of the repressed interests, representing patients and the wider public. Throughout the broader history of organised medical care, patients have often been considered passive, and even deferential to figures of medical authority. Considering the contextual specificity in which Alford's theory is based, his theory evidently leans on this, although it is evident that the role of patients has substantially changed over the decades.

Alford makes clear that no structural interest should be seen within a vacuum, and that no one group is entirely isolated from the others. Alford understood that the categorised interest groups included subgroups, and that structural interest groups are able to coordinate when issues that would be mutually beneficial arise. However, this collaboration is not guaranteed to be undertaken on an equitable basis and may result in one structural interest group being used to advance the interests of another. While, traditionally, Alford documented this as patients and the wider public, the community, being the repressed interest, and consequently being locked out of the decision-making process, today, questions abound more over if those 'community interest' groups are being co-opted by the other structural interests, and potentially being used to advocate against their own interest. He also made clear that while interest groups remain contiguous over the longer term, their short-term goals may appear less well coordinated.

The health care landscape has undoubtedly become more complex since the publication of Alford's work, with the rise of the pharmaceutical industry and the changing nature of the patients and public more generally in their attitude towards clinicians becoming more prominent. Clinicians are now subjected to more coordinated, strong, and often successful challenges from managers, and have even fielded challenges from patient groups, which have albeit been less successful. While the designation of dominant, challenging, or repressed interests may have changed over time, the basic dynamics of structural interest group conflict and coalitions remain unchanged. Perhaps, therefore, interests are to be better understood relationally as opposed to structurally. While the cultural and contextual specificities of Alford's work must be accounted for, the real strength of Alford's work lies in its attribution of key stakeholder groups, and the interactions between those groups as a defining feature of health care politics. By highlighting the competing interests of the key stakeholder groups, his argument has strong face validity and has been used by analysts studying health systems across the world. Other authors have developed the concept beyond the tripartite groupings of Alford to examine the interplay of other groups and particularly new structured interests such as other health care professions (North and Peckham, 2001) and GP fundholding (Checkland et al., 2009). Alford's thesis of the dynamics of 'reform without change' has also been applied to policy sub-sectors (Woo and Howlett, 2015). The medical profession's position as holding dominant interest has also been questioned as doctors are a more heterogeneous group than Alford suggests, with a number of different medical groupings (Hunter, 1996).

Such studies demonstrate how interests are mobilised within health care policy making, identifying how dominant interests and coalition of interests can change over time whilst also demonstrating elements of Alford's central thesis of how structured interests can resist change. This may reflect more clearly observations made by others that new interests can emerge and become engaged in the policy process creating a more pluralistic approach than identified by Alford (e.g., Heclo, 1978; Richardson, 2000). In health care, the analyses by North and Peckham (2001) and Checkland et al. (2009) demonstrate new emerging interests of new health care practitioner groups (e.g., nurses) and new managerial interests – in this case primary care commissioners. However, these analyses do not particularly undermine Alford's central thesis of dominant and challenging structured interests being primarily between corporatist rationalisers and professional monopolisers. More troubling in applying Alford's theory at a macro system level is a blurring of the medical profession with managerial or corporatist structures – an issue raised by Checkland et al. (2009) in their discussion of GP fundholders. There has been a growing development of medical leadership, seen as '… a resource to reconcile professional aspirations with health systems objectives' (Baker and Denis, 2011: 356–357). Some authors have suggested that this is the rise of corporate medicine clearly blurring the boundaries of Alford's dominant and challenger interests. At the macro level, Alford also does not include the role of Government as a key policy institution or interest – a role more acknowledged in wider policy discussions of interests (e.g., Heclo, 1978; Richardson, 2000). Clearly, governments are able to instigate key policy shifts and set core agendas as a dominant interest based on more ideological grounds.

However, in terms of the modern 'relevance' of Alford, and interests, even Alford made clear that his theory was concerned with the 'bigger picture', and that while in the short term actions may appear conflicting, when considered over the longer-term a clear pattern emerges of dominant interests maintaining or expanding their control. Within this, it is clear that even Alford anticipated the broader nature of this theory, and that the attribution of structural interests to small policy changes (over the short term) would not neatly fit within his more rigid theory. Alford's theory, and Interests, are therefore less capable of capturing subtle differences, at the single policy level but are applicable at a sub-sector level as well as at a system level. Providing an explanation of how ideas may dominate policy agendas.

Ideas in policy analysis represent the content and strength of actors' values and knowledge in the policy process (Hall, 1993; Lavis et al., 2004; Surel, 2000). Ideas shape agenda-setting, policy formulation and implementation by determining which representations of the problem and potential solutions will be heard and understood by policy-makers (Hall, 1993; Sabatier and Weible, 2007; Surel, 2000). As such, wider 'ideas' shape both the interpretation of problems and policy responses and can be found at all levels in the policy process. This highlights the role of policy actors and the role of policy entrepreneurs – political actors and those actors who are framing policy problems and solutions (Kingdon, 2011). Drawing on Alford's theory, ideas are promoted by key interest groups who seek to dominate the policy agenda. The influence of ideas on policy was developed by Hall (1993) who posited the concept of policy and paradigms. These help to understand the context for how policy follows periods of continuity where change remains incremental but also why fundamental change occurs even if the problem, policy and politics streams are not aligned. Hall (1993) argues that most policy change is first or second order in that it involves adjustments to policy or the introduction of novel instruments but the underlying tenets or 'accepted reality' that policy is predicated on is not changed. Third order change marks a profound policy disjuncture – borne from a 'fundamental shift in the way that policymakers understand and address a policy problem' (Studlar and Cairney, 2014: 514) – that may be unrelated to preceding incremental first and second order changes. It involves 'radical changes in the overall terms of policy discourse' (Hall, 1993: 279) and helps understand the more enduring policy shifts that help frame other changes in health policy.

Combining these frameworks into a broader framework such as the 3Is potentially provides a valuable tool for understanding policy change. To examine the extent of such explanatory power within a temporal framework, we will examine the development of NHSE from 2012 to the present day in terms of its role as a policy actor and how it has become a powerful policy actor promoting managerial interests, emerging as the key corporate rationaliser and setting the current policy agenda. Drawing on these theories of ideas, institutions and interests, we demonstrate in the following sections the value of a more multi-faceted approach to understanding policy change and their inter-relationships. Such an approach helps to demonstrate how the establishment of NHSE as a policy entrepreneur with significant institutional power has been able to promote its new agenda, replacing dominant political ideas of the internal market in the English NHS. In this way, NHSE has demonstrated its dominant position as a corporate rationaliser able to influence further up the hierarchy as well as down.

APPLYING THE 3IS FRAMEWORK TO POLICY CHANGE OVER TIME: NHS POLICY 1989 TO 2019

The English NHS is characterised by considerable policy driven change over the course of its existence (Pollitt, 2007). The pace of this change, and the frequency of associated organisational 'redisorganisations' (Smith et al., 2001), has intensified since the introduction of the internal market in the early 1990s, which created the separation of planning and commissioning services and the provision of health care services. These policy changes have been the subject of extensive analysis (Exworthy et al., 2016; Harrison and MacDonald, 2007; Klein, 2013a), therefore we only provide a very brief summary here. However, such analyses have tended to focus upon the political forces and ideas that have led to the policies (Klein, 2013b), or to apply a single policy analytic lens (Powell and Exworthy, 2016). Policy changes in the period between 1990 and 2019 have variously been attributed to paradigm shifts following influential ideas (e.g., bureaucracy, market, network) while others have pointed to the consistency of the broader institutional frame and argue that policy change has been more limited (Currie et al., 2012; Exworthy et al., 1999; Harrison et al., 1992). More recently, some analysts have argued that the shift towards managers and markets created the conditions upon which more dramatic shifts have been built (Ferlie, 2016; Hodgson et al., 2022).

By the late 1980s, the UK Government was under growing pressure to act to address systemic problems in the face of cancelled operations, ward closures and significant criticism from within the NHS, professional bodies, commentators, the press and the wider public. In 1989, a White Paper, *Working for Patients*, was published leading to the 1990 NHS and Community Care Act, which created the NHS internal market. The broad thrust of policy was in many ways a continuation of an underlying ideological commitment to marketisation and decentralisation, which had earlier led to the introduction of general managers into the NHS (Harrison et al., 1992), developing provider units (hospital and community service providers) and the competitive outsourcing of cleaning and catering in the NHS. Politically significant public concern and a substantial Conservative Government majority in both the House of Commons and the House of Lords secured the passing of the Act. There was some opposition from the medical profession but while mobilising what had traditionally been a significantly powerful interest within health policy, on this occasion ideological changes were dominant and enacted. More importantly, the Government mobilised NHS management to implement the new system thus supporting a corporatist challenge to the medical profession. Although, at least in its earliest manifestation, the NHS market arguably remained more 'quasi' than real, with minimal actual competition between providers and limited recourse to formal modes of contracting (Allen, 2002; Exworthy et al., 1999), its introduction nevertheless changed fundamentally the way in which health coverage for populations was planned and provided in the UK.

Whether the reforms of 1990 represented a paradigm shift has been questioned by many commentators. Essentially, the NHS remained publicly funded, publicly provided, free and universal. It is also true, however, that policy change was influenced by a 'New Public Management' approach which had gained traction across the public sector (Ferlie, 2017) and prioritised consumerism, choice and marketisation – all features of the developing internal market characterising patients as consumers, and market forces (competition) seen as the best approach to ensure efficiency (Flynn and Williams, 1997; Tilley, 1993). The ideological dominance of the internal market remained a key element of NHS policy, shaping policy changes through the 1990s and 2000s including, for example, the move under New Labour to convert all NHS trusts into 'Foundation Trusts' with quasi-corporate structures, and greater financial and commercial autonomy. As such, it was clear that a significant paradigm shift had occurred (Hall, 1993), which crossed over both sides of the political compass, despite the fact that the introduction of the market-based reforms had little obvious impact on the essential nature of the NHS.

However, Exworthy (1998) has argued that, whilst the quasi-market appeared at a policy level to be a major paradigm shift, in practice, historical local collaborative relationships limited the impact of marketisation and prevented a full paradigm shift. Organisational relationships and practices represented strong institutional forces that limited the impact of a full application of marketisation. An alternative view has been presented by Hoggett (1996) who regarded the introduction of the purchaser – provider split as a significant governance shift – rather than a functional one as suggested by Exworthy et al. (1999), which had implications for local and national policy development and implementation. He argued that the reforms fused traditional hierarchal forms of integration with new '… forms of horizontally integrated production but within which central controls are stronger rather than weaker than before' (Hoggett, 1996: 16).

What is clear is that 1990 represented a significant shift that reframed much policy debate and had an organisational impact within the NHS. The strength of the ideological shift is much clearer when viewed from our future point of reference. Its dominance being illustrated by policy development post-1997 when the Conservative Party Government was replaced by a Labour Party one. The election of a Labour government in 1997 led to a new round of reforms presented as a political 'third way', different from both the old left and the new right, and characterised by Powell (2002) as fundamentally driven by pragmatism and populism, eschewing ideology and adopting a mantra of 'what counts is what works' (Secretary of State for Health, 1997: 14). The Labour Government, while rejecting market approaches arguing that the internal market was bureaucratic and inefficient, nevertheless developed a policy response from within the same policy paradigm introduced in 1990 by retaining the purchaser/provider split, and even intensifying corporate managerialisation through extensive use of targets and giving new powers to regulators. New purchasers evolved – Primary Care Trusts – which took on full responsibility for commissioning services for the population in a geographical area, including local oversight of general practice services. The Government retained a policy focus on a market-based approach despite a rhetorical commitment to 'partnership'. Solutions to problems would be through increased competitive pressures on providers, through demand side reforms with the strengthening of patient choice, and through supply side reforms by supporting more pluralistic provision including new private providers (Department of Health, 2003; Le Grand, 2007).

In 2010, New Labour were replaced by a Conservative/Liberal Democrat Coalition Government who proposed further reforms to address the problem of poor health care outcomes relative to comparable countries and a service that was insufficiently patient centred (Secretary of State for Health, 2010). The principles and underlying aims of previous policies were implicitly presented as sound – their failure was due to deficient execution rather than design and their obstruction by a cumbersome system. The policy solution was to give patients more choice to improve efficiency through competitive forces; and to give greater support to clinical involvement in commissioning to improve decision-making and obtain better value for money. This led to the Health and Social Care Act 2012. The changes introduced by the Act have been comprehensively described elsewhere (Exworthy et al., 2016; Timmins, 2021) but included the wholesale abolition of swathes of NHS organisations, the creation of new ones to replace them and the division of responsibilities in different ways, creating complex governance structures. However, the underlying policy architecture of the purchaser/provider split remained mostly intact with new commissioning organisations led by local clinicians more firmly in charge and commissioning care from an increased range of competing providers. The reforms did highlight shifting interests in supporting new primary care medical leaders and representing changing patterns of professional and corporatist interests.

Responsibility for overseeing the system was transferred from the Department of Health to the new arms-length body, known as NHS England (originally NHS Commissioning Board) seemingly splitting policy development from operational management of the NHS and presented as removing operational management from political interference. NHS England (NHSE) also took on responsibility for NHS budget allocation to local commissioners and responsibility for many operational issues including primary care contracts and commissioning specialist services.

Since 2012 there has been a distinct shift in the policy frame of the NHS. In October 2014, NHS England and six NHS regulators and arms-length bodies, presented an assessment of the NHS and a statement of intent for its development in the *Five Year Forward View* (FYFV). While the framing of the problem contains familiar aspects from previous policies (i.e., demographic pressures, and more consumerist expectations from patients) it also highlighted the divisions between different parts of the health and care systems (primary, community and acute services) noting that it was '… increasingly a barrier to the personalised and coordinated health services patients need' (NHSE, 2014: 16). The FYFV also identified the divide with mental health and social care services and the need for additional resources. The proposal, though, was not another reorganisation but rather for the development of new models of care based on integrated working. The FYFV resulted in a range of new inter-organisational initiatives to develop and provide exemplars of new models of health care planning and delivery, bringing together commissioner and provider organisations across primary, secondary, community and social care boundaries. While elements of the purchaser/provider split were retained, the emphasis was on collaboration – a policy theme that has continued to develop since 2014 challenging the dominance of the market model of co-ordination.

In particular, the development of integrated care highlighted the coalition of management and professional interests which both supported the concept of integration. Integration was promoted by NHSE and culminated in the Health and Care Act 2022 which institutionalised integration within the English health and care systems.

The FYFV, the more recent *NHS Long Term Plan* (NHSE&I/DHSC, 2019) and the subsequent Health and Care Act 2022 marked a significant break with the emphasis on commissioning and competition repealing sections of previous legislation that promoted competition. The emphasis now is on integration and in the 2021 White Paper *Integration and Innovation: Working Together to Improve Health and Social Care re All* (Secretary of State for Health, 2021) there is explicit recognition of the problem of transaction costs associated with the internal market and an acknowledgement that competition has hindered integration between providers. The FYFV strongly encouraged localised planning and integration between commissioners and providers, working together as a whole 'health economy'.

'Delivering the Forward View' (NHS England, 2015: 4) most clearly set out the policy shift: 'For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve'. The Forward View and its planning guidance clearly represent a significant departure from the consistency embodied in previous NHS policies. Even though the HSCA12 enshrined certain competitive dynamics in statute, the era of policy specifying commissioning through competition between discrete organisational entities appears to be changing into one where place-based planning and integration between commissioning and providing organisations are to be the principal means of arranging and delivering health care services. The extent of the shift was clearly set out in the Next Steps document where it was proposed that some areas would end internal market arrangements and develop new integrated organisations unifying services – including direct management of community and hospital services.

Clearly, it was not envisaged that policy leadership would shift from the Department of Health to NHS England. The HSCA 2012 established NHS England (initially named the NHS Commissioning Board) as a new statutory body, with the intention of reducing the abilities of the Secretary of State for Health (SoS) to 'micromanage and intervene'. The SoS's role, and that of the Department of Health, was to provide a 'short mandate' to NHSE to oversee the provision of health services. The establishment of NHSE as an 'arms-length' body was to remove political interference and control of the NHS by the SoS. The new body was to be 'a lean and expert organisation, free from day-to-day political interference, …' (ibid.: 30). Accountability was to be achieved through a mandate issued by the SoS which set out the duty of NHSE and the nature of its work. The mandate was intended to set direction for the NHS and ensure the NHS was accountable to Parliament and the public. The mandate was refreshed on an annual basis by the Secretary of State to ensure that NHSE's objectives remained up to date. However, drawing entrepreneurially upon its institutional power, and enabled by a system with in-built contradictions, NHSE has demonstrated a dominant corporate approach to setting the new policy framework for health and care in England, albeit an approach that has support among professional interest groups and the wider public – although potentially for different reasons (Kodner, 2002).

POLICY CHANGE AND THE INTERPLAY OF INSTITUTIONS, INTERESTS AND IDEAS

What then led to a substantial policy shift post the reforms of 2012? Key external actors such as the DHSC and political policy makers had not identified any specific willingness to shift away from a marketisation approach to NHS commissioning and service delivery. Neither had there been any assessment focused on a change in the dominant policy problems or key interests. In fact, competition and privatisation of services was central to the 2012 Act as the way to address the longstanding perceived problems of the NHS. However, while the HSCA12 specified in great legislative detail how the new system should operate, the system itself was incredibly complex and increased 'institutional ambiguity' (Ackrill and Kay, 2011: 47) in the NHS, which resulted in fuzziness over who was in charge at multiple levels. This complexity and ambiguity enhanced the ability of new policy entrepreneurs to successfully promote their interests. As Baumgartner and Jones (1991) argued, disruptions such as this provide opportunities for issues to break out of one policy-making venue, in this case led by the Department of Health and political policy-makers, and for other policy actors to produce policy solutions. Integration as a policy and institutional solution had been advocated by many analysts, politicians and policy-makers for some time (for example see Ham, 2010, 2014). Over many decades, ideas of integration have been incrementally adopted but as a dominant idea it had failed to gain significant policy traction until after 2014. Even so, change in the NHS is difficult due to the influence of institutionalised professional and managerial working practices and structural institutional constraints. For institutional theorists the NHS represents 'a field', a set of 'organizations that, in the aggregate, constitute a recognized area of life' (DiMaggio and Powell, 1983: 148). It exhibits characteristics of mature, highly institutionalised fields with embedded 'established networks' and 'federations of organisations' strongly ingrained (Maguire et al., 2004: 659).

Similarly, DiMaggio and Powell (1983) argued that fields comprise powerful institutional forces that lead members to become more similar to one another over time. As such, change is seen as being shaped by external actors who can shape the 'rules of the game' that regulate the institutional structures. Institutional theory therefore sees actors within the institutional field as either being constrained in their ability to affect change due to institutional forces, or as peripheral, lacking power to enact change. It was perhaps such circumstances that led Alford (1975) to describe the New York hospital system as being dynamic but without change. However, increasing system complexity and increased heterogeneity are conditions which can disrupt this structural account of institutional fields, which instead can come to operate in more locally contingent and relational ways (Gore et al., 2018; Wooten and Hoffman, 2016). NHS Policy through the 1990s and up to 2012 clearly reflected the way political policy makers as external actors shaped change and embedded new institutional structures based on new public management approaches. In many ways, the dominant market focus has continued to be reflected in government policy but within the NHS there has been an increasing focus on integration and collaboration promoted in particular by a coalition of key interests, but particularly NHSE and system managers or 'corporate rationalizers'. While the 2012 Health and Social Care Act reinforced this dominant focus, its operational restructure created conditions favourable to institutional change. In its wake, the key policy actor has been NHSE setting out new policy ideas, which have then been adopted by government policy makers resulting ultimately in the Health and Care Act 2022. The new Act establishes regional integrated Boards and Systems, effectively ending the purchaser-provider split in the NHS in England. The move to geographically based collaboration through the new integrated care systems is NHSE's solution to maintaining and improving patient care. Collaboration and integration are the new buzzwords (Allen et al., 2020).

To understand this change requires closer examination of the role of NHSE as a *policy entrepreneur* and agent of change. Collaboration and integration are not new ideas and have been part of what Kingdon (1984) has described as the 'primeval policy soup' – with ideas in dialogue between academics, think tanks and NHS managers in a variety of forums for several decades. However, it failed to gain significant traction and has been absent from key policy initiatives since the 1990s which have been situated within the policy paradigm of the internal market. One key feature of the HSCA12 was the removal of some power from the Department of Health, investing it instead in the arms-length body NHSE. By ceding some control, the Government reduced their direct exposure to blame for problems in the NHS when they occur and creating a significant change of actors in the politics and policy streams. At the same time, ceding power to an arms-length body introduced, perhaps unintentionally, a new powerful policy player thento the policy process, Cairney (2007) has suggested that such new powerful internal actors can disrupt the monopoly of existing policy makers, and thus establish new policy paradigms. This increased power formalised through its institutional role allowed NHSE to promote its corporatist agenda and challenge the market agenda of the government.

NHS England were able to intervene strategically and gain influence through entrepreneurial activities from 'above' and 'below': from above, structural transformation and ambiguity created strategic resources for change (Gore et al., 2019; Hammond et al., 2019). From below, incentivised local action could open up new ways of working, establishing coalitions of interests which could capitalise upon localised evidence of impact to create substantial pressure for system change to enable scaling up (Bailey et al., 2017; Checkland et al., 2022). The FYFV identified the problem of fragmentation that occurs through market-based approaches – a problem identified by a wide variety of analysts and other commentators since the introduction of the 1990 reforms (e.g., Klein, 2005). Incentivising local actors to find solutions to this problem arguably undertook some of the work that the 2012 HSCA failed to; yet at the same time this approach chimed with the entrepreneurial stance embedded within the Act – evidenced in the intention of the act to sweep away bureaucracy and ministerial influence and liberate the 'front line'. This demonstrates some of the conditions upon which effective institutional entrepreneurialism is based, described as a form of 'praxis' in which embedded agencies are able to expose institutional contradictions and undertake reflexive work to develop and adapt existing institutional resources for a new purpose (Seo and Creed, 2002).

However, possibly in recognition of the extent to which NHSE has proven itself able to exceed its formal mandate, the other major change in the 2022 Health and Care Act, which was not requested by the NHS leadership, is a big shift of power back to the Secretary of State who will re-acquire significant powers to intervene. Current proposals are that the Health Secretary will get new powers to direct NHSE, intervene early in local reconfiguration decisions, decide about the creation of new provider organisations and to abolish professional regulators and NHS arms-length organisations without needing legislation in parliament. These powers extended to the SoS allows them to exercise a large degree of control over the running of the NHS in general, and, perhaps importantly, NHSE in particular. The Act confers functions on the SoS to direct NHSE as well as other NHS bodies in specific circumstances. The Act confers power on the SoS to transfer functions between any of a defined group of relevant Non-Departmental Public Bodies (NDPBs), and to delegate functions of the SoS to these NDPBs. These are 'Henry VIII' powers. Interestingly, these functions do not extend to 'making NHSE redundant' (Part 3, 87(3)) but mark a shift back to government becoming more dominant. As such, the structurally rigid interpretation of Alford may appear now to be more limited and, without modernisation, no longer provides a convincing picture of power relations in today's NHS. However, interests should be understood within a broader framework and the adoption of integration as government policy and acceptance amongst professional, managerial and public interests suggests that the dominance of certain structured interests (in this case the corporatist rationalisers) remains particularly relevant within the institutional framework of health care and how ideas are promoted by individual, and coalitions of, interests.

At the same time, NHSE has increased its areas of responsibility through absorbing NHS Improvement in 2019 and the Act abolishes Monitor and the NHS TDA and transfers their functions to NHSE. Beyond their formal mandate it could also be argued that the approach NHSE took to policy implementation promulgated through the FYFV and Long-Term Plan have helped to establish an approach to policy making which permits a form of loose central steering by incentivising local networks of actors. This appears to be effective in enlisting those coalitions of interests which are able to align local interests around the national steer, and become a basis for new inter-organisational partnerships, thus becoming a means of incorporating resistance or conflict that might attend unpopular reforms (Bailey et al., 2017, Jensen et al., 2018). At the same time, this appears to offer flexibility to policy actors, who can capitalise on success and distance themselves from failure, while also providing a practical apparatus through which success can be managed more strategically (Checkland et al., 2021; Hammond et al., 2019). These benefits involve trade-offs of various kinds: local solutions that are the product of time-limited incentives are often not spreadable, scalable or sustainable, and can lead to the imposition of idiosyncratic processes when attempting to replicate elsewhere (Bailey et al., 2017; Goff et al., 2021). Furthermore, enterprising individuals and groups that benefit from investment in this way are more likely to benefit from future investment, thus reinforcing place-based inequalities (Bailey et al., 2017; Hutchinson et al., 2021). Perhaps most concerningly, and echoing long standing critiques of entrepreneurial government (e.g., du Gay, 1993), the permissive approach to formal governance that is to some degree necessary to enable innovation within temporally and spatially discrete projects (Hodgson et al., 2019; Sahlin-Andersson and Soderholm, 2002), can become inscribed in the policy process more generally, leading to policy being implemented which lacks fundamental details concerning governance, responsibilities and accountabilities. Each of these trade-offs are visible to greater or lesser degrees in the content of the Health and Care Act and in the White Paper which preceded it. Among other things, this raises a serious concern about the extent to which 'integration' will be achieved when together these trade-offs reinforce fragmentation, heterogeneity and inequality between different parts of the health and social care systems (Gore et al., 2018; Hammond et al., 2017). This returns us to the consideration of what constitutes 'effective' institutional entrepreneurship with respect to the maintenance of core standards and the need for responsible stewardship of institutional resources within a publicly-funded system of health care in which both financial and moral issues are at stake (Khan et al., 2007).

CONCLUSION

This chapter has provided an overview of the 3Is framework and, through its application to contemporary NHS policy, demonstrated its usefulness for taking a longer view of health policy changes. As institutionalised as the NHS might appear to be in popular political discourse, it has been, from the very outset, an attempt to achieve a settlement among conflicting interests. Clearly mobilised interests do matter and need to be considered in health policy – even where strong institutional forces are present. The UK example of how a new institutional entrepreneur was able to create a dominant position to promote new policy ideas counter to those prevailing over the previous 15–20 years is instructive, highlighting the value of utilising the 3I framework – especially when analysing policy change over time. Alford's theory of structural interests fits well into the framework as it helps to highlight how interests can become dominant through institutional status and therefore either, as Alford found, 'reform without change' or in the example discussed in this chapter, institutional power strengthening corporatist interests to promote a 'third order' (Hall, 1993) change in the ideas underpinning health policy. The rise of corporatist interests is observed by standing back to view policy change over time, validating Alford's bigger picture approach that analysing structural interests does provide a way of viewing policy change. However, the institutional position of interests is probably an increasingly important factor – whether sustaining the medical profession's dominant position (particularly in studies of sub-sectors of policy) or demonstrating how the creation of NHSE and its entrepreneurial policy role has strengthened corporatist interests. A more detailed account than is within the scope of this chapter would also need to consider how the interplay of interests and institutions is shaped by broader political-economic factors outside of the immediate sphere of health policy. If rising corporate interests in health policy are reflective of broader political-economic shifts since the 1970s then this underscores Alford's vision when he anticipated the broader nature of this theory. Studies following on from Alford have considered the limitations of applying structural interest theory to small policy changes (over the short term). Irrespective of the shifting dominance of different interests it is likely that 'reform without change' may be more linked in health care to institutional resistance rather than resistance by dominant interests or, at least potentially, where significant interests combined with institutional forces create resistance or drive through change. This suggests that incorporating an analysis of interests remains a valuable tool in health policy analysis.

Structural interest theory has more value when combined with analysing institutions and ideas, in exploring the broad spectrum of health policy the 3Is framework draws these different approaches together into a single analytical framework which have explanatory validity. In particular, the framework encourages the analyst to explore the interplay between institutions (processes, context), interests (actors, power) and ideas (content, evidence, values) (Palier and Surel, 2005; Walt, 1994).thee 3I framework offers a comprehensive set of variables to consider in the analysis of policy change, especially where policy process frameworks such as MSA or PET are unable to provide sufficient explanation being more useful in the study of single polices (Lavis, 2004; Lavis et al., 2002; Palier and Surel, 2005; Schlager, 1997; Waddell et al., 2005). The 3Is framework also provides a way of drawing on different but complementary analytical lenses to examine unfolding policy as argued by Schlager (1997). It provides a valuable framework for the interpretation of broader policy areas and for examining the temporal aspects of policy change (Compton and 't Hart, 2019; Weible and Schlager, 2016).

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8. Institutions and health care research

Martin Powell and Daniel Béland

INTRODUCTION

Institutions are one of the ‘3Is’ of institutions, ideas, and interests (Hall, 1997), which have been included in the ‘3I’ model (e.g., Shearer et al., 2016). Institutions have been defined in different ways and cover many different elements. Amenta (2012: 49) has pointed to the ‘eclectic conceptualization of institutions’. One of the most cited definitions (see e.g., Kay, 2005; Steinmo and Watts, 1995) states that institutions refer to ‘the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy. They can range from the rules of a constitutional order or the standard operating procedures of a bureaucracy to the conventions governing trade union behaviour or bank-firm relations’ (Hall and Taylor, 1996: 938).

Hall and Taylor (1996) pointed out that the ‘new institutionalism’ has given rise to at least three different analytical approaches or schools of thought: historical institutionalism, rational choice institutionalism, and sociological institutionalism. They noted that it is paradoxical that these three schools of thought developed quite independently of each other, at least judging from the paucity of cross-references in the literature. Schmidt (2008) suggested four types, by adding ‘discursive institutionalism’. This chapter focuses on historical institutionalism (HI) for two main reasons. First, Béland (2019: 7) considered that HI is ‘the purest form of institutionalism in the sense that it is centred primarily on institutional explanations, which is actually not the case for rational-choice or organizational institutionalism’ (see also Parsons, 2007). Second, HI tends to be the dominant type of institutionalism in the literature on health policy. This is why some of the leading and most highly cited HI studies have discussed health policy (e.g., Hacker, 1998; Immergut, 1992a, 1992b; Steinmo and Watts, 1995).

HISTORICAL INSTITUTIONALISM

HI had its origins in comparative politics and in the intellectual movements to bring the ‘state back in’ to the analysis of politics (Amenta, 2012; Evans et al., 1985), with the term ‘historical institutionalism’ being linked to Steinmo et al. (1992) (e.g., Amenta, 2012; Fioretos et al., 2016; Hall and Taylor, 1996). Historical institutionalists associate institutions with ‘organizations and the rules or conventions promulgated by formal organization’ (Hall and Taylor, 1996: 938).

HI is grounded in the assumption that political institutions and existing policies help constitute the ‘rules of the game’ that impact the behaviours and strategies of the social and political actors involved in policymaking (Béland, 2019; Campbell, 2004; Fioretos et al., 2016; Hall and Taylor, 1996; Lecours, 2005; Pierson, 1994; Skocpol, 1992; Steinmo et al., 1992; Weaver and Rockman, 1993). Consequently, as its name emphasizes, historical institutionalism focuses on institutional explanations of human behaviour, which are distinct from ideational, psychological, and structural explanations in social science research (Parsons, 2007). Simultaneously, historical institutionalism is distinct from rational-choice institutionalism and organizational institutionalism, which account for structural and ideational factors, respectively (Hall and Taylor, 1996). Consequently, it is possible to follow Parsons (2007) and suggest that HI is the form of institutionalism that is the most closely linked to institutional explanations in the strict sense of the term, which is precisely why we begin our discussion of the role of institutions in health care with a section that draws extensively on HI as it applies to the field of health care.

To map key concepts and perspectives associated with historical institutionalism, we can draw on the distinction by Jacobs (2016: 341) between synchronic and diachronic effects of institutions. One the one hand, synchronic historical institutionalist arguments identify 'a short-run effect of prevailing political-institutional arrangements on the relative political influence of political actors. Arguments about synchronic institutional effects (…) the ways in which the "rules of the game" favour or disadvantage particular types of actors and demands over others' (Jacobs, 2016: 341). On the other hand, diachronic effects stress the weight of historical political and policy legacies and their impact 'on how political structures have, over time, shaped the political capacities and the policy demands that actors bring to the political battlefield' (Jacobs, 2016: 344).

As far as synchronic effects are concerned, a key claim associated with historical institutionalism is the constitutional rules and political institutions that create potential opportunities for various constituencies to shape the policy process (Béland, 2010a). The concept of 'veto point' applied by Immergut (1992a, 1992b) to the study of health care reform in Europe illustrates this approach. For instance, comparing post-war health care reform in France, Sweden, and Switzerland, she argued that, in the latter country, federal institutions increased the political influence of Swiss physicians in ways that were not available to their counterparts from France and Sweden, two much more centralized unitary states. For Immergut (1992a, 1992b), in Switzerland, constitutional rules and political institutions associated with both federalism and direct democracy (referendums) rather than greater organizational capacity on the ground is what explains why physicians in Switzerland benefited from greater veto power over health insurance reform than their colleagues in France and Sweden. This example points to the fact that, for historical institutionalism, political institutions help determine the potential impact of interest groups within the policy process by providing them 'varying opportunities to veto policy' (Kay, 1999). This statement suggests that such actors do have agency, which is a common assumption of HI (Hall and Taylor, 1996; Parsons, 2007).

Overall, as many different elements pass for institutions, many different approaches pass for HI. Hall and Taylor (1996) claimed that historical institutionalists are eclectic, pointing to an eclectic mix of the 'calculus' approach embraced by rational choice scholars and the 'cultural' approach of sociologists. However, 'eclecticism has its costs', particularly in terms of 'specifying the precise causal chain through which … institutions [affect] the behaviour they are meant to explain' (Hall and Taylor, 1996: 950).

Béland (2019: 7) pointed out that HI is centred on the historical development of institutions. By definition, HI has a strong temporal orientation. However, even when dealing with single-country case studies, an institution's historical development is typically studied from a comparative angle. HI has a rich comparative component much less evident in the two other forms of institutionalism.

Fioretos et al. (2016) claimed that HI developed a distinct conceptual toolbox for understanding the causal mechanisms that underpin processes of institutional durability and change.

It includes temporal concepts such as critical junctures and path-dependence that have long informed contributions of HI, as well as newer concepts like intercurrence and modes of gradual institutional change (p. 10). They explained that critical junctures feature extensively within HI scholarship because they may be initial markers of path-dependent processes, but 'perhaps no concept is more closely associated with historical institutionalism than path dependence' (p. 11). However, there are different approaches within path dependence. First, path dependence is understood as self-reinforcing processes 'involving positive feedback' (Pierson, 2004: 20). Second, the role of historical contingency is regarded as important. Early events that trigger path-dependent processes may be accidental, and attention to contingency provides a foundation for exploring how apparently random, accidental, and small events can have major consequences over time.

Fioretos et al. (2016) continued that the extensive attention given to critical junctures and path-dependent processes has led to characterizations of HI as a tradition that has favoured explanations of change that rest on notions of history as a process characterized by punctuated equilibria, followed by long periods of institutional stability. However, this has more recently been challenged by newer tools such as gradual institutional change. The work of Thelen and colleagues (e.g., Mahoney and Thelen, 2010; Streeck and Thelen, 2005) have stressed the importance of gradual institutional change as an alternative to studies of punctuated equilibria and stable orders.

Other scholars stressed different tools from within the institutionalist analytical toolbox. For example, according to Broschek (2013), path dependence is the most prominent tool within the burgeoning literature of HI. Similarly, Greener (2005) stated that, HI's most distinctive feature is an image of social causation that is based around the notion of 'path dependence' – one means by which the 'historical' gets into HI. Capoccia and Kelman (2007) argued that path dependence is a crucial causal mechanism for historical institutionalists, and the concept of 'critical junctures' is an essential building block of HI. In contrast, Béland (2010) focused on two of the most prominent institutional factors referred to in health care research: 'veto points' and 'policy feedback'. Broschek (2013) argued that there are two variants of HI. The first, and most prominent strand, is the 'critical junctures and path dependence framework' which sheds light on the issue of continuity within dynamic processes. The second concerns 'gradual institutional change' (GIC), including processes such as displacement, layering, drift, and conversion (e.g., Hacker, 2004; Mahoney and Thelen, 2010; Streeck and Thelen, 2005). Lynch and Rhodes (2016) pointed to mechanisms of path dependence, increasing returns, feedback mechanisms, and slow-moving causal processes. The following sections explore some of the different HI approaches and tools.

Policy Feedback and Path Dependency

Following the lead of institutional economics, some key decision or action at a critical juncture or choice point brings about institutions with mechanisms that provide increasing returns to action and self-reinforcing processes. Along with the most extreme versions of path-dependent arguments are ones that produce historical 'lock-in', even with suboptimal outcomes such as the example of the QWERTY typewriter (e.g., Amenta, 2012).

Focusing primarily on continuity, Pierson (1994, 1996) pointed to the central role of policy feedback, a concept that refers to ways in which, as they develop over time, existing policies create constraints and opportunities for political actors while shaping their behaviour.

The phrase 'develop over time' in the previous sentence is essential because it points to the synchronic effects that Jacobs (2016: 345) associated with the concept of policy feedback. So, how do existing policies as they develop create institutional effects that help shape future decisions and policy paths? To answer this question, we can draw on some of the early historical institutional work on policy feedback while using health care examples to illustrate broad theoretical claims (on this issue, see Béland, 2010b).

One major form of policy feedback concerns how 'new policies affect the social identities, goals, and capabilities of groups that subsequently struggle or ally in politics' (Skocpol, 1992: 58). This quote points to the reality that, over time, existing public policies shape interest group politics (Pierson, 1993: 598–605). For instance, in health care, the development of health care systems directly impacts the mobilization of professional groups, insurance companies, and health care providers. As Hacker (2002) pointed out, this is true of both the public and the private components of health care systems, which both affect patterns of interest group mobilization over time. From this perspective, public feedback is not only about public policies in the strict sense of the term but also about private yet publicly regulated institutions that can produce diachronic effects as they develop.

Simultaneously, beyond interest groups in the narrow sense of the term, historical institutionalists like Campbell (2003) have demonstrated how public policies can reshape public attitudes and even patterns of political participation over time in a way that creates opportunities and/or obstacles for policy reform. As Campbell (2002: 571) argues, using the example of US Social Security, a federal old-age insurance programme, which 'helps explain the high rates of political participation by seniors, especially low-income ones, who participate at higher rates than would be predicted by their resource levels because of their dependence on Social Security.' This work suggests that individuals who receive public benefits that affect them in a direct and existential way are more likely to vote and organize politically because they have so much at stake in terms of preserving their entitlements. This argument applies to health care beyond the field of old-age pensions, something that Campbell (2003) herself suggested in her work.

Another form of policy feedback concerns how, over time, new public policies foster state building and pave the way for more ambitious policies along the road. As Skocpol (1992:58) wrote in *Protecting Soldiers and Mothers*, due to the implementation of 'new policies using new or existing administrative arrangements, policies transform or expand the capacities of the state. They therefore change the administrative possibilities for official initiatives in the future' while affecting 'later prospects for policy implementation.' In the field of health care, this would mean that the development of hospital insurance policies would help pave the way to a more comprehensive health insurance system by extending state capacities upon which new reforms could be built.

Finally, another form of policy feedback concerns lock-in effects according to which 'Policies may create incentives that encourage the emergence of elaborate social and economic networks, increasing the cost of adopting once-possible alternatives and inhibiting exit from a current policy path. Individuals make important commitments in response to certain types of government action. These commitments, in turn, may vastly increase the disruption caused by new policies, effectively "locking in" previous decisions' (Pierson, 1993: 608). According to Pierson (2000), over time these lock-in effects can pave the way to path dependence, as transformative change becomes increasingly difficult to enact due to the high costs of shifting paths away from the existing entrenched logic. This does not mean that transformative change is impossible but, rather, that it tends to be a rare occurrence and the product of exceptional circumstances. In the field of health care, Wilsford (1994) popularized this claim more than 25 years ago and it remains a leitmotiv of some of the most recent literature in the field (Xu, Gorsky and Mills, 2020).

The above discussion about policy feedback focuses implicitly on self-reinforcing effects, under which support for existing policies tend to increase over time. Yet, as Jacobs and Weaver (2015) have recently argued, using health care reform as an example, policies as they develop can become weaker and weaker through what they call self-undermining feedback effects. According to them, such self-undermining effects constitute 'a set of *endogenous* forces—processes deriving from policy itself—that frequently generate strong pressures, and expand the political opportunities, for policy change.' In other words, self-undermining policy feedback, instead of promoting path dependence, weakens support for the status quo as policies develop. Considering this, self-undermining feedback is the opposite of self-reinforcing feedback, which is typically conducive to the production of the status quo associated with path dependence. Jacobs and Weaver (2015: 442) drew our attention on three distinct types of self-undermining feedback: 'the emergence of *unanticipated policy losses* for mobilized social interests, *cognitive* processes arising from interactions between strategic elites and loss-averse voters, and expansions in the *menu of available policy alternatives*.' In their work, Jacobs and Weaver (2015) illustrated these types of self-undermining feedback using the example of the 2010 Federal Affordable Care Act in the United States, an ambitious reform that has faced key challenges since its enactment. Yet, as Jacobs and Weaver (2015) acknowledged, in the case of the Affordable Care Act and beyond, self-undermining and self-reinforcing feedback can co-exist within the same policy as it develops. This creates analytical challenges but also makes for more subtle empirical analysis, as scholars recognize that, simultaneously, some aspects of a policy are self-reinforcing while others are self-undermining (Béland, Rocco and Waddan, 2019).

Pierson (2004) discussed (positive) policy feedback as one of four potential institutional reproduction mechanisms: coordination problems (actors need stable institutional rules of the game to compete and cooperate), veto points (institutional arrangements give specific actors the power to prevent change), asset specificity (actors develop assets like knowledge and expectations tied to specific institutional arrangements), and positive feedback (moves in particular institutional directions are self-reinforcing and make change more costly).

Amenta (2012) claimed that there is disagreement within the historical institutionalist camp about how central the role of path dependency might be. The strong version, involving lock in and self-reinforcing patterns, suggests that path-dependent processes are rare and important. However, the weak version, holding simply that contingency matters, suggests that path dependence is ubiquitous, though less and variably influential, involving a series of small and incremental changes, rather than a brief disjuncture in a critical period, or a 'punctuated equilibrium'.

There is a large literature on each of these concepts. For example, for path dependence, Greener (2005) stated that it has become, within a short space of time, a widely used concept in social science studies that often have remarkably little in common in terms of their conceptual framework or approach. He continued that many studies appear to use the term inconsistently, with little agreement on its definition or use of an explicit analytical framework, with path dependence often appearing to be a metaphor for a political organization in which 'history matters', and in danger of becoming meaningless. For instance, he stated that Pierson, one of the most significant writers on path dependence (see, for example, Pierson, 1993, 1996, 2000), has commented that the diversity of studies now being published under its name risks 'concept stretching' (Pierson, 2000a: 252) occurring.

Kay (2005) discussed several criticisms of path dependency: (1) it is a fashionable label for the intuition that 'history matters' without a clear and convincing account of decision-making over time; (2) it explains only stability and not change; (3) its normative implications are confused and mostly left unexplored. However, he concluded that, despite being theoretically inchoate and difficult to operationalize empirically, path dependency is a valid and useful concept for policy studies.

According to Mahoney (2000), path dependence is often regarded as little more than the vague notion that 'history matters' or that 'the past influences the future'. He suggested that all path-dependent analyses minimally have three defining features. First, path dependent analysis involves the study of causal processes that are extremely sensitive to events that take place in the early sequence. Second, early historical events are contingent occurrences that cannot be explained on the basis of prior conditions or initial events. Third, once contingent historical events take place, path-dependent sequences are marked by deterministic causal patterns or what can be thought of as 'inertia'. He linked path dependency to periods of institutional genesis corresponding to 'critical junctures'.

Critical Junctures

According to Capoccia and Kelemen (2007: 341), the concept of 'critical junctures' is an essential building block of HI. They defined critical junctures as '*relatively* short periods of time during which there is a *substantially* heightened probability that agents' choices will affect the outcome of interest' (p. 348). They continued that junctures are 'critical' because they place institutional arrangements on paths or trajectories, which are then difficult to alter. They stressed that a critical juncture should have a duration that is short relative to the path-dependent process it initiates. Moreover, while many scholars have defined critical junctures on the basis of their outcome (change), they contended that change was not a necessary element of a critical juncture. 'If change was possible and plausible, considered, and ultimately rejected in a situation of high uncertainty, then there is no reason to discard these cases as "non-critical" junctures' (p. 352). They stressed that the 'institutional economics' perspective is insufficient by itself, as it fails to discuss the role of key or influential actors (such as political leaders, policymakers, bureaucrats, or judges) who steer outcomes toward a new equilibrium during a phase of institutional fluidity.

Critical junctures constitute the starting points for many path-dependent processes. However, despite the theoretical and practical importance of critical junctures as the genetic moments for institutional equilibria, analyses of path dependence often devote little attention to them, the concept of critical junctures has been invoked casually, without a great deal of methodological or conceptual rigor. Yet, the literature offers little methodological guidance to those who would employ the concept of critical junctures. The paucity of conceptual instruments available to define, study, and compare critical junctures is striking when compared with the rich conceptual apparatus (for example, increasing returns, lock-in, sequencing) used to analyse path-dependent processes themselves. In their view, several suitable methods included process tracing, 'systematic process analysis,', 'analytic narratives', and, generally, any form of structured, theory-guided narrative. Finally, they considered that the analysis of contingency is another key element for critical junctures. They discussed the importance of counterfactual analysis, including the criteria of clarity, logical consistency, theoretical consistency and historical consistency (the ‘minimal-rewrite rule’).

Gradual Institutional Change

This focuses on the work developed by Thelen and colleagues (see Béland, 2010; Fioretos et al., 2016). Fioretos et al. (2016) pointed out that this work stresses that critical junctures that generate new institutions that are reproduced for long periods of time are not the only, or even the main, determinants of institutional development. Theories of gradual institutional change or endogenous institutional change developed as a response to the view that theories based on path dependence or critical junctures have difficulty in explaining institutional change, as they tend to have a stability bias, relegating change to exogenous shocks. The ‘Gradual Change Framework’ (Rocco and Thurston, 2014) appears to be associated with many different terms such as ‘gradual institutional change’, ‘cumulative, but transformative’ change, ‘small, slow, and gradual reform’, ‘incremental, gradual transformations’, ‘subterranean political processes’, ‘hidden change’ and ‘silent revolutions’ of incremental adjustment (Powell, 2016).

Thelen (2004) formulated a theory of institutional and policy change, including a critique of the ‘punctuated equilibrium model’ that long episodes of inertia follow rare ‘critical junctures’ linked with exogeneous shocks. She identified two main forms of incremental yet transformative change occurring between critical junctures: layering and conversion.

Streeck and Thelen (2005) identified five types of gradual institutional change: displacement, layering, drift, conversion and exhaustion. Displacement occurs when existing rules are replaced by new ones. Layering is where new rules are attached to existing ones, thereby altering the ways in which the original institutional rules structure behaviour. Drift happens when rules remain formally the same but their impact changes as a result of shifts in external conditions. Conversion occurs when rules remain formally the same but are applied in new ways. Exhaustion concerns the gradual breakdown or withering away of institutions over time.

Mahoney and Thelen (2010) presented a model of four modal types of institutional change (displacement, layering, drift, and conversion) which is different to Hacker (2004, below) in the labelling of the dimensions and the definitions of the modes. Moreover, van der Heijden (2010, 2011) noted some differences in Thelen’s definitions of terms over time. Their model includes political context, institutional characteristics and change agents. The classification of change agents is developed from two questions: does the actor seek to preserve the existing institutional rules, and does the actor abide by the institutional rules? This leads to a 2x2 matrix (c.f., Hacker, 2004) with four change agents: insurrectionaries; symbionts; subversives; and opportunists. Insurrectionaries (do not preserve or follow); symbionts (preserve but do not follow); subversives (do not preserve but follow); and opportunists (have ambiguous preferences and exploit whatever possibilities exist).

Rocco and Thurston (2014) claimed that a theoretical advance in the GCF is its recognition of ‘change agents’, but they regarded the types as vague labels or metaphors, arguing that they cannot be readily tracked with the standard tools for observing institutional change. They argue that it is necessary to operationalize the framework with observable indicators. Moreover, commentators point to problems of unclear causal mechanisms (e.g., van der Heijden, 2010, 2011). Moreover, Béland (2010) suggested that these terms tend to describe rather than explain policy change.

HISTORICAL INSTITUTIONALISM AND HEALTH CARE

As we have seen, there are many different approaches to HI. This section presents a selection of studies of HI in health care (see e.g., Béland, 2010; Béland and Powell, 2016; Powell, 2016) in broadly chronological order. They have been selected to indicate the variety of approaches and include the most highly cited studies and more recent studies focusing on different parts of the world.

Hacker (1998) examined developments in Canada, USA and UK in terms of historical sequence, timing, and policy legacies. He first reviewed the three most common families of explanations advanced to explain health policy divergence among nations: economic explanations, cultural explanations, and interest group explanations. He considered that these explanations all suffered from notable weaknesses and turned to HI. He examined three of the major institutional features that have shaped the prospects for government-sponsored health insurance: state administrative capacity, federalism, and overall government structure (particularly the contrast between parliamentary and presidential systems). Arguing the need to go beyond the truism that history matters, he focused on path dependence, which was explained as a policy passed at time T1 that may significantly constrain the range of possible options at time T2. He continued that an alternative, though by no means incompatible, conception of history's role also popular among historical institutionalists is that of critical junctures. Despite the strong tendency toward self-reinforcing processes or 'lock-in' in the medical sector, windows of opportunity for policy change have opened up in Britain, Canada, and the United States at similar historical moments (almost anticipating the title of Wilsford, below). For example, he observed that opportunities for fundamental change in health policy have historically been rare but pointed to two critical junctures in the development of British health policy: the passage of the National Insurance Act in 1911 and the creation of the NHS after World War II.

As suggested above, Immergut (1992a, 1992b) compared the politics of national health insurance in France, Switzerland, and Sweden. She used a formal perspective on institutions, notably 'veto points', to show why political decision-making follows characteristic patterns in different polities. She argued that from similar starting points, these health systems developed in divergent directions which are explained by analysing the political institutions in each country.

Wilsford (1994) applied the idea of path-dependency to an examination of health policy reform in Germany, France, Great Britain and the United States. His notion of path dependency is taken from the economic history literature, particularly from David (1985), who explored the 'manifestly suboptimal' continued use of the QWERTY typewriter keyboard layout, in what he termed 'QWERTY-nomics.' This suggested that decisions made early on in the path may lead to 'lock-in' of a pattern that is collectively suboptimal. However, he argued that neo-institutionalist explanations of path dependence (e.g., veto points) without change are not able to deal with the frequent importance of unpredictable contingency in occasionally bringing about important moments of big change that depart significantly from the path. He introduced the notion of conjunctures, which are 'fleeting comings together of a number of diverse elements into a new, single combination' (p. 257). However, he stated that 'the actual coming together of a propitious conjuncture in itself is perhaps the most highly unpredictable element of all – both as to when it will occur (timing) and as to whether it will occur at all (actuality)' (p. 257).

However, he argued that while that big reform is not the norm across all systems, it is more likely in countries such as the UK, where strong, centralized state structures in a policy domain can sometimes lead, paradoxically, to greater departures from the established policy path. He points to a 'structural engineering of a wholly new policy path' or 'fundamental transformation' associated with the Thatcher 'Working for Patients' (WfP) internal market, which 'almost all observers believe to be the most significant reform of the British health care system since it was established in 1948' (p. 265). He claimed the notion of 'conjuncture' in understanding the timing of the NHS reforms. He discussed a number of factors associated with 'conjuncture': Thatcher's increased political authority after the 1987 general election, the increased heterogeneity of the medical profession, the existence of the earlier managerial reforms, the template offered by Enthoven for an alternative organizational structure, and its lack of threat to both patients and the general public meant that, for a short time, reform was possible. However, there was no clear justification for the choice of these factors. Despite using the term 'conjuncture' or 'conjunctures' over 50 times, it is still not fully clear what it is. It appears to be similar to a 'critical juncture'. It seems that the conjuncture is 'the time at which these endogenous and/or exogenous changes occur together' (p. 270), and that 'crisis', is 'the most effective kind of conjuncture against strong structural frameworks' (p. 258). He pointed to the 'quasi-nonscientific element of the path-dependent model of policy change' that 'it is difficult to forecast either a specific conjuncture in advance or its effects' (p. 272). Wilsford concluded that 'in a simple way, history matters, and it matters a great deal' (p. 275). As we shall see, this simple truism forms the base for much of the loose, metaphorical use of path dependency.

Also adopting a path dependency approach, Steinmo and Watts (1995: 330) argued that 'America did not pass comprehensive national health care reform in 1994 for the same reason it could not pass it in 1948, 1965, 1974, and 1978. The United States is the only democratic country that does not have a comprehensive national health insurance system (NHI) because American political institutions are structurally biased against this kind of comprehensive reform'. However, Béland (2019: 10) argued that some proponents of HI have adopted a purely deterministic approach to policy stability and change that is problematic at best.

Veto points (Immergut, 1992a, 1992b, above) are not the only noteworthy phenomena when the time comes to assess the impact of constitutional rules and political institutions on health care reform. This is something clearly in evidence in the work of Maioni (1998), who compared the development of health insurance in Canada and in the United States after World War II. When she seeks to explain why Canada created universal health insurance while the United States failed to do so, she stresses how, in Canada, the existence of socialist and social democratic parties, the Co-operative Commonwealth Federation (CCF) and later the New Democratic Party (NDP), combined with the decentralized nature of federalism drove the development of universal coverage in that country. This is the case because the enactment of universal insurance programmes by the CCF and the NDP in the province of Saskatchewan, which other provinces immediately followed, exerted a pressure on the federal government to provide financial support to provincial health insurance systems. This logic was exacerbated in the mid-1960s by the presence of a minority Liberal government at the federal level, which depended on NDP support to get things done. In this context, provincial pressures and the role of the NDP at the federal level combined to push the Liberals to introduce the Medical Care Act, which became law in 1966. This legislation created federal matching funds for health insurance that created an incentive for the provinces that had not adopted health insurance to do so over the next five years. By the early 1970s, Canada had developed a decentralized health care system financed in part by the federal government, an outcome Maioni (1998) described as the consequence of political mobilization shaped by the interaction between two main political institutions: the party system and federalism, which points to the role of territorial governance and institutions in health care.

Hacker (2004) explored health care reform in affluent democracies, focusing in particular on Britain, Canada, Germany, the Netherlands and the United States. He stated that Immergut (1992a, 1992b) convincingly argued that opponents of large-scale government entry into the health field have been advantaged when a polity has a large number of 'veto points', such as federalism and a separation of powers between the executive and legislature. He argued that political systems may be either *veto-free* or *veto-ridden*, and medical systems may be either *hierarchical* or *decentralized*. He presented these in a 2x2 matrix, with Britain's big legislative breakthrough placed in the veto free/ hierarchical cell. More generally, he claimed that veto-free/hierarchical regimes are the settings in which structural reforms are most likely to be enacted and implemented. He continued that the British experience strongly suggested that internal policy 'conversion' and policy 'drift' were more important than formal legislative reform. However, these terms do not appear on his 2x2 matrix (c.f. Mahoney and Thelen, 2010), and he states that the term 'drift' was taken from Hugh Heclo (1974) while 'conversion' was taken from Kathleen Thelen (2003). He concluded that structural reform was not the crucial catalyst of change we usually assume it to be, but rather explaining the most critical shifts requires attention to two powerful sources of *internal* policy change, to which neither health policy experts nor students of the welfare state have given sufficient emphasis: *conversion*, or the decentralized restructuring of policies by actors empowered under them; and *drift*, or the failure to update policies to reflect changing circumstances (p. 722).

Bevan and Robinson (2005) followed Wilsford (1994), who drew on David (1985), in arguing that path dependence may explain why health care policies that are actually in place in any country were typically suboptimal. They used path dependence to see whether they helped to understand why policies as implemented in the English NHS were suboptimal. They examined policy paths over four periods marked by significant structural change: the creation of the NHS, the 1974 reorganization, the 1991 internal market, and the policies of the Labour government in 1997. They argue that inertia led to suboptimality in terms of the control of total costs, the equitable distribution of hospital services, and efficiency in delivery. However, they explored path dependence without any discussion of the 'Piersonian' (e.g., 1994, 1996) language of lock-in effects or increasing returns.

Territorial institutions are essential to understand health care development, in both unitary and federal states. Yet, such institutions are even more central in federal states, where authority over health care can become quite complex over time. For instance, this is the case in the United States, where Medicare is a purely federal health insurance programme for people aged 65 and older while Medicaid is a programme partially financed by the federal government but operated by the 50 states – a situation which leads to a significant level of territorial policy fragmentation across the country. This has been especially the case since the adoption of the Affordable Care Act (Obamacare) in 2020, as many Republican-controlled states have turned down the opportunity to expand Medicaid for ideological and political reasons, despite the presence of strong fiscal incentives to do so (Béland, Rocco and Waddan, 2016). From this perspective, federalism can have a direct impact on the politics of health care but also on the variation of health coverage and services across a country's territory. Yet, it is crucial to acknowledge the ‘varieties of federalism’, as each federal system is unique, which helps explain why the impact of federalism on health care reform varies sometimes greatly from one case to the next. In this context, federalism should not be reduced to a simple binary variable (unitary versus federal states) but, instead, understood in its broader institutional context. Thus, instead of studying federalism in and of itself, the historical institutionalist scholar should explore how federal institutions interact with other political, social, and economic institutions (Greer, Béland, Lecours and Dubin, 2023).

Rico and Costa-Font (2005) explored institutional change under health care federalism in Spain, examining the relative explanatory power of institutions (and history) versus actors’ power resources (and politics). They claimed that the path dependence framework, despite its intuitive appeal, had dubious conceptual consistency and predictive power, with both problems deriving from its institutionalist foundations. They argued that there are three main determinants of policy change: actors (the players), institutions (the rules), and action (the game), and that recent institutionalist path dependence theory (e.g., Pierson, 2000) has started to incorporate action and actors into the analysis. According to them, Spain stands out as a deviant case study against the predictions of path dependence theory, as previous research suggested that implementation of the NHS was not impeded, but fuelled, by the parallel process of federalization. In short, their central claim was that formal institutions played a subsidiary role to political actors as causes of policy. This emphasis on agency is a key contribution to the contemporary debate on policy change in health care.

On his side, Greener (2006) argued that the path dependence present in the NHS can be described in terms of the relationship between the state and the medical profession established in 1948 but that is now under serious threat because of the move from it being necessary in formation to being more contingent. This has meant a movement from a situational logic of protection and compromise to one of elimination and the forcing of choice, as the interests of the state and the medical profession appear to have diverged under New Labour.

Ross (2007) stated that no major study of path dependence in social policy has tested the theoretical premises of increasing returns processes specified by Pierson (2000) in his excellent analysis of increasing returns. She concluded that the case of the NHS does not offer a good fit with increasing returns arguments: the NHS has not replicated and changed in the manner described by path dependence theory. Policy development is driven by a far more complex and endogenous set of forces than can be captured by a parsimonious model of returns. Importantly, the cumulative effect of incremental moves is transforming the NHS in fundamental ways, a pattern of change that is inconsistent with path dependence theory’s punctuated equilibrium model.

Nikolentzos and Mays (2008) asked whether existing theories of health care reform can explain the Greek case of reform (1983–2001). They reviewed three main bodies of literature that examine the importance of the relationship between the state and the medical profession as well as other interest groups for the implementation of health care reform: theory of professions; historical institutionalism; and structural interest theory. They concluded that preliminary analysis suggested that HI offered the greatest potential to explain the outcome of health care reforms.

Sitek (2010) aimed to apply the new institutionalism to the politics of health care reform in post-communist Central Europe. He focused on veto points, drawing on Immergut (1992a, 1992b) and Hacker (2004), who stated that: stripped down to the basics, this approach divides countries into those that are ‘veto free’ and those that are ‘veto ridden’. He discussed the notions of path dependence or critical juncture. He concluded that the reform experience in Central and Eastern Europe highlighted the importance of the process and sequence of changes, making HI approaches particularly suitable from the analytic point of view, but that the experience of the post-communist countries shows that mainstream institutional explanations were overly deterministic.

Del Rosario et al. (2021) analysed the health care systems of the Philippines and Vietnam before and during the COVID-19 Pandemic, drawing on Steinmo's (2008) historical institutionalism approach. They focused on the strengths and weaknesses of the major health institutions of the two countries prior to the pandemic. According to Steinmo (2008), the research method that is therefore most instrumental to perform HI is process tracing. They concluded that each country's history of health care governance impacted the way they handled the incidence of COVID-19, and therefore concluded that HI helped in understanding the socioeconomic, cultural and political contexts which influenced the national governments' COVID-19 response. This seems to equate HI with national context.

Greener and Powell (2022) drew on the framework of institutional change proposed by Mahoney and Thelen (2010) to compare the responses to Beveridge's Giants of Want and Disease in the creation of the British welfare state in the 1940s. They argued that health care represents a mix of displacement (existing rules are replaced by new ones) and layering (new rules are attached to existing ones, involving amendments, revisions or additions to existing rules). The major change introduced by Minister of Health, Aneurin Bevan – the nationalization of the hospitals – may be considered as both layering and displacement. However, in the most significant 'rule change' of the clear commitments to a free and universal service, Bevan's plan can also be regarded as closer to displacement. Finally, Bevan represents a 'change-agent' of a mix of opportunist (in his deal-making with the medical profession) and insurrectionist.

CONCLUSION

As the above review suggests, institutions are a crucial type of explanation in health care policy research. Yet, what passes for institutional analysis, and particularly HI, varies significantly. Put another way, health care studies have drawn on a large variety of tools in the HI toolbox. Moreover, the tools have been used in vastly different ways. On the one hand, some of the path breaking accounts in HI have been focused on health care (e.g., Hacker, 1998; Immergut, 1992a, 1992b). On the other hand, HI has been used in a vague sense that 'history matters'. Moreover, institutions do frequently interact with other factors to produce certain policy effects, including patterns of stability and change. These interactional effects are discussed in other chapters of this volume, including the one of ideas, interests, and institutions, and the one of the roles of ideas and transnational diffusion. Future research should concentrate more systematically on these interaction effects, which are already central to the contemporary scholarship on policy stability and change (Béland, 2019). More generally, health care scholars should pay close attention to how they define institutions in contrast to other factors, especially material, ideational, and psychological explanations (Parsons, 2007). Institutional explanations are both powerful and diverse but their study requires clear definitions and rigorous empirical analysis, something illustrated by some of the work reviewed in the present chapter, which we hope will help health care scholars navigate the institutionalist literature on health care policy and appreciate its internal diversity and the key concepts such as policy feedback and path dependence it has popularized in recent decades.

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9. When organizations byte back – producing health and care as policy puzzlement

Jean-Louis Denis, Élizabeth Côté-Boileau and Janine Badr

INTRODUCTION

Public sector reforms have placed at the top of their agenda the notion of service and delivery improvement (Andrews et al., 2019; Pollitt and Bouckaert, 2017), borrowing concepts and practices associated with the private sector. The long-standing recognition of an implementation gap between policy intention and its execution in the day-to-day life of a system (healthcare, education) has also triggered a growing interest on how to better articulate policy goals with the behaviors of local implementers in charge of delivering policy outcomes (Cloutier et al., 2016). In this chapter, we focus on policies that target the delivery side of health systems, namely organizations in charge of delivering healthcare services to meet the primary, preventive, curative, palliative and community care needs of patients and population groups (World Health Organization, 2000).

The creation of publicly funded health systems (or major public healthcare programs, as in the US) in most high-income countries is considered a landmark development in the history of welfare states and policies. However, a combination of factors has raised questions in various jurisdictions about the ability of these systems to deliver accessible and appropriate care in the most efficient way and reduce persistent health inequities (Evans and Stoddart, 2017; Mackenbach, 2012; Mechanic and Rochefort, 1996; Saltman and Duran, 2016). Most of these systems have failed to adapt healthcare delivery sufficiently to changing demographic and epidemiological conditions such as population aging and the growing prevalence of chronic and mental health conditions (Amalberti et al., 2016). Moreover, issues relating to the organization of health systems in low- and middle-income countries have been a major focus of policy debates and developments within the context of a global call for universal health coverage (Kieny et al., 2017; Sachs, 2012). The notion of health system's strengthening, promoted by WHO in early 2000, underlines the importance of having properly designed, governed and organized health systems to get the maximum health benefits from every dollar dedicated to the provision of health services (World Health Organization, 2007). While our chapter focuses on healthcare models of organizations that have, for the most part, been developed in countries of the global North, we contend with many colleagues that similar attention needs to be paid to how best to organize the provision of care and, more broadly, health interventions in low resources settings.

The context described above has generated increasing policymaker interest in the way healthcare is delivered through various organizational forms and a mix of private and public providers. To achieve broader health system goals, it is no longer enough to fund healthcare and leave care delivery and services to professionals and managers. Faced with growing costs, rising population expectations, and newsworthy failures in assuring high-quality and safe care, governments are broadening their health policy agendas in order to make systems function better and more proactively. Of course, political ideologies and competing visions of the role of the State also come into play in this growing interest for organizations as policy instruments (Pollitt and Bouckaert, 2017).

The policy focus on the delivery side of health systems dates back to the 1970s and 1980s, when changing global economic conditions and growing costs prompted governments of high-income countries to look more closely at healthcare expenses and at the marginal benefits of increasing spending on healthcare (Evans and Stoddart, 2017; Marchildon and Di Matteo, 2014). The need for primary care models within communities to respond to most common health needs of a population (Starfield et al., 2005) and integrated care (Valentijn et al., 2013) to ensure better coordination of patients' pathways gained prominence as potential policy responses to these dilemmas. The persistent challenge has been for innovations in these policy responses to translate at enough scale and pace into new ways of organizing and delivering care that help meet expectations for improvement and equity, and to defeat resistance of some providers or organizations. In a paper written some ten years ago, we explored this growing centrality of organizational arrangements and innovations in contemporary health reforms (Denis and Forest, 2012). At the time, appetite for major health reforms in the US, and for major health system improvements in the UK and in many European jurisdictions (Pimper et al., 2017; Pollock and Roderick, 2018) were huge and there were widespread demands for organizational innovations to serve policy goals of access, cost control, and health improvement of the population (Shortell et al., 2015; Tabriz et al., 2017). Our analysis focused on the challenge of creating more complete organizations that could better perform health system functions and align with policy intentions.

The notion of organizations as policy instruments is debatable (Brunsson and Olsen, 2018; Brunsson and Sahlin-Andersson, 2000; Germov, 2005; O'Reilly and Reed, 2010). For health reformers, it reveals the determination to establish organizations that can provide better public services, including healthcare. The dilemma of having in place high-performing organizations have been documented in both the context of publicly-funded health systems and of health systems where both private providers and financing play a bigger role (Baker, 2008; Bohmer, 2011). For observers of public sector reforms, it is associated with growing managerialism in public institutions and organizations and may be associated with undesirable policy approaches and options. In this chapter, we focus on organizations as a tool for policymakers to design, adapt and improve health systems. Our chapter is written in the perspective of government's interventions and regulations to improve health system functioning and outcomes. We acknowledge that in some systems, the US for example, insurers play a crucial role in driving health system changes. We suspect that our considerations on organizations as policy instruments are both valuable for governments and other influencers in health-policy making.

While our examples are related to health systems of the global North, recent and growing interests to develop national policies for quality and safety of care in countries from the global South (World Health Organization, 2018) suggest that more attention to the delivery side of health systems in health policies will be center stage. In this chapter, we look to scholarly work on health organizations to enrich our understanding of the policy tools involved in governing by instruments (Lascoumes and Le Galès, 2007; Salamon, 2000). Governing by instruments implies, among other things, developing capacities within governments to anticipate the feasibility and acceptability of policies in targeted organizations and publics based on feedback from health providers and people with lived experience of care.

In the first section, we explore key organizations mobilized as instruments in contemporary health policies, using an interpretive and inductive approach. We consider organizations as policy instruments in situations where policymakers drive their creation or evolution to achieve large-scale changes and broad policy goals in health systems. We do not focus on strategies adopted by autonomous local organizations to deal with the vagaries of delivering care. Organizations are considered dynamic entities that provide opportunities for policy learning and adjustment through time (Busenberg, 2001). More specifically, we look at clinical networks (CNs), accountable care organizations (ACOs), and learning health systems (LHS) as three exemplars where organizations are mobilized as policy instruments. These three organizational forms have triggered growing interests among researchers, policymakers, health providers and managers for more than two decades. We propose a set of analytical considerations for the development and mobilization of organizations as policy instruments.

EXEMPLARS OF ORGANIZATIONS AS POLICY INSTRUMENTS

The exemplars presented below are selected based on three criteria: 1) the ambition to promote at large scale a new organizational form within health systems, 2) an explicit focus on resolving or attenuating critical health policy dilemmas by promoting a new organizational form, and 3) the availability of theoretical or empirical literature to analyze the potential and limitations of these forms. Three exemplars of organization as policy instrument are briefly described: clinical networks (CN), accountable care organizations (ACO), and learning health systems (LHS). These exemplars are umbrella entities that cover a variety of specific organizational arrangements. We deliberately adopt a more generic treatment of these forms and do not look at the multifold variations in their enactment in various national jurisdictions. We also do not choose to discuss how specific contexts—such as more fragmented health systems—may influence the benefits or failures associated with these forms. This would require more in-depth analysis in context. However, we think they are enough developed and revelatory to inform an analysis on the role of organizations within the delivery side of health systems as potential options to improve health systems. Having said this, we pay attention in discussing these three organizational forms to their broader potential for generalization across context.

a. Clinical Networks

Networks are defined as "*groups of three or more legally autonomous organizations that work together to achieve not only their own goals but also a collective goal*" (Provan and Kenis, 2007). Unlike vertical bureaucracies, networks are characterized by increased lateral or horizontal patterns of exchange and collaboration, interdependent flows of resources and operations, reciprocal lines of communication, and fluid circulation of knowledge (Castells, 2011; Nohria and Eccles, 1992; Smith-Doerr and Powell, 2010). CNs typically mobilize a variety of stakeholders, such as researchers, governments, health authorities, providers and patient partners, around shared purposes and accountabilities (Abu-Laban et al., 2018). Networks can be mandated or expect to evolve gradually, sharing resources and strategic orientations to deal more effectively with problems that cannot be dealt with by any single organization, namely through the adoption of evidence-based practices (Addicott et al., 2006).

Various types of networks have been identified (Ferlie et al., 2010). Traditional *provider-based networks* are informal referral networks of health professionals managing specific clinical conditions or cases (Bazzoli et al., 1999; Leatt et al., 2000; Mitchell and Shortell, 2000; Provan and Kenis, 2007). *Managed or mandated networks* aim to increase collaboration among autonomous organizations or agencies to better coordinate care and services and to lower the costs for specific disease conditions or population segments. This type of network has been studied empirically in various healthcare systems (Addicott et al., 2006, 2007; Denis et al., 2011; Ferlie et al., 2010). Increased connections among members will potentially enable better coordination of care and outcomes, as well as system-level innovation and improvement (Curry and Ham, 2010; Wasylak et al., 2019; Yiu et al., 2019). Strategic Clinical Networks (SCN) in Alberta (Canada) are a contemporary example (Manns et al., 2019) of formally mandated and supported CNs, involved in a wide range of clinical, community and research partnerships.

The demonstrated value of CNs

The positive value impact of clinical networks is variable (McInnes et al., 2015) and benefits and limitations of formal (mandated or managed) and informal (organic) types of CNs have been widely debated. Managed networks combine attributes of hierarchical and collaborative relationships among network members (Burns and Stalker, 1961; Denis et al., 1999, 2011; Granovetter, 1973; Ramsay et al., 2009; Vindrola-Padros et al., 2021). Studies suggest that the benefits of CNs largely depend on initiatives at operational and clinical levels, and on the quality of collaboration among clinical actors (Noseworthy et al., 2015). Attention to resources and competences needed to optimize patient care or population health interventions within these networks is also important (Bohmer, 2011; Curry and Ham, 2010).

There is no consensus in the literature on the potential and limits of managed or mandated networks to improve clinical outcomes and patient care (Curry and Ham, 2010; Ferlie et al., 2010). However, a model combining formal mandates and governance with collaborative approaches to stimulate professional and provider engagement seems to be a plausible option to maximize CNs' benefits. In Alberta, the planning process for SCNs highlights "leadership support, multilevel engagement, alignment and coordination with clinical, research and community partners, and robust measurement and reporting as key enablers for improvement in the health system" (Wasylak et al., 2019, 554). Brown and colleagues' (2016) systematic review finds positive relationships between CNs, improved quality of care and patient-reported outcomes based on studies of a specific population (e.g., cancer, cardiovascular care, diabetes, etc.) and in different healthcare systems (Brown et al., 2016). Key success factors include shared clinical leadership, locally-driven quality improvement, clinical capacities, and inclusive organizational culture (Brown et al., 2016; D'Alleva et al., 2019). Networks help reduce fragmentation in the delivery of care (Touati et al., 2006; Turrini et al., 2009) and can improve access and appropriateness of care (Gale et al., 2012). Overall, there are indications that CNs have potential to improve the delivery of care and services, but further studies are needed to better understand the conditions associated with high-impact networks.

Challenges with CNs

As suggested by Benson (1975) in his classic paper on inter-agency coordination, cooperation among autonomous entities is highly uncertain and operates according to a political economy based on mutual respect, protection of core activities and rules for conflict resolution.

Effectiveness of managed or mandated networks will vary according to the attention paid to the organic and professional dynamics of healthcare delivery (Greenhalgh and Papoutsi, 2018). Structural conditions and planning processes often create tensions between community, clinical, organizational and policy priorities and partners, affecting the capacity to deliver integrated care (McClellan et al., 2010; McInnes et al., 2015; Noseworthy et al., 2015). The development of managed networks is constrained by numerous contingencies including protective behaviors around the resources of network members and professional turfs.

Another challenge in sustaining and scaling up CNs is assuring sufficient political and economic investment in their development and implementation. In publicly-funded health systems, trust between governments and health providers, and the long-term engagement of multiple stakeholders are key factors to success (Noseworthy et al., 2015). In addition, CNs must find ways to address health equity concerns. The development of population health approaches and capacities drawing on digital (data) infrastructure to target the health priorities of vulnerable populations and deliver appropriate interventions beyond the healthcare system appears crucial.

b. Accountable Care Organizations

Concerns over the quality and cost of care in the US (Frandsen and Rebitzer, 2015; Kreindler et al., 2012; Moore, 2014) stimulated interest in incentives and risk-sharing approaches that culminated in the promotion of ACOs (Addicott and Shortell, 2014; Anderson, 2018; Palazzolo, 2015; Reddig, 2018; Wilks et al., 2017; Wu et al., 2016). According to Shortell (2016, 695), "ACOs are not really new organizations. Rather, they are pre-existing organizations that are defined as ACOs based on their willingness to accept accountability for the cost and quality of care for a defined population of patients" (Kreindler et al., 2012; Shortell, 2016).

ACOs were formally created, under the Obama administration through the Patient Protection and Affordable Care Act (PPACA) (Public Law 111–148, 2010) in 2010 to support innovative models of care (Frandsen and Rebitzer, 2015; Keren and Littlejohns, 2012; Luft, 2012; Spitzer and Davidson, 2013). Since 2010, over 900 ACOs have developed in the US, providing healthcare services to 10% of the national population (Kaufman et al., 2019). They are expected to improve population health, cost control, and patient experience (Barnes et al., 2014; Moore, 2014; Richman and Schulman, 2011; Rodriguez et al., 2019).

ACOs are defined as "provider groups that coordinate to provide high-quality care within a spending target for a defined patient population" (Ganguli et al., 2020, 722), and build on a long tradition of work on economic incentives in health systems (Enthoven, 1991). They take the form of legally constituted networks of hospitals, primary care providers, specialists and other system partners (e.g., insurers), and are contracted and funded on a three-year basis by the Center for Medicare and Medicaid Services (CMS) to meet specific improvement goals around dimensions of the Quadruple Aims—namely patient experience, population health, cost reduction, and human resources wellbeing (Cohen, 2014; Decamp et al., 2014; Frandsen and Rebitzer, 2015; Pasquale, 2012; Wilson et al., 2020). In 2018, 45% of all ACOs were physician-led, 30% system-led, and 25% hospital-led (Muhlestein et al., 2020).

ACOs are financially and clinically accountable for coordinating care across organizational boundaries and can be financially rewarded (up to 50% of annual savings) or penalized based on performance (Barnes et al., 2014; Lewis et al., 2014, 2017; O'Halloran et al., 2012).

The demonstrated value of ACOs

Studies on ACOs find that outcomes vary across organizations (Anderson, 2018; Clarke et al., 2016; Comfort, 2019; Dupree et al., 2014; Fisher et al., 2007; Ganguli et al., 2020; Moore, 2014; Neprash et al., 2017; Peckham et al., 2018). Performance disparities among ACOs may emerge from important differences in payers, contract incentives and local assessment of performance outcome measures (Kaufman et al., 2019).

Several studies find that ACOs achieve considerable cost savings. For instance, a study by Fisher and colleagues (2014) argues that the financial benefits of ACOs might be greater for vulnerable ("high cost") populations but this can be short term. Wilson and colleagues (2020), conclude that ACOs "outperform traditional fee-for-service models across the quadruple aim goals, although with mixed evidence about health outcomes" (Wilson et al., 2020). More recently, the ACO incentive model emerged as an important vehicle to continue to deliver population healthcare during the COVID-19 pandemic (Lieneck et al., 2021). Flexibilities and payment models allow for better and greater participation of ambulatory care organizations within ACOs, which calls for organizations that provide outpatient care (outside of hospital settings) (Bleser et al., 2020; Lieneck et al., 2021).

ACOs also appear to bring benefits by highlighting the importance of social determinants of health and social care needs (Browne et al., 2021) and, health partnerships (Goodrick and Reay, 2016; Nyweide et al., 2020), patient engagement (Millenson et al., 2019; Rodriguez et al., 2019), strengthening the non-physician role and appropriateness of care (Lewis et al., 2014; McClellan et al., 2010), improving health information technology (Kaufman et al., 2019; Wu et al., 2016), and the diffusion of innovations (Dorr et al., 2018).

Overall, ACOs have generally demonstrated favorable outcomes over the past ten years, though further analysis is needed to document the impact of these organizations on sustainable improvements to patient and provider experience, the governance of healthcare and population health outcomes (Barnes et al., 2014; Peckham et al., 2019).

Challenges with ACOs

The ACO reform represents a significant landmark in American health policy (Cohen, 2014; McClellan et al., 2010; Moore, 2014; Shortell et al., 2015) but the shared accountability model raises significant implementation and delivery challenges (Fisher et al., 2012; Lewis et al., 2017; McClellan et al., 2010; Moore, 2014). Addicott and Shortell (2014, 270) argue that the greatest challenge for ACOs "is to determine governance structure(s) and accountability mechanisms that facilitate the most effective combination" (Addicott and Shortell, 2014). The development and implementation of shared accountability in ACOs requires organizational maturity and capacities that are also unevenly distributed (Luft, 2012; Millenson et al., 2019; O'Halloran et al., 2012; Palazzolo, 2015; Pasquale, 2012; Shortell, 2016; Tabriz et al., 2017; Wu et al., 2016). Secondly, ACOs face important challenges in fostering integrated care across boundaries between social care and healthcare (Barnes et al., 2014; Clarke et al., 2016; Decamp et al., 2014; Keren and Littlejohns, 2012). Third, existing capacities in data analytics and health information technology limit the development of ACOs (Browne et al., 2021; Dorr et al., 2018; Fisher et al., 2012; O'Halloran et al., 2012; Palazzolo, 2015; Pasquale, 2012; Tabriz et al., 2017; Wu et al., 2016). Lastly, the incentive structure of ACOs does not guarantee provider motivation and ability to work together towards common goals nor does it specify the role of primary care in the development of these organizations (Dupree et al., 2014; Ganguli et al., 2020; Kaufman et al., 2019; Moore, 2014; Rodriguez et al., 2019; Ryan et al., 2015).

c. Learning Health Systems

Learning health systems (LHS) are defined as systems of care "in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families active participants in all elements, and new knowledge captured as an integral by-product of the care experience" (Institute of Medicine US, 2010). Over the past 15 years, LHS's potential in transforming and improving healthcare has been increasingly recognized (Sheikh, 2020). At the core of LHS is the idea of a data driven approach (Enticott et al., 2021). Timely access to data around patients, healthcare workers, spending, and changes in day-to-day processes of health systems is seen as crucial to support decision making and achieve improvements. This requires routinely collected data through structured information systems (i.e. patient registries) (Foley and Zahran, 2021). Thus, Electronic Health Records (EHR) development is emblematic of this focus on data as a core capacity for LHS (Platt et al., 2020). LHS rely also on softer instruments to improve care, such as learning communities, defined as "a group of peers who come together in a safe space to reflect and share their judgements and uncertainties about their practice and to discuss ideas or experiences to collectively improve" (Wilson, 2019, 7).

LHS drive continuous improvement where data collection leads to new knowledge that feeds healthcare practice and quality improvement efforts (Foley and Zahran, 2021). It is expected to contribute to improving patient outcomes and experience, to reduce practice variations, accelerate evidence translation into practice, inform health priorities, enable value-based healthcare, maximize the outcomes of technological innovation, and enhance healthcare performance by providing continuous feedback, evaluation and personalized professional development (Foley and Zahran, 2021). Emphasizing high expectations, national and international organizations in the US and Europe, like the American Society of Clinical Oncology (ASCO), the American Heart Association etc. have embraced LHS concepts and goals (Wouters et al., 2020). Some countries, like Australia, Sweden and New Zealand, promoted LHS initiatives at the national level by instituting systematic data entry (i.e., patients related outcomes, pain registries, care information, etc.) as a routine clinical practice (Enticott et al., 2021).

The demonstrated value of LHS

LHS appear promising for healthcare transformation as new technologies increasingly facilitate access to data (Hartley and Seid, 2021; Platt et al., 2020). LHS may have positive impacts on individual providers, health organizations and systems (McLachlan et al., 2019). Recent studies assessing LHS impacts report benefits for patients and clinicians, improvements in clinical services and organization and system-level performance, as well as in research, evidence generation, and use and appropriateness of care (Enticott et al., 2021).

At regional and national levels in New Zealand and Australia, LHS stimulate benchmarking practices across health organizations and support quality improvement at a large scale. Regionalized LHS initiatives in the US, like the Community Health Applied Research Network (CHARN), enable the creation of operational infrastructure to support patient-centered outcomes research nationally and to develop a common research agenda for LHS development (Vargas et al., 2018).

Although LHS principles seem clearly established, efforts in this direction are uneven. 1) A minority of healthcare organizations and systems have fully integrated LHS into their operations, with routinized continuous cycles of improvement driven by data and improvement activities (Budrionis, 2016; Harvard Business Review Analytic Services, 2019; Scobie and Castle-Clarke, 2020). 2) Most empirical studies on LHS describe the technical developments and analytical capacities required, with fewer studies assessing outcomes on healthcare systems (Enticott et al., 2021; Foley and Zahran, 2021; Foley and Vale, 2017; Platt et al., 2020). This might explain why LHS are widely adopted but harder to scale up. 3) LHS are more likely to deploy in high-income countries than low- and middle-income countries due to unequal digital access and resources (English et al., 2016).

In practice, the LHS model can take different forms depending on the level of research's embeddedness into practice. Wouters and colleagues (2020) classified LHS models on a four-level incremental scale of development (Wouters et al., 2020):

1. *Optimizing LHS model*, where organizations work at encouraging patients and professionals to engage in scientific research by tackling barriers to their participation.
2. *Comprehensive data LHS model*, where data are systematically and routinely collected from various sources and analyzed to test or generate hypotheses about care processes.
3. *Real time LHS model*, where data analysis is used to continuously support and improve clinical outcomes according to evidence on the relation between process of care and outcomes. This suggests a continuous and in real-time interaction between care and research, generating new hypotheses that can be subsequently tested and refined for better care.
4. *Full LHS model*, where clinical and pragmatic trials are embedded into routine care delivery. This model is quite new and requires close and well-developed collaboration between researchers and practitioners. While challenging to implement, its impact on the quality of care could be significant and in line with expectations for LHS (Gould et al., 2020).

As one example, Kaiser Permanent Southern California reports positive impacts of incorporating research into practice on a routine basis. Researchers help clinicians and healthcare providers ask the right questions, set study objectives, and research priorities and actively contribute to rigorous evaluations to reduce practice variations and promote evidence-informed practice (Gould et al., 2020). It should also be noted that this model both fosters and depends on close collaboration between various stakeholders: clinicians, patients, community partners, organizational leaders, technical and administrative support personnel, funding organizations and researchers (Gould et al., 2020; Hartley and Seid, 2021; Platt et al., 2020).

Many LHS initiatives tackled more specifically chronic disease conditions and can be generalized to document population health issues and healthcare service availability in real time. The context of COVID-19 has demonstrated the importance of real-time data and its impact on public health policies and population health.

Challenges with LHS

The LHS model incorporates principles and characteristics of complex and adaptive systems (Snowden and Boone, 2007) characterized by non-linear, interdependent and consequential interactions among a variety of system components and stakeholders. The development and implementation of LHS involves considerable challenges in orchestrating these distributed capacities.

A first challenge is the quality of data and interoperability of information systems (Foley and Zahran, 2021). Data is the product of a knowledge-generating process based on different information sources, such as clinical and medical judgment, EHRs, health trajectories or trends, patient experience, research findings, etc. (Foley and Zahran, 2021). Data collection must be accurate and representative of what is really happening in the system: different systems must be able to communicate and analyze data based on similar standards and methodologies (Foley and Zahran, 2021; Wouters et al., 2020). Besides, the regional and national initiatives described earlier require high levels of interoperability, including the use of interoperable EHR. While LHS initiatives encourage use of new information technologies they may fall short of solving the coordination problems if interoperability issues are not properly addressed.

Information infrastructures need also to be coupled to social and cultural changes which represent common challenges in healthcare delivery reforms. In the case of LHS, it implies creating participatory communities and promoting healthcare actors' collaboration to change health outcomes through continuous evaluation methodologies driven by real time data (Vinson, 2021). The implementation of LHS also requires skills and training to enable adoption (McLachlan et al., 2019). Non adoption or abandonment of LHS initiatives can be related to unclear value propositions from an administrative or user perspective, usability issues, perceived threats to professional scope of practice, fear of job loss, or concerns over the safety/welfare of patients (Greenhalgh et al., 2017).

Translating generated knowledge into practice change requires the development of innovative strategies for knowledge utilization. In the UK, the National Institute for Clinical Excellence (NICE) recognizes that moving to more structured or executable knowledge products will require a change in processes, methods, technologies, and skills (Foley and Zahran, 2021). Making knowledge computable at the point of care and building organizational and individual capacity is therefore essential for LHS success (Foley and Zahran, 2021).

ORGANIZATIONS AS POLICY INSTRUMENTS: ASPIRATIONS, CHALLENGES AND POLICY IMPLICATIONS

The Potential of Organizations as Policy Instruments

To respond to health system challenges, policies must have an impact on the way care and services are delivered to various segments of the population (Bohmer, 2016; Ham et al., 2016). This assumption underlies the growing interest in organizations as policy instruments. Shortell and Addicott (2016), using examples from the US and the UK, argue that, in response to growing pressure to better perform at a reasonable cost, and the growing body of scientific knowledge, policymakers are paying more attention to reorganizing the provider side of healthcare (Shortell and Addicott, 2016). They note that policymakers today are more inclined to promote large scale organizational innovations, using macro policies to facilitate the execution of core delivery functions such as continuous quality improvement and evidence-informed care and practices. They also suggest that the growing centrality of organizations in health policy focuses attention on the complex relational dimensions of care delivery. Relations between professions, between providers and managers, and between providers and patients are considered crucial determinants of quality. Moreover, policymakers must learn from the delivery side of the health system, and approaches that favor variations of models in local contexts may be an important source of policy learning. These developments raise several questions: How can policies create and work through new organizational forms to attain broad policy goals? How does experience with new organizational forms inform the development of more effective health policies? How can policies influence the development and activation of capacities (resources, competencies) to support new organizational forms? Our exploration of the three organizational forms described in section 1 enables us to provide responses to these policy questions based on real-life experience.

There is emerging evidence of the benefits brought by these three organizational forms (CN, ACO, LHS) along with a larger body of research on the development, implementation, and benefits of networks more generally. Evidence from health systems indicates that potential benefits seem to relate to policies that help structure and support networks. Managed or mandated networks are potentially productive when they rely on more elaborate forms of collaboration, in which the benefits of hierarchical authority combine with more organic processes and practices. In CNs, this suggests that policy initiatives should combine hard and soft instruments and leave space for professional autonomy and leadership. This is clearly the case in examples like the SCNs in Alberta.

Evidence on the benefits of ACOs is mixed and this should be considered an ongoing policy experiment given the diversity of organizational arrangements and their varying levels of maturity. ACOs differ in terms of their emphasis on the sharing of risk and accountability and their financial incentives. Experience suggests that there is an important learning curve for organizations and clinical providers before they can use and respond to incentives. This is an important lesson for policymakers. The ACO as an organizational form involves a complex mix of policy instruments and should not be reduced to its economic dimension. Studies show that capacities for improvement and data analytics are crucial. ACOs can be conceived as networks of providers that embark on a new policy experiment to achieve better outcomes and systemic care integration, which makes collaboration and partnerships appear just as important as hierarchy. ACOs provide opportunities to closely link the behaviors and engagement of autonomous clinicians to improvement objectives. ACO and networks can be considered as complementary organizational forms where efforts are made to link health providers across the continuum of care.

The LHS is a relative newcomer in health policy but is rapidly gaining popularity through the efforts of providers, researchers, and policymakers in different jurisdictions. Scientific and clinical leaders play an important role in the dissemination of LHS, as exemplified by the journal *Learning Health Systems* (https://onlinelibrary.wiley.com/journal/23796146) and the Learning Health Systems Project and contribute to policy momentum. LHS is a technology-driven organizational form that opens a new space for policymakers in the development of informational infrastructure and data analytics capacities. While the LHS form is still in emergence, the close partnerships between research, science, and clinical practices give it the potential to achieve better outcomes; current evidence tends to support this claim (Melder et al., 2020).

Some jurisdictions have already adopted the LHS to guide their improvement efforts at a large scale. One of the first countries to institutionalize LHS at a national level is Switzerland. The Swiss Learning Health System (SLHS) aims to bridge research, policy, and practice to build scientific capacities for health systems and services research, and to develop standards for the management of health information (Boes et al., 2018). In Australia, New

Zealand and the US, national initiatives to improve chronic care have been deployed in collaboration with clinicians, researchers, and patients who all actively contribute to continuous care improvement (Marsolo et al., 2015; McLinden et al., 2019). A report (Forest and Martin, 2018) commissioned by Health Canada in 2018 on strengths and weaknesses of Canadian health systems proposed the LHS model as a promising approach to renovate publicly-funded health systems across the country.

A focus on the organization as policy instrument goes well beyond recognizing implementation challenges in policy analysis (Matland, 1995). It underlines the importance of anticipating the feasibility, acceptability, and potential organizational responses to policy impulses. Four lessons can be derived from our exemplars. *First*, work on complex adaptive systems suggests that change and improvement result from significant interactions and exchanges between policymakers and providers (Best et al., 2012). Each of the organizational forms seeks to penetrate the micro fabric of care delivery to achieve broad policy goals. *Second*, capacities to drive health system improvement are recognized as important at each level of governance, from macro policy to the meso level of managing provider organizations, to the micro level of high-performing clinical teams. Diversity (gender, race, disability) in leadership at system level is also important to achieving health equity (Simon et al., 2020). Capacities are heterogeneous and distributed in broad policy networks (Rhodes, 2006) and policymakers have a role in supporting the development and orchestration of capacities within the delivery side of the system. Capacities include analytical capacities within government and on the delivery side to appreciate health outcomes and appropriateness of care, as well as operational capacity to manage and organize care efficiently.

Organizations such as CNs, ACOs and LHS have potential to develop and activate capacities to impact on care and services. *Third*, there is greater recognition of the importance of these types of organizations in healthcare as catalysts for new forms of agency, including among non-health stakeholders such as NGOs or actors from other sectors like education and housing, to improve outcomes and equity (Shortell and Addicott, 2016). Each of the organizations we analyzed create new roles for clinical leaders and patients, and increase capacities for leadership, clinical data analytics, and improvement. *Fourth*, in each of these forms, knowledge and tools play a regulatory and enabling role to accelerate change and innovation (Ferlie and McGivern, 2014).

Knowledge and tools can be considered a subset of the broader capacities required to achieve policy goals and warrant specific policy consideration. Major investments are required to provide the data infrastructure that supports new organizational forms and train personnel in continuous improvement methods and collaborative practices. In addition, more attention to skill-mix innovations and to ensure that providers from various professional groups work at their full scope in practice is warranted. Policymakers have a key role in achieving these large-scale changes.

In our analysis, we consider three organizational forms as context and pretext to explore the potential of organizations as a policy instrument within the toolkit of policymakers. We conceive these three forms as generic organizational arrangements that can be transposed and adapted within the contexts of health systems of the global North and global South. A variety of organizational arrangements can be derived from relying on and mixing these forms. Analysis of health systems development in low- and mid-income countries recently underlined the importance of organizational capacities and, more broadly, of organizing for structuring and improving these systems (Balabanova et al., 2010; Irimu et al., 2018; Mills, 2014; Sheikh et al., 2020). Further work is needed to probe empirically the potential and limitations of these forms in a diversity of settings and jurisdictions.

The organizational forms we presented in our analysis are not necessarily distinct but can be complementary. For example, CNs can be seen as a way to materialize LHS in the context of a digital transformation of health systems (Manns et al., 2019; Manns and Wasylak, 2019). More particularly, collaborative learning health systems (CLHSs), where actors (communities of patients/families, clinicians, researchers, etc.) come together around common goals, are another example where attributes of LHS take shape within networks (Hartley et al., 2021; Seid et al., 2021). Each organizational proposition to achieve large-scale improvement in health systems will have to tackle the challenge of delivering appropriate care at reasonable cost: the credo of value-based care. Controlling costs and delivering better outcomes cannot be achieved without addressing the delicate question of accountability and incentives in healthcare. In principle, ACOs put this question at their core. Proponents of CNs and LHS incorporate, or will need to incorporate, elements related to accountability and incentives. Accountability is a puzzling issue in health policy and further attention needs to be paid to how the organization as policy instrument can contribute to strengthening this aspect of health systems.

Organizations and Governing by Instruments

The three organizational forms explored here have the potential to change the relationships between governments, health organizations, providers, patient rights movements, and civil society formations, and open up possibilities for new regulations (Lascoumes and Le Galès, 2007; Salamon, 2000). The development and implementation of these forms is associated with the promotion of new political rationalities in the governance of health systems. Traditionally based on dominant interests of the medical profession and payers or funders, the mobilization at a large scale of these new organizational forms seems to leave more space for patient preferences, evidence regarding appropriateness of care, and attention to health equity. The organization as policy instrument explicitly calls for capacity development and the creation or valuation of new roles like nurse practitioners and community health workers within care delivery. The formal entry of clinical leaders, like physicians, in coordinating or managing roles and expansion of the data analytics within health systems introduce new actors into the governance of health systems with the potential to better reconcile the multiple logics involved in the production of care, such as the professional and managerial logics (Gibeau et al., 2020).

Each of the three organizational forms are associated with an expansion of tools to better connect the delivery of care to policy objectives and exert new forms of control. Policymakers are in a very privileged position to create conditions that help bridge policy goals and delivery dynamics. Can policymakers be better equipped to mobilize organizations as policy instruments? Recent literature on policy capacity in various sectors including healthcare have focused on the development of capacities as a major determinant of policy success or failure. Looking at the three types of policy capacity (analytical, political, and operational), the mobilization of organizations as policy instruments requires analytical capacity in governments to get and use data for continuous improvements and to systematically relate costs to outcomes. These data should also be sufficiently granular to document care and outcomes for specific segments of the population. Analytical capacities are also fundamental to initiate and support major experiments that relate to the design and implementation of new organizational forms.

Political capacity relates to the ability of a government or reformers to marshall support for change and innovations within the health system. Recent work on policy capacity for health reforms in Canada (Denis et al., 2022) suggests that various approaches can be used to test policy options like broad consultation with a diversity of stakeholders and public commissions. Capacity to test feasibility and acceptability of policy options within governments appears crucial (Blanchet and Fox, 2013). Operational capacity relates first to the ability of governments to get properly organized to support a given reform, in our case the design and implementation of new organizational forms in health systems. Coordination among departments and units within governments, ability to produce timely reports and to lead evaluation of large-scale initiatives are part of such capacity. Just as important is the sensitivity and knowledge of policymakers to the reality of the delivery side of the system. Further thinking and research are needed to more precisely assess the type of policy capacity required to mobilize organizational forms as policy instruments.

The transformative impact of new organizational forms needs to be assessed more critically using, for example, recent work on governmentality in healthcare (Ferlie and McGivern, 2014). Policies to transform health systems can have both desirable and undesirable consequences, and a nuanced approach is required to study both the use of organizational forms as policy instruments, and policy instruments as a means of organizing care delivery. The transformative impact is also dependent on ability to spread these forms within and across health systems. SCNs are already considered in many jurisdictions as a way to achieve integrated care and services for a specific population. ACOs provide an opportunity to rethink the relationship between health providers and organizations on one side, and payers and patients (or communities) on the other side. Because the intent is to channel resources around targeted outcomes, including efficiency, and to value accountability to a given population, such models will probably expand in health systems where current organizational arrangements, including primary care, have major deficiencies in this regard. LHS is currently of major interest in many jurisdictions and their implementation will largely depend on the ability to modernize informational infrastructure and to a commitment among policy and health leaders to data-driven care.

The literature on policy instruments distinguishes between harder, more coercive, and softer, or less coercive, instruments (Blomqvist, 2016). For policymakers, the mobilization of organizations as policy instruments involves astutely blending hard and soft instruments. This is coherent with what we know about the relational aspects of healthcare. Economic incentives are often proposed to steer health systems from a distance (Robinson, 2010; Warner and Murt, 1984), however our analysis reveals that economic incentives are part of a large sophisticated mix of instruments available to guide the choices and behaviors of organizations and providers. The emerging science of improvement in healthcare illustrates this broader approach (Ham et al., 2016; Molloy et al., 2016). In addition, new investments are required to fully mobilize these organizational forms and maximize their contribution to governing by instruments.

CONCLUSION

The organization as policy instrument has the potential to better connect policy and delivery worlds and translate investments into improvements. Organizations are bundles of capacities and levers for improvement, including economic incentives, information, and leadership

(Denis and Forest, 2012). Promoting the importance of organizations as policy instruments may help infuse the early phase of policy development with a greater sensitivity to the reality of health delivery. In addition, policymakers can anticipate implementation challenges with more granularity when they pay sufficient attention to the reality of delivering and improving care. Policy evaluation must also take into account the subtleties of organizing in healthcare and move beyond assessments that conclude on policy failure or implementation challenges. Attention to organizations may favor a more comprehensive approach to the whole policy cycle by considering the inherent interdependency across each phase of policy development.

Organizations are a collective representation of the delivery of care and services that go beyond the fragmented world of professions, health domains, and specialities. There is also an expectation that new organizational forms will provide conditions for new forms of engagement by health providers and people with lived experience of care. The view of the organization as a mediated space has potential to stimulate innovation and adaptation in health systems. We still need to confirm whether new organizational forms will be better able to mediate between potentially competing logics, interests and values (Quadagno, 2010; Saks, 2005). In their determination to rely on new organizational forms as policy instruments, policymakers must pay attention to the politics that structure the delivery of care. Finally, the leadership of policymakers and capacities within government are key to governing by instruments.

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10. Governance and health policy

Scott L. Greer and Phillip M. Singer

INTRODUCTION: WHAT IS GOVERNANCE AND HOW DOES IT MATTER TO HEALTH POLICY?

Governance is how societies make and implement decisions, in health and in other arenas (Greer, Wismar, Figueras and McKee, 2016). It is therefore widely accepted as a core element of health systems and policies. The World Health Organization's (WHO) widely-used "building blocks" framework, for example, makes it one of six essential elements to strengthening health systems alongside service delivery, workforce, information systems, access to essential medicines, and finance (World Health Organization, 2010). It is hard to find a discussion of issues in health service design and improvement that does not refer to governance in some way. Whether it includes ensuring that resources are not misallocated, that funding, policy, and resources align with means and ends, ensuring that people do what they ought, conforming to the rule of law, or meeting the needs of users and the broader population – governance is essential.

This chapter begins with a discussion of governance, starting with the general development of the concept and its rise to prominence, then focusing on its application in health. In the second part, this chapter digs into a case study of a key component of governance of any health system: federalism.

WHY GOVERNANCE? A BRIEF HISTORY OF THE CONCEPT

Governance originally referred to how publicly listed companies are organized, focusing on topics such as the composition and role of boards and their chairs. It developed a broader usage and became a major focus of attention in the early 21st century for two reasons. The first is that it was a way for international institutions, which cannot usually comment on the political organizations of their member states, to address more overtly political issues. This function is one reason why the governance literature has such an elaborate vocabulary with which to discuss politics while sounding apolitical. The "good governance" literature, which essentially specifies the right way to run a country, is therefore very easy to criticize (Thomas, 2015), even if it can be made useful (Grindle, 2004, 2007). The basic goal of good governance literature, as Francis Fukuyama describes it, is "getting to Denmark". That goal is obviously flawed for any countries that cannot realistically approximate Denmark (which is to say, almost all countries) and for anybody whose goals in politics do not include nudging their country closer to Danish standards of public administration (Fukuyama, 2004).

Second, governance became a major topic as a response to the seeming breakdown of old dichotomies, such as between state and market. On one hand, trends such as "new public management" and neoliberal policy reforms made the state more permeable, more dependent on outside contractors, and less likely to deliver services through its own workforce (Dunleavy and Hood, 1994; Hood, 1991). On the other hand, empirical research showed the importance of all kinds of networks, professional and other, and led scholars to focus increasingly on how centering on governments and public administration missed the many and complex ways policies were actually delivered (Bevir, 2013; Frederickson, 1996, 2005).

The result was a word – "governance" – used in conversations from stock exchanges to health care systems to the World Bank, one that combined strong and often unfounded normative assumptions with empirical research spanning questions of politics, public administration, economics, and social policy.

Governance clearly matters because the way things are decided and done obviously matters, and because the concept is of interest to so many people and groups for so many different reasons. One cannot characterize a health system without discussing its governance and leadership. So what is governance?

ELEMENTS OF GOVERNANCE

The governance literature is broad and diverse, and its definitions of good governance varied and frequently arbitrary (Barbazza and Tello, 2014; Greer, Vasev, Jarman, Wismar and Figueras, 2019).

Comparing different scholarly and organizational definitions of governance makes definitions of governance look utopian and arbitrary. Utopian because a definition of governance tends to be a list of good things, but with no clear sense of how to get there. Arbitrary because of the way that they vary. For example, the WHO and UNDP do not include the control of corruption in their definitions of (good) governance while only the Council of Europe lists sustainability. It would be wrong to infer that the WHO and UNDP do not care about corruption while nobody but the Council of Europe thinks sustainability is a value.

The actual problem lies in the basic project of identifying the elements of "good" governance. To understand governance as an empirical proposition is a basic activity of many social scientists; if we say governance is how societies make and implement decisions than most people working in the study of politics, and many engaged in areas such as social policy, economics, and public administration, are studying just that. That includes the ones studying largely undesirable forms of governance well known to political scientists such as rentier states, sultanistic regimes, and state failure, as well as less apocalyptic ones found in generally stable and wealthy countries.

Instead of making a list of desirable attributes and risking the twin problems of utopianism and arbitrariness, it makes more sense to think of governance as a set of issues common to decision making and policy. In one synthetic effort (Greer et al., 2016), we concluded that governance problems and challenges fall into five broad categories: Transparency, Accountability, Participation, Integrity, and Capacity. In other words: are decisions and the grounds on which they are made, public (transparency)? Are decision makers and implementers required to account for their actions to somebody legitimate (accountability)? Do affected populations have the ability to participate in decisions (participation)? Do institutions and organizations have clear missions and abide by the rule of law (integrity)? And do governments have the capacity to monitor and formulate policy in light of all the challenges of understanding complex societies, economies, and scientific knowledge (capacity)? Each of these, of course, is an issue at every level of government as well as in constitutional design; the old question of politics – "who will watch the watchmen?" – is a thesis about accountability, for example, while transparency was a preoccupation of thinkers such as Bentham and Weber, participation is ultimately about democracy, and so forth.

It is possible to list a wide variety of administrative and policy ideas that can be used to expand or change the effects of these five dynamics, ranging from budgeting procedures to expanding opportunities for litigation and simplifying consultation (Greer et al., 2019; Lillvis and Greer, 2016). Good policy analysts will often be familiar with this menu of options. For example, if the problem is of how to change the offerings of a local NHS system, there are lively debates and different approaches to the question of what kind of public participation is most appropriate (Jones, Fraser and Stewart, 2019; Stewart, Greer, Ercia and Donnelly, 2019).

Health policymakers will often also make major changes to entire systems in order to change governance. It is worth noting that a good analysis will always ask what decisionmakers are actually trying to do with organizational change. Reorganizations have been done in many places and times for reasons that have little to do with better policy outputs: to have an excuse to fire senior people, to get rid of an inconvenient unit, to create a big enough ministry for a minister with a big ego or a small ministry useful in coalition negotiations, and so forth.

The organization structures in health can vary widely across countries. Common forms in rich countries' health care systems include the development of technical agencies for functions such as health care quality improvement (Busse, Klazinga, Panteli, Quentin and World, 2019), independent agencies to run health care facilities such as the Irish Health Services Executive or various management devices in the UK NHS (Greer, Rowland and Jarman, 2016), internal "mimic markets" that separate purchaser and provider (Klein, 1995), and judicialization of rights to health care.

GOVERNANCE IN THE ABSTRACT AND GOVERNANCE IN PRACTICE

In short, there are many reasons not to focus on governance in the abstract or to make it a primarily normative concept. Governance is better viewed, like finance or workforce, as a topic and a cluster of issues, problems, actors, and policy solutions. As in other policy areas, the issues cluster into problems such as accountability or transparency. But to jump from an essentially diagnostic approach to governance – asking what the role of governance is in an existing or potential policy – to normative advocacy for some ideal of "good governance" is risky at best.

Governance is thus best understood in the concrete. Furthermore, it is also best understood in a way that squarely addresses the political dimensions. Governance-speak might often be used as a way to avoid talking overtly about politics, but understanding governance is difficult – if not impossible – if we do not recognize that governance is about politics and discussing governance can be, in itself, a political intervention.

In the spirit of taking politics and conflict as a focus of governance, and avoiding the technocratic way in which it is presented, we use the example of federalism and health. Federalism structures social policy so deeply as to make it next to impossible to discuss policy in federal countries without it (for an example, if you speak of decentralization to Canadian health researchers, they will often take that to mean decentralization within provincial health systems, since the fundamental fact of provincial power within a federal health system is so obvious as to not look like a policy at all). Federalism shows that politics, power, and equity is the stuff of governance.

FEDERALISM AND GOVERNANCE

In 2006, the Canadian political scientist Keith Banting stated the central issue of federalism and social policy in very clear terms:

> Stripped to its core, the logic of social citizenship holds that a sick baby should be entitled to public health care on the same terms and conditions wherever he or she lives in the country. Stripped to its core, the logic of federalism holds that the public health benefits to which a sick baby is entitled also depend significantly on the region in which he or she resides. (Banting, 2006)

While Banting's focus is on the sick baby's ability to receive health care, other social policy areas can be exchanged in its place and the tension within federalism would remain intact. Traditional theories of social citizenship and the welfare state that focus on the non-territorial duties and benefits of citizenship are in tension with traditional theories of federalism, which focus on the importance of empowering and enabling divergence by regional governments.

Here, we approach federalism and social policy through the lens of equity, developing Banting's point about the sick baby and its treatment. We consider the direct and indirect mechanisms by which federalism interacts with, and contributes to, issues of equity. When governments in federations try to make social policy, they inevitably and sometimes intentionally raise questions of territorial equity. This is a feature, not a bug, of federalism: it makes territorial inequities between different federal units visible and politically salient. That, in turn, makes other inequalities, such as income, wealth, language, gender, race, or ethnicity territorial through their interaction with a territorial federal politics. Writing about the quest for civil rights in the United States in the 1960s, William Riker argued that if you "disapprove of racism, one should disapprove of federalism" (Riker, 1964).

This part of the chapter takes the following form. First, we briefly discuss the political theories which undergird the sick baby. Second, we discuss the institutional and financial mechanisms which result from and are exacerbated by federalism. Third, we highlight the COVID-19 global pandemic as a case of territorial inequality and health care and lessons learned. Lastly, we end with some broad conclusions about federalism and social policy.

THE POLITICAL THEORY OF THE SICK BABY

It might be helpful to quickly review some arguments with especial relevance to social policy and the basic question of how we should consider the treatment of equity (see also Greer and Elliott, 2019).

That there are borders to social citizenship is a given (Banting, 1999; Greer & Mätzke, 2009; Powell, 2002; Wincott, 2009). Citizenship pertains to a state, not to humanity (universal rights are human rights, not citizenship rights). There is no universal health care or pension for the global citizenry – there are only political jurisdictions with varying levels of social rights available within them. The questions for territorial politics are what the borders are and why (certain) people within them have particular social rights.

The tension between nationalism, multinationalism, and federalism is the most common basis for arguing that the sick baby receives different treatment in different parts of a single federal country. Many federal countries are federal because they are multinational – because a high level of territorial autonomy is a key strategy of their collective solution to the problems of multinational co-existence. In the simplest terms, multinational states are often federal in order to contain challenges from nationalists whose ideal would be secession (Stepan, 1998). If one believes that Catalonia, Flanders, Quebec, Tigray, or Scotland should be a separate nation, then it logically follows that one would be suspicious of arrangements that share resources and fates between places that they would like to see separated.

This logic can hold even for separatists in areas that are financially subsidized by their federations, with some arguing that national self-determination is worth a loss of subsidy. Unsurprisingly, though, stateless nations which clearly benefit from interterritorial redistributions often lack strong secessionist movements. This argument is best captured by Stepan's distinction between coming-together federations, relatively homogeneous and rare cases in which similar units voluntarily federated, and the more common staying-together ones, in which federalism is a pragmatic response to fissiparous tendencies such as secessionism (Stepan, 2004). Federations with strong nationalist challenges, in particular, obviously contain populations who neither want nor accept a shared citizenship that would create equal rights across the federation (Greer, Béland, Lecours and Dubin, 2022; Lecours, 2021).

There is a second, influential approach, grounded in the economics of "fiscal federalism" (Boadway and Shah, 2009; Oates, 1999, 2005; Weingast, 2013). It is a form of "tough love", arguing that poorer places should have weaker welfare states. That poorer governments can buy fewer things is common sense in many places. A more elaborate rationale is that forcing governments to raise their own resources (e.g. spending taxes they must raise from their own voters) forces them to be responsible in the distribution of policy benefits. If governments raise their own resources, then they can also compete, creating forces that improve their prioritization and efficiency, resulting in inter-state competition. To the extent that subsidies equalize between governments, they reduce the democratic accountability of governments to taxpayers and the competitive incentive to use resources well. This is the basis for much of the newer "fiscal federalism" work, which has evolved from an older preoccupation with equalization towards much more elaborate work focused on the ways intergovernmental finance can harness these mechanisms. In this logic, inequality is a reflection of local resources, and the best incentive to get the parents of the sick baby to support political leaders who will pursue public administration and economic development strategies that improve the care of children in the future. By this theory, even homogenous countries should have decentralized, democratic, and competitive governments because such a system has powerful incentives to optimize resource use, even if the "market for government" concludes that the optimal use of resources might be tax cuts rather than better children's health care.

Charles Tiebout focused on this connection between inter-state competition and decentralization in the 1950s, arguing that with increased variation in policies, individuals (and by extension other organizations) can locate in jurisdictions which match their preferences (Tiebout, 1956). While the evidence of inter-state competition on policy recipients is mixed (Conlan, Posner and Rivlin, 2009; Rom, 2006), its policy effects and the shift towards more onerous programmatic restrictions is decidedly clearer (Singer and Willison, 2019).

These are the two main theoretical arguments for a sick baby being treated differently. The first questions whether the sick baby does actually belong to exactly the same community of citizens with social rights. The second accepts the shared citizenship but weakens the concept of social citizenship rights in pursuit of other goals such as limited or more efficient government expenditure.

SHARED RULE, SELF-RULE, AND THE SICK BABY

Returning to the Banting quote at the start of this chapter, there is a telling qualifier in the second sentence: the sick baby's rights "also depend significantly" on where it lives. In other words, the logic of federalism is not that each unit and its citizens are independent of each other, but rather that there are variable and ever-changing significant ways in which different orders of government depend on each other. This variation contributes to the inequity which arises through federation.

The basic distinction in analyzing these questions is between the elements of self- and shared-rule in a given federation (Elazar, 1987; Hooghe et al., 2016). Self-rule refers to the ability of a given jurisdiction's leaders to make policy decisions on their own, unbound by government hierarchy. Shared rule refers to a jurisdiction's ability to involve themselves in and shape the politics and policies of other levels. Thus, for example, the United States has a very high level of formal self-rule, with states able to make many decisions on their own, but a very low level of shared rule, with states formally almost unable to shape federal decisions. Germany and Austria, by contrast, have very high levels of formal self and shared rule, with the state governments making up the members of their upper houses (Falletti, focusing on the Latin American context, draws a useful tripartite distinction between administrative, financial, and political decentralization (Falleti, 2010)). Self-rule and shared rule are both continuous and complex institutional arrangements. Scholars have developed usable international data, including the Regional Authority Index, which provides a valuable way to grasp different allocations of authority and their patterns in formally federal and non-federal countries (Hooghe et al., 2016) as well as research that is more sensitive to idiosyncrasy in policy and therefore harder to compare in quantitative terms (Dardanelli et al., 2019; Fierlbeck and Palley, 2015; Greer and Elliott, 2019; Steytler, 2022).

The analysis of self and shared rule is further complicated by gaps between fields of political science. Broadly, analysts of federalism, and especially comparative federalism, tend to focus on formal political institutions. If asked how a federation works and who has what autonomy and power, they will examine constitutions and laws; if asked how a federation allocates resources, they will focus on formal constitutional mechanisms for interterritorial equalization. The problem is, as the next section discusses, that formal political rules of obvious relevance to federalism are only part of what shapes and constrains federations. There are serious limits to what they alone can tell us about a federation.

INTERGOVERNMENTAL RELATIONS, INTERGOVERNMENTAL FINANCE, PROGRAMMATIC DESIGN, AND THE SICK BABY

Having the legal power to do something is not the same as having the actual resources to do it. The sick baby's problem might be that it lives in a jurisdiction where the level of care it needs or is legally supposed to get is not affordable. Declarations of social rights are frequently, carefully, written to avoid an actual obligation to provide a standard of equal social rights that the fiscal system cannot provide. Different political systems adopt different systems of intergovernmental finance in an effort to equalize, to some extent, the baby's social rights.

One conceptually simple way to equalize rights in a federation is to simply establish them through the central government. Social insurance systems, for example, are noticeably resistant to interaction with federal states, with the result that even in states known for decentralization (such as Belgium) the social insurance system remains resolutely opposed to incorporation into federalism debates (Laible, 2019). Even in some other highly decentralized countries such as Spain, the UK and the US, old-age support and pensions are often still administered by the central government rather than territorial units (Greer, 2019; Greer, Elliott and Oliver, 2015). Importantly, social welfare programs are often treated in the opposite manner – with decentralized levels of jurisdiction actively working to limit benefits and introduce draconian measures that increase administrative burden and other types of red tape on recipients. For Peterson, following Tiebout, the price of federalism means that central governments should be responsible for redistributive policy, while subnational governments should have control over basic infrastructure, education, and transportation policy (Peterson, 1995).

Another strategy to ensure equal rights within a federation is to support equalization between governments, whether by distributing taxes according to a formula or actually redistributing between them (Boadway and Shah, 2009). The focus in this kind of system is on ensuring that all governments have the financial ability to deliver a broadly similar level of services. It creates equalization not so much between people but between governments. Other policy tools, such as constitutional provisions or framework legislation, then try to shape what governments do with the money in order to make sure it equalizes the sick baby's treatment. The United States is the only federation that does not have explicit interterritorial equalization of any kind (though Ronald Reagan ended a brief experiment in "revenue sharing" that did just that) (Conlan, 1998).

A third strategy is the distribution of conditional grants of various kinds. In these instances, the central government transfers money to state or regional governments for explicit purposes, for example matching funds to provide health care, social care, or education. In these systems, intergovernmental politics is often about the nature of the grants (e.g., what they are for), the amount of money that goes in, and how it is calculated. For example, much of the history of Canadian social policy can be written as a story of arguments about just that. In principle, conditional grants are conditional – governments which do not agree to the conditions do not get the money. Such a conceptually hard bargain, of course, is actually a political negotiation – as American Democrats found out when a Republican Supreme Court decided that the conditional structure of Medicaid and its funding sources did not allow them to use it to create a universal expansion as part of the 2010 Affordable Care Act (Béland, Rocco and Waddan, 2016; Grogan, Singer and Jones, 2017). Additionally, the rationale and use of conditional grants have varied over time. For example, in the United States, the traditional view of conditional grants has changed from providing financial assistance for states to achieve their policy goals to the central government using grants to coerce states to meet federal policy goals (Hueglin and Fenna, 2015), while executives negotiating waivers turn federalism into a way to centralize power within their respective governments (Thompson, Wong and Rabe, 2020).

Conditional grants are the basis of federal social policy in much of the New World, and do much of the work to equalize social rights in the absence of equalization. But do not underestimate their impact in European countries where – in theory – they do not matter.

Thus, for example, we have the apparent paradox that Germany has a well-established and much-documented separation of powers and system for redistribution between its federal states, and yet federal governments influence state budgets in clearly partisan ways. The German equalization system might remain stable, but specific grants for initiatives in areas such as education allow federal governments to reward their co-partisans in state governments (Kleider, Röth and Garritzmann, 2018).

Each of these three approaches to financing federations has different costs and benefits, each country uses a mixture of them, and it is difficult to draw convincing lessons across borders. In part, this is because there are important contextual differences that mean the abstract logics work differently in different policy contexts. It is also, however, because this taxonomy is an awkward fit with programmatic legacies and the ways in which programs, once established, shape governments and the politics of a given policy through feedback loops.

It is a truism of comparative politics and public policy that policies create politics (Campbell, 2012; Mettler and SoRelle, 2018; Pierson, 2001; Schattschneider, 1935). This does not just mean the politics of beneficiaries who organize to support their benefits. It also means that decisions about the structure of programs in federations shape those federations. While federal political institutions and politics condition program design at the inception, the program then starts to shape what the governments are and do, and how they relate to the public. Thus, for example, the United States has a mixture of health care financing systems that range from direct federal provision (e.g., the Veterans' Administration for former military members), direct federal financing (Medicare for individuals 65 years and older, as well as those with certain chronic conditions, and disabilities), state-federal financing (Medicaid – a social welfare program for individuals with low incomes), and a mixture of state-federal interactions in areas such as health care subsidies and marketplaces. The result affects what the states are and do, reshaping state budgets and politics around these health programs (Béland, Rocco and Waddan, 2019). In Austria, by contrast, the federal states have an often informal and steadily more limited role in most areas of social insurance, refocusing their politics elsewhere (Falkenbach and Heiss, 2021; Mätzke and Stöger, 2015). The basic structure of programs such as Austrian social insurance, or the US's fragmentation, becomes extremely sticky, making change as slow and hard as constitutional arrangements.

That is one reason why experts in the public policies of any given country are so often uncomfortable with characterizations of federalism overall. They are too likely to be aware of ways in which the actual policies, and policymaking, diverge from the high-level federal design. The other reason is that different policy areas have different politics, and some systems (e.g. the US) are more prone to separate policy areas out than others (this is a general point, Mätzke makes the case for more rigorous policy area comparisons within countries as a key tool of comparative politics (Mätzke, 2009)). Finally, the relative age of the welfare state and the federation matter. Only the UK and Belgium have attempted to develop a federal political system of any kind after establishing a mature welfare state. In every other welfare state, the federation was either established during a key period of its growth, or predated it, meaning its programs reflect intricate intergovernmental politics.

COVID-19: SHINING A LIGHT ON THE SICK BABY

Banting's hypothetical sick baby was relatively unlikely to be seriously ill or die due to the very real COVID-19 pandemic – that was more likely to be the fate of the baby's grandparents. But, still, thousands of real children have died from COVID-19 and scores more have been infected and hospitalized. The pandemic cast a powerful and unforgiving light on political systems and how they shape health and equity during an infectious disease outbreak (Greer, King, da Fonseca and Peralta-Santos, 2021). While the long-term effects of COVID-19 on politics are unknown and might turn out to be underwhelming, it offers an unparalleled opportunity to learn about how social policy and politics shape equity in federations.

The politics of the sick baby are about territorial politics: whether a baby in Catalonia should have the same chances as a baby in Madrid, or whether a baby in Nova Scotia should have the same risks as a baby in Alberta. Territory does not easily characterize the consequences of COVID-19 because the concentration of particular industries, populations, risks, and importantly the policy set and enforced by subnational governments, were what shaped outcomes. There were pronounced inequalities in who was infected, who became sick, and who died (Clouston, Natale and Link, 2021). These inequalities were due to different chances of exposure in the workplace, informal care settings, or at home, and then to different levels of vulnerability which social epidemiology shows are a result of socioeconomic inequality (Bambra, Lynch and Smith, 2021; Roberts and Tehrani, 2020). They did not easily map onto borders of big units like states or provinces.

There are four key issues in federalism and social policy that have clearly been shown by the pandemic and response over time. The first is the extent to which, in a crisis such as the COVID-19 pandemic's sudden arrival in 2020, federalism is part of what we can call the "politics of agency" (Greer, Massard da Fonseca, Raj and Willison, 2022). Agency means the ability to be an actor – to act and do something. Political institutions such as presidentialism, proportional representation, and federalism, shape that agency. A very pronounced pattern in the pandemic was that political institutions shaped who had agency. State-level leaders in countries where the federal executive was otiose or actively harmful, such as Brazil, India, and the United States, were able to solve the collective action problem of feeling empowered to act and did so. In more centralized polities, there were few such cases (though some mayors in places as different as Miami and London fought to maintain restrictions other politicians opposed). Part of the challenge to responding quickly to an unexpected event, such as COVID-19, is the multiple layers and stakeholders in a federalist government.

The second key issue is the unavoidable role of politics in the politics of centralization and decentralization. Politics is often, at its crudest, about credit-claiming and blame-shifting (Hinterleitner, 2017; Weaver, 1986). At the start of the pandemic, in 2020, there was much credit to be had for heads of government in dominating the issue. Later in 2020, many heads of government saw political benefit in (wrongly) proclaiming the end of the pandemic, declaring premature victory, and taking credit for overseeing the conclusion of a successful campaign against the virus. The policy response was then decentralized, meaning that other politicians would have to take blame for future public health measures and viral spread. Partisanship and polarization were largely tamped down very early in the pandemic, because there was little payoff to fractiousness. Yet, as the pandemic wore on, politics shaped policy position and enactment on issues such as masking, business closure, and other public health efforts (Adolph, Amano, Bang-Jensen, Fullman and Wilkerson, 2020). Ultimately, the political cueing by media and political elites trickled down to the public, with ideology and political party the strongest and most consistent predictor of views and behavior during COVID-19 (Gadarian, Goodman and Pepinsky, 2021). This chapter is about vertical centralization and decentralization – the distribution of real power between different orders of government. But if we look at politics horizontally, *within* government, we see a very similar pattern: subnational governments, ministers, and specialist agencies often gained and lost power in sync, as a result of the broader political strategies of heads of government and other key politicians (Greer et al., 2022).

The third issue is the degree to which it showed the variable extent of alignment, and mis-alignment, in federations. One of the basic issues is that central governments almost always enjoy a "vertical fiscal imbalance" in which they have more and more flexible sources of revenue than other governments (Watts, 2000). In the context of 2020's economic shocks, this mattered a great deal because public health powers, and willingness to use them, were often under the purview of state governments while the fiscal capacity to put the whole economy into suspended animation was under the central government. The result was that even if regional or state governments had considerable agency, they could not match it with the necessary money out of their own resources (Béland, Dinan, Rocco and Waddan, 2021; Greer et al., 2021).

The fourth and final issue is that it showed the extent to which politics in federations is unified, and regional or state governments cannot oppose the central government or overall politics for long. In no federation did smaller orders of government turn out to be able to avoid national political trends and maintain much tougher standards (Canada's Maritime Provinces probably lasted the longest, to overall good effect).

CONCLUSION: AVOIDING AND ADDRESSING THE PROBLEM OF THE SICK BABY

Taken together, we have argued that governance matters in issues of institutions and public administrations. This is particularly the case within health systems – where lives and livelihoods are literally in the balance with policymaking, adoption, and implementation. While there are various frameworks to help develop "good governance", as we have shown here, there are complications associated with actually improving performance. In particular, we have highlighted the challenge that federalism places on governance – by highlighting the problem of the sick baby.

The problem of the sick baby, stripped down to its core, seems to demand simple solutions: unitary governments, social rights guaranteed by law and transfers, or acceptance that the baby's care should depend on jurisdiction. In practice, no federal system has adopted such extreme solutions; logic bends before the credit-seeking, blame-avoiding, and coalition-building of political actors. The result is, as this chapter has shown, a set of systems that both create and limit policy divergence, with various institutional, programmatic, and financial arrangements that shape policy and equity.

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11. Mind the gap: tackling health inequalities

Mark Exworthy and David J. Hunter

INTRODUCTION

Health inequalities have long been recognized by public health practitioners and research and yet, in many health systems, the issue often holds a precarious position on the agenda of politicians and policymakers. A significant volume of research evidence has been generated regarding the scale of the issue and its many manifestations – demographically, geographically and temporally. However, governments, not least those in the UK, have not always acknowledged or addressed the issue sufficiently to ameliorate it. There has been a notable lack of commitment and capacity to make progress. This chapter seeks to explain this apparent paradox. It uses an in-depth case-study of English health policy since 2010 to describe the nature and scale of the issue, to examine recent and current policy as it pertains to health inequalities, and finally, to explain policy outcomes with reference to Kingdon's (1984) 'multiple streams' framework (MSF).

DEFINING HEALTH INEQUALITIES

Numerous definitions of health inequalities have been proposed but commonly, they refer to:

> The systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically (Starfield, 2011; Starfield and Birn, 2007).

Here, we use the term 'health inequalities' to refer to inequalities in health status and in health care. However, we do acknowledge distinctions between them. Regarding the former, the general pattern is one in which those in more advantaged circumstances enjoy better health across longer lives than those in less advantaged circumstances. Regarding the latter, we refer to the allocative decisions of policymakers and practitioners in determining the location and nature of service provision. This includes the 'inverse care law' (Hart, 1971).

Terminology

The use of the term 'health inequalities' in the UK has changed over time, often in relation to shifting political climates (not to evidential discoveries). This variability has generally reflected political ideologies rather than changes in evidential circumstances. For example, in the 1990s, the Conservative (Thatcher and Major) governments did not recognize 'health inequalities' *per se* (Graham, 2009). Initially, there was no acknowledgement but later on, the term 'health variations' was adopted in official documents. This was reflected in, for example, research commissioned by the government.

> While the term [variations] did not equate precisely to health inequalities, it was a tacit recognition that they posed a policy problem (Exworthy, 2002, p. 176).

From the late 1990s, with the advent of the Labour (Blair and Brown) governments, the term 'inequalities' became more widespread. However, in the past decade or so, there has been some slippage in its use, partly due to the emergence of the term 'disparities.' For example, in the UK, a former health minister, Sajid Javid, referred to the 'disease of disparity' (Allegretti, 2021), and in 2021, one of the agencies which replaced Public Health England was called the Office for Health Improvement and Disparities. 'Disparities' has been used widely in the USA (where the term 'inequalities' is much less common) (Exworthy et al., 2006). In this chapter, we focus on the use of the term 'inequality', examining the way it is perceived and framed by politicians and policymakers.

Equality might be considered proportionally (as equal 'shares') whereas equity can be considered in relation to social characteristics such as need. It does not necessarily follow that inequality is the converse of equality. The former is commonly associated with principles of social justice, more linked to equity. However, definitions of equity (in relation to health and health care) are often rather more ambiguous. Le Grand et al. (1990) suggest that 'there is no universally agreed interpretation of equity for the allocation of health care resources' (p. 115), making policy development in this field problematic. One way to approach the equity matrix (Sen, 1992) which comprises two dimensions: distribution of what and distribution amongst whom? The first focuses on what is being distributed: health or health care, and the type of equity such as inputs, access and use. The second refers to the reference group (such as age, gender or social class). This matrix generates multiple equity statements, rather than a single one (Harrison and Hunter, 1994; Powell and Exworthy, 2003).

The term 'social determinants of health' (SDoH) is inter-linked with health inequalities. Whilst the former are unequally distributed, SDoH are commonly portrayed in a socio-economic model of health in which the 'determinants of health [act] as layers of influence, one over another' and in which there are 'interactions between these layers' (Acheson, 1988, p. 10). Bambra (2019) explains the implications of this model succinctly:

> The poorer someone is, the less likely they are to live in good quality housing, have time and money for leisure activities, feel secure at home or work, have good quality work or a job at all, or afford to eat healthy food – the social determinants of health (p. 3).

Among the myriad of factors, health care contributes relatively little to overall health improvement (McGinnis et al., 2002). In short, the SDoH are the 'causes of the causes' of ill-health which are structurally inequitable (Marmot and Wilkinson, 2005).

The causes of health inequalities have often been contested. In one of the first national investigations into health inequalities, Black (1980) identified four potential explanations:

- artefactual explanations,
- natural or social selection,
- materialist or structuralist explanations, and
- cultural or behavioural explanations.

This influential report concluded that 'weight of evidence pointed towards material factors for health inequalities' (Exworthy and Oliver, 2011). Over the past few decades, there has been growing (academic) consensus regarding explanations of the genesis of health inequalities, which broadly supported Black's conclusion (Acheson, 1998; Marmot, 2010, 2020). In relation to geographical inequalities in health, Bambra (2019) distinguishes between compositional effects (the characteristics of people) and the nature and attributes of the place they live in (the context) (p. 77). Moreover, both are overlain by the socio-political and macro-economic environments, such as economic recession and austerity.

However, this consensus is not universal. Whilst academic communities have generally adopted a materialist explanation of health inequalities, some politicians and their acolytes (mainly on the political right) continue to emphasize individual agency in such explanations. Yet, even during the Labour governments (1997–2010), there continued to be an emphasis on individualized solutions to public health problems, as Hunter (2005) explains.

THE MSF AND HEALTH INEQUALITIES

Notwithstanding definitional debates, and the multi-factorial nature and complexity of the issues, health inequalities have been described as an example of 'wicked problems' in the sense they comprise those 'public policy challenges that are complex, hard to resolve, keep shifting, have multiple causes and solutions, and cut across jurisdictions' (Exworthy and Hunter, 2011, p. 205; Rittel and Webber, 1973). This conceptualization thus lends itself to notions which necessitate the confluence of multiple influences. Hence, here, we consider Kingdon's (1984) approach in explaining the extent to which multiple streams have been conjoined.

John Kingdon's book *Agendas, Alternatives and Public Policies* has become a popular text for policy analysis; it has been cited over 30,000 times (according to Google Scholar; April 2023). At the core of the book is the 'multiple streams' framework (MSF). Its wide application may reflect its adaptability to multiple contexts and settings – Kingdon originally applied it to health care and federal transportation policy in the USA. He was interested in two questions. First, how do issues get onto the policy agenda in the first place, given the array of competing pressures? Second, once on the agenda, which factors shape the alternative course of action(s) that policymakers may or may not acknowledge? The focus is thus on the pre-decision process (Durant and Diehl, 2008). Which issues get the attention of politicians and policymakers in the first place? The model was thus less about the implementation of any given policy.

The premise of the MSF is that the policy process comprises the problem, the policy and the politics streams (Béland, 2016). These three separate streams need to conjoin or be coupled in order for the issue to reach the policy agenda. If they remain separate or if only two are linked, then no action will occur.

The 'problem stream' refers to the factors which frame the nature of the issue to the relevant stakeholders. This might include, for example, the definition of the 'problem' such as poverty measurement or obesity. Of course, such definitions can be contested (see political stream, below). Indeed, framing of problems is a classic field of public administration (Edelman, 1988; Goffman, 1974; Rein and Schon, 1993; Stone, 1988). For example, Jones and Exworthy (2015) found that plans to centralize hospital services in one area was framed as a:

> rhetorical strategy for implementing organisational change in the context of community resistance to service closure and a concomitant policy emphasising the importance of public and patient involvement in planning (p. 196).

In their example, community resistance was subverted by the appeal to a frame of evidence-based policy and patient safety.

Problems can thus be framed in various ways. First, problems may be framed in terms of indicators such as routinely collected data on health status or performance indicators of a health service. This might also include published research evidence. Second, problems might also 'emerge' in the form of a crisis (perhaps most notably in the form of the COVID-19 pandemic, but not solely limited to that). Critical incidents or public inquiries can, for example, focus attention on issues which had previously been neglected. This might include evidential inquiries. Third, feedback might take various forms. User feedback has not always been encouraged or employed systematically in public services (Hirschman, 1970). Feedback might also be in the form of media content, public opinion, or through elected representatives. These various ways of framing the problem shape the ways in which that problem is perceived (Frame Works, 2022), creating the sense in which (some) stakeholders feel that 'something must be done' to address it; the problem is thus worthy of intervention by public policy. Of course, some stakeholders may be working with different or alternative definitions of problems which may, in turn, lessen the chance of coupling with other streams.

The 'policy stream' refers to the various strategies, proposals, initiatives and policies which might address the problem, as framed. These might be advanced by interest groups as well as policymakers. Kingdon describes graphically the policy proposals as 'floating in a primeval soup' waiting to be selected. Proposals may be advanced through formal mechanisms (such as civil servants, white papers, etc.) but also by lobbyists, think tanks and academics. Selection takes place through a filtering process which meets three criteria. The policy must be technically feasible, congruent with dominant values, and anticipate future constraints. The feasibility criterion could relate to clarity of objectives, the infrastructure for implementation and delivery, and the nature of the phenomenon being tackled. The congruence criterion considers the degree to which any policy proposal is consistent with the dominant prevailing political values. The future criterion refers to potential issues which might include goal drift or expected turnover of senior leaders.

The 'political stream' refers to the factors in which interest groups and stakeholders engage in conflict, power bases, negotiation, bargaining, consensus building and compromise. In practice, the factors to be considered in this stream include public opinion, re-organizations, elections, the role of lobbying by relevant parties, and (planned or unexpected) administrative change, among others. The latter might comprise the turnover or appointment (or departure) of a government minister, chief executive or senior official.

The 'streams' may remain separate and the issue will remain outwith the policy agenda. The notion of 'multiple streams' is apt here as the confluence of streams implies a more forceful process. However, the streams may be coupled by chance (randomness), the cycles of organizational or political change (such as staff turnover or periodic elections) or by the actions of a policy entrepreneur. It follows that the notion of 'streams' implies a dynamic, iterative process by which issues get onto the policy agenda but also are removed from it. Indeed, issues may be placed insecurely on the agenda and might only last for a short period of time (Beland and Katapally, 2018), subject to the exigencies of other imperatives. Similarly, issues which may already be on the policy agenda could be relegated as 'typically rare and brief opportunities for reform' – the policy window – dissipate (Béland, 2016, p. 234); for example, the nature of the 'problem' may be perceived differently, policies may prove less effective than intended, and coalitions of support may dissipate. This dynamism implies the need to adopt research methodology which captures the change over time.

Kingdon posited that the conjoining of streams might be aided by the actions of policy entrepreneurs (individually or collectively). Béland and Katapally (2018) clarify the definition of policy entrepreneur thus:

> Policy entrepreneurs are powerful political and social actors who are in the business of articulating specific problems that move in and out of the policy agenda with new or existing policy solutions (p. 369).

This person (or persons) facilitates the connections between the problem, policy/policies and politics streams by investing their own social skills and social capital in the process (Oborn et al., 2011). This might involve using their networks, devoting their scarce time, offering goodwill and trust, staking their reputation, or mediating between competing interests. The notion of policy entrepreneur highlights the agential role within this model. Kingdon's use of the 'entrepreneur' metaphor is significant because it is more than simply being a broker or facilitator, or even being a risk-taker. For Kingdon, entrepreneurs 'do more than push for their proposal – they lie in wait' (p. 181), anticipating their opportunity. 'Lying in wait' might be seen as passive since the entrepreneur can be strategic in the ways they deploy their skills and capital (Waring et al., 2018). For example, they may be instrumental in framing an issue in a particular way, as Béland and Katapally indicate:

> … drinking and driving only became perceived as a collective problem worthy of government intervention when policy entrepreneurs mobilized to depict drinking and driving as a social problem rather than a purely individual and moral issue (p. 370).

In any case, their opportunism is critical since the confluence of streams cannot be predicted in advance. As the skills of the entrepreneur may initially point towards facilitation, brokering and expertise, it is tempting to think of entrepreneurs as occupying formal leadership positions within organizations – the government minister, chief executive or a senior doctor. However, it might equally point towards a community leader or social campaigner.

Kingdon's model avoids the linearity of models which are based on 'stages' and the technocratic aspects of others (Greer, 2015). Also, some previous models (such as incrementalism; Lindblom, 1959) had a narrow focus on the implementation process itself, separate from the wider policy context. However, the MSF does contain some limitations. Tracing the influence of the myriad of factors within and between the streams requires significant data collection over time and space. Kingdon's model has been critiqued on the basis that it is broadly similar to the 'garbage can' model (Cohen et al., 1972; King, 1985). This notion is also similar to one proposed by Webb and Wistow (1986) who suggested 'streams of policy which interact, compete and conflict' (Exworthy and Powell, 2004, p. 265). The garbage can model also rejected the linearity of policy from 'choice opportunity' to decision, instead favouring inter-connectedness of problems, solutions, participants and choices. The parallel with Kingdon is that the problems, solutions and participants are only effective in the 'choice-opportunity' (the can). In what Cohen et al. called 'organized anarchy', such choice-opportunities give rise to decisions.

Kingdon's MSF has been applied in health care and public health settings. Exworthy et al. (2002) applied the model in relation to the English health policy relating to health inequalities. Their case-study examined contrasting case-studies on local areas. They later expanded this local perspective to argue for an approach which combined national and local policy; a development which they termed ‘big and little windows’ (Exworthy and Powell, 2004). Exworthy and Oliver (2011) applied the MSF in relation to the three evidential reports on health inequalities. Richmond and Kotelchuck (1991) adopted an approach similar to the Kingdon’s MSF, using instead a different trilogy of knowledge base, social strategy and political will (Attwood et al., 1997). These broadly map into the problem, policy and politics streams of Kingdon’s model.

ENGLISH HEALTH POLICY

The analysis of health policy which follows is inevitably partial and selective, but we focus on a range of policies which will later be interpreted in terms of the MSF. We start our analysis in May 2010 when the UK Coalition government was elected. This period allows a more in-depth picture of policy developments over two decades, during Coalition or Conservative governments and during which major external shocks have occurred.

Since 2010, English health policy has been dominated by austerity (on-going) and responses to the COVID-19 pandemic (2020 onwards). Moreover, public policy was also dominated by Brexit in this period; we argue the consequences from it will hit the poorest areas of the country hardest. Austerity refers to the range of fiscal policies that were introduced by the Coalition government (Conservative/Liberal Democrat) from 2010 and which hit the public sector hardest. We specifically refer to England rather than the UK because policies to tackle health inequalities in other devolved territories of the UK have been discussed elsewhere (see Harrington et al., 2009; Smith, 2007).

An inventory of the key English policy reforms and other contextual information for this period is provided in Table 11.1.

From the outset of the Coalition government in 2010, health policy began to take a different direction from that adopted by the previous New Labour government which had, up until the financial crash of 2008, injected significant new funds into the NHS (Charlesworth et al., 2016). The Coalition government’s neoliberal ideology and desire to shrink the state, and commitment to achieve financial balance resulted in severe cuts to public spending over the next decade. While the NHS did not suffer as severely as some sectors, notably local government and public health, its funding did not keep pace with demand. Responsibility for public health locally was returned from the NHS to local government (upper tier authorities, including county councils and unitary authorities) in 2012 (as before 1974), partly on the basis that local government was better placed to address the social determinants of health, and not simply as part of a *health care* system. This re-location of public health posed challenges in constructing ‘a shared consensus over the “facts” when addressing complex, multi-agency [public health] problems with long time horizons and outcomes that are not always easily quantifiable’ (Brackley et al., 2021, p. 1664). Critics also wondered how far devolving responsibility for public health to local government would put at risk a national approach to improving health and wellbeing and tackling inequalities (Hunter, 2016a). Since many of the forces leading to poor health were the responsibility of national governments, how far local authorities could address these on their own was a key concern. Moreover, public health sustained especially severe cuts to its budget (Buck, 2020). Between 2010 and 2017, government funding for local authorities halved (Lewer and Bibby, 2021). Since then, as various funding taps get turned

Table 11.1 Summary of selected English health reforms with implication for health inequalities, 2010–2022

Date	**Policy / reform / programme**
May 2010	UK general election, leading to Conservative/Liberal Democrat coalition government
July 2010	*Equity and excellence: liberating the NHS* white paper (cmd.7881) published
October 2010	Comprehensive spending review (cmd.7942) published
November 2010	*Healthy lives, healthy people* public health white paper (cmd.7985) published
January 2011	Child Trust Fund abolished
March 2011	Public Health 'Responsibility Deal' launched
April 2011	Child benefit frozen until 2015
January 2013	Child benefit withdrawn from individuals earning more than £50,000
March 2013	Housing benefit/local housing allowance restricted to the Consumer Prices Index (as are other benefits)
April 2013	Health and Social Act (2012) enacted ● Clinical Commissioning Groups (CCGs) introduced ● Public Health England formed ● Public health function moved to local authorities ● Health and Wellbeing Boards created
October 2014	NHS England 'Five year forward view' published
March 2015	Manchester devolution of health and social care (memo of understanding)
May 2015	UK general election: Conservative government formed
Jan 2016	Government publishes `Childhood obesity: a plan for action'
June 2016	UK votes to leave the European Union
October 2016	Draft Sustainability and Transformation Plans submitted
June 2017	UK general election: Conservative government formed
April 2018	Soft Drinks Industry Levy introduced (announced in 2016 Budget)
Jan 2019	NHS England 'Long term plan' published
December 2019	UK general election: Conservative government formed
March 2020	Start of COVID-19 pandemic
October 2021	Public Health England abolished to be replaced by two new bodies: the UK Health Security Agency, and Office for Health Improvement and Disparities
April 2022	Health and Care Act received Royal Assent. This Act replaces HSC Act 2012. Act provides for the introduction of ICSs
July 2022	Integrated Care Systems (ICSs) (42) launched
January 2023	Health inequalities white paper shelved
April 2023	Hewitt Review of Integrated Care Systems

Source: Adapted from Bambra (2019, p. 14); Exworthy and Mannion (2016, p. 7); https://www.nuffieldtrust.org.uk/health-and-social-care-explained/nhs-reform-timeline

off and on, 'the jigsaw puzzle of local government public health funding is getting harder for anyone outside government to piece together' (Buck, 2022).

In addition to funding pressures and the public heath function, health policy during the early years of the Coalition government was marked by major structural reforms affecting the NHS. The changes, known as the Lansley reforms after the Secretary of State for Health, Andrew Lansley, who was personally committed to them, were not popular with either the public or those providing services. It was not clear what particular problem the changes were intended to address as the NHS at the time enjoyed high public satisfaction levels and was performing well. It seemed to most observers that the reforms were a costly and unnecessary distraction (Exworthy et al., 2016). The LSE-Lancet Commission on the future of the NHS concluded that ‘reorganisation on a large scale is often a disruptive process without any evidence of benefit’ (Anderson et al., 2021, p. 2).

It was during the decade between 2010 and 2020 that health inequalities widened sharply in the UK. The Marmot report, published just before the change of government in 2010, documented the widening health gap and proposed several policies embracing the life course to tackle the social gradient in health. These required action across government at all levels as well as between them (Marmot et al., 2010). A commitment to tackling health inequalities was also a priority for the Coalition government in its public health white paper published soon after taking office (Secretary of State for Health, 2010). This was offered as a response to Marmot’s critical review with Lansley acknowledging in his Foreword that health inequalities ‘have been getting progressively worse’ in a country ‘where the wealthy can expect to live longer than the poor’ (2010, p. 2).

For a time, it was hoped that the government and NHS were serious about tackling public health and health inequalities (Hunter, 2016b). The NHS Chief Executive, Simon Stevens, who was appointed in 2013, quickly asserted his authority. In his slim plan for the future direction of the NHS, entitled *NHS Five Year Forward View*, Stevens endorsed his support for refocusing the NHS from being an ill-health service to one according higher priority to improving health (NHS England, 2014). More recently, this shift was given added impetus by Hewitt (2023) in her review of ICSs (see below). Stevens also revisited the inquiry led by former banker, Derek Wanless, commissioned by Gordon Brown when Chancellor. Wanless had argued that the NHS’s future sustainability depended on giving a higher priority to public health and prevention, including tackling health inequalities (Wanless, 2002, 2004). The government at the time endorsed Wanless’s critique and recommendations which Stevens revisited in 2014. In doing so, he rounded on successive governments’ failure to implement the Wanless changes they had signed up to and called for a ‘radical upgrade in prevention and public health’ (2014, paras 3 and 4).

Stevens’ commitment was reaffirmed and set out at greater length in the *NHS Long Term Plan* published in early 2019 (NHS England, 2019). This contained a whole chapter on improving population health, especially in those areas of greatest need, with stronger NHS action set out on prevention and health inequalities. The Plan was also committed to NHS support for wider social goals. In many communities, the NHS is the largest, if not only major, employer and was therefore viewed as an anchor institution contributing to the prosperity and development of such places, including the health of their populations (Vize, 2018).

But the promising start and good intentions did not survive the impact of austerity or the grip of neoliberalism on successive Conservative governments. Over the years since 2010, the UK has become poorer and sicker, and health inequalities have widened. As a report from the IPPR Commission on Health and Prosperity concluded: ‘population health is going backwards … with rising rates of death and impairment’ (Thomas et al., 2023). In 2020, Marmot revisited his 2010 review and concluded that, far from any visible improvement, the position had sharply deteriorated (Marmot et al., 2020a). Among the review’s key messages were the following: since 2010, life expectancy in England has stalled – ‘if health has stopped improving it is a sign that society has stopped improving’ (2020, p. 3); there are marked regional differences in life expectancy with the North East being especially hard hit; people in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas; and deprived areas and areas outside London and the South East have sustained the largest spending cuts thereby undermining their capacity to improve the social determinants of health. Perhaps the most damning criticism was levelled at the government for failing to prioritize health inequalities despite the mounting evidence showing concerning trends. More recent evidence seems to reinforce this worsening situation as the Office for National Statistics (2022) reported that:

> In 2018 to 2020, males living in the most deprived areas were living 9.7 years fewer than males living in the least deprived areas, with the gap at 7.9 years for females; both sexes have seen statistically significant increases in the inequality in life expectancy at birth since 2015 to 2017.

Marmot's updated review coincided with the arrival of COVID-19 in the UK and as the pandemic took hold, it quickly became evident that among those who suffered most were those who were poor and living in deprived neighbourhoods (Maddock et al., 2022; McGowan and Bambra, 2022). Moreover, the growing pressures on the NHS kicked the *Long Term Plan* into the long grass as health policy became preoccupied with mere survival and avoiding potential collapse as a result of the rising number of people infected with COVID-19. The traditional focus on beds and hospitals reasserted itself and replaced any attempt to refocus the NHS on upstream health promotion and tackling inequalities in line with Stevens' intentions. With the rising backlog of cases requiring NHS care, coupled with severe staff shortages and funding pressures, it seems likely that the NHS's attention will be focused on survival and muddling through over the next few years (Marmot et al., 2020b).

In addition to the NHS's preoccupation with the impact of the pandemic, it has also been coping with the effects of a major reorganization in the past decade (Exworthy et al., 2016). The changes are an admission of the failure of the Lansley reforms, with their emphasis on competition rather than collaboration which resulted in the NHS becoming more fragmented and unable to adopt a system-wide response to the challenges facing it. The Health and Care Bill reached the statute book in April 2022, with the launch of Integrated Care Systems (ICSs) across the NHS in England in July 2022. Their place-based and whole systems focus, combined with an emphasis on collaboration in place of competition, is in keeping with Stevens' firm commitment to reshaping the NHS from being a sickness service to becoming a true health service. The government claims that integrated care will enable 'greater ambition on tackling health inequalities and the wider determinants of health' (Department of Health & Social Care, 2021, para 1.9, 9). It believes the experience of the pandemic has made the case for integrated care even stronger. The reforms are supported by 'triple aim' thinking which includes supporting better health and wellbeing for all (Berwick et al., 2008). However, less than a year into ICSs, a review commissioned by the Chancellor, Jeremy Hunt, and led by a former health secretary under the last Labour government, Patricia Hewitt, recommended that greater attention needed to be given to prevention, requiring a significant shift in resources (Hewitt, 2023). Many of the themes in the review are not new and come at a time when the NHS is under tremendous pressure with a growing backlog of elective care as a result of industrial unrest, a continuing financial squeeze, and ongoing staffing and retention issues. This context, combined with a lukewarm response to the report from government, has led many observers to conclude that the impact of the Hewitt review will be minimal. Ministers' priorities lie elsewhere and there is an absence of political commitment to tackle the crisis in population health (Alderwick, 2023).

Other than creating a degree of turbulence the NHS in its present state could well do without, the likely impact of the 2022 changes remains uncertain. However, there is a general consensus that merely introducing new structures will be insufficient to bring about and embed the kind of change that is needed. For that to happen, new relationships and partnerships, especially with local government, need to be put in place. As these have never been especially good, it will take time for them to happen (Alderwick et al., 2021; Hunter, 2019). As Leader of Greater Manchester city council, Sir Richard Leese, commented: 'you can't legislate for a collaborative culture' (Leese, 2021). Form has to follow function although, all too often, when it comes to NHS reform, it is the other way round. While the experience of managing COVID-19 locally resulted in agile health systems being forged in a time of crisis with a focus on integration, a concern is that these will come to a 'grinding halt' as a fixation on bureaucracy takes over (Serle, 2021). Moreover, staff stress and burnout (compounded by the effects of working during the COVID-19 pandemic) is creating a vicious cycle of decreased staff retention (Gemine et al., 2022).

Changes have also occurred in public health since the sudden and unexpected demise of Public Health England (PHE) in late 2021 following the government's criticisms of the agency's handling of aspects of the pandemic. Rather than seeking to reform PHE from within, a decision was taken by the Secretary of State for Health (at the time this was Matt Hancock), without consultation, to replace it with two new bodies – the UK Health Security Agency (UKHSA), and the Office for Health Improvement and Disparities (OHID). How effective the new bodies will prove to be remains unclear at this stage in their lives. But there has been much criticism from the public health community over their introduction and over how far they will be well-positioned to tackle health inequalities.

In particular, there is concern that, whereas PHE sought to improve integration around the three pillars of health protection, health improvement and healthcare public health, the splitting of functions between two new organizations risks fragmentation and a loss of focus on health inequalities (Hunter et al., 2022; Weale et al., 2023). There is a worry that, if the UKHSA concentrates on potential external threats to the exclusion of a focus on non-communicable diseases and stalled improvement in life expectancy, then it can only further weaken the government's response to the poor overall health status of the UK (Scally, 2021a). Another observer makes the point that a lesson from COVID-19 is that 'health protection and infection control fail if they have nothing to say about inequality' (Wilkinson, 2021).

Responsibility for health inequalities lies with OHID. Its name has given rise to much criticism and puzzlement. Why the word 'inequalities' was replaced with the less common term 'disparities' has puzzled many public health practitioners (Scally, 2021b). Among its responsibilities, OHID (which is located within the DHSC) will be expected to develop cross-government working to develop a 'health in all policies' approach in tackling the social determinants of health. A white paper on tackling the drivers of disparities in health outcomes had been expected in 2022. However, in a written answer to a Parliamentary question, the government signalled that the white paper would be shelved. In describing this decision as 'deeply disappointing', Nightingale and Merrifield (2023) warned of a 'dangerous pattern for action on health'. The white paper had been eagerly awaited as providing OHID with its strategic focus and mission, so its withdrawal has left the new agency disappointed and without a sense of purpose. Yet there is no shortage of public health issues demanding a response from government.

An immediate priority is tackling the problem of poor diet and obesity given that over 64% of adults in the UK are obese or overweight with the problem for adults, and especially children, heavily concentrated in deprived areas (Baker, 2022). The UK has the third highest level of obesity in Europe, behind only Malta and Turkey (Metcalfe and Sasse, 2023). The government had initially promised to take forward recommendations from the Dimbleby (2021) review towards a National Food Strategy, but news reports had suggested the government would defer bans on junk food (BBC, 2022a). Such a move would seem to run counter to efforts to halve childhood obesity by 2030. Indeed, in March 2023, Henry Dimbleby resigned from his post as adviser to the government, claiming that its obesity strategy made no sense (BBC, 2023). But how far efforts to tackle obesity and other lifestyle issues will move away from an individual behaviour focus to involving interventions that address the commercial determinants of health is less clear. Exhorting individuals to change their lifestyle choices has been the default position of successive governments, with the ban on smoking in public places introduced under New Labour a notable exception, although only after hesitancy on the part of the prime minister, Tony Blair, had been overcome. But the present government shows few signs of shifting from 'lifestyle drift', with its narrow focus on individual behaviour change, to a population health perspective that demands attending to the social and structural determinants of health (Popay et al., 2010). Such a shift would require interventions involving regulation and taxation which go well beyond somewhat peripheral interventions such as banning junk food advertising on TV or including calories on menus, both of which will have limited impact. Despite the introduction of a sugar tax under the Coalition government, the present government has shown no interest in following Scotland's lead over introducing minimum unit pricing to control alcohol consumption. Among many Conservative MPs, there remains an ingrained hostility to the 'nanny state' (Cohen, 2022). The obesity crisis reflects this mindset and a refusal on the part of government to act on the root causes, including tackling the commercial determinants of health (Metcalfe and Sasse, 2023). Instead, the solution is seen to lie in Big Pharma offering new treatments such as the so-called 'skinny jab' which is viewed as a weight loss game changer (McCartney, 2023). But preventing obesity should be a priority rather than treating it by medication which, despite claims to the contrary, offers no magic bullet or long-term solution. As has been argued, a considerable part of the solution lies in listening to 'nanny' (Hutton, 2023).

Hopes of a shift in government thinking rest on its 'levelling up' agenda which was set out in a lengthy white paper published in April 2022 (Secretary of State for Levelling Up, Housing and Communities, 2022). Structured around 12 missions, it set out a comprehensive set of policies amounting to a long-term strategy for tackling deep-seated inequalities and disparities across the country. While the white paper was high on ambition, there remained concerns that the government lacked the political will to undertake the level of investment that would be required if levelling up was to mean anything beyond a neat sound-bite and vague aspiration (Hutton, 2022; Jennings et al., 2021). The IFS (2020) describe levelling up thus:

> A 'left-behind' area, in need of 'levelling up', is characterised by broad economic underperformance, which manifests itself in low pay and employment, leading to lower living standards in that area … The health of the population may also be relatively poor: in some cases, this could be a legacy of deindustrialisation or long-term unemployment, as well as deep-rooted socio-economic issues (p. 325).

Merrifield and Nightingale (2021) recommend that the government needs to consider health as a measure of levelling up, implement a cross-government approach to improving health, empower local and regional government, invest government funding where it is needed most, and support people back into work.

There is thus a disconnect between the white paper's analysis of the scale of the problem and what is required to tackle it, and the government's continuing neoliberal fixation with balancing the books through austerity measures and cuts to public spending. Such fiscal conservatism is in marked contrast to Germany when the country was reunified after the collapse of the Soviet Union. The West German government invested two trillion euros between 1990 and 2014 to redevelop East Germany and reunite the country. This is the equivalent of £71 billion every year compared with the UK's levelling up fund which is £4.8 billion in total (Enenkel, 2021). Investment on the scale required is inconceivable in the UK's weakened economy and with a government intent on reining in public spending.

But there are other potential impediments to progress in levelling up. In the near future, as noted earlier, it is likely that 'public attention, political focus, cash and funding mechanisms' will remain firmly focused on acute care (Buck, 2021). As a consequence, finding the 'bandwidth and space to move upstream' and tackle health inequalities will be hard and require a determination on the part of ministers that has not so far been in evidence. Optimism that this will be forthcoming is therefore in short supply with the levelling up initiative resembling a slogan rather than a policy.

Glimmers of hope can be found at the local level where there have been encouraging signs of a 'health in all policies' approach being adopted, coupled with an acknowledgment that public health entails changes in sectors beyond health in order to improve health and wellbeing (Local Government Association, 2016). Greater Manchester has committed itself to levelling up and improving health equity within the means and powers available to it (Marmot et al., 2021). But without further devolution, and less central control and commitment from national government as called for in the Hewitt review, there will be limits on how far change will be possible locally (Brown and Jones, 2021). Also, a framework called 'Core20Plus5' has been established focusing on the most deprived 20% of the population and addressing 5 clinical areas. This framework allows some autonomy for 'local leaders to make choices about which areas to focus on in reducing inequality, within an overall framework set' nationally (Lewis et al., 2022).

Sloggett (2022) argued that the current policy and political climate was more favourable to tackling health inequalities than at any other time in recent history, citing the confluence of national and local factors. Nationally, the health promotion taskforce (chaired by the Prime Minister), the creation of OHID and the Health Disparities white paper and locally, the 'Core20Plus5' and placed-based initiatives such as ICSs amount, he argued, to a concerted strategy towards health inequalities. However, one year on from Sloggett's comments, his assessment seems a wildly optimistic assessment. The national and local policies to which he refers have either not appeared or are likely to be insufficient to meet the stated objectives in life expectancy when faced with countervailing factors such as the inequalities wrought by the effects of fiscal austerity, the COVID-19 pandemic, the rising cost of living, the continuing consequences of Brexit, and pre-existing levels of poverty in the UK. Moreover, Bunn (2021) noted that some critiques of government approaches have highlighted the 'lack of the value placed on taking a long-term, whole systems approach; creating connected and cross-cutting policy, and learning from previous approaches to health inequalities.' Other commentators on the levelling up agenda consider it to be lacking in ambition and bold action (Pope et al., 2022; Ralston et al., 2022). Therefore, it is highly questionable whether these policies will, in turn, translate to improvements in health inequalities. At this stage, it seems doubtful in the extreme.

REVISITING THE MSF: THE CASE OF HEALTH INEQUALITIES

In this section, we seek to explain and interpret the recent and current English health policy relating to tackling health inequalities in terms of Kingdon's MSF. We consider the role of (and extent to which) policy entrepreneurs in coupling (or decoupling) those streams, before concluding whether health inequalities has secured a position on the policy agenda in England and which factors have shaped the alternative courses of action for policymakers.

1. Problem Stream

For many years, evidence about the scale and extent of health inequalities has been accumulating, with new evidence highlighting how such inequalities are affecting individual and communities. The main causes and manifestations of health inequalities are thus largely known; the 'problem' has been defined in that sense. Other frames are also possible and so are liable to be contested. Twenty years ago, Wanless identified the problem stream thus:

> what is striking is that there has been so much written often covering similar ground and apparently setting out the well-known major determinants of health but rigorous implementation of identified solutions has often been sadly lacking (2004, p. 3).

More recently, some businesses have entered the debate by considering the impact of their practices (such as employment, procurement and environmental impact) (Maani et al., 2023; Marmot et al., 2022) but these are probably in the minority.

Wanless compared the clarity of the problem stream with the opaqueness of the policy stream (see below). However, whilst research and epidemiological evidence has defined the problem stream, other stakeholders continue to see the issue as one of individual/personal responsibility or perhaps beyond the scope of government itself, devolving decisions to other bodies, locally or nationally (e.g., Javid, 2021). This makes the 'problem stream' less secure. More intractably, Frame Work Institute (2022) describe how public perceptions about the SDoH are disconnected from support for policies:

> It's a problem because when people struggle to see how jobs, homes, hardship and discrimination drive our health, they are less likely to support the policies and actions that are needed to address these issues (p. 2).

Across various measures, the problem of health inequalities has become even more acute in the past decade, with extant evidence providing a stark assessment of this worsening issue. This retrenchment of health inequalities has been manifested prominently in two particular ways. The first is austerity. Bambra (2019) cites evidence which suggests that 'austerity has increased existing health inequalities such as that between the North and the South of England and between deprived and affluent neighbourhoods" (p. 18). There is a gap of 20 years in life expectancy across the UK. Whilst this evidence has arguably prompted policymakers and some think-tanks to respond, there has been some acknowledgement of health inequalities as 'problems.'

The second is the COVID-19 pandemic. Not long into the COVID-19 pandemic, starting in 2020, it soon became apparent that COVID-19-related deaths were heavily skewed towards people of colour, especially NHS staff (Platt and Warwick, 2020). However, in 2023, as the

UK addresses a 'post-COVID-19' situation, the previous challenges of non-communicable diseases will remain at the forefront (Hunter, 2023). Health problems such as mental health, alcohol and obesity will continue to pose significant challenges to the NHS and wider health system, not least because these have been intensified during the COVID-19 pandemic and reinforced by the cost of living crisis since late 2022. The re-framing of these inequalities as 'disparities' might suggest that politically they are recognized but disparities suggests a more emollient wording, akin to the term 'variations' favoured by the Thatcher government in the 1980s.

2. Policy Stream

Graham (2004) drew a key distinction in policies aimed at tackling health inequalities, demonstrating that policy (at the time) revealed a 'range of understandings of what it means to tackle health inequalities' (p. 115). Policies, she argued, including strategies to improve the health of the poor, to close the gaps between the poorest and more affluent groups, and to address the link between socio-economic position and the overall health of the population. Whilst these understandings are all concerned with the unequal distribution of health, they differ in respects which have implications for the formulation and implementation of policy. For example, in policy matters, it matters whether the objective is to improve the health of the poorest (say, 10% of the population) or the reduce the 'health gap' between them and the wealthiest. The link between socio-economic position and population health perhaps best fits with the notion of the social gradient (Marmot, 2003). The 'gradient' approach implies that progressive step-wise deterioration in health by, say, each income decile, addressing the whole of the population, not simply a segment of it. In a similar way, Olivera et al. (2021) found a lack of clarity of their documentary analysis of 'formal plans to reduce health inequalities' (p. 1), comprising vagueness in conceptualizing health inequalities, and lack of commitment to action.

Policy initiatives in the period since 2010 have often been marked by continuity despite growing evidence of health inequalities. For example, commenting on policy developments over a decade ago, Hunter (2008) suggested that 'the promised refreshed health inequalities strategy contains no new departure from existing policy' (p. 143). Whilst there have been some recent policies initiatives (see Section 2), it is not clear that the distinctions made by Graham (2004) have been acknowledged in these policies. Indeed, if anything, there is a tendency to revert to the more simplistic interpretation of health inequalities as simply one of disadvantage, *viz*. to improve the health of the poorest.

3. Politics Stream

The Labour government (1997–2010) was the 'first in a generation to recognize health inequalities as a priority' (Hunter, 2008, p. 144). Policy initiatives have continued to appear since 2010 but they have not always been accorded the same priority or enjoyed the same prominence in health policy within government departments or even across government (Exworthy and Hunter, 2011).

As we have noted, the past decade has been marked by austerity, Brexit and the COVID-19 pandemic. Ostensibly, these are separate developments but they can also be seen as inter-linked. Arguably, all three reflect the disaffection among deprived, marginalized and disadvantaged groups who have not benefitted from the apparent benefits of economic globalization and pro-market policies over recent decades. Populist politicians have claimed to provide ready-made solutions to those ‘just about managing’ and those ‘left behind’ (Speed and Mannion, 2020). Proposals to ‘level up’ or ‘build back better’ invariably lack specific detail on what actions are required despite having some electoral appeal in the 2019 general election (among so-called ‘red wall’ constituencies). Hunter (2008) claimed that the lack of action on tackling health inequalities has often been ‘the absence of both the political will and the determination to act to close the income and heath gaps … that appear to remain problematic’ (p. 144). In so many ways, this claim continues to hold true.

4. Policy Entrepreneur

Individuals (or groups of individuals) who have conjoined the three streams of the MSF invest their social and political capital to secure the issue on the policy agenda. From our analysis, it is not clear that any single individual has managed to achieve this across all streams. However, we point to two persons who are not politicians but who may stake some claim to occupying the policy entrepreneur role in this case study. Here, we do not seek to arbitrate as to who has been most effective, but rather, we note the scale of the challenge of operating across three contrasting streams.

Professor Sir Michael Marmot has long researched health inequalities, with his research on British civil servants remaining a landmark study (Marmot et al., 1978). However, despite many years of publishing studies on inequalities, it was probably only in the 2000s that he became more involved with policy initiatives to tackle them (Exworthy et al., 2003). In the last 25 years, he has been involved, *inter alia*, in the Acheson inquiry (1998), the WHO Commission on Social Determinants of Health (2008), the Marmot Report (2010) and its 10-year follow up (Marmot, 2020). Indeed, he was knighted in 2000 for ‘services to epidemiology and the understanding of health inequalities’. More recently, he has held dialogues with various businesses, seeking to address some of the commercial dimensions of health (Marmot et al., 2022). He continues to be a strong advocate for tackling health inequalities, rooted firmly in the evidence but perhaps lacking the political connections to make and deliver effective policy at national level. However, action has been increasingly local, such as through coordinated local initiatives called ‘Marmot cities’, such as Coventry.

Jamie Oliver is a celebrity chef, restaurateur and author of numerous books. However, it is perhaps his TV documentaries about obesity, especially among children, which have brought the issue to the attention of politicians and policymakers, as well as raising public awareness. His appearances at a parliamentary select committee hearing in October 2015 (Health Committee inquiry into childhood obesity strategy) and May 2018 (Health and Social Care Committee inquiry into obesity) were galvanizing to public debate and political action. He has also criticized recent government plans to defer implementation of its obesity strategy, claiming that it was ‘falling apart’ (BBC, 2022b). Given his interest and background, his attention has primarily been on obesity, rather than on the wider health inequalities.

5. Overall Assessment

Hunter (2008) claimed that, after a decade in power, the Labour government had achieved ‘modest gains’ (p. 145) but also noted critics who claimed the government had not done enough, especially in the face of worsening health inequalities. Arguably, this state of affairs has continued to the present day, with Dixon (2022) arguing that, despite numerous initiatives, health policy remains ‘tentative’ and ‘uneven’, with implementation being ‘spotty’.

Exworthy et al. (2002) also employed the Kingdon MSF model to conduct a similar analysis in England two decades ago. Clearly, a different climate prevailed in national policy and civic society (including public opinion). Their study examined the extent to which the issue of health inequalities had become secure on the agenda of local statutory agencies. They concluded that:

> the issue of health inequalities is on the agenda nationally and locally but implementation is hampered by deficiencies in performance management, insufficient integration between policy sectors, and contradictions between health inequalities and other policy imperatives (p. 79).

CONCLUSION

This chapter has examined the case of policy to tackle health inequalities in England by applying Kingdon’s MSF. Our analysis suggests that the position of health inequalities on the policy agenda remains fragile despite the COVID-19 pandemic having exacerbated the role played by inequalities in its spread, and its devastating impact on the most deprived communities. While there are some positive and encouraging indications in each of the three streams, it is not clear that they have been conjoined sufficiently to give confidence and ensure that policy can be implemented and halt, let alone reverse, a state of worsening inequalities and poorer health more generally.

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12. Long-term care

August Österle

INTRODUCTION

Chronic illnesses, disabilities or frailty can make humans dependent on others. Long-term care has become an established term to address this particular social risk where care, help and support by others are needed. Long-term care is an old social risk but it is a relatively novel addition to the social policy agenda. Modern health care systems and the prominent role of welfare states in these systems are rooted in the late 19th century. The recognition of long-term care as a distinctive welfare state issue has a far more recent history. With a few earlier exceptions, many countries have started to establish more comprehensive long-term care systems since the 1990s, while in many others they still do not exist as such (Ranci and Pavolini, 2013; Scheil-Adlung, 2015). The understanding of what long-term care entails, how it is addressed in public policy, or how it is linked to health policy differs widely across countries. The challenges, however, are shared around the globe. Ageing populations, growing long-term care needs, pressure on traditional arrangements of care provision and care work shortages make long-term care a major health and social policy concern of the first half of the 21st century.

Having a chapter on long-term care in a health care policy handbook reflects the close connections between the two branches. Long-term care needs often follow an initial acute health care need because of accidents, ill health or long-term limitations in physical or mental health. Until today, patients have had to stay in hospitals because there has been no long-term care option to discharge them to. There is the rhetoric about collaboration between the two sectors, but also the realities of disconnected long-term care systems. To varying degrees, medical professions are involved in assessing long-term care needs. Long-term care also involves medical services, raising questions about how the provision of these services is organised and how it is funded. Overall, while the focus in health care systems is mainly on cure, rehabilitation and the prevention of ill health, long-term care addresses the range of health and social services to support people with chronic illnesses or disabilities.

This chapter explores long-term care and long-term care policies, with a particular emphasis on the links with health policy. For illustration, it will refer to examples from several countries, in particular countries represented in this volume. In the first part, the chapter introduces the concept and definition of long-term care and briefly explores the emergence of long-term care as a distinctive policy field. Then, the chapter presents the cornerstones of long-term care systems in terms of regulation, delivery and financing. This is followed by an analysis of ideas, institutions and interests that are shaping the understanding and definition of long-term care as a policy field, how it develops and how it is linked or delimited from other policy areas, in particular health policy. A discussion of main challenges and perspectives leads to a brief summary conclusion.

WHAT IS LONG-TERM CARE?

Related to the novelty of long-term care as a policy field, the understanding of the terminology used and the concrete practices of delivering care work and its regulation still differ widely. Definitions usually address three aspects: the needs resulting from chronic illness, disability or frailty, the range of services provided to those affected and the duration of required provision. For example, in a very basic definition the OECD states: 'Long-term care is the care for people needing support in many facets of living over a prolonged period of time' (OECD, 2011, p. 39). The European Union defines long-term care as '… a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care' (European Commission, 2021a, p. 17). According to the US National Institute on Ageing (2023), long-term care 'involves a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own'. The WHO (2023) emphasises the broader objectives of long-term care as being able to: 'enable older people, … to receive the care and support that allow them to live a life consistent with their basic rights, fundamental freedoms and human dignity'.

While these definitions indicate a common understanding of the concept of long-term care, the terminology used, the policies and the practices vary strongly across countries. Terminological differences are a reflection of how societies dealt with these care needs and of different current practices of long-term care, and in turn they impact these practices. While long-term care has become a term that is widely used in practice and in the academic study around the world, in specific country contexts other terminology is used more frequently. In the UK, for example, social care is commonly used to refer to long-term care services (Lewis, 2022), but social care is a broader concept, also covering, for example, child protection services, fostering, adoption, services for the homeless or support for those with substance misuse problems. In the US, long-term services and support (LTSS) is used to refer to services addressing those in need of long-term care (Wysocki et al., 2015).

One important feature of defining long-term care is to consider the age of those in need of care. The risk of requiring long-term care increases with age, but children and younger adults are not excluded from the risk. Still, 'older care', 'elderly care' or 'aged care' is commonly used in this context, even as a synonym for long-term care. In fact, some countries differentiate in their policies between those of an advanced age (e.g., beyond 65 years of age) and those of younger ages. For example, while the German long-term care insurance does not define any age limit for beneficiaries, the Japanese long-term care insurance addresses the population aged 65 and above, and – if approved by an assessment – people aged between 40 and 64 years.

Above all, policies addressing long-term care needs require a definition of the specific 'needs' and 'services'. These definitions do not only delimit access to certain public policies, they also shape the broader societal understanding of long-term care. While health care systems usually have a broad common core package of medical and nursing services that are covered, the content of service packages differs widely in long-term care. Needs and services that are potentially involved include health care and nursing, help and support in activities of daily living (e.g., eating, getting in and out of bed, dressing, moving around, using the toilet) and the instrumental activities of daily living (e.g., preparing meals, housework, shopping, managing money), but also social relationships and emotional support. Definitions of needs and services can emphasizs a health or a social orientation, consider underlying limitations or emphasise the required care and support, and, not least, hugely vary in the thresholds that define eligibility to publicly (co-)funded support (Ranci et al., 2018).

Not least, long-term care often includes, or is linked to, medical care. The distinction between health and social care can become an anchor in defining provision and funding of long-term care and is used by the OECD in calculating long-term care spending (OECD, 2020b). However, disentangling health and social long-term care is challenging and often hinders an integration of services. Medical care and nursing care for those in need of long-term care can be provided in different contexts: in hospitals, in outpatient health care, but also in long-term residential or community care settings. In practice, these arrangements differ between countries as do the arrangements in funding respective services, e.g., by linking it to the professional providing the service or the context in which it is provided. The funding of health and social services for long-term care exemplifies the huge differences in the logics and the underlying idea of public and private responsibilities in the health and the long-term care sector. In the OECD world, with the major exception of the US, health services are free or with limited co-payments at the point of use. In contrast, a mix of public and private resources is used to fund social long-term care services. While some benefits might be universal, most services apply some form of means- and/or asset-testing or co-payment regulations (Roland et al., 2022). In England, for example, as a general rule, paying for social care is means-tested, beyond a certain threshold services are not funded publicly. Specific benefits, however, such as the attendance allowance and continuing healthcare funded by the NHS in case of serious disability or illness, do not apply means-testing (Wittenberg et al., 2022).

Finally, the organisation and governance of long-term care is characterised by major tensions arising from the dichotomies of individual and social responsibilities, of emotional and economic perspectives on care, between family and non-family care, paid and unpaid care, or formal and informal care provision (issues that are taken up below). In the realities of long-term care systems, these concepts often become blurred: family carers are perceived as (co-)providers but also as co-clients of long-term care policies – there is paid family care, voluntary non-family care, informal grey economies of care and under-paid formal care provisions. Long-term care is heterogeneous, variable, gendered and often invisible (both on the side of care needs and of care work).

THE EMERGENCE OF LONG-TERM CARE (POLICIES)

In the late 19th century, social insurance reforms addressing the social risks related to accidents, illness, income in old age and, later on, unemployment became the building blocks of modern welfare states. With these developments, social policies moved beyond a residual orientation and established social rights. The 20th century, up into the Golden Age of the welfare state, saw a diversification of approaches, in particular with the emergence of the Beveridge orientation, and an extension of personal and material coverage (Kuhnle and Sander, 2021).

Almost throughout the 20th century, long-term care was a hidden social policy. Long-term care (usually not addressed as such) remained the responsibility of the individual and the family. The welfare state role in long-term care was scattered, mostly residual and social assistance oriented. Family policy became a strong policy field in the 20th century, but with a prime orientation at childcare. Hospitals often became a temporary long-term care setting (formally or informally), when a return back home was not possible and a place in a residential care setting not available. Pension policies were addressing income replacement in old-age, but partly with flat-rate or means-tested top-up elements addressing dependency. Disability policies were addressing needs of younger age groups with disabilities, emphasising education and work-related programmes or living arrangements. The provision of what is now called long-term care was largely left to families; the role of charitable organisations and the welfare state remained residual.

From the mid-20th century until the 1980s, two developments impacted long-term care policies (without actually using the term long-term care). In many Western European countries, new social assistance regulation replaced the traditional poor law orientation. In the UK, the 1948 National Assistance Act created the foundation for social care. In Germany, in 1961, a new national social assistance law was established. These, and similar developments in other countries establishing new social assistance and/or social services legislation, address specific vulnerabilities including care needs in old age, they establish legal rights to support, and strengthen the shift from poorhouses or almshouses to nursing homes (Thomson, 1983), while public responsibility in long-term care remained rather limited. Secondly, health system reforms had an impact on long-term care. In the US, for example, in 1965, with the introduction of Medicaid – a publicly-funded and means-tested health programme for low-income households – this health institution became a new player in funding long-term care in nursing homes, but not home care (Watson, 2010). Legal changes in social assistance and/or health care in the early decades of the second half of the 20th century have changed the understanding of public responsibility in long-term care – particularly regarding the role of old age homes – but it did not fundamentally change strong family orientations in long-term care. This was already different in the Nordic European countries and the Netherlands in that period. These were the first countries to substantially expand the public role in long-term care and move beyond a residual role of the state. These developments created the foundation for comparatively high levels of service coverage and public long-term care expenditure in the Nordic countries and the Netherlands. In Sweden, these developments are rooted in the 1950s with major expansions of residential care and – different from most other European countries at that time – of community care in the 1960s and the 1970s (Meagher and Szebehely, 2013). In the Netherlands, the development was further strengthened in 1968 by the introduction of a social insurance for exceptional medical expenses, including long-term care (Da Roit, 2013).

In the 1990s, a new and still ongoing wave of establishing distinct and more comprehensive public long-term care systems started (Gori et al., 2016; Ranci and Pavolini, 2013). Several OECD and non-OECD countries established new long-term care programmes, others reformed and expanded existing programmes. This happened not least as a response to demographic challenges of an ageing population. Increases in long-term care needs (in terms of the population affected but also in terms of the character of needs), care work shortages (OECD, 2020a) and growing pressures on providing care informally (related to lower birth rates, changing living arrangements of families, or an emphasis of paid full employment) required novel responses to long-term care. In addition, strengthening the role of home care and more generally community care, rather than long-term care in institutions, further contributed to legal and practical changes. An early example of this new wave of long-term care reforms, in line with a more comprehensive understanding of long-term care, is long-term care insurance in Germany. It was established in 1995 as the fifth pillar of the country's social insurance model (Theobald and Hampel, 2013). The approach establishes long-term care as a distinctive social risk, not distinguishing between frail older and younger disabled groups, and providing a comprehensive legal frame for different long-term care provisions (cash for care, home care, residential care and support for informal carers). Several other countries followed the idea of social long-term care insurance, including Luxembourg (in 1996), Japan (in 2000) and Korea (in 2008) (Fischer, 2022).

Other countries also developed more comprehensive approaches to long-term care in the 1990s and the early 2000s, emphasising it as a distinctive social risk. Austria, in 1993, built its long-term care system on a nationwide, universal cash benefit and took measures to expand the social service infrastructure, in particular in home care (Österle, 2013). In Spain, the 2006 Dependency Act established a universal right to long-term care with provisions in cash and in services (Peña-Longobardo et al., 2016). The Czech Republic was the first country in the Central Eastern European region to establish a more comprehensive long-term care approach, similar to Austria, emphasising a new cash benefit and an extension of the social service infrastructure (Österle, 2011).

In other countries, expansions and reorientations were more strongly built on the existing legal framework, but with important, often stepwise amendments and additions. Examples include England (Glendinning, 2013) and Sweden (Meagher and Szebehely, 2013). For an overview of the status-quo of long-term care policies in all European Union members states, see European Commission (2021b). While reforms in that period often led to substantial expansion of public support, most importantly in terms of new or extended cash-for-care programmes and of home care provisions, reforms also aimed at or resulted in important structural changes and tightening of programmes. A common re-orientation is the explicit prioritisation of home care. Other trends in European countries – emphasising issues of cost-containment, partly leading to a cut-back of public responsibilities, and with substantial variation between countries – include marketisation and privatisation, re-familialisation, or public support becoming more focused on those with intense care needs (Da Roit, 2021; Rostgaard et al., 2022).

The history of low levels of public support for long-term care and a focus on residential care into the 1990s also applies to the US, Canada and Australia. In the US, the aforementioned Medicaid programme remains the main public programme in long-term care. From the 1970s, in addition to the original focus on residential care, states were given the option to also provide in-home and community-based services. In the provision of services and beyond Medicaid provisions, market arrangements dominate in the US (Howes, 2016). In Canada, funding and provision of long-term care are the responsibility of provinces and territories leading to varying long-term care policies across the country. This has led to repeated calls for a stronger federal role (Tuohy, 2021). The Australian long-term care system also expanded stepwise with early programmes but still very limited levels of delivery in the 1980s. In 1997, the Aged Care Act and several new programmes introduced around 2014 became the basis for the current system that is also strongly influenced by ideas of new public management and marketisation (Mears, 2016).

In low- and middle-income countries, comprehensive public long-term care systems do not yet exist; in many low-income countries even very residual social protection is limited or non-existent. Long-term care is widely understood as a family responsibility (Curreri et al., 2022). However, across the globe, old age and long-term care is increasingly recognised as a social risk in government plans and addressed in local, regional and even, partly, in national initiatives (Glinskaya et al., 2022). In 2016, China launched pilots for long-term care insurance in several regions. To allow for experimentation, the pilots vary – within a national framework – in terms of population coverage and benefits, while they are closely connected to existing health insurance funds in terms of funding (Feng et al., 2020; Zhu and Österle, 2018). The growing challenge of ageing societies and its implications for long-term care are also recognised in the other BRICS countries. In India (Agarwal and Bloom, 2022), in Brazil (Lloyd-Sherlock et al., 2022), in Russia (Zenina, 2021) and in South Africa (Lloyd-Sherlock, 2019) (growing) long-term care needs are addressed in policy papers and social protection reform debates, and various local and regional initiatives develop programmes or extend infrastructure that can help to advance nationwide developments. In Türkiye, along the development of universal health care coverage, steps have been taken to expand cash and in-kind benefits for the older population and persons with disabilities (Erdogan, 2022). (For more detailed regional overviews see, Yiengprugsawan and Piggott (2023) or Walker and Wyse (2021) for Asia and the Pacific region, Hussein and Ismail (2017) for the Arab region, Maharaj (2020) or WHO (2017a) for Africa, and Calvo et al. (2019) for Latin America.)

This very brief global overview of the development of long-term care systems emphasises a common trend to increasingly recognise long-term care as a distinctive social risk, to establish more comprehensive public support systems, while at the same time considering private financial resources (e.g., via means-testing) and informal care work (e.g., via support for family care). However, economic, political, social and cultural factors have a huge impact on the concrete features of long-term care systems, that consequently vary largely between countries and within countries far more than for health care systems. Not least, these variations become visible with huge variations in public long-term care expenditure (see below).

Besides the initiatives taken by several countries establishing comprehensive long-term care systems, there is also a growing recognition of the long-term care agenda in the work of international organisations, including the OECD (e.g., OECD, 2011, 2020a), WHO (e.g., WHO 2017a, 2023) and ILO (e.g., Scheil-Adlung, 2015; Tessier et al., 2022). In line with these developments, long-term care has become one of the principles in the European Pillar of Social Rights (European Commission, 2023), and McKinnon (2022) makes the case to also formally recognise long-term care 'for the elderly' in the ILO Convention on Social Security (Minimum Standards) (No. 102). The following sections will show how these developments translated into concrete long-term policies and how these were shaped by ideas, institutions and interests.

LONG-TERM CARE SYSTEMS: DELIVERY, FINANCE AND GOVERNANCE

Data on long-term care expenditure can provide a very preliminary picture of long-term care systems, and the extent to which the public sector is involved. OECD countries, on average, spend about 1.5% of GDP on long-term care (OECD, 2020b). Public spending ranges between more than 3% of GDP in Northern European countries and the Netherlands, between the OECD average of 1.5% and below 2.5% in many Western European countries, the US, Canada and Australia, and below 1% or even 0.5% in several Southern and Eastern European countries, Korea and Chile. OECD data further indicates that the majority of public spending is on residential care, while the share of public spending as compared to private spending tends to be larger for home-based care then institutional care. Korea and Japan stand out in terms of a very substantial share of hospital-based long-term care spending (OECD, 2020b). Taken together, while the availability and the quality of comparable data for long-term care is still limited, existing figures confirm the overall picture of huge variation between countries in public long-term care spending (OECD, 2020b). The hidden cost of informal care is usually ignored in long-term care expenditure data. Around the globe, informal carers, mostly women within family networks, are the main providers of long-term care work. Even in countries with the most expansive public coverage for long-term care, informal care accounts for a very substantial share of care provision. In a recent study, the hours value of informal care in the EU was estimated to be between 2.4% and 2.7% of EU GDP (European Commission, 2021c). This is above the level of public long-term care expenditure as % of GDP in most OECD countries (OECD, 2020b).

Along with the growing recognition of long-term care and with several countries establishing more comprehensive long-term care systems in the past three decades, attempts have also grown in research to compare and to cluster long-term systems. These approaches have mostly focused on European or OECD countries. The analyses use different criteria, focusing on expenditure data, on sets of criteria in the spheres of finance, provision and regulation, and on the interplay of formal and informal long-term care. In a recent study, Ariaans et al. (2022) use a combination of OECD data and institutional information, namely the extent of supply, the public-private mix, access regulation in terms of choice and means-testing, and performance. Other attempts to identify care regimes have been focused on social care services more broadly, including long-term care and childcare, focusing on public and family responsibilities in social care and the types of (de-)familialism (Anttonen and Sipilä, 1996, Leitner, 2003; Verbakel et al., 2022). In a recent review of the respective literature, Fischer et al. (2022) suggest a framework to study long-term care systems globally, by combining the aforementioned dimensions of delivery, financing and regulation with the role of state, societal actors, for-profit actors, private individual actors and global actors. In what follows, the three dimensions and the roles of specific actors will be used as a frame to very briefly characterise long-term care systems.

Long-term care is about providing a potentially wide range of services. Delivery of these services involves three main questions: what to provide, where to provide, and who provides? As mentioned before, long-term care services can include a wide range of medical and nursing services, support addressing activities of daily living and of instrumental activities of daily living, but also broader social and emotional support or palliative care. The place of delivery could be the home of the person in need of care, a residential care setting or alternative housing and caring arrangements, such as day care centres or assisted living facilities. Historically, nursing home provision has been the main public or charity response, if family or other informal care was not available, developing from the poorhouses to the modern nursing home industry (Thomson, 1983). In the second half of the 20th century, there has been further considerable extension in the availability of care homes, above all in countries with relatively little pre-existing infrastructure. The provision of care services in the home of the user became more prominently addressed in public policies from the 1980s and the 1990s. Today, with a reference to the preferences of users but also to financial considerations, support for care in the private home of the user is often given an explicit priority over other arrangements. The European Pillar of Social Rights, for example, addresses the right to affordable and good quality long-term care, ‘in particular home-care and community-based services’ (European Commission, 2023).

Finally, the who question of delivery addresses the role of family or other informal care workers, the role of formalised and paid care work arrangements, requirements in terms of qualifications and professionalisation, but also questions about the welfare mix in provision, i.e. the role of and the interaction between state, for-profits and non-profits as providers of these services. Care in the private home of the user often implies that most (or all) of the care needed is in fact provided by family members. In the EU, an estimated 12–18% of the adult population provide informal care on a weekly basis. The majority are women, and it is mostly women who reduce working time or even stop working when caring, thus losing pension entitlements because of informal care-giving (European Commission, 2021c). In the past three decades there has been a slowly growing focus on family carers, as (co-)producers of long-term care and as co-clients of professional social services. Policies addressing family (or, more broadly, informal carers) include measures supporting them in their caring role (e.g., via training and consulting or care leave programmes), recognising their role as carers (e.g., via cash benefits, social insurance coverage or even models of formal employment of family members) or relieving them of their care-giving role (e.g., by providing access to social services) (Schneider et al., 2016). The development of professional long-term care services is characterised by an emphasis on community-based provisions, a re-orientation of the nursing home sector focusing on those with more severe care needs, but at the same time efforts to develop these institutions into a more home-like setting that emphasises quality-of-life and not just a medicalised provision of care. The development of this professional sector is characterised by huge country (and even within-country) variation in the concrete welfare mix, and the changing role of public, private for-profit and non-profit organisations as providers of the respective services. Independent from the institutional structure, care worker staff shortages are a continuing challenge that became even more severe with the COVID-19 pandemic (Meeks and Degenholtz, 2021). Finally, in many countries around the global, from around the mid-1990s and as the result of a lack of professional services to meet the needs of users, long-term care increasingly has been provided by live-in or live-out migrant care workers who are employed by private households (Spencer et al., 2010). Several countries have seen attempts to regularise this sector and to integrate this particular type of care provision into the overall care regime (Di Rosa et al., 2018; Österle, 2018), but a large grey economy of care work with the associated vulnerabilities and risks of exploitation persists (ILO, 2021).

What kind of delivery arrangements are used is co-determined by several factors, including values and perceptions with regard to (non-)family care and care in the private home, the availability of family or other informal care resources vis-à-vis the alternatives, but also the question of funding these alternatives. Financing is relevant on the micro level of the individual care arrangement, but also on the macro level of funding long-term care provisions (Costa-Font and Courbage, 2012). On the micro level, the majority of long-term care work is provided informally and mostly unpaid by family members or other informal networks. If these resources are not available or not sufficient, paid arrangements come into play. These could be publicly (co-)funded offers, but also private arrangements, found either in a regular long-term care market, but also in grey economies of care work, the latter often involving migrant care workers. Means-testing and co-payment arrangements for publicly funded long-term care provisions are an important indicator of the scope of public responsibility in long-term care and a measure taken to contain public long-term care spending (Gori and Luppi, 2022). Not least, major financial contributions from service recipients at the point of use, is another major distinction between health care and long-term care, and more specifically between the health and the social component of long-term care.

From a macro perspective, financing usually distinguishes between public funding (via taxes or social insurance contributions) and private funding (via mandatory or voluntary private insurance, out-of-pocket funding and most importantly in long-term care the use of time to provide care informally). Establishing comprehensive long-term care systems requires a decision about the funding regime (Roland et al., 2021). In a global perspective, only some of the countries with a social insurance tradition, have also taken up this orientation in organising public funding of long-term care (e.g., Germany, Luxembourg, Japan and South Korea) (ILO 2023). Social insurance principles are also applied to ongoing long-term care pilots in China, which are closely linked to existing health insurance systems (Zhu and Österle, 2018). In the majority of countries, public long-term care funding is either tax funded or a mix of social insurance and tax-funded arrangements (ILO, 2023). In countries without distinctive long-term care policies, public long-term care expenditure tends to be very low and hidden in several other welfare sectors, most notably health care, disability policies or policies addressing the poor.

The third major dimension of long-term care systems is governance and regulation. The past three decades have seen a clear trend establishing long-term care as a distinctive social policy field, either covering the entire population or specifically addressing the older population. This trend is also supported by calls for establishing a social right to long-term care (e.g., European Commission, 2023; McKinnon, 2022). Respective developments have led to an extension of public responsibilities in long-term care, above all in regulation and in funding, less and more varied in the concrete provision of services. Typically, public roles in long-term care are decentralised, whereby local and regional actors have a stronger role in governing service provision, while major care-related cash benefits and broader coordination are central responsibility (Costa-Font and Greer, 2013). Historically, public and non-profit providers have dominated the provision of long-term services. However, since the late 20th century, several countries have incentivised a growing role of for-profit providers and of large international provider chains, a trend commonly described as the marketisation of long-term care (Brennan et al., 2012; Harrington et al., 2017). Respective changes started early in the US and intensified with the introduction of Medicaid in the mid-1960s. In the UK, since the 1980s, several policy changes in the NHS and in social care policies, together with financial pressure, led to the growth of the for-profit sector. Even in Sweden, historically the stronghold of public provision, a considerable share of nursing home provision, starting in the 1990s, is now publicly funded, with private for-profit provision (Armstrong and Armstrong, 2021). These developments are driven by several factors: a traditional market orientation in the US, major legislative changes such as devolving responsibilities to local authorities or the purchaser and provider split, regulatory incentives for this type of provision, the closing down of long-stay hospitals together with ideas of new public management and the choice agenda (Brennan et al., 2012; Harrington et al., 2017).

A distinctive governance feature is the relationship between health and long-term care systems, and the boundaries that are defined more rigidly or are kept rather vague, allowing very different practices on meso and micro levels of care provision. Respective policies are key for the quality of the integration of health and social care services (Hixon, 2016) and include questions and tensions about the place of provision of health and nursing services for those in need of long-term care, the quest for intensifying prevention and rehabilitation in the context of long-term care, the allocation of specific tasks nurses and other care workers are allowed to perform, or questions about, and implications of, generous and universal public funding for health-related, but often very moderate and means-tested, public funding for social care provisions.

Another bundle of regulatory questions is linked to the definition of long-term care needs, eligibility for different support systems, and the quality of provisions. The identification and measurement of needs can be based on the limitations in performing (instrumental) activities of daily living, on measuring time and/or qualification of the support that is required, or it could be linked more specifically to certain outcomes. A major challenge in this endeavour is to link the technical quality of care that dominates the practice of quality assurance with a broader quality of life understanding, including concerns such as meaningful activity, relationships, dignity, autonomy, etc. (Kane, 2001). Beyond the general aim of ensuring high-quality care, several factors have intensified debates about adequate instruments to assess and control the quality of long-term care services: potential trade-offs between social and fiscal sustainability, the importance of local governance and provision in long-term care and related risks of spatial variations in levels of quality, and the growing role of marketisation and private for-profit actors in long-term care which is seen both as a risk and as a potential for quality in long-term care (OECD, 2013). The Care Quality Commission in the UK is a major example for a national quality assurance, in which quality concerns in health care and in social care are brought together under one umbrella (Smithson et al., 2018).

Defining social policies requires the definition of certain thresholds in (long-term care) needs, but also the type of support that is provided and potentially other criteria that are taken into account for the provision and funding of support measures. Different from health care, but similar to childcare, there is a broad range of options between cash benefits bound or not bound to a specific use, in-kind services, measures supporting informal carers and measures in the tax system, but also the choices users can make in these options. On the funding side, long-term care systems apply co-payment regulations, means- and asset-testing, the consideration of informal care resources and the definition of family obligations in long-term care. The mix of these provisions and funding arrangements is a reflection of cultural values and social policy traditions, of influences in long-lasting policy processes and also a starting point for the aforementioned efforts to identify long-term care regimes.

IDEAS, INSTITUTIONS AND INTERESTS

The previous two sections have shown huge variation in the development of long-term care policies and the features of these systems. This section will use the 3Is framework – ideas, institutions, interests (see e.g., Shearer et al., 2016) – to briefly explore factors that shape past, current and future developments in long-term care.

First, three important sets of ideas will be explored: the idea of social rights vs individual and family responsibilities, the quest for autonomy and independent living, and the concept of sustainability. Long-term care was, and still is, widely understood as a family responsibility. In the 20th century, ideas of social rights and social citizenship strongly shaped the growing role of the welfare state in providing social protection. Almost throughout that period, long-term care was left out of these considerations. Prevailing ideas and beliefs about the role of the family in (long-term) care shape expectations and realities around care giving, and the ways in which public policies address the sphere (Knight et al., 2022; Saraceno, 2016). The focus in the academic discourse has changed over time, and varied between countries (Anttonen and Zechner, 2011; Daly, 2002). Overall, traditional familialistic orientations in long-term care policies remain strong, but have been increasingly questioned and challenged since the end of the 20th century. Contesting traditional family arrangements, emphasising gender equality (Rummery, 2021), and the weakening of the male breadwinner orientation in the context of demographic and economic challenges have intensified the need and the quest for expanding social rights in long-term care.

A more comprehensive debate about long-term care, how to address it as a social policy field and how to define and design a public responsibility has emerged and broadened only since the 1990s. While many countries started to implement new and more extensive approaches to public long-term care policies, the link to the idea of family responsibilities in long-term care remained strong, for ideational, ideological and economic reasons. In the 2020s, not least with a view to further sharpening demographic challenges, the definition of individual (in the case of long-term care explicitly, or implicitly extended to the family) vs. public responsibilities remains a key feature of long-term care policies, while the idea of a social right to long-term care receives growing recognition on a global scale (McKinnon, 2022).

A second major set of ideas that shapes long-term care policies is about the quest for autonomy and independent living. The disability movement became a forerunner in fighting for independent living, empowerment, autonomy and social inclusion. However, the agenda mainly referred to younger disabled people, and not the older population. As with care in family policy, age remained an important dividing line. In long-term care, discourses tend to be more deficit-oriented, they focus on organising the necessary care and support for the older population and often focus on care workers and less on care users. This has partly changed with the emerging long-term care reform agendas from the 1990s (Boyle, 2008; Morrison-Dayan, 2023). In several countries, disability groups and ideas from disability movements impacted policy developments. As a consequence, many countries also abolished or weakened age-related distinctions in long-term care provisions.

Thirdly, the idea of sustainability shapes long-term care policies, mostly in its financial (and more recently also in its social) dimensions. Long-term care emerged more prominently on the social policy agenda when welfare state debates became increasingly driven by fiscal sustainability concerns. Information on the demographic challenge of escalating numbers of dependent older people and expected growing limitations to informal long-term care giving – due to demographic developments, family constellations and growing female labour force participation – became a driver for public long-term care policy debates (e.g., European Commission, 2021). It was used as an argument for an extension of public responsibilities, but at the same time as an argument to limit or to even cut back public spending. More recently, growing consideration is also given to the social dimension of sustainability, emphasising the intertwined wellbeing of care receivers and care givers (Keating et al., 2021).

Besides ideas, institutions strongly co-determine the contours of policy processes and newly emerging policy solutions. Almost throughout the 20th century, long-term care was not existent as a distinctive public policy, policy provisions were widely scattered between the health sector, old age provisions, disability policies, and social assistance, sectors that themselves are characterised by very different logics in terms of provision, funding and governance. In a comparative perspective, none of these sectors and logics became a predominant recipe in the development of long-term care policies. Health care is one important example. Health care and long-term care are intertwined in many ways, but follow different ideas and logics in terms of the aims, the role of the individual and family, funding arrangements and not least the scope of societal responsibilities. Not least, long-term care is characterised by a strong role of local and regional actors, as a result of historical developments but also as recognition of potentially diverse social settings and requirements (Costa-Font and Greer, 2013; Tuohy, 2021).

With the emergence of long-term care as a distinctive policy field and the establishment of social rights, social policies extended the role of the national level. At the same time, international organisations started to address long-term care: exploring challenges and future directions (e.g., OECD, 2011, 2020a), emphasising global issues and in particular the situation in the developing world (e.g. WHO, 2017a, 2023), addressing the (lacking) social rights of care workers and advancing the quest for establishing long-term care as a social right (e.g., European Commission, 2023; ILO, 2023; Tessier et al., 2022).

Along with these governmental institutions, providers of long-term care impact policy developments both in their provider role and in their agency role. In several countries, nonprofit organisations have been the main providers of non-family care and they have had a strong agency role in the development of more comprehensive social policies in this area. For-profit market actors in long-term care have a prominent history in some countries (most notably in the US). Following ideas of new public management, marketisation and privatisation in health and long-term care provision has also opened up opportunities in countries that originally limited their market access (Armstrong and Armstrong, 2021; Brennan et al., 2012).

In addition to (and closely connected with) ideas and institutions, interests – preferences, behaviour and the power of policy actors – are shaping policy solutions that are put forward and potentially implemented. The heterogeneity of care needs and the diverse options to address the needs is also taken up by the aforementioned actors to push their specific interests and preferences, e.g., in terms of public vs. private market roles in providing and funding long-term care. Providing cash for care rather than services is one example that the same policy potentially connects to rather diverse interests (Da Roit et al., 2016). Cash programmes have been pushed as a measure emphasising choice and autonomy. But cash programmes are also closely linked to a market logic, giving the power to choose and to buy to the receiver of the benefit, and to a lesser extent, to an expert in the health or long-term care field. Following again another logic, cash for care can also work as a means to support family care or informal care, either as a payment to the informal care giver, or as payment to the user of care, explicitly or implicitly as a financial recognition for the informal care that is provided.

CHALLENGES AND PERSPECTIVES

Across the world, the COVID-19 crisis has helped sharpen an awareness for long-term care and the vulnerabilities of those in need of care as well as those providing care. After the acute crisis, this awareness has seemed to dwindle away, but the challenges have not. In fact, with demographic ageing, challenges in terms of needs and the coverage of these needs will further intensify. Three questions can summarise these challenges, namely who needs care, who provides care and how is care organised and funded?

In terms of the 'who needs care' question, two factors – demography and health – are important. The proportion of the population aged 65+ will increase across all regions worldwide. According to the UN's population forecasts, the percentage of the population aged 65 and over will increase globally from 9.7% in 2022 to 16.4% in 2050, from 18.7% to almost 27% in Europe and North America, and from 12.7% to 25.7% in Eastern and South-Eastern Asia (UN, 2021). Relative increases are even more significant for those aged 80 and over. These developments will lead to a strong further increase in the need for long-term care. The actual extent, however, will be co-determined by the health status of the population. An emphasis on healthy ageing and prevention can have a strong moderating effect on future health care needs but also long-term care needs (see, e.g., European Commission, 2021a). Another approach that can help reduce the impact of ageing populations on future long-term care needs is rehabilitation, which only recently has received some more attention in long-term care under the term 'reablement' (Rostgaard et al., 2023). All these activities should not only consider the older population but also children and younger adults, populations that are often hidden in long-term care debates, as well as specific care needs. Dementia is the most prominent example, and an example that has received growing recognition on national levels and internationally (WHO, 2017b). In 2017, in the OECD, about 17 million people were affected. Between now and 2050, this group is expected to grow to 41 million only in that region (OECD, 2018).

Growing long-term care needs lead to the second question, namely 'who provides care?' As shown throughout this chapter, family members, above all women, are the main providers of care. This role, however, is challenged in several ways. Demographic developments, fewer children per family, members of families living further apart, economic pressure to work full-time and for longer periods into old age for a living, but also requirements built in social security programmes (as in pension systems) can limit the opportunities to provide informal, unpaid care within families. In addition, ideas, beliefs and regulations about responsibilities between children and their parents, or broader family networks, impact on the level of informal care support. Altogether, this has led to a growing use of formal and paid care work arrangements, both in the context of newly established welfare programmes but also as a market development. In reality, the formal long-term care sector is characterised by huge care worker shortages (OECD, 2020a). This is also due to low pay and often precarious work arrangements. In countries around the globe, the employment of migrant care workers in private households – often as a grey economy of care work – has become an important response to care work shortages and a response to professional services that are either not available or not affordable. While some countries have made attempts to regularise this sector (with mixed success), live-in care workers, as domestic workers more generally, in many countries do not have access to social protection and might be deprived of very basic rights, putting them at huge risk of exploitation and violence (ILO, 2021).

In a situation where already existing care work shortages are faced with further growing care needs, the 'how is care organised and delivered' question (see above) becomes even more pressing: searching for the right mixes of family care, publicly (co-funded) long-term care provisions and the regulation of private market arrangements, new delivery arrangements that acknowledge person-centred quality-of-life orientation, arrangements that address inequalities in long-term care (Kröger, 2022), the use of new technologies (Lukkien et al., 2021), or funding and delivery arrangements that consider fiscal but also social sustainability concerns (Keating et al., 2021; OECD, 2011).

CONCLUSION

Ageing populations, growing long-term care needs, pressure on traditional arrangements of care provision and care work shortages make long-term care a major health and social policy concern of the first half of the 21st century. The challenges are shared around the globe. However, historical trajectories, ideas, institutions and interests lead to quite distinctive outcomes in the development, in terms of the organisation and governance of long-term care systems, in terms of its links with the health care system, and in terms of the level of public vs. private responsibility in long-term care.

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13. The path of the COVID-19 pandemic and the policy responses to it in ten countries

Ian Greener

INTRODUCTION

The COVID-19 pandemic represents the most significant global public health challenge in 100 years in that it has reached every country, with (at the time of writing in late March 2022) at least six million deaths being directly attributed to it, and a far greater number by other measures such as those from 'excess mortality'. The pandemic represents a crisis for governments in which many have taken extraordinary measures – with some countries closing – at times of most concern over the virus, nearly all non-essential business activities in their economies and requiring people to stay at home except for a limited range of purposes. Two years on from the initial identification of the virus, we have seen several mutations of it, requiring governments to renew their efforts as new 'waves' appear. At the same time, even within existing waves, there have been very different policy responses, and considering which appear to have been most effective is both useful learning in terms of assessing responses to COVID, but also insightful in a broader sense in answering whether some governments have been able to adapt their responses as they have learned more about the virus.

This chapter attempts to identify the path of the pandemic graphically, by considering publicly-available data in terms of case numbers and deaths, looking at the rise and fall of the numbers and attempting to understand the drivers for the changes in cases. It suggests that a key difference in the trajectories of the countries has been due to a range of policy factors, including vaccination rates, the extent of border controls, the 'stringency' with which different countries imposed restrictions on their countries, and the levels of societal and governmental trust present in countries. These are clearly not the only factors which led to differences in COVID-19 case numbers and mortality (Islam et al., 2021; Singh et al., 2021), but they do have considerable explanatory power in showing the differences between the path of the pandemic in different countries, and so represent a useful 'first cut' at understanding different policy responses.

As well as identifying key factors, we also need a range of countries to consider. The ten countries included in the chapter are an attempt to find a trade-off in terms of, on the one hand, having strong health infrastructures which could have been deployed to the challenge of the pandemic (and so, representing rich industrial nations), but on the other also having distinctive factors about their health systems and pandemic responses which led to significant variation within the case and mortality numbers. The first countries included in the chapter are Australia and New Zealand, included because of the distinctive approach taken to the pandemic in terms of the very strong border controls that they imposed. The United States is included because of its extremely high case numbers and mortality rates in order to understand how the world's most expensive health system could have (in terms of the pandemic) gone so badly wrong. To offer a comparison with the United States geographically, Canada is also included, especially as cross-national studies of healthcare often include both nations, giving the paper a range of studies to draw from. The next two countries chosen were the United Kingdom and Sweden. The UK, despite having run numerous pandemic preparedness exercises (Dyer, 2021), appeared to struggle in terms of its response, but was a leader in terms of initial vaccine take-up, and its inclusion gives the opportunity to explore how these factors compared to those from other countries. Sweden represents a fascinating case study because of its policy response being based significantly upon emphasising individual responsibility rather that the more formal measures taken in many other countries. The next two countries included are Japan and Belgium. Japan's response to the pandemic has something in common with Australia and New Zealand because of the strong border controls it imposed, but in many ways represents a more extreme case because it was constitutionally barred from imposing the 'lockdown' situation present in other countries. At the same time, however, Japan hosted a major sporting event during the pandemic. Belgium was included because of the very low trust levels in government present at the beginning of the pandemic, and, in common with the UK, what looked like a very poor initial response. The final two countries included are Germany and Italy. Germany is included because of the strong testing infrastructure that was present in the early stages of the pandemic and the very high levels of governmental trust present there. Italy is included as one of the first countries (outside of China) significantly affected by the pandemic to consider whether being so adversely affected early on has had longer-term consequences in subsequent waves of the virus.

The chapter will take primarily a graphical approach. The reason for this is to try and look across the different countries to identify patterns in the different factors in a dynamic way. It would certainly be possible to apply advanced quantitative techniques such as time-series analyses to this task, but that strategy comes with substantial risks in limiting understanding of the results as the barriers to entry for understanding the data will be high. It is certainly true that some formidably complex analyses of COVID-19 comparative data already exist (Hale et al., 2021; Wang et al., 2021). However, exploring the data graphically comes with the advantage of being more accessible to a wider range of readers, as well as avoiding the dangers of being over-precise with data that may be subject to significant levels of error. In other words, we simply do not know for sure how many COVID-19 cases for how many deaths have occurred, and have to do our best to understand what has happened with imperfect measures. If there is a gold standard measure of the number of deaths, it is based on the 'excess mortality' measure (Wang et al., 2022), but even this approach is based on the modelling of data that can lead to odd outcomes such as negative excess mortality in a year after there have been a large number of deaths, even though the total number of people dying in total is higher than in other countries. Applying exact quantitative techniques to imperfect data risks giving a sense of precision which simply is not present.

It is also possible to take cross-sections of the data at particular moments, and apply comparative analysis to it. This represents a more promising strategy, and has been done in relation to the first six months of the pandemic to capture the initial governmental responses (Greener, 2021a). However, now we have two years of data, it is useful to try and explore how the pandemic developed beyond that point, and additional cross-sectional points are harder to identify as the 'waves' of the virus have arrived at different times in the countries in the sample here. Without making some assumptions that may over-reach the limits of the imprecise data, applying quantitative analysis, even in a more case-driven way that advocates of Qualitative Comparative Analysis (Ragin, 2014) would suggest, appears to be difficult to argue for.

The data presented in the chapter is all available from publicly available sources, and will be systematically compared to attempt to explain the reasons why the key measures appear to diverge for different countries, and what we can attempt to learn from that. Of course, different interpretations are also possible, but by having debates around the path of the pandemic and the different policy responses to it, the aim is to add to our understanding of the last two years (and beyond), and hopefully to learn some lessons from that process.

AN INITIAL MAPPING OF THE DATA – COVID-19 CASES AND COVID-19 DEATHS

There are a range of possible ways we might attempt to measure the pandemic. Of these, COVID-19 cases are important because the virus, even for people who may not become seriously ill with it, appears to potentially hold long-term health consequences for a significant number of those who have fallen ill ('long COVID'), and this will clearly be a key public health concern going forward. COVID-19 deaths are also a crucial measure – governments have a responsibility to try and minimise harm to their citizens, and so COVID-19 deaths (in the context of other possible harms) are a key measure of that. The two most commonly-used measures of COVID-19 deaths are the officially reported figures, which may both over-estimate deaths (people can die *with* COVID-19 as well as *from* COVID-19), but also under-estimate them (if COVID-19 is not tested for, is not detected or is not reported as a cause of death). As noted above, the problems with estimating COVID-19 deaths have led to calculations that attempt to capture 'excess mortality' – or the number of deaths countries have experienced during the pandemic compared to those which we might have expected (derived from epidemiological or econometric models). We will look at both. This gives us three initial measures to compare countries in terms of – case numbers, reported deaths, and excess mortality. Comparing the ten countries in the sample across these measures leads to the following graphs.

Setting the Context

A first step is to look at the data for COVID-19 in terms of cases and deaths. This gives us a sense of the story of the pandemic before we consider the policy responses to it. The next section looks at reported COVID-19 cases and deaths, and one estimate of excess mortality.

COVID-19 Cases

We can plot the number of recorded cases, with all the caveats about data quality outlined above, in Figure 13.1 below.

The chart here is plotted logarithmically (on the Y axis, case numbers) as this allows us to look across the different country data and spot trends more easily. Some preliminary patterns do seem present.

First, all the countries clearly have an initial 'spike' of cases in March 2020, but with an initial separation between Australia, New Zealand and Japan with the fewest cases, and the other seven countries with higher numbers (especially taking the logarithmic scale into account). After then, Australia and New Zealand remain significantly below other countries

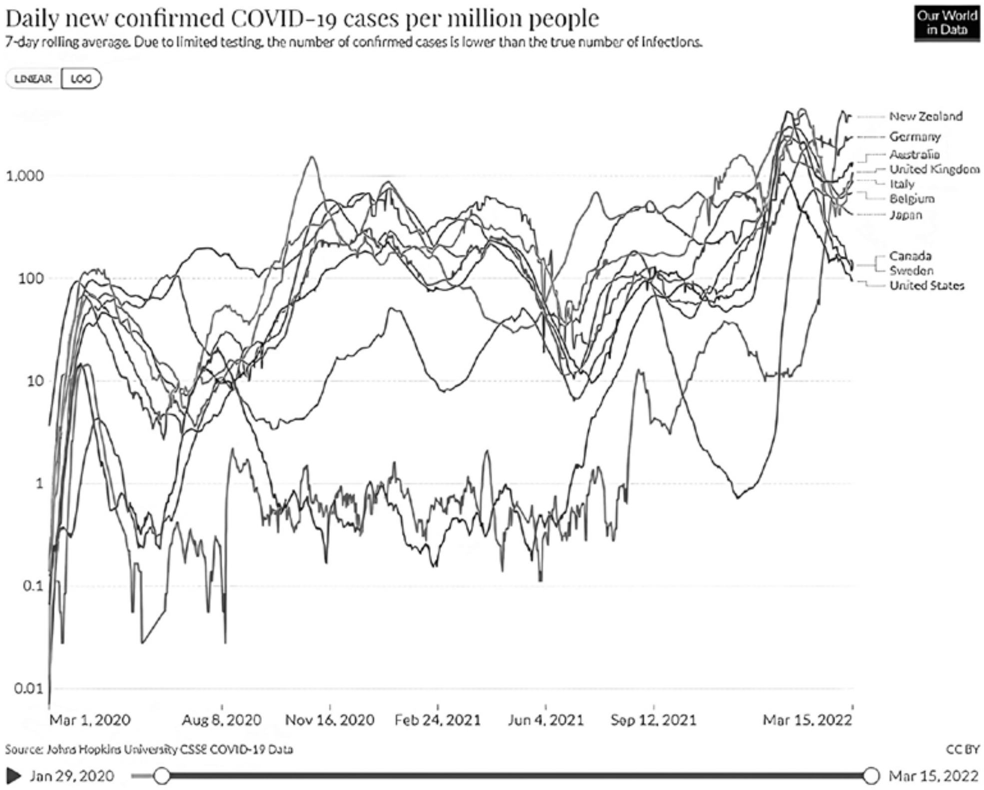


Figure 13.1 *Daily confirmed COVID-19 cases per million people, January 2020 – March 2022*

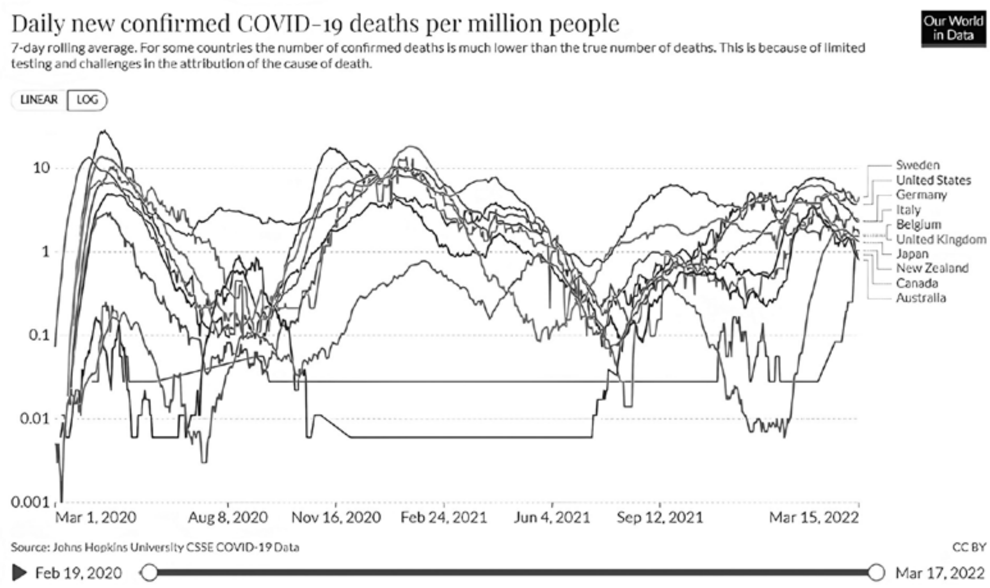
right through to 2022, and with Japan either below or at the bottom end of the rest of the countries in the sample in almost every period. These three countries, in terms of case numbers, appear to have had the fewest.

In more general terms, cases amongst the countries in the sample seem to have initial peaks in March 2020, then another in winter 2020 which proved difficult to recover from, before case numbers fell in June and July 2021, before steadily rising again to another peak in February and March 2022.

The United States appears to have most consistently had the highest number of cases, but ends with the lowest of all nations in March 2022. The United Kingdom performed poorly initially before seeing a sharp fall in cases, then another sharp rise in the winter of 2020. Case numbers then fell back in summer 2021 before being at consistently high levels since. The UK, Italy and Sweden appear to be a candidates for the highest levels of variability in case numbers, especially, again, taking the logarithmic scale into account. Other countries in the top cluster appear to follow the pattern outlined in the paragraph above, but with less variability than the UK. Belgium appears to have had consistently higher numbers of cases (compared to other nations in the cluster) and Germany and Canada had lower numbers.

As the pandemic has developed, new variants of the virus have been identified. The World Health Organisation (https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/) lists a bewildering array. However, it makes sense to consider the introduction of new variants as preceding the rises in case numbers outlined above, with the 'Beta' variant in September 2020 and the Omicron variant of November 2021 being especially important.

If we move now to COVID-19 deaths, the reported figures are in Figure 13.2 as follows:



Source: Johns Hopkins University, CSSE COVID-19 Data

Figure 13.2 Daily confirmed COVID-19 deaths per million people February 2020 – March 2022

COVID-19 Deaths

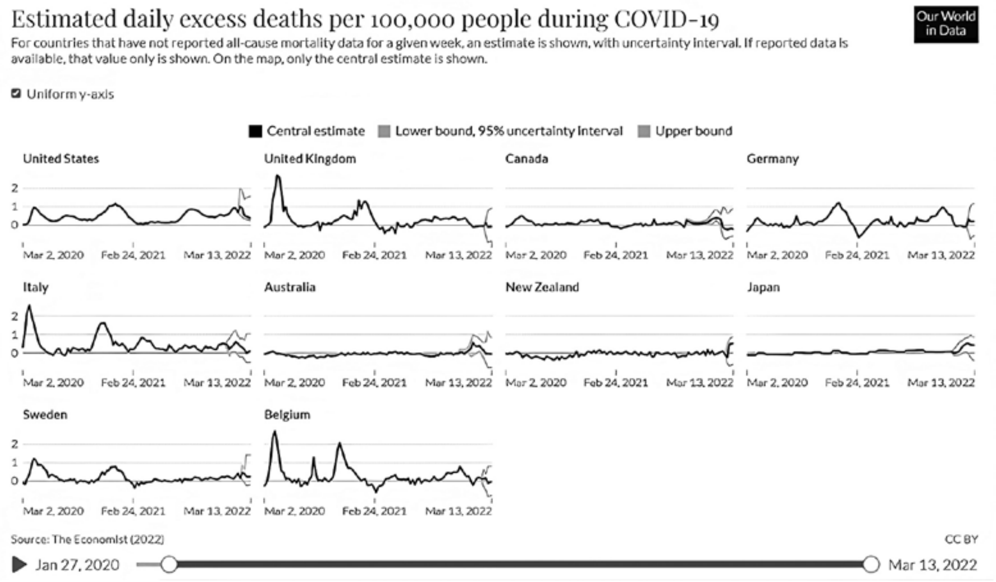
In general terms, we can see, in common with the cases graph, an initial spike in deaths (again plotted logarithmically) in March 2020, followed by a drop (in most countries except the United States) as we move to and through the summer of 2020, followed by a sharp rise that remained in place until March or April (again with some exceptions) before a significant fall until around August 2021, when rises appear again and remain largely in place until March 2022.

There are two countries with the fewest deaths at the lower end of the graph – Australia and New Zealand – so as well as having fewer cases, they had fewer mortalities. Here, they are often joined by Japan. The United States has consistently higher numbers of deaths in the top cluster of countries, with Canada and Germany consistently appearing at the lower end of deaths in the countries, and Italy and Belgium at the higher end. The United Kingdom and

Sweden show considerable variability moving from being amongst the higher numbers of deaths to the lowest numbers in other periods.

Excess Mortality

Excess mortality requires a statistical model of some kind to calculate, and with the calculations growing more complex over time, especially in high mortality countries, as they have to take into account mortality figures from previous periods of the pandemic. This often results in the generation of a range of models which require careful interpretation (Wang et al., 2022). The most widely reported excess mortality numbers come from the *Economist*,[1] and are reported on OurWorldInData with the following pattern shown in Figure 13.3.



Source: *The Economist*, 2022

Figure 13.3 *Estimated daily excess deaths per 100,000 people during COVID-19 January 2019 – March 2022*

These figures require some interpretation in that they are the central estimates of a range of models, and run either above (for most countries) or below the expected central line. Australia, New Zealand and Japan show, by this measure, the lowest levels of excess mortality, closely followed by Canada. Germany appears to do well in the first year of the pandemic before having a sharp rise in late 2020, and a smaller rise in 2022. The United Kingdom appears to have two peaks of excess mortality at the beginning of the pandemic and in winter 2020, whereas Italy and Belgium have those peaks but also several others as well. The United States is consistently above the excess mortality line for nearly all periods.

There appears to be some consistency then across these three measures in terms of the strongest performers (Australia, New Zealand and Japan, but with Canada also having a strong case), as well as for the worst, with the United States (consistent high cases and deaths as well as excess mortality), the United Kingdom (with very high peaks, but also periods when it is high performing), Belgium (with high peaks especially before March 2021 but generally better performance after then) and Italy (consistently high cases, mortality and excess mortality) falling into that group. Germany's initially strong performance has not been as strong after the first year of the pandemic. Sweden appears to have had two peaks in the first year, but has done consistently better since then.

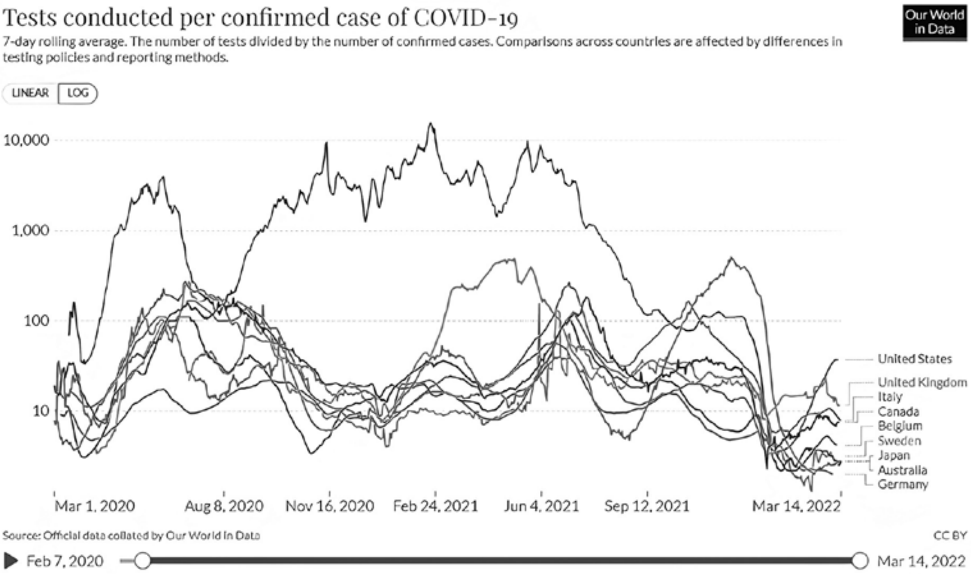
POLICY RESPONSES

There are three initial measures of policy response we can consider. First, we can look at testing regimes. Throughout the pandemic, but especially in the first year, testing was regarded as perhaps the most important thing that could be done by government to try and protect its people. More than this, testing gives us an index of how well the virus was being contained when we explore the ratio of tests to cases – a high ratio here suggests a country which is able to deal with the number of cases present in its borders and effectively deal with them (Greener, 2021). A low ratio suggests a country struggling to put in place sufficient testing capacity to successfully deal with its COVID-19 cases – and also a substantial risk that cases may be being underestimated because of the lack of testing capacity. Second, we can explore vaccination rates – but these clearly do not affect the first year of the pandemic. We would suspect that, the more successful a country has been in ensuring high take-up of the vaccine, the better it might do in terms of subsequent performance in terms of cases (with evidence suggesting vaccines reduce transmission) as well as deaths, but also in terms of dealing with excess mortality from other conditions – as the capacity of hospitals to go back to nearer normal is gradually restored. Third, we can look at 'stringency' indexes which look at the range of measures governments have put in place in response to the pandemic. These can give us clues as to whether governments responded to rising case numbers or attempted to anticipate them. Finally, there are border controls, which are a part of stringency, but also play a key separate role in pandemic response which is based on limiting the movement of infected people. Three countries especially put a strong emphasis on such controls in 2020 and 2021 in ways that others within the sample did not.

Tests Per Case

In the early phases of the pandemic, the number of tests being carried out and positive rates were often reported as in index of the prevalence of the virus. The number of tests, along with the 'R' number, become prominently reported. We do not report the 'R' rate here as, although the measure has been an important one, it does not tell us much about the ability of a country as a whole to deal with the virus. An 'R' rate of two matters far less if there are only a handful of cases present than if the virus is already widespread – it is a highly contextual factor.

Instead, by considering tests per case we can get a sense of how quickly the testing infrastructure for the virus was put in place, and how well it was able to deal with rises in case, identifying 'pinch points' at which the infrastructure was struggling, and periods when it appeared more successful. The tests per case graph appears in Figure 13.4 below:



Source: Our World in Data.

Figure 13.4 Tests per confirmed case of COVID-19 March 2020 – March 2022

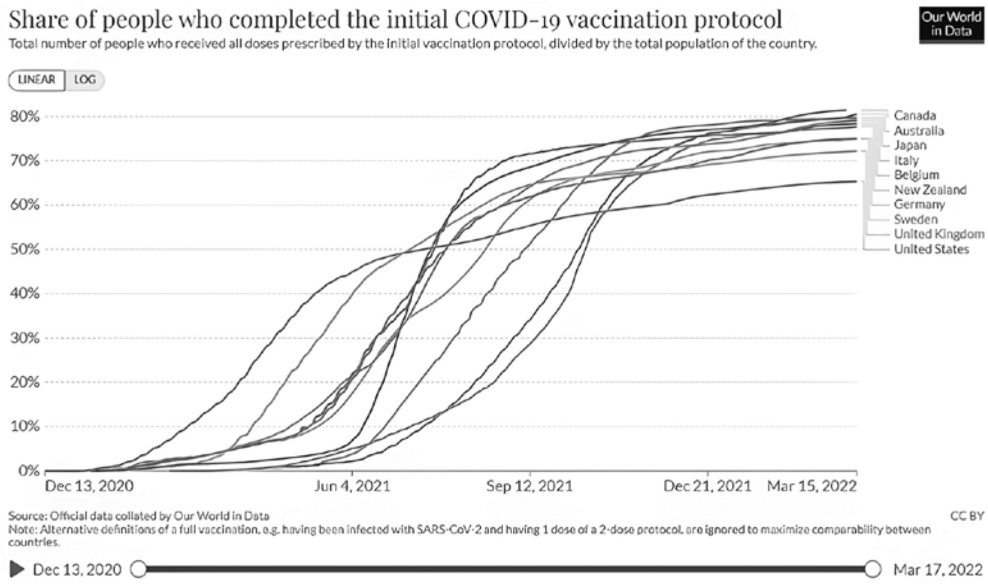
For tests per case, a log graph of the ratio of tests per case is used, otherwise Australia (the data for which goes off the top off the graph, hence the flat line there) compresses the rest of the data to an extent which makes it unreadable.

The tests per case chart suggests an initial introduction of testing infrastructure in March 2020 which initially struggles across most nations (except Australia) to deal with the rising numbers of the pandemic. There is generally a steady rise in testing infrastructure (except in the United States where progress is much slower) through the middle months of 2020, peaking in August, when the ratio begins to fall in most countries to a trough in December 2020 and January of 2021 (except in the United Kingdom, where there is a steep rise in January and February 2021). The tests per case then rises again in the middle months of 2021 (except in the UK where it falls back to comparatively middle performance) with another decline at the end of 2021. In 2022, numbers recover a little but still to a low level. Australia also goes through a considerable fall in its test per case ratio in 2022, eventually moving to second-worst performance. There is no data for New Zealand, sadly, for its test per case ration, but we can sensibly suggest it might follow the pattern of Australia given it has a similar pattern in case numbers.

What is striking about the tests per case graph is the extent to which COVID-19 appears to be working to a cycle for most countries where cases fall off in the middle months of the year, before rising at the end of the year through to the beginning of the next one. This could be due to the winter/summer cycle which would fit several of the countries in the cycle (except for Australia and New Zealand), with a great ability for outdoor living in the summer reducing the ability of the virus to spread in indoor confined areas (Greener, 2021b).

Vaccine Take-up

We can examine take-up of the COVID-19 vaccine by plotting the percentage of people who have received all required doses from December 2020 onwards. This produces Figure 13.5.



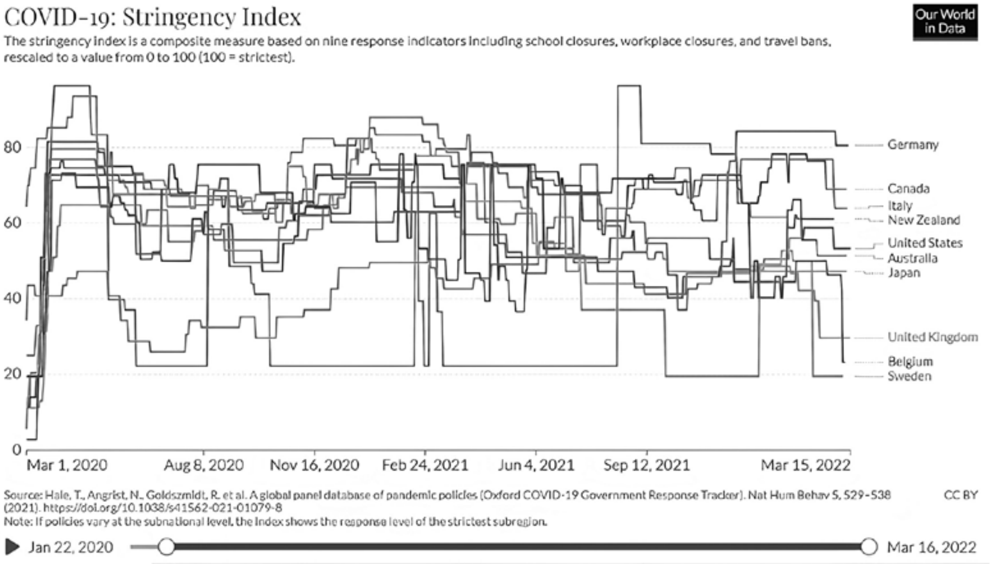
Note: Alternative definitions of a full vaccination, e.g. having been infected with SARS-CoV-2 and having one dose of a two-dose protocol, are ignored to maximise comparability between countries.
Source: Official data collated by Our World in Data.

Figure 13.5 Share of people who completed the initial COVID-19 vaccination protocol

The chart shows initially very strong take up in the United States up to June 2021, followed by a plateauing at around 65% in March 2022 at which point it has the lowest levels of the sample. With almost the opposite pattern, Canada does not start with a vaccination programme until June 2021, at which point there is a rapid rise to it having the highest levels at the end of the period. The United Kingdom and Sweden have a pattern lagging slightly behind the United States, with the second highest take up in the first half of 2021 but then a much slower rate of growth once around 50% of the population was reached, until they fall to having the second and third lowest overall levels of the sample. Germany do only slightly better, starting strongly by then falling back as the pandemic develops. Australia and New Zealand have similar patterns to one another, but with Australia having a higher end point. Japan also performs strongly.

Stringency

It is difficult to encapsulate the range of measures different governments have put in place to try and deal with the pandemic. One way of attempting to capture response though comes through measures of ‘stringency’, which measure a range of different factors from school closures through to workplace closures and travel bans. The Oxford measure (included here) ranges between 0 and 100, and shows the pattern shown in Figure 13.6.



Note: If policies vary at the subnational level, the index shows the response level of the strictest subregion.
Source: Hale, T., Angrist, N., Goldszmidt, R. et al. A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker). Nat. Hum. Behav. 5, 529–538 (2021).

Figure 13.6 COVID-19 stringency index

The charts here show a significant rise in stringency (as we would expect) in nearly all countries at the start of the pandemic. However, we can clearly see some low stringency outliers with New Zealand having the least stringent measures for most of the pandemic, and for the first year, Japan following a similar pattern. Sweden, after fewer initial measures were put in place, kept a more consistent pattern of stringency up to May 2021 where it moved to being the least stringent of the countries here for most of the rest of period covered. Of the rest of the countries, Belgium has consistently had the least stringent policies, with the United States following a similar pattern up until very recently, and Canada has most consistently the most stringent. The United Kingdom has shown considerable variability, being amongst the most stringent up to February 2021, and after then falling to amongst the least stringent. Australia has shown considerable variability but much of this may be at state rather than national level as pockets of cases appeared.

The stringency graphs also indicate a considerable amount of countries moving in step with one another, although not always from the same initial levels. Within that ‘within-step’ movement however, some countries appear to move earlier than others, and some later. It is unsurprising that Italy was an ‘early-mover’ in the first wave as it was first affected. Italy also appears to be an early mover in both increasing and decreasing stringency in waves after then.

Canada, as noted above, has consistently high stringency throughout the pandemic, perhaps creating a more consistent approach and avoiding some of the very high peaks in stringency seen in countries such as the United Kingdom.

There are also countries which have moved increasingly out of step with others. Despite its high case numbers and mortality, the United States has seen a slow fall in stringency across the two years after restrictions were initially imposed, perhaps suggesting the differences in views States were taking to the pandemic and the fragile political situation. Sweden, too, appears out of step with other nations in reducing stringency after 2020 in a more obvious way than the United States. The United Kingdom's pattern appears mostly in step with other countries up to February 2021, after which it has reduced stringency and measures appear to have become decoupled from cases or deaths. Belgium's stringency was lower than most other countries in the first year of the pandemic, and then has fallen more or less in line with the UK's strategy since then.

Border controls are an important part of COVID-19 stringency. Although countries such as Germany put in place restrictions in the earlier part of the pandemic, relatively few countries in the sample have enforced such controls throughout the pandemic, with only New Zealand, Australia and Japan consistently and rigorously applying them. What these countries also have in common is a lack of land borders, giving them an additional advantage in terms of ensuring stronger levels of compliance.

OTHER CONTEXTUAL FACTORS

Finally, we can consider two more contextual factors: trust and confidence. Policy changes have to occur in the context of the countries they have to work within. Pandemics require quick, concerted action, and then for the public to comply with public health measures. This requires at least some degree of societal trust – both in the government, and trust in other people to follow the guidelines too.

Trust

Table 13.1 *Trust in government*

Country	Trust in government	Confidence in government	Trust in others
Australia	44.6	30.3	48.5
Belgium	29.5	-	-
Canada	60.0	46.1	46.7
Germany	65.4	44.2	39.5
Italy	37.5	23.8	26.6
Japan	42.3	39.9	33.7
New Zealand	62.9	50.0	56.6
Sweden	67.1	50.7	62.8
United Kingdom	34.7	29.3	40.2
United States	46.5	33.4	37.0

Source: OECD's 2020 'How's life' report.

The OECD's 2020 'How's life' report includes a measure of trust in government, and the 2020 World Values survey measures of trust in other people, and confidence in the government. All figures are measured in percentages (Table 13.1).

There are some startling differences here. Belgium, the UK and Italy have the lowest government trust levels, with Sweden, Germany, New Zealand and Canada the highest. There are no figures for Belgium for other measures. In terms of government confidence, the lowest levels are in Italy, the United Kingdom, Australia and the United States, with New Zealand, Sweden, Canada and Germany the highest. Trust in others is lowest in Italy (by some margin), the United States and Germany, with the highest results in Sweden and New Zealand – the only countries with scores above 50%.

Trust, stringency and vaccination work together in complex relationships. The question is whether we can see any patterns in the data which might help explain the relationships outlined above. Trust has to be considered a structural factor in this analysis as we do not have consistent dynamic measures across the countries through the pandemic. We can, however, attempt to map levels of trust against stringency, attempting to interpret the patterns presented above, as follows:

Table 13.2 *Trust and stringency*

Country	Trust in government	Confidence in government	Trust in others	Stringency
Australia	M	L	M	M (but variable by State)
Belgium	L	n/a	n/a	M (early) L (later)
Canada	H	M	M	H
Germany	H	M	L/M	M
Italy	L	L	L	H
Japan	M	M	L	L
New Zealand	H	H	H	L
Sweden	H	H	H	M (first half) L (second half)
United Kingdom	L	L	L/M	H (early) L (later)
United States	M	L	L	M (but variable by State)

Source: Author's own.

This data allows us to see how individual countries have fared, bringing together the measures to explore each country's experience of the pandemic and its policy response to it.

INDIVIDUAL COUNTRY CASES

Australia

Australia has medium levels of trust in government, low confidence in government, medium trust in other people, and has had medium stringency (but with variation state by state). It also has had, for the majority of the pandemic, lower numbers of cases, lower numbers of deaths and lower excess mortality. Australia has, for the majority of the pandemic, had the highest numbers of tests per case, due to its lower number of cases. Australia went from being very low in terms of vaccination rates, to the second highest by the end of the period under consideration. However, when combined with its closed borders policy, this combination appears to have been extremely effective in dealing with COVID-19 in 2020 and 2021. It now faces the challenge of ‘opening-up’ again, with tests-per-case numbers now very low, and the testing infrastructure under considerable pressure due to rising case numbers. Whether it needs even higher vaccination rates seems to be the key question, and whether, in an environment of relatively low trust, such a strategy is possible.

Belgium

Belgium has the lowest levels of governmental trust in the survey, and no measures of other forms of trust. Belgium performed poorly in the first year of the pandemic in terms of tests per case, showing only a small improvement in the second year. It has had medium levels of stringency earlier on, and lower levels later in the pandemic. It has had higher numbers of cases and higher levels of cases and deaths especially during the first 18 months of the pandemic. Belgium saw a rapid rise in vaccination rates in summer 2021, and has around 80% of the population fully vaccinated. However, how it now finds a way forward with low government trust remains a challenging issue.

Canada

Canada has higher levels of government trust, medium government confidence, medium trust in others and has pursued a high stringency approach. It has consistently been the best performing of the countries without strong border controls in terms of tests per case, case numbers, deaths and excess mortality. Canada has gone from being a vaccine laggard in June 2021 to having the highest rates in the sample. It appears to have been amongst the highest performers of countries which did not put in place hard border controls.

Germany

Germany has high levels of government trust, and medium levels of government confidence, it has low to medium levels of trust in other members of the public. Germany performed very well in the first six months of the pandemic in terms of tests per case, but then fell to near the bottom performance of the countries in the sample in the winter of 2020, before seeing another improvement (as case numbers fell), and, finally, ends the two years at the bottom again. Germany’s stringency levels have been in the middle range. Germany performed strongly in the first year of the pandemic, but has struggled especially with deaths since the winter of 2021, although case levels remained relatively low during that period. Germany went from being a vaccine leader to risking falling behind other nations with its take-up curve flattening out. Its vaccine levels and the apparent lack of scalability of its testing infrastructure, both appear to be causes of concern, especially in the light of Germany’s worsening performance after the first year.

Italy

Italy has low levels of all kinds of trust. Italy, after being the first country hit by the pandemic in the sample here, appears to have put in place a strong testing infrastructure which has scaled with its case numbers, and it is among the best performing on the tests per case measure after the early months of the pandemic (Waitzberg et al., 2021). A medium stringency approach has been taken, and with Italy performing, in terms of case numbers and deaths, in the middle of the sample for most of the pandemic, but consistently poorly in terms of excess mortality. Italy has high take-up of the vaccine and has had throughout the pandemic. This combination of factors suggests that high take-up of vaccine, alone, is not enough to be successful in terms of COVID-19 outcomes.

Japan

Japan has medium levels of trust in government, and low trust in other members of the public. Japan's testing infrastructure has shown variability with rising case numbers clearly causing problems in the last months of 2020, and in April 2021 before a significant improvement in the early months of 2022, followed by a fall to being amongst the worst performing of the countries on this metric. This suggests that Japan is struggling to achieve scalability in its testing as case numbers increase, even to comparatively modest levels (in relation to the rest of the sample). Japan has pursued a medium level stringency policy, but is constitutionally limited in terms of policies such as lockdowns. It has had amongst the lowest case and death levels (just behind New Zealand and Australia) and excess mortality rates are very low. Japan has had strong border controls through the pandemic, but hosted a major sporting event in July and August 2021 – a time when global cases were rising. Japan has gone from being a vaccine laggard in June 2021 to having one of the highest rates of protection.

New Zealand

New Zealand has high levels of trust and has been able to have a low stringency policy because of its strong border controls over the first two years of the pandemic, which resulted in very low case numbers, low deaths and low excess mortality. New Zealand, like Australia, was a vaccine laggard with numbers being low as late as August 2021, but the closed borders policy appears to have protected the population. Having opened its borders, it is now seeing significant rises in cases (the highest of all the countries in the sample) and deaths (middle of the sample) suggesting there is some protection for the people of the country, but its high levels of trust in both others and government will be tested going forward as its borders become more open (Bromfield and McConnell, 2021).

Sweden

Sweden has high levels of trust in government and in other people. Its approach to pandemic handling has generally been low in terms of stringency, especially in the second half of the pandemic. Sweden has also seen a separation of political and public health leadership due to its highly delegated political system (Petridou and Zahariadis, 2021) which resulted in a less nationally consistent response to the pandemic (Saunes et al., 2021). Case numbers have often been high, especially up to June 2021, and then medium up to March 2022 when they rose to height again. Its death rates follow a similar pattern, however its excess mortality numbers suggest strong performance, especially after the first year. Sweden has gone from an early vaccine leader to one of the three worst performing countries (along with the UK and USA), with around 75% of people being fully vaccinated.

United Kingdom

The UK has low levels of government trust and confidence, and low to medium trust in other people. Its stringency was very high in the first year of the pandemic, but has been gradually reduced to low levels since then. The UK's test per case ratio went from being amongst the lowest in the early months of the pandemic to being amongst the best for the rest of the time period considered here, suggesting that it has managed to achieve a relatively scalable infrastructure despite the variability of its case numbers. Its case numbers were high in the first year of the pandemic, with its government's performance being described as 'dismal' (O'Donnell and Begg, 2020), before falling to very low in the summer of 2021, then rising again after that period. COVID-19 deaths form a similar pattern, but with the UK's rise in deaths not being as comparatively bad as its rise in cases. The UK shows high excess mortality through February 2021 in two distinct waves, but with better performance after then. The UK was a vaccine leader until July 2021 when other countries appear to have overtaken it, and it now has the second lowest vaccination figures amongst the nations included. The UK needs another summer boost, as it has had in previous years, as low trust levels, low stringency and low vaccination rates suggest it is particularly vulnerable.

United States

The United States has medium trust in government, but low confidence, and low trust in others. The USA has struggled to put in place a scalable testing infrastructure for most of the pandemic, but ends the time period under study with the highest test per case ratio of all the countries in the sample. It has had a medium stringency approach but with variation by state, and with existing research suggesting the lack of access to a public health system becoming a major barrier to a better pandemic response (Unruh et al., 2021). The United States has had high numbers of both cases and deaths in most periods until very recently, and poor levels of excess mortality in most periods of the pandemic, with a brief respite in the summer of 2021. The USA saw a strong start to vaccination but this levelled off around June 2021 and has increased only slowly since, putting it in last place amongst the countries in this sample. Combined with patchy government and people trust, and variable stringency depending on state, the USA, like the UK, needs a boost in the summer where it might focus on improving vaccination rates.

WHAT DOES ALL THIS MEAN?

Now we have looked at individual countries, we can finally look across the countries and across the data to see what we can learn. A first observation is that the countries that have performed best in terms of both COVID-19 cases and COVID-19 deaths were those that quickly put in place hard border controls for the pandemic up to early 2022. The three countries here that this did – Australia, New Zealand and Japan – have the benefit of not having land borders and so having strong controls over the flow of people in and out. This strategy, although it has been frustrating for those living in the countries and those wishing to travel to them, has resulted in far lower case numbers and mortality than in other countries. Japan even managed to host the Olympic games, with strong COVID-19 measures in place, without seeing its case numbers or death levels rise to those in the rest of the world.

The challenge that these countries now face is how to 'open-up' again. Although all three have relatively high vaccination rates, they are experiencing rising case numbers as freedom of movement is re-established. The danger is of the virus now running through a population, especially those who have remained unvaccinated, and of the gains of the last two years being lost.

It is also the case that the strategy of strong border controls was available to another country in the sample – the United Kingdom – but was not pursued. The UK also has the advantage of being an island, as well as having strong popular sentiment around increased border controls coming from Brexit. Future inquiries into the handling of the pandemic might place the issue of why strong controls over the moment of people were not put in place in the UK, and of the role of international bodies such as the WHO, national advisory bodies such as SAGE, and governmental decision-making processes in coming to that decision.

A key factor which Canada, New Zealand and Sweden (all of which are very much at the low end of the sample in terms of cases and mortality) have in common is high trust in government. Trust in government during a pandemic is clearly important in order to get people to comply with the public health messages and, where needed, implement strong measures designed to protect the population. Germany, which also performed strongly in the first year of the pandemic, also has high trust in government. However, at least one low trust government has performed strongly during the pandemic (Australia), suggesting that Australia's policy of border controls appears to have overcome any issues about government trust by blocking off the introduction of the virus. However, as Australia opens up, getting people to trust any public health measures that may be required could be a more significant challenge than it is in nations with higher levels of government trust.

Public health messaging, increasing testing capacity to, in turn, increase tests per case and trying to respond to rising cases by increasing stringency were effectively the only strategies for governments available in the first year of the pandemic. It is understandable that there was less emphasis on these factors in the second year of the pandemic after the development of the vaccine, but a combination of low stringency, low tests per case and vaccination rates in many countries suggests a lack of focus on the core pandemic response. It certainly appears to be the case that keeping all of these factors at higher levels appears to be a more successful strategy (as in the case of Canada, which will expanded upon in a moment). However, high tests per case was not enough in itself (as the cases of Italy and the UK appear to demonstrate).

For the Northern Hemisphere countries in the sample, there is a seasonal element to case numbers and deaths from the virus. This is most clear in the tests per case graph, which for the majority of countries, emphasises the extent to which winter months have led to considerable problems in the first two years of the pandemic. This may be due to a range of factors –from increased socialisation during the Christmas holiday season, through to a greater indoor lifestyle and more opportunities for the virus to spread, especially as more infections variants have arrived. What this does seem to strongly suggest, however, is the need for improved ventilation and greater awareness of the importance of air flow in winter months to try and contain spread in the winter of 2022.

As the pandemic has developed, and vaccines have been developed, it is understandable that an increased emphasis has been put on their use by government. However, it is clear in the graph showing the proportion of those who are fully vaccinated (Figure 13.5), that rates have a tendency to stall beyond a certain point. As more 'booster' jabs become necessary, the extent to which governments can continue to engage their people and repeatedly come forward risks being a crucial factor. How this relates to government trust levels and (for Northern Hemisphere countries) the extent of seasonality, are surely areas of future research. At the time of writing in March 2022, stalling vaccination levels may be less of a problem during summer 2022 if the pattern of the past years repeats itself and case numbers fall in the summer months, but at the end of the year, declining vaccination-based immunity and a return to the winter months may prove extremely challenging. There appears to be little sign, because of the numerous virus mutations, that herd immunity is a successful strategy.

We can also identify particular countries which offer strong lessons from the first two years of the pandemic, considering what other countries can learn from the factors covered in the paper. Australia, New Zealand and Japan have already been considered in terms of their closed border policy, which appears to have protected those countries very well in the first two years, but what of the challenges they may now experience as they open up their economies?

Canada appears to have performed well in terms of cases and mortality compared to several of the countries in the sample. That success, in terms of the factors measured here, appears to be a mix of high trust in government, maintaining high tests per case (so having a scalable system of testing – except at the end of 2021) and a consistent approach to stringency (Unruh et al., 2021). Whereas other governments have varied their measures considerably, and case numbers appear to have become increasingly decoupled from stringency (the United Kingdom and Belgium are examples), Canada has taken a far more consistent approach, keeping measures in place to protect its people. The argument presented in other countries for reducing measures as vaccination rates increase, do not appear to have been applied. Canada is the highest vaccination rate country in the sample, and the second highest in terms of stringency at the end of the period under consideration. This combination of factors – high trust in government, consistently high stringency, and high vaccination levels – appears to have put Canada in the strongest position of the countries which chose not to put in place the hard border controls of Australia, New Zealand and Canada.

Germany and Sweden have gone down two different routes in their COVID-19 responses. Germany's response to the pandemic appears to have been successful in the first year, but with falling vaccination rates, and a testing system that does not appear to scale well as cases rose steeply in 2021, it now seems to be falling behind other nations in this sample. It would be interesting to disaggregate the data for Germany further to explore regional differences as the divide between the former-West and former-East remain very clear in studies of health inequalities in other domains.

Sweden has become a case presented in some areas of the media as supporting the idea that government should not put in place restrictions, and instead the general public should be trusted to take the necessary precautions during the pandemic (Boyle, 2022). There seem to be several points that do not entirely support this claim which can be made clearer by putting it in the context of other countries that have gone down a road of reducing stringency when the opportunity has arisen. In this sense, Sweden has something in common with Belgium, the United States and the United Kingdom. In terms of COVID-19 tests per case, Belgium has performed comparatively poorly through the pandemic, as has the USA until fairly recently, and Sweden has also done poorly. In contrast, the UK quickly put in place a strong testing regime, but even that new infrastructure struggled in the winter of 2021. In the second year of the pandemic Sweden saw some success in terms of falling COVID-19 death numbers from

February 2021, with numbers remaining comparatively low until January 2022, even if case numbers took longer to fall in that period. Sweden, in terms of low stringency countries, is having significantly higher levels of government trust and trust in other members of the public than Belgium, the USA, and the UK, which perhaps made a strategy of reduced stringency at an early time point more possible. However, since August 2021, death numbers in Sweden have undergone a significant rise, suggesting that all is not entirely well there. In all, it is hard to conclude from the data here, that in the absence of strong border controls, a low stringency approach appears to be successful in containing either deaths or cases.

Finally, because of its role as the first of the countries included here to be significantly affected by the pandemic, Italy needs some discussion. Italy was the first of the countries in this sample with significant numbers of COVID-19 cases, and the images of Italian cities in lockdown were the first warning that the virus had spread significantly beyond China. In terms of the data here, Italy is interesting in that, after the first wave, Italy appears to have quickly put in place a testing regime which for long periods of the pandemic has had amongst the highest tests per case of all those in the sample (but still with clear problems in the winter of 2020) and has had generally consistently high levels of stringency (in common with Canada). However, Italy has still, at several points during the pandemic, had very high case numbers and high death numbers, and in almost every period has had significant levels of high excess mortality. It is one of the worst performing countries in the sample. What Italy's data appears to suggest is that a combination of low government trust, low trust in others, and an initially poor testing infrastructure (not withstanding Italy's misfortune to be the first nation in the sample hit by the virus), has meant that even high and consistently high levels of stringency, and a fairly strong performing vaccination programme, cannot offset its initial disadvantage. What is worrying is that, although there have been considerable variations in both cases and deaths throughout the pandemic, the overall 'rankings' of countries in terms of their broad rankings, has not changed as much as we might expect. There are cases, such as Germany, which have performed gradually worse, and New Zealand and Australia now face new challenges as they open-up their countries again. However, it seems that an initially poor performance in responding to the virus has a significant effect on subsequent periods, causing a disadvantage which is difficult to overcome. The sources of this disadvantage would be a subject of additional fascinating research.

CONCLUSION

This chapter has explored data from the first two years of the pandemic for ten countries, looking for patterns in their vaccination rates, stringency and testing regimes to see if there is anything we can learn in terms of cases and deaths. The data was explored graphically, accepting that much of the data we have on COVID-19 is likely to be imperfect, and that applying standard statistical techniques risks generating claims which might appear to be robust, but could also be due to mismeasurement. We need to treat this data with extreme care.

We can draw some lessons. As noted above, New Zealand, Australia and Japan have done best amongst the countries, in terms of the outcomes measured, and it is hard not to conclude that their strategy of very strong controls over borders to international travel had led to far lower case numbers and mortality than in other nations. As these countries open their borders again, they will face new challenges, but will hope to offset them with robust vaccination programmes. Time will see whether this works.

There appears to be little evidence that a policy of low stringency has worked in terms of the outcome measures in the paper. The inclusion of Sweden has shown often very poor performance in terms of both cases and deaths, especially in the first year of the pandemic, and even though performance was much better in terms of these measures in the second year, attempting to copy the Swedish approach in countries with lower levels of governmental and interpersonal trust would be taking a significant risk.

Canada has proven to be amongst the most successful nations which did not put in place strong border controls to the same extent as New Zealand, Japan and Australia, and its mix of high government trust, high and consistent stringency, and a scalable testing regime that has been amongst the best in dealing with case number variations appears to have been effective. Other nations have much to learn from this, as well as asking themselves why their governmental trust levels might be so low, and what they might do to restore the trust of their public.

Finally, perhaps the biggest concern is the policy gap that is now appearing in several countries. Vaccination programmes are stalling except for very targeted groups. New mutations of the virus continue to emerge, but there is little sense that governments are in control of the situation. Perhaps most concerning of all are the issues of long COVID (the incidences of which are difficult to measure), the impact of the virus on young people especially because of the disruption to their education and wider social development, and the possible hidden long-term health effects on even those who appear to have recovered from the virus. At the end of 2023, it appears that the worst of the pandemic has passed in terms of it being an immediate threat. But the long-term effects of the virus look to be with us well into the future.

NOTE

1. https://github.com/TheEconomist/covid-19-the-economist-global-excess-deaths-model.

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14. Providing, financing and regulating health care

Martin Powell

INTRODUCTION

As the following chapters illustrate, there are many different types of health care system. There are many different approaches to produce typologies that classify systems. This chapter will focus on the three elements of providing, financing, and regulating health care. It will be argued that the character of a health care system can be best explored through the public-private mix of these three elements. This requires two discussions. First, it will be argued that providing, financing, and regulating health care are important elements, and that regulation has tended to be relatively neglected. Second, there are different approaches to the public-private mix, and a three-dimensional approach containing the above elements is the most promising route.

This chapter begins by focusing on the importance of the dimensions of providing, financing and regulating health care and the public-private mix. It then discusses two possible lenses for exploring these issues of publicness and the mixed economy of welfare, before setting out the main components of provision, finance and regulation. Finally, it draws these points together to form some conclusions. Although the majority of the literature is based on the global North, it does explore some of the much sparser literature on the global South.

TYPOLOGIES OF HEALTH CARE SYSTEMS: PROVISION, FINANCE AND REGULATION

De Carvalho et al. (2021) identified 41 studies of typologies of health care systems worldwide, offering 42 classifications over a period of six decades, covering 1828 cases and 103 countries, with the number of classified cases varying from 3 to 1172. They noted that most studies focused on high income nations, with only 12 typologies including global South countries/regions as cases. Most of their studies referred to provision of services (29), financing (29) and regulation (28). However, those broad terms disguised some variation. They grouped all themes related to the input of resources into each health care system (e.g., expenditure and financing schemes under Finance). Typologies generally measured the financing mix of systems (25). Service provision comprises the elements related to the delivery of health care services, such as human resources, infrastructure and ownership. Most typologies regarded service provision in ownership terms (20), with the most frequently employed criterion being the share of hospital beds in public ownership. Finally, all elements that deal with the regulatory and administrative function of the systems were included under the regulation category. They pointed out that some studies use different terms to refer to this function, such as stewardship, governance, and organisation. They stated that despite the great variety of aspects typologies use to measure regulation, state intervention (20) and basis of entitlement/eligibility and coverage (20) are the most utilized criteria.

Freeman and Frisina (2010) argued that the standard tripartite or trichotomous classification of health systems into national health services, social insurance systems and private insurance systems showed three main weaknesses. First, there was 'perennial misrepresentation' that the US is a 'private' system, but it is not. Second, a set of binary decisions (about finance, provision and regulation) was regularly reduced to one fundamental one as a result of the priority given to financing mechanisms both in description and classification. Third, this had the implication of the relative paucity of attention given to the matter of regulation.

Moran (1999) was one of the first to attempt combining the dimensions of funding, service provision and governance in health care. He used the three governing arenas of 'production', 'provision' and 'consumption' to construct four types of 'health care states': the 'entrenched command and control state', the 'supply state', the 'corporatist state', and the 'insecure command and control state'.

Some important linked contributions arguing for the importance of finance, provision and regulation as vital elements in health system typologies were produced by German scholars. Rothgang et al. (2005) pointed out that many comparative studies with respect to the role of the state in health care have exclusively concentrated on financing and expenditure. Ever since the OECD published the first edition of its health care data in 1985, most international comparisons have centred on the financial dimension. However, even if the state neither finances nor provides services directly, it can engage in regulation. They then discussed six objects of regulation: coverage, the system of financing, the remuneration of providers, the access of providers to markets, the access of patients to providers, and the benefit package (cf. Böhm et al., 2013; Wendt et al., 2009).

Wendt et al. (2009) developed a typology based on three dimensions that define health care systems: financing, service provision, and regulation. They pointed to three broad sets of actors and co-ordination mechanisms: hierarchical state intervention, collective negotiations, and dispersed exchange processes on markets. Each dimension can be dominated by state, societal, or private actors, providing 27 distinct combinations. The financing dimension consisted of state or tax financing, social insurance contributions, and private insurance and out-of-pocket payments. Many classifications of the service provision dimension identified public/private mixes, but they argued for a trichotomous concept as private non-profit providers, reflecting a societal element, are neither similar to for-profit market actors nor part of the state administration. Finally, they argued that the regulation dimension can be structured as the relation between financing agencies, providers, and (potential) beneficiaries. They identified six objects of regulation (cf. Rothgang et al., 2005). They continued that pertinent question for classifying the regulation dimension that thus arises is 'who is in charge of regulating and controlling these relationships?'

However, Böhm et al. (2013) argued that only ten of the 27 types are logically plausible, and then empirically classified 29 of 30 OECD health care systems into five different types: the National Health Service (NHS, eight cases), the National Health Insurance (NHI, five cases), the Social Health Insurance (SHI, four cases), the Etatist Social Health Insurance (ESHI, eleven cases), and the Private Health System (PHI, one case).

They set out their five types. First, NHS represented an ideal type where regulation, financing and provision are governed by the state. The NHS type included the Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden), the UK, and two southern European countries, Portugal and Spain. NHI systems combined NHS regulatory structures and tax financing with dominantly private service provision. NHI systems include Australia, Canada, Ireland, Italy, and New Zealand. SHI represented a dominant role of societal actors in health care regulation and financing, whereas services were mainly delivered by private for-profit providers. ESHI was the only completely mixed health care type that existed in reality, characterized by a clear hierarchy of the three dimensions: the state is responsible for regulating the system, financing is organized by societal actors, and provision has been delegated to private hands. Eleven of their countries showed these characteristics and so made ESHI their most frequent type. Among the different countries that belonged to this type, three clusters were identified. First, Central and Eastern European (CEE) countries formed a group including the Czech Republic, Estonia, Hungary, Poland, and Slovakia; the second group comprised the Asian countries Japan and Korea. The third group of ESHI types included countries such as Belgium, France, Israel, and the Netherlands that in the past have frequently been categorized under SHI systems. Finally, the core features of a PHS were coordination by market actors, private financing sources, and for-profit providers. This health care system type was generally considered the most common one up until the early 20th century, but since Switzerland changed to the corporatist SHI model in 1996, the USA was the only the private system in the OECD.

While this scheme is more useful than studies that provide a crude public-private differentiation, as it pointed to the importance of regulation, the 'less differentiated conceptualization of regulation only allows for the archetypical combinations of modes of interaction and corresponding actors' (Böhm et al., 2013, p. 268). Moreover, the very wide conceptualization of regulation is not closely linked to the regulation literature (e.g., Walshe, 2003; below). Maarse (2006) noted that the boundary lines of private agents were not clear due to public regulations. For example, France had many for-profit hospitals, but they were subject to extensive government regulation on tariff setting. This means that portraying the for-profit hospitals as a purely private entity is highly misleading. It is possible to argue that purely private agents do not exist because they are always embedded in a system of public regulation that determines the scope for private activity.

However, it has been argued that it is difficult to apply typologies developed mainly on the global North to the global South (de Carvalho et al., 2021; Doetter et al., 2021). de Carvalho et al. (2021) pointed out only 12 of their 42 typologies include global South countries/regions as cases, and that the health care systems of LMICs are far from homogeneous. They differ from arrangements of the North both in terms of amounts of resources and the institutional set-up of the systems, with their key features including heavy reliance on international actors and segmentation. First, in the period from 1990 to 2016, aid from bilateral, multilateral and other donors provided more than US$531 billion to economies of the Global South for financing health care. In some 20 nations, foreign transfers are responsible for more than one-third of all funds available for health, with external funds often being 'conditional' or contingent on the fulfilment of predetermined conditions. A second key feature is segmentation, which refers to the coexistence of different modalities of financing, service delivery and affiliation, each of them targeting different population groups according to income, social status and/or type of employment.

They discuss the question of whether existing health care system typologies reflect the particularities of the global South. One major issue is data availability, with many classifications drawing on OECD data. They argued that typologies in general employed similar criteria for classifying systems, not acknowledging important differences between and within regions. Moreover, the content/criteria used to assign systems to types have not changed much since the first classification was developed in the 1960s. They pointed out that none of the examined typologies accounted for the presence of international actors in health care systems, quantified external resources, and that segmentation, a prominent feature of health systems in the global South, was explicitly addressed in only six typologies.

Doetter et al. (2021) aimed to develop a typology that considered a larger pool of countries, and to expand their classification criteria, in order to account for the great variance of health care systems globally. Their starting point was based on the three core dimensions of regulation, financing, provision. They stated that all frameworks accounted for the role of the state and private actors in organizing the health care system. Seven out of ten studies solely measured the public–private mix of the systems, considering the responsibility of only state and private for-profit actors. However, typologies developed over the last decade still fail to account for the influence of global actors, despite their considerable role in Latin America, Africa and Asia. They aimed to construct a 'novel typology' to overcome the OECD bias of most existing typologies and to provide an equally useful classification for LMIC. The most original feature was to systematically categorize actors along a public–private axis. Their Table 3 focused on the role of state, societal, private collective, private individual, and global actors in finance, provision and regulation. They pointed out that whenever actor constellations were used to classify health care systems, only domestic actors were accounted for, but this neglected the potentially large role of international interdependencies, particularly of a financial nature (e.g., foreign aid, bi-lateral transfers from other states, IGOs, INGOs, private donors, etc.), that is an important feature of many LMIC health care systems. They argued that the relevance of global actors could most easily be measured in the financing dimension. For example, in 2017, ten counties (with nine of them in Africa) had external financing covering over one-third of total health spending, with the extreme case of Mozambique where global actors financed between 60 and 80 percent of total health spending.

Their 'healthcare typology matrix' (their Table 4) produced some 80 (4 × 5 × 4) potential health care system types. However, they argued that only 5 of the 80 types were likely to exist in the real world. First, type 1 (state regulation, finance, provision) of state dominance in all three dimensions were widespread before 1990 in Soviet countries. The 'pure societal type' (type 26, societal regulation, state finance, societal provision) was represented by community-based health insurance programmes which have been suggested to increase health care coverage in global South countries. In 'pure private types' (types 51, private regulation, private collective finance, private provision, and 55, private regulation, private individual finance, private provision) the government only takes responsibility for framework regulations of markets. Health care will have to be purchased directly or covered by voluntary health insurance using risk-rated premiums. Very high out-of-pocket spending shares of 70 percent and more in some countries of the global South (e.g., Nigeria, Yemen) indicated that it is necessary to take the existence of individual private systems into account. Finally, the 'pure global actor type' (type 80, global regulation, global finance and global provision) where all dimensions are dominated by non-domestic actors can serve as a further reference point. This situation, where global actors took on all main responsibilities of the health care system probably indicated a failed state or the temporary collapse of domestic regulations due to natural disasters or war.

Almost 20 years ago, Koivusalo and Mackintosh (2004) pointed to the problems of commercialization of health care in LMIC. They argued that bodies such as the World Bank, OECD and WHO had promoted a model of health service reform that included: provision of health services by a 'mix' of public, private and voluntary providers; the retreat of government to a mainly regulatory role, with responsibility for direct provision of services in public health and primary care for the poorest; but with user charges for government health services; contracting-out; corporatization in the hospital sector; liberalization of insurance provision for health care, and a shift towards insurance rather than tax-based financing mechanisms. They summed up this model as a reliance on private provision and insurance where possible, with public finance – and as a final fallback public provision – for the poorest. They identified some of the main impacts as: commercialization, measured by the share of private in total health spending, was generally higher in lower income countries; the poorer a country, the more likely the population is to face the most regressive form of health finance, out of pocket expenditure; and that commercialization as measured by expenditure indicators was unrelated to commercialization in terms of ownership of provision. Put another way, pattern of publicly and privately owned provision does not map onto the public/private 'mix' in expenditure (see below).

THE PUBLIC-PRIVATE MIX

The second issue concerns the public-private mix. There has been a long debate in social and health policy over the public-private mix or 'privatization', in terms of public versus private or the state versus market. However, this has tended to generate more heat than light as definitions and operationalizations of 'privatization' are often implicit, unclear and conflicting, with unclear academic and stakeholder definitions resulting in a 'Tower of Babel' (Powell and Miller, 2014). Debates over privatization have always been highly contested. After the contested spelling (privatization versus privatisation) comes contested definitions. The widest definitions regard privatization as *any* shift from public to private, while the narrowest definitions focus on one specified element (e.g., introducing charges) (see, for example, Maarse, 2006; Powell and Miller, 2013, 2014).

Maarse (2006) argued that it was too simple to conceptualize privatization as a simple dichotomy between public and private. There were multiple public/private boundaries in health care. He suggested a continuum ranging from precursors of privatization to moderate forms of privatization to radical forms of privatization. However, he also advocated a 'pragmatic approach' by investigating privatization from four different perspectives: health care financing, health care provision, health care management and operations and health care investment. Eurofound (2017) suggested types of privatization such as: outsourcing of health-related services; Public Private Partnerships; change in the legal status of hospitals (corporatization or formal privatization); and full privatization. Following Maarse (2006), it suggested that this last form could be deemed radical if privatization is seen as a continuum.

Powell and Miller (2013, 2014) argued that there were many different types of privatization such as moving from public to private in terms of ownership or provision ('selling off assets') or finance (commodification). For example, in the UK, politicians tend to use the dictionary 'minimalist' definition of asset transfer in denying they are privatizing the NHS, while critics tend to use a 'maximalist' definition involving a reduction in state activity in one of the areas of provision, finance or regulation (see MEW below).

According to Eurofound (2017), it was difficult to explain and operationalize the concept of privatization, because various terms (e.g., liberalization, marketization and recommodification) covered similar processes and because of the blurred boundaries between public and private service provision. For example, in order to differentiate between marketization, liberalization and privatization in the case of hospitals, it was necessary to understand the process of transformation and how and in what forms private players became increasingly involved in hospital services.

As we shall see below, some studies tend to use a wide variety of cognate terms such as privatization and corporatization (Braithwaite et al., 2011), marketization (Martinussen and Rydland, 2022). Other studies seem to focus on a wide variety of dimensions. For example, Bambra et al. (2014) appeared to cast a very wide net with their independent variables being 'financial and organizational health care system reforms' that have an effect on the health equity of high-income countries. Finally, yet more studies appear to focus on one dimension, only to explore others. For example, Modi et al. (2018) asked whether it matters if, in a publicly *funded* health system such as the NHS, care is *provided* publicly or privately (my emphasis)? However, they appeared to focus on commodification, which is a financial dimension (cf. Esping-Andersen, 1990; Maarse, 2006).

PUBLICNESS

Publicness is largely absent from social or health policy literature (but see Anderson, 2012, 2013). There are many different approaches to publicness, but it is often divided into core and dimensional approaches (e.g., Anderson, 2012; Andrews et al., 2011). The traditional core definition is similar to a one-dimensional MEW focus on the 'legal core' of ownership (below). The (two-) dimensional account focuses on economic and political authority. Bozeman (1987) defined publicness as 'a characteristic of an organization which reflects the extent to which the organization is influenced by political and economic authority', with political control as the essence of publicness: 'all organizations are public because political authority affects some of the behavior and processes of all organizations' (p. 17).

According to Andrews et al. (2011), the 'dimensional' model of publicness combined ownership (public, private or non-profit), funding, (government grants versus consumer payments) and control (by political or market forces). The model was dimensional in the sense that all three variables should be viewed as continuous rather than categorical, and organizations can be more or less public on each of the three dimensions. They argued that the number of studies that directly compared public and private effects on performance in the same industry and over the same time period was not great. Furthermore, most studies focused only on ownership while neglecting the funding and control dimensions of publicness and examined effects on efficiency and effectiveness without paying much attention to equity. They concluded that the existing evidence suggested that publicness made little difference to performance. However, such results should be treated cautiously as substantive and methodological problems made it impossible to conclude with any confidence that publicness made a positive or negative difference to organizational performance or to judge which of the three dimensions of publicness was most important and for which aspects of organizational performance.

Anderson (2012) produced a two-dimensional grid for health care organizations. Using examples from the UK, he differentiated between hospitals with Foundation Trust (FT) status, having increased economic authority but reduced political authority, and those under direct NHS control, and subject to high levels of both economic and political authority. This suggested some decline in publicness as FTs were less public than non-FT hospitals.

Anderson (2013) analysed Sayre's (1953) assertion, that 'public and private organizations are alike in all unimportant respects' in relation to health care. He argued that the extant evidence pointed overwhelmingly to two basic conclusions; that Sayre's 'important aspects' (outcome measures such as efficiency and effectiveness) are not fundamentally different between the public and private sectors; and that, in fact, neither are his 'unimportant aspects' (design factors such as management, structure and organization). He concluded that the fundamental question (does publicness have a significant effect on organizational performance?) has been answered with a 'resounding no', and that we can refute Sayre's assertion that, as far as health care is concerned, 'public and private organizations are alike in all unimportant respects' once and for all. Rather, 'public and private organizations are alike in all important respects' and that the list of important respects is headed by management and organization.

There appears to be few studies that explore publicness in health care, and fewer still that take a three-dimensional view by examining 'regulation' in the form of political control or political authority. We now turn to the approach favoured here of analysing the three dimensions through the Mixed Economy of Welfare (MEW) (cf. Powell and Miller, 2014).

MIXED ECONOMY OF WELFARE

Scholars in social policy have focused on the Mixed Economy of Welfare (MEW) three-dimensional model (Powell, 2019). A one-dimensional analysis, focused on ownership, assumes that this is the only aspect that matters. A two-dimensional analysis focuses on ownership and finance. A three-dimensional MEW examines provision, finance and regulation (cf. Le Grand et al., 2019). This broadly fits with studies of health care systems that focus on the dimensions of provision, finance and regulation (e.g., Powell and Miller, 2014; Scott, 2001; Wendt, 2009).

The three-dimensional model (Powell 2019, his Table 1.1) differentiates between provision and finance across state, market, and voluntary and informal sectors. The third dimension, state regulation, is indicated by inclusion of an H (high) and L (low) regulation. It can be used to explore movement between origin and destination cells to point to different types of privatization. For example, 'full' privatization would entail movement across all three dimensions from the cell denoting state funding and provision with high regulation to that of the cell with market funding and provision with low regulation. The major disadvantage is that while the MEW provides a clear heuristic picture, it is difficult to provide clear measures as there is no obvious common metric. Privatization can be seen as less state provision, finance or regulation, but while it is possible to measure provision or finance, regulation is more problematic (see below). The following sections explore the three dimensions in more detail.

PROVISION

This focuses on the provision or ownership of health care facilities. Some studies focus on the dichotomy of public and private providers, while others use a trichotomy of public, private for profit (PFR) and private not for profit (PNP) or third sectors providers. According to Böhm et al. (2013), of the five 'empirical' types, only one has state provision – NHS (e.g., Denmark, Finland, Iceland, Norway, Spain, Sweden, Portugal, Spain, UK), while the other four types have private provision (21 nations). They pointed out that while most classifications only identified public/private mixes, the trichotomous concept was more meaningful since private non-profit providers, reflecting a societal element, were neither similar to for-profit market actors nor part of the state administration.

A Eurofound (2017) study argued that four types of hospital can be linked to privatization: public sector autonomous hospitals (e.g., NHS Trusts in the UK); private management of publicly owned hospitals (e.g., Portugal), private for-profit hospitals (e.g., France, Germany); and private non-profit hospitals (e.g., the Netherlands). Eurofound (2017) set out different forms of privatization such as: outsourcing of health-related services; Public–Private Partnerships (PPPs); change in the legal status of hospitals so that it can operate under private law (formal privatization or corporatization); full privatization (the sale of publicly owned hospitals to private corporations).

Commissioning, Outsourcing and Contracting Out Services

Eurofound (2017) stated that outsourcing was mostly concerned with non-medical activities. It noted that in France hospitals have outsourced cleaning and catering functions since the 1970s. England followed in the 1980s, and this was followed by some clinical services (ISTC, etc.). It noted that outsourcing of clinical services has also occurred in countries such as Austria, Hungary, and Portugal.

Public–Private Partnerships (PPPs)

The definition of PPP has been contested, and there are a number of different forms. Acerete et al. (2011) pointed out that for health care, most accounting literature focused on hospital PPPs, notably the UK Private Finance Initiative (PFI) model whereby the private sector finances and constructs a hospital building and then delivers the service and maintenance functions over a period of around 30 years. This model is also in use in Spain, Italy, Mexico, South Africa, France, and Australia. However, they pointed to models using private finance such as franchising, BOO (build, own, operate) and BOOT (build, own, operate, transfer), the contracting out of clinical services, such as the UK's Independent Sector Treatment Centres (ISTCs) and similar schemes in Romania and Peru, as well as management contracts in Brazil.

Eurofound (2017) noted that there were no official data about the number of PPPs in many European nations because this information was not included in official statistics. However, PPPs have been fairly widespread in the UK, with over 130 PPP arrangements completed, underway or having been approved since 2001. In both Spain and the UK, PPPs tend to take the form of private finance initiatives (PFIs). In the UK, PFIs involve the private partners designing, building and in many cases operating new infrastructure with contracts typically lasting 30 years. In Spain, PFIs were first applied in Madrid in 2007; and spread to other regions. For instance, in the Valencia region, the administrative concession model is commonly used (five hospitals have this model). One of the best-known examples of concession in this region is the hospital at Alzira that applied administrative concession processes back in 1999, setting a good example for other privatization models to follow.

Roehrich et al. (2014) conducted a systematic review of over 1400 PPP papers from the period 1990–2011. They pointed to differing conceptualizations of public–private partnerships, and that there is great variation in the scale and scope of private and public responsibility (their Figure 1) ranging from ‘public responsibility’ (e.g., contracting out) to ‘private responsibility’ (e.g., divesture/full privatization), with associated variations in risk transfer. They concluded that in terms of outcomes, the extant literature offered an incoherent picture of PPP outcomes with regards to its benefits and disadvantages.

Torchia et al. (2015) noted that PPPs have become popular worldwide as a way of improving health care service delivery. They carried out a systematic review of 46 articles for the period 1990–2011, that identified six lines of research: effectiveness, benefits, public interest, country overview, efficiency and partners. They argued that while PPPs are not a new concept, there is no one single agreed-upon definition of the term. PPPs in the health sector can take a variety of forms depending on the degrees of public and private sector responsibility and risk. However, questions as to their actual effectiveness, efficiency and convenience, still remain unanswered.

Languille (2017) set out a literature review on PPPs in education and health in the global South since 2000. She reviewed 134 health-related papers, with some 60 percent read thoroughly. There is indeed no commonly accepted definition of PPPs. The literature on health PPPs targeting low- and medium-income countries can roughly be divided into three main streams. First, there was an abundant literature that focused on global health initiatives (GHIs), especially the Global Fund to Fight HIV-AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation (GAVI). Second, a few studies set out in-country arrangements for the construction and maintenance of health facilities and the delivery of health services (cf. the literature for high-income nations). Third, some studies explore ‘demand-side financing schemes’ that subsidize users to purchase services from accredited providers (e.g., voucher schemes). She pointed out that both proponents and sceptics of PPPs stress the general lack of evidence on the effectiveness of PPPs, in both sectors and for the different PPP types.

Joudyian et al. (2021) carried out a scoping review on the use of PPPs in the provision of PHC services. They found 3488 studies which became a final 61, with a high proportion in the global South: 32 in Asian and 11 in African countries. There were three broad categories: PPPs contracted out for basic PHC services, PPPs in health education and promotion programmes, and PPPs in services for infectious diseases. They concluded that despite some positive outcomes and achievements, these PPPs faced multiple challenges, particularly during the starting and implementation phases, which were explored in five areas: education, management, human resources, financial resources, and information and technology systems.

Corporatization of Public Hospitals

According to Eurofound (2017), ‘corporatization’ or a change of legal status of public hospitals to become companies under private law has taken place in several countries such as Austria, Estonia and Poland, with the objective of reducing public debt, introducing new management strategies, increasing the independence of hospitals and giving better access to finance. Corporatization has been the main form of privatization in Portugal.

Full or Partial Privatization of Hospitals

Eurofound (2017) stated that the sale of public hospitals – partially or in their entirety to private providers – was rare in most of the nations under review. It noted that partial privatization of public hospitals in Austria first took place in the 1990s, but such privatizations have rarely occurred since.

According to Braithwaite et al. (2011), the European Observatory on Health Systems and Policies defined privatization of health care services and hospitals as the transfer of ownership of what was a public body into private hands, that is, into either private for-profit or private non-profit organizations. However, this classic type of privatization of asset transfer ('selling the family silver') is not common in the health sector. There are some examples in Germany. According to Maarse (2006), after the reunification in 1990, there was a massive and unprecedented privatization in primary care in the eastern part of Germany. In only one year, what was primarily a public provider system converted to a mainly private system. There was also a significant growth of for-profit hospital care, largely through takeovers, both in the East and in the West. Jeurissen et al. (2021) pointed to a for-profit hospital boom after German reunification, as reunified Germany had to cope with large numbers of neglected public hospitals in the eastern part of the country and privatization seemed an appealing solution. For-profit hospitals were accorded prominent roles in most of the new states.

Scourfield (2016) pointed out that this type of privatization was rare in the UK. The Labour government in 2003 signed a three-year 'franchising' deal to let the private firm Tribal Secta Ltd act as consultants to manage Birmingham's indebted Good Hope Hospital. In 2012, the first ever operating franchise was awarded to a private provider to run an NHS district general hospital, Hinchingbrooke in Cambridgeshire. The Director of Strategy for the local Strategic Health Authority argued that 'This is not a privatisation because the staff and assets will remain within the NHS'. However, less than three years into what was supposed to be a ten-year deal, the franchisee, Circle, announced its withdrawal from the contract.

A number of reviews have explored the impact of ownership in health care. However, they have used a range of different terms. Braithwaite et al. (2011) examined the impact of 'privatization' and 'corporatization' on public hospitals. They reviewed 2319 articles using content analysis to uncover several themes but pointed out that much of the underlying argument was ideological rather than evidence-based, and the evidence is often weak and at times conflicting.

Bambra et al. (2014) examined systematic reviews of the effects of health care system organizational and financial reforms (system financing, funding allocations, direct purchasing arrangements, organization of service provision, and health and social care system integration) on equity in health care access and/or health status in high-income countries. They identified 1283 studies, but only nine met all aspects of the inclusion criteria and were included in the synthesis. Four reviews contained data on general system financing, one covered direct purchasing arrangements, and there were three on the provision of services and two on health and social care system integration. However, the quality of the reviews was very variable with three high quality, one moderate quality and five low quality. They appeared to focus on a wide range of dependent variables, concluding that private insurance and out-of-pocket payments, as well as the marketization and privatization of services, have either negative or inconclusive equity effects. In short, financial and organizational health care system reforms have had either inconclusive or negative impacts on health equity both in terms of access relative to need and in terms of health outcomes.

Herrera et al. (2014) asked 'does ownership matter?' In what they claimed to be the first systematic review about ownership of health care providers that explores with a broad perspective the effects of this governance characteristic, they narrowed down 5918 references from 2002–2013 to nine studies, but only one was regarded as reliable, with eight having important limitations. They examined evidence for the three possible comparisons – PNFP vs PFP (6 studies), PNFP vs Public (3 studies), and PFP vs Public (1 study) – and mixed combinations of ownership types. They concluded that in broad terms ownership does seem to have an effect on health and health care related outcomes. Significant differences in terms of mortality of patients and payments to facilities were found between PFP and PNFP providers, with both higher in PFP facilities. However, there are no conclusive results in terms of quality and economic indicators such as efficiency. Moreover, no clear differences were found when comparing PNFP and public providers, as well as for PFP and public providers.

Eurofound (2017) noted that most systematic reviews and studies focusing specifically on hospitals and ownership come from the USA. The majority of the systematic reviews that include EU nations concluded that their findings were inconsistent, meaning that the direction/significance of efficiency of private hospitals differs between the papers included in the review. In terms of quality of care, the overall outcome was relatively mixed, with no consistent relationship found (their Table 7). The results differed between finding a negative relationship (four articles), a positive relationship (four articles) and no significant relationship (one article).

Modi et al. (2018) appear to conflate the terms by asking whether it matters in a *publicly funded* health system such as the NHS if care is *provided* publicly or privately (my emphasis)? However, they go on to claim that at the heart of the question of who should provide health services is their commodification, through the application of market mechanisms, so that health care is regarded as a product to be bought and sold. They concluded that major non-public sector provision impedes monitoring of quality and effectiveness and leads to inequity and exploitation, with suboptimal care for both rich and poor.

Tynkkynen and Vrangbæk (2018) carried out a scoping review comparing the performance of public and private hospitals in Europe. They first summarized the state-of-the-art as presented in previous international review papers. The overall impression from previous review studies was mixed. Some studies found that public hospitals are more efficient than private, while others found no significant difference. In general, it appears that PNFP hospitals tend to be closer to public hospitals in outperforming PFP hospitals in terms of quality and efficiency. A general observation across the studies was that the true effect of ownership seems to depend on the institutional context and that there are significant differences across regions and markets and over time. However, they noted that the reviews contained a number of methodological problems.

They then searched between 2006 and 2016 finding 480 studies, with a final sample of 24 papers. Of those, 17 discussed economic effects, and seven studies addressed quality. They argued that public hospitals were most frequently reported as having the best economic performance compared to private not-for-profit (PNFP) and private for-profit (PFP) hospitals. PNFP hospitals are second, while PFP hospitals are least frequently reported as superior. However, a sizeable number of studies did not find significant differences. Moreover, the results were mixed in terms of quality, and it was not possible to draw clear conclusions about the superiority of an ownership type. In particular, a major weakness in many studies was the failure to control for quality and other operational dimensions, which may have influenced the results.

FINANCE

As Thomson et al. (2013) pointed out, traditional classifications of health systems often differentiated tax-financed systems ('Beveridge' in western Europe and 'Semashko' in former Soviet Union countries) from social health insurance systems ('Bismarck(ian)'). Public contribution mechanisms (tax and social insurance contributions) are statutory (compulsory) and pool health and financial risks over time and across individuals. Private contribution mechanisms are generally voluntary, involving pre-payment (private health insurance and medical savings accounts (MSAs)), or payments made at the point of use ('Over the Counter' or OTC payments or 'Out of Pocket Payments' or OOP). While private health insurance involves some risk pooling across individuals, OOP payments and MSAs do not. Similarly, Wagstaff and van Doorslaer (1992) point to four sources of finance for health care systems: general taxation; social insurance contributions; private insurance premiums, and out-of-pocket payments. According to Böhm et al. (2013), two of their five types had state financing (NHS and NHI) two had societal financing (SHI, ESHI), and one (PHS – USA) had private financing.

In more detail, direct taxes are levied on individuals and corporations (for example income tax, corporate tax, property tax). Indirect taxes are levied on the consumption of goods and services (for example value-added tax, VAT). Taxes may be collected by central, regional or local governments. They can be channelled to the general government budget or earmarked for specific purposes (e.g., health). While direct taxes tend to be proportionate or progressive, indirect taxes are often regressive. SHI contributions are generally based on a proportion of employment income, but may also cover non-contributors, such as unemployed people, retired people or non-working dependants. Conversely, the government or other body may make contributions on behalf of non-contributors.

PHI contributions tend to be flat rate. Medical savings accounts involve compulsory or voluntary contributions by individuals to personalized savings accounts earmarked for health care. They originated in Singapore and have since been used in PHI markets in the USA and South Africa. MSAs do not involve risk pooling (except in so far as they are combined with insurance). OOP payments take three broad forms: direct payments for services not covered by the statutory benefits package; cost sharing (user charges) for services covered by the benefits package; and informal payments.

Direct payments are used to pay for health care not covered by any form of pre-payment, usually for services obtained in the private sector. Cost sharing requires the covered individual to pay part of the cost of care received, and takes a range of forms. Statutory cost sharing refers to user charges applied to services included in the publicly financed benefits package. Informal payments (also known as 'under the table' or 'envelope' payments) are charges for services or supplies that are supposed to be free and are prevalent in several of the newer European Member States, as well as Greece. Cost sharing and informal payments lower the level of financial protection provided by public coverage.

According to OECD (2021), compulsory or automatic coverage, through government schemes or health insurance, formed the bulk of health care financing in OECD countries, with some three-quarters of all health care spending in 2019 covered through these types of mandatory financing schemes. It pointed out that central, regional or local government schemes in Norway, Denmark, Sweden, Iceland and the UK accounted for 80 percent or more of national health spending. In Germany, Japan, France and the Netherlands, more than 75 percent of spending was covered through a type of compulsory health insurance scheme. In the United

States, federal and state programmes, such as Medicaid, covered around one-quarter of all US health care spending in 2019. OPP financed one-fifth of all health spending in 2019 in OECD countries, with the share broadly decreasing as GDP increases. In France, OPP spending was below 10 percent, but more than 35 percent in the Russian Federation (Russia) and China, and above 60 percent in India (p. 194). In short, it is generally argued that public finance is superior to private finance (e.g., Thomson et al., 2009).

An important element in privatization in health care financing (Maarse, 2006) is decommodification which was defined by Esping-Andersen (1990) as the transformation from a market commodity into a nonmarket commodity. Maarse (2006) measured privatization in health care financing in monetary terms as a shift from public to private spending or, more concretely, as a decrease in the public fraction in health care spending (or an increase in the fraction of private spending).

An early study by Wagstaff and van Doorslaer (1992) examined health care financing systems and their progressivity characteristics for ten nations. They distinguished between the tax-financed systems of Denmark, Portugal and the UK, the social insurance systems of France, the Netherlands and Spain, and the predominantly private systems of Switzerland and the US. They argued that tax-financed systems tend to be proportional or mildly progressive, that social insurance systems are regressive and that private systems are even more regressive. Out-of-pocket payments are, in most countries, an especially regressive means of raising health care revenues. They concluded that while tax-financed health care systems (e.g., Denmark, Ireland, Portugal and the UK) tended to be mildly progressive or proportional, social insurance systems (e.g., France, the Netherlands and Spain) and predominantly private systems (such as the American and Swiss systems) tended to be regressive, with the latter systems being particular regressive.

Tuohy et al. (2004) asked how private finance affected public health care systems in five nations that exemplified different ways of drawing the public/private boundary. They argued that it was not enough to look at the level and the share of public and private spending per se, as it was also necessary to consider how the relationship between public and private finance was structured. They stated that there were at least four basic models for the structuring of this relationship: parallel public and private systems; co-payment; group-based; and sectoral. While these models were idealized types, with no national system providing a pure example of any one model, many combined elements of several models. However, they identified examples of systems whose central tendency represents a particular model: parallel systems (hospital sectors of Britain and New Zealand), extensive co-payment (New Zealand ambulatory sector), group based (Netherlands, USA), and sectoral (Canada). Finally, Australia represents a deliberate attempt to find balance among a number of models, combining co-payment across a broad range of services with a parallel quasi-private system. They concluded that while their evidence was suggestive rather than definitive, it suggested that increasing the private share of total health care expenditure does not offer a solution to the challenges facing public finance systems.

Bambra et al. (2014) explored four reviews that included studies of general system financing interventions. While these interventions varied considerably, they concluded that private insurance and out-of-pocket payments, as well as the marketization and privatization of services had either negative or inconclusive equity effects. More widely, their ‘strong’ conclusion was that ‘market-style reforms’ were bad for health equity.

From their title, Martinussen and Rydland (2022) appeared to wish to analyse recommodification in Europe, 2010–2018. However, they stated that their aim was to investigate the association between health care marketization and health system outcomes across European nations. They stated that they employed indicators of health care decommodification in order to measure a country's degree of health care marketization. They continued that decommodification referred to the extent to which an individual's access to health care was dependent upon their market position. They then set out three indicators that assessed the financing, provision and coverage of the private sector, and so reflected the varied role of the market in a health care system: private health care expenditure as an amount of GDP, private hospital beds as an amount of total hospital bed stock, and public health care coverage. However, it could be argued that only the expenditure indicator is valid, as commodification relates to finance, differentiating free at the point of use care from commodified (e.g., out of pocket) care. An internal or external market that provides care free at the point of use could be argued to be marketized but not commodified. Conversely, charges introduced or increased for a public service would be commodified but not marketized. They found that the strongest substantial associations were between coverage and satisfaction, with high public health care coverage being associated with higher satisfaction, and that private financing of services was associated with lower satisfaction, but with a small size effect.

REGULATION

Regulation is perhaps the least explored and most unclear of the three dimensions. This is partly due to a lack of consensus on 'regulation', and partly due to a lack of studies on the effectiveness of regulation. First, regulation often seems to be conflated with cognate terms such as governance and stewardship. Many of the studies that discuss 'regulation' do not discuss the regulation literature (below). For example, Rothgang et al. (2005) pointed to the dominant regulatory mechanism of hierarchy (UK NHS), collective bargaining (Germany SHI) and markets (USA PHI), and suggested six major areas of regulation: coverage, the system of financing, the remuneration of providers, the access of providers to markets, the access of patients to providers, and the benefit package (cf. Böhm et al., 2013; Wendt, 2006; Wendt et al., 2009). However, while the financing and the service provision dimension allowed quantitative measurement, the concept of regulation was qualitative in nature.

Wendt (2006) examined changing modes of regulation (hierarchy, self-regulation, and market) in health care systems. Böhm et al. (2013) considered that of their five types, three (NHS, NHI, ESHI) had state regulation, one (SHI) had societal regulation and one (PHS USA) had private regulation. They claimed that their regulation dimension can be structured as the relation between financing agencies, providers, and (potential) beneficiaries. They then set out six objects of regulation.

Many studies (for example, Lewis et al., 2006; Walshe, 2003) pointed out that regulation is difficult to define but tend to set out the definition from Selznick (1985, p. 363) of 'sustained and focussed control exercised by a public agency over activities which are valued by a community.' As Walshe (2003, p. 9) put it, what distinguishes regulation from many and varied mechanisms for performance management is that generally the regulator is a 'third party' to any transaction or interorganizational relationship.

According to Hood et al. (1999), we are said to live in the age of the 'regulatory State' (adding later the 'age of inspection' or 'audit society'). They explained that the phrase suggested modern states were placing more emphasis on the use of authority, rules and standard-setting, partially displacing an earlier emphasis on public ownership, public subsidies, and directly provided services. They continued that regulation was a much-used word that was rarely defined with precision, but it broadly denoted the use of public authority (often in the hands of specialized agencies) to set and apply rules and standards.

Both regulation and regulators can be regarded as diverse. They found that all parts of the public sector faced multiple, not single, regulators, and that those multiple regulators tended to work independently and with little awareness of the activities of their counterparts. They identified seven relatively distinct types of regulators inside government – public auditors, professional inspectorates, ombudsmen, central-agency regulators, funder-regulators, departmental regulators of agencies, and central-government regulators of local authorities, and the NHS.

They set out a cybernetic (control theory) perspective, where control must contain some method of setting standards (a 'director'), some way of gathering information about whatever is being controlled (a 'detector'), and some way of modifying behaviour (an 'effector') if the system swings off limits. For the director element, they found wide variation among overseers within government. Turning to detection, they claimed that most of the regulators obtained their information by one or more overlapping methods – inspection, audit, certification, authorization, and adjudication or mediation. Finally, for the effector element, they claimed that the ways of changing behaviour also varied widely too. However, they did not analyse the NHS in any detail. Moreover, there appeared to be little effort to evaluate the success of regulation in achieving its objectives.

Perhaps the most comprehensive text on regulation on health care remains Walshe (2003), who explored how and why health care organizations were regulated, what forms regulation took what regulators did, and how regulation changed their behaviour and impacted on their performance. He set out three main aims of regulation: improvement, assurance and accountability, together with three regulatory models: compliance, deterrence and responsive. Deterrence models stressed compliance, while compliance models focused on persuasion and encouragement rather than formal or punitive enforcement. Responsive or 'smart' regulation was a flexible model that allowed regulatory agencies in both earlier models to choose their approach depending on performance or risk levels. He then set out three main regulatory processes: direction, detection and enforcement. Direction defines standards and removes systemic barriers through the provision of external policy impetus. Detection refers to the measurement and monitoring of performance. Enforcement is central to regulation and covered the methods used to educate, persuade, influence and force behavioural change. He used a slightly different framework to Hood et al. (1999) for evaluating regulation which included: the regulating organization; regulatory goals/objectives; the scope of regulation; the regulatory model; direction; detection; and enforcement. He then applied this to different organizations in the UK such as the Commission for Health Improvement.

Lewis et al. (2006) stated that regulation can be divided conceptually into 'economic regulation' and 'quality regulation'. Economic regulation refers to regulating the activities of organizations as they related to each other or to consumers within a market, such as the management of market entry and exit, anti-competitive behaviour and pricing. Quality regulation relates to controls over the nature of the product offered to the consumer (or controls over the competence of those delivering the product. Moreover, regulation may be *ex ante* or *ex post*.

Ex ante regulation refers to regulatory controls that seek to prevent adverse behaviour or outcomes, while *ex post* regulation takes action after an offence has been detected.

Walshe (2003) and Oikonomou et al. (2019) set out the complex history of regulation in the UK. An important landmark in professional (or self) regulation was the Medical Act 1858 which established the General Council of Medical Education and Registration of the UK (later the General Medical Council) which maintained entry to, and exit from, the medical profession in the form of the 'Register'. Moreover, other non-governmental agencies such as the medical Royal Colleges, have an important role in regulating medical training. Beyond this there was limited regulation of either state or private provision. For example, for the first 50 or so years of the NHS, regulation of the private health care sector was limited, and undertaken by the NHS. However, a new national regulatory agency, the National Care Standards Commission (NCSC), was established by the Care Standards Act 2000, and it formally assumed responsibility for regulating a wide range of health and social care providers in England from April 2002.

While there was some general government regulation with a role in health care (e.g., the Audit Commission, the National Audit Office, and the Health Service Ombudsman), there was little regulatory attention to NHS organizations, which were regarded as accountable through a straightforward bureaucratic hierarchy to central government and the Minister of Health.

Scandals in the NHS led to greater regulation. After failures of care in long stay institutions, the Health Advisory Service (HAS), the 'first true external oversight body' (Oikonomou et al., 2019) or 'the first regulator for the NHS' (Walshe, 2003) was set up in 1969. The Conservative government (1979–1990) created a number of regulatory bodies (such as the NHS Litigation Authority, now NHS Resolution). However, the Labour government (1997–2010) saw a rapid and continuing growth in health care regulation which involved setting up new organizations. These included the National Institute for Health and Care Excellence (NICE) which determined whether (mainly new) treatments ought to be made available for the NHS based on assessments of their cost effectiveness and the Commission for Health Improvement (CHI), which later became the Care Quality Commission (CQC), as a quality regulator to oversee and inspect the clinical quality of all NHS services. However, only two years after the creation of the CHI, and only two weeks after the National Care Standards Commission had taken over responsibility for regulating private health and social care, the Department of Health published proposals to rationalize health and social care regulation by creating two new 'super-regulators' – a Commission for Healthcare Audit and Inspection, to regulate all health care provision, and a Commission for Social Care Inspection, to regulate all social care. Monitor, a regulator for Foundation Trusts, was set up in 2004. Its role included assessing NHS Trusts for Foundation Trust status, ensuring FT were well led, preventing anti-competitive behaviour, and setting prices for NHS-funded care. However, all this regulation did not prevent further scandals such as 'Mid Staffordshire' which was regarded as a defining moment for the whole regulatory regime.

Oikonomou et al. (2019) mapped over 126 organizations that exerted some regulatory influence on NHS provider organizations, including three national overseeing bodies, 18 statutory regulators, 104 organizations with regulatory effect, and finally a grouping of all the NHS Commissioners (211 CCGs and 10 ICSs). They stressed that many of these organizations would not see themselves as regulators and regulation might not be their primary function, but they all exert some regulatory influence on the NHS. They argued that Regulatory landscape of health care is complex and multifaceted, and it appeared that no one, not even regulatory organizations, had a complete understanding of all the bodies with regulatory impact on the NHS.

There have been some comparative studies of regulation in health care. Lewis et al. (2006) carried out a comparative study of regulation in Germany, New Zealand, the Netherlands and the Autonomous Community of Catalonia in Spain. Helderman (2012) explored the rise of the regulatory state in health care by comparing the Netherlands, England and Italy. They concluded that by 2010 the NHS in England had moved away from a 'dirigiste' state but had not moved into a 'regulatory' state.

Schweppenstedde et al. (2014) pointed out that there is a lack of international consensus on what constitutes 'effective quality regulation', given the diversity of governance and financing of health care systems within which providers in OECD countries operate. They selected six countries: Australia, Finland, Germany, the Netherlands, and the United States of America (USA) and included England for comparison. These countries used a combination of policy instruments to assure quality and safety in the provision of health and social care. They describe four principal regulatory strategies to ensure quality and safety in the health and social care sectors: command and control (e.g., licensing professionals and facilities, enforcing performance standards); meta-regulation (self-regulation is monitored by an external third party e.g., consumer complaints ombudsmen); self-regulation and voluntarism (where organized groups regulate the behaviour of their members e.g., clinical governance, voluntary hospital accreditation); and market mechanisms (e.g., incentive payments, governance by contracting, and performance league tables). They claimed that all of the countries employed these strategies. However, all nations used mechanisms of command and control, mostly in relation to professional licences, and elements of self-regulation and voluntarism, while meta-regulation was common, through mechanisms such as external clinical audit, mandated incident reporting and ombudsmen. The explicit use of market mechanisms appeared to occur less frequently. This was summed up in their Table 2.3, which reported the regulatory activities and mechanisms for health and social care governance.

However, they concluded that the overall evidence of the effectiveness of regulatory strategies towards ensuring care quality and safety at system level was scarce. Moreover, it was difficult to derive overarching conclusions of whether one system was more effective than another, given the complexity of the health and social care systems, and the diverse political and cultural contexts within which regulatory mechanisms operate. Finally, as the report focused primarily on collecting information on existing regulatory mechanisms and actors responsible for ensuring quality of care, it was not possible to identify best practice.

Bloom et al. (2014) argued that efforts by the governments of LMICs to import institutional arrangements for the regulation of health markets from the advanced market economies have had limited success. They discussed issues of what and who is regulated. They claimed that certification of health providers was the most common regulation of health markets in LMICs, and that the regulation of medicines and medical equipment has developed in most LMICs in recent years. Finally, many LMIC governments have made efforts to facilitate access to the poor. They concluded that attempts to import models from the advanced market economies have not often been effective, but that there was little systematic evidence on strategies for building effective institutional solutions to the problem of asymmetric information in LMICs. Similarly, Sheikh et al. (2015) argued that regulating health care is a major policy challenge in many LMICs, especially those with a strong private health sector, and that regulatory approaches in these countries have often regarded as ineffective. They examined regulatory actions targeted at modifying the costs, quality and accessibility of health care, and the conduct of health care providers, concluding that the health regulatory architecture in the two states they investigated (Delhi and MP) was inadequately developed.

CONCLUSIONS

This chapter has covered much ground in examining the public-private mix of health care systems using the three dimensions of provision, finance and regulation, and drawing on material from many nations. The overarching conclusion must be that despite an extensive literature, our knowledge of providing, financing and regulating health care remains fairly thin. First, in terms of description, it is difficult to find an accurate picture of recent trends. This is partly due to problems in conceptualizing and measuring the basic terms. A fairly clear, albeit dated, picture has been given by Maarse (2006) who wrote that the results of his study indicated limited privatization in health care spending in all countries selected, with the exception of Belgium and, particularly, Poland. He found some evidence for a shift from public to private in health care provision, notably in Germany (hospital care), the United Kingdom (long-term care and community care), and Poland (primary care). Finally, there were signs of privatization in health care management and operations, as well as health care investments. In short, he argued that the overall picture was diverse, but there was evidence that health care in Europe has become somewhat more private. We need more recent evidence that updates this study and unpacks the claim of 'somewhat more private' in terms of clear definitions, criteria and operationalization.

Second, given the problem note above with the independent variable, it is even more difficult to come to clear conclusions about the dependent variable of the effects of privatization. Many of the studies and reviews (above) tended to use a wide variety of cognate terms, focused on a wide variety of dimensions, with some claiming to focus on one dimension only to explore others. The studies seemed to focus on a very wide variety of dependent and independent variables, with absent or problematic control measures. Moreover, it has been claimed that many studies exhibited methodological problems and were broadly regarded as low quality. Our knowledge concerning both description and evaluation is even more limited for the dimension of regulation, and for LMICs.

It has been argued that the public-private mix of health care systems relating to the three dimensions of provision, finance and regulation are an important ingredient of the character of a health care system and should be the focus of more effort in the study of health system typologies. However, at present, there are significant gaps in our knowledge of both the level of, and effects of, privatization in health care systems, especially concerning regulation, and LMICs. It is also not fully clear how the three dimensions interact. Can aims such as universal health coverage or equity be achieved through one dimension alone? If so, which is the best route, or can objectives be achieved only by a combination of the dimensions? The evidence from LMIC suggest that regulation alone is unlikely to achieve objectives (e.g., Koivusalo and Mackintosh 2004). Put another way, it looks unlikely that governments can simply 'steer' (regulate) without also having to 'row' (provide and/or finance).

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15. International organizations and global health policy: actors, priorities, and recent developments

Shiri Noy and Derek Richardson

INTRODUCTION

International organizations are key actors in global health. In many ways, they signpost and create basic infrastructure for not only international but also national and sub-national health programs and policies. The World Health Organization (WHO) and World Bank (WB), in particular, have been dubbed the two "global ministries of health" (Deacon, 2007), as they provide a myriad of resources in the form of funding, technical and other expertise, coordination and communication, and set priorities and propose solutions to global health challenges (Kuhlmann et al., 2015). However, as is often repeated, with great power comes great responsibility. These organizations often have vested interests of their own and may be most responsive to the demands and concerns of the global North and developed countries. Other organizations, including bilateral agencies, also have particular characteristics and priorities that guide their health aid activities. Our goal in this chapter is to provide an overview of the landscape of international health organizations, policy, and governance. Inevitably there are organizations that we do not cover, which have import in particular countries and times. We also note that each of these organizations have entire books and a whole corpus of work devoted to their activities, which is beyond our scope here, and we hope that the references provide a starting point for deeper reading on each.

We argue that international health organizations influence and are influenced by global health policy. This constitutive relationship affects how international organizations design and implement their projects on the ground, which has implications for their beneficiaries. Sometimes the relationship is catalytic, providing solutions to health issues and saving lives; other times initiatives fail and may even exacerbate negative outcomes, opening international health organizations and designers of health policy to criticism from scholars, practitioners, and beneficiaries alike. Research suggests that there is not enough coordination among organizations to mount effective responses to global and international challenges. Studying international health organizations in isolation risks overlooking the crucial role health policy plays in shaping these organizations' activities, outcomes, and effects on target populations. Importantly, however, while health policy is developed on a global stage and may in turn be construed as a product of the international health system or global health governance, its systems are governed at the state level (Marmor and Wendt, 2012) and enacted at the local level.

INTERGOVERNMENTAL ORGANIZATIONS AND HEALTH

We first review the major intergovernmental organizations (IGOs) in the scene of "global health," focusing on those whose mandate and mission include working on policies about health. There are many more organizations, both governmental and nongovernmental, that do not particularly profess to work on/in health policy and yet their work has important implications in the global health landscape. Some examples include the International Monetary Fund (IMF), with notable literatures about how structural adjustment has affected health outcomes and policies. In this chapter, however, we limit the scope of our review and analysis to organizations that have a professed involvement in health and health policy, but note that these play important roles in the field of "global health governance," albeit sometimes indirectly.

The World Health Organization

Background

The World Health Organization (WHO) is likely the best-known international organization working in health. Established in 1948 (after extended discussion and negotiation beginning in 1945) as a specialized agency of the United Nations, it was tasked with coordinating international public health (Chorev, 2012; Cueto et al., 2019). The constitution was adopted in 1946 by 51 member-states committed to conceptualizing health as a right rather than a limited biomedical definition. The World Health Assembly convenes UN-member states, where member countries are directly represented under a single vote per state; thus, other foreign affairs and geopolitical conflicts or priorities often affect decision making in the assembly, which was characterized by Cold War divisions during its early decades, for example (Chorev, 2012).

Activity

Despites changes in its priorities and activities over time, the WHO has been strategic in its work – sometimes purporting to espouse dominant, global North states' frames and priorities while other times resisting them (Chorev, 2012). Broadly, the WHO coordinates priorities, centralizes information for dissemination, and offers technical support. In its earlier years, it played an integral part in massive global health successes, such as the eradication of smallpox. Scholars have pointed to several "phases" of the WHO's activities, with some focusing on disease outcomes (e.g., AIDS, Ebola) and others tracing differences across directors or priorities (Chorev, 2012; Gostin et al., 2015). The WHO also promotes particular health policy approaches, such as the recent One Health agenda in Europe and Universal Health Coverage (UHC) (Amuasi et al., 2020; Gostin and Friedman, 2015). Importantly, the WHO's resolutions, as well as recommendations it can make to member states, are not binding, though they may be influential.

The WHO's finances, especially since the 1990s, have been described as "weak and unstable" and a contributing factor to "fragmented leadership in global health" (Cueto et al., 2019, p. 328). Often, over half of its money comes from "extrabudgetary" donations rather than those that are assessed and based on countries' wealth and population. Many of these donations are for specific disease control initiatives, which creates competition within the WHO among program directors, regional offices, and headquarters over resources and priorities (Cueto et al., 2019).

Criticisms

The WHO has been criticized for its failure in leadership on several occasions, most recently during COVID-19 and previously with Ebola; however, this is partly due to its status as a normative rather than an operational leader, partly owing to its funding structure and issues therein (Wenham, 2017). Criticisms have centred not only around action, but also surrounding leadership. For example, the WHO's often interchangeable use of "swine flu" for the H1N1 virus at the beginning of that pandemic led to economic and political decisions that included bans and killing of livestock in countries without any cases (Kamradt-Scott, 2018). Part of its difficulties in coordination and normative leadership are due to its administrative structure, with regional offices and central headquarters often struggling to communicate and coordinate. Indeed, this structure has "frequently been identified as contributing to a range of inefficiencies, duplication of effort, poor health outcomes and obstructive infighting" (Kamradt-Scott, 2018, p. 203), and this criticism has been extended to COVID-19 (Agartan et al., 2020).

The World Bank

Background

The World Bank was founded along with the International Monetary Fund (IMF) at the Bretton Woods, New Hampshire conference of the 44 nations in 1944. While the goal of the IMF was to promote international economic stability by helping countries manage their exchange rates, the mission of the World Bank (then the International Bank for Reconstruction and Development) was to facilitate economic development among poor countries and help rebuild the economies shattered by World War II (Babb, 2009, pp. 41–42). By custom, the World Bank is headed by a US citizen whereas the IMF is headed by a European. The Executive Directors, representing the World Bank's 179 member countries (Driscoll, 1996, p. 4), constitute the Board of Directors and usually meet twice a week to supervise borrowing and financing decisions as well as other administrative issues.

The World Bank currently comprises two major organizations: the International Bank for Reconstruction and Development (IBRD, originally the sole component of the World Bank) and the International Development Association (IDA, founded in 1960). The poorer the country, the more favourable its borrowing conditions (World Bank, "How we Classify Countries"). In contrast, all member nations, both wealthy and poor, have the right to financial assistance from the IMF (Driscoll, 1996, p. 4). In making loans to developing countries, the World Bank does not compete with other sources of finance; it assists only those projects for which the required capital is not available from other sources on reasonable terms (Driscoll, 1996, p. 6).

Activity

The World Bank has changed its approach over time, shifting from an emphasis on primary healthcare lending in the early 1980s, health reform through the mid-1990s, and health systems more recently (Tichenor and Sridhar, 2017). In the global health financing landscape, despite the proliferation of additional organizations, the World Bank remains a uniquely powerful agency for several reasons. First, in some world regions, such as Latin America, it remains the single largest external funder of health care (Noy, 2017). Second, while there are many more actors participating in global health governance, the World Bank's historical domination of the global health funding field has endowed it with a reputation as a particularly respected actor net of its monetary investments and lending in health (Kaasch, 2015). Third, it is an important source of health data such as the World Development Indicators, and it is sometimes the only source of data in some places and on some outcomes, particularly those tied to its projects. Finally, and most discussed in the literature, it remains a funder of last resort to national governments and can attach conditions to loans and projects (Clinton and Sridhar, 2017). Recent research calls for increased attention to the many facets of the World Bank's activities and organizations and notes the importance of not only considering the World Bank's work vis-à-vis governments, but also other global health organizations and partners (Tichenor et al., 2021). Alongside the WHO, the World Bank and other foundations (reviewed below) have increasingly been moving towards partnerships under separate umbrellas, such as the Gavi Alliance and the Global Fund to Fight AIDS under the leadership of the Gates Foundation.

Criticisms

The World Bank has historically been the largest external funder of global health since it began direct lending in health in 1980 (Ruger, 2005). Its role in health policy and the effects of its programs, projects, and loans have been widely studied and debated, with apparent differences both over time and across countries and world regions. Much scholarly attention has focused on the adverse health effects of the World Bank's structural adjustment programs, particularly in sub-Saharan Africa (Coburn et al., 2015; Forster et al., 2020; Kentikelenis, 2017; Shandra et al., 2004, 2011; Thomson et al., 2017), and there is significant criticism of the World Bank alongside the IMF in terms of the social implications of structural adjustment. This well-warranted criticism suggests that the World Bank's work – not specifically in the health sector – has had important, often detrimental, effects on population health outcomes and health equity (Forster et al., 2020). Nevertheless, there is increasing evidence that the World Bank may have changed its approach, moving away from privatization efforts and embracing universal health provision (Harris, 2017; Noy, 2017, 2018, 2021; Reich et al., 2016). The continued focus on human capital and efficiency, however, may undermine the goals of universal healthcare in the context of a rights framework.

National Aid Organizations and Bilateral Assistance

Another set of important actors in global health policy are national bilateral aid agencies. While each has its own distinctive history and evolving priorities, they share some commonalities. In particular, they reflect national priorities and much of their funding flows through nongovernmental organizations (NGOs) to recipient countries. They are also often criticized for being wielded as political tools in international relations rather than focusing on development priorities. Below, we review some overall trends in these agencies.

Background

Most industrialized nations in the global North have bilateral aid agencies that provide aid to less developed countries. These agencies receive funding from their home country's government to then distribute directly to other states. The Organization for Economic Co-operation and Development (OECD) classifies bilateral foreign aid as Official Development Assistance (ODA), which has been the "gold standard" and primary source of financing for development aid (Ilasco, 2021; OECD, 2021b). ODA comes in the form of grants and soft loans and is administered with the purpose of promoting economic development and welfare in recipient countries. This excludes military aid and transactions that serve commercial purposes (OECD, 2021b).

Net ODA from OECD countries has risen steadily from just below USD 40 billion in 1960 to an all-time high of USD 161.2 billion in 2020 (OECD, 2021c). The top national contributors of ODA have been fairly consistent over the past decade (Coppard et al., 2012; Ilasco, 2021). In 2020, the United States gave USD 35.47 billion in ODA, followed by Germany (USD 28.31 billion), the United Kingdom (USD 18.56 billion), Japan (USD 16.27 billion), and France (USD 14.14 billion) (OECD, 2021b). Country rankings differ when calculating ODA as a percent of countries' gross national income (GNI). For developed countries, the United Nations set a target of committing 0.7% of GNI to ODA, and as of 2020 only six countries have met or exceeded this target: Sweden (1.14%), Norway (1.11%), Luxembourg (1.02%), Denmark (0.73%), Germany (0.73%), and the United Kingdom (0.70%) (OECD, 2021b).

Among these top donor countries, most established their bilateral aid agencies or some rudimentary version of it during or following the World War II era. For example, France created the Central Fund for Free France (CCFL) in 1941, which underwent various organizational transformations before becoming the Agence Française de Développement (AFD) in 1998, which remains its bilateral aid agency today (AFD, 2021). Similarly, the United States began providing foreign aid in 1948 through the Marshall Plan, which was designed to assist with rebuilding war-torn Europe, before establishing its official bilateral aid agency, the United States Agency for International Development (USAID), in 1961. Japan, however, did not establish its own bilateral aid agency, Japan International Cooperation Agency (JICA), until 1974, mostly due to its late transition from being an aid recipient to aid provider (Stallings and Kim, 2017).

Activity

Currently, bilateral aid is delivered within the framework of the United Nations' Sustainable Development Goals (SDGs), which acts as a "blueprint to achieve a better and more sustainable future for all" across the globe (AFD, 2021; UN, 2021). However, most bilateral aid agencies determine country- and sector-specific allocations according to their own national interests. In other words, despite having a philanthropic dimension and seeking to enhance coordination in the interest of sustainable development, ODA is often treated as a foreign policy instrument to advance political and economic interests in other countries (Carbonnier, 2010). As such, countries' bilateral aid agencies regularly shift their approach to aid and funding priorities. For example, USAID initially focused on technical and capital assistance programs before emphasizing "basic needs" in the 1970s, employment and income generation in the 1980s, democracy building during the 1990s, and global health in the 2000s (USAID, 2019). These shifts coincide with changes in macroscopic socio-political conditions, such as the rise of neoliberalism in the 1980s, the fall of the Berlin Wall in 1989, and recognition of HIV/AIDS and other infectious disease epidemics in the 1990s and early 2000s. Meanwhile, East Asian donors like Japan and South Korea have concentrated their aid delivery to other Asian countries rather than having a more global focus, and tend to prioritize projects that promote economic growth (e.g., building infrastructure and production facilities) over projects that seek to alleviate poverty, build democracy, and promote human rights (Stallings and Kim, 2017).

Despite these country-specific idiosyncrasies, most bilateral aid agencies report sector-specific ODA disbursements with health being among the most-funded sectors.

According to 2019 totals, the top overall donors to global health are the United States (USD 1.78 billion), the United Kingdom (USD 1.01 billion), Germany (USD 712.55 million), France (USD 849.42 million) and South Korea (USD 516.98 million) (OECD, 2021a). Health funding supports projects that range from distributing vaccines and other pharmaceuticals, building clinics and hospitals, training healthcare professionals, and supporting maternal and reproductive health. Most recently, health ODA has been directed toward responding to the COVID-19 pandemic. In 2020, countries that belong to the OECD's Development Assistance Committee (DAC) contributed USD 12 billion to COVID-19 related activities (OECD, 2021c).

Criticisms

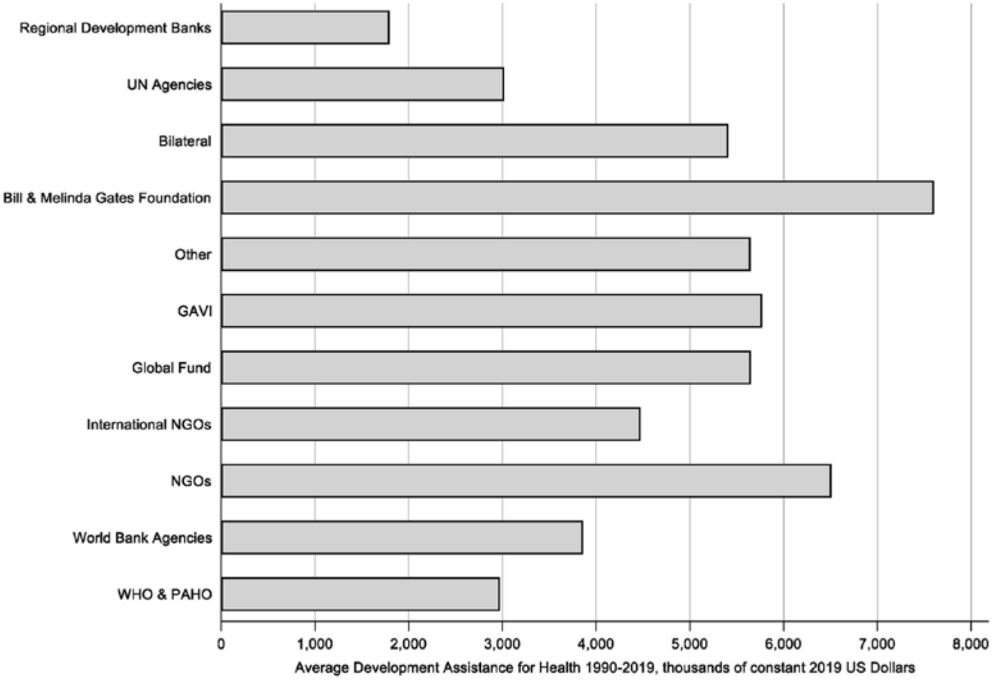
According to Carbonnier (2010), criticisms against bilateral aid originate from three distinct ideological schools of thought: neo-Marxist, populist, and neoliberal. Neo-Marxist critics construe ODA as a means for wealthy donor countries to dominate poor countries and entrench them in dependency relationships. Populist critiques take issue with the allocation of money abroad and prefer devoting taxpayer revenue to national economic and social priorities. Finally, neoliberal critics charge that ODA provision creates ineffective administrative bureaucracies in recipient countries that serve to support corrupt and non-democratic leaders. More generally, many scholars and development practitioners question the overall effectiveness of bilateral aid; that is, whether spending on various development programs leads to sustainable improvements in beneficiary communities. These critiques range from agenda-setting to measuring impact, and oftentimes draw upon neo-Marxist and neoliberal ideologies (e.g., Elayah, 2016; Gharib, 2017; Sraieb, 2016; Tsikata, 1998).

INTERNATIONAL NGOS AND FOUNDATIONS

Much has been written about the rise of international nongovernmental organizations (INGOs) and foundations in the global health governance field, particularly because in many countries and regions, their monetary contributions and budgets exceed those of intergovernmental organizations (IGOs) and sometimes even of governments. Many IGOs were established after World War II and the Cold War to rebuild and increase coordination among states. INGOs in health, on the other hand, have proliferated more recently, possibly in response to the global nature of contemporary problems. These actors often work with state governments, and while they are influenced by national priorities, they also influence national priorities despite not being elected or accountable to people nor governments in the same ways that IGOs are. This has raised important questions about how INGO-state relations shape global health priorities, responses, and directions without the traditional structures of accountability, especially with increased cooperation with IGOs such as the WHO. As we discuss below, this has led to myriad criticisms, but also caused some excitement about the diversification of the global health landscape and the challenges of coordination. Some are optimistic about INGOs creating a more level playing field for the involvement of new actors and ideas, countering the outsized influence that Western, developed countries have had on discourse, resources, and decisions in IGOs. Others, however, note that INGOs are another form of global North/Western-based influence in global health.

Figure 15.1 provides an overview of the channels through which development aid for health has flowed, showing the average between 1990 and 2019 (Institute for Health Metrics and

Evaluation (IHME), 2020). As Figure 15.1 indicates, while IGOs and regional banks still have an important role in international health financing, much of the funding in the last 30 years has been funnelled via local and international NGOs as well as foundations. This underscores the financial import of these organizations in global health. Below we review some of the primary actors in the global health INGO fields.



Note: "Other" category includes The Coalition for Epidemic Preparedness Innovations (CEPI), the European Commission, the European Environmental Agency, and the US Foundation.
Source: Institute for Health Metrics and Evaluation (IHME).

Figure 15.1 Average development assistance for health

Gates Foundation

Background

The Bill & Melinda Gates Foundation (henceforth referred to as the Gates Foundation) has become one of the most active and influential actors in global health. Initially focused on specific disease initiatives like malaria, tuberculosis, and HIV/AIDS, the Gates Foundation has broadened its foci by partnering with and investing in organizations that innovate technological solutions to health problems and intervention delivery. It directed over USD 4 billion to its Global Health Program in 2020 and committed USD 666.6 million to the WHO for 2020–2021, making it the second largest voluntary contributor to the WHO (WHO, 2021). The Gates Foundation also provides considerable funds to, and has representation on the boards of, the Gavi Alliance, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and UNAIDS (Harman, 2016).

Activity

The Gates Foundation's size, prominence, and influence in global health philanthropy has been compared to that of the Rockefeller Foundation in the early- to mid-20th century (Birn, 2014; Harman, 2016; Levich, 2015), but requires recontextualization in light of neoliberal globalization and what some scholars call "philanthrocapitalism" (Birn, 2014; Bishop and Green, 2008). Post-Cold War neoliberal ideology reduced the role of states in the provision of social services and resulted in the redirection of funds away from state-run health institutions and the privatization of healthcare services. The non-profit sector and civil society organizations were perceived as more efficient and effective actors and became preferred partners for providing health services both domestically and internationally. The neoliberal turn was followed by a shift in philanthropic giving such that billionaire-led private foundations apply hyper-competitive, profit-making, result-oriented approaches to charitable giving (Birn, 2014, p. 20; Bishop and Green, 2008; McGoey, 2015).

Criticisms

While the Gates Foundation has been praised for its dedication to overcoming health problems in developing countries, its efforts have been criticized on several fronts. First, the Gates Foundation occupies a position of authority in global health governance that gives it unprecedented and unchecked influence over agenda-setting. The Gates Foundation's largesse shapes which health issues are prioritized for research and interventions. It has also been criticized for abiding by a narrow, biomedical conception of health that sees "health as the product of technical interventions divorced from economic, social, and political contexts" (Birn, 2005, p. 515). Second, some critics problematize the Gates Foundation's choice of partners. An analysis of the Gates Foundation's disbursements from 1998 to 2007 reveals a preference to partner with organizations and institutions located in the global North, thus contributing to the underdevelopment of health infrastructure and knowledge bases in the countries it seeks to help (McCoy et al., 2009; McCoy and McGoey, 2011). These concerns coincide with criticisms launched against the Gates Foundation for investing its assets in corporations whose activities contradict its charitable goals, such as ExxonMobil, Chevron, and Coca-Cola (Birn, 2014; McCoy & McGoey, 2011; McGoey, 2015). Furthermore, the Gates Foundation's tendency to partner with actors outside of established multilateral frameworks raises questions of accountability and legitimacy. The Gates Foundation is only accountable to its three board members – Bill Gates, Melinda Gates, and Warren Buffett – and its "lack of democratic mandate means there is no mechanism for popular oversight of its internal decision-making" (Stevenson and Youde, 2020, p. 403). With respect to legitimacy, since the Gates Foundation partners with elite institutions in the global North and since these institutions stand to benefit from receiving its funds, the Gates Foundation is able to "engage in a process of self-legitimation that in effect buys consent to its rule and … influence in global health governance," and this consent is "not based on a pluralist polity of global actors, but on institutional elites" (Harman, 2016, pp. 364, 363).

Médecins Sans Frontières (Doctors Without Borders)

Background

Médicins Sans Frontières (MSF) is an INGO that provides medical and humanitarian relief to populations affected by natural disasters and conflicts in more than 70 countries (Doctors Without Borders, 2021a). Also known by its English name, Doctors Without Borders, MSF was founded in 1971 by a group of French physicians who worked with the International Committee of the Red Cross (ICRC) during the Biafran war and were dissatisfied with its emergency assistance response (Chen, 2014). Contra ICRC, these physicians believed medical aid should be provided to needy populations without states' permission, a value that Bernard Kouchner, MSF's co-founder, terms "le droit d'ingérence" or "the right to interfere," and aid organizations should bear witness to and publicize human rights abuses, governmental corruption, and beneficiaries' plight, a practice MSF terms "témoignage" or "witnessing" (Chen, 2014; Dechaine, 2002; Fox, 1995).

Initially a loosely organized group of volunteer healthcare professionals (Savelsberg, 2015), MSF expanded from its Paris headquarters to now having offices in 21 countries, including an international secretariat, MSF International, located in Geneva, Switzerland (Doctors Without Borders, 2021b). Its membership grew substantially, especially during the 1980s, from originally having 300 volunteers in 1971 to now employing over 40,000 personnel (Dechaine, 2002; Doctors Without Borders, 2019, 2021c). Moreover, MSF has broadened its repertoire of aid provision from projects that offer immediate, short-term relief to projects that require longer-term engagement, such as malnutrition, mental health counselling, and gender-based violence (Chen, 2014).

Activity

Since its inception, MSF has applied its interventionist and advocacy-based approach to international aid in a number of humanitarian crises (Fox, 1995; Savelsberg, 2015). Among their more notable engagements include chartering a boat to rescue Vietnamese refugees fleeing the country via the South China Sea in 1978. This intervention caused an internal conflict within MSF, as "younger members of Doctors Without Borders took the position that the predicament of the 'boat people' surpassed the competence and capacities of a medical humanitarian organization like theirs" (Fox, 1995, p. 1608). These members also rebuked Kouchner's mobilization of the media to publicize and dramatize the refugee situation, ultimately resulting in Kouchner and other members establishing a separate medical humanitarian organization, Médicins du Monde, or "Doctors of the World," in 1980 (Fox, 1995).

During these early decades, MSF worked primarily at the level of refugee camps; however, during the 1990s conflicts and projects began taking on a larger scale, creating a need to set up and provide aid in conflict zones (Savelsberg, 2015). For example, in 2004 MSF aided in the Darfur region of Sudan amid violence between rebel and government forces. Initially understaffed and overwhelmed by the affected population's needs, MSF raised international awareness of the suffering in Darfur by releasing a retrospective mortality survey from the internally displaced person (IDP) camps and challenged the government's insistence that no massacres had occurred (Savelsberg, 2015). While these acts of *témoignage* oftentimes criticize or direct blame toward state leaders, MSF has also challenged international organizations such as the WHO. For instance, when the WHO released a celebratory report on the successes of its global HIV/AIDS treatment program in 2005, MSF identified persistent barriers that have undermined the delivery of antiretroviral (ARV) treatment in developing countries, such as trade laws that interfere with generic drug production and underinvestment in research and development for diagnostic and therapeutic tools ("Médecins Sans Frontières Challenges WHO Conclusions about Global AIDS Treatment," 2005).

Criticism

MSF, like other international health organizations, is not immune to criticism. Primarily, many observers question the organization's fulfilment of their mandate of political and ideological neutrality, especially with respect to *témoignage*. On the one hand, MSF believes neutrality does not require silence, as James Orbinski, former president of the MSF International Council stated, "Silence has long been confused with neutrality, and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption … We are not sure that words can always save lives, but we know that silence can certainly kill" (Doctors Without Borders, 2021d). On the other hand, MSF has been accused of violating this alleged neutrality, such as in Somalia where the group's efforts "appeared to favour one local faction over another, [which] resulted in hostilities against relief workers" (Sharp et al., 1994, p. 389) and in Sudan, where the government accused MSF of collaborating with the International Criminal Court (ICC) following the indictment of President Omar Hassan Ahmad Al Bashir for ethnic cleansing (Savelsberg, 2015).

MSF's *témoignage* also requires use and exploitation of mass media. This has raised concerns over the "theatricalization of human disaster," which can dehumanize victims and desensitize spectators to their suffering (Fox, 1995, p. 1612). Moreover, MSF's professional relationship with the media gives it significant control over how humanitarian crises are presented to the public and how narratives surrounding interventions are constructed. Such narratives often portray MSF workers as heroes and identify the "victims" and "villains" of catastrophes (Dechaine, 2002; Fox, 1995). Observers worry that MSF manipulates the media in self-serving ways, for example, "to propagandize, to compete with other relief agencies for funds, recognition, and prestige, or to stage manage their activities for media coverage" (Fox, 1995, p. 1613). Furthermore, narratives of victimhood impose a victim identity over populations receiving care from MSF, which characterizes them as powerless and lacking agency (Chen, 2014).

Red Cross

Background

With its origins dating back to 1863, the International Committee of the Red Cross (ICRC) is the oldest medical humanitarian organization in the world. Its initial purpose was to treat wounded and sick soldiers on the battlefield, which had previously been under the auspices of military medical personnel and religious groups (Dromi, 2016). The 1864 Geneva Convention codified the protection of victims of war, granting inviolability to wounded soldiers and humanitarian medical workers, regardless of nationality (Dromi, 2016; Forsythe, 2005), and nearly a century later the 1949 Geneva Convention and its Additional Protocols and Statutes provided the ICRC with its mandate (Forsythe, 2018; Harroff-Tavel, 1993). Specifically, the ICRC has a right of initiative to act in the event of international armed conflicts, and the Additional Protocols extend protection to civilians and victims of non-international conflicts (Forsythe, 2005; ICRC, 2014). The ICRC also operates according to seven Fundamental Principles that "provide an ethical, operational and institutional framework for the work of the Red Cross and Red Crescent Movement around the world", namely: humanity, impartiality, neutrality, independence, unity, universalism, and volunteerism (Forsythe, 2005; Harroff-Tavel, 1993; ICRC, 2016). These principles apply to all 192 National Red Cross and Red Crescent Societies, which follow the leadership of the ICRC Assembly in Geneva, Switzerland.

Activity

The ICRC's original work entailed providing medical care and aid to military casualties and detainees in prison camps; however, following World War II and especially after the Cold War, the ICRC has broadened the scope of its activities (Forsythe, 2018; Harroff-Tavel, 1993; Wylie, 2002). Much of this expansion is due to the unique humanitarian needs stemming from protracted conflicts that increasingly involve violence within rather than between states, and between loosely organized parties rather than clearly defined actors (Forsythe, 2018; Harroff-Tavel, 1993). While still assisting victims and prisoners of war, today the ICRC also provides food and medical assistance to civilians; rebuilds infrastructure in conflict-affected areas; shares expertise in public health, logistics, and emergency medical relief; restores contact between family members separated by conflicts or catastrophes; traces persons missing due to violence and unrest; and raises awareness about international humanitarian law and the Red Cross and Red Crescent Principles (Forsythe, 2018; Harroff-Tavel, 1993; Wylie, 2002). The Red Cross has also begun intervening in humanitarian crises that lack manmade causes, such as the 2014–2016 Ebola crisis in West Africa (Forsythe, 2018).

Criticisms

Criticism directed toward the ICRC generally falls into three categories. The first concerns its fulfilment of its principles of neutrality and confidentiality. Critics question the appropriateness of remaining neutral and withholding information from international criminal tribunals, such as in Nazi Germany, Yugoslavia, and Rwanda (Wylie, 2002). These criticisms take on heightened valence with the growing belief that humanitarian interventions are inherently political and the emergence of organizations like Médicins Sans Frontières that openly name and shame perpetrators of war crimes and human rights violations (Wylie, 2002). The second category of criticisms pertains to the ICRC's collaborations with the private sector. Under its current president, Peter Maurer, the ICRC has increasingly received donor support from, and coordinated its activities with, corporate actors. Some critics believe accepting money from corporations presents a conflict of interests and violates principles of humanity, independence, and neutrality (Forsythe, 2018). These critics view capitalist exploitation as a contributor to humanitarian crises and believe corporations' financial support to the ICRC should not result in profit-making (Forsythe, 2018). Finally, some worry that the ICRC will lose its traditional identity and unique niche in international humanitarian community as its activities continue to tread toward work typically performed by development organizations (Forsythe, 2018).

Oxfam

Oxfam (abbreviated from the original Oxford Committee for Famine Relief) is one of the largest development agencies in Great Britain, and was established in 1942 "to assist those in Nazi-occupied Europe especially by providing food aid to people in Greece who were suffering due to the Allied blockade" (Stephen, 2001, p. 107). Following the war, Oxfam worked as a charity sending aid (both financial and material) to various groups throughout Europe (Offenheiser et al., 1999). Subsequently, its attention shifted toward assisting developing countries. In the 1960s, Oxfam began discussing the possibility of an American affiliate, which was then established in 1970 and shortly began work in South Asia (Offenheiser et al., 1999). Since then, the US and UK Oxfams have each been working as INGOs on a host of development issues. In the 1990s, Oxfam committed to addressing gender inequalities, working towards gender justice both within the organization and globally (Crewe, 2018). In the 2000s, Oxfam decided to embrace a "rights-based" approach to development focused on equity and systemic change rather than only relief in health and other sectors (Aaronson and Zimmerman, 2006). In recent years, Oxfam has been the subject of several scandals, centring around allegations of sexual misconduct of its staff in several African countries (Prakash, 2019). These scandals have raised questions about the charity and NGO sector in development, and its inability to correct or improve upon some of the very issues it seeks to circumvent by working outside the nation-state governance system.

REGIONAL DEVELOPMENT BANKS AND SOUTH-SOUTH COOPERATION

Alongside the increased role that foundations are playing in global health policy agenda-setting and activity, there has been increasing emphasis on South-South cooperation (SSC) and coordination. SSC seeks to challenge the dominant paradigm of global North countries contributing aid to countries in the global South (Buss and Faid, 2012). Regional development banks (RDBs) are multilateral, regionally-focused financial institutions providing resources – financial and technical – for development (Ottenhoff, 2011). While the following four RDBs provide development loans and assistance and have their own independent status, they regularly cooperate with each other and other institutions such as the World Bank. The cooperation intends to foster economic, social, and political coordination with attention to the particular needs of the global South. This involves cross-country efforts, though its formal infrastructure is dominated by regional associations, indicative of a multipolarity of the global landscape in the aftermath of the Cold War.

Inter-American Development Bank (IDB)

Tracing its founding back to 1959, the Inter-American Development Bank (IDB) is the oldest of the regional banks (Retzl, 2015). It began operations in 1960 with the task of promoting economic development and is headquartered in Washington, DC. Its origins are in the Cold War, which "pushed the United States to seriously consider a regional bank" (Retzl, 2015, p. 40). While Latin American countries are its borrowing members, the US and additional countries are members, though borrowing members retain over 50% voting share (Retzl, 2015). It lends money at commercial rates of interest for purposes including education, climate change, water and sanitation, and infrastructure (Formiga, 2021). The IDB has been more involved in social development projects than other regional banks. In keeping with its Cold War roots, the focus on inequality was to "prevent a repeat of the Cuban revolution" (Retzl, 2015, p. 41). In turn, the IDB has focused on poverty-reduction, which includes health and a strong focus on sanitation and sewage projects, though spending on health (separate from water and sanitation) comprised 2–4% of the Bank's spending in the 2000s (Retzl, 2015, p. 50).

The Union of South American Nations (UNASUR)

The Union of South American Nations (UNASUR) was established in 2004 (and renamed to UNASUR in 2007) by 12 member states, and represents a merger of previous Mercosur and Andean Community members building on previous proposals for regional free trade organizations (Herrero and Tussie, 2015). In 2008, UNASUR created a South American Health Council, tasked with coordinating public health activities (Agostinis, 2019). The South American Institute for Health Governance (ISAGS), headquartered in Brazil, was created via an agreement of member states and has worked to train future heads of health systems, conduct research, and promote cross-national and sectoral information sharing.

African Development Bank (AfDB)

The African Development Bank was established in 1964 with "a strong commitment to addressing African interests and priorities" for the continent (Clifton et al., 2021, p. 56). It was the first RDB that was grounded and owned exclusively by regional members in an effort to prevent external control. It is an outlier among its RDB peers in that non-regional (non-borrowing) members have a 40% voting share as compared to regional (borrowing) members, allowing it to retain more autonomy in the face of external influence (Clifton et al., 2021; Mingst, 2014). As with evidence about the World Bank's effects on health outcomes, some research suggests that the AfDB's structural adjustment lending is associated with higher levels of maternal mortality while its health investment lending is associated with decreased maternal mortality (Sommer et al., 2019). This suggests possible inconsistencies in how health is treated within the AfDB, and dovetails with additional research that suggests that aid to the continent, both from the World Bank and the AfDB, does not reach the poorest areas (Briggs, 2018).

The Africa Union (AU)

The African Union (AU) was formed in 1999 with the intention of integrating the continent, addressing regional challenges, and securing representation in the global economy. The AU has signed many agreements on health, working on regional strategies to achieve member countries' goals, including global benchmarks such as the health Millennium Development Goals (MDGs), but also strengthening national health systems. A recent focus has been on the "triple burden" (Buss and Faid, 2012, p. 315) of communicable diseases, non-communicable diseases, and violence. A recent Heath Plan 2016–2030 emphasizes an "Africa-driven response to reduce the burden of disease" (African Union, 2016, p. 15). While the AU represents an important facet of regional cooperation, critics point to lacking tangible progress (Buss and Faid, 2012).

Asian Development Bank (ADB)

The Asian Development Bank was founded in 1966 and consciously modelled after the World Bank. The US and Japan hold the largest share of votes with nearly 13% each (Kilby, 2011). Although health activities comprised a minor portion of the ADB's lending in the 1990s (between 1.5% and 5%), the nature of its lending has changed, transitioning from a focus on tertiary-care hospitals to emphasizing primary care (Arco and Bank, 2001; Bulman et al., 2017). The ADB has instead traditionally focused on infrastructure, though it has been criticized for its lower investments and attention to health and education (O'Keeffe et al., 2017). This focus on infrastructure has sought to enhance "global competitiveness" regionally, in the context of the World Bank (Cammack, 2016). In the past two decades the ADB has embraced a "human security" approach, which has included attention to health and epidemiological threats, perhaps particularly prescient given the COVID-19 pandemic (Caballero-Anthony and Amul, 2014; McCawley, 2017).

The Association of Southeast Asian Nations (ASEAN)

The Association of Southeast Asian Nations (ASEAN) was founded in 1967 with five member countries and is currently comprised of ten nations. Its broad aim is to enhance "economic growth, social progress, and cultural development" and "promote regional peace and stability" (Buss and Faid, 2012, p. 313). In the health context, recent HIV/AIDS and SARS outbreaks in the region illuminated the need for adequate response mechanisms. Consequently, ASEAN has prioritized "non-interference and consensual decision making" among member nations, yet its capacity to improve coordination and strengthen local health systems remains an open question (Buss and Faid, 2012, p. 313). Such matters and their resultant health policies are often framed as issues of health security (Amaya et al., 2015; Azmi, 2020).

European Bank for Reconstruction and Development (EBRD)

Established in 1990, the European Bank for Reconstruction and Development (EBRD) is the youngest of the four regional banks (Weber, 1994). Its mandate and mission was to promote market economics and democracy in Central and Eastern European countries in post-Cold War Europe (Weber, 1994). Health, however, is not listed as one of the sectors or "topics" that the EBRD works on, although there has been financing for health infrastructure (e.g., hospitals) and municipal water and sanitation infrastructure (EBRD, 2021).

COVID-19: A WINDOW INTO GLOBAL HEALTH GOVERNANCE

The (mis)management of COVID-19 globally beginning in 2019 has highlighted the many challenges and given credence to many of the criticisms raised above. The global health and global health policy landscape is incredibly complex and sometimes disjointed, despite increased efforts at coordination between and across foundations, IGOs, INGOs, and regional, national, and community actors (Global Preparedness Board, 2020). In particular, it has brought into sharp relief the difficulties of coordinating efforts to resolve the pandemic and in ensuring access to vaccines, especially across national borders. The COVAX initiative, an alliance between global health institutions including GAVI and the WHO, outlined the allocation of vaccines based on population size for participating countries (20% of the population in each country would be vaccinated before additional distribution would be considered), though bilateral contracts between countries and vaccine manufacturers are allowed (Herzog et al., 2021; Stein, 2021). However, COVAX was ultimately "undermined" in that "the world's richest countries were [by late 2020 already] buying up vaccines, often far beyond their needs" (Stein, 2021, p. 8). Additionally, major global health actors have debated amendments to the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) with respect to vaccine production. While countries like South Africa and India argue that a waiver would increase equitable vaccine distribution worldwide by allowing poorer countries to produce or import generic versions of vaccines, the Gates Foundation – and Bill Gates himself – strongly opposed such efforts, citing concerns about a lack of technical capacity in Southern countries and threats to pharmaceutical innovation (Allison, 2021; Cao, 2021; Mookim, 2021). It was not until the Biden administration expressed support for the TRIPS waiver that the Gates Foundation reversed its position, further indicating coordination issues and conflicts of interest between global health actors (Cheney, 2021).

Overall – for vaccines and beyond – Larionova and Kirton (2020, p. 8) summarize that the international response to COVID-19 has been "assessed as late and inadequate." They note that this insufficient response is largely owing to three reasons: first, the increased weakening of international institutions vis-à-vis private foundations and the growth of other communal, national, and other actors which complicates coordination; second, nationalistic approaches to global problems; and third, that there is no "premier forum for global cooperation for the well-being and protection of people" (Larionova and Kirton, 2020, p. 13). Much has been written about the future, treating COVID-19 as a critical moment or juncture, and noting that while it is a crisis, it also represents a "window to catalyse international collective action" (Geng et al., 2021). Such collective action would presumably require durable infrastructures for communication and coordination, as well as buy-in from national and other authorities to ensure that measures would be enforceable across and within borders.

CONCLUSION: MISSED AND REALIZED OPPORTUNITIES

Taken together, our overview of health governance suggests some important progress and much work remaining. Critical scholars distinguish between "functional" and "foundational" critiques, where functional approaches seek solutions from within the system, whereas foundational critiques argue that existing structures must be abolished or entirely rethought and overhauled (Schuller, 2007). We note that much of the literature focused on health policy governance takes a functional approach, taking the current structure as a given, and working to better understand and improve the efficacy and equity of the system. However, recent critiques have increasingly raised system-wide issues, not limited to but including coordination issues, fractured communication, the lack of a central authority, and the increasing financial power of foundations that are not elected nor necessarily responsive to citizenry and the public. Together, criticisms suggest that while much of these organizations' efforts have improved health outcomes and moved us toward more inclusive policy, for example, in the form of universal coverage, these developments have also come at a cost, with some arguing that they have weakened local infrastructures and reflect neo-colonial, neo-imperialist, and other unequal arrangements. Further, some point to long-term damage at the expense of short-term help, and the ways in which power and coercion, alongside lack of accountability and continuity, have influenced the field.

Altogether, our review suggests that there is a need for increased communication, if not cooperation. COVID-19 and the threat of future pandemics and other social crises highlight how health problems, while felt locally, have global ramifications. Such global threats require global responses, or at least coordinated responses, which are especially difficult in a late-stage global capitalist context in which profiteering drives decision-making, and in the face of increasing nationalism in developed and developing countries alike. Some recent initiatives and cooperation suggest an awareness of this need and work to address it. For instance, the Health 8 (H8), comprised of eight organizations – the WHO, World Bank, GAVI, the Global Fund, UNICEF, UNFPA, UNAIDS, and the Gates Foundation – formed in 2007 with the objective of "strengthening their collaboration in global health in order to achieve better health outcomes in developing countries" (WHO, 2007). More recently, the Pan-European Commission on Health and Sustainable Development proposed the formation of a global health board under the G-20 group of nations with the goal of coordinating "health, economic, and financial policies within governments and internationally" and improving pandemic preparedness and response (Chadwick and Lei Ravelo, 2021). Future success rests on communication, coordination, and governance that views itself as truly global among these organizations, rather than multi-national or inter-national, which can then advise and harness the governance of countries. This requires a rethinking of power and priorities, with the global nature of problems and solutions being treated as the starting, rather than the end point, appended on existing institutions constructed for social problems that are inter-national in nature and scale. In this way, global interests can be mobilized to meet and advance the world's health needs.

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16. International comparisons: who has the best health system in the world?

Irene Papanicolas and Alberto Marino

INTRODUCTION[1]

International comparisons of health systems draw broad public attention and can exert major influence on policymakers. When properly conducted, these performance comparisons may comprise a rich source of evidence by showcasing national data with a different frame of reference. This can encourage reflection on new and existing data points; generate the empirical basis for further investigation and even reform; and serve as a way for stakeholders to hold their systems to account. Over the past decade, the volume of health systems comparisons has grown, with many different stakeholders producing league tables of health system performance (Smith et al., 2018). This has been in part fueled by the increased availability of metrics on health system performance made available nationally and through international organizations, but is also likely the product of increasing public expectations with regards to what their health systems should provide, coupled with a drive for accountability (EHCI, 2018). However, the growing efforts in health system benchmarking gives rise to new risks. Caution is required as initiatives that rely on poorly validated measures and biased policy interpretations may lead to seriously adverse policy and political impacts. Moreover, multiple (and at times conflicting) sources of information that are not clearly explained may also have the effect of eroding the public's trust in health systems and information itself.

These benefits and challenges were highlighted over the course of the COVID-19 pandemic when international health system comparisons became mainstream. The sudden onset of the COVID-19 pandemic placed the performance of the health system at the centre of public discourse and the news cycle. Nations across the world were faced with a common goal – mitigating the effect of the pandemic – and the possibility of examining the relative performance of countries who had taken different approaches offered a potential source of information at a time when this was needed. International performance comparisons offered the public, policymakers and researchers the potential for mutual learning and even policy transfer. Yet, along with the appreciation of the potential that international comparisons hold, came the realization that there are key challenges to benchmarking health systems, such as deciding what indicators to compare, dealing with the limitations in data, and not over-interpreting the information provided.

As health systems emerge from the pandemic and are faced with new challenges to their sustainability, such as dealing with a backlog of care, demographic changes and inflationary pressures, there is more than ever a need to harness the potential of comparative health systems performance assessment. Yet, to be informative, these comparisons need to be credible initiatives that carefully outline their objectives and what they add to what is already known. New comparative efforts need to also be explicit about what they *cannot* infer, showing the limitations of current measures and suggesting fruitful future improvements. In this way, comparisons have the potential to further public and policy discourse and guide health system improvement.

This chapter seeks to consider, in depth, the main challenges of health system comparison to better outline why some league tables may sometimes appear to show conflicting results and consider how benchmarking can be used to draw meaningful insights for those interested in what they have to offer. To this aim, the chapter is structured in four sections. Following the introduction, the next section considers the state of comparative data, highlighting where we can compare health systems and the gaps in what we can observe. This is followed by a section that presents a set of recent benchmarking efforts that explicitly or implicitly rank health systems and considers how they differ and what we can learn by looking at them individually and as a whole. The last section outlines the key gaps and challenges in the comparative health systems space and considers the priorities and challenges for the future.

INTERNATIONAL DATA: WHO? WHAT? WHERE? WHEN?

International comparisons of health systems can have varied objectives, but many seek to compare the relative performance of a health system. Health system performance is often defined as the extent to which the health system meets its key objectives, such as health improvement, or value for money. Yet, as outlined in numerous international and national health system frameworks, the objectives of health systems are multi-faceted, and thus comparative efforts are often conducted across numerous performance domains (see Papanicolas et al., 2022). Table 16.1 below outlines some of the performance domains that are commonly benchmarked across systems and the motivation for their comparison.

The ability for stakeholders to make any kind of health system comparison is inherently constrained by data availability. One of the difficulties in conducting a well-rounded performance comparison across the many dimensions outlined in Table 16.1 is that progress in the development of data collection across them is varied. Some areas, such as population health, can be quite reliably captured through established indicators, while other areas – such as people centeredness – are in earlier stages of development. Moreover, some dimensions of health systems are hard to capture due to their complex nature and intensive data requirements, such as quality of care. While inherently of interest, comparable data across some of these performance domains are very limited, especially in low- and middle-income countries where less data may be available for particular performance domains, and there are concerns about the quality of some existing data sources (Hung et al., 2020). As a result, data availability, as opposed to policy importance, can be one of the primary factors determining what comparisons are being made.

While the focus of many comparisons is often on the health system objectives (mainly performance), data is still required to understand the other factors that can influence these objectives, such as data on health system structures, the demographic characteristics of the populations being compared, the health policy landscape, and the broader socio-economic and cultural context within countries. This information can be used to make more meaningful empirical comparisons through using them to identify potential comparators (see, for example, Joumard, 2010), to adjust for exogenous variation (Barber, 2017; WHO, 2000), or to assist in the interpretation of results.

Table 16.1 Key performance domains of health systems used to compare health systems

Performance Domain	Motivation for International Comparison	Areas of Interest for Comparison
Population health	● To provide a comparison of health within and across countries considered from a broad aggregated perspective, which includes their contributions to many of the risk factors for disease as well as to the delivery of health care. ● To provide a comparative assessment of how health systems contribute to population's health.	● Life expectancy ● Mortality by age group and condition ● Morbidity ● Avoidable mortality ● Population risk Factors
Quality of care	● To provide a comparative assessment of how health services assist individuals in realizing their potential health. ● To examine differences in the safety of service provision, the effectiveness of care provision and the timeliness of care. ● To compare the experiences of patients going through the system	● Performance of different areas of the health services (preventative care, primary care, secondary care, long-term care, mental health). ● Health service outcomes ● Health service processes ● Patient reported outcomes ● Patient reported experience measures
Access to care	● To examine differences in the accessibility of care the health system affords to its population ● To identify demand and supply side barriers in access to care	● Unmet need (overall and related to specific factors such as cost, time, perceived quality) ● Supply of health services
Equity	● Provides an assessment of inequalities in health amongst different population/ demographic/ social groups within and between countries. ● Provides an assessment of inequalities in access and/or utilization of services amongst different population/ demographic/ social groups within and between countries. ● Provides an assessment of inequalities in financing of health services amongst different population/ demographic/ social groups within and between countries. ● Provides an assessment of inequalities in responsiveness by health services amongst different population/ demographic/ social groups within and between countries.	● Distribution of health status by population/ demographic/ social groups ● Distribution of access/ utilization of health services by population/ demographic/ social groups ● Progressivity of financing system ● Distribution responsiveness of health services by population/ demographic/ social groups
Financial protection	● To provide a comparative assessment of the extent to which citizens are protected from the financial consequences of illness	● Fairness of financing ● Out of pocket spending ● Catastrophic expenditures on health care ● Impoverishing expenditures on health care

Performance Domain	Motivation for International Comparison	Areas of Interest for Comparison
People centredness/ health system responsiveness	● To provide a comparative assessment of how responsive the system is to the population it serves	● Citizen satisfaction with the health system ● Population trust in the health system
Efficiency / value for money	● To provide a comparative assessment to identify which parts of the health system are not using resources as well as they should be, based on the experiences of other health systems.	● Value for money of services ● Waste of resources ● Effective coverage ● Disease costs

Source: Adapted from Papanicolas and Smith (2014).

Table 16.2 Summary of large international data collection efforts

Performance Domain	Database (organization)	Regions covered (countries)	Frequency	Source
Quality of care	Health Care Quality Indicators (OECD)	OECD and partners	Yearly	National statistics
	Patient-Reported Indicators Survey (OECD)	OECD and partners	n/a	Surveys
	Health Consumer Powerhouse Surveys (HCP)	Europe	Yearly	National statistics, surveys, interviews
	Service Provision Assessment (DHS Program)	Africa (21)	Variable	Surveys
Patient experiences	Patient-Reported Indicators Survey (OECD)	OECD and partners	n/a	Surveys
	Health Consumer Powerhouse Surveys (HCP)	Europe	Yearly	National statistics, surveys, interviews
	International Health Policy Surveys (CWF)	High-income countries (11)	2 years	Surveys
Population health	UNAIDS (UNAIDS, UNICEF, WHO)	Global	Yearly	National statistics, surveys
	Demographic and Health Surveys (DHS)	Africa, Southeast Asia, Latin America and Caribbean	5 years	Surveys
	GBD Compare (IHME)	Global	Yearly	Projections, surveys
	Global Health Observatory (WHO)	Global	Yearly	National statistics
	Ageing cohort studies (HRS, SHARE, ELSA, etc.)	US (HRS), Europe (SHARE), UK (ELSA), etc.	2 years	Surveys
	European Health Interview Survey (Eurostat)	Europe	5 years	Surveys
Expenditures	System of Health Accounts (OECD, WHO, Eurostat)	Global	Yearly	Health accounts (SHA)
	World Development Indicators (World Bank)	Global	Yearly	National statistics
Health systems structure	Health systems profiles (CWF)	Selected high-income and BRICS (21)	Variable	Qualitative information
	Health Systems Characteristics Survey (OECD, IADB)	OECD, Latin America	4 years	Surveys
	Health Systems in Transition (Observatory)	Europe, OECD	Variable	Qualitative information
	Health Financing Progress Matrix (WHO)	Global	n/a	Surveys
Health care resources	OECD. Stat (OECD)	OECD and partners	Yearly	National statistics
	ILOSTAT (ILO)	Global	Yearly	National statistics
	Health For All (WHO)	Europe	Yearly	National statistics
Public attitudes towards health and social inclusion	Afrobarometer (UN)	Africa	2–3 years	Interviews
	Eurobarometer (EU)	Europe	Yearly	Interviews
	EU-SILC (EU)	Europe	5 years	Surveys
	World Values Surveys (WVS)	Selected global countries (80)	Variable	Surveys

Performance Domain	Database (organization)	Regions covered (countries)	Frequency	Source
Health policy and reform	Health Systems and Policy Monitor (Observatory)	Europe	Variable	Qualitative information
	COVID-19 Government Response Tracker (Oxford)	Global	Variable	Qualitative information
	Migrant Integration Policy Index (MIPEX)	Selected global countries (56)	5 years	Qualitative information, surveys

Source: Authors.

Table 16.2 outlines some of the key existing databases containing information on important performance domains and relevant country information. This table is not comprehensive, but attempts to showcase some of the larger efforts that exist to provide harmonized, comparative information across multiple countries. The databases included represent data that is collected and/or harmonized mostly by international organizations, national organizations with an international focus and/or research groups. The data sources included broadly represent four main types of data: (a) data collections from national health accounts or statistical institutes, or international data collection frameworks (e.g. OECD health care quality indicators); (b) administration of national or international surveys to households, physicians, patients or policymakers and government officials (e.g., EU Health Interview Survey, Commonwealth Fund International Survey of primary care providers); (c) projections and re-elaborations of existing data (e.g., indexes) using novel or proprietary methodologies (e.g., Health Consumer Powerhouse); (d) a rich source of data comprised of narrative or qualitative information summarizing different policies and/or health system structures (e.g., Health System in Transition profiles). Some of these data collections across different databases or organizations use the same national sources or have developed common methodological frameworks for the reporting and harmonization of data (e.g. the Gateway to Global Ageing (2022), which harmonizes ageing cohort studies across countries that conducted the surveys).

The information in Table 16.2 can also help to identify gaps in data collection efforts, both in terms of the areas covered and in geographical coverage. Perhaps unsurprisingly, high-income countries (HICs), particularly in Europe, have the most overlap in data areas covered, often limiting comparisons to subsets of those countries. While global data are more widely available in the areas of population health and expenditure indicators, there are still gaps in the areas of quality of care, patient experiences, and health systems structure across all geographical regions. Some of the most difficult performance areas to compare are the cross-cutting dimensions of performance, such as equity and efficiency, which inherently require data available in more than one performance domain. Equity requires data that can be examined across different demographics and socio-economic groups, while efficiency analysis requires some information on both health system inputs and outputs (see Cylus and Pearson, 2016; Hernández-Quevedo and Papanicolas, 2013).

Over time, there have also been more systematic collection efforts to collect data on health systems structures, such as the OECD's Health System Characteristics Survey (2019) and the European Observatory's Health Systems and Policy Monitor (2022). COVID-19 saw more active data collection in this area, with multiple datasets created to capture different policies adopted by countries to combat the spread of the virus, such as the Blavatnik School of Government's COVID-19 Policy Tracker (2022). This was used to create indexes of stringency and to better understand the potential impact of the virus across different health systems, showing the potential for further use of these data in health systems comparisons moving forward. Currently, data on health structures are missing for many health systems outside of the European and OECD areas, and even within the HIC regions they are not collected with as much frequency as other data. There are, however, numerous qualitative descriptions of health systems within *ad hoc* health system assessments and policy reports. More work is needed to draw this together in a systematic way, enabling its use for comparison and/or the interpretation of other benchmarking activities.

The timeliness of data available for comparison is also dependent on the sources from which data is extracted, and the regions from which data is collected. For example, organizations that collect data from national health accounts or statistical institutes often have yearly data collection schedules, while datasets based on the administration of surveys may be updated less frequently, if at all. For comparative efforts relying on secondary data there is also the complication that data from the same year may not be available for all countries being compared, and therefore the benchmarking is comparing data for different years across the various countries being studied. This often becomes more of a challenge when international comparisons are broadened out to include more countries.

While the amount of data available for health system comparisons has grown considerably over the past two decades, there are still pockets of data across some regions and domains and large gaps in others. Some of the main barriers to the production of comparable health systems data include: (1) a lack of the resources needed to ensure data timeliness and appropriate data infrastructures at the country and international level; (2) lack of a coordinated approach to the measurement of certain performance domains, or from certain regions, due to missing international frameworks or agreements, such that data within domains may be collected across regions but not in the same way; and (3) the lack of harmonization protocols which can render data difficult to compare.

As central data hubs work to harmonize and publish the data to be used for comparative work, another crucial point to consider is the transparency and accountability in the data collection and harmonization of data. In his consideration of the role the Institute of Health Metrics and Evaluation (IHME) has played in shaping the global health landscape by becoming the go-to provider of population health metrics for many researchers, doners and agencies in the global health space, Mahajan (2019) lays out two broad aspects of accountability that need to be considered in this regard. First, who (and how) are the metrics collected and their purveyors held accountable? And second, who is accountable for how the metrics are used to shape policy, and how is this enforced? To ensure accountability on both these fronts, transparency with regards to the data collection, harmonization and analysis is crucial.

There is more to be learned from successful efforts at data collection and coordination. For example, the efforts to coordinate health expenditure data across countries led by the OECD, WHO and Eurostat, resulting in the System of Health Accounts (2001) have been very effective. Since its inception in 2001, most countries have conformed to SHA standards in the process of collection and reporting of expenditure and revenues of the health system (OECD et al., 2017), making health expenditure data some of the most accessible, timely and comparable. Over time, efforts continue and data comparability is improved. Current challenges include harmonizing definitions for governmental and private sources, integrating the collection of health-related spending that falls under social spending, and more. Initiatives such as the Patient Reported Indicators Survey (PaRIS) led by the OECD (CIHI and OECD, 2019) and the Health Progress Financing Matrix led by the WHO (WHO, 2020) provide a glimpse towards what the future of health care data may look like if collection standards are upheld and implemented routinely in the data collection processes of national institutions.

LEAGUE TABLES: WHO IS THE BEST IN THE WORLD?

Some international comparisons set out to be "league tables" – which we can broadly think of as comparative exercises that aim to provide comparative rankings of performance across (comparable) countries. While some league tables will use explicit rankings which can generate more attention, they can also be met with more scrutiny (Cylus et al., 2016; McKee, 2010). For this reason, many international comparisons are presented in a way that showcases comparative data but refrains from explicitly stating who the "best" and "worst" performers are. In practice, however, many comparative publications produce the information needed for external audiences to conduct some relative assessment of performance, should they wish to do so. For the purposes of this section, we consider both explicit and implicit ranking exercises.

The explicit, or implicit, ranking of countries can be very powerful in terms of the attention that it brings to health systems. For example, the 2000 World Health report generated unprecedented media coverage after its publication of health system performance rankings, fueling a public interest in health policy and health systems performance (Smith et al., 2018). The news reached various popular media outlets even years after publication. In 2009, a YouTube video entitled, "We're number 37" was released containing a song referring to the USA's 37th ranking in the Report (Papanicolas and Smith, 2013). Similarly, the publication of the UK's relatively poor cancer survival rates compared to the rest of Europe, published as part of the *Eurocare* studies (Sant et al., 2003; Thomson and Forman, 2009), were instrumental to national policy focus on cancer in England from 2000 onwards (Richards, 2010), and have even been credited by some as a key factor in motivating large expenditure increases in the NHS during the Blair government (Briatte, 2010). In this section we move on from considering what data is available to carry out comparisons and instead consider what recent comparative efforts have focused on, and why their relative assessment of country performance may differ.

Who is Assessing Health Systems?

It is important to consider who is carrying out a performance comparison, as this is likely to influence the perspective taken, and thus the information chosen to compare. Broadly, we can think of comparisons being conducted by three main stakeholders with slightly varying objectives. The first group would be international or national organizations, such as the WHO, OECD, and the NHS Confederation, with the objective of using international benchmarking to inform national policymaking. Often this group has a direct mandate from one or more countries, and often access to national statistical offices that can facilitate the production of comparable metrics. This group is more likely to provide comparative information across countries but refrain from making explicit rankings, particularly after the criticism the WHO faced for this following its World Health Report (WHO, 2000).

The second group comprises of public, private or third sector institutions with for-profit or not-for-profit mandates, such as the Commonwealth Fund, Bloomberg, and the Health Consumer Powerhouse. This group differs from the first in that they are often at an arm's length from policymakers, which can allow more flexibility in the selection of indicators but also less access to national statistical offices, thus requiring the use of secondary data sources or the collection of primary data to carry out the comparisons. For this group, the publication of comparative reports can serve to draw attention to important policy issues they want to highlight, and often employ explicit rankings to achieve this aim.

The final group carrying out comparative work is research institutions or individual researchers, often working in collaborative groups on a project. Often these are grant-funded projects with a more specific focus, such as the measurement of health outcomes or expenditures. The outputs produced can vary from a peer-reviewed journal article to the production of harmonized data or even datasets. Examples include the Global Burden of Disease (GBD, 2019), EU funded projects such as HealthBasket (Busse et al., 2008; Schreyögg et al., 2005) and EuroDRG (Busse, 2012), examining comparative expenditures, and EUROHOPE (Hakkinen et al., 2013; Iversen et al., 2015), ECHO (Bernal-Delgado et al., 2015) and ICCONIC (Figueroa et al., 2021) examining variations in utilization and/or pathways of care. It is often the case that for this group the collection and harmonization methodology itself is the main research contribution, and while explicit or implicit rankings may be found in the data or articles, they are not the central product of the work.

What Do League Tables Assess?

As noted above, international comparisons of health systems often set out to assess the relative performance of the health system's outcomes or the system's value for money (outcomes relative to health system expenditure or, more generally, inputs). However, given the many different objectives of health systems (Papanicolas et al., 2022) – including health improvement, equity, and financial protection – this task can become quite broad and data intensive. As a result, many league tables will focus their efforts on comparing a more specific set of objectives (e.g., quality, people-centredness, coverage, and health outcomes) and/or a specific subset of the population (e.g., specific countries, patient groups, children, and migrants) where data might be more available. Importantly, some league tables represent new efforts at data collection (e.g., MIPEX, 2020) and showcase relative performance in areas where comparisons have been previously lacking. Table 16.3 considers some international benchmarking exercises in health systems performance. The table aims to reflect the considerable variability that exists across benchmarking efforts in all areas, including the choice of domains being compared, the populations of interest and the range of countries compared.

As Table 16.3 illustrates, most health systems comparisons restrict their focus to specific subsets of countries, often at similar levels of economic development and/or with similar levels of health system spending. Often the justification for comparing countries within similar geographies, or levels of economic development, is that they are similar in their structures, challenges, and health system objectives. As we saw in the previous section, it is also the case that greater amounts of comparable data are available between these subsets of countries. However, limiting the comparison to countries that share these similarities may also limit the potential for mutual learning (Skopec et al., 2019). As the challenges health systems face become increasingly global, such as pandemics and climate change, there is also more rationale to broadening out comparisons (Jha, 2021).

A key challenge relating to comparisons across countries is accounting for differences in the boundaries of health systems. Different stakeholders and different countries may consider the health system to comprise of a broader or narrower set of activities. There is no consensus as to whether a definition of the 'health system' should encompass the wider determinants of health outcomes, and whether it should include activities which impact health outcomes such as public health, health promotion and targeting social determinants of health (Papanicolas and Smith, 2013). There can be no right answer to this question, as there are solid arguments to promote the use of both wider and narrower boundaries. However, the lack of consensus on this issue makes national and international performance assessment difficult. Any comparative effort should be explicit about the boundaries they are setting so that readers of the report card are clear about the actions being compared.

Table 16.3 *Scope and coverage of selected international benchmarking efforts*

League table	Key area(s) of comparison	Population studied	Regions (Countries)	Aims	Publication type
Health at a Glance (2021)	League tables in Health status, Risk factors, Access, Quality, Resources, and COVID	General population	OECD (37)	To identify relative strengths and weaknesses across six, policy relevant and actionable dimensions of health systems	Report
World Health Report (2000)	Efficiency	General population	Global (192)	To explain the widening gap in death rates between rich and poor around the world through differing degrees of efficiency with which health systems organize and finance themselves	Report
Mirror, Mirror (2021)	Access to care, care processes, administrative efficiency, equity and outcomes	General population	High-income (11)	To assess the performance of the United States compared to 10 other high-income countries	Report
International Health Care Outcomes Index (2022)	Health outcomes	General population	Selected HIC (19)	To assess the performance of the UK health care system with those of 18 similar, wealthy countries	Report
MIPEX (2020)	Migrant health integration	Migrants	Selected global (56)	To engage key policy actors about how to improve integration governance and policy effectiveness for migrants	Report
EuroHealth Consumer Index (2018)	Patient rights, accessibility, outcomes, range of services, prevention, pharmaceuticals	General population	Europe (35)	To provide healthcare consumers with tools to benchmark health policies, services and quality outcomes	Report
Euro Heart Index (2016)	Cardiac care (prevention, procedures, access and outcomes)	Cardiac patients	Europe (30)	To compile information about CVD care provision in Europe and to demonstrate the situation of data availability, quality and representativeness	Report
Eurocare (2020)	Cancer survival and outcomes	Cancer patients	Europe (27)	To collect and communicate about regional differences in incidence rates, gender patterns, and trends within Europe for common cancers	Database
Incidence of catastrophic health spending (ongoing)	Catastrophic expenditure	General population	Global (192)	To reduce the regressive burden of out-of-pocket payments for health by reducing the spectre of catastrophic health care expenditures	Database
Global Health Security Index (2021)	Health security and outbreak preparedness	General population	Global (195)	To provide recommendations about health security to countries, international organizations, the private sector and philanthropies	Report

League table	Key area(s) of comparison	Population studied	Regions (Countries)	Aims	Publication type
Lozano (2020)	Universal health coverage	General population and age subgroups	Global (204)	To give an assessment of global progress towards universal health care	Journal article
Papanicolas et al. (2019)	Expenditure, coverage, structural capacity, utilization, quality, population health	General population	High-income (10)	To determine how the UK NHS performs relative to other high-income countries	Journal article

Source: Authors.

Applying different boundaries across assessments can also explain different relative rankings of countries across them. For example, among the comparative exercises reported in Table 16.3, different league tables have applied different boundaries to the exercises they conduct. The Health Consumer Powerhouse's Euro Heart Index (2016) has opted to deselect indicators related to environmental or lifestyle factors such as life expectancy or mortality from lung cancer or heart disease, in order to focus on indicators that benchmark health system performance only. Conversely, the Bloomberg Healthiest Country Index (2019) ranks 163 countries across a wide range of health variables including many risk factors, and population and environmental health variables such as sanitation and access to clean water. Each of the report cards justifies the narrower or broader boundaries based on the objectives of the exercise, however, they will produce vastly different assessments based on what they are looking at.

Another consideration is whether the appropriate unit for comparison are countries themselves. Many countries have very decentralized health systems, such as Spain and Italy, where federated budgets and policies effectively create a network of smaller regional health systems with low mobility barriers that operate under the same guise only nominally (OECD, 2021); while other countries, such as the United States, present a mix of public and private health systems that differ largely in terms of prices, negotiating power of providers and purchasers, incentive systems for health professionals, access, and equity, and more (Rice et al., 2020). Countries also differ in their size and populations covered. For example, it has often been noted that in comparative studies it would be more appropriate to compare the United States to Europe rather than the individual member states within Europe (Papanicolas et al., 2018). In the future, the increasing data available on health system organization and structures can be used to better refine comparisons and break them apart into sub-units that reflect governance structures, also allowing for more policy transfer and learning from region to region.

Whatever the choice of comparator, it is important to consider how the composition of the reference group will change the conclusions drawn. For example, many recent comparisons of the English NHS have been carried out with different sets of countries, coming to quite different conclusions about its relative performance, even in the same areas (Table 16.4). The choice of comparators is therefore obviously critical. This is particularly relevant when the comparison is being made on the levels of performance in one country (e.g., population health outcomes, total expenditures, etc.) to the levels of the others. Depending on the objective of the exercise, it may be more appropriate, therefore, to compare countries relative to their performance on some agreed upon thresholds of normative performance, such as whether they are optimizing their goal attainment given their health expenditure (health system efficiency) or achieving quality thresholds set by global standards (see Kruk et al., 2018).

Another difference across benchmarking efforts is whether they focus on the entire population or on specific patient groups. Here, too, there are different advantages and disadvantages to consider. When examining a distinct patient group, a comparison might allow for more actionable insights if stakeholders have a better idea of where to look for sources of variability within countries (e.g., risk factors, diagnosis, and treatment). This may help the comparison to yield more actionable insights for policymakers. On the other hand, it may be harder to generalize from a focused comparison how well the health system is performing overall. While rankings between a general population and a specific disease group may present similar differences across health systems, it is not necessarily a given that these differences will necessarily arise again or persist as other sub-areas of care are being compared.

Table 16.4 *Variability in English health system performance ranking by report card*

		Mirror, Mirror	Civitas	Health at a Glance	Papanicolas et al. (2019)
	Domains	Access, care processes, administrative efficiency, equity, outcomes	Expenditure, health status, outcomes	Health status, risk factors, access, quality, resources	Expenditure, coverage, structural capacity, utilization, quality, population health
	Comparators	High-income (11)	High-income (19)	OECD (38)	High-income (10)
Health expenditure	Timeline	1980–2019	2011–2019	2019	1998–2017
	Data	HCE % GDP	HCE % GDP	HCE per capita	HCE per capita
	Outcome (rank)	Lower than average (8th)	Close to average (10th)	Close to average (18th)	Significantly lower than average (10th)
Structural resources	Timeline	n/a	n/a	2019	2010–2017
	Data			Number of doctors, nurses, and beds per population	Number of doctors, nurses, and beds per population
	Outcome (rank)			Close to average to lower than average (27th doctors, 21st nurses, 30th beds)	Lower than average (8th doctors, 10th nurses, 7th beds)
Life expectancy	Timeline	n/a	2000–2019	2019	1998–2017
	Data		LE at birth	LE at birth	LE at birth
	Outcome (rank)		Significantly lower than average (17th)	Close to average (23rd)	Lower than average (7th)
Avoidable mortality	Timeline	2009–2019	2003–2016	2019	2010–2017
	Data	Avoidable deaths per 100,000 pop., age-standardized, all causes	Treatable deaths per 100,000 pop., age-standardized, all causes	Avoidable deaths per 100,000 pop., age-standardized, all causes	Treatable and preventable deaths per 100,000 pop.
	Outcome (rank)	Significantly higher than average (2nd)	Significantly higher than average (2nd)	Close to average (14th)	Significantly higher than average (1st)
Access to care	Timeline	2017–2020	n/a	2019	2010–2017
	Data	Affordability performance score		Population satisfied with availability of quality care	Waiting times and unmet needs
	Outcome (rank)	Significantly higher than average (1st)		Close to average (17th)	Close to average (no rank)

Note: Countries compared across all four reports include Australia, Canada, France, Germany, the Netherlands, Sweden, and the United States. Countries compared across at least three reports include Denmark and New Zealand.

Source: Authors.

Methodologies for Comparison

Depending on the area of focus, league tables will also differ in the methodology they employ to compare countries. Some comparisons will attempt to produce one score or measure of performance that they rank across countries (e.g., Bloomberg Healthiest Country Index; Commonwealth Fund; Health Consumer Power House; WHR, 2000), while others will present a breadth of information on a set of indicators that they do not seek to aggregate (e.g., OECD Health at a Glance). Each of these approaches has advantages and disadvantages, which should be considered against the main objective of the league table that is being produced.

Policymakers and government officials, as some of the primary targets of such works, may find the production of some concise measure that summarizes a breadth of information appealing due to their succinctness. For this reason, composite indicators – indicators which combine separate performance indicators into a single index or measure – are often used to rank or compare the performance of different health systems (Goddard and Jacobs, 2009). However, there are concerns that if composite indicators are not carefully designed, they may be misleading and lead to serious failings if used for health system policymaking or planning (Smith, 2002).

The main worry with composite measures is that reducing the measurement of objectives (or entire performance dimensions) to one single indicator runs the risk of being too simplistic, and may mask many of the variations in underlying performance or in the individual indicators used to create the composite. This is particularly true if the indicator encompasses performance domains or countries where there is little choice of data, or questionable sources of data are used to populate the index. Additionally, the creation of composite indicators requires a number of decisions to be made, including which measures to include and their relative weight in the index. While these decisions can be based on different frameworks, methodologies or even consensus, they are ultimately subjective and will influence the composite indicator being created, and the relative country rankings they produce. Thus, when using composite indicators, it is prudent to include the information that is summarized in the indicator, to provide an insight into the performance of each component. In addition, the composite, and its inputs, should be presented with proper uncertainty measures, which may be more informative than measures of central tendency (Naylor, 2002).

FUTURE COMPARISONS: NEW DIRECTIONS AND FUTURE CHALLENGES

International comparisons provide vast potential for within and cross-country learning. They do this by providing a benchmark that allows the public to identify areas in which the system appears to perform above or below expected. But more importantly, comparisons provide an impetus to understand what is driving this performance, and in some cases guidance on where to look for potential solutions. Over time, the large advances in data collection, data linkage and data standardization in health and health care have improved the amount and quality of data available for comparisons.

The recent experience of the pandemic has provided the world with a unique opportunity to experience both the potential and limitations with international comparisons, as the comparison of health data across countries became normalized, albeit predominantly for COVID-19.

The use of comparative data by a range of stakeholders brought to light the current challenges and future opportunities for this area, specifically in data collection, data interpretation and the use of data to inform policy.

From early in the pandemic the limitations of data for cross-country comparison became apparent, as it was difficult to compare even simple metrics such as COVID-19 testing rates, caseloads, hospitalizations and deaths in a meaningful way, due to differences in the national infrastructures used to define, collect, report and distribute data. These challenges have underlined the importance of data harmonization and the role that international organizations can play in helping to set standards for this. Similarly, the differential impact of COVID across populations, even within the same countries, highlighted the necessity of collecting and/or linking health data to data on population demographics and risk factors. The demand for comparative data to understand this differential effect allowed longstanding barriers to comparative efforts to be broken down, such as delays in accessing or linking data. Current enhanced data sharing efforts are still often limited to COVID related research, but they have illustrated some of the capabilities to further comparative research, particularly in areas related to equity.

The use of comparisons throughout the pandemic also highlighted the difficulty in deciding what to compare across countries, and the dynamic role of health system performance. Across different stages of the pandemic, international comparisons have been used to inform policy by comparing different aspects of country performance, including the spread of the virus, its toll on pandemic related and excess deaths, differences in the types of public health and economic policies implemented, vaccinations, equity of health outcomes and care delivery and more. As the public and policymakers look to interpret this data it becomes less clear what a “good performer” is, and what the appropriate time horizon for comparison is. Are good performers the countries with the fewest deaths, the most vaccinations, or the least inequity across outcomes? Is it too early to judge the performance of countries, as the impact of the pandemic’s disruption to health care, education and employment is yet to be fully realized? How much of this variation is attributable to health systems themselves, versus the broader social, demographic, cultural and contextual factors at play? Moreover, the outcomes being compared also reflect local priorities which often may vary.

This experience should serve to underline that comparative health system performance assessments will produce different relative rankings depending on the perspective taken, the priorities being examined, and the time frame explored. So, while league tables can be informative in understanding variation across countries, they are also fraught with risks. Because of the variability across countries, simply changing the focus of comparison can alter relative rankings. Policymakers should be aware of the intent of the comparison and the decisions related to what data is collected, presented, and analysed before attempting to understand what a relative ranking means and whether this signals potential for improvement.

Finally, while the pandemic saw a broad use of comparative information on a range of metrics to question health policy and hold politicians to account., and while this has shown the ability for benchmarking to broaden the discussions of how to learn from other countries, it has also shown the risks that arise. Poorly presented data can harm policy if it is uncritically accepted and used to support potentially inappropriate reform or used to reject comparisons altogether, thus missing out on opportunities for cross-country learning.

To conclude, international comparisons can be informative for policymakers and the public if carefully conducted and clearly presented. Health systems are complex and multi-dimensional and league tables may produce variable rankings depending on what they are comparing and when. As more data becomes available for health system comparisons, the number of different league tables assessing countries will continue to grow. With such assessments more commonly placed in the public domain, picked up in the media, and used to form public opinion about the performance of health systems, it is important that these assessments are properly explained and the assumptions behind them are made explicit. In order to motivate change, stakeholders need to be able understand the characteristics and processes that contribute to relative levels of performance. This requires authors to be transparent about the data sources and methods used to construct league tables as well as clear explanations about what can and cannot be inferred from the data presented. If carried out in this way, performance comparisons have the opportunity to inform and motivate a broader program of change.

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17. Japan’s health care system – muddling through and incremental changes

Naoki Ikegami

INTRODUCTION

Japan’s health system is financed by social health insurance (SHI) and delivered mainly by the private sector. This chapter provides a historical description on how SHI expanded to cover virtually the entire population in 1961, on how the financing and delivery of services have evolved so as to meet the challenges of the aging society, and the key role played by the fee schedule. It then describes the problems in providing long-term care via the health care and social welfare systems that led to the introduction of public long-term care insurance in 2000.

SHI was enacted in 1922 with objectives similar to Germany 40 years earlier: to suppress socialist movement and increase the productivity of the workers. However, the Japanese employment-based health insurance (EHI) differed from the Bismarck model in the following aspects. First, the national government established Government-managed Health Insurance (GMHI) for those employed in companies with less than 300 employees. Subsidies from the general expenditure budget were allocated to GMHI because the wage level of their enrolees was lower than in large companies. Second, in order to contain these subsidies, the government set the GMHI fee schedule and negotiated terms with the Japan Medical Association (JMA) that represents all physicians but is dominated by private practitioners. Third, the fee schedule covered all healthcare services, including hospital care, because most hospitals were small and owned by doctors, and pharmaceuticals, because doctors did most of the dispensing. The proportion of employees enrolled in EHI gradually increased. In 1939, EHI was expanded to include their dependents. In 1943, the GMHI fee schedule was adopted by all EHI plans as a war-time measure to rationalize resource allocation.

For the self-employed and members of their household, the government legislated the Citizens’ Health Insurance (CHI) in 1938. CHI was not mandatory but municipalities were encouraged to establish CHI and to have their residents enrol. The army promoted the establishment of the CHI because they wanted to draft healthy soldiers to fight in the war with China that had started in 1937. At that time, over half of the population were in farming households and not covered by the EHI. The CHI plans established their own fee schedule and negotiated terms with the local providers or provided services directly by building clinics and hospitals. This chapter aims to provide an overview of Japan’s health system and traces the major policy transformations in relation to broader political, economic and social developments. A distinctive component of this history is the evolution of the long-term care system, which developed in response to the challenges facing Japan’s aging population.

In 1956, when the country had recovered from the ravages of World War II, Prime Minister Iichiro Hatoyama of the Liberal Democratic Party (LDP) promised universal healthcare coverage to the Japanese population. The LDP had been established in the previous year by the merger of the two conservative parties, the Liberal Party and the Democratic Party. To achieve this objective, a new CHI Act was legislated in 1958. This Act mandated all municipalities to establish CHI and all individuals not enrolled in EHI plans to enrol in CHI. All CHI plans had to adopt the EHI fee schedule. This allowed CHI enrolees to access the doctors and hospitals with EHI contracts because providers would be paid the same amount for delivering the same service. By 1961, virtually all residents of Japan were enrolled in SHI plans and virtually all doctors and hospitals had contracts with all EHI and CHI plans (Ikegami et al., 2011). Parenthetically, the same fee schedule was used for those on public assistance who were not enrolled in SHI plans.

However, coverage was provided by over 5000 EHI and CHI plans. The number of CHI plans has since decreased because some municipalities have merged, but today there are still over 3000 SHI plans. The premium rates of plans that enrol those with lower income and older age composition tend to be higher than the plans that enrol those with higher income and younger age, and less generous in non-statutory benefits such as health promotion. However, they all cover the same medical services listed in the fee schedule. Neither the LDP, supported by business, which has been in almost continuous power since 1955, nor the opposition parties, supported by big labour unions, have proposed a restructuring of the SHI because if EHI and CHI were to merge, the premium rate of the EHI plans would increase. The national government has mitigated the disparity among SHI plans by providing subsidies from the general expenditure budget to plans that have enrolees with low average income and by cross-subsidizing healthcare expenditures of the elderly.

To contain subsidies, the national government has controlled healthcare costs on the supply side by revising the fee schedule, and on the demand side by revising the coinsurance rate. The fee schedule sets not only the fee, but also the conditions of billing of each item. Thus, by tightening or relaxing the conditions of billing, the government has controlled the volume of each item. For example, although Japan has the highest per capita number of CT scans in the world, costs have been contained by decreasing the fee and by restricting the billing of images taken by equipment with high density to referral hospitals. On the other hand, to encourage doctors to deliver services in line with policy goals, such as end-of-life care in the community, new fees have been listed and increased (Ikegami, 2019).

Much like the US, most hospitals and virtually all clinics are in the private sector. However, the delivery of service is more tightly controlled than the British NHS because of the strict control of payment to providers by the national government. The role of local governments has been mainly restricted to subsidizing the hospitals they own that compose only 10% of the total. This is because, although local governments are insurers for the CHI, the flow of money from the plans to providers has been controlled by the national fee schedule. The second tier 47 prefectures are responsible for drawing health plans but their main function has been restricted to regulating the number of beds in the planning areas. The main responsibility of the third tier 1700 municipalities is to provide ambulances and preventative services. Hospitals, including those in the public sector, have made their own decisions based on their evaluation of patient needs and the expected revenue from delivering services under the fees and conditions set by the fee schedule.

On the demand side, costs have been controlled by making patients pay coinsurance. When SHI was first introduced in 1922, there was no coinsurance because the objective lay in returning workers back to their workplace as quickly as possible. However, when CHI was established for the self-employed and members of their household in 1937, a 50% coinsurance was imposed. Dependents of EHI also had to pay a 50% coinsurance when they became eligible in 1938. In the CHI, the coinsurance rate was reduced to 30% for the household head in 1963, and for other household members in 1967. However, access to healthcare for older people continued to be restricted. Note that in Japan, all employees on retiring must leave EHI and enrol in the CHI.

The left-wing coalition governor of Tokyo decided that the prefectural government would pay for the coinsurance of almost all older people in 1969. His initiative was rapidly taken-up in nearly all the other prefectures. In 1973, the national government was forced by public pressure to abolish coinsurance for all elders aged 70 and over. The costs were financed by grants from the national budget. In the same year, catastrophic coverage was introduced for dependents enrolled in the EHI. If the coinsurance amount exceeds 30,000 Yen in a calendar month, the patient would be reimbursed for further amounts. In 1975, catastrophic coverage was also made available in the CHI. Thus, all residents of Japan now had financial protection.

Demand from older people increased dramatically and became a heavy burden for the national government. It was exacerbated by the slowing of economic growth after oil prices had tripled in 1973. To mitigate the fiscal burden, the government enacted the Elders' Health Act in 1983. This Act reintroduced coinsurance for elders, although initially a nominal amount of 400 Yen (3 Euros) per visit and 300 Yen per hospital day. Its main objective was to force EHI plans to contribute to the financing of the healthcare costs of the elderly. By 1990, the EHI plans were contributing an amount equivalent to the amount they would have paid if the plan had the same proportion of older people as the general population. For example, if the proportion of those 70 and over in an EHI plan was 1% and the expenditures of this age group enrolled in this plan was one billion yen, the plan had to contribute ten billion yen to the pooling fund because the proportion of those 70 and over in Japan in 1990 was 10%. The EHI plans strongly protested.

In response, the Elders' Medical Care Act was legislated in 2004. All people 75 and over were transferred to the new Late Elders' Health Insurance (LEHI) in 2006. The LEHI plans were administered by a coalition of municipalities in each prefecture (prefectural governments had refused to become the insurer). However, although 50% of LEHI expenditures were financed by taxes and 10% from the premiums levied on older people, 40% continued to be financed by contributions from the other SHI plans. Moreover, although people aged 65 to 74 remained enrolled in their respective SHI plans, their expenditures were cross-subsidized by all plans except the LEHI. As a result, in 2020, EHI plans' contributions to the LEHI and to the health expenditures of people aged 65 to 74 have increased to compose nearly half of their revenue. The EHI plans have demanded revising the financing of older people's healthcare costs.

The immediate reaction to the LEHI was strong protests from those 75 and over who had their premiums increased when they were transferred from the municipality-based CHI to the prefecture-based LEHI. Their protests were widely reported by the media (but the delight of the older people whose premiums had decreased was NOT reported). Also, the new fee that was listed only in the LEHI fee schedule which paid to have a meeting for discussing the patient's end-of-life care was criticized because it appeared to encourage terminating the treatment of the elderly (the fee was delisted three months later). The LEHI was a key factor that led to the defeat of the LDP in the 2009 election. The newly formed Democratic Party of Japan came into power with a pledge to abolish the LEHI. However, they were voted out of office in the 2011 election before they could do so. The Elders' Medical Care Act has since become firmly established.

Aside from the above reforms, the only other policy issue that has been widely covered by the media was that of expanding privately financed healthcare. This was debated when Shinichorou Koizumi was prime minister from 2001 to 2006 (Ikegami, 2012). Under his leadership, the postal service had been privatized. His next target was healthcare. The Deregulation Council had recommended that the restrictions on extra-billing (billing of items not listed in the fee schedule) and balance billing (billing more than the amount set in the fee schedule) be abolished.

However, the Finance Ministry opposed deregulation because it would lead to increasing costs for the government. In their view, by making new healthcare services and pharmaceuticals more rapidly available, it would increase the pressure on the government to list them in the fee schedule leading to increases in SHI expenditures. Accordingly, the Minister of Health, Labour and Welfare and the Minister of Administrative Reform agreed to implement very limited deregulation in 2004. Extra billing has continued to be mainly restricted to new technology not yet approved for reimbursement by SHI, and balance billing has been restricted to extra-charge rooms in hospitals. In the former, as was the case for heart transplants, the hospital must submit a proposal for testing its efficacy to the council of experts in the MHLW. The council decided in favour which led to heart transplants being listed in the fee schedule. In the latter, the proportion of extra-charge beds in hospitals is restricted.

This chapter is divided into three sections. The first is on the development of doctors and hospitals. The second is on the development of the fee schedule. The third is on long-term care. Public long-term care insurance (LTCI) was implemented in 2000 to meet the needs of the aging society, and to reform long-term care that had been delivered by the healthcare and the social welfare sectors. Since then, the proportion of people 65 and over in the general population has increased from 17.4% in 2000 to 28.9% in 2020, which is the highest percentage in the world. The proportion is projected to be at 37.7% by 2050 because of the low birth rate and the strict restrictions on immigration. Aging has become the key issue in health policy in Japan.

DEVELOPMENT OF THE MEDICAL PROFESSION AND HOSPITALS

By the mid-18th century, Japan had a well-established provision of services by practitioners mainly in the Japanese form of traditional Chinese medicine. It was focused on medication to the extent that the practitioners were also referred to as apothecaries. Payment was theoretically made only for the cost of medication because it was regarded as morally unacceptable to charge patients for performing a humane act. However, the unstated *quid pro quo* was that patients were expected to pay according to their ability, and therefore payment was often munificently if they had the means. This norm served a useful purpose for the government. It absolved the government of the responsibility of providing medical care by making it a duty of the practitioner to provide services and the duty of the patients to pay according to their means, and not according to the services they had received (Ikegami, 1995).

Medical practice was an exception to the rigidly divided society of that time because it was open to all classes and there was competition based on skill. However, practitioners recognized a hierarchy among themselves, with those appointed as personal doctors to the feudal lord being ranked the highest. Compared with Western nations, there was little development of guilds and of professional identity among traditional practitioners in Japan. The other difference was the absence of institutional care for the sick and indigent provided by religious organizations or by the government. The selfless practice of philanthropy was not a religious duty for the popular Buddhist and Shinto sects that promised the granting of secular wishes, nor was it a secular duty under the Confucian ideology favoured by the rulers, which emphasized practical ethics. Care of the ill, disabled, and elderly, was regarded as the responsibility of the family (Ikegami, 2021).

When Emperor Meiji was inaugurated in 1868, the government embarked on a policy of rapid Westernization. However, resources allocated to healthcare were limited because the country was facing foreign aggression and internal uprisings. The government decided to concentrate its limited resources on establishing a state-of-the-art medical school at Tokyo University, to which German doctors were invited as professors. Its graduates went on to become the faculty of other national universities as they were later established.

The general public continued to be treated by the pre-existing practitioners who, together with their sons, were given a license to practice medicine in 1882. However, from 1883, the license to practice medicine was granted only to those who had graduated from accredited medical schools or had passed an examination on Western medicine. The only concession to traditional medicine was to legislate a license for practitioners of acupuncture and moxa. Thus, unlike other East Asian countries, a parallel track for becoming doctors in traditional medicine did not develop.

The development of hospitals was also fiscally constrained. Government hospitals were limited to those serving the army and navy, to the teaching of medical students, and to quarantine patients with infectious diseases. These hospitals, together with those established by organizations such as the Red Cross and Farmers' Cooperatives, have been referred to as being in the "public sector" in Japan. Most hospitals were established in the "private sector" by doctors as extensions of their clinics. In both sectors, the hospital director must legally be a doctor who has both clinical and administrative responsibilities. Nurses were trained almost solely for the purpose of assisting doctors. The family continued to provide care after the patient had been admitted to the hospital.

Because of the shortage in trained doctors and well-equipped hospitals, a close and long-standing relationship developed between the professors of university clinical departments and the hospitals to which doctors were dispatched. Doctors tended to remain attached to their university clinical departments. This hierarchical and closed structure of doctors impeded the development of professional specialist organizations. Career advancement depended on the professor so that young doctors tended to focus more on research than on acquiring clinical skills. Their objective lay in obtaining the research degree of Doctor of Medical Science, which was regarded as a mark of professional competence by the public.

However, there were alternate career paths for doctors. Doctors dispatched to small affiliated hospitals could expand their departments and become the hospital director. Almost all doctors continued to practice after becoming hospital director. Many also decided to go into private practice. By doing so, they usually had to focus on primary care because they were not able to use the facilities of the hospital. However, some expanded their clinics to hospitals and a few managed to develop their hospital into a regional medical centre.

After World War II, the occupying forces reformed the delivery of services based on the American model with some success. The two-tiered system of medical education was abolished by upgrading or closing vocational-level schools. All graduates had to pass the national licensure examination. Nurses became responsible for the care of patients and the position of "director of nursing" was created. The post-war economic growth stimulated the expansion of the delivery system. The number of hospital beds increased threefold from 1954 to its peak in 1993. However, the hierarchical yet competitive private-sector dominated delivery system has remained largely intact.

Currently, one-third of the doctors are in clinics, which are overwhelmingly solo-practices. Doctors may profess any specialty but the majority proclaim internal medicine, followed by paediatrics and orthopaedics. The boundary between specialists and primary care doctors has continued to be blurred in Japan (the OECD report has referred to the doctors in clinics as semi-generalist/semi-specialists). Accreditation as a specialist was initially made by the Society of Anaesthesiology in 1963. In 1980, 22 academic societies began discussions on establishing a standardized accreditation process. In 2014, 18 specialties were recognized as the "basic specialities". In 2018, "comprehensive medicine" (primary care) was made the 19th basic specialty area. Those who had already been recognized as specialists by their respective societies were grandfathered-in. In 2019, accreditation as a specialist was legally recognized. The delay in the formal recognition of specialists is one reason why private healthcare insurance has not developed for their services. It has been restricted to providing cash benefits that may be used to pay for extra-charge rooms and other incidental expenses.

Hospitals have expanded based on decisions made by their doctors. Approximately four-fifths of the hospitals are in the private sector. The functions of hospitals and clinics overlap. Most hospitals maintain large outpatient departments. Two-thirds of the hospitals are small and have fewer than 200 beds. However, the private sector generally does not provide high-tech services because their fees tend to be set low. This is why these services tend to be provided by the subsidized public-sector hospitals. In both public and private hospitals, doctors are full-time employees who earn seniority-based salaries which tend not to be related to the revenue they bring to the hospital. The income of doctors in public-sector hospitals tends to be lower than that of the private practitioners in clinics but they are compensated by their higher prestige.

Prior to the capping of hospital beds in the late 1980s, doctors could expand their clinics into hospitals, and hospitals could increase their number of beds. Since then, the prefectural government has regulated hospital beds. However, the number of beds continued to increase until 1991 because some hospitals rushed to increase them before the cap was enforced. As a result, Japan today has the highest per capita number of hospital beds in the world at 12.8 per 1000 population (OECD, 2021). However, about half of the beds are to provide post-acute care, long-term care, and psychiatric care which would be mostly delivered in non-hospital settings in other countries. Despite the increase in the number of hospital beds, the delivery system has continued to be focused more on outpatient care: Japan has one of the highest rates of doctor visits and the lowest rates of hospital admissions among advanced industrialized countries. So far, however, waiting lists have not been an issue in health policy (Ikegami and Ikeda, 1996), and patients who are unable or unwilling to wait are referred to other hospitals.

FINE-TUNED REVISIONS

Revising the Government Fee Schedule

The government asked the JMA to design the GMHI fee schedule when SHI was legislated. The fee schedule included hospital services and pharmaceuticals because many of the hospitals were extensions of the doctors' clinics and most of the doctors did their own dispensing. Payment was on a fee-for-service basis but the fees were set as "points". Points were converted to yen based on the GMHI premium revenue of the prefecture. Thus, expenditures were equal to the premium revenue plus the subsidy from the national government. If providers in the prefecture billed more points per enrolee than the national average, then the conversion factor of the prefecture would be lower than the average.

The GMHI fee schedule became the model for other SHI plans. The fees were much lower than the normal and customary rate. Moreover, doctors were not allowed to balance bill (charge more) or extra-bill (charge extra for services not listed) as benefits were in the form of services and not in cash, as would have been the case for an indemnity type insurance. The JMA agreed to these terms because implementing SHI was a national goal and because those enrolled in the plans initially composed only 3% of the population. Moreover, doctors would no longer be at risk of not being paid by patients who are enrolled in SHI.

The floating conversion rate was abandoned when the GMHI fee schedule was adopted by all EHI plans in 1943. Since then, setting the global revision rate has become a critical decision for the government. As Figure 17.1 shows, the national government finances one-quarter of total SHI expenditures. This amount composes one-tenth of the national expenditure budget. These ratios have been stable and are two sides of the same coin.

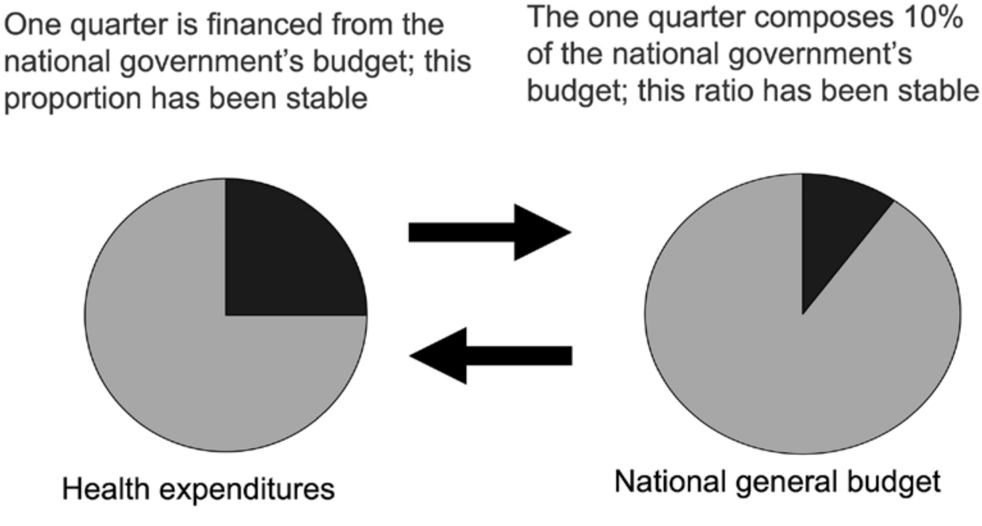


Figure 17.1 Social health insurance expenditures and allocations from the national government's budget

To contain budget allocations, SHI expenditures must be contained. This has been achieved by setting a low increase rate, or sometimes, a minus global revision rate. The Ministry of Finance have pushed for the latter, while providers have lobbied for a high positive revision rate. Up till the 1970s, providers had the advantage because of the rapid economic growth and inflation, and also because the JMA was presided by the powerful Taro Takemi from 1957–1982. However, from the 1980s, as the economy began to stagnate, the revision rate declined and the process became more structured.

On the demand side, the government first estimates the impact of population changes on SHI expenditures. The population of Japan has declined by 2% from its peak of 125 million in 2008 to 122 million in 2020. The immigration policy has restricted the entry of those wanting to work in Japan. On the other hand, the population aged 65 and over has increased by eight million to now compose 28% of the total. Moreover, aging has progressed within the 65 and over population. When compared by five-year age groups, per capita expenditures for those aged 80 to 84 are more than twice the amount for those aged 65 to 69. Population aging has increased SHI expenditures annually by 1% to 1.6%. Next, the impact of revising the coinsurance rate and/or catastrophic coverage on SHI expenditures is estimated from past trends.

On the supply side, the Prime Minister is under pressure from the JMA to increase the global rate. The JMA has made political contributions and endorsed candidates of the LDP. The fiscal space has been expanded by reducing the price of pharmaceuticals and devices by about 4% on average. Since pharmaceutical and device expenditures compose about one-quarter of the total, their reduction has reduced SHI expenditures by about 1%. However, the increase from population aging would negate this decrease. Thus, if SHI expenditures are to be reduced, service fees must be lowered. Figure 17.2 shows the impact of doing so in the 2002 and 2006 revisions. Parenthetically, the expenditure decline in 2000 was the result of health services being transferred from the SHI to the LTCI.

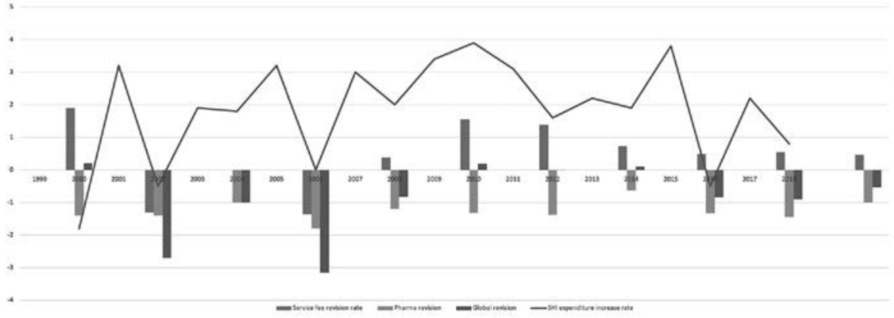


Figure 17.2 *Revision rate of service fees and pharmaceutical prices, global revision rate, and the annual increase in social health insurance expenditures*

The SHI expenditure estimates may not be accurate. For example, expenditures declined in 2021 because COVID-19 led to a decrease in the number of doctor visits and hospital admissions. To offset the decline in revenue and additional costs of preventing the spread of infection, the government has provided grants, temporarily raised the basic fees for all providers and introduced new fees for treating COVID-19 patients. The 2021 MHLW survey on the providers' financial condition showed that these measures have allowed providers to offset the impact of COVID-19. Based on these results, the Ministry of Finance demanded service fees be decreased in the following fiscal year, starting April 1, 2022. However, given the public feeling of gratitude to healthcare workers and the coming election of the upper house in July, 2022, the government decided to increase service fees by 0.43% on December 19, 2021 (effective from April 1 when the new fiscal year starts).

This increase rate was lower than the 0.47% increase in 2020. Most of the increase will be allocated to raising the basic hospital fee in order to finance nurses' wage increases and to expanding SHI coverage in reproductive health (this had been promised by the previous prime minister, Yoshihide Suga, in order to raise the birth rate). Expenditures will also increase by about 1% as a result of population aging. However, these increases would be offset by the 1.37% decrease in SHI expenditures by lowering pharmaceutical and device prices.

Thus, SHI expenditures for fiscal year 2022 have been budgeted as below:

> 0.43% (increase from raising service fees) − 1.37% (decrease from reducing pharmaceutical and device prices) + 1% (increase from population aging) = 0.06%

Based on these factors, the national government calculated the amount it would subsidize SHI plans from its general expenditure budget.

Pharmaceutical and Device Prices

Health expenditures in Japan have been mainly contained by setting the pharmaceutical launch prices low and decreasing them further when the fee schedule is revised. The launch price of pharmaceuticals is set as follows. For products that have a comparator, the prices are based on their relative advantage in efficacy and safety. For products that do not have a comparator, prices are based on their R&D and production costs as reported by the manufacturer using the method set by the government. In addition, the price of the product in the United States, United Kingdom, Germany, and France is taken into consideration. Since 2020, pharmaco-economic analysis has also been used but all products that have efficacy are listed.

Once listed, the price will be revised on an item-by-item basis. For established products, it is revised based on the volume-weighted price at which the product is sold by the wholesalers to the dispensing pharmacies, doctors' offices and hospitals. The MHLW conducts the Pharmaceutical Price Survey of the price and volume of every item listed in the formulary in the year before the revision. The price of established products is revised so that it would to be 2% more than its volume-weighted average market price. For new products that do not have much competition, the price is lowered if sales exceed the amount that had been projected by the manufacturer. The rationale is that the pharmaceutical company would then have recovered the amount based on which they had decided to invest in the R &D of the product.

However, despite these above measures to contain costs, from 2012 to 2019, pharmaceutical expenditures increased by 17%, compared with a 13% increase in SHI expenditures and a 12% increase in the GDP. The main reason for this increase was the launch of new pharmaceuticals, in particular bio-products which are more difficult to produce generics.

The prices of devices are set by "functional groups", such as the one for artificial knee joints, to which devices are grouped. A new functional group is established when the device is evaluated as being innovative. Functional groups have been established because, unlike pharmaceuticals, the improvement of devices could be continuous. The price of each functional group is revised based on the government survey of the market price and volume of the devices that compose the functional group. The price of the functional group will be revised so that it would be 2% higher than the volume-weighted market price of the devices that compose the group.

Service Fee Revisions

After the global budget has been set, it is allocated to the medical, dental, and pharmacists' dispensing sectors. The fees and conditions of billing are negotiated on an item-by-item basis with the respective provider organizations. The policy objective has been to contain costs and to nudge providers to deliver services that are in line with policy goals. The volume of the item will increase if the conditions of billing are relaxed. On the other hand, volume will decrease if the conditions of billing are tightened. The volume of each item listed in the fee schedule is available from the National Claims Database. Although the impact of revising the conditions of billing on the volume would not be as direct as revising the fee, if the volume increases or decreases more than anticipated, the conditions could be revised in the next fee schedule revision.

The fee of a new item is set by comparing its effectiveness with that of an existing similar procedure and the impact on the budget, and not on its cost price. Volume is controlled by the conditions of billing. For example, PET scans may not be billed for screening patients suspected of having cancer. It is restricted to patients who already have been diagnosed with cancer to examine its spread. In contrast, for services that the government wants to expand, such as end-of-life care in the community, high fees with relatively lenient conditions have been set. Adherence to the conditions of billing is audited by on-site visits by the MHLW's regional office. They cross-check the procedures billed in the claims with medical records. If the records do not provide evidence of meeting the conditions of billing, the provider will be ordered to return the amount they had inappropriately billed in the past six to twelve months.

The revisions are negotiated with JMA and other provider organizations. The government's goal is to expand primary care, rehabilitation and post-acute care to meet the needs of the aging society. These services are delivered by clinics and in the small private-sector hospitals which are the main constituents of the JMA. Thus, they basically have the same priorities. In contrast, the specialists are not well represented in the negotiation so their fees have tended to be relatively low. This is why specialist services are mainly provided by public-sector hospitals.

Before making revisions, the financial state of providers is surveyed by the MHLW. Results are analysed according to the type and size of hospitals, and the specialty of the doctors' clinics. The latter would be the equivalent to the doctor's income in 90% of the offices which are solo practices. In general, public-sector hospitals have deficits and private-sector hospitals have profits. However, the focus is on any changes which resulted from the last revision, rather than any differences among the various types of providers. Thus, if profits in private hospitals decrease and deficits in public sector hospitals increase, it will strengthen the providers' demand to increase the global rate. If the differences across hospital types increase, fees could be respectively revised to decrease them.

Revisions have also been made to nudge providers to deliver services that are in line with policy goals (see examples below).

Develop DRG Type Payment

A DRG (diagnoses-related group) type of payment, the DPC (Diagnosis Procedure Combination), was introduced for acute inpatient care in 2006 to control costs. However, because of the differences in the length of stay across hospitals, instead of a per admission fee, a per diem fee was set for each DPC group. These fees decline as the patient's length of stay increase. The first period is up to the 25th percentile, the second period is from the 26th to the 50th percentile, the third period is from the 51st up to twice the standard deviation, and the fourth period is above this value. Virtually all acute hospitals have opted to be paid by DPC because their revenue would increase by transferring services to outpatient care in which services will be billed fee-for-service.

In 2012, bonus coefficients for meeting policy goals were introduced. For example, if the hospital's length of stay is shorter than the mean after adjusting for the case-mix, there is a bonus based on the extent to which the hospital had decreased lengths of stay. Although the increase in hospital revenue from each coefficient is small, less than 0.01% of the total, it has provided financial incentives to which hospitals have responded.

Reward Primary Care

A bonus fee was set in the 2014 revision for doctors to provide medical oversight for patients who have two or more of the following conditions: diabetes, hypertension, hyperlipidaemia, and cognitive disease. Doctors may opt for an inclusive fee, which is much higher, that includes the cost of pharmaceuticals and laboratory tests. The conditions of billing include having earned credits for continuing medical education, reviewed all medications (including those prescribed by other doctors), and communicating with other doctors and long-term care providers as needed.

Up-grade Nurse Staffing Levels

Most hospitals in Japan were established as extensions of doctors' clinics. The family was responsible for providing nursing care, meals and bedding (futon). Under orders from the occupying forces, the 1948 Medical Service Act was enacted which made hospitals responsible for providing these basic patient services.

To incentivize hospitals, bonus fees were set for hospitals that met the basic standards in 1951. All hospitals eventually met the standards for meals and bedding, but standards for nursing have since become complicated because of the lobbying by the Japan Nurse Association (JNA) to set higher staffing standards and to raise the ratio of registered nurses in the nursing staff. They have been opposed by the JMA because small private hospitals have difficulty in attracting registered nurses. Despite their opposition, the bonus fees have nudged acute hospitals to increase their staffing level and to increase the proportion of registered nurses (long-stay hospitals are not eligible for bonuses).

DEVELOPMENT OF LONG-TERM CARE

Historical Background

The care of the elderly was historically the responsibility of the family, in particular of the daughter-in-law. Government support was restricted to the destitute without any family. The 1963 Welfare Act for Elders expanded services to all older people and established "special care homes for aged (SHA)" as well as home-helper services. However, these services continued to be de facto limited to older people with low income, living alone.

Access to social services increased when the "Five Year Plan to Expand Health and Social Services" (popularly known as the "Gold Plan") was announced in December 1989. The Gold Plan was introduced by the Liberal Democratic Party in order to win back votes (in particular female votes) after losing seats in the election that followed the introduction of the consumer tax (VAT) in July 1989. Although "health" was included in the name, the plan focused on expanding social services for the elderly by increasing subsidies from the national to the municipal governments. The Gold Plan turned out to be highly popular, and was extended from a five-year to a ten-year plan in 1994. By the time it was completed in 1999, the number of full-time equivalent home-helpers was planned to increase from 38,945 in 1989 to 170,000; and the number of adult day care centres to grow from 1,615 to 17,000 in the same period. These targets were generally met.

However, access to services was controlled by the local government's social welfare offices. The process was bureaucratic and subject to the ad hoc decisions of the official in charge. Priority was given to the poor and to those without family. Payment was made based on a sliding scale: those with high income paid more for the same service. There were considerable geographical variations in the availability of services because the decision was left to the mayor.

In the healthcare sector, long-term care services rapidly developed after "free" (no coinsurance) healthcare for older people was introduced in 1973. Hospitals quickly realized that they could fill their beds with long-stay patients. Thus, SHI began to cover long-term care services by accident and not by design. The quality of inpatient care was generally low. For example, the floor space per bed that had been set in 1948 remained unchanged and was 4.3 square metres. Nurse staffing levels were low so that patients had to hire private attendants. Fee-for-service payment led to over-prescribing and excessive ordering of laboratory tests.

In response, the government introduced a new type of facility to provide intermediate care in 1986: the "health facility for elders (HFE)". The minimum floor space per bed was set at 6.4 square metres, the fee was an inclusive per diem amount, and hiring of private attendants prohibited. Many HFE were built but very few were converted from hospitals because they did not fulfil the floor space requirements. It was also difficult for HFE to admit post-acute patients who had been discharged from hospitals because their staffing level was too low. Instead, many were admitted from the community to provide extended respite care. The function of the HFE became similar to the SHA but the residents were less frail because of the pressure to discharge them back to the community.

A flat per diem payment was introduced to hospitals delivering long-term care in 1991. This led to hospitals admitting patients who required only light care. In 2000, the number of hospital beds that met the staffing conditions for long-term care numbered 241,160 which is 15% of the total number of hospital beds.

The Design of LTCI

The government had two options to resolve the above issues: expand tax-based social welfare services or introduce a new social insurance program. The former was dropped when Prime Minister Morihiko Hosokawa's announcement of a new "National Welfare Tax" (a de facto increase of the consumer tax from 3% to 7%) divided his eight-party coalition cabinet and led to his resignation in April 1994. He had become prime minister in August, 1993 after the LDP had split over electoral reform. It was the first time since 1955 that LDP was voted out of office. However, the LDP returned to power in the coalition government in June 1995.

The new government, by default, decided to fund long-term care through a new social insurance program (Ikegami, 2021). Although the public had opposed increases in consumer tax, they appeared to be willing to pay new premiums for LTCI. The LTCI benefits are restricted to services (no cash benefits). From the health sector, most LTC hospital beds, HFE, day care, and visiting nurse services were transferred. From the social service sector, SHA, day service, home-helper services, and home-improvement (such as installing ramps) were transferred.

Enrolment in LTCI is mandatory for all those 40 and over. The insurers are the municipalities. Each municipality revises the premium rate of those 65 and over residing in the municipality every three years based on the estimated increase in LTCI expenditures. There is a threefold difference in premium rates across municipalities. The premiums levied of those 65 and over finance 20% of LTCI expenditures; 30% is financed by the premiums from those aged 40 to 64. Premiums for the latter are levied together with their SHI premiums, pooled at the national level, and allocated to the municipalities as a matching fund. For those enrolled in EHI, employers contribute half of the premiums. Neither employees nor employers have objected despite the fact that only 3% of the total LTCI expenditures are spent by those 40 to 64. Their composition is low because not only are long-term care services focused on the elderly but also because LTCI benefits are available only when the need arises from an "age-related disease" (such as Alzheimer's or a stroke). The remaining half of the expenditures is financed from taxes. In allocating the premiums of those aged 40 to 64 and the subsidies from taxes, adjustments are made to balance the differences in the income level and age structure of the elders among the municipalities.

Those in need of LTCI services apply to the municipal office. The municipal office sends an assessor who asks the applicant questions on the extent to which he or she needs assistance in dressing, eating and so forth. The responses to the 74 items are fed into a computer which sorts the applicant into the seven eligibility levels (or marks them ineligible) based on an algorithm designed by the MHLW. The municipality's expert panel makes the final decision on the eligibility status after reviewing the reports from the assessor and from the attending doctor. In community care, the monetary amount of benefits range from 49,700 Yen for the lightest level to 358,300 Yen per month for the heaviest level (about 400 to 2500 Euros at current rates). These amounts have remained the same. Those eligible may purchase services up to this amount and may also purchase additional services by paying out-of-pocket. Thus, equity standards differ from health care but very few actually pay more. After certification, the beneficiary chooses a care manager agency that draws the care plan for delivering the services and contracts the respective providers.

Fees are set by the LTCI fee schedule. It is similar to the SHI fee schedule but differs in the following aspects: the conversion factor to yen differs according to the geographical area (it is 16% higher in metropolitan Tokyo) and revisions are made every three years. Providers are allowed to extra-bill and balance bill but very few of them do so. In institutional care, it is a per diem fee that differs by the type of facility and the eligibility level of the resident. Room charges and meals are not included as benefits, but they are partially covered by the LTCI for residents with low income so that they do not have to apply for public assistance. The per diem fee differs by the type of provider: LTCI hospitals have the highest – and SHA the lowest – fee.

In designing the LTCI, the MHLW's first priority was that older people who had been receiving LTC services from social welfare would not be disadvantaged after their transfer to LTCI. Eligibility criteria were set low and the benefit level high so that low-income beneficiaries living alone could continue to receive the same services. However, when services were made available to all those meeting the eligibility criteria based on their functional status, the number eligible for LTCI services increased rapidly. The second priority was to expand long-term care services to meet the increase in demand. For-profit companies were newly certified as LTCI providers (but they were not allowed in LTCI hospitals, HFE, and SHA).

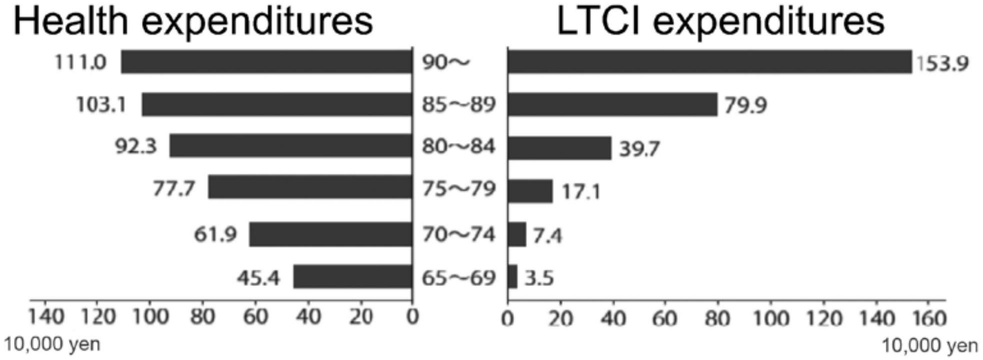
To contain costs, a 10% coinsurance was levied and, as in SHA, the fees and conditions of billing were set by the LTCI fee schedule. For the services that had been transferred from healthcare, the fee and the conditions of billing remained basically the same. For services transferred from social services, fees were set based on the unit cost of each item that had been used for budgeting purposes. Fees for services transferred from healthcare were higher than fees for similar services transferred from social welfare. In institutional care, SHA have the lowest fee followed by HFE and LTCI hospitals. These fee differences are paid by residents as coinsurance which is why SHA have the longest waiting lists. However, there is no triaging of admissions. The excess demand has been met by private homes that levy higher charges from residents. The LTCI allows more balance billing and extra billing than the SHI.

After the introduction of LTCI, long-term care services expanded rapidly. However, despite the belief that older people prefer to age in place and remain in their homes as long as possible with the support of community services, the demand for institutional care has continued to increase. The reason lies in the difficulty of meeting the needs of those requiring 24 hours, 7 days a week coverage, especially those with dementia in community settings. The excess demand has been met by private homes for the aged, group homes, and "housing for elderly with services", the latter having been established in 2012. They are required only to have an alarm system and provide consultation on the services available in the community. However, many have a home-helper agency and a day care centre in the same premise or building. The introduction of the "housing for elderly with services" has blurred the differences between "community care" and "institutional care".

Containing LTCI Costs

In 1997, the MHW estimated that LTCI expenditures would more than double from 4 trillion yen in 2000 to 10.5 trillion yen in 2010, as services expand availability and assuming an annual inflation rate of 3% (Research Committee on the History of LTCI, 2016). The policy goal was to expand services to the level of the Nordic countries. Actual expenditures did not reach 10 trillion yen until 2018, but because the enactment of the LTCI was delayed for three years and there was no inflation, these estimates were more or less accurate. However, the financial burden has increased because the GDP has stagnated. The premium rate for those aged 40 to 64 enrolled in the NHIA (reorganized from the GMHI) has doubled to 1.73% in 2018.

The LTCI fee schedule has been less effective in containing costs than the SHI fee schedule for the following reasons. First, LTCI was a new entitlement program which led to a rapid development of services (as intended). Second, it is not possible to contain LTCI expenditures by decreasing pharmaceutical prices as in the SHI. Third, the impact of population aging has been greater in LTCI. As Figure 17.3 shows, SHI expenditures for those aged 90 and over were 2.4 times more those aged between 65 and 69, but LTCI expenditures were 44 times more (Cabinet Office, 2016). The impact of population aging will increase as the baby boom generation (those born between 1947 and 1949) will continue to age.



Health expenditures: MHLW (Ministry of Health, Labour & Welfare),
LTCI expenditures: Cabinet Office
Population: Statistics Bureau

Figure 17.3 *Comparison of per capita health and long-term care expenditures by age groups in 10,000 Yen*

User charges for hotel services were increased in institutional care in 2006 but they have had little impact on containing costs because the charges were reduced for those with low income who composed the majority (Ministry of Finance, 2018). In 2015, not only the residents' income but also their assets were taken into consideration: those having more than 10 million Yen (70,000 Euros) in a bank account had to pay the full bed and board charge irrespective of their income (MHLW, 2016). However, property assets were not assessed so that there are very few residents on public assistance. In 2018, the coinsurance rate was increased to 20%, and 2019, to 30% for those in the highest income level. However, the percentage of those paying the higher rates composes less than 10% of the total (MHLW, 2016).

Benefits for those in the light care level have been reduced by establishing an intermediate eligibility level between the lightest and second lightest levels in 2006. Most of those in the second lightest were transferred to the new level. In 2016, the services for those in the two lightest levels came to be decided by the municipal authority, and not by the beneficiaries themselves. However, although those in the two light levels compose a quarter of all beneficiaries, their expenditures amount to only 6% of total LTCI expenditures because the amounts to which they are entitled are low.

Municipalities as insurers can do little to contain costs. As in health care, the fees and the conditions of billing are set by the MHLW. The municipal government must approve all applicants as LTCI providers if they meet the facility and staffing standards set by the MHLW. Once approved and established, the municipality has no control on the residents that the facility admits. The number of older people in private homes and "residences for elderly with services" (rented rooms with common dining areas with services provided from contracted providers) has continued to increase despite the expansion of community services. They have increased because it is difficult to meet the needs such as those with dementia requiring 24 hours, 7 days a week care in community settings. However, the difference between "institutions" and special "housing", including their costs, is rapidly disappearing.

CONCLUSION

The fiscal space has been rapidly decreasing because of the slow economic growth rate, the aging of the population and the introduction of the LTCI. Premiums and/or taxes must be increased. Of the two, tax reform has been more difficult. Every government that has increased the consumer tax (VAT) has lost seats in the next election. In contrast, premium increases have been more acceptable because the decision is made at the level of each plan and is an insidious process. Moreover, the premium rates of EHI plans are relatively low compared with the rates in Germany (see Gerlinger in this volume). For example, the rate in the NHIA is 10% (NHIA, 2021).

Thus, more funds could be made available by increasing the premium rates of EHI plans that have relatively low rates. Introducing risk-adjusting according to the age, income and other extrinsic factors of the enrolees would also make financing more equitable and allow SHI plans to merge. Such reforms are urgently needed. The CHI plans of the rural areas have become unsustainable because of population decreases and aging. However, the restructuring of SHI plans has not even been discussed. Both management and labour want to retain EHI plans because, should they merge with CHI plans, labour costs would increase for management and take-home wages would decrease for workers. This may be the reason why neither the ruling LDP nor the major opposition party, the Democratic Party of Japan, have proposed structural reform.

As a result, health policy in Japan has been focused on revising the coinsurance rate and the fee schedule. Coinsurance has generally been increased and has become 30% in principle for all. However, the high rate has been mitigated by two factors. One is that for most elders, it is 10%. The other is that there is catastrophic insurance for all with benefits more generous for those with low income. This is why Japan has a relatively high proportion of its health expenditures publicly financed (OECD, 2021). Thus, equity has been maintained though with a caveat. Patients must pay the coinsurance and then apply to have the amount exceeding the ceiling reimbursed. Some may not have adequate knowledge of their entitlement. This is why private health insurance plans with cash benefits irrespective of the out-of-pocket payment are popular (Kwon, Ikegami and Lee, 2020). Parenthetically, the extent to which the coinsurance for children is decreased or waived according to the child's age and the household income differs in each municipality. This may be one reason why, in contrast to "free" healthcare for the elderly, it has not expanded into a national program.

The fee schedule revision has been the critical issue for providers because it determines their revenue. For the Ministry of Finance, the global rate determines the amount of funds that must be allocated to health care from the general expenditure budget. The resulting conflict has been mitigated by lowering pharmaceutical prices. Once the global rate is set, item-by-item revisions are made after reviewing the financial condition of providers. The fees for services delivered by provider types that have large profits would be reduced while those showing a deficit would be increased. Revisions are also made to nudge providers to deliver services in line with policy goals such as improving nurse staffing levels and providing end-of-life care in community settings.

In making these revisions, the government has negotiated with the JMA and other professional associations. As part of the bargain, the government has agreed to uphold JMA's cardinal principle of allowing doctors to open clinics and proclaim their chosen specialties. This has made gate-keeping very difficult to implement. However, the government has revised the fee schedule in order to nudge large hospitals to focus on specialist services and small hospitals on post-acute care. In addition, the MHLW has provided new funds to facilitate the merger of small public-sector hospitals in rural communities in 2021. However, the amount of funding is very limited.

To conclude, the Japanese health system has developed by incrementally revising the fee schedule, the coinsurance rate and the catastrophic coverage rate. The national government's allocations to SHI plans must stay within the budget set by the Ministry of Finance. Structural reforms based on ideological commitment to equity or efficiency have generally not been made. The exceptions are the mandating of all residents not enrolled in EHI to enrol in CHI in 1958 and the introduction of "free" medical care for elders in 1973. Prime Minister Koizumi, in office from 2001 to 2006, attempted to restructure the system based on his commitment to market principles. However, he was opposed by the Ministry of Finance. The Ministry feared that deregulation would increase, not decrease, SHI expenditures because the public's expectations of health care would escalate.

Health care expenditures have mainly been controlled by the fee schedule. LDP politicians have been wary of contemplating structural reforms after their traumatic experience in introducing LEHI. The opposition party must prioritize the interests of its supporters, the labour unions. While health care costs have been relatively contained, LTC costs have accelerated after the introduction of the LTCI and because of population aging. Attempts have been made to contain LTCI costs by increasing the coinsurance rate for elders with high income. However, it has had only a marginal impact because only 10% of the elders aged 65 and over pay the higher rates (most elders have low income). Moreover, unlike health care, LTCI costs cannot be contained by lowering pharmaceutical prices, or by selectively lowering service fees. The latter would exacerbate the already critical labour shortage of LTC workers.

Under these precarious fiscal conditions, Japan was hit by the COVID-19 epidemic. To meet this crisis, the government has had to increase expenditures to prop-up economic activity, and to finance expenditures in the health care and LTC sectors. They have contributed to increasing government debts from two to three times the GDP. However, other high-income countries now have fiscal deficits, if not at Japan's level. Thus, Japan's health policy is likely to continue on its set path and incremental adjustments will continue to be made.

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18. China’s health care system and policies

Xian Huang and Jane Duckett

INTRODUCTION

The health care system of the People’s Republic of China (PRC, China) has benefitted from rapid national economic and social development over the past four decades. China is now an upper middle-income country, and its total health spending has risen, to over 5.4 percent of GDP in 2019,[1] only just below the average for countries at this level of development.[2] The quality of care is higher, especially for better-off citizens, and social health insurance covers most of the population. Health care technologies have also improved and are more widely used. For example, in some localities, urban citizens can book hospital appointments with their chosen specialist using mobile phone apps, while telemedicine is increasingly used to provide primary care.

But, at the same time, and despite efforts at reform since 2009 to tackle problems created by commercialization and underfunding in the 1980s and 1990s, China’s health care system is still beset by enormous difficulties. Access to care is still highly unequal, while poor primary care puts pressure on hospitals and increases the overall cost of provision. There is also significant regional variation in the quality of care, with poor provision in the countryside and smaller towns compared to major cities. Social health insurance programmes are segmented and vary in generosity, while individual out-of-pocket (OOP) payments remain high by international comparison. Even public hospitals are widely seen to be profit-driven, and while recent reforms have sought to change this (for example, by reducing markups on medicines that hospitals sell), they have had limited impact. Medical ethics are an issue of concern across the sector, while medical disputes and violent attacks on medical professionals are common (Huang, 2021; see text box, p. 312).

Current health policies – as set out in the “Healthy China 2030” outline plan adopted in 2016 and reiterated in the 14th Five Year National Health Plan published in 2022[3] – stress the need to focus on population health and prevention rather than curative care, on “equalizing” access to public health services and reaching remote areas, integrating social insurance schemes, and on strengthening primary care and reforming public sector hospitals,[4] but they also permit “diversification” and the growth of private sector provision. Reformers have struggled to tackle vested interests, however, and as a result, progress on primary care and hospital reform, on “equalization” and social health insurance integration are slow.[5] Meanwhile, a looming issue is China’s rapidly ageing population, which will put increasing pressure on the health care system. The COVID-19 pandemic – and the likelihood of other pandemics – is another threat to the health care system because it puts a huge strain on hospital finances and in the absence of proper referral systems, hospitals struggle to cope with sudden influxes of patients.

In the rest of this chapter, we will first set out how health policy is made and implemented, and how medical professionals are educated and trained. We will then describe the health care system, focussing on delivery, financing, and resultant inequalities, before setting out the trajectory of health care system reform over the last 40 years. We will move to discuss current health care system challenges before concluding on the unresolved problems and the prospects for resolving them.

HEALTH POLICY IN CHINA

Policymaking: Agenda-setting and Policy Formulation

China's health care system governance is led by the National Health Commission (NHC),[6] a ministerial body within the national government that leads a hierarchy of health commissions at each level of the PRC's four-level subnational governmental system (i.e., provinces, prefectures, counties and townships).[7] This means the NHC issues policies to the provincial health commissions in each of 31 provincial-level governments, which in turn cascade them to subordinate health commissions via their prefectures. It organizes the formulation of national health policies, regulations and standards and their implementation. It is charged with coordinating health system reform, planning disease prevention and control, drawing up medicine policies and measures to deal with population ageing, as well as public sanitation, health care institution and services management and evaluation, medical personnel qualifications and service standards. The National Health Care Security Administration (NHSA) handles social health insurance and oversees health insurance fund management, the National Medical Products Administration is responsible for medicines and medical technology safety, while the Ministry of Civil Affairs' Social Assistance Department delivers medical financial assistance for the poorest citizens.

On a routine basis, health policy formulation is led by the NHC in a bureaucratically-dominated process. But the overall direction of health and other policies is set by the leadership of the Communist Party of China (CPC), which is organizationally distinct from the governmental system that it controls.[8] From the late 1970s, for example, the CPC leadership set China's economy and health care system on the path away from state planning and toward marketization and commercialization. While the health care system was not in the 1980s and 1990s a priority sector for government investment, it rose up the CPC's political agenda in the early 2000s for three main reasons: the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic, which revealed the system's problems and showed the cost of health system neglect; leadership awareness that health care costs had become a significant cause of poverty; and the "new Left" gaining influence within China as the gross inequalities in access to health care (as well as incomes) became more apparent (Kornreich, Vertinsky and Potter, 2012). Since the early 2000s, policies to expand social health insurance, raise reimbursement rates, and make health care more affordable for people on low incomes appear to have been driven by the CPC's overall agenda of creating a "moderately prosperous society" so as to boost its political legitimacy (Duckett and Munro, 2022).

Beyond the government bureaucracy, medical professionals and international organizations influence health policy but Chinese non-governmental organizations (NGOs) are weak. Former medical professionals often take up roles in national and local health commissions, and there are very close relationships between government health departments and government-organized medical professionals' organizations, which are often led by retired health officials. Leading health sector professionals can also discuss, propose, and shape policies as members of the Chinese People's Political Consultative Conference, an influential advisory body. International organizations, most notably the World Health Organization, United Nations Development Programme and the World Bank, have also been influential, bringing in ideas and resources that contributed to changing understandings of health care, modes of funding, and outcomes. Patient groups, however, are usually small, unfunded, localized and marginalized due to restrictions on the formation of non-governmental organizations (Duckett, 2019).

Policy Implementation and Evaluation

In China's centralized political system, the NHC issues national health policies and cascades them down for local implementation. But in China's decentralized fiscal system (Montinola et al., 1995), public finance for health care provision comes largely from local governments, whose resources vary depending on the strength of the local economy. Recognizing the very different levels of economic development across the country, national policy is often broad in scope and allows details to be determined at local levels. As a result, policy implementation varies under the influence of local circumstances and priorities. Furthermore, local health commissions are constituent departments of local governments (whether at provincial, prefectural, county or township level), whose leaders have career incentives to invest in economic growth rather than health care and other social provisioning. Local governments therefore fund priority public health initiatives – especially maternal and child health, vaccinations and preventive care. They also administer social health insurance, pooling funds locally in accordance with a nationwide set of parameters. But they have reduced their share of spending in many other areas, sometimes privatizing hospitals, facilitating their profit-seeking or using them to promote economic growth. For example, they often construct new hospitals in development zones because they can push up property prices.

Health policies are not consistently subject to rigorous evaluation, though local health commissions are set targets – for example, the numbers of beds and doctors per capita of the local population. Local governments also sometimes recruit researchers to study and promote their initiatives, and the central government can send in teams to "inspect" local initiatives and pilot schemes. But in a country so large – with 685 cities and around 542,000 villages – this is not routinely done. Information controls and censorship mean that there are also limited opportunities for public or media scrutiny and that published health system data often obscures inequities and problems in policy implementation.

Regulation of Medical Professionals: Education and Training

China's medical education and training system comprises three tiers (Anand et al., 2008; Zhu et al., 2016). The first tier involves a degree-oriented medical education or bachelor program, including five years of undergraduate medical study followed by three years of residence. The second tier consists of junior medical colleges, which provide three years of study after high school leading to a tertiary vocational diploma. The third tier is provided by secondary vocational schools which deliver very limited medical training after junior middle school leading to a secondary vocational diploma. Under the current system, if second- or third-tier medical graduates (those without a bachelor's degree) wish to become assistant doctors, then they can obtain the full doctor licensure after having accumulated a certain number of years of work experience and having passed an examination (Wu et al., 2014).

China adopted this multi-tier medical education and training system, based on the Russian "feldsher" system, in the 1950s to increase the supply of health care professionals at a lower cost. This system – and the barefoot doctors in rural areas with even less training – was praised for improving population health and for reducing China's mortality rate in the period from the 1950s to the late 1970s (Zhang and Unschuld, 2008). However, recent studies point out that the three-tier system has had adverse impacts on health care equity and efficiency, especially in the post-1978 era during which China has experienced an epidemiological transition from communicable to non-communicable diseases (Hsieh and Tang, 2019; Zhu et al., 2016). Moreover, the geographic distribution of doctors with different educational training is uneven. More highly-educated doctors are more likely to practice in urban areas and larger hospitals. These distributive outcomes of the multi-tier medical education and training system not only increase urban–rural disparities in health care delivery and service quality (Anand et al., 2008; Hsieh and Tang, 2019), they also fuel the hospital-centred health care system in China as patients choose large hospitals in an effort to be treated by good doctors (Hou et al., 2014; Hsieh and Tang, 2019).

Over the last two decades, reforms of the medical education system have accompanied overall health care system reforms (Hou et al., 2014; Zhu et al., 2016). In 2009, the Ministry of Education and the Ministry of Health launched a comprehensive reform of medical education both to improve the distribution and to enhance the quality of the health workforce. The 2009 reform aimed to improve the quality of doctors instead of increasing the quantity of human resources for health, indicating a significant change of government view towards the trade-off between quantity and quality in training health care professionals. Nonetheless, the government still maintains the heterogeneous medical training system and medical graduates from the three-year tertiary vocational tier are the main source for the rural health workforce (Hsieh and Tang, 2019).

CHINA'S HEALTH CARE SYSTEM

Health Care Delivery

In China, health care is delivered by providers that are categorized into three tiers: primary, secondary, and tertiary. This categorization is not based on the types of medical services that they provide but the quantity of beds and personnel in them. Primary care facilities are mostly township or community health centres with between roughly 20 and 99 beds and with a minimum of three doctors and five nurses, while secondary and tertiary hospitals have 100–499 and over 500 beds, respectively, with a minimum of 0.88 and 1.03 health workers per bed (Qian and Blomqvist, 2014). Most providers deliver a mix of traditional Chinese medicine (TCM) and what is usually called "Western medicine", though there are some TCM-only hospitals.

The tiers are differentiated not only by infrastructure but also by human resources. There is a substantial gap between hospitals and primary care facilities in the proportion of trained staff. Although primary care facilities (e.g., urban community health centres or stations, rural health centres, village clinics, and independent outpatient clinics) comprise 96 percent of all health care facilities in China, most health workers are employed in hospitals because of the smaller size of primary care institutions (Zhang et al., 2017). Low wages and lack of career opportunities – relative to medical professionals in hospitals – have often been blamed for the shortage of primary care workers (Zhang et al., 2015). Services provided by primary care facilities are often deemed low quality. As a result, there is a lack of trust in primary care institutions among patients, which – because there is no gatekeeper system and people can seek care directly from secondary or tertiary hospitals – in turn leads to lower utilization of these institutions (Duckett et al., 2016; Li et al., 2020). It is common in China for patients to seek medical attention from hospitals even for minor illness or chronic conditions.

SLOW GROWTH IN PRIMARY CARE PROVISION

Primary care facilities have been growing more slowly than hospitals. Between 2006 and 2016, the number of primary care facilities increased by only 4.7 percent, whereas the number of hospitals has increased by 51.4 percent (Zhang et al., 2020). The share of outpatient service provided by primary care facilities had dipped from 61.8 percent in 2010 to 53.1 percent in 2018; while the share of outpatient service provided by hospitals increased from 34.9 percent in 2010 to 42.4 percent in 2018 (National Health and Family Commission, 2019).

REGIONAL DISPARITIES IN HEALTH CARE PROVISION

Higher tier health care providers are disproportionately concentrated in affluent urban areas. Previous studies show that most quality health resources are concentrated in hospitals, especially in tertiary hospitals, of which 47 percent are located in the eastern provinces; 30 percent of provinces in China have attracted 50 percent of quality health resources (Zhang et al., 2015). This reinforces regional disparities as well as the urban–rural gap in China's health care provision. Tao Zhang and colleagues (Zhang et al., 2017) found that residents living in the eastern developed regions were more likely to use hospitals for outpatient care, while residents living in the western undeveloped regions were more likely to use primary care institutions for inpatient care.

China's health care delivery is thus centred on hospital provision, and this hospital provision is dominated by public hospitals that operate on a for-profit basis, though the NHC and NHSA control prices of some procedures and medicines. Since the mid-1980s, government subsidies to public hospitals and clinics have declined substantially (see Health Financing below). This not only makes it difficult for governments to reform and regulate some aspects of public hospital provision, but it also means that even though social health insurance has grown as a share of health spending, public hospitals and health care providers rely heavily on user fees and drug sales to survive financially. In 2011, expenditure on drugs as a share of total health expenditure was 43 percent compared with an OECD average of 16 percent, and drug revenues accounted for 41 percent of total hospital income (Yip and Hsiao, 2014). Moreover, the government set some medical prices below cost to assure affordability for the general public, while allowing prices for new and high-technology diagnostic services to be set above cost and permitting a 15 percent profit margin for drugs (Yip et al., 2010). Consequently, Chinese public hospitals act much like private profit-driven enterprises. Over-prescription of drugs and tests is prevalent as hospitals regularly receive kickbacks from drug companies and medical suppliers for prescribing their products. Bonuses for doctors, which make up a large share of their total compensation, are linked to the profits they generate for the hospital, including the free goods from companies (Qian and He, 2018). Hospitals compete to introduce high-technology services and expensive drugs that increase their profit margins (Qian and He, 2019). These profit-driven behaviours have led to a multitude of social issues plaguing China's health care system, including distrust between patients and doctors (Tam, 2012), violence against doctors (Huang, 2021), and corruption (Tam, 2011). As Yip and Hsiao (2014: 809) put it, "Unlike most public hospitals in the world, Chinese public hospitals are an embodiment of both government and market failures."

HEALTH CARE DISTURBANCES

Health care disturbances, or *yinao* in Chinese, involve the disruptive and violent behaviour of patients and their families toward health care personnel and institutions. They include such actions as blockading hospital entrances, destroying hospital property, and attacking doctors or nurses. Such disturbances were rife throughout China in the 2000s. *Yinao* are often triggered by misunderstandings, miscommunications, and a lack of trust between patients and doctors. Since 1978, the largely free health care provision of the socialist state-planning period has been replaced by a contributions-based social health insurance system in which patients must pay out of pocket, including making co-payments and paying for costs that exceed the insurance reimbursement limit. Patients must pay up-front OOP and then make a claim for reimbursement. As consumers, patients have acquired a strong sense of entitlement since they are paying for their own medical services. In response, many doctors practise "defensive medicine" – overprescribing diagnostic tests, procedures and drugs – to protect themselves in case of medical disputes, while hospitals have increased security patrols and installed security cameras. These escalating security measures have further fuelled the distrust between doctors and patients.

The vicious cycle of distrust–*yinao*–distrust between Chinese doctors and patients has been reinforced by resource misallocation or disorganization in the health care system (Huang, 2020a). With primary care institutions short of funding and well-trained medical professionals, services provided by primary care facilities are commonly deemed low quality. Patients often travel long distances and pay unreasonably high expenses for medical services, even primary care, in tertiary hospitals. As a result, tertiary hospitals are overcrowded and their doctors are overloaded while patients do not receive satisfactory care.

At the same time as public sector providers have commercialized, China's private health care sector has grown. While the Chinese government re-stated its commitment to public health care financing (both directly and through social health insurance) and provision of primary care in its 2009 health reform initiative, it also encouraged private investment in the health care system including the hospital sector (Gusmano, 2016). Although the government wants to encourage private investment in areas that are underserved, most private health care is concentrated in affluent urban areas and in hospital services. Private hospitals in China are either high-end specialist hospitals that cater to the rich or small-scale hospitals providing elective services, such as cosmetic surgery, for the general public (Yip and Hsiao, 2014). In 2011, 12 percent of hospital beds in China were private (Gusmano, 2016), and private hospitals accounted for just 10 percent of total hospital admissions (Yip and Hsiao, 2014). Since then, the private sector has continued to expand. In 2015, the number of private hospitals exceeded the number of public hospitals for the first time. The share of hospital beds in private hospitals increased to 21.6 percent in 2016. There has also been a significant rise for the indicators of both the supply capacity (including number of hospitals, number of hospital beds and the average number of hospital beds per hospital) and the health care delivery (inpatient numbers and bed occupancy rates) of private hospitals. However, the growth rates of private hospitals have been lower than those of public hospitals (Deng et al., 2018). Moreover, the disparity in size between private and public hospitals has increased: the average public hospital bed number (per hospital) was around 3.3 times higher than that of private hospitals in 2005, while it was 4.7 times higher in 2016 (Deng et al., 2018). In addition, the supply capacity growth of private hospitals exceeds their actual health care delivery. Hence, the public–private disparity is even larger in terms of health care delivery. In 2016, the total visits to private hospitals was only 13 percent of the total number of hospital visits, and the bed occupancy rate of private hospitals was a third less than that of public hospitals (Deng et al., 2018).

Health Financing

Health care in China today is financed through a mix of public spending by both central and local governments (for preventive care, maternal and child health and insurance subsidies, particularly for poorer areas), social health insurance and private payments (both OOP payments and private insurance, with the latter a small share of total health care finance in China). Between 1980 and 2005, total health expenditure increased at an annual rate of 18 percent; the average medical expenditure for an outpatient visit in a comprehensive hospital increased 77-fold and the average medical expenditure per inpatient increased 116-fold (Huang, 2013). The rapid increase in health care expenditure involved at least three structural changes in China's health financing.

First, the share of government funding in health decreased until the early 2000s. In 1980, government spending accounted for about one-third of total health expenditure in China; in 2003, this share had decreased to less than one-fifth. A majority of Chinese hospitals remain in the public sector, but government subsidies to them have, as noted above, declined in the market reform period that started in the late 1970s. Government subsidies to public hospitals fell to 30 percent of hospital revenues in the 1970s and approximately 20 percent in the 1980s to around 6 or 7 percent in the 1990s, and they remained low throughout the 2000s (Chan, 2018). Meanwhile, income from drug sales consistently made up approximately 45 percent of total hospital revenue from 2004 to 2011 (Chan, 2018). As health care providers were permitted to receive a fee for administering injections and infusions as well as a profit of 15 percent on prescribed medicine, the overuse of such treatments and the medicine overprescription are very common in Chinese hospitals, helping to push up health care costs.

Second, accompanying economic liberalization, the financial burden of health care was increasingly shifted to individuals. OOP payments as a share of total health expenditure grew from 20 percent to almost 60 percent between 1978 and 2002 (Smith, Wong and Zhao, 2005). Yip (2009) reports that the OOP expenses associated with a single inpatient admission increased from 70–80 percent of per capita annual income in 1993 to more than 200 percent in

2003. As a result, the fraction of people not seeking care because of financial reasons increased from 12 percent to 18 percent between 1993 and 2003 (Yip, 2010); poverty due to catastrophic health expenses also increased in the 1990s (Liu et al., 2003). Although the upward trend in the share of OOP payments was reversed later in the 2000s thanks to significant expansion of social health insurance coverage and government subsidies, individuals' and households' financial burden for health care is still comparatively high: in 2019, OOP payments in China were at 35 percent of total health expenditures whereas the global average was 18 percent.[9]

Third, although social health insurance has played an important role in financing health care in China since the early 2000s, it faces increasing financial pressure and its impact on financial protection for individuals is still limited. Health insurance expansion may lead to higher OOP spending and provide limited financial protection for several reasons (Wagstaff et al., 2009): by increasing the quantity of care used, by encouraging the use of higher-level (and more costly) providers, and by encouraging providers to deliver a more costly type of care. Studies of Chinese social health insurance so far provides mixed evidence about its financial protection. Some studies show that the social health insurance has had modest impacts on reducing household OOP spending and financial burden (Fang et al., 2019; Sun et al., 2009; Yip and Hsiao, 2009b), many others find no measurable effects of social health insurance on reduction of financial risk (Liu and Zhao, 2014; Wagstaff et al., 2008, 2009).

In the 2000s, the Chinese government's contribution to health care financing noticeably increased. Over the last decade, the share of public spending on health remained at around 30 percent of total health spending, while social spending (which includes social insurance as well as charitable spending) increased from almost 35 percent of the total in 2011 to 42 percent in 2020. Individual expenditures fell as a share of total spending from almost 35 percent to 28 percent over the same period (National Bureau of Statistics, 2022).[10]

Health Care and Health Inequalities

Inequalities are a prominent problem and challenge in China's current health care system. First, there is a significant urban–rural divide. Before the Urban–Rural Resident Basic Medical Insurance (URRBMI) that integrated the urban and rural resident basic medical insurance systems (discussed below) was established nationwide in 2016, registered urban residents were entitled to different health insurance programs from rural residents, with the urban programs providing more generous benefits than their rural counterparts (Huang, 2014; Zhang et al., 2017). At the same time, government spending in urban areas has been around five to six times higher than in rural areas (Yip, 2010). As a result, rural households shoulder a higher financial burden and face higher financial risks for health care than their urban counterparts do. According to the 2003 National Health Services Survey data, rural residents in the lowest income quintile spent the highest percent of their income on health care; in rural areas, an episode of hospitalization can cost as much as six times an individual's income, and in urban areas, the cost is about four times an individual's income (Yip, 2010). Based on the 2008 National Health Services Survey data, researchers found that household income significantly contributes to the pro-rich health inequality in both urban and rural China and this effect is considerably larger in rural areas (Guo et al., 2020).

Second, social health insurance is regionally segmented, causing particular problems for China's internal migrants. Chinese social health insurance programs are administered by local governments at different levels. They were established at the district level in cities and the county level in rural areas. By 2010, about half of social health insurance programs were still operated by county-level governments. As a result, China had 2852 rural cooperative medical schemes, 333 schemes for urban employees, and 333 schemes for urban residents without employment (Meng et al., 2015). Within broad national frameworks for each scheme, local programs can have different benefit packages and different rules regarding OOP payments. Although the 2009 health reform initiative promoted regional (mainly city-level) integration of social health insurance, and long-term goals are said to be provincial and then national level integration, so far progress has been limited and hundreds and even thousands of units (i.e., cities, counties) operate social health insurance independently (Meng et al., 2015). This means that they set the detail of health insurance schemes and manage the social insurance funds within general guidelines issued by the national and then provincial governments. Regional differences in health insurance regulations and policies are so pronounced that it is difficult for individuals to continue their current health insurance enrolment if they move to other localities beyond their hometown where their households are registered. This feature of Chinese social health insurance puts migrants at a particular disadvantage. Migrants have to go back to their hometowns (where they are registered residents and are eligible to participate in local resident health insurance) to obtain health care at hospitals designated under their local health insurance program and so be eligible for health insurance reimbursement; otherwise, they either have no health benefits or forego insurance reimbursement for some or all of their expenses in the area where they live or work (Zhou et al., 2022). Consequently, the actual insurance benefits that migrants enjoy are usually much more limited than those of local residents (Qin et al., 2014).

Moreover, the majority of financing responsibilities for the urban and rural residents' (but not the urban employee's) social health insurance programs fall upon the local (city or county) governments. The governments of poorer regions have a harder time meeting the financial responsibilities than the governments of more prosperous regions. This disparity in funding ability creates significant barriers in reducing inequality in China's health care system. As a result, the generosity and coverage of social health insurance significantly varies across regions depending on local governments' fiscal capacities and local economic conditions (Huang, 2015; Liu et al., 2008).

Third, social health insurance is stratified. Chinese health insurance programs are designed and organized around social groups: state employees, formal workers, informal workers, and non-working residents are each included in different programs with distinct contribution and benefit rates. Individuals usually have no free choice of social health insurance. For example, informal workers or migrant workers without long-term labour contracts are unlikely to be enrolled into the health insurance for urban employees (Gao et al., 2012; Muller, 2016). Moreover, the benefits (e.g., reimbursement rates) of the three major social health insurance programs vary in generosity. As to inpatient costs, for example, urban employees enjoy the highest level of protection (at least 66 percent of costs covered); the inpatient costs of urban non-working residents and rural population have been reimbursed by only 49 and 35 percent, respectively (Liu et al., 2016).

The inequalities in China's health care system may contribute to disparities in health status (e.g., life expectancy, infant mortality rates, maternal mortality, and epidemiological transitions) (Tang et al., 2008; Yip, 2010) and health care utilization across regions and income quintile groups (Liu et al., 2008; Xie, 2011). They certainly reflect the generally regressive social welfare provision in China (Gao, 2010). The urban–rural divide, regional segmentation, and social stratification that characterize the current health care system are all present in other

Chinese social welfare policies such as old-age pensions and unemployment insurance (Liu et al., 2016) and have been formalized by the Social Insurance Law promulgated in 2010. It reflects a "stratified expansion" strategy in China's social welfare provision – maintaining a particularly privileged provision for their elite support base while extending modest provision to the wider population to prevent social unrest (Huang, 2020b).

It should be noted, however, that there is some evidence that the aforenoted health inequities in China, such as urban–rural disparities, persist but have decreased over time. This has been attributed to the expansion of social health insurance coverage (Fu et al., 2014), rising health insurance reimbursement rates (Xu et al., 2018), and the integration of urban and rural residents' schemes since 2016 (Zhou et al., 2022). However, without fundamental change of the decentralized and urban-rural-divide governance system and the current political regime that lacks genuine mechanisms for public participation, health care inequalities due to regional socioeconomic disparities and individuals' sociopolitical status are likely to prevail in China.

HEALTH CARE SYSTEM REFORMS

From State Planning to Commercialization

The People's Republic of China (established in 1949) was widely praised for introducing barefoot doctors and basic sanitation, vaccinations and health care from the 1950s. In the cities, as the Communist Party-state nationalized industry and set up a system of economic planning, urban enterprises and other public sector employers ("work units") provided a package of benefits that included health care provision for employees and their dependants. In rural areas, "communes" were formed from the late 1950s but they provided nothing like the same level of health care as in the cities. In the mid-1960s, however, China's leader Mao Zedong criticized the Ministry of Health for its urban focus, calling it the "Ministry of Urban Gentlemen's Health" – and removed some of its leaders. He was anti-elitist and anti-professional, and pushed the extension of paramedics, known as "barefoot doctors", across rural areas. The rural health care focus was not, however, matched by a significant shift in health care spending in the countryside. Urban health care provision remained much higher in quality and was subsidized for many public sector workers (Duckett, 2011).

From the late 1970s, however, following Mao's death, his health policies were reversed and medical professionals were reinstated into leadership positions in the Ministry of Health. Under Deng Xiaoping, the Maoist "better red than expert" approach, which valued political loyalty over knowledge and training, was reversed, and greater emphasis placed on expertise, training and technological developments. Despite support for the medical professionals in terms of some of these policies, they were not accompanied by increased spending. Spending levels remained low and instead barefoot doctors and hospitals were permitted to charge fees for some services and medicines – though the prices for many services were regulated (Duckett, 2011).

In the cities, as China embarked on economic reform and openness in 1978, it began to reform the work-unit financing of urban health care that covered the health care provision for employees and half the cost of their dependants' health care and medicine. During the early stage of reform, from 1988 to 1994, health reforms focused on reducing the medical care expenses burden on state enterprises (Gu, 2001). After the experiments with "co-payments" and "risk pooling" of health insurance in some cities between 1988 and 1994, compulsory social health insurance combined with individual premium contributions began to operate in about 60 Chinese cities in 1994 (Gu, 2001). Finally, a social health insurance program, Urban Employee Basic Medical Insurance (UEBMI), was established for urban formal employees in late 1998. This program established national framework for locally-administered social health insurance for urban employees in formal work.

From 1998 and through the first decade of the 21st century, China's health care reforms focused on implementing and expanding social health insurance. Early in this period (1998–2003), due to concerns about the financial resource constraints of both Chinese government and enterprises, the central government's strategy was to expand the population coverage of urban employee social health insurance while keeping benefits modest. But the implementation of this strategy was mostly left to the local governments, particularly local leaders. Chinese local leaders, mindful of their political careers in the centralized personnel system, proactively design and implement social health insurance policy according to local socioeconomic conditions and to prevent social unrest in their jurisdictions, which could put their career prospects in jeopardy (Huang, 2015). This resulted in different mixes of inclusiveness and generosity in different localities across China (see Table 18.1). The local choices for generosity and inclusiveness of social health insurance provision are jointly determined by levels of local fiscal resource and social risks.[11]

Table 18.1 Factors shaping local variation in social health insurance provision

		Social risk level	
		High social risks	*Low social risks*
Resource levels	*Good fiscal resources*	Inclusive and generous	Exclusive and generous
	Poor fiscal resources	Inclusive and meagre	Exclusive and meagre

Source: Authors' own calculations.

Social health insurance expansion also entailed establishing new health insurance programs for social groups other than urban formal workers. In 2003, the New Rural Cooperative Medical Insurance (NRCMI) program was initiated, for the first time providing social insurance for rural dwellers and helping to rapidly expand health care services into rural areas. In 2007, another residency-based health insurance program, Urban Resident Basic Medical Insurance (URBMI), was introduced in urban areas to incorporate urban informal workers and non-working residents into social health insurance. By 2010, more than 237 million employees (including retirees) were enrolled in UEBMI and over 195 million urban residents (including college students, teenagers and the elderly without pensions) were beneficiaries of URBMI. Meanwhile, 832 million rural people were covered by the NRCMI. Although the enrolment of residency-based programs (URBMI, NRCMI) were almost four times larger than that of the employment-based health insurance program (UEBMI) thanks to the health insurance expansion, the level of benefits that the residency-based health insurance provided was low. A comparison of the per capita expenditures of UEBMI, URBMI, and NRCMI programs indicates that the health insurance generosity for urban employees was significantly higher than the ones for urban non-working and rural populations. In 2010, the expenditure of the UEBMI program was 13 times higher than the combined expenditures of the URBMI and NRCMI programs (Huang, 2020b). Unlike the UEBMI, which is financed by employers' and employees' contributions withdrawn from payrolls at a fixed rate, the funding of URBMI and NRCMI relied heavily on ad hoc subsidies from the government, especially local governments. Due to this feature, the URBMI and NRCMI are more susceptible to variation in local economic development and public finance among localities.

The 2009 Health Care System Reforms

In 2009, the central government unveiled its plan for a new round of health care system reforms. The uneven implementation of social health insurance expansion in the early 2000s and the large variations in local health care provision compelled this reform to focus on three policy areas that aimed to increase the accessibility and affordability of health care and the efficiency of health care provision.

First, the reforms sought to integrate the multiple social health insurance programs while consolidating the universal coverage of social health insurance. By 2011, the coverage of Chinese social health insurance had reached around 90 percent of the population; from 2014 onward, the coverage rate of social health insurance remained over 95 percent. Despite the almost universal coverage of social health insurance in terms of participation across the population, the system was highly fragmented and decentralized with multiple social health insurance programs co-existing and managed separately in each city or county. As a remedy, in the 2009 reform the government initiated several experimental policies for social health insurance integration, including upgrading the pooling of UEBMI funds from county to city levels and merging URBMI and NRCMI to form a new health insurance program – URRBMI – for the non-working population across urban or rural areas. Like many other reforms in China, the implementation of these policies is uneven and evidence of the policy impacts in pilot cities is mixed, contingent on the vastly distinct constraints and resources local governments hold (Huang and Kim, 2020; Meng et al., 2015; Muller, 2017). Recent studies found that URRBMI has significantly increased middle-aged rural residents' hospital use (Huang and Wu, 2020) and improved financial risk protection for rural residents, especially low-income ones, due to a decline in OOP payments (Zhou et al., 2022).

Second, the 2009 reforms sought to develop accessible provision of primary care and public health services at local levels. Accompanying the abolition of work unit-based social provisions and the development of market-oriented economic reforms in the 1990s, many local health care providers such as health stations and centres at the village or township levels (rural areas) and the community levels (urban areas) had been either privatized or had gone out of business (Duckett, 2011). The 2009 health reforms aimed to re-establish, either directly by local governments or indirectly by public–private partnerships, the grassroots health care institutions that are crucial for the accessibility and equity of primary care and public health services for many people (Huang, 2013; Muller, 2019).

Third, the 2009 reforms involved measures aimed at streamlining health policymaking authority and improving hospital governance. China's health policy authority had been dispersed and fragmented with various ministries holding decision-making power in different aspects of health care provision (Duckett, 2003; Hsiao, 2007; Huang, 2020b). Against this backdrop, administrative reforms were carried out to streamline the policy authority. In 2018, the power of health insurance policymaking and fund management was transferred from the NHC, Ministry of Human Resources and Social Security, Ministry of Civil Affairs, and National Development and Reform Commission (NDRC) to the newly-established vice-ministry level NHSA.

As part of the 2009 health reforms, the Chinese government committed to spending an additional 850 billion yuan (about 125 billion US dollars) between 2009 and 2011 to subsidize individuals' enrolment in social health insurance and to build a health care delivery system with emphases on public health services and primary care delivery. To be noted, of the 850 billion yuan of new financing, the central government was only responsible for 40 percent, while local governments were responsible for 60 percent, or a total of 520 billion yuan (Yip and Hsiao, 2009a). Moreover, the central government's fiscal subsidies mainly go to the western and inland regions, leaving the wealthy eastern regions completely on their own in social health insurance and health care financing. The skewed geographic distribution of central fiscal subsidies under the decentralized government spending system intends to equalize public health spending across regions and support the poorer regions in health financing, but it can enlarge the regional differences in health benefits and quality as the local governments in wealthy regions have full autonomy in setting their benefit levels and eligibilities while their poor counterparts' hands are more tied; it also contributes to local governments' incentives for "local protectionism" in health care provision as health subsidization is made based on the headcount of local residents (Huang, 2020b).

The 2009 health care system reforms evolved into the 13th Five Year Plan (2016–2020) and Healthy China 2030 strategy. In May 2022, with a delay probably caused by the COVID-19 pandemic, the State Council issued its 14th Health Five Year Plan (2021–2025). Common goals across these health strategy and planning documents include the need to prioritize prevention and public health as well as to improve primary care and shift away from an over-emphasis on hospital-based curative care. How, concretely, these goals will be achieved remains unclear, with primary care requiring significant investment and public hospital reform so far proving particularly difficult. It is notable that the 14th Five Year Health Plan focuses on creating a network of medical groups involving primary (community care) and hospital providers.

Public Hospital Reform

China's public hospital reform has centred on such measures as removing drug mark-ups, increasing government budget allocation, adjusting fee schedules, and reforming payment methods. It is an ongoing trial-and-error process with localities exploring various policy innovations and the central government evaluating, propagating, and rolling out the successful models. From 2010 to 2012, various public hospital reform schemes were experimented with in 17 pilot cities (Huang, 2013; Yip et al., 2012). Given the difficulties and unsatisfactory results of the earlier round of public hospital reforms, in 2016 the reform focus was further refined to county hospitals and some prefectural-city-level hospitals while the list of cities for experimentation was expanded to 200 (Yip and Fu, 2019).

The difficulty of public hospital reform in China is derived from its archaic and complex governance structure. Like social health insurance, Chinese public hospitals are governed by multiple ministries and agencies with competing bureaucratic interests and dispersed decision making power. Hospital personnel are managed by both NHC (as medical professionals) and Ministry of Human Resources and Social Security (SS) (as state employees); hospital finance (profits, surplus) is jointly determined by the Ministry of Finance (i.e., government subsidies), NHSA (payments for treatments, services, and medicine by social health insurance), and NDRC (pricing of medical materials, treatments, services and medicine), hospitals' strategic investment and development decisions such as acquisition of equipment and infrastructure construction need to be approved by NHC and NDRC. Facing conflicting policies, regulations, and rules from the multiple ministries that govern them, public hospitals are often unclear about their functions, social responsibilities, and accountabilities (Yip et al., 2012). Under China's fragmented and decentralized health governance system, comprehensive reforms are hard to emerge or be realized due to lack of consensus and leadership, while piecemeal reforms for public hospitals are often faced with resistance from some stakeholders, such as hospital directors and pharmaceutical and medical device companies, whose incomes are closely related to the profitability of hospitals.

CHALLENGES FACING CHINA'S HEALTH CARE SYSTEM

COVID-19 and the Policy Response

The COVID-19 pandemic hit China first in late 2019, and by late April 2023 it had officially claimed over 120,000 lives, a figure that understates the true number because the Chinese authorities adopted a narrow definition of a COVID-19 death.[12] The Chinese government's early response to COVID-19 drew widespread criticism over lack of transparency and policy inconsistency. However, from March 2020 to the fall of 2022, it contained the widespread transmission of COVID-19 and managed to handle this unprecedented public health crisis (He et al., 2020; Mei, 2020). It did so mainly using non-pharmaceutical interventions such as strict controls on people's mobility, as well as by constructing temporary hospitals to extend health system capacity and the requisitioning of buildings to isolate people who tested positive for the virus. From mid-2020 to late 2022, the authorities successfully contained multiple local outbreaks of the COVID-19 virus, but then suddenly relaxed restrictions and allowed it to spread. The resultant influx of largely elderly patients – many unvaccinated – put enormous pressure on the health system from December 2022 into Spring 2023.

The pandemic drew attention to at least three shortcomings in the system and may spur reforms to tackle them. First, China's health care resources have long been largely allocated to hospitals rather than to primary care facilities and public health institutions. The overcrowding in hospitals and shortages of hospital beds for COVID-19 patients in the early outbreaks in Wuhan, the first epicentre of the pandemic, were partially attributed to the long-lasting problem of resource misallocation in China's health care system. It was only on January 24, 2020, that the Wuhan health authority began to implement a referral system to take advantage of the capacity of 205 primary care providers – with patients being referred to hospitals from primary care clinics (Qian, 2020). Although the rapidly-installed referral system did not eliminate medical resource shortages in Wuhan due to structural weaknesses in the primary care facilities such as lack of health workers, medical equipment, and diagnosis capacity, the outbreak brought to the fore the important role that primary care centres or clinics could play in screening and monitoring for COVID-19 and maintaining routine care on other health conditions (Li et al., 2020).

Second, China's social health insurance provides insufficient financial protection to individuals as it leaves outpatient care and catastrophic diseases barely covered. Consequently, patients may be reluctant to seek medical attention when COVID-19 symptoms are either mild or very serious. To address this problem in the short run, on January 21, 2020, the Chinese government announced that the costs of COVID-19 treatment would be reimbursed fully by social health insurance or medical assistance (Qian, 2020). Then, in summer 2020 when the first wave of Covid infections receded in China, new reform initiatives emerged, including formally establishing a reimbursement scheme for outpatient care and reducing the role of personal savings accounts in social health insurance while enlarging the social pool for health insurance funds to increase the sustainability of insurance funds. Reform in these regards is never decisive, however, due to fierce contention and resistance from vested interests. In the spring of 2023, thousands of retirees converged on municipal parks and other public spaces to protest against these policy changes in social health insurance.[13] It remains to be seen whether the COVID-19 pandemic proves to be a critical juncture for successful institutional change and substantial reform in China's social health insurance.

Third, there is scope for technology to play a greater role in the health care system. As in other countries, the COVID-19 epidemic has spurred the creative deployment of digital technology and platforms in China's health care. For example, health care providers have been promoting and using virtual appointments, online consultations, and drug delivery (Li et al., 2020; Yan et al., 2020), which have played a significant role in ensuring access to care for the non-COVID-19 patients as well as in screening and treatment for COVID-19 during the pandemic. The use of communication and information technology in health care and its impact on the accessibility, equity, and efficiency of health care delivery as well as health outcomes in China in the long term, need to be rigorously and objectively assessed.

Long-term Care

China's population aging, which stems from low fertility rates and increased life expectancy, is seen as a major problem by the government and a great deal of resource is being invested in exploring options for elder care and improving the relationship between health care and personal care for the elderly. Elder care is an underfunded and still relatively new sector, however, and so policies and reforms in integrating health and personal care for the elderly are not widely implemented. In 2016, China launched long-term care insurance (LTCI) pilots in 15 cities. All of the pilots are financed by existing social health insurance programs (UEBMI, URRBMI), earmarking a particular percentage or fixed amount per person from the existing risk-pooled funds for long-term care services (Chan and Shi, 2022; Feng et al., 2020). Empirical studies have emerged to evaluate the effect of these pilots on health and long-term care access, quality, and cost (Lu et al., 2017; Yang et al., 2016; Zhu and Osterle, 2019). But the long-term effectiveness and sustainability of these pilots remain to be seen. In 2020, the central government decided to expand the LTCI pilots to an additional 14 cities across the country (Chan and Shi, 2022; Feng et al., 2020).

CONCLUSION

China's health care system underwent a major reorientation away from state planning in the 1980s and 1990s, as it became much more commercialized and private provision grew. Since the early 2000s, health policies have focused on extending basic social health insurance across the whole population, reforming hospitals to deal with negative consequences of their fee-for-service orientation, and improving primary care. Although all these policies have led to some incremental reductions in China's highly inequitable system, much remains to be done. The COVID-19 pandemic may prove to be a possible critical juncture and opportunity for change, but the obstacles are substantial. Indeed, many of the problems highlighted during the COVID-19 pandemic – notably the obstacles to poorer people seeking diagnosis and treatment – were the same during the SARS epidemic of 2003, which triggered major reforms that have had only limited success. Almost two decades later, strong vested interests in the current hospital-centred system, a decentralized fiscal system, and lack of local government incentives to invest in health care mean that it will be difficult to make fundamental changes.

Reforming health care systems is difficult in any country. China's specific context is particularly challenging given its vast size and population, its high levels of regional and individual income inequality, and its political system. Because fiscal decentralization is credited with having delivered high levels of growth over the last four decades, the CPC leadership is reluctant to centralize resource allocation and allow the national government to play a more redistributive role. It is also reluctant to allow its citizens the freedom to organize and challenge vested interests in the current system – for example, by allowing patients to form non-governmental organizations. Instead, it pursues incremental reforms, controls access to health system-related data and publishes data in ways that help obscure inequities and other problems. Any efforts to address problems more fundamentally are therefore most likely only if the CPC leadership are willing to significantly increase government spending on health. Based on patterns of policy change over the last 40 years, and given the looming problems due to China's ageing population, health policies seem unlikely to take a radical turn in the short to medium term.

NOTES

1. World Bank, 2022. Worldbank data online.
2. World Bank, 2022. Worldbank data online.
3. State Council Office, 2022. 14th Five Year National Health Plan. This Plan focuses on building the links between primary and hospital providers more than on hospital reform, but it is too early to tell whether this is a significant shift in strategy.
4. For a simple summary of the evolution of reform policies and plans from 2009 to 2020, see Tao et al. (2020).
5. As indicated in a recent World Bank and World Health Organization (2019) report: *Healthy China: Deepening Health Reform in China*. Washington, DC: World Bank.
6. Formerly the Ministry of Health. The Ministry was restructured to, and renamed, the National Health and Family Planning Commission in 2013 and renamed again the National Health Commission in 2016 after China changed its one-child policy.
7. Chinese cities can be provincial, prefectural or county level.
8. The Premier, who heads the governmental system, is a leader of the CPC and a member of its (currently seven-man) Politburo Standing Committee. Ministries and bureaus all contain a CPC organization that oversees their work, and most leading government officials are CPC members.
9. World Bank, 2022. World Bank data online.
10. Note that individual expenditures are not the same as OOPs. Figures for the latter are based on household consumption surveys (i.e., the demand side of health care), and tend to capture only cash payments, while those for the former are based on the charges and revenue data of health care institutes (i.e., the supply side of health care) and may include non-cash payments by individuals for medical treatment, medicine, and preventive care.

11. Here "social risks" is used as a compound of different risks that are covered by, or related to, social health insurance. For example, those localities with a larger dependent population (such as the elderly and children) have higher health risks, and those localities with more labour-intensive manufacturing sectors have higher risks of workplace injuries and sickness.
12. Up to date figures can be found on the webpages of the World Health Organization at: https://covid19.who.int/region/wpro/country/cn. Last accessed 27 April 2023. Estimates of the actual number of deaths have ranged between about one and two million (e.g. Dyer, 2023).
13. Keith Bradsher, "China's cities are cutting health insurance, and people are angry," *New York Times*, February 23, 2003.

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19. Health policy processes in India: institutions, interests, ideas and contemporary debates

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INTRODUCTION

Recent data on health status in India indicates impressive reductions in infant and child mortality and maternal mortality, and a noteworthy increase in life expectancy (Selvaraj et al., 2022). Despite these important gains, health outcomes in India remain relatively poor in comparison to similar contexts. For example, India bears one of the highest burdens of child malnutrition in the world; over one-third of children under five are stunted, and a further one-third are underweight (Abarca-Gómez et al., 2017; Krishna et al., 2018). These statistics – already concerning – outwardly mask an even more troubling picture in terms of wide disparities in health status by state/territory, class, caste, indigeneity, religion and other factors (Balabanova et al., 2013; Kochupurackal et al., 2021). India fares worse in health status than its economically less developed neighbors, Sri Lanka and Bangladesh (Barber et al., 2017), suggesting that factors other than macroeconomic growth constrain progress towards health equity in the country. Despite its label as one of the fastest-growing economies globally, the country is yet to improve upon its classification as one of 47 lower-middle-income countries in the world (World Bank, 2022). The legacy of centuries of colonial exploitation continues to shape systems, structures and norms, and vast socioeconomic inequities by caste, religion, region and indigeneity, among other aspects, remain stubbornly in place. The changing economic, epidemiological and population profile of the country, alongside political shifts, have major implications for both contemporary and future health policy in the country.

Health policy processes, combined with underlying social inequalities in India, have contributed to inequitable health outcomes. India's health system is often labelled a classic 'mixed health system', with high levels of out-of-pocket health financing and market provision of services, coexisting alongside a poorly financed government delivery system. In recent years, major national-level efforts to improve access, utilization and affordability have been instituted such as the National Health Mission (NHM) and the Pradhan Mantri Ayushman Bharat Yojana. Despite these efforts, the public health system remains fragmented, poorly regulated and underfunded with just over 1% of the GDP being spent on health (National Health Accounts, 2022).

India's growth as a hub for medical tourism and medical innovation must be juxtaposed with the fact that a significant proportion of its own population is unable to avail the benefits of such efforts. Health care services are largely accessed from the private sector, with approximately 70% of out-patient services, nearly 60% of in-patient services, and 90% of medication dispensing taking place in the for-profit or not-for-profit private sector (Lahariya, 2018; Selvaraj et al., 2022). A vast majority of the population continues to utilize traditional, complementary and alternative medicine (TCAM) alongside 'Western' or modern biomedicine. These systems of medicine are, however, poorly integrated at both policy and practice levels despite considerable vacillation in patterns of provider prescriptions and patient utilization (Josyula et al., 2016).

Many factors influence the way health policies are shaped in India. The positioning of health within India's legal and political framework is an important starting point. The country currently has 28 states and 8 union territories; and the diversity in health systems across and within individual state geographies adds further layers to the analysis of health policies. Adding to this complexity are the divisions in the responsibilities for health between the state and central government; increasing privatization; the co-existence of multiple systems of medicine; and the dominance of certain interest groups over others in agenda setting and policy formulation. These structures and policy dynamics also explain, to a large extent, why some states, such as Kerala and Tamil Nadu, have made significant progress on many health and social indicators when compared to others (VR Muraleedharan, Dash and Gilson, 2011).

In this chapter, we analyze these contemporary processes in India, taking a constructivist lens. That is, we have considered health policies as social phenomena that are influenced by ideologies and principles, power-relationships between different actors and institutions, as well as several other situational and historical factors. The chapter begins with a brief description of the health system in India in terms of financing, regulation and health care delivery. We then provide an overview of the health status and inequities, followed with a detailed description of health policy processes in India, using an organizing framework of ideas, interests and institutions. The chapter concludes with reflections on the way forward, in the light of the COVID-19 pandemic and recent reforms in the public sector.

HEALTH SYSTEMS IN INDIA: AN OVERVIEW

India's mixed health system, with its heavy reliance on for-profit and not-for-profit private service delivery and financing, has long been at odds with formal government policy on health. Around the time of independence, a tax-payer-funded government health care service, delivered through a pyramidal health care delivery structure was envisaged, intended to deliver universal care to all (Health Survey and Development Committee, 1946). While the architecture of pyramidal health care delivery has been faithfully retained over the years (see Figure 19.1), the essential vision of a universally accessible and comprehensive state-funded health care system has largely remained prescriptive. The 'written' policy rhetoric on universal health care provision has therefore not translated into the appropriate level of action needed to cater to the needs of 1.3 billion people in the country.

Service Delivery

In the public sector, the aforementioned pyramidal health care delivery system consists of the following structure: at the local level, sub-centers (recently upgraded as health and wellness centers under Ayushman Bharat) typically serve a few villages (population of 3000–5000); primary health centers serving several villages (population of about 20,000–30,000); community health centers typically located in small towns catering to about 80,000–120,000; and district hospitals at larger towns and cities catering to entire districts, where populations may range from 150,000 to 3,800,000 (Government of India, 2018; Selvaraj et al., 2022). The funding for these services is largely derived from the state government, with supplementary financing from the union government through various national programs such as the National Health Mission (National Health Accounts, 2022). Medical colleges and multi-specialty hospitals provide specialized services for populations within the state, but in practice, often cater to an enormously large patient population from across state lines, such as the All-India Institutes for Medical Sciences or the National Institute of Mental Health and Neurosciences (NIMHANS). Outside of this structure, union (i.e., federal) agencies such as the military and railways offer health services for their employees, and employees of the union government can access services through the Central Government Health Scheme (Selvaraj et al., 2022). TCAM services – grouped together into a newly created union ministry at central government called the Ministry of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy (or AYUSH) – are increasingly available in the public sector, and major debates have long existed regarding the ability for AYUSH providers to provide modern biomedical services, such as prescription of certain medications or surgeries (Balsari et al., 2017).

Long years of financial neglect have led to several infrastructural deficiencies in India's public sector health system. A thriving private sector is said to have evolved in India 'by default, not by design' (Reddy, 2022). Recent estimates suggest that about 70% of outpatient care and 60% of inpatient care happens in the private health sector (Sundararaman and Muraleedharan, 2015). The private sector, largely unregulated, consists of an 'extreme' level of heterogeneity in the types of practice (Mackintosh et al., 2016). Providers practice multiple systems of medicine (biomedical, traditional or a combination of both), have varying levels of formal qualification, and starkly different levels of quality, a statement that can arguably apply to the public sector (Das et al., 2012). Complicating matters is that patients utilize different services or providers in myriad combinations, creating challenges in the continuity of care. In the last several decades, the corporatization of health care in India has resulted in major shifts in service delivery, labor markets and financing (Marathe et al., 2020). Further, health care is an accelerating industry in India, 'expected to double in value between 2017 and 2022: from US$62 billion to US$133 billion' (Marathe et al., 2020).

Financing

Despite stated intentions, successive governments have not adequately invested in building the public health care sector. Currently, public health spending in India is around 1% of the Gross Domestic Product, one of the lowest in the world (National Health Accounts, 2022). Table 19.1 shows the last decade of public expenditure in India. This expenditure is shared by the central government and the state; the center-state share being 31:69 in 2015–2016 (NHP, 2020), with some exceptions for economically weaker states and territories. Much of the health expenditure – around 70% as per recent estimates (National Health Accounts, 2017–2018) – occurs out of pocket. As noted by Selvaraj et al., this system 'continues to push over 55 million people into poverty every year, with over 17% of Indian households incurring catastrophic levels of health expenditures annually' (Selvaraj et al., 2022). Out-of-pocket payments occur formally and informally, with evidence pointing to high levels of bribes in order to access health care (Sudarshan and Srinivas, 2011).

Since the mid-2000s, several state and national-level insurance schemes have been initiated in order to address the growing challenges in health financing. Despite the impressive gains in insurance coverage for low-income populations, evidence suggests that insurance programs have not (yet) been effective in reducing out of pocket payments (Garg, Chowdhury and

Sundararaman, 2019). Protection of citizens from sudden financial shocks, as well as from aggregated costs of routine, 'day-to-day' ailments has been inadequate, exacerbating inequities in health care access and health outcomes (Boby, Rajappa and Mathew, 2021).

Table 19.1 Public health financing in India 2009–2017

Year	Public expenditure on health as percentage of GDP	Per capita expenditure on health (INR)
2009–2010	1.12	621
2010–2011	1.07	701
2011–2012	1.1	802
2012–2013	1.09	890
2013–2014	1	913
2014–2015	0.98	973
2015–2016	1.02	1112
2016–2017 (RE)	1.17	1397

Source: Authors' own calculations.

In an effort to address high catastrophic expenditures and to work towards universal health coverage, the government launched the aforementioned Ayushman Bharat Scheme in 2018. This health care scheme comprises of two strategies (Press Information Bureau, 2018), an insurance scheme named Pradhan Mantri Jan Arogya Yojana (PM-JAY) and a primary health care initiative. PM-JAY is a large-scale public insurance scheme for secondary and tertiary hospitalization care, for which eligibility is based on certain pre-decided deprivation criteria. PM-JAY can be thought of as the culmination of several smaller insurance schemes for financial protection against hospitalization that have been launched by central and state governments since 2008 (Garg, Chowdhury and Sundararaman, 2019; Reddy, 2018;). PM-JAY defines a specific list of secondary and tertiary health care procedures and seeks to make these available to the poor, without payments at the point of service delivery in empaneled public hospitals or empaneled private hospitals, upon referral from a local government hospital

Despite PM-JAY's efforts at creating a national insurance system, concerns persist. These include poor empanelment in rural areas, bureaucratic delays and inefficiencies in authorizing claims from private hospitals on time, social exclusions and fraudulent claims. There has also been limited effort towards developing more efficient public financing through strategic purchasing of health care from the private sector (Joseph, Sankar and Nambiar, 2021; Saxena et al., 2022; Trivedi et al., 2022). Furthermore, a small proportion of the population employed in the central government, and low-income organized labour are covered by the Central Government Health Scheme and Employee's State Insurance, that are separately administered and do not overlap with PM-JAY, while a small proportion of urban high-income individuals opt for private health insurance providers.

The second strategy involves the expansion and strengthening of public primary-level care services through the setting up of Health and Wellness Centers (earlier known as sub-centers and primary health centers). These centers are intended to enable the provision of comprehensive care, and to expand the nature of services available at the primary level (Ved, Gupta and Singh, 2019). Recent evaluations suggest that the model has promise, but is facing some start-up issues. For example, a new cadre introduced at primary-level facilities, Community Health Officers, requires support, training and integration (National Health Systems Resource Centre, 2022).

Regulation

Regulating the labyrinthine health system in India has proven to be complex and often ineffective, despite decades of 'well-intentioned' regulatory and legal reforms in the areas of pharmaceuticals, medical education, private health sector practice, patients' rights, and other areas (Nandraj, 2015; Peters and Muraleedharan, 2008; Sheikh, Saligram, and Hort, 2015). Despite its pervasive nature, few states have adopted institutional frameworks, such as the Clinical Establishments Act, to regulate this sector. As a result, private health facilities in many parts of the country have extremely limited oversight in the areas of quality, treatment, pricing, recordkeeping and other aspects of facility management and patient care.

As the volume of services funded by insurance programs grows, an emerging area of focus is the regulation of rates and the relationship between payers (insurance schemes) and providers. This dynamic is, at present, largely dependent on rates set by payers, with some element of negotiation with providers (with the caveat that the stance of government providers is highly limited due to the use of salaries to compensate providers). However, the regulation of these rates is highly specific to the type of insurance program, with more regulation in the case of programs such as the Central Government Health Scheme (Vellakkal, Juyal and Mehdi, 2012) and weak regulation in the case of private plans (Hunter et al., 2022). There is also a high level of variability in state-level capacity to bargain and fix prices for secondary and tertiary care, and the implementation of the scheme varies and depends heavily on state and district government capacity (currently a challenge in the domain of private sector engagement). Programs such as the Central Government Health Scheme and the Employee's State Insurance program are managed independently from government bodies responsible for public sector health services, resulting in a distinct system with a separate bureaucracy catering to a well bounded target population.

In the context of patients' rights, Putturaj et al. (2020) note that regulations to address physician malpractice in the state of Karnataka manifest in a 'maze of organisational units to deal with grievance' that allow bureaucratic units to 'shirk responsibility' when faced with malpractice complaints from patient and community groups. Following decades of corruption and mismanagement, the primary professional council for regulating medical education and practice, the Medical Council of India, was abolished, and a new National Medical Commission was put in its place with key reforms in its composition and remit. Regulation of 'non-qualified' providers of both modern biomedicine and Indian systems of medicine is also a longstanding challenge in India, despite these providers being the predominant source of primary health care for many in the country (Das et al., 2012).

HEALTH AND INEQUITIES

Since independence in 1947, much progress has been made in improving health outcomes. In the year 1951, overall life-expectancy of people in India was 32 years, the infant mortality rate was 146/1000 live-births and the maternal mortality ratio was 2000/100,000 live-births (Zodpey and Negandhi, 2018). As per the recent census (2011), life-expectancy has more than doubled and other surveys point to important downward trends in maternal mortality (113/100000, SRS, 2017) and infant mortality (38/1000 live-births, SRS, 2017). These are commendable improvements, but nonetheless, health indicators in the country remain a major cause of concern. For one, India still contributes a significant fraction of global child deaths (UN Report, 2020), has the highest burden of tuberculosis cases in the world (WHO, 2015) and a rapidly increasing burden of non-communicable diseases; with over 77 million adults living with diabetes, India has been called the 'diabetes capital of the world' (Jha et al., 2021).

Another important concern is persistent inequities in health outcomes and access to health care in the country. Inequities in India exist along several intersecting axes – income, employment, spatial (rural v. urban), state/geography, caste and indigeneity, religion and gender (Ravindran, Gaitonde and Srinivas, 2018). Jharkhand and Kerala have comparable populations, but the public sector hospital infrastructure in Kerala is almost 3.5 times that of Jharkhand (Goel, Sharma and Kashiramka, 2021). Some states, such as Kerala, Tamil Nadu and Maharashtra, have achieved the Sustainable Development Goal targets of less than 25 under-five mortality per 1000 live births, while others, including Madhya Pradesh, Assam and Uttar Pradesh, continue to see significantly high levels (Registrar General of India, 2022). Intra-state inequities are also a key concern; in analyzing fourth and fifth rounds of the National Family Health Survey, Kochupurackal et al. (2021) found concerning levels of severe acute malnutrition in 341 districts, including districts where severe acute malnutrition has typically not been a major challenge. Further, socio-economic inequities in health outcomes are an important cause of concern; for example, a recent study shows that there was a gap of 7.6 years of life expectancy between the poorest-fifth and richest-fifth of the population (Asaria et al., 2019).

Entrenched socio-cultural and/or political marginalization pertaining to caste, indigeneity and religion has also significantly worsened health inequities. Dalit communities (formerly so-called 'untouchables' in the caste system in South Asia) and Adivasi (or indigenous) communities experience extreme social and economic marginalization, in addition to longstanding exclusion from access to health services. Between 2013 and 2016, life expectancy differences between high-caste and scheduled caste/scheduled tribe (SC/ST) sub-populations were 4.2–4.4 years for women and 6.1–7.0 years for men (Gupta and Sudharsanan, 2022). Differences between SC and high-caste men have increased in the last several decades, a worrying trend that is an indication of worsening social divisions and oppression. In comparison to high-caste Hindus, Muslims have a worsening life expectancy gap, with data between 2013 and 2016 showing a 2.8- and 2.6-year difference for women and men respectively. Marginalized communities also experience significant discrimination in accessing health and social services within the country, contributing to poor outcomes and mistrust between communities and the health system. For example, Dalit and Adivasi groups have lower rates of utilization of health services, and also face low quality care upon accessing services (Subramaniam, 2018).

IDEAS, INSTITUTIONS AND INTERESTS

Ideas

As defined by Béland (2016, p. 736), ideas are the 'changing and historically-constructed "causal beliefs" of individual and collective actors'. In India, one of the best sources for understanding how ideas in health policy have evolved is in official government positions on health. The 'written' policy rhetoric in India has historically conceptualized health as a broad development issue, and supported the development of a public health system in the country intended to provide comprehensive health care to all (Government of India, 1983; Health Survey and Development Committee, 1946). Written policies have repeatedly emphasized a system that identifies the government as a key actor in the regulation and provision of health care; and endorsed the pluralistic health care system in India (comprising of modern biomedicine and alternate systems of medicine) as one of the strengths of health care in India. Despite these written intentions, the framing of health and the health system itself in more actionable terms has been very different. That is, in documents that assist health planning and programming in India (such as national five-year plans), the role of the government, as well as the development of a health system based on the values of equity and universality, get diluted. Two main ideational debates, therefore, seem to be present – the nature of the types of services that citizens can have access to, and who will provide those services.

The roots of these chasms lie in decisions taken during the period of colonialism. Early colonial approaches to health had emphasized the health of European administrators through urban facilities providing 'Western' medical services, with minimal attention to accessing health services for populations living in rural settings that made up the vast majority of the country (Arnold, 2000; Bala, 1991). Public health approaches to contain infectious diseases such as the bubonic plague, cholera and smallpox, were enacted in the late 19th century with the expressed goal of limiting spread outside of India; these approaches dealt 'vertically' with a few sets of diseases, and did not encourage the development of a strong public health system in the country (Ramasubban, 1988). Approaches to health workforce followed similar patterns, with a focus on the needs of urban elites through regulation of biomedically trained doctors, while neglecting policy frameworks for traditional providers (Muraleedharan, 1992). As a result, government policy strongly emphasized biomedicine in the development of the health delivery and health workforce systems, despite the reliance of the vast majority of the Indian population on traditional systems of medicine.

As independence neared, the need for a radical shift in the ideas of 'health 'in the colonial era was felt by the reformers. One of the first visionary documents of the public health system in India, the Bhore Committee report, emphasized on moving away from an urban-centric system with disease-focused approaches to conceptualizing health as an important development issue in the country. This report envisaged a tax-payer-funded public health system – in the line of the National Health Service of the United Kingdom – that was a comprehensive 'free for all' and accessible to everyone, emphatically stating that:

> No individual should fail to secure adequate medical care due to inability to pay. (Health Survey and Development Committee, 1946)

There are several instances that illustrate how action on the ground diverges from written rhetoric on health policies in India. As noted by Béland, this stage – implementation – is a 'crucial aspect of policy development', and yet, receives limited attention from scholars (Béland, 2016). Below, we give a brief historical description of the manifestation of ideational processes in policy implementation, in order to better understand the misalignment between policies as written and as implemented.

Horizontal v. Vertical

Due to major fiscal constraints and low funding commitments from successive governments, a very diluted version of these ideas was implemented in the two decades after independence (Government of India, n.d.). Instead, echoing a similar focus by the British, vertically-funded programs for family planning and against tuberculosis, malaria and polio were prioritized with support from external aid agencies through financial and technical resources. The first National Health Policy of India was adopted in 1983 (Government of India, 1983). This document was influenced largely by the ideas in the Alma Ata Declaration, bringing back to the forefront the political commitment of governments to health and endorsing many of the values of the Bhore Committee Report once again. This resulted in a small bump in increased funding to the development of the public health sector in the years that followed. However, this increase in funding did not translate into strengthened systems and further, did not sufficiently address the need for strong links between health and other sectors as part of a focus on social determinants of health. In the period following economic liberalization in the early 1990s, investments in the strengthening of health systems declined, and the emergence of new international aid agencies gave prominence to a different set of vertical programs that aligned with the achievement of the Millennium Development Goals. All this led to less focus on the development of the underlying health system in the country.

Public v. Private

Alongside weak investment in public sector health systems, the private sector grew extensively in the post-independence period, with limited efforts at strong regulations to ensure quality and appropriate treatment. In the early 1990s, a ‘paradigm shift’ (Agartan and Béland, 2023) took place, with neoliberal ideas of ‘free markets’ and ‘minimal government interference’ gaining prominence within global development policy (Cornia, Jolly and Stewart, 1987). Many countries, in the wake of a global economic crisis were forced to go through structural adjustment programs, advocated by the World Bank as a condition to monetary loans, intended to bring about reduction in country-level fiscal deficits (Cornia, Jolly and Stewart, 1987). This ‘paradigm shift’ in ideas happened in India as well, with deliberate withdrawal of the government from all social sectors including health (Duggal, 1992). By this time, the private medical sector had been well established in India, particularly in urban areas, and it catered to the curative needs of a large section of the population. In line with the changing ideas of this era, a revised health policy was adopted in India in 2002. This revised policy moved away from the goal of ‘health for all’ and emphasized building a public health system largely for populations that could not afford private care (Government of India, 2002).

In 2005, the government – in recognition of the need to strengthen the public health system – launched the National Rural Health Mission (NRHM). The mission, through a multi-prong approach including flexible financing, participatory processes, improving managerial capacity and making room for local innovation, was supposed to ‘bring about architectural corrections in the health system’ (Government of India, 2005). This mission has now evolved to cover urban areas and has been re-named the National Health Mission (NHM). But, it seems to have lost political priority with changing governments. In 2017, a new National Health Policy has been adopted in India to achieve the goals of Universal Health Coverage, another ideational shift in line with international trends (Government of India, 2017).

Systems of Medicine

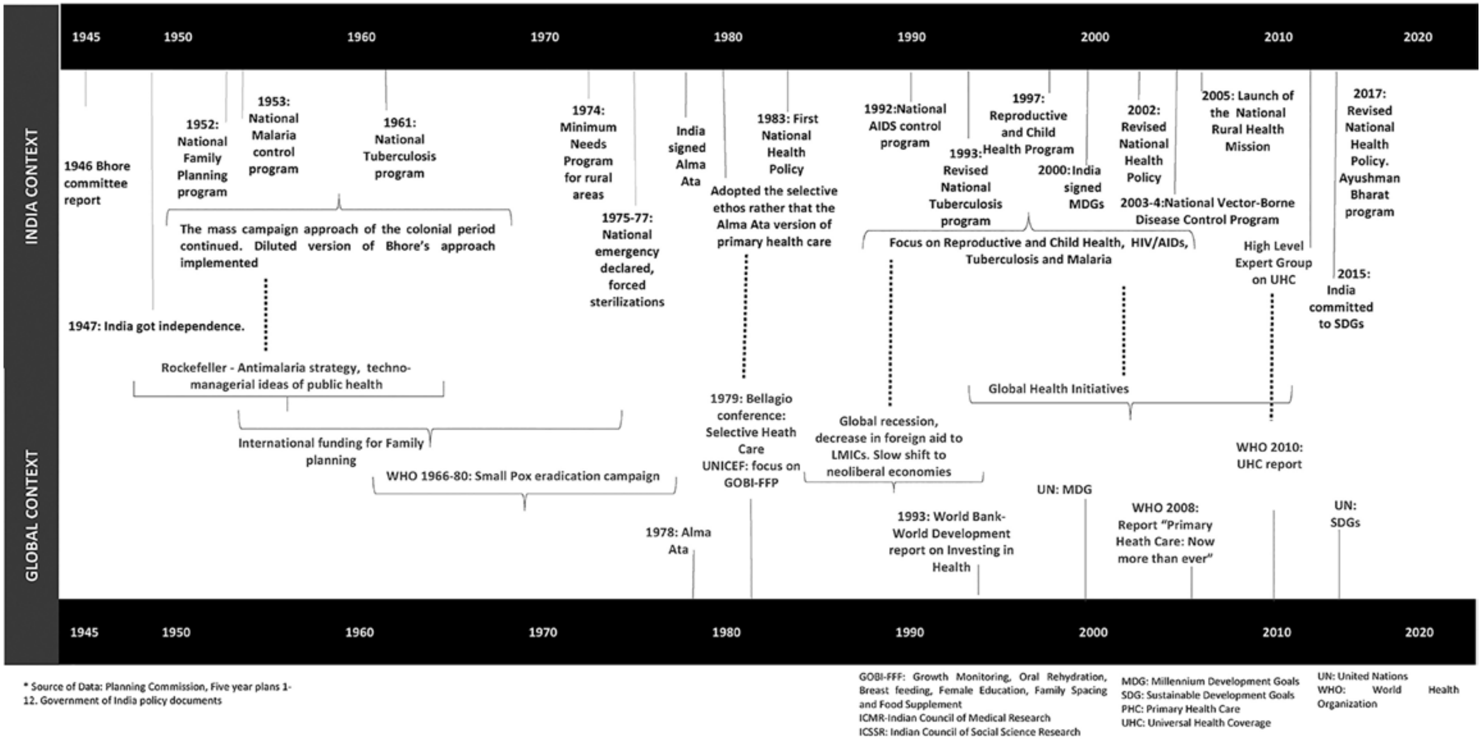
Public sector services established by the colonial government strongly emphasized 'biomedicine' at the expense of traditional systems of medicine, and built systems around supporting the access of Europeans to health services, primarily in urban areas. The approach taken during the colonial period by the British resulted in policy frameworks that persist until this day. Some of these decisions included: 1) emphasizing biomedicine within the state's approach to health, including health authorities and services (i.e., Indian Medical Services); 2) prioritizing epidemic control and mass prevention or treatment measures; 3) separating medicine and public health; and 4) providing a regulatory platform for biomedicine, particularly for doctors, while excluding non-physician clinicians or traditional medicine practitioners from the wider regulatory framework. As a consequence, policy attention and resources focused on services utilized by a smaller proportion of the population, without sufficient attention to expansion of health services across the country in addition to minimal integration with traditional medical services widely used by the population.

The focus on biomedicine continued in the post-colonial era, coinciding with an overarching embrace of science, technology and 'modernity' by the leaders and elites of newly independent nations. Jawaharlal Nehru, the first Prime Minister, spoke forcefully of the need for a 'scientific temper', and for science to form the basis for independent India. These goals were applied to an overarching policy framework in the colonial period that was largely maintained from the post-colonial era (Sriram, Keshri and Kumbhar, 2021). For example, considerable attention was given to establishing tertiary hospitals and teaching institutions, such as the All-India Institute of Medical Sciences, modelled after Johns Hopkins University (Ruddock, 2021). Attention was given to increasing the number of doctors within the country, without addressing the underlying challenge of geographic maldistribution of health workers. Most importantly, biomedical doctors appeared to dominate policymaking in health systems design.

These tensions continue to animate health policy debates in India. To illustrate, access to doctors in rural parts of India remains a major obstacle. In response to the persistent lack of clinical health workers in biomedical facilities, the government recently introduced a new cadre of Community Health Officers, nurses with additional clinical training; more significantly, this cadre falls under the ambit of the National Medical Commission, the apex regulatory body for doctors (Government of India, 2019). However, this phenomenon is occurring alongside an accelerated 'intertwining' of traditional medical systems and religion, which has occurred alongside the rise of Hindu majoritarian political power in recent decades. This situation has resulted in parallel policy frameworks that intersect at multiple points but remain uncoordinated and/or contested (Sharma, 2021).

Ideas and Power

Discussions of actors and power must accompany investigations into ideational processes. Global events and the transfer and diffusion of ideas *did* influence the direction of India's health policies throughout history. It is not just the quantum of financial aid – external aid to India for health is only about 2% of the total health budget – but rather, the power dynamics shaped by colonialism and other factors that have privileged 'external' ideas alongside a growing prioritization of indigenous systems of medicine (Sriram et al., 2018). The adoption of certain ideas can be considered a result of coercion (family planning strategies in the 1950s



Source: Authors' own calculations.

Figure 19.1 *Timeline of India's policies that link to international events and situations* and the structural adjustment plans in the 1990s have often been perceived as coerced measures by Indian experts). But other global ideas that have been perceived as 'success stories' have often been emulated in the country as well. Figure 19.1 depicts how policies in India link to international events and situations.

Institutions

Marchildon and Bossert note that health care is 'one of the most financially onerous and contested social policy responsibilities of governments in the early twenty-first century' (Marchildon and Bossert, 2018), and as such, lends itself to a rich analysis of the role of federalism in contexts such as India. India, like other federal systems, is often caught in longstanding and dynamic debates about centralization and decentralization of responsibility across its levels of government.

As described in the Constitution of India, responsibility for health in India exists at three levels – state governments, the union government and concurrently, or as the joint responsibility of states and the union government (Government of India, n.d.). Table 19.2 outlines the responsibilities for health policy and systems at various levels of government. Health is frequently referred to as a 'state' subject; yet, this responsibility is primarily in the area of service delivery. Other aspects of health policy prioritization and formulation fall within a matrix of responsibility between the center, state and local levels. The central government, in this arrangement, is meant to offer policy directions and fund priority programs in the country (Rao, 1952). In the decade following independence, several vertically-funded programs – that is, programs funded by the central government but operated through state machinery – were launched, the most important ones being for family planning (1952) and malaria (1953). Over the years, as new priorities entered the political discourse, these programs grew in number. The entry of large global health initiatives contributed further to more vertical, techno-managerial approaches to 'fixing' health care in the country. Implementation takes on further complexity, with policy implementation largely falling on local levels, often without feedback loops between local and 'higher' levels of policymaking.

Policy processes within this institutional framework are often driven by three sets of actors – elected representatives/political leaders, bureaucrats and managers/practitioners – and further influenced by a vast array of actors, including the court system, political parties, industry, professional associations and unions, development agencies, academic institutions, transnational groups and networks, civil society and other actors. The organizations involved within this framework are also dynamic with shifting power dynamics alongside political changes. For example, while the Ministry of Health and Family Welfare (MoHFW) has often served as the 'nerve center' for policy processes at the national level, its responsibilities in recent years have evolved considerably. NITI Aayog, a government think tank established to replace the erstwhile Planning Commission, has taken on an increasingly important role in developing national-level health policy. Decision-making authority also rests in new organizations within the institutional framework, such as the National Health Authority – responsible for overseeing PM-JAY, and the Ministry of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH), a Cabinet-level authority for traditional systems of medicine.

The judiciary has also played an assertive role in health policy in India. For many decades, the Supreme Court of India and various High Courts across the country have been involved in a range of health policy matters, such as access to treatments and services, medical education, and regulation of tobacco, alcohol and other substances (Dsouza and Bhojani, 2021; Jain and Stephens, 2008).

Table 19.2 Responsibility of health policy and systems by level of government in India (updated from V.R. Raman)

	Health	Family Welfare	Medical Education &Health Research	AYUSH	Pharmaceuticals and Medical Devices
Union Government	National Health Mission; TB, HIV, vector-borne diseases, IDSP; other verticals	Reproductive and child health	Medical education and health research	AYUSH education and research	Pharmaceutical and device regulation
State Government	Tertiary and secondary health facilities; regulation of private sector	Primary health facilities	Medical education and medical college hospitals	AME/secondary health facilities	Production, procurement
Local Government	Clinics and dispensaries			Clinics and dispensaries	

Source: Authors' own calculations.

In India, an additional concern was that there were too many vertical programs operating independently. In 2005, the central government tried to bring all vertical programs into one umbrella through the National Rural Health Mission (Government of India, 2005). However, in many places, this was seen as the addition of another bureaucratic layer. The Mission has sometimes been seen by some states as the imposition of the center's power over them, and has been criticized for not taking into adequate account state-level realities while implementing such schemes.

One example of state-center power tussles has been pointed out in a case-study done by Parashar et al. (2020), on a flagship policy of the government – The Janani Shishu Suraksha Karyakram (JSSK) in Himachal Pradesh. JSSK was a centrally-funded program launched in the year 2011 to provide fully-free maternal and child health services, but has had limited success. While many factors contribute to its limited success, one important issue that deterred its local acceptance was that it was viewed as a centrally-imposed program on the state, one that was not a state-priority but had to be implemented to 'save the reputation' of the state and 'keep bringing money' to the state (Parashar et al., 2020).

Overall, complex arrangements pertaining to health have led to power tussles between the center and the states; and these power-tussles have been an important feature of India's policy landscape. Further, these center-state power dynamics are not uniform, with some states having stronger institutions and resources to negotiate more aggressively in their favor, when compared to more economically-disadvantaged states. Moreover, problems in implementation cascade further down the 'system' for service delivery. In the Indian context, the 'know-do' gap at the level of patient-provider interactions is often observed, where frontline workers know what is to be done, and yet do not do it. The reasons for why such 'know-do' gaps occur and the influence of frontline 'micro-practices of power' on policy implementation have been studied less in India's context, but a few studies that illuminate such gaps are summarized below.

One local case-study on public sector doctors has attempted to elaborate on why well-intended primary care policies that run from peripheral health clinics got diluted in practice (Ramani et al., 2021). Doctors, as head of these clinics, were held responsible for the implementation of several policies at these centers. However, they were expected to execute these schemes with few human or material resources, and were given limited support from higher authorities in the system. They reported that policy schemes 'came and went', and no explanations were given to them as to changes or modifications in these schemes. Further, within the system, doctors were subtly discouraged from taking any clinical risks that could result in mishaps and consequently give the government a 'bad name'. One can conclude that the institutional environment at these peripheral clinics fostered the execution of a diluted version of well-intentioned policies, rather than the one that is seen in written policy ideals of the country. Studies on nurses and other outreach workers have also echoed similar issues, with their performance being limited by inadequate supervision, lack of support, limited availability of resources and challenging relationships shaped by caste dynamics, seasonal migration, and corruption (John et al., 2020; Pyone et al., 2019).

Interests

Interest groups involved in health policy processes at the national- and state-levels in India can be broadly characterized in the following groups: private health sector industry (pharmaceuticals, medical devices, corporate hospitals), private industries impacting health (food, agriculture, alcohol, tobacco, technology, etc.), 'small' health sector industries (small hospitals and nursing homes, pharmacies), occupational groups (doctors, nurses, pharmacists, community health workers, etc.) and civil society (patients' rights groups, health advocacy organizations). India has also had a long history of engagement of external groups rooted in its history of British colonization. In recent years, external groups involved in health policy processes in India include donor organizations (philanthropies, bilateral agencies, multilateral agencies), international professional organizations, academic institutions in high-income countries and multinational companies.

Similar to many contexts, health policy processes in India appear to reflect 'elite' capture, reflecting broader trends amplifying the influence of elites in public policy. For instance, health policy pertaining to service delivery continues to be driven by the medical profession, illustrated by the ways in which doctors' associations have blocked efforts to develop non-physician cadres in order to expand care options for rural communities. It is also important to examine which groups are *not* typically involved in health policy processes. Communities marginalized on the basis of caste, religion and region, rarely have seats at the table in developing policy. Periodically, civil society groups have been successful in the past, particularly in the context of expanding community participation in health programming (Gaitonde et al., 2017). For example, the prominence of community-based health programs in the 1970s leading up to, and following, Alma Ata showed positive outcomes and were successful in ensuring the 'communitization' of major health reforms, such as the National Rural Health Mission in 2005 (Gaitonde et al., 2017). However, despite occasional gains, civil society groups have faced considerable struggles in securing attention to, and sustained action for, their stated policy goals.

Lobbying in India is not governed by explicit laws or regulations, resulting in myriad formal and informal advocacy mechanisms for interest groups. Community-based organizations and civil society have often resorted to collective action and agitations in order to ‘push back’ and safeguard rights in instances that are particularly stark but not addressed by formal institutions, such as the courts. This is especially the case with grievance redressal and patient rights. Redressal mechanisms remain highly fragmented across multiple government actors, departments and entangled in bureaucratic red-tape, making them inaccessible for the most vulnerable (Putturaj et al., 2022). On the other hand, more powerful and well-organized corporate actors work through special interest industry groups such as the Federation of Indian Chambers of Commerce & Industry or the Confederation of Indian Industry, in addition to their own trade associations or industry interest groups. Lobbying in Indian health policy has periodically veered into corruption, one of the most prominent examples being medical education (Nundy, Desiraju and Nagral, 2018) and the arrest of the former leader of the Medical Council of India on charges of bribery in exchange for establishing medical colleges.

The regulation of the private health sector highlights these challenges. With the onset of economic liberalization, successive governments have wrestled with two issues – their desire to expand entrepreneurship in the health space, while addressing the historically weak regulation of the private sector. Interest groups, such as those representing corporate hospitals, small hospitals and single doctor clinics, have fought vociferously to weaken legislation in this area, by demanding strong roles in mechanisms to set prices and diluting grievance redressal mechanisms.

CURRENT SITUATION AND RECENT POLICY REFORMS

In this section, we will focus on two aspects of contemporary health policy in India – digitalization of health care in India and responses to the COVID-19 pandemic.

Digitalization in India

The current political environment in India is in favor of being ‘Atma Nirbhar’ (self-sufficient), and looks to digitalization as a way forward for the country to use its progress in information technology (IT) as a pathway to tackle socio-economic challenges. Digitalization has pervaded many sectors in formal and informal ways; in the health sector, it has several applications in service delivery including telemedicine and the provision of remote care, supervision of staff, local level data entry through applications and behavior change messaging through social media. The Ayushman Bharat Digital Mission, adopted in 2020, has gained considerable traction amongst decision makers. This mission seeks to set up patients’ electronic health records, and act as a claims platform for the PMJAY insurance scheme. This idea has had strong political support at the national level, though contested by an alternate discourse that has been cautioning about the implementation challenges and limited dialogue across levels of government, as well as ethical issues – such as data privacy – involved in this mission (Al Dahdah and Mishra, 2022). Draft legislation on data privacy, confidentiality, access and management is yet to be passed, and such policy is urgently needed in order to provide a guiding framework for ongoing and future reforms.

Digitalization of health in India also raises important questions about how such policy integrates with existing systems. The Government of India's Kilkari program, a mobile health (mHealth) program currently implemented in 13 states, is an interesting example in this regard. Through this program, prerecorded voice calls and messages on maternal and child health are sent to beneficiaries' phones, beginning from the second trimester of pregnancy till the child is one year old. Early evaluations of the Kilkari program point to acceptability of sharing mobile numbers to participate in the program and its impact in terms of increasing men's knowledge on immunization (Chakraborty et al., 2021). Implementation challenges include inaccuracies in collecting mobile numbers by frontline workers, operational challenges, and a need to complement digital efforts with alternate means of communication (Chakraborty et al., 2021; Mohan et al., 2022). Policy efforts around digitalization necessitate wider investment in health systems strengthening in order to unlock its potential.

COVID-19 and its Sequalae in India

Since early 2020, countries across the world have struggled to launch and sustain a balanced response to COVID-19 (Lal et al., 2021). In India, the crisis has been particularly acute, due to an under-resourced public health, health care and social services system. The experience of the pandemic has amplified and exacerbated inequities and weaknesses in the system (Aiyar et al., 2021).

Global recognition of the seriousness of the COVID-19 disease, particularly the declaration of the situation as a public health emergency, led to national- and state-level acknowledgement of the need to take measures to combat the disease (Ministry of Health and Family Welfare, 2020). India's federal system once again presented opportunities and challenges in facing the pandemic; certain states, such as Kerala, Maharashtra and Tamil Nadu, had developed capacities to address health emergencies, due to previous outbreaks and health emergencies. However, the balance between national and state-level authority veered sharply towards the federal in late March 2020. From March 24, 2020, a three-week, nation-wide lockdown was imposed by the union government, and has since been considered one of the most stringent in the world. The lockdown resulted in several months of severe restrictions on movement, the loss of livelihoods and reverse migration from towns to villages, having an adverse effect on the economy of the country. The focus from the union government gradually gave way to the states driving the response, resulting in a highly uneven set of policy responses to COVID-19 across the country during the devastating second wave in April–June 2021 (Reddy, 2021). The second wave of COVID-19 was particularly challenging with major shortages of hospital beds, oxygen, medication and other essentials, resulting in high mortality and morbidity due to COVID-19, in addition to high proportions of non-COVID-19-related mortality and morbidity caused by weaknesses in routine and urgent care. The exact rates of mortality and morbidity during this time have been a subject of intense scrutiny and debate between government officials, civil society, journalists and academics.

The case of vaccinations in India is also reflective of key policy debates within the country. Vaccinations began in January 2021 and over 67% of eligible individuals have been vaccinated with two doses (Our World in Data, 2023), an impressive achievement for the union and state governments. India's position as a leader in low-cost pharmaceuticals, including vaccines, was critical to its success. The Serum Institute, an India-based company that is the world's leading producer of vaccines, played a pivotal role in the production of COVISHIELD™ and a partnership between the National Institute of Virology and Bharat Biotech produced COVAXIN®. Policy challenges in the context of vaccinations included the regulatory process for the development and approval of vaccine candidates, registration for vaccinations and pricing debates.

CONCLUSION

Health inequities are a major cause of concern in India. Rapidly changing socio-economic conditions, urbanization and demographic shifts have led to changes in disease patterns, resulting in an increase in the burden of non-communicable diseases in the region. These changes are occurring at a point where India continues to struggle with equitable reductions in maternal and childhood mortality, malnutrition and other disease conditions. The current public health system infrastructure, capacity, quality and financing is incommensurate with the levels needed to deal with these disease burdens, challenges that were starkly highlighted during the COVID-19 pandemic.

Over the last two decades, there has been political traction in moving forward an agenda on health. This agenda has been shaped by myriad influences, including international debates on Universal Health Coverage, Sustainable Development Goals and health security, as well as localized debates around systems of medicine and the balance between public and private health sectors. Health policy is at a particularly dynamic moment. A broader suite of policies geared towards expanding access to health services and strengthening financial risk protection are locking into place but require additional funding and implementation support in order to effectively translate these policies into practice. Thus, the country will continue to offer important learnings and insights for addressing complex health challenges in the 21st century.

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20. Health policy in Australia

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INTRODUCTION

Australia is a federation under its Constitution, and consequently, healthcare has divided responsibilities between the six states and two territories on the one hand, and the Federal Government (the "Commonwealth") on the other. The Federal Government's responsibilities extend to national issues and each state and territory to the role of "system operator", with particular responsibilities for running public health and public hospitals (see Figure 20.1).

Source: Adapted from https://commons.wikimedia.org/wiki/File:Australia_states_blank.png#filelinks (added text to existing figure). Made by User: Golbez, CC BY-SA 3.0, via Wikimedia Commons.

Figure 20.1 Australia's states and territories

This simple, introductory account belies a range of complications. Due to the imperfect nature of federations generally, and Australia's specifically, and the complexity of the governance arrangements and politics, responsibilities have ended up being idiosyncratically separated: see Boxes 20.1–3. Split responsibilities create a need for many aspects of health policy, governance and management to be negotiated, and the boundaries of who does what are sometimes clear, and sometimes more opaque.

BOX 20.1 AUSTRALIAN GOVERNMENT RESPONSIBILITIES

- Subsidising primary care, through the Medicare Benefits Schedule (MBS)
- Subsidising medicines, through the Pharmaceutical Benefits Schedule (PBS)
- Supporting and regulating private health insurance
- Supporting and monitoring the quality, effectiveness, and efficiency of primary healthcare services
- Subsidising most aged care services, such as residential care and home care, and regulating the aged care sector
- Collecting and publishing health and welfare information and statistics through the Australian Institute of Health and Welfare (AIHW)
- Funding for health and medical research through the Medical Research Future Fund and the National Health and Medical Research Council
- Funding veterans' healthcare through the Department of Veterans' Affairs
- Funding community-controlled Aboriginal and Torres Strait Islander primary healthcare organisations
- Maintaining the number of doctors in Australia (through Commonwealth-funded university places) and ensuring they are distributed equitably across the country
- Buying vaccines for the National Immunisation Program (NIP)
- Regulating medicines and medical devices through the Therapeutic Goods Administration (TGA)
- Subsidising hearing services
- Coordinating access to organ and tissue transplants
- Ensuring a secure supply of safe and affordable blood products
- Coordinating national responses to health emergencies, including pandemics
- Ensuring a safe food supply in Australia and New Zealand
- Protecting the community and the environment from radiation through nuclear safety research, policy, and regulation

Source: The Australian Health System (Department of Health, 2019).

BOX 20.2 AUSTRALIAN STATE, TERRITORY AND LOCAL GOVERNMENT RESPONSIBILITIES

- Managing and administering public hospitals and regulating private facilities
- Delivering preventive services such as breast cancer screening and immunisation programs
- Funding and managing community and mental health services
- Public dental clinics
- Ambulance and emergency services
- Patient transport and subsidy schemes

- Food safety and handling regulation
- Regulating, inspecting, licensing, and monitoring health premises

Source: The Australian Health System (Department of Health, 2019)

BOX 20.3 SHARED RESPONSIBILITIES

- Funding public hospital services
- Workplace health and safety
- Preventive services, such as free cancer screening programs including those under the National Bowel Cancer Screening Program
- Registering and accrediting health professionals
- Funding palliative care
- National mental health reform
- Responding to national health emergencies
- Environmental and public health services
- Community-based health and home care services

Source: The Australian Health System (Department of Health, 2019)

As with all healthcare systems in the modern era, Australia's faces considerable headwinds. The coronavirus disease pandemic (COVID-19), beginning in 2019, stretched the system's capacity, for example, and the Federal Government ducked responsibility for quarantine—even though this is a clear federal responsibility under section 51 (ix) of the Australian Constitution. Another challenge is the public-private mix (about a third of healthcare is private, and two-thirds is public, depending on what is being measured) posing a problem for equity of access and care delivery. The private sector is predominantly funded through health insurance contributions, workers compensation and accident insurance, and co-payments (out-of-pocket expenses) (Australian Institute of Health and Welfare, 2018a).

Australia's population of 25.7 million is spread across a large Continent of over 7.7 million square kilometers, but most of the population lives in coastal cities. Consequently, care providers are disproportionally located in the urban areas and regional centers. This uneven distribution of services leads to inequalities, notably in rural, regional and remote areas.

Healthcare expenditure has been rising for three decades and is currently at 10.3% of Gross Domestic Product (GDP), amounting to AUD$202.5B (USD$142.8B) (Australian Institute of Health and Welfare, 2021b). Over a million people are directly or indirectly engaged in the health workforce, including 98,400 medical practitioners, 334,000 nurses and midwives, 133,400 allied health professionals such as physiotherapists, pharmacists, and psychologists, and 20,600 dental practitioners as of 2018 (Australian Institute of Health and Welfare, 2020a). Life expectancy, at 81.2 years for males and 85.3 years for females, is in the top third of all countries (Australian Bureau of Statistics, 2021).

According to the Commonwealth Fund, a think tank which benchmarks the healthcare systems of selected high-income countries, Australia's is one of the higher performing systems internationally on many dimensions (Schneider et al., 2017). The Commonwealth Fund's report, *Mirror, Mirror 2017*, assessing 11 high-income countries according to multiple criteria including equity, health outcomes and access, ranks Australia number two, behind the United

Kingdom (UK) which was ranked first, and, in descending order, following Australia, are The Netherlands, New Zealand, Norway, and Switzerland (Schneider et al., 2017). Additional selected key data on Australia by way of a snapshot is provided in Box 20.4.

BOX 20.4 A SNAPSHOT OF AUSTRALIAN HEALTHCARE

On a typical day there are 850 babies born, 440 people die, 380 are diagnosed with cancer, 170 people have a heart attack, 100 people have a stroke and 1,300 people are hospitalised due to an injury. Australia spends AUD$467 million (USD$334 million, €313 million, £263 million) on healthcare each day; there are 406,000 visits to a general practitioner (GP); 777,000 pharmacy prescriptions are filled; 21,400 presentations are made to emergency departments; 6,000 elective surgeries are performed; and 26,000 community mental health consultations occur.

By international comparison, Australia has a largely young and relatively fit population, although there is rapid ageing, with baby boomers making up an increasing proportion of the population. Smoking has fallen dramatically across the last 40 years (only 14.5% of the population now smokes daily). The major health challenges parallel those of other high-income countries—coronary heart disease, diabetes, dementia and Alzheimer's disease, suicide, and musculoskeletal disease. Australia ranks high in the proportion of adults who are overweight or obese (almost two-thirds, 63%) (Australian Institute of Health and Welfare, 2018a).

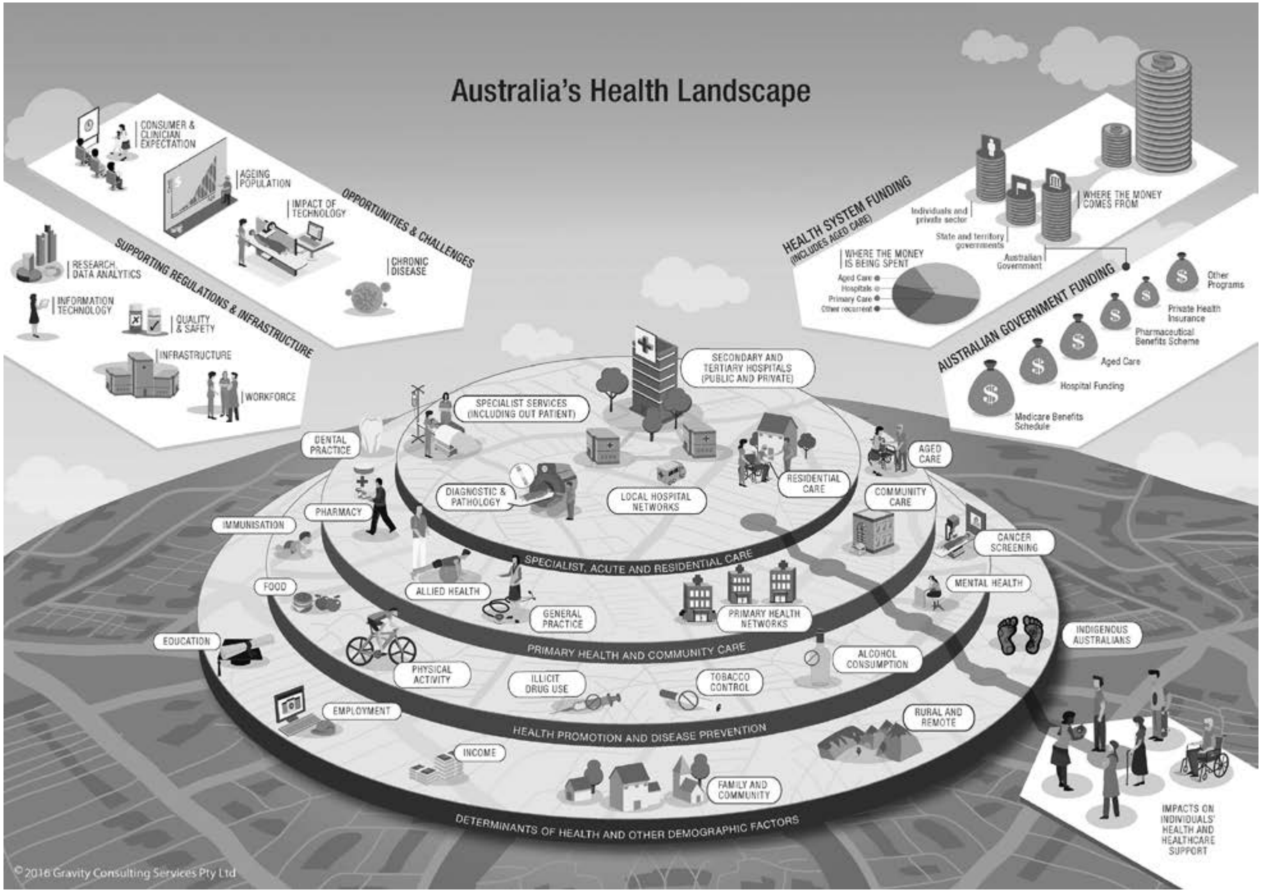
Having established by way of an introduction key aspects of health policy and the care system, we will deal in turn with specific issues in detail. First, we present ideas, interests, and institutions; then agenda setting, policy formulation, and implementation; policy evaluation; governance and regulation; health financing; healthcare delivery and workforce issues; healthcare reforms in recent decades; health and healthcare inequalities; challenges posed by COVID-19 and policy responses; health technology assessment; and long-term care. Finally, we provide a discussion and conclusion and point briefly to where the system is heading, and where health policy, if done well, might take it.

IDEAS, INTERESTS, AND INSTITUTIONS

Australia's federated health system has a multiplicity of stakeholders involved in its policy development, governance, management, and delivery. This is how the Australian federal Department of Health sees the system (Figure 20.2).

There are many institutions, groups, communities, and individuals who act to influence the health agendas (mainly set by the Federal Government, and the state and territory jurisdictions) in Australia. We list here some of the more important:

- Peak organisations that train and represent health practitioners, and recommend best clinical policy, e.g., colleges such as the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons (RACS), the Australian College of Nursing (ACN) and many other health professionals' associations.



Source: © Gravity iLabs.

Figure 20.2 A representation of the Australian health system

- Regulatory bodies such as the TGA and the Australian Health Practitioner Regulation Agency (AHPRA).
- The Australian Medical Association, representing the interests of doctors.
- The Pharmacy Guild, representing pharmacy and pharmacy employers.
- The Australian Commission on Safety and Quality in Health Care (ACSQHC) which coordinates national initiatives and designs improvement strategies for quality and safety, and recommends standards of care.
- Health consumer advocacy groups representing patients, families, and communities, e.g., Consumers Health Forum of Australia, Diabetes Australia, and many others.
- Industry, including the private health insurance sector, pharmaceutical companies, technology companies.
- Organizations that represent the health sector, e.g., Australian Healthcare and Hospitals Association.
- Unions representing health professionals.
- Political parties.
- The media.

All of these agencies and bodies interact, often via a pushing and pulling policy, and approach the system, in different ways. The book *A Strife of Interests: Politics and Policies in Australian Health Services* (Sax, 1984) historically called the Australian health system "a strife of interests" based on a famous quote from Ambrose Bierce who said, of politics, that it was "a strife of interests masquerading as a contest of principles". From a policy perspective, the key players are the Federal Government, the state governments, and the various regulators and agencies with designated responsibilities. From a political perspective, the Australian Medical Association, the media in its various forms, and special interest groups such as the Pharmacy Guild along with the specialty colleges, wield power in favour of their members and are lobbyists for them. Doctors, particularly, as in other health systems such as the UK's, are powerful agents advocating for their own, and sometimes their patients', interests.

The major group with a key stake in the system and dependent on good policy is Australian citizens. The Australian public has a strong inclination that their healthcare preferences should inform the priorities of services provided (Braithwaite et al., 2019; Wiseman et al., 2003). In that regard, the most recent survey, conducted in October 2021 of 5,100 citizens, representative of the Australian population, reported overall favourable views of their care but with continued concerns over multiple aspects of the system, including inadequate workforce capacity and unaffordability of some medicines and treatments (see Table 20.1 for a snapshot of views) (Zurynski et al., 2022).

AGENDA SETTING, POLICY FORMULATION AND IMPLEMENTATION

Australia has a universal public health insurance program (known as Medicare) that assures access to free public hospitals and primary healthcare, with many services and procedures (including medicines and medical devices) funded or subsidised through reimbursement under the MBS, thereby increasing affordable access (Biggs and Cook, 2013; Duckett and Willcox, 2015). Approximately 50% of Australians buy private health insurance to pay for private

Table 20.1 Summary of key findings from the 2021 Australian Consumer Sentiment Survey

Affordability and access

- 14% of people with chronic conditions could not pay for healthcare or medicine because of a shortage of money
- 24% did not fill a prescription or omitted doses of medicine – over a third said this was because of cost
- 30% of people with chronic conditions were not confident they could afford needed care if they became seriously ill
- 37% used telehealth in 2021, compared with less than 6% in 2018
- 34% had difficulty accessing care out of hours or on weekends in 2021 compared with 24% in 2018
- 55% of people in regional and remote regions said they needed more doctors, nurses, and health workers

Experience and satisfaction when receiving care

- 23% of people experienced discrimination or disrespect whilst accessing healthcare and people who identified as Aboriginal and/or Torres Strait Islander or LOTE were over-represented
- 84% were satisfied with healthcare services they received
- 71% of people who used telehealth said it was as good as or better than face-to-face

Opinions of our healthcare system

- 23% believed that residential aged care services are bad or very bad
- 30% said their confidence in the health system has increased since the COVID-19 pandemic

Psychological distress

- 24% experienced serious psychological distress – these rates are higher than pre-pandemic population prevalence rates
- 39% with psychological distress accessed a telephone advice line
- 35% with psychological distress accessed care through video conferencing
- 85% with psychological distress were satisfied with the care they received via digital health modalities

Source: The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey (Zurynski et al., 2022).

hospital care, dental services, and other services that are not, or only partially, covered by Medicare. There is an ongoing debate on what the role of private health insurance should be because it not only complements public sector services, but also substitutes for some of them. Taxation incentives are provided for higher income individuals to take up private health insurance, and the overall principle of the insurance sector is as a "community rating" scheme, but there is also "risk equalisation" among insurers (Australian Prudential Regulation Authority, 2022).

The Australian health policy agenda cannot be divorced from the system's complex organisational and funding structures, and responsibilities at different levels of government. As noted, responsibility for funding and regulating the healthcare system is largely shared between the Australian Government at the Commonwealth level, and the state and territory governments at the jurisdictional level (see Boxes 20.1–3). The long-term plans for distribution of funds and priorities for hospitals are covered by the National Health Reform Agreement (NHRA) which includes a Long-term Health Reforms Roadmap (Department of Health, 2021a). The NHRA is jointly agreed by health ministers at the Commonwealth and jurisdictional level and sets out aspirational objectives for the healthcare system. Things like mental health, PBS, MBS, and pharmacy care are covered and negotiated in other ways outside the NHRA's purview.

When it comes to implementing the health policy agenda in Australia, the roles and responsibilities of the Commonwealth and jurisdictions can overlap. This creates waste through duplication of effort, confusion about who is responsible for what, and disputes about funding and cost-shifting between the different levels of government. The fragmentation between Commonwealth and jurisdictional responsibilities also enables the shifting of blame should policies go wrong, responses to crises not go to plan, or funds allocated are not spent as intended, with each level of government blaming the other for policy failures or lack of policy and strategic response to ongoing problems. The roll-out of the Australian COVID-19 vaccination policy provides a timely recent example (Box 20.5).

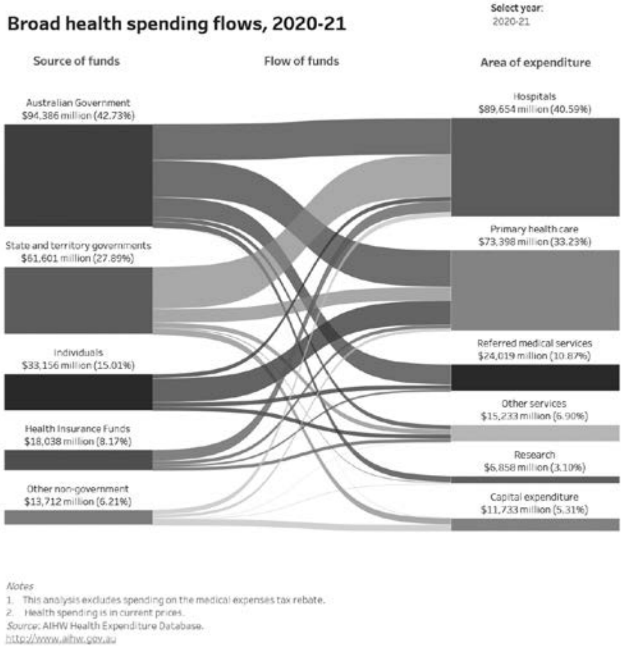
BOX 20.5 CASE STUDY ILLUSTRATING THE CONSEQUENCES OF MISALIGNED POLICY SETTING AND IMPLEMENTATION RESPONSIBILITIES AT THE FEDERAL AND JURISDICTIONAL LEVELS IN AUSTRALIA

The Australian Government was responsible for setting the vaccination policy and strategy and for procurement of vaccines for Australia early in the COVID-19 pandemic. The vaccination implementation policy was set at the federal level and accompanied by a staged roll-out strategy, with reliance on general practitioners and public health services in the jurisdictions to deliver vaccinations. Decisions made at the federal level led to over-reliance on one vaccine, vaccine supply shortages, significant pressure on the primary care system, disputes among the jurisdictions about which jurisdiction deserved to get more of the scarce vaccine supply, and eventually the jurisdictions setting up mass-vaccination hubs to supplement vaccine delivery. This led to Australia being under-prepared for vaccinations during the COVID-19 Delta wave, with vaccination rates being one of the lowest among all Organisation for Economic Co-operation and Development (OECD) countries (Choiseul et al., 2021), though Australia later caught up. Although Indigenous populations living in rural and remote Australia were prioritised for vaccination, when the Delta wave hit, only 8% of this population in areas of Australia had been vaccinated (Choiseul et al., 2021). This has been attributed to a failure of coordination between the Federal Government and governments in the jurisdictions to deliver vaccination to these prioritised vulnerable populations (Choiseul et al., 2021).

To underscore these challenges, the OECD has drawn attention to the ongoing difficulties with the Australian approach to health policy and healthcare system reform, highlighting the complexity of the system not only in terms of policy responsibility and multiple distributed and misaligned funding flows (see Figure 20.3), but also in terms of how the flow affects patients. Put simply, the OECD described the Australian health system as “too complex for patients” (Calder et al., 2019, p. 2).

POLICY EVALUATION

Learning from policy success and failure requires long-term commitment to policy monitoring, evaluation, reflection, and response in terms of policy adjustment and fine tuning, to meet ever-changing needs and contexts. These are rarely accomplished in Australia, as there is no peak body or identifiable group responsible for ongoing reform. While policies tend to be set for the long term, health programs developed under policy priorities are often undertaken over the short term and, depending on the political motivation, can be evaluated at 12–24 months, or not at all. In addition, such evaluations are often limited in scope and resourcing, and mostly



Source: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/main-visualisations/broad-flows used under a Creative Commons BY 4.0 (CC-BY 4.0) licence, http://creativecommons.org/licenses/by/4.0/.

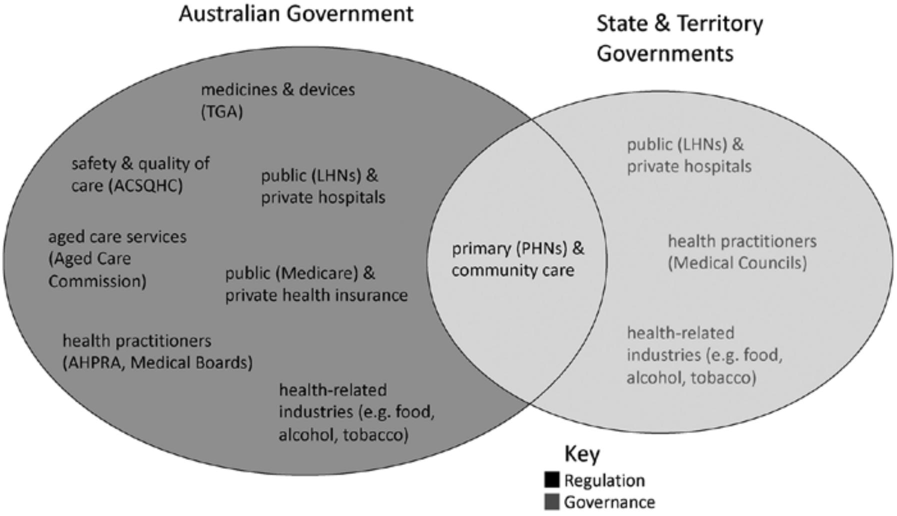
Figure 20.3 A depiction of funding flows from Commonwealth, state, and private sources

conducted by researchers with a policy interest, or consulting companies on request from government on an *ad hoc* basis, or sometimes for political expediency. Even when evaluations are undertaken, it is often unclear how the findings of those evaluations are fed back to inform future policymaking and implementation. Negative evaluation findings or evidence of policy failure are seldom viewed as assets for future decision-making (Kay and Boxall, 2015). On the other hand, Australia is at the international forefront of evaluating medicines and medical devices, with many countries—such as China—looking to Australia for guidance.

Nevertheless, health policy makers have access to significant data resources and intelligence that can be harnessed for policy monitoring, evaluation, and future priority setting. Notable examples include data collections and reports from the Australian Bureau of Statistics (ABS), MBS and PBS claims data, hospital performance data in the jurisdictions and national program data (although these are by no means unified between the states and territories), the Independent Hospital Pricing Authority, the AIHW and the Australian Atlas of Health Care Variation (Australian Commission on Safety and Quality in Health Care, 2021a). Although these data resources exist, there are enormous roadblocks to accessing the information including strict privacy and data security regulations and high costs of data linkage. One of the priorities of the NHRA is to enhance health data access, sharing and use, including for policy evaluation. Whether this situation will improve over time or simply be perpetuated is unknown. The Australian Government does have a strategy to link data with health determinants, which it has started to undertake, such as through a Multi-Agency Data Integration Project (Australian Bureau of Statistics, 2020). This may be a bright spot in a dimly-lit digital room.

GOVERNANCE AND REGULATION

As we have seen, regulation and governance of health and health-related services in Australia is shared between federal and state health departments and in some cases, such as environmental-health related services, with local governments (for a simplified, snapshot version, see Figure 20.4). Various regulations set the standards for provision of care and can include accreditation of organisations and individuals (Department of Health, 2021b). Governance includes the processes of auditing and reviewing organisations to ensure that standards are met, combined with investigations, risk monitoring and education (Department of Health, 2021b).



Source: Derived from health policy documents (Department of Health, 2021b)

Figure 20.4 Snapshot of regulation and governance of health and health-related services

The Federal Government directly regulates medicines and devices, aged care services, private and public (Medicare) health insurance and health-related industries (e.g., alcohol, tobacco) (Australian Institute of Health and Welfare, 2016). Public hospitals are regulated by state governments but jointly funded, while private health organisations are governed through states and territories (Australian Institute of Health and Welfare, 2016). Regulation and governance of the health workforce, including providers in hospitals, primary and community care are managed jointly by federal and state governments (Australian Institute of Health and Welfare, 2016). Provision of primary care is a federal responsibility, largely managed through PHNs (Department of Health, 2021c). Four large regulatory bodies at the national level with considerable reach, and that warrant further explanation, are the TGA, AHPRA, the Aged Care Quality and Safety Commission (ACQSC), and the ACSQHC.

Therapeutic Goods Administration (TGA)

The TGA is the largest health regulatory body in Australia, and is responsible for regulating prescription medicines, vaccines, sunscreens, vitamins and minerals, medical devices, blood, and blood products (Department of Health, 2022a). It regulates the supply, import, export, manufacturing, and advertising of therapeutic goods through pre-market assessment, post-market monitoring and enforcement of standards, and licensing of Australian manufacturers.

Australian Health Practitioner Regulation Agency (AHPRA)

It is important to protect the public by ensuring that those who provide care are trained and qualified to do so (Australian Health Practitioner Regulation Agency & National Boards, 2022). The National Registration and Accreditation Scheme (NRAS) for health practitioners was established in 2010 and covers 15 health professions (e.g., doctors, nurses). A National Board for each profession registers practitioners and, in collaboration with professional associations, sets the standards that must be met. AHPRA, established in 2015, monitors and audits registered health practitioners to make sure they are complying with Board requirements. A National Code of Conduct sets minimum standards to be met by healthcare workers who are not registered under the NRAS.

Aged Care Quality and Safety Commission (ACQSC)

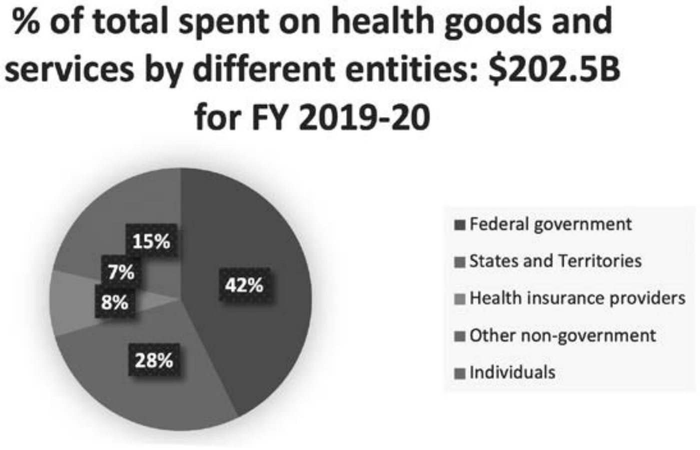
This Commission, established in 2018, assesses and monitors quality of care and services against the Aged Care Quality Standards (Aged Care Quality and Safety Commission, 2022). The eight standards have been in effect since mid-2019 and apply to all aged care settings including residential and home aged care services. In response to the Royal Commission into Aged Care Quality and Safety (2018) the Australian Government is developing a new regulatory framework for aged care, to come into effect in mid-2023.

Australian Commission on Safety and Quality in Health Care (ACSQHC)

The ACSQHC develops and maintains the National Safety and Quality Healthcare Standards (NSQHS) for delivering care in hospitals and health services across Australia (Australian Commission on Safety and Quality in Health Care, 2022). The eight standards cover key care concerns such as high-prevalence adverse events, healthcare-associated infections, medication safety, and responding to clinical deterioration. All public and private hospitals, day procedure services and public dental practices are required to be accredited to the NSQHS. The ACSQHC also develops and maintains clinical care standards for ensuring care is delivered in alignment with the best evidence.

HEALTH FINANCING

Turning to financing, Australia has operated a hybrid system of public (Medicare) and private health insurance since 1984. Medicare was originally created by the Whitlam Government in 1975, which was then called Medibank. All Australian citizens are covered by Medicare, as the universal provider of funding, for most services they need; private health insurance is optional, but there are incentives to purchase it. There are currently 37 different private health insurers. Overall spending on health goods and services in the 2019–20 financial year (FY) was AUD$202.5B (USD$142.8B), equivalent to: 10.3% of GDP, 26.3% of tax revenue, and AUD$7,926 per person (USD$5,700) (for further details see Figures 20.5–7). Spending by the Federal Government rose 5.6% year on year (YOY), higher than the ten-year average of 3.2%, largely due to measures related to the COVID-19 pandemic, pressures on the system to provide more and better-quality care, acquisition of technology, and population ageing. Individuals contributed 14.7% of total spending, which is just below the OECD average, and indirectly through private health insurance contributions (OECD, 2022).

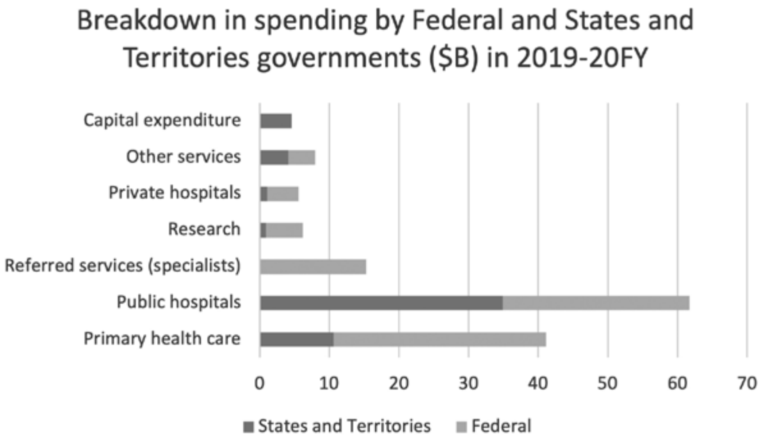


Source: Australian Institute of Health and Welfare material (Australian Institute of Health and Welfare, 2021b).

Figure 20.5 Expenditure by contributors

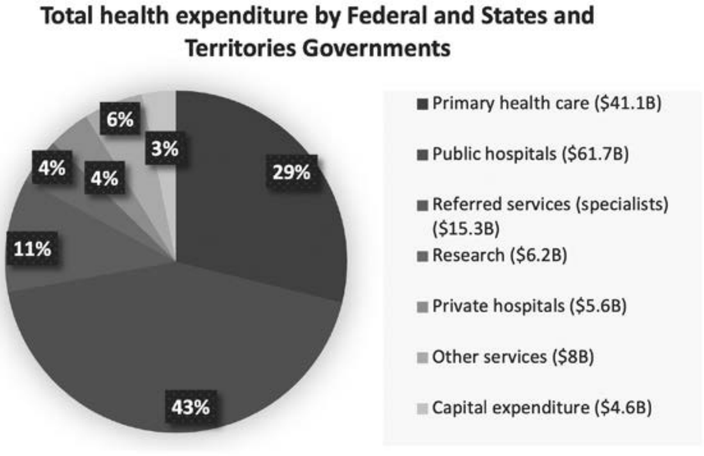
Government sources provide the largest contribution with different levels of government having both an explicit and shared funding role (Figure 20.5). As discussed, these agreements were set out in the 2011 NHRA and are regularly reviewed.

Public hospitals, a key expenditure item (see Figures 20.6 and 20.7), have shared funding arrangements with the Federal Government, subsidising medications and services through the MBS and PBS whereas the states and territories who, as we have seen, largely own and manage the facilities, contributed 57% of the budget. Primary care is partially covered by the Federal Government through MBS payments for GP visits (AUD$11.3B; USD$8.1B), but state and territories contributed 26% for this sector.



Source: Australian Institute of Health and Welfare material (Australian Institute of Health and Welfare, 2021b).

Figure 20.6 Funding allocations



Source: Australian Institute of Health and Welfare material (Australian Institute of Health and Welfare, 2021b).

Figure 20.7 Proportional allocations

HEALTHCARE DELIVERY AND WORKFORCE ISSUES

The World Health Organization (WHO) has recognised a global health workforce shortage and Australia is by no means exempt from the challenge this poses (Department of Health, 2022b; World Health Organization, 2016). No care system can function without an appropriately skilled, qualified, and empowered workforce. The Australian National Skills Commission estimates that approximately 300,000 additional trained workers will be needed in the healthcare and social care sectors over the next five years (National Skills Commission, 2022).

It goes without saying that the COVID-19 pandemic exacerbated the situation and laid bare the inadequate surge capacity within the system. Interruptions to medical training programs and visa restrictions limiting entry of overseas-qualified health professionals are further contributing to the problem, which is ongoing at the time of writing.

The maldistribution of the health workforce (with many rural towns and hospitals currently having no on-site doctor and being reliant on a fly-in-fly-out workforce or telehealth), leaves communities vulnerable. A great deal of policy ingenuity has been expended on this problem, with no obvious, and certainly no breakthrough, solutions. Incentives to increase the rural medical workforce, including additional payments and rural terms for medical students have had minimal sustainable impact (May and Scott, 2021). The General Practitioner workforce is particularly under threat with an ageing workforce and many GPs planning to retire or reduce hours of work in the next five years (Deloitte Access Economics, 2019). In addition, fewer medical graduates are choosing to take the general practice training route, preferring specialist medical training predominantly delivered in large metropolitan hospitals. Workforce shortages are even more acutely felt in the aged care sector, the mental health sector, and for remote and Indigenous communities.

Workforce and skills shortages, high staff turnover, and instances of toxic workplace culture constitute long-term, deep-seated, complex, and intractable problems that are all-too-readily viewed as part of the fabric of our healthcare system. We have pointed out the seriousness of unprofessional behaviour of healthcare professionals (Westbrook et al., 2020). Despite this being apparent for many years, healthcare workforce planning at the federal government level has concentrated predominantly on the supply of doctors (Department of Health, 2021d) rather than resolving some of the entrenched problems. With the approximately one million-strong workforce that includes at least 18 different health professions, this lack of whole-of-workforce planning is a major policy oversight and calls for a more comprehensive workforce planning approach to abound (e.g., Chiarella et al., 2020). The Australian Government Budget papers (2022–2023), predictably, for example, allocate funds to several organisations and national strategies, however, specific funding for workforce planning is largely absent (Department of Health, 2022b). Without a comprehensive workforce plan, the issues outlined here are likely to be prolonged with no obvious strategy to solve them.

HEALTHCARE REFORMS IN RECENT DECADES

Reforming Healthcare

Australia has had almost 50 years of publicly-funded healthcare, initially through Medibank, and later Medicare, providing Australians with universal health insurance based on either a free, or subsidised fee, for primary or specialist healthcare services. Medicare operates in tandem with the MBS, providing rebate payments for professional health services, and the PBS, providing subsidised prescription medications for approved medications (Calder et al., 2019). In 2004, Medicare Plus was introduced to provide a safety net for out-of-pocket (OOP) healthcare expenses (Hilless et al., 2001).

Private health insurance membership has varied over time, with around 44% of Australians estimated to have private health insurance in 2019 (Australian Institute of Health and Welfare, 2020b). Increasing private health insurance premiums, and OOP expenses for health consumers, are seen as the main drivers for decreasing private health insurance membership (Duckett and Nemet, 2019). In order to ease demand pressure on the public hospital system and offer a choice of healthcare professionals and hospitals, successive Australian Governments have continued to encourage voluntary private health insurance membership, such as through offering tax incentives, and enabling more comparability of private health insurance schemes by introducing a tiered product approach (Department of Health, 2021e; Healy et al., 2006). However, there is no evidence that increased membership leads to significant declines in waiting times (Cutler and Bilgrami, 2022).

At the jurisdiction level, the Australian Federal Government steers priorities for healthcare spending through successive five-year NHRAs with Australia's eight state and territory jurisdictions. The priorities of the most recent NHRA 2020–2025 focus on providing safe, high quality, cost-effective healthcare, enhancing health literacy of consumers, encouraging use of preventive health services, and improving health outcomes through care coordination, with ongoing performance monitoring (Department of Health, 2022c).

Health Priority Setting Reforms

The WHO's *Global Strategy for Health for All* mandate helped stimulate Australia's approach to reforming their national health priority setting (World Health Organization, 2018). Initially, three health priorities were advocated in Australia, namely cardiovascular disease, injury, and nutrition. After a series of reviews and revised approaches to priority setting, four (later nine) national health priorities were established: cardiovascular disease, cancer, injury, and mental health, with diabetes added in 1996, asthma in 1999, arthritis and musculoskeletal conditions in 2002, obesity in 2008, and dementia becoming the ninth national priority area in 2012 (Better Health Commission, 1986; Department of Human Services and Health, Australian Ministers' Advisory Council and National Health and Medical Research Council, 1994; Nutbeam et al., 1993). Collectively, these nine health conditions represent 70% of the total healthcare load, have the highest burden of premature mortality, are associated with demonstrated health inequalities, have known opportunities for prevention and treatment, and the incidence (or prevalence) of each condition is able to be monitored to gauge improvement over time (Australian Institute of Health and Welfare, 2022). Despite these health priority-setting initiatives, Australia's ageing population, increasing prevalence of chronic health conditions, and adoption of new technologies and treatments are concertedly leading to increasing costs of healthcare.

Reforming the Delivery of High Quality, Cost-effective Healthcare

Australia's rhetoric, especially from politicians and selected other stakeholders, is that the healthcare system provides safe, evidence-based quality healthcare in a cost-effective manner. Yet, particularly for individuals with chronic health conditions, the system struggles to deliver connected services across the continuum of care (Bennett, 2013). In response to fragmented care delivered by uncoordinated services, Australia piloted integrated care trials for people with complex chronic health conditions in the late 1990s with the aim of improving the coordination of care, reducing healthcare costs, and enhancing health consumer quality of life.

These coordinated care trials identified appropriate health consumer groups and care interventions, but despite substantial investment, the trials were not able to demonstrate significant benefits for the healthcare system or consumers. During the trials, there was higher health service use and associated costs, and the health outcomes and quality of life of consumers did not significantly improve (Gardner et al., 2013). Issues relating to short timeframes, design and implementation, and a lack of suitable outcome measures, were identified as potential reasons for the trials not achieving their aim (Gardner et al., 2013). Overarchingly, though, they demonstrated the challenges of radical reform.

Movement towards the delivery of value-based care that is outcome-focused and a drive for performance monitoring and performance-based funding of hospitals saw the establishment in 2011 of the Independent Hospital Pricing Authority (IHPA) and the now defunct National Health Performance Authority (NHPA). IHPA was primarily developed to introduce a nationally consistent approach to activity-based funding, although IHPA has recently focused its attention on value-based healthcare. IHPA established national activity-based funding mechanisms and continues to benchmark national performance across public hospitals, designed to improve hospital efficiency. From 2016, the AIHW took over the functions of the NHPA and reports on a range of healthy community indicators for each PHN (Australian Institute of Health and Welfare, 2018b). These sorts of benchmarking initiatives have been enhanced in some jurisdictions, such as New South Wales, where the Bureau of Health Information reports publicly on the performance of public hospitals through the MyHospitals performance website, including reporting on patient-reported experience outcomes (Bureau of Health Information, 2022). The movement towards value-based care has focused the Australian health providers on delivering safe, high quality, and cost-effective healthcare in the right place at the right time (Koff and Lyons, 2020).

HEALTH AND HEALTHCARE INEQUALITIES

The complex mix of federal and state funding approaches (Glover, 2020; Organisation for Economic Co-operation and Development, 2015) also adds a layer of complexity to patients' ability to navigate care pathways (Dickinson and Ledger, 2018). This is particularly noticeable for those with more complex or longer-term needs, for example: the elderly, people with a chronic condition, individuals with multi-morbidities, and those with mental health problems. In addition, people with a physical or mental disability, who may need a range of different care facilities and support systems in place, can be hindered in leading independent lives (McDermott et al., 2017).

As discussed, the Federal Government provides funding and indirect support for inpatient and outpatient care through the MBS and for outpatient prescription medicine through the PBS (Dickinson and Ledger, 2018). Australia's regionally-administered, universal public health insurance program (Medicare), is financed through general tax revenue and a government Medicare levy; the latter is paid by the working population (Glover, 2020). Private health insurance is subsidised by the Australian Government and offers varying degrees of coverage for OOP fees (Glover, 2020); it does not cover out-of-hospital medical services, such as GP or specialist visits, although it does cover allied health services. However, as with other inequalities in the system already mentioned, such as patient navigation through the system, access to services and service provision for the most vulnerable, inequality in funding for services across jurisdictions and states, and inequality in financial support for patients in different systems and healthcare settings, are also highly problematic (Mossialos et al., 2017). This is particularly evident in terms of access to specialist services in rural and remote regions, while disparities across socioeconomic groups continues to affect health outcomes (Mossialos et al., 2017). Indigenous populations in Australia, in particular, experience disparities in funding and services compared with other population groups (Mossialos et al., 2017). In attempting to limit disparities in rural and remote locations, the Federal Government provides incentives to encourage general practitioners and other healthcare providers to work in these areas to improve services and provide joined up care. The challenge is being further addressed by the increased use of telehealth, with uptake having risen sharply since the onset of the COVID-19 pandemic (Mossialos et al., 2017).

Despite the efforts of the ACSQHC and the ACQSC, inequalities in health have been said to have had a detrimental impact on patient involvement in the healthcare system, which, according to Braithwaite et al., (2019) has, up to 2013, been delivered in a somewhat piecemeal fashion. Since 2013, however, the system has benefitted from several healthcare initiatives trialling patients' more direct involvement in their care. This has been supported by new standards of care delivery, developed by the ACSQHC, and accreditation of organisations who involve patients in service planning, while patient-reported outcome measures (PROMs) are now widespread, e.g., in areas such as hearing health (Braithwaite et al., 2019; Hughes et al., 2019). The National Safety and Quality Primary and Community Healthcare Standard, published in 2021, also includes a Partnering with Consumers standard, where patients are actively involved in discussions around improvements to healthcare (Australian Commission on Safety and Quality in Health Care, 2021b). In response to wanting greater patient inclusivity, the Australian Medical Council (AMC) now requires graduate clinicians to recognise the value of evidence-based medicine principles and practices, including greater involvement of patients and families in decision-making to enhance treatment and care (Australian Medical Council, 2012). On the other hand, inequalities persist. Vulnerable and disadvantaged groups include those with poor ability to co-pay or afford health insurance, Indigenous populations, those in rural and remote communities, those with low levels of health literacy, and older adults.

CHALLENGES POSED BY COVID-19 AND POLICY RESPONSES

In addition to primary responsibility for public health and hospitals, the states and territories also have responsibility for schools, and for law and order. Similarly, each state has its own public health legislation and the jurisdictions to a considerable extent went their own way in dealing with the COVID-19 pandemic. Since the pandemic began, the states and territories exercised their emergency powers to impose lockdowns, limit the movement of people, foreclose non-essential businesses, and shut down schools and public facilities, but did so in different ways. The states and territories also instituted their own public health measures during the pandemic, such as providing COVID-19 testing facilities, institutional tracing and tracking procedures, quarantine arrangements and mask mandates. However, there was recognition for the need for national coordination in responding to the pandemic: on 27 February

2020, the Prime Minister announced the activation of the Australian Health Sector Emergency Response Plan, and on 13 March 2020, an extra-constitutional "National Cabinet" was formed (Department of Health, 2020; Parliament of Australia, 2020).

In early March 2020, a targeted action plan was initiated by the Australian Government Department of Health to develop and refine the National COVID-19 Primary Care Response (PCR). This action plan acknowledged the essential role of general practice in the nation's pandemic response and had been informed by the lessons from previous pandemics. The PCR was supported by a funding package of AUD$2.4 billion (USD$1.7B), announced by the Australian Government on 11 March 2020, which included AUD$1.1 billion (USD$780M) specifically allocated to support the COVID-19 response in primary care. Key components of the PCR included: a new whole-of-population funding model for telehealth (telephone or video consultations); establishment of call centres to triage people with fever or respiratory symptoms, provide advice and direct them to the most appropriate health services; establishment of general practice-led respiratory clinics; online infection prevention and control training for care workers; measures to safeguard the health of members of remote Indigenous communities; and ensuring consistent messaging to members of the nation's primary care workforce (Desborough et al., 2020).

Notably, new funding provided through the MBS enabled a shift to the use of telehealth for all appropriate consultations between patients and their healthcare providers. On 30 March 2020, bulk-billing incentives for people with healthcare concession cards and children aged under 16 years being seen in general practice were increased to limit the barriers for the population needing to access healthcare services and advice, and to support the financial viability of the nation's general practices. The use of telehealth has been described as "transformational" by the Australian Government and has played a critical role in ensuring the continuity of care of Australian patients throughout the pandemic (Department of Health, 2022d). By December 2021, the number of telehealth consultations in Australia had reached over 62 million (The University of Queensland Australia, 2021). In recognition of the success of telehealth, on 13 December 2021, the Australian Government announced that it would become a permanent fixture of Australia's healthcare system.

Overall, Australia's response to the pandemic has been largely characterised by early delays and missteps, but later, effective actions and policies (Braithwaite et al., 2021; Clay-Williams et al., 2020; Tartaglia et al., 2021). However, the pandemic has highlighted shortcomings with the system that need to be addressed. Before COVID-19, Australia faced challenges with maintaining enough experienced healthcare professionals to meet the growing demands from an ageing population and increases in chronic disease. The system has now been dealing with COVID-19 for over two years, with reports that healthcare workers are exhausted and burnt out. Australia's aged care system has also been reported as a "shocking tale of neglect" (Royal Commission into Aged Care Quality and Safety, 2021a). Key challenges for the future will be to preside over higher standards of care in the aged care sector and to support the needs of Australian healthcare workers.

HEALTH TECHNOLOGY ASSESSMENT

The Australian Government contributes approximately 61% of all government funding to healthcare (Australian Institute of Health and Welfare, 2021b). Most of that spending is committed to subsidising hospitals, health technology (including pharmaceuticals) through the PBS, medical services through the MBS, and vaccines through the NIP. The Australian Government also determines which prosthetic products private health insurers must pay benefits for, and their prices.

The TGA assesses, regulates, and monitors health technologies to ensure they are safe and effective and perform to the level expected within society. A new health technology must be approved by the TGA and listed on the Australian Register of Therapeutic Goods before it can be supplied to consumers. The subsequent path taken for reimbursement and post-market surveillance is determined by whether the product is a medicine, vaccine, medical service, device, or prosthesis.

Australia uses health technology assessment (HTA) to inform whether health technology should be subsidised by the Australian Government. The Pharmaceutical Benefits Advisory Committee (PBAC) recommends to the Minister whether a new medicine should be listed on the PBS. It has two sub committees, the Drug Utilisation Sub Committee (DUSC) and the Economics Sub Committee (ESC). The ESC is informed by detailed critiques undertaken by specialised university groups of PBAC applications, which must include an economic evaluation of the new medicine. It has been mandatory in Australia for an economic evaluation to be undertaken in submissions to PBAC since 1993, making Australia the first country to legislate economic evaluation of health technology (Hailey, 2009; Henry, 1992).

The Medical Services Advisory Committee (MSAC) has an Evaluation Sub Committee and a Population, Intervention, Comparator, Outcomes Advisory Sub Committee (PASC) that determines the population, intervention, comparator, and outcomes to be assessed for medical services. The Prosthesis List Advisory Committee (PLAC) assesses prosthetics and recommends whether a new technology should be listed on the Prosthesis List.

These committees, where feasible, use evidence and best practice methodologies for assessing quality, safety, clinical effectiveness, and cost effectiveness. Australia does not use an explicit cost effectiveness threshold when determining cost effectiveness, but committees do compare the change in quality-adjusted life years (QALYs) to the change in costs associated with the new technology.

HTA is also undertaken at the state and territory levels by jurisdictional governments. These too cover medicines, medical services, and devices, although not to the same extent as the federal level. There is concern that the fragmented approach to HTA at the jurisdictional level is inefficient, creates conflicting advice, and delays access to innovative health technology. Jurisdictions have agreed with the Australian Government to create a nationally cohesive and federated health technology assessment process to ensure HTA better informs policy and purchasing (Department of Health, 2022c).

LONG-TERM CARE

The phrase "long-term care" in Australia is almost synonymous with residential aged care. Although there are people aged under 65 years who require care in a long-term facility due to disability, this care has historically been provided within residential aged care facilities (RACFs). Recently, policies have been enacted that attempt to ensure that younger people no longer need to live in these settings, with targets set for no people aged under 65 years living in these facilities by 2025. A strategy to facilitate these individuals living at home or in supportive accommodation (e.g., specialist disability accommodation) is primarily provided through the National Disability Insurance Scheme (NDIS) (Australian Government, 2020).

In thinking about long-term *aged* care, 6% of older Australians (≥ 65 years) live in these RACFs, and this rises to 20% for those ≥ 80 years. Dyer et al. (2020) have suggested this represents an over-reliance on institutional care because Australia has the highest proportion of older people in RACFs compared with 11 other OECD countries, including New Zealand, the US, and Canada. Providers of RACFs are primarily not-for-profits (56%), followed by for-profit (33%) and public facilities (11%) (Royal Commission into Aged Care Quality and Safety, 2021b).

Political reform of the aged care sector in Australia has been ongoing for decades, with policies variously aimed at regulation, quality improvement, and the reduction of costs. In the 1980s, policy was largely centred on curtailing residential care and expanding community care, as well as improving quality and access (Howe, 2002). Part of this involved the introduction of assessments by an Aged Care Assessment Team (ACAT) to evaluate older peoples' suitability for residential care, a practice still used today (Lorkovic, 2020). In the mid-1990s, major reform involved redefining the separate levels of hostel and nursing home care under residential care, creating a single scale for classification of care need and implementing a new quality assurance system (Rosewarne, 2002). This *Aged Care Act 1997* also reconfigured aged care as a welfare, rather than a health service, which had the effect of replacing many degree-qualified nursing staff with less expensive care staff (Henderson and Willis, 2020).

The initial introduction of a quality assurance scheme was seen as improving the care of vulnerable older people, however, there was a lack of definition of clinical indicators by which to assess care quality (Rosewarne, 2002). In the past decade there has been a growing recognition of quality issues, highlighted most comprehensively by the Royal Commission into Aged Care Quality and Safety (2018–2021), a large scale, three-year-long inquiry into the nation's aged care sector that included 10,574 public submissions from individuals and organisations. The Royal Commission noted that there was limited high quality data available by which to assess quality and found that at least one in three people in aged care experienced substandard care such as assault, overuse of chemical or physical restraint, or understaffing that led to unmet needs (Royal Commission into Aged Care Quality and Safety, 2021a; Ludlow et al., 2021a, 2021b). It made 148 sweeping recommendations for improvements to the sector covering quality assurance and regulation, workforce, and funding.

Other reforms over the past two decades have involved the adoption of consumer-directed care in both residential and home-based aged care (Henderson and Willis, 2020; Moore, 2021). Although positioned as providing consumers with more flexibility and choice, these strategies have also contributed to the marketisation of the sector, an increase in private for-profit actors and effectively shifted responsibility from governments to older people and their informal care givers (Henderson and Willis, 2020; Lorkovic, 2020).

All of this suggests that despite continued evolution of a long-term care policy, the aged care system remains complex, poorly resourced, and not fit-for-purpose. Moreover, continued policy change has placed significant strain on care and nursing staff, who are increasingly expected to undertake managerial and quality assurance activities and documentation in addition to the already wide scope of demanding work they are required to do within RACFs (Venturato et al., 2006). While policies are intended to provide guidance to care at the coalface, there is frequently a disjuncture between the "rhetoric" of policy documents and the "reality" of providing care to older and cognitively-impaired people (Venturato et al., 2013).

DISCUSSION AND CONCLUSION

This chapter has documented many facets of Australia's health policy environment, its governance arrangements, and its delivery system. On the one hand, as a federated system, it can be seen as fragmented and siloed in terms of policy responsibility, governance, and structure, and poorly integrated for patients at delivery level, but also at meso and macro levels. As we have seen, it has variously been criticised for presiding over inequities, being excessively politicised, providing insufficient focus on evaluation, being too bureaucratic, and taking too long to satisfactorily address important issues such as patient safety and making improvements to residential aged care.

On the other hand, because Australia is a high-income country, it allocates over 10% of GDP to healthcare, and has access to technology and a well-trained workforce—and healthcare is an important issue for voters at every election—Australia's healthcare system routinely appears on the top, or near the top, of analyses of the performance of healthcare systems, such as in the reports put out by the Commonwealth Fund (Glover, 2020). It contributes to enviable population health outcomes.

Policy and systems reform of any healthcare system is, of course, a journey, not a destination. It is never easy to reform, let alone transform, an entire system that is as complex as healthcare (Braithwaite et al., 2017, 2018). Yet, healthcare policy in Australia is largely responsive and draws on best practice international knowledge and evidence but implemented with a unique Australian flavour.

Our final point is to end on this apparent contradiction. On many measures, Australia's healthcare system is as good as other high-income systems and, on some indicators, it is amongst the best; invariably, it benchmarks against other countries as a strong, upper-quartile performer. Yet it exhibits significant flaws – inequities seem entrenched, fragmentation is a perennial problem, aged care has been described as a national disgrace, and the health of Indigenous Australians is disturbingly poor. This snapshot of critiques also provides the blueprint for future policy reform: to capitalise on the system's strengths and tackle these shortcomings over time. Will it be able to accomplish that, say, over the next ten years? That is the serious policy question for which there is, as of now, no clear answer.

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Table 20.2 Glossary of terms and abbreviations

Aged Care Assessment Team	ACAT
Aged Care Quality and Safety Commission	ACQSC
Australian Bureau of Statistics	ABS
Australian College of Nursing	ACN
Australian Commission on Safety and Quality in Health Care	ACSQHC
Australian Health Practitioner Regulation Agency	AHPRA
Australian Institute of Health and Welfare	AIHW
Australian Medical Council	AMC
Coronavirus Disease of 2019	COVID-19
Drug Utilisation Sub Committee	DUSC
Economic Sub Committee	ESC
Financial Year	FY
General Practitioner	GP
Gross Domestic Product	GDP
Health Technology Assessment	HTA
Independent Hospital Pricing Authority	IHPA
Languages Other Than English	LOTE
Medicare	Australia's universal public health insurance program.
Medicare Benefits Schedule	MBS
Medicare Plus	A system introduced to provide a safety net for out-of-pocket healthcare expenses.
National Disability Insurance Scheme	NDIS
National Health Performance Authority	NHPA
National Health Reform Agreement	NHRA
National Immunisation Program	NIP
National Registration and Accreditation Scheme	NRAS
National Safety and Quality Healthcare Standards	NSQHS
Organisation for Economic Co-operation and Development	OECD
Out-of-Pocket	OOP
Pharmaceutical Benefits Advisory Committee	PBAC
Pharmaceutical Benefits Scheme	PBS
Population, Intervention, Comparator, Outcomes Advisory Sub Committee	PASC
Primary Care Response	PCR
Primary Health Network	PHN
Quality Adjusted Life Years	QALY
Residential Aged Care Facility	RACF
Royal Australasian College of Physicians	RACP
Royal Australasian College of Surgeons	RACS
Technical and Further Education	TAFE
The Commonwealth	The Australian Federal Government
The Commonwealth Fund	A think tank which benchmarks the health systems of selected high-income countries.
Therapeutic Goods Administration	TGA
United Kingdom	UK
World Health Organization	WHO
Year on Year	YOY

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21. The pathologies of the United States health care regime

Philip Rocco and Alex Waddan

INTRODUCTION

The United States health care system can be summarized in about six words: *a laggard outlier among advanced democracies*. Evidence of American exceptionalism now bleeds through the pages of academic journals, foundation briefs, and comparative life-expectancy statistics. These exceptions, both individually and collectively, are pathological. On cost, the U.S. currently spends nearly twice as much per capita as the average OECD country; American providers are far more prone to using expensive technologies and specialized procedures than their peers are. On access, the U.S. is nearly two standard deviations below the OECD's average rate of insurance coverage. On service provision, the U.S. has fewer physician visits than peers in most countries, likely due to limited access and a low supply of physicians. On outcomes, the U.S. far surpasses its peers on indicia of chronic disease, high suicide rates, avoidable deaths, and preventable causes (OECD, 2017; Tikkanen and Abrams, 2020).

The American response to the COVID-19 pandemic represented the convergence of these pathologies. While the U.S. was ranked as the top country globally in terms of pandemic preparedness in 2019—and while U.S.-supported research led to early breakthroughs in vaccine development—it also remained a global leader in viral spread, hospitalizations, and mortality for the duration of the pandemic; and in the midst of a tidal wave of disease, Americans were asked to shoulder a large share of the costs and risks of the pandemic alone (Bollyky et al., 2022; Kavanagh and Singh, 2020).

These interrelated dynamics are best thought of as the consequences of a distinctive political and institutional regime that envelops health care in the United States. Policy regimes, as May and Jochim (2013) argue, are governance arrangements constituted by mutually reinforcing policymaking *institutions*, coalitions of mobilized *interests*, and pervasive *ideas* about the appropriate role of public policy or the state in society. As we argue in this chapter, the uniquely fragmented character of the American state not only creates impediments to change, it also ensures that changes that occur both advantage well-organized groups and are less likely to reconstruct pre-existing institutional arrangements. Similarly, the historical weakness of American political parties has meant that successful reform proposals are more likely to reflect the demands of intense preference outliers as opposed to the demands of median voters. As the influence of organized labor has waned over the last 50 years, this has meant that the dominant players in shaping health care policy are often associations of providers or insurers. This configuration of interests has placed a thumb on the scale of governance models in which public subsidy of private financing and care arrangements reside. These arrangements have, in turn, reinforced a major ideational impediment to health policy reform—an anti-statist public philosophy—both by rendering the state less visible and, when more visible, less apparently salutary in the lives of citizens. After reviewing the research on each element of this regime,

Table 21.1 *Health care coverage in the U.S., 2021*

Source	Enrollment (millions/percentage of U.S. population)
Private health insurance – Group	178 (54.3%)
Private health insurance – Non-group	34 (10.2%)
Medicare	60 (18.4%)
Medicaid/CHIP	61 (17.8%)
Military – TRICARE	8 (2.5%)
Military – VA Care	3 (1%)
Uninsured	27 (8.3%)

Note: Percentages add to more than 100 as some people have more than one source of insurance
Source: Keiser-Starkey and Bunch (2022).

we consider how future researchers might evaluate its potential robustness or vulnerability to systemic change.

BACKGROUND: THE LANDSCAPE OF AMERICAN HEALTH POLICY

Before describing the elements of the American health care regime, let us first review a few basic features of the American health policy landscape. Of these, the most important is fragmentation of health care finance itself. As Table 21.1 shows, the U.S. lacks universal insurance coverage. Private health insurance—largely provided by employers in the group market, and to a lesser extent by non-group plans which are sold on government-run insurance exchanges—is the primary source of coverage. In 2021, some 211 million Americans received health insurance coverage through one of these private sources. The predominance of private coverage accounts in large part for the high rate of "churn" in U.S. health care—in which individuals lose and then regain coverage—a dynamic which often results in lapses in needed care (Sommers et al., 2016). Similarly, the existence of multiple private payers not only has the tendency to increase the overall cost of coverage, given the significant amount of administrative overhead this creates for providers, it also accounts for Americans' relatively high levels of out-of-pocket spending (Frakt, 2018; OECD, 2017).

Private coverage co-exists with multiple public systems of insurance coverage. In 2021, 18.4% of Americans received health coverage through Medicare, a federal health insurance program created in 1965 that covers most services for people over the age of 65 and for certain younger individuals with permanent disabilities. Medicare's internal finance structure is itself fragmented. Traditionally, most inpatient care was covered by "Medicare Part A" payments while physician services and outpatient care was largely covered by "Part B". In recent years, Medicare has also become increasingly partially privatized. Under Part C, roughly 34% of Medicare beneficiaries are enrolled in private "Medicare Advantage" (MA) plans that bundle services but often require steep out-of-pocket payments. While still publicly funded, Part D, which covers prescription drugs, operates exclusively through either standalone private insurance contracts or Medicare Advantage—Prescription Drug Plans (MA-PDs) (Kaiser Family Foundation, 2019).

The other major public health insurance program in the United States is Medicaid, which covers 1 in 5 Americans. Created along with Medicare in 1965, Medicaid evolved in fits and starts from a program serving only severely disabled and extremely poor Americans to the source of financing for nearly a fifth of all personal health care spending in the U.S., including the vast majority of long-term care spending, which is not covered under Medicare. Unlike Medicare, however, Medicaid is jointly financed and administered by federal and state governments. As a result of this federal-state partnership, eligibility standards and benefit generosity varies considerably from state to state. While federal standards dictate a minimum package of benefits, a number of states elect to expand those benefits to include optional services such as prescription drugs, physical therapy, and dental care. In 2010, the passage of the Affordable Care Act allowed states to expand Medicaid to non-elderly adults with incomes up to 138% of the Federal Poverty Level ($17,236 for an individual in 2019) (Rudowitz et al., 2019). Despite a generous funding formula, with the federal government covering most of the costs for newly eligible individuals under these rules, as of 2022 a dozen states have still refused to expand this coverage.

While Medicaid and Medicare target coverage towards adults, the State Children's Health Insurance Program (CHIP) is aimed at financing coverage for children. Like Medicaid, CHIP is means-tested, targeting low-income children and pregnant women in families with annual income above Medicaid eligibility levels but who lack health insurance (MACPAC, 2022).

The final sources of public coverage—the U.S. Department of Defense's Veterans Affairs and TRICARE programs—are restricted to military service members, veterans, and their dependents. In 2021, over 8 million individuals had TRICARE and 3 million individuals had VA Care.

The combination of high costs and limited accessibility of health coverage in the United States means that many Americans go without needed care. While there is a voluminous literature on this pattern, one recent example will suffice here. Galvani et al. (2022) attribute 77,675 deaths during the COVID-19 pandemic to the loss of employer-sponsored insurance and to background rates of uninsurance. Understanding not only how this system came to be, but how it reproduces itself, is the subject we turn to now.

REGIME POLITICS AND AMERICAN HEALTH POLICY

The American health policy landscape is the product not of conscious planning, but of a particular configuration of political forces that congealed at discrete moments in the development of the American state. As we detail below, the institutions of American government have permitted only brief moments of political opportunity at which reformers have been able to expand access to health care. Yet, even when those windows have opened, an anti-reform phalanx of major trade associations—whose membership has shifted over time—has usually been able to prevent the reconstruction or universalization of the system. Even at the apex of union membership in the United States, a major driver of universalism in other national contexts, prior political developments helped to diminish the labor movement's appetite for universal coverage. As labor's political strength waned and the Democratic Party adopted a more neoliberal posture, efforts towards "national health insurance" waned, supplanted by more modest programs that aimed at filling gaps in coverage rather than reconstructing the system itself. Yet, in part because this fragmented and privatized approach to health care finance has exacerbated the high cost of health care in the United States, it has proven inherently unstable—creating new pressure on the left flank of the Democratic Party for "Medicare for All". Even so, these financing arrangements have simultaneously unleashed new forms of concentrated opposition to reform. Privatized and indirect service provision, ironically, has also amplified anti-statist currents in American ideology, further undermining political support for significant change.

Institutions: Legacies of Fragmentation

Perhaps the most defining characteristic of the American health care policy regime is fragmentation. This is true in at least four ways. First, as scholars since Steinmo and Watts (1995) have noted, American *political institutions* are horizontally fragmented, as a consequence of both presidentialism and bicameralism. These constitutional features, combined with informal institutions like the Senate filibuster and historically weak political parties, have contributed to a profound status quo bias in American politics writ large. Even during moments of political opportunity, these institutional designs affect the character of change by privileging the preferences of well-organized interest groups. The canonical example of this dynamic is the failure of President Bill Clinton to enact his vision for national health care reform. Organizations deeply opposed to the initiative—including employers and the insurance industry—took advantage of the numerous veto points in the legislative process to bring the legislation to a halt. Relatedly, the passage of the Patient Protection and Affordable Care Act nearly two decades later hinged on circumventing these veto points. President Barack Obama allowed congressional leaders to drive the process of legislative drafting, watering down the content of the reform to appeal to its most significant rivals from the health care, pharmaceutical, and insurance industries (Beaussier, 2012).

Further complicating this already fragmented configuration of power was the emergence, in the late 1970s, of the Congressional Budget Office—another key legislative veto point for comprehensive health legislation has emerged in the form of the Congressional Budget Office (CBO), an office tasked with "scoring" legislation by estimating the impact that it would have on both revenue and spending. While Congress has always debated how much government initiatives should cost, the creation of the CBO and the canonization of its cost estimates have helped make the "price tag"—a term rarely used to describe acts of Congress until the 1980s—one of the most prominent and visible aspects of lawmaking. Following the passage of budget austerity measures, CBO scores began to have an almost "psychological" effect on members of Congress. Members would soon begin shelving or heavily revising costly proposals so as not to, in Reischauer's words, "screw up the PAYGO scorecard" (Rocco, 2021). This has not only made the CBO the place where health reform "goes to die", it has also led members to design health legislation in ways that conceal important costs and administrative defects (Saldin, 2017).

Second, another source of fragmentation in health policymaking is the arrangement of American *federalism* (Béland, Rocco, and Waddan, 2016). Not only do state governments retain significant regulatory and fiscal authority under the U.S. Constitution, state and local governments developed administrative capacity prior to the emergence of a robust federal governing apparatus. This meant that the authority to make critical decisions over public health was fractured along state lines from the outset. Because the quality of state-level democratic institutions is highly variable, this means that health outcomes in the United States—including life expectancy and infant mortality—are contingent both on states' policy choices and whether voters can effectively hold state governments accountable (Pacheco and LaCombe, 2022; Rodriguez et al., 2022). It also meant that—as the federal government developed during the Progressive Era and thereafter—Congress had strong incentives to undertake new functions by leveraging fiscal and administrative partnerships with the states (Johnson, 2007). Perhaps the largest federal policy intervention along these lines was the creation, in 1965, of the federal-state Medicaid program. Initially designed as a small, residual appendage to the larger, federally run Medicare program, Medicaid evolved largely through a cycle of state experiments, innovations, and open-ended federal funding into one of the largest sources of health insurance in the United States—the source of financing for nearly half of all live births in the country (Centers for Medicare and Medicaid Services, 2020). Yet the quality of services insured by Medicaid—and the ease of access to the program—varies considerably across the country. These variations have direct consequences on key policy outcomes, including life expectancy and infant mortality, as well as critical policy feedback effects on Medicaid recipients' propensity to participate in politics (Michener, 2018). Further, given the procyclical character of subnational revenues, Medicaid requires significant federal support to remain a viable source of insurance coverage during economic crises (Rocco, Béland and Waddan, 2020).

Third, U.S. health care policymaking is also fragmented in another important sense: *state functions related to public health are institutionally decoupled from those related to the provision and financing of individual medicine*. The development of public health infrastructure began in 1798, far earlier than that of other formal governing capacities, with the formation of the Marine Hospital Service, which eventually morphed into the Public Health Service (USPHS), a uniformed corps led by the Surgeon General. The USPHS's responsibilities included brute-force health interventions, including quarantine, and eventually, the control of communicable diseases and medical research—functions eventually taken on by the Centers for Disease Control and Prevention and the National Institutes of Health. While the USPHS could have been the locus for a large-scale public health insurance program prior to World War II—as the result of an agreement brokered by President Franklin Delano Roosevelt, Surgeon General Thomas Parran, and leaders at the American Medical Association, the initiative ran aground for two essential reasons. First, it was subject to conflict from other agencies within the burgeoning federal government, notably the Social Security Administration, who were suspicious of the USPHS's relationship to the American Medical Association. Second, the initiative faced legislative opposition in the apartheid "Solid South", whose congressional delegates wanted to restrict federal intervention to the eradication of communicable diseases without undermining white supremacy (Sledge, 2017). This "missed opportunity" helps in part to explain the enduring misalignment in planning for public health and individual medicine in the United States.

Finally, and in a way most importantly, U.S. health policy is characterized by fragmented *financing arrangements*. As seen in Table 21.1, there are various payers for insurance in the U.S. and it is critical to understand how these disjointed arrangements came into place. Whereas most other OECD countries expanded coverage through one form of public insurance or another, the U.S. followed a different trajectory. Beginning in the 1940s, Congress passed several reforms—ranging from a wartime tax break for employer-sponsored insurance to the inclusion of health coverage as a subject for collective bargaining—that virtually guaranteed a significant segment of care would be financed through employer-purchased plans. Consequently, private—though government-subsidized—financing constitutes a far larger segment of total health expenditure in the U.S. when compared to other OECD countries. More than half of Americans receive insurance from employers or through individually purchased plans (Kesier-Starkey and Bunch, 2021).

Early investments in a fragmented, private approach to health finance helped to stymie future efforts at comprehensive health reform, in part by peeling off potential support constituencies. As early as the 1950s, organized labor showed minimal interest in abandoning its bargained-for plans in favor of national health insurance (Quadagno, 2006). Rather, both business and labor organizations eventually supported the provision of health insurance (with the exception of long-term care) to Americans over the age of 65 through the federally run Medicare and means-tested federal-state Medicaid programs. It is worth noting that while these latter two programs are publicly financed, they are increasingly run through private managed-care companies. At present, over 80% of all Medicaid recipients and over 40% of Medicare beneficiaries are enrolled in private managed-care plans (Freed et al., 2021; Hinton and Stolyar, 2022). The rise of the "delegated welfare state" has intensified the challenge of public accountability (Morgan and Campbell, 2011). Institutional restrictions on executive-branch have also historically delimited the capacity of government to experiment with alternatives to this arrangement beyond rather incremental reforms (Rocco and Kelly, 2020).

These fragmented financing arrangements contribute to several increasingly well-known pathologies (Pizer and Gardner, 2011). Perhaps most significantly, fragmentation means that needed health care is underprovided. As the costs of medical care rise—in part due to the fragmentation of the risk pool itself—both public and private payers shift additional payment responsibilities onto individuals, either through raising premiums or out-of-pocket payments, or simply by refusing to provide insurance coverage (Kaiser Family Foundation, 2022). Under provision can also result from the U.S.'s relatively high rate of churn, that is gain, loss, or change in coverage. One in four consumers, on average, move in and out of health insurance coverage at least once or twice over a 12-month period. The consequence of lacking insurance—either because of cost or churn—is significant (Sommers et al., 2016). Gaps in coverage result in worse health outcomes and delays in needed treatment. As the results of a randomized trial carried out by the U.S. Internal Revenue Service suggested, individuals between the ages of 45 and 65 who received a reminder about signing up for coverage had, after two years, a mortality rate 6% lower than those who did not receive the reminder (Goldin et al., 2021). During COVID-19, uninsured Americans were significantly less likely to be tested for the virus and far more likely to be hospitalized. According to one estimate, had there been full health insurance coverage of the population, there would have been 60,000 fewer deaths, 26% of the total death toll in the first year of the pandemic (Campbell et al., 2022; Gaffney et al., 2022).

Interests: The Private Ends of Public Policy

If institutions give structure to regimes, *organized interests* constitute regimes' governing capacity. In the United States, where major political parties are organizationally weak and lack formal mass-membership, a mutating cast of intense policy demanders have set, and continue to shape, the boundaries of health policy development in significant ways. At the same time, the political and economic contradictions unleashed by this regime also create significant instabilities and opportunities for systemic change.

A comparative study of health policy development might begin by analyzing how "left power resources" (e.g., union density and labor party strength) shape health policy choices in the United States. The evidence points to several significant political dynamics. First, organized labor has been relatively weak compared to OECD peer countries. Most obviously, the United States has no labor party and, early in the 20th century, trade unions constituting the American Federation of Labor (AFL) explicitly rejected calls to form such a party, weakening their capacity to pursue major policy changes. While organized labor was arguably crucial to the passage of Medicare and Medicaid, labor leaders largely rejected plans for universal coverage, which they believed would jeopardize union-negotiated and employer-provided benefits. By the 1970s, political divisions within labor—particularly between the AFL's George Meany and Walter Reuther of the United Auto Workers—helped to undermine support for significant developments in national health insurance. By the end of the 20th century, shifts in the American political economy, combined with the passage of "right-to-work" laws at the state level, further decimated labor's ranks (Quadagno, 2006). Where labor is concerned, support for comprehensive health reforms is most prominent among "alt-labor", a coalition of organizations working to advance worker rights following the collapse of unionization. The labor movement also remains disconnected from potential sources of support for universal health care, including sick or disabled individuals classified by the state as unproductive surplus populations (Adler-Bolton and Vierkant, 2022).

As organized labor's power to shape health policy declined, the Democratic Party, which had itself been an engine of health policy reform between the 1930s and the 1960s, also began to transform from within. Facing the pressure of stagflation in the 1970s, as well as the rising costs of their patchwork of health policies, Democrats increasingly abandoned Keynesian economic ideas in favor of new forms of economic expertise, which emphasized the primacy of markets as an allocation mechanism (Mudge, 2018). Among these ideas was the idea—first propounded by the economist Mark Pauly and later tested in the RAND Corporation's Health Insurance Experiment—that shifting costs onto individuals in the form of copayments would disincentivize the "overuse" of health care, thereby reducing costs (Berman, 2022). Ideas about the power of markets gained traction within the Democratic Party in the 1990s, not so much as a means of defending against attacks from conservative Republicans, but from a shifting ideological consensus within their own ranks, which were increasingly constituted by middle-class professionals rather than movement actors representing poor and working-class Americans. Hence, by the early 2000s, Democratic Party leaders increasingly eschewed reforms that expanded the provision of services by the federal government in favor of solutions that relied on public subsidy of private solutions (Geismer, 2022).

In the absence of these countervailing forces, health policy in the United States has ultimately been shaped by a phalanx of powerful private actors—mainly trade groups of health care providers, manufacturers, insurers, as well as peak employer associations. Yet the members of this phalanx have varied over time, as have their goals and strategies. Prior to major federal interventions in health care, the main interest-group players were physicians, in the form of the American Medical Association (AMA), who feared that federal control of their practice would follow federal financing (Starr, 1982). Other prominent organizations, including hospital administrators and large manufacturers, invested in the creation of private insurance plans (starting with Blue Cross) as a means of weakening support for government-provided health insurance and limiting the rise of trade unions.

While the anti-reform phalanx did not always stick together when less encompassing reforms were on the table, they have routinely succeeded in beating back proposals for *universal* health insurance. Manufacturers ultimately joined organized labor in supporting Medicare in 1965. Yet, beginning in the 1970s, the health insurance industry itself took an increasingly prominent role in policymaking—building coalitions with small-business organizations, physicians, and pharmaceutical manufacturers to beat back President Clinton's 1993 proposal and to significantly alter the content of what would become the Affordable Care Act, the Obama administration's signature health reform. By 2019, a coalition of medical providers, insurers, and manufacturers had reconstituted the phalanx into an "astroturf" group called the Partnership for America's Healthcare Future. The group had bought up nearly half of all political ads in Iowa during the run-up to the Democratic presidential primary. The cause for their concern was that presidential frontrunners had expressed renewed enthusiasm for major health reforms, specifically "Medicare for All" (Himmelstein and Woolhandler, 2021).

It is worth noting that the industrial players that dominate the health policy space derive their power not only from their instrumental lobbying capacity or political clout, but from their structural position within the economy of U.S. health care (Culpepper, 2016). Given that the health care sector occupies roughly 17% of the U.S. Gross Domestic Product (GDP), providers and manufacturers have significant structural power stemming from their capacity to withhold investment in response to reforms that undermine fragmented and inefficient systems of health finance (Swagel, 2022). Indeed, because these reforms could lead to lower provider rates and job losses—their proponents typically amend them with compensating side payments. This, in turn, further increases their cost, often pushing them outside the zone of legislative acceptability set by the austerity-oriented congressional budgeting process (Saldin, 2017).

Beyond the credible threat of withholding investment, providers and insurers have other sources of structural power within the U.S. health policy regime. Providers' enduring power comes from an information asymmetry built into the process for pricing health services. Beginning in the 1980s, the AMA became engaged in setting prices for services in the Medicare program via the Resource-Based Relative Value Scale Update Committee (RUC). This relatively obscure committee leverages information asymmetries to structure prices for U.S. medical services, readily accepted by the federal Centers for Medicare and Medicaid Services, which have grown to become the highest prices in the world (Laugesen, 2018). Insurers, by contrast, increasingly derive their power to shape health policy from their role in the delivery of public programs like Medicare and Medicaid. Not only has the growth of private managed care within Medicare and Medicaid padded insurers' profits in recent decades, this development has also enabled insurance companies to credibly threaten payment reforms that disadvantage their bottom line will result in waves of coverage losses (Kelly, 2016; Kelly, 2022, 2023).

What magnifies these sources of structural leverage is that American social welfare policy—evermore anemic and residual—has little ability to address rising income inequality, which remains a significant predictor of both acute and chronic illnesses (Braverman et al., 2010). The U.S. health care system has thus become the primary site at which the downstream effects of economic dislocations are dealt with, such that entire regions now build their economies around the provision of health care to chronically ill and disabled populations (Winant, 2021). Rising inequality thus enhances the resources and institutional linkages that give insurers, providers, and pharmaceutical manufacturers their power.

While this configuration of interests is no doubt formidable, it has also created a series of contradictions that render it unstable. Among providers, political sorting and intra-professional salary gaps have created a series of political wedges (Bonica et al., 2014). Whereas conservative high-salaried specialists generally oppose the creation of universal social insurance, a progressive insurgency in fields like primary care and internal medicine support it. Not only do resolutions related to Medicare for All now routinely divide, rather than unify, the AMA's House of Delegates, they have also engendered support from other medical societies, including the American College of Physicians and the Society for General Internal Medicine (American College of Physicians, 2020; Physicians for a National Health Program, 2020; Scott, 2019). And while large employers continue to oppose universal coverage reforms given their potential impact on worker leverage, rising prices for health insurance and a workforce increasingly vulnerable to infectious and chronic diseases has also created a divide among small businesses on the question of single-payer health care. Perhaps most importantly, because the profit-driven health care system has created a vast workforce of poorly paid nurses, hospital staff, and personal care attendants, it has the potential to become a profoundly important site of class formation and social change should essential workers build the capacity to take collective action (Winant, 2021).

Ideas: Lineages of the Anti-statist State

The third component of the U.S. health policy regime is a set of ideas which serve as organizing principles for policymaking (May and Jochim, 2013). The most prominent of these is the idea that the exceptional character of American health care, with all its attendant pathologies, reflects a purposeful rejection of the type of state intervention in social policy common to most rich countries. According to this perspective, the U.S. is a welfare state outlier by design rather than by accident. A classic articulation of this view from the mid-20th century was Louis Hartz's, *The Liberal Tradition in America* (1955). Hartz does not exactly champion the concept of "rugged individualism" but he sees it as having framed much of the country's political development. Other well-regarded scholarship from the same period did not always repeat Hartz's message of an anti-statist trajectory but it often neglected, or at least downplayed, the role of the state in American political development. This writing came even in the immediate aftermath of the New Deal era of social policy innovation from thinkers often broadly sympathetic to that political project (Gorer, 1944; Myrdal, 1944; Schlesinger, 1949; Trilling, 1950), hence reinforcing the idea that American society had accommodated itself to a relatively smaller welfare state and a prioritization of individualism over collectivist policy tools. The Hartzian historical narrative has been much criticised from a variety of perspectives (Morone, 2005), most obviously because it glosses over the state's role in maintaining hierarchical power structures but also, if implicitly, for ignoring the manner that the state collaborated at different points with the private sector and social movements (Balogh, 2018). The purpose here, however, is not to re-litigate the legitimacy of Hartz's thesis but is to point to the way individualism, however imprecisely defined, has provided a continuing ideological framing for conservatives rebutting proposals for an extended state intervention in social policy, especially health policy. This has been a "core idea" holding together a value system of anti-statist beliefs.

In more explicitly political terms, this emphasis on the importance of self-reliance rather than government support was reinvigorated and celebrated by Reagan-era conservatism. Following several decades of groundwork laid by conservative intellectuals, President Reagan (1981) declared that "government is not the solution to our problem; government is the problem." Indeed, one of the defining features of what one historian described as the "Age of Reagan" (Wilentz, 2008) was the alleged hostility to "Big Government". Apparently conceding ground to this hostility, in his 1996 State of the Union speech, Democrat President Bill

Clinton declared, "the era of big government is over" (Clinton, 1996). Then, in the summer of 1996, he signed into law the Personal Responsibility and Work Reconciliation Act that ended an entitlement program largely targeted at poor, single-parent families that had been part of the 1935 Social Security Act (Weaver, 2000). In doing so, Clinton effectively accepted the legitimacy of conservative ideas about the dangers of welfare dependency (Béland and Waddan, 2012).

Yet, this rhetoric and actions hid social policy expansion that did take place during the 1990s and beyond. Importantly, however, this activism often came in the form of the "hidden" (Howard, 1997) or "submerged" (Mettler, 2011) welfare state. A prime example of a redistributive policy that has grown significantly since its creation in the mid-1970s is the Earned Income Tax Credit (EITC). As a refundable credit, the EITC is a clear success on its own terms as it incentivizes labor force participation and helps lift many low-income households out of poverty (Falk and Crandall-Hollick, 2016). It is also popular with its recipients, with surveys suggesting that it does not come with the same stigma attached to other forms of means-tested cash welfare (Sykes et al., 2015). Yet, for advocates of social policy expansion, the rationale for this popularity is a double-edged sword. First, while successfully providing benefits through this type of policy mechanism can be a model for some other forms of activity, it is inherently limiting if social welfare expansion is confined to off-the-books indirect expenditures. Second, the "submerged" nature of policy has meant that its success is not widely understood and hence it does not provide the foundation on which to build a wider alternative policy regime. Put differently, the growth of EITC has not been accompanied by the maxim that "policy changes politics" (Campbell, 2003). The evidence suggests that even EITC recipients do not credit government for the support provided (Shanks-Booth and Mettler, 2019), thus denying political oxygen to champions of more explicit redistributive policies.

In fact, as the U.S. health care's fragmented arrangements evolved in the mid-20th century, the hidden welfare state, if not labelled as such at the time, acted in a way that undercut the arguments of those calling for more direct state intervention in the provision of care. The decision not to treat employer-provided health insurance as a form of salary and therefore to leave it free from federal income tax and payroll taxation has been fundamental to the sustainability of that form of insurance provision. According to the Tax Policy Center (2022), excluding these employer-provided benefits from the tax code "cost the federal government an estimated $273 billion in income and payroll taxes in 2019, making it the single largest tax expenditure." To provide some context, the federal government spent $605 billion on Medicare in 2018 (Cubanski, Neumann and Freed, 2019), with conservatives expressing their angst that this was runaway government spending: yet, the tax expenditures to support employer-provided insurance receive relatively little comment.

In opposing efforts at comprehensive health care reform, conservative leaders have tacitly acknowledged that a successful reform involving more extensive and transparent state intervention might lead to a changed political and policy paradigm. Writing in late 1993, the then-influential conservative strategist and thinker, William Kristol, distributed a memo to Republican leaders stressing the need to kill off the Clinton administration's floundering reform package. Kristol warned that should the Health Security Act (HSA) become law, it would: "re-legitimize middle-class dependence for 'security' on government spending and regulation," reviving the reputation of the Democratic Party while striking "a punishing blow against Republican claims to defend the middle-class by restraining government" (Johnson and Broder, 1997: 234).

As it was, despite Clinton's efforts to promote reform as a signature issue, the initiative made almost zero legislative progress. Once the package emerged in the public realm it came under sustained fire from employers, insurers, and a range of professional and industry health care interests (Skocpol, 1997; Starr, 1982). In partisan terms, Republicans were united in opposition while, critically, Democrats were divided in their response. On the left of the party there was disappointment that the administration had developed a complex plan under the guise of "managed competition" rather than adapted a single-payer model to the U.S. context (Hacker, 1996). Yet, the real damage to the prospects for reform came from more conservative Democrats who viewed the package as too far to the left. Walter Zelman (1994: 11), a White House adviser who worked on the reform plan, saw it as drawing on "the best of competing ideas to create a new, higher-level synthesis, and in doing so to overcome the ideological and political deadlock that has marked the reform debate over the past decade." In the end, however, as a further Clinton adviser, Sidney Blumenthal (2003: 121) lamented, "The assiduous care the task force took to put together a centrist approach alienated both liberal and conservative Democrats" with everyone frustrated by the potential "bureaucratic monstrosity".

In the aftermath of the failure of the HSA and then the catastrophic midterm elections of November 1994 for the Democratic Party, it looked as if the Clinton administration would flounder through the remainder of its first mandate. But, the political landscape changed again and once again health care policy and politics were key to developments. This time the Republicans over-reached. Led by the new Speaker of the House, Newt Gingrich from Georgia, Republicans proposed major cuts to future Medicare spending and a restructuring of the program (Weaver, 1996). This attempt to turn Medicare into a wedge issue, driven by ideological hostility, backfired and Clinton was at least partially able to position himself as a protector of the popular Medicare program (Jacobs and Shapiro, 2002: 67).

These partisan fault lines from the early to mid-1990s persisted over the next quarter century through the passage of the Affordable Care Act (ACA) in 2010, through the failure of Republicans to repeal that law in 2017, and beyond into the Biden presidency. First, Republicans remained unified in opposition to plans to expand the government's role in the provision of care. As President Obama and congressional Democrats worked to craft the ACA through 2009, Senator Max Baucus of Montana, the Democrat Chair of the Senate Finance Committee, worked to woo support from the remaining Republican moderates. This was a forlorn exercise. Baucus did win over Senator Olympia Snowe of Maine to pass a version of the ACA through SFC but she, like all her party colleagues, voted against the final bill. Outside Congress, the emergent Tea party thrived on its opposition to "Obamacare". In turn, this created a feedback loop whereby congressional Republicans, having whipped up their base in opposition to big government, were now pressured from below to continue that opposition.

Importantly, Republican opposition continued after the passage of the ACA and extended beyond Washington, D.C. into Republican-controlled state governments, fulfilling the prediction of social scientists Eric Patashnik and Julian Zelizer (2013: 1073) about the potentially damaging consequences of enacting legislation along highly partisan lines: "Divisive enactment may undermine the credibility of the government's promise to stick with the new policy, which discourages the organizational adaptations needed to make the policy effective." Opposition to the implementation of the ACA took several forms (Béland, Rocco and Waddan, 2016), but perhaps the most consequential was the refusal of several states to join with the so-called Medicaid expansion. The ACA was designed to encourage all states to provide health coverage through Medicaid to everyone in a household with an income below

138% of the federal poverty line. The intent was to establish an effective minimum national base line for the Medicaid program for the first time since it was established in 1965. That federal government encouragement to the states took the form of significant fiscal incentives combined with the threat of financial sanctions against non-compliant states. However, in 2012, the Supreme Court deemed the sanctions to constitute federal overreach (Waddan, 2013) and, driven by ideological conviction, Republican legislators and Governors refused the enticement of extra federal funding. The real-world consequence was to deny millions access to health insurance.

If Republicans demonstrated their capacity for opposition to the ACA, similarly to the 1990s, they were less successful when trying to make their own sequel and enact their own policy ideas. Having promised to repeal the ACA and having voted for partial and full repeal multiple times while Obama remained in a position to veto those votes, the GOP came unstuck when they took control of all levers of government in Washington in January 2017. Despite employing the Reconciliation process to bypass the need for 60 votes in Senate, the effort to "repeal and replace" the ACA fell short of the 50 votes needed in that chamber. This time around it was the Republican leaders who found themselves stymied by a recalcitrant handful of members on their own side combined with a united partisan opposition. In addition, medical interest groups, having accommodated themselves to the ACA, rallied to its defense and the CBO, in repeatedly projecting that the adoption of Republican plans would lead to a big jump in the number of uninsured Americans, proved itself an obstacle to conservative as well as more liberal reform (Béland, Rocco and Waddan, 2019).

For their part, the Democrats did depart from the roadmap of the 1990s in a significant way by coming together to enact the ACA. As the newly-elected President Obama, along with large congressional majorities, prioritized health policy, there were signs of the tensions of the 1990s repeating themselves as those on the left of the party preferred a single-payer option while more centrist members of the congressional caucus insisted on adding to the existing framework of provision rather than replacing it. The centrists largely won this argument, especially as the left had few options other than to support the emerging legislation or see a prime opportunity for policy change of any sort evaporate.

The legislative process leading to the ACA has been well documented (Béland and Waddan, 2013; Jacobs and Skocpol, 2010, 2011), but some items included and excluded from the final legislation merit attention. First, the ACA did expand the state's role in the financing of care. Most directly this came through the Medicaid expansion. This represented an important break with previous principles governing Medicaid as it proposed to expand eligibility without invoking any measure of "deservingness". Prior to the ACA, almost all states prevented healthy working-aged adults from enrolling on Medicaid, in line with the values of "rugged individualism". The ACA did apply an income-test for eligibility but did not further investigate household circumstances. In addition, subsidies were provided for households with incomes up to 400% of the poverty line to purchase insurance in the private sector. This latter aspect worked differently to the tax credits of the EITC but can be seen as part of the "submerged" welfare state rather than the more explicit means of state support of the Medicaid expansion. A further instrument of state power came in the form of the so-called "individual mandate", which required people, unless they were in an exempt category, to buy insurance. This proved to be the most unpopular element of the law (Kaiser Family Foundation, 2012).

Second, the ACA may have filled the gaps in coverage—but it did not undermine the fundamentally segmented approach to health finance in the United States. The legislative process kicked out even mild efforts to change the logic of this system. One idea, advanced by progressives, was to introduce a so-called "public option" whereby a government scheme would compete with private insurance providers (Brasfield, 2011). A trial version of this was included in the House bill, but in Senate, where every vote was needed to defeat Republican efforts at a filibuster, the objections of a small number of Senators kept it out of that chamber's bill. The legislative endgame meant that the Senate's bill formed the basis of the final legislation, and the public option did not become part of the ACA. This episode illustrates the importance of pivot points within a party's caucus, handing a handful of legislators disproportionate influence and limiting the chances of more radical reform plans.

In the immediate aftermath of the passage of the ACA, Democratic leaders celebrated their triumph and announced that the battle over health policy reform was settled for the time being. This proved a naïve illusion as Republicans battled against the law through at least the next three federal election cycles. It also underestimated continuing tensions within the Democratic Party about whether the ACA was the destination of policy change or a staging post on the way to a more radical end point. This came to public attention as Democrat candidates for the 2020 presidential nomination clashed about whether to modify the ACA to make it work more effectively or lean into a much more expansive role for the state and push for a form of Medicare-for-all. In February 2020, a *Politico* report commented: "The idea of shifting everyone in the United States into a single government-run health insurance plan with generous benefits has rocketed from the leftist fringes to the political mainstream in just a few years" (Ollstein, 2020). And to some extent there was a shift towards a more collectivist ideological approach, away from the emphasis on cost-benefit efficiencies and supposed rational incentives that had steered much of the party's thinking since the late 1970s and led policy towards revisions of market models rather than a comprehensive role for the state.

Nevertheless, Democratic leaders varied considerably when it came to their positions on health reform. Some of the leading contenders for the nomination ranged from Vermont Senator Bernie Sanders' embrace of the idea of a fully government-funded national health insurance scheme through to former Vice President Biden's preference for building on the ACA and maintaining an important role for private insurance. The 2020 election itself saw Biden win the presidency with the narrowest of congressional majorities in both chambers. In these circumstances, comprehensive health policy reform was a non-starter, but arguments about the merits of a single-payer overhaul of U.S. health care arrangements have persisted. In justifying their position, both sides call on public opinion. Medicare-for-all advocates point to polls such as one by Morning Consult in April 2021, suggesting that there is 55% overall support for such a reform (Galvin, 2021). Coverage losses experienced during the COVID-19 pandemic only increase public support for universal health reform (Fox, Choi, Lanthon and Croke, 2021). Further, policy framing does indeed shape public attitudes towards reform; proposals framed as an expansion of existing programs (Karra and Sandoe, 2020). That public opinion has simultaneously trended towards more comprehensive reforms while remaining starkly polarized along partisan lines says much about the persistent divide between operational liberalism and philosophical conservatism in American public opinion. It also suggests that, in the battle for health care reform, public opinion itself is less of a hard constraint than a malleable raw material.

CONCLUSION

It is by now conventional wisdom that, when compared to peer countries, the U.S. approach to health policy yields systematically higher costs and worse outcomes for most of the population. At its base, most research on health politics and policy is an attempt to understand, at one level or another, either the roots of this pathology, or how—considering the abundant evidence of failure—this institutional arrangement reproduces itself. Taken together, a policy *regime* perspective has much to offer in answering these questions. There is, we have argued, a mutually reinforcing set of institutional arrangements that inhibit an effective response to systemic failure. On the one hand, the fragmentation of American political and policymaking institutions not only arrests comprehensive institutional changes and reduce accountability, it also tilts the surface of play in favor of well-resourced interests and preempts the cohesion of a mass base for general-interest reforms. Hence, even at the apex of "left power resources" in the United States, existing policy arrangements internally divided organized labor on the question of comprehensive health reform while uniting providers, employers, and insurers. Consequently, even the expansion of access to health care has usually entailed a significant role for private interests in both the provision and financing of care. This has meant that pharmaceutical manufacturers, provider groups, and insurance companies are not merely interests like any other within the policy arena, but actors with a unique form of structural power to dictate the substance of health reforms. Rather ironically, suboptimal policy arrangements—often delivered through administratively burdensome or otherwise illegible means—have done little but reinforce the anti-statist sentiments in American public opinion, polarizing support for popular reforms.

What the policy-regime perspective cannot tell us—as its proponents freely admit—is the conditions under which this configuration of interests, ideas, and institutions is most susceptible to change (May and Jochim, 2013). Still, the evidence we've presented here provides more than a few directions for further analysis. To begin with, future research is needed on the regime's numerous sites of vulnerability. The COVID-19 pandemic has illustrated internal contradictions which will only intensify in the coming years, potentially creating a seedbed for change. Not only are the medical professions more fragmented than ever on the question of comprehensive health reform, inefficient allocation of resources during the early days of the pandemic have highlighted the weaknesses inherent in the separation between public health and individual medicine. Further, repeated efforts to shore up the institutional patchwork of health financing have not slowed the increase of out-of-pocket costs most health care consumers continue to experience. As temporary fixes passed during the COVID-19 pandemic—perhaps most notably coverage expansions within Medicaid and enhanced subsidies on the individual market—expire, the rising costs of care associated with population aging will increase the prevalence of churn and underinsurance. Population aging will also accentuate the inadequate supply of care, especially in remote areas of the country.

On their own, none of these dilemmas is likely to preempt institutional reproduction. Yet they may help catalyze efforts to destabilize the regime. Such efforts might include initiatives to problematize the institutions that act as impediments to fiscally expansive social reforms, including the Congressional Budget Office (Rocco, 2021). Another stream of institutional changes worthy of analysis focus on halting institutional layering within Medicare and Medicaid that has increasingly privatized both programs while propping up the power of managed care companies. This includes efforts supported by congressional progressives and by the Biden administration to create new *public* benefits within the Medicare program and to cut payments to Medicare Advantage (Caress, 2022). While these measures have stalled in Congress, efforts to politicize the privatization of Medicare and Medicaid have continued. Here, one need only look to the fact that state chapters of the AMA have recently called for private Medicare programs like ACO REACH to be terminated because they "limit care to maximize profit" (Arizona Medical Association House of Delegates, 2022).

A careful kind of scrutiny is warranted when assessing purportedly "non-reformist" reforms. As noted above, the fragmented character of American political institutions selects for incremental reforms that, even when fiscally or programmatically significant, simply reinforce the existing set of interests or institutional arrangements and divide coalitions for greater policy change (Morgan and Campbell, 2011). To the extent that the political conditions do not allow for ruptural change, proposals for modest reforms should be assessed for their potential effects on regime stability. For example, one might consider whether implementing single-payer reforms on the state level would result in a cycle of policy diffusion across the states or, given their operational challenges in states with procyclical revenue streams and no control over the money supply, would they instead impede future changes (Buccholz, Attar, and Friedman, 2021).

The reality, however, is that the policy changes most likely to emerge through the U.S. legislative process are also the least likely to destabilize the health policy regime. Not only are American governing institutions closely divided along partisan lines, minority rule—most notably in the form of the Senate filibuster and an increasingly conservative federal judiciary—appears tenacious. Under these conditions, even modest versions of non-reformist reform are likely to fail. Instead, change is likely to emerge at what many scholars might regard as the periphery of formal health policy. One potential site of change is the labor movement. While union density continues to decline, there is evidence of increasing militancy—as indicated by strike activity—particularly within already-unionized sectors, including health care (Maisano, 2022). Whether a stronger labor movement can translate into a consolidated force for change in health policy is a subject worthy of further scholarly attention. So too are efforts to strengthen working-class power within the Democratic Party, through creating locally rooted surrogate organizations that can field candidates, unlock the potential of urban electorates, and provide a mechanism for accountability within Congress (Abbott and Guastella, 2019).

The research agenda we have sketched out here is likely to push scholars of health politics and policy beyond their comfort zones. For research in this area to progress, this is a necessity. Thanks to the several decades of pathbreaking scholarship, we have a reasonably strong understanding of how the tangled web of U.S. health policy reproduces itself. The most important questions focus on the conditions for its reconstruction.

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22. Canada’s health care system: the promises and challenges of a federated system

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INTRODUCTION

Canada is a high-income country, politically organized as a federation of 10 provinces and three sparsely populated territories. While Canada is the second largest country in the world in terms of geographical area, it has a very low population density. In 2023, it reached 40 million inhabitants (Statistics Canada, 2023). Its population is highly unevenly distributed, with 76.6% of the population concentrated within 100 kilometers of the US border, an area that comprises only 4% of its territory (Statistics Canada, 2017a). These geographic and demographic realities constitute one of the many challenges for equitable delivery of health care in Canada.

Canada’s health care system was established in the mid 20th century during the post-World War II period. Its development can be described as incremental, as the establishment of the system that Canadians enjoy today was developed over three decades. Modelled in part on the British Beveridge system, Canada’s health care system stems from the initiative of one province, Saskatchewan, to publicly insure hospital and diagnostic services in the late 1940s. Over time, the other provinces and territories established similar systems. While the delivery of health services falls within provincial and territorial jurisdiction, this roll-out was encouraged, and indeed, incentivized by the financial support of the federal government. In time, the federal government enshrined the principles of a publicly insured, universal health care system into law under the Canada Health Act (CHA) in 1984. Canada’s health care system has changed little in its organization and financing since then.

Canada’s longstanding commitment to the principle of universality does not preclude the system from facing several challenges. A major challenge relates to comprehensiveness of coverage. All provinces and territories, which oversee most of the governance, financing, and delivery of services, abide by the CHA in publicly insuring the “medically necessary” physician and hospital services through a single-payer system and on a first-dollar coverage basis; all other services (which are not specified in the federal law) are publicly covered through a patchwork of provincial and territorial programs for certain populations according to various cost-sharing schemes. Thus, most Canadians must assume additional costs through private insurance schemes, if available, or out-of-pocket payments. This first-dollar coverage of a limited basket of services has earned Canada the reputation of a public system that offers “deep but narrow” coverage (Raza, 2021). This is especially salient for pharmaceuticals; Canada is indeed the only high-income country with a universal health care system that does not include public coverage for pharmaceuticals.

Canada’s health care system also suffers from coordination and accountability issues between levels of government. Due to the nature of federalism and the division of powers related to health care, greater policy authority falls to the provinces and territories on matters related to health care, while the federal government exerts influence through its fiscal powers, regulation, and for some facets of procurement, such as in national vaccination campaigns. These coordination issues and features of decentralization became even more salient during the COVID-19 pandemic.

This country chapter on Canada describes the major features of the health care system relating to its historical development, organization, regulation, and financing. Within this backdrop, we also shed light on implications of these features such as sustainability and inequalities. We furthermore elaborate on ongoing challenges related to coverage for pharmaceuticals, long-term care, and intergovernmental collaboration, all of which have been heightened in the context of the COVID-19 pandemic.

Throughout this chapter, we define Canada's health care system using a singular noun, when, in fact, a plural noun would be more appropriate. This is because, as the chapter presents below, most of the policy prerogatives on matters related to health care – governance, regulation, financing – are under provincial and territorial jurisdiction. However, to be concise, we describe broad and common characteristics across provinces and territories (PT). Where appropriate and pertinent, we highlight differences across PT systems. Finally, adopting a broad strokes approach allows us to characterize more clearly the federal government's role in health care, one which often receives less attention.

IDEAS, INTERESTS, AND INSTITUTIONS

Canada's colonial history is reflected in several institutional features of the health care system. First, as is the case in many other countries that have a history of European colonialism, Indigenous peoples in Canada have suffered from systemic discrimination that persists to this day (Reading, 2018). Second, the waves of colonialism, first by the French and then by the British, have also left their imprint on many institutions: while the current Canadian political system is based on the Westminster model, a French legacy is still evident in the province of Québec. This legacy shapes not only ideas but also institutions, with perhaps the most striking difference being that, in Québec, the legal system is based on the Napoleonic Civil Code, while a British Common Law system prevails in the rest of Canada. The tensions that arise from these co-existing traditions in the same federation often shape the dynamics of policy reforms in Canada. Indeed, a third important institutional feature of Canada is its federal structure. This federal structure has enabled the co-existence of heterogenous subpopulations, marked by the aforementioned waves of colonialism, and, later, of immigration. For instance, this structure ostensibly facilitated the persistence of a francophone majority population in Québec alongside majority anglophone provinces (except for New Brunswick, the only bilingual province). These institutional tensions between a federal centralizing power and claims to provincial autonomy (arising notably from longstanding cultural differences or ideas) have left profound marks on the organization of health care in Canada.

The division of powers between levels of government – the provinces/territories and the federal government – regarding health care can be traced back to confederation in the late 19th century. Canada took a first formal step towards independence from British rule in 1867, as four independent colonies formed a federation under the British North America (BNA) Act of 1867, today known as the Constitution Act of 1867. The BNA laid out the division of powers between the federal government and the provinces (formerly colonies). Though it was not expected that they would carry implications for health care in contemporary times, two sections are noteworthy. Section 92 of the BNA outlines exclusive powers to the provinces. The subsection stating that "the Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals", makes hospital care a provincial responsibility and implies that other types of medical care are within the purview of the provinces and territories.

Section 91 of the BNA outlines the federal powers. Though not clearly laid out, certain passages are of interest for health care. For example, federal fiscal and residual powers, namely under the principle of "peace, order and good governance" (or POGG), allow for federal influence on matters related to health care. On the one hand, fiscal spending powers allow the federal government to transfer funds to the provinces and territories to support service delivery. This federal power is fully embedded in the Canada Health Act (1984) and the conditional federal transfers for health care defined below. On the other, under the principles of POGG, the federal government can intervene in times of national emergencies. These two sections became particularly salient in the context of the COVID-19 pandemic as described below. Section 91 also outlines how the federal government is responsible for providing health care for particular groups, namely Indigenous peoples, veterans and inmates.

Given this legislative framework, it is therefore not surprising that Canada's health care system stems from a provincial initiative. In the early 20th century, health care was primarily paid out-of-pocket by individual users. Some charitable entities and faith-based hospitals also provided care to vulnerable populations and operated on a per diem reimbursement from provincial governments (Maioni, 2015). In 1947, concerned with access to care and indebtment, Saskatchewan premier Tommy Douglas implemented the country's first universal hospital services plan. Influenced by the British Beveridge model of general taxation to support public funding for health services, the program forestalled the development of parallel private hospital insurance. With federal support through national health grants, the model was incrementally adopted by other provinces, such as British Columbia (1949), Alberta (1950) and Ontario (1955). Public coverage for hospital insurance was enshrined in federal law under the Hospital and Diagnostics Services Act (HIDS) of 1957, which offered provinces 50–50 cost-sharing if they followed a set of national standards; by 1961, all provinces were participating (Naylor et al., 2020).

With public funding for hospitals secured, a policy window for expanding public coverage to physician services opened. The initiative stemmed again from Saskatchewan in 1962. Contrary to the proposal to publicly insure hospitals, this proposal was met with fierce opposition from physicians, who feared losing income and independence in practice with government oversight. This culminated in a 23-day physician strike in Saskatchewan, which was resolved with the signing of the Saskatoon Agreement of 1962. This agreement stipulated that, physicians would remain self-employed professionals retaining contractual autonomy from the province and that they would be remunerated on a fee-for-service basis by billing the province for their services. The pressure from the interests of physicians would indeed foreshadow decades of negotiations between provincial and territorial governments and physicians that persist to this day, what Tuohy describes as Canada's "collegial" approach to decision-making on matters related to health care (Tuohy, 1999). Following the Hall Commission in 1964, the federal government recommended all provinces and territories follow the Saskatchewan model to expand existing public hospital insurance by including public insurance for physician services. This led to the Medical Care Act (1966), which again offered provinces 50–50 cost-sharing if they extended public coverage to physician services; by 1972, all provinces were participating.

In the 1970s and early 1980s, Canada suffered, as many other high-income countries did, from severe inflationary pressures coupled with high unemployment rates. This fiscal pressure did not spare health services, which occupied increasing shares of provincial budgets. In parallel, the federal government was gradually rescinding its initial 50–50 cost-sharing agreement, leading provinces to bear an ever-increasing share of a rising health care budget. This, in turn, led to cuts in services, increasing differentiation between provincial health systems, and a creeping reliance on unregulated user fees. Meanwhile, on the global scene, in the early 1980s, Canada sought to further its independence from the UK, and embarked on a repatriation endeavor which was formalized in 1982 with the creation of the Canadian Charter of Rights and Freedoms. Furthermore, within this repatriation agenda, there was a desire to formalize features of the Canadian identity, which included universal health care (Boychuk, 2008). Concretely, the Canadian federal government demonstrated global leadership in its political support for health promotion principles on several occasions over the 1970s and 1980s: in 1974, with the publication of *A New Perspective on the Health of Canadians* (Lalonde, 1974), widely recognized as one of the first political acknowledgements that governments' responsibilities towards their populations' health reaches beyond the provision of health care, and again in 1986 with the *Ottawa Charter*, which established the foundation for the health promotion movement (Tulchinsky, 2018).

It is notably within this context of the tension between the national challenge of interprovincial variations in access and equity and Canada's public adhesion to global welfare principles that we can understand the establishment in 1984 of the Canada Health Act (CHA), which enshrined in law the framework for Canada's current universal health care system. Specifically, five principles were articulated, which represented the criteria and conditions that all provincial and territorial health plans had to abide by to receive the federal transfers for health care. The five principles of the CHA are still in force today. "Public administration" implies that the provinces and territories must provide health services to their residents on a not-for-profit basis. This principle reinforces these jurisdictions' accountability in providing health care. "Comprehensiveness" implies that the aforementioned publicly insured services relate to "medically necessary" physician and hospital services. "Universalism" implies that provinces and territories must ensure that all "medically necessary" services are available to all residents. "Portability" implies that publicly insured services are available to all Canadians across Canada, regardless of the province or territory that they are in. And finally, "accessibility" implies notably that there are no additional charges (user fees) or over billing for publicly insured services. This last provision has perhaps been the most impactful in leading the Canadian provincial health systems to legislate against the private insurance and funding of health care, notably by banning the dual practice of physicians in both public and private sectors for publicly-funded Medicare services (Flood and Archibald, 2001; Hurley and Guindon, 2020).

The 1990s represented the apex of severe cutbacks in health care spending in Canada, felt across the country. As previously mentioned, as the federal government slowly rescinded the 50–50 cost sharing agreements with provinces and territories, it established in its place, in the 1990s, the Canada Health and Social Transfers (CHST). The CHST represented a system of block transfer payments to the provinces and territories for health and other social services falling under the purview of provinces and territories, such as education. These transfers proved to be unsustainable over time due to the impacts of cutbacks in health care and growing needs. The CHST system was replaced in 2004 with the Canada Health Transfers (CHT) under the new Health Accords.

The conditionality of federal health transfers is described in the Canada Health Act, and the CHT contrasts with equalization payments in Canada, which are unconditional federal transfers to provinces. This implies that to receive federal funds, provinces and territories must abide to the principles outlined in the CHA and spend the funds in accordance with the priorities set out by the federal government. Flood and Thomas argue that the federal government's decision to adopt a conditional approach, first observed in the CHA, was based on a series of compromises to ensure buy-in and embed accountability structures. Specifically, the federal government aimed to appease numerous interests, such as those of physicians who wanted to remain independent from government interventions, as well as those of provinces and territories who wanted to maintain their prerogative on matters under their legislative purview (Flood and Thomas, 2016).

In more recent times, the principles of the CHA have increasingly been criticized for being unable to respond to contemporary population health needs and accountability challenges. First, there are concerns with regards to the scope of public coverage. As it is limited to hospitals and physicians, there are increasing demands for public coverage for long-term care, pharmaceuticals, preventative and restorative dental care, and mental health services. Canada's notion of "medically necessary" is indeed comparatively limited. Compared to OECD peer countries with universal health care systems, Canada has a relatively limited scope of services, the major limitation being the exclusion of pharmaceuticals. There are also increasing demands on behalf of the population to publicly insure other services such as dental and mental health services. As such, the argument for increased coverage stems from both the expectation of what is "universality" for health care (i.e., drawing on SDG goals) as well as contemporary needs and public opinion (e.g., new technologies, aging population, deinstitutionalized care, mental health).

The CHA also increasingly faces accountability challenges. Such challenges include a lack of mechanisms to monitor how provinces and territories are delivering services and their quality. Indeed, Canada's approach contrasts with other OECD countries with clear audit systems (e.g., the US Medicaid program). But most importantly, a major challenge relates to the increasingly weak accountability that provinces and territories feel towards the conditionality of the federal funds. This is largely because federal transfers represent a shrinking component of a provincial/territorial budget. However, subsequent federal administrations have sought to use their spending powers embedded in CHT to shape provincial and territorial health systems beyond the basic principles set by the CHA, which we discuss in the next section. These accountability issues were further highlighted in the context of the COVID-19 pandemic where provincial and territorial relief efforts vary significantly across the country (e.g., vaccination campaigns, testing and broader public health rules such as masking and lengths of lockdowns).

This brief history highlights how, even though the provision of health services remains under the purview of provincial and territorial governments, the federal government has played an important role in shaping the health care systems of this country, through its legislative and fiscal roles. The federal government has indeed mobilized the spending powers described in the Constitution Act (1867) to provide the impetus for the universal hospital, and, later, physician insurance systems that have been rolled out across the country and constitute one of the hallmarks of Canadian identity. The CHA, and the conditionality of the federal health transfers it established, is in clear alignment with this institutional legacy, though there are ongoing concerns.

AGENDA SETTING, POLICY FORMULATION, IMPLEMENTATION, AND EVALUATION

As presented in the previous section, the current state of the Canadian health care system reflects a persistent institutional legacy owing to the country's federated structure and associated division of powers between jurisdictions. This institutional legacy is still playing an important role in the agenda setting, led by the federal government. Indeed, most of its policy actions in recent decades (since the early 2000s) have reflected tensions between a tendency towards federal interventionism (often resisted by many provinces on the grounds that it oversteps federal constitutional powers) and laissez-faire (driven by a staunchly fiscally-conservative political agenda that also bore the looming threat of further disinvestments).

The motivation for interventionism arises periodically out of the concern that the Canada Health Transfer framework offers very little oversight for, and recognition of, the role of federal dollars in provincial health spending. For instance, in 2004, Prime Minister Paul Martin convened the provinces a ten-year Health Accord to reduce wait times, an issue widely recognized as a persistent "wicked problem" in the Canadian system (Martin et al., 2018). This was achieved notably by increasing the CHT by 6% annually. However, under Prime Minister Stephen Harper's subsequent leadership (2006–2015), the federal government let the Health Accord expire in 2014. While this ostensibly afforded the provinces more freedom to set their priorities, the federal government also warned provinces that, as of 2017, the 6% annual rate of increase in the CHT previously conceded would be reduced to 3% (Martin et al., 2018). When the Trudeau government took power in 2015, they surprised many by both maintaining this de-escalation policy and eschewing a pan-Canadian health accord; instead, they used the financial leverage it created to establish bilateral agreements with the provinces in pursuit of federal health funding priorities (mental health and home care in 2016–2017; long-term care in 2021).

Despite this important power to spend, implementation has at times been slowed down or even stymied due to federal-PT dynamics: bilateral agreements have in some cases severely slowed down the process of implementation, as with the mental health and home care investments, which took almost two years to rally all provinces. In addition, the *Canadian Charter of Rights and Freedoms* has also been invoked by citizens and other interest groups on several occasions to seek changes to the health system, sometimes in the direction of a broader basket of publicly insured services (e.g. for children on the autism spectrum disorder or for medical assistance in dying, which we describe in further details later in this chapter) and in other instances, to challenge provincial laws that curtail the private health insurance and care market (Manfredi and Maioni, 2018).

GOVERNANCE AND REGULATION

Because of the constitutional division of powers, much of the governance and regulation of the Canadian health systems is primarily under the jurisdiction of the provinces. Space constraints prevent a deeper investigation of each jurisdiction's approach to these issues (because there are significant differences between provinces and territories). For instance, Hutchison and colleagues reviewed the primary care innovations adopted by the Canadian provinces in response to federal funding and uncovered significant variation in not only the timing, but the nature of the reforms implemented (e.g., not all provinces established primary care teams, and when they did, the roll-out in various provinces took the better part of a decade) (Hutchison et al., 2011). Nevertheless, one trend worth noting is the seemingly perennial pendulum swing among Canadian provinces, between regionalization and the centralization of services, perhaps owing to the challenge of delivering services to a small population spread over a large territory (which maybe inevitably leads to unmet needs attributed to the current governance model).

The term "collaborative federalism" has increasingly been used to describe intergovernmental relations on matters related to health care in Canada. Collaborative federalism implies co-determination of national policies and cooperation in governance strategies between levels of government, either between federal and subnational (provincial, territorial) jurisdictions, or between subnational jurisdictions (Cameron and Simeon, 2002). Canada's health care system counts a dense network of intergovernmental and intra-provincial/territorial collaborations – agencies, councils, committees – which are examples of collaborative federalism. The federal government indeed funds a number of "pan-Canadian health organizations" (or PCHOs), which include the Canadian Institute for Health Information (CIHI), the Canadian Agency for Drugs and Technologies in Health (CADTH), the Canadian Health Infoway, and the Mental Health Commission of Canada (MHCC). Further details on these and other PCHOs are summarized by Marchildon and colleagues (Marchildon et al., 2020). The Council of the Federation is an example of an intra-provincial/territorial organization which gathers the 13 premiers of the provinces and territories. Beyond health care provision, the federal government plays an important role in regulation on the pharmaceutical front, through Health Canada, which approves drugs and prescribed uses. Since 1987, the Patent Medicine Prices Review Board (PMPRB) regulates the price at which pharmaceuticals manufacturers can sell to hospitals, pharmacies and other wholesalers of patented drugs.

FINANCING

Health care represents a massive fiscal undertaking for all high-income countries, and Canada is no exception. In 2021, Canada allocated \$308 billion (CAD) towards health care, representing \$8,018 per capita (see Table 22.1). Health care spending represented 12.7% of the country's GDP in 2021, a share which has in fact been steadily growing over time. Health care in Canada is financed by both private and public revenue. About 70% of total health care revenue comes from public sources (i.e., primarily general taxation), while the remaining 30% is from private sources (e.g., private insurance, out-of-pocket payments). This "70–30 split" has been stable since 2000. At the subnational level, provincial and territorial governments allocate about 37% of their budgets to health care (Canadian average).

Table 22.1 Summary of health care spending in Canada, 2000–2021 (CAD$)

Expenditure	2000	2005	2010	2015	2018	2019	2020^{f}	2021^{f}
Total health expenditure (in millions)	98,609.9	140,489.5	192,956.0	228,095.8	255,913.1	267,215.6	301,454.8	308,043.3
Total health expenditure (in millions), 1997 dollars	91,035.0	114,160.9	137,580.0	148,241.5	162,505.5	165,289.9	177,972.0	180,029.3
Total per capita spending	3,213.54	4,357.11	5,674.36	6,388.72	6,904.41	7,108.05	7,931.93	8,018.54
Public per capita spending	2,257.59	3,048.23	4,000.13	4,528.14	4,844.21	4,985.65	5,953.03	5,987.16
Private per capita spending	955.95	1,308.88	1,674.23	1,860.58	2,060.20	2,122.40	1,978.89	2,031.38
Total expenditure as % of GDP	8.9	9.9	11.6	11.5	11.5	11.6	13.7	12.7
Public expenditure on health as % of total health expenditure	70.3	70.0	70.5	70.9	70.2	70.1	75.1	74.7
Private expenditure on health as % of total health expenditure	29.7	30.0	29.5	29.1	29.8	29.9	24.9	25.3
P/T government public expenditure on health (in millions)*	63,672.2	90,388.6	125,868.3	150,197.0	165,879.2	172,912.0	196,699.1	202,091.7
P/T government expenditure on health as % of general government expenditure *	35.9	38.9	36.2	37.6	36.5	36.7	—	—

^{f} Forecasted estimates.
* Total provincial/territorial government programs correspond to total provincial/territorial expenditures less debt charges.
Notes: All estimates are reported in calendar year; CIHI applies a fiscal year conversion methodology. CIHI reports provincial/territorial government spending with the inclusion of federal transfers (CHT) and less debt charges (Canadian Institute for Health Information, 2021b). Unless otherwise indicated, all estimates are in current dollars.
Source: B and D series from CIHI's National Health Expenditures Trends (Canadian Institute for Health Information, 2021).

Canada's allocations to various sectors of the health care system have been relatively stable over time. Table 22.2 shows that in 2021, hospitals, physicians and drugs received the largest shares of total health care spending (23.1%, 12.3% and 13.0%, respectively). Table 22.2 also breaks down each sector's allocation by private and public sources. Physicians and hospitals are largely funded through public funds (98.0% and 91.5%, respectively), whereas 100% of public health funding comes from public funds. Drugs are largely financed by private sources (37.5% from public sources and 62.5% from private sources, the latter composed of out-of-pocket payments and supplementary private health insurance), which highlights the quasi-universal nature of Canada's health care system that excludes most outpatient drugs from the public purview.

Canada's health care system is financed through various financial flows. General taxation through direct and indirect taxation is collected by the provinces and the federal government and directed towards consolidated funds. Revenue from general taxation covers all publicly-funded health services. Private health insurance and out-of-pocket payments are supplemental or complementary to cover the costs of services falling outside of the purview of the CHA (e.g., dental care, pharmaceuticals). Private revenue is from two sources: out-of-pocket

Table 22.2 Health care spending by use of funds, 2021 (current dollars)

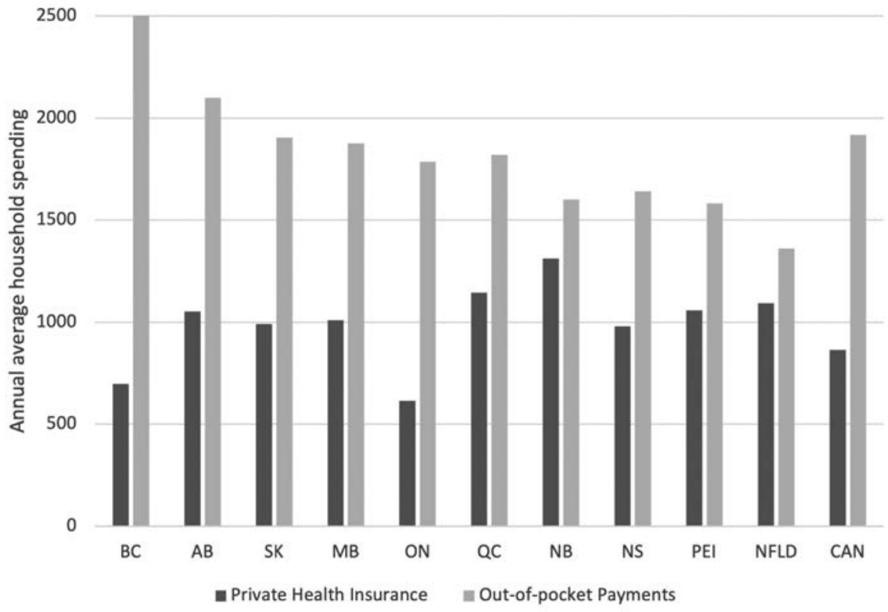
Funds	Per capita spending	Total allocation (in millions)	Share of total health expenditure (%)	Share of allocation from public sources (%)	Share of allocation from private source (%)
Hospitals	1,993.96	76,592.1	23.1	91.5	8.6
Other Institutions	1,010.66	38,634.2	11.7	64.6	36.3
Physicians	1,060.64	40,544.6	12.3	98.0	1.9
Other Professionals	839.75	32,100.7	9.7	11.5	87.6
Drugs	1,123.68	42,954.4	13.0	37.5	62.5
Capital	287.97	11,008.2	3.3	84.1	17.1
Public Health	431.53	16,495.9	5.0	100.0	—
Administration	232.84	8,900.7	2.7	36.8	61.9
Other Health Spending	700.48	26,776.9	8.1	84.1	15.5
Total	8,616.75	329,388.3	100.0	73.3	25.9

Source: C series from CIHI's National Health Expenditures Trends (Canadian Institute for Health Information, 2021).

payments and private insurance, the latter most often being employer-based. Though excluded from the basket of publicly insured services, all provinces and territories also have established public programs for drugs for deemed vulnerable groups, such as children and low-income individuals, but these programs vary widely across jurisdictions in terms of deductibles and eligibility criteria (Campbell et al., 2017). With the exception of Québec, provinces do not impose a mandate on the minimum coverage from private insurance schemes, thus leading to sometimes significant and certainly inequitable contributions from out-of-pocket spending across the country (Campbell et al., 2017; Sorin et al., 2019). Figure 22.1 shows that household private spending on health care is higher, on average, on out-of-pocket spending compared to private insurance.

The "Non-insured health benefits" (NHIB) program, financed and administered by the federal government, covers a range of health services (e.g., pharmaceuticals, dental, health professional services) that fall outside of the basket of provincial and territorial publicly-insured services for Indigenous people who are registered under the terms of the Indian Act. The term "status Indian" and "registered Indian" are legal terms used by the federal government under the Indian Act (Marchildon et al., 2020). Indigenous peoples in Canada include three distinct groups: First Nations, Inuit, and Métis. Currently, only registered First Nations and Inuit peoples are eligible under the NHIB. Provinces and territories provide insurance schemes for all three groups, but there is a significant degree of heterogeneity across jurisdictions (Lavoie, 2013).

Physicians are primarily paid by public funds on a fee-for-service (FFS) basis by billing a provincial reimbursement agency (Figure 22.2). With the notable exception of Nova Scotia (43.4%), FFS remains the most common form of clinical payment, ranging from 61.2% in Saskatchewan to 87.5% in Alberta. FFS is often viewed as a more lucrative reimbursement model for physicians because payments are based on volume, compared to alternative clinical payment schemes such as capitation and salaried models. As a result, physicians in Canada receive comparatively higher annual clinical payments; indeed, the remuneration levels presented in Figure 22.3 would put physicians in the top 1% of all Canadian earners (for which the threshold value was CAD$244,800 in 2018) (Government of Canada, 2012a).

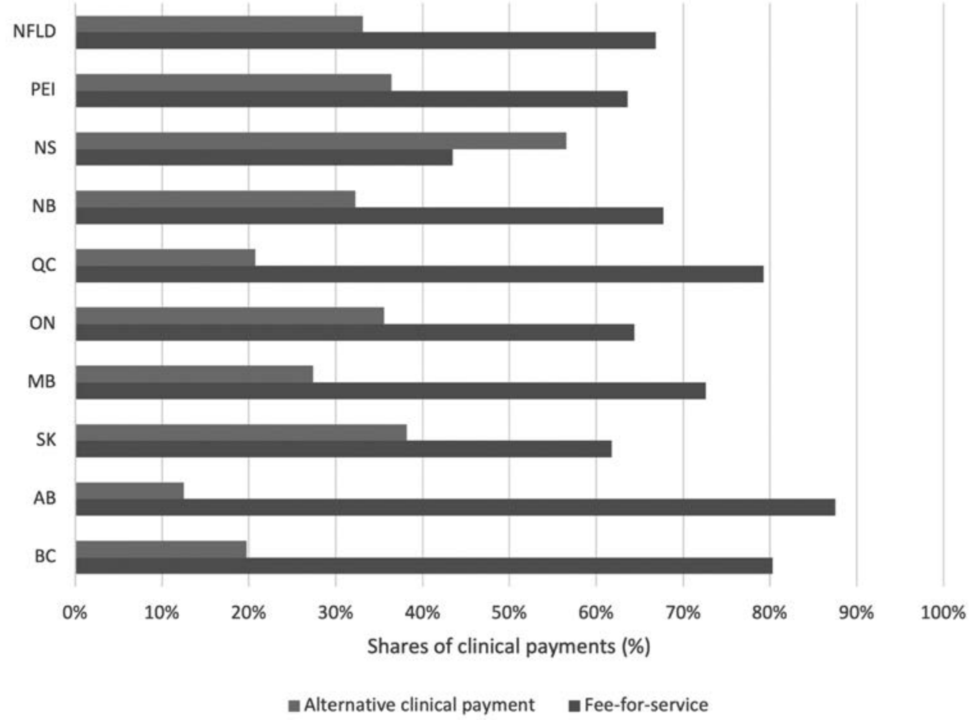


Source: Household spending, Canada, regions and provinces (Table: 11-10-0222-01 (formerly CANSIM 203-0021)) (Government of Canada, 2012b).

Figure 22.1 Annual average household spending on health care by private sources, 2019

The story is different when examining clinical payments between specialists and family physicians (general practitioners) across provinces. Figure 22.4 shows exceptions to the broad trends previously presented. In particular, Ontario (followed closely by Nova Scotia) has a relatively lower share of total clinical payments from FFS for family doctors at about 44%. Ontario has indeed been active to shift physician reimbursements from the FFS model to capitation, which now makes up more than 50% of their remuneration (Marchildon and Hutchison, 2016).

Hospitals in Canada are predominantly publicly-funded through global budgets. Global budgets for hospitals are determined by: 1) historical spending (i.e., how much hospitals have previously received, with adjustments for inflation), 2) population growth (i.e., how many people the hospital is serving), or 3) a combination of both (Hébert et al., 2017). The global budget approach has been criticized for being outdated and incapable of accounting for the financial needs of hospitals. Since 1995, there has been a series of hospital payment reforms in Canada, specifically towards activity-based funding (ABF). Under the ABF logic, the more specialized services provided, the more funds a hospital receives. It is also viewed as a mechanism to improve hospital performance, notably on wait times: if hospitals have an incentive to increase activities, they might innovate their practices to attain a greater efficiency. In general, the activities completed are based on Diagnostic Related Groups (DRGs) codes. Ontario, the only province in which a majority of hospitals are not owned and managed by provincial governments or their agencies, stands out as the province with the most experience in ABF models, applying and iterating ABF models since 2001 using DRGs (Hébert et al.,



Notes: FFS: fee-for-service; ACP: alternative clinical payments. Alternative clinical payments include salaries.
Source: National Physician Database – Payments data (Canadian Institute for Health Information, 2020b).

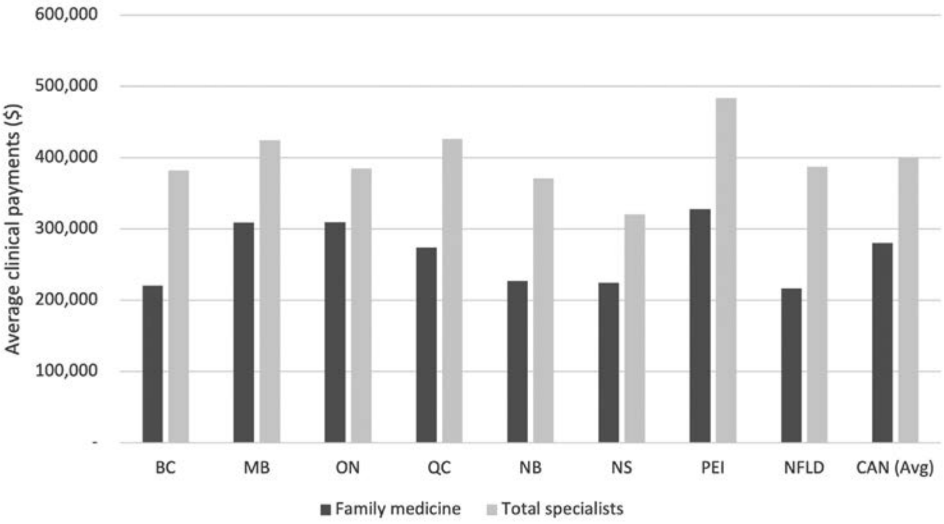
Figure 22.2 Shares of clinical payment types to all physicians, by province 2018–19

2017). Other provinces are slowly also transitioning towards ABF models, thus suggesting the structure's diffusion. In 2010, 23 of British Columbia's largest hospitals had fully transitioned to a form of ABF using DRGs and Alberta had started a transition towards ABF for long-term care facilities.

Finally, although Canada has historically been an important catalyst in the health promotion movement on the international stage, public health investments maintain a relatively low profile in provincial and territorial health care budgets. In fact, although the OECD ranks Canada as the top spender in preventive spending (public health), significant differences between provinces in terms of allocations and growth over time are observable (Ammi et al., 2021).

HEALTH CARE DELIVERY

As mentioned above, provision of health services in Canada has been defined as coverage that is "deep but narrow" (Marchildon et al., 2020): "deep", because the coverage is very comprehensive for services that are publicly insured. This idea is illustrated by public,

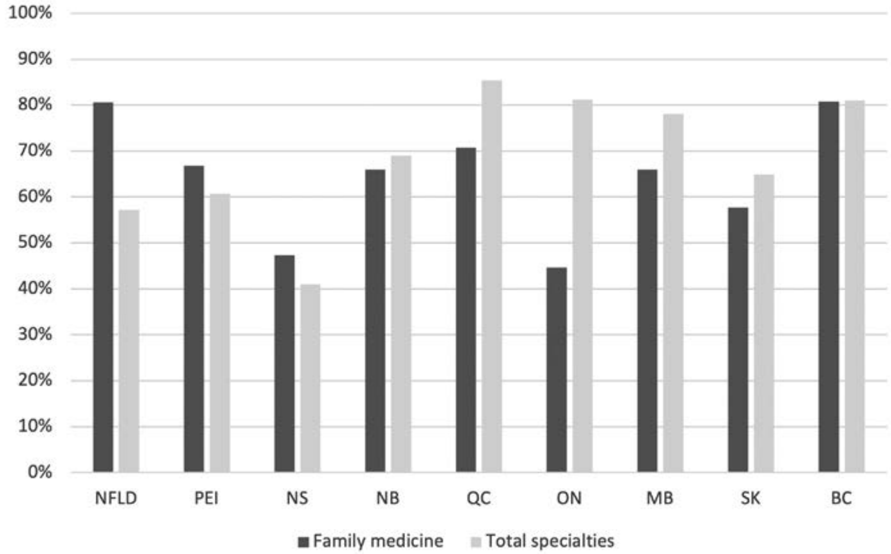


Note: Data are unavailable for Saskatchewan and Alberta in 2018/19.
Source: National Physician Database – Payments data (Canadian Institute for Health Information, 2020b).

Figure 22.3 Average clinical payments to family physicians and specialists, by province 2018/19

first-dollar coverage of all physician services and of all pharmaceuticals and therapeutic treatments within hospitals. Yet, this coverage is also deemed "narrow" because the basket itself of publicly-covered services mandated by the Canada Health Act is less comprehensive than that of other OECD countries with universal health care systems. This means that other essential health services such as preventative and restorative dental care, mental health services, long-term care, and outpatient pharmaceuticals are not included in the public coverage. This implies significant inequalities in access to care for these services, a situation to which provinces and territories have tried to remedy with residual programs to offset costs for disadvantaged groups (Campbell et al., 2017).

Across all provinces and territories, primary care represents the first point of entry into the health care system. Primary care in Canada involves general medical care for common conditions, regular management of chronic conditions and health promotion activities at the individual level. Primary care exerts a gatekeeper function towards other services through referral and prescriptions. These services, commonly provided by family doctors (general practitioners, GPs), are all publicly insured under the CHA. However, the delivery models can vary across Canada. While most physicians still work as independent workers paid on a FFS basis, team-based models are increasingly common, thanks to the financial impetus provided by the federal government in the early 2000s. For example, in Québec, "family medicine groups" were established in 2002 to bring primary care physicians into team-based practices, along with other health professionals (e.g., primarily nurses, but sometimes also pharmacists, or other health professionals) (Hutchison et al., 2011). Finally, in the Northwest Territories and Nunavut, the majority of remote northern communities receive primary care services



Note: Data are unavailable for Saskatchewan in 2018/19.
Source: National Physician Database – Payments data (Canadian Institute for Health Information, 2020b).

Figure 22.4 Shares of fee-for-service payments to family medicine and specialties, by province 2018–19

through nurse-led community health centres (CHCs) with occasional physician fly-out visits (Peckham et al., 2018). Access to primary care remains a major challenge across Canada, leading many to rely on walk-in clinic or emergency department care. Provinces and territories have tried to address this problem using legislation to expand the scope of practice of other health care professionals to deliver primary care, and have the same referral and prescribing power, such as midwives, nurse practitioners, physician assistants and pharmacists (Carter and Quesnel-Vallée, 2014).

Acute care is largely delivered in hospitals. Most hospitals in Canada are private and not-for-profit. Table 22.3 shows that the top reasons for hospital inpatient stays in Canada for 2021–2022 were for births, COVID-19 and heart failure. Despite the high volume, the lengths of hospital stays vary and may be relatively short. Surgeries are also predominantly conducted in hospital, with specialized ambulatory services (such as elective surgeries) generally provided in the outpatient departments of hospitals. Table 22.4 shows that the top surgical procedures are caesareans, as well as fractures and hip replacements. Over the past decades, some provinces have experimented with subcontracting for-profit private medical centers to provide select elective surgeries (Allin et al., 2020).

Table 22.3 Number, percentage and average acute length of stay for top-ten high-volume inpatient hospitalizations, Canada

	Most responsible diagnosis for inpatient hospitalizations in 2021–2022	Number of inpatient hospitalizations in 2021–2022	Percentage* of inpatient hospitalizations in 2021–2022 (%)	Average acute† length of stay of inpatient hospitalizations in 2021–2022 (days)
1	Giving birth	355,337	12.3	2.1
2	COVID-19	77,344	2.7	10.1
3	Heart failure	67,972	2.4	9.2
4	Acute myocardial infarction	66,078	2.3	4.9
5	Substance use disorders	53,496	1.9	5.4
6	Other medical care (e.g., palliative care, chemotherapy)	51,860	1.8	8.7
7	COPD and bronchitis	51,436	1.8	7.1
8	Neurocognitive disorders	48,582	1.7	16.3
9	Mood (affective) disorders	48,376	1.7	12.6
10	Osteoarthritis of the knee	46,844	1.6	2.4

* Percentage is calculated using all acute inpatient hospitalizations in the Hospital Morbidity Database and Ontario Mental Health Reporting System in 2021–2022, within the province/territory.

† Includes the acute portion of length of stay.

Source: Canadian Institute for Health Information. *Inpatient Hospitalization, Surgery and Newborn Statistics, 2021–2022*. Ottawa, ON: CIHI; 2020 (Canadian Institute for Health Information, 2020a).

Table 22.4 Number, percentage, and average acute length of stay for top-ten high-volume inpatient surgeries, Canada

	Surgical interventions in 2021–2022	Percentage* of inpatient surgeries in 2021–2022 (%)	Average acute† length of stay of inpatient surgeries in 2021–2022 (days)
1	Caesarean section delivery	8.3	2.7
2	Fractures	3.9	10.2
3	Hip replacement surgery	3.8	6.3
4	Knee replacement surgery	3.8	2.8
5	Removal of appendix	2.8	2.6
6	Coronary artery angioplasty	2.8	4.8
7	Removal of gallbladder	2.4	4.1
8	Hysterectomy	2.1	2.2
9	Pacemaker insertion	1.7	8.5
10	Colectomy	1.5	11.6

* Percentage is calculated using all acute inpatient hospitalizations in the Hospital Morbidity Database and Ontario Mental Health Reporting System in 2021–2022 within the province/territory.

† Includes the acute portion of length of stay.

Source: Canadian Institute for Health Information. *Inpatient Hospitalization, Surgery and Newborn Statistics, 2021–2022*. Ottawa, ON: CIHI; 2020 (Canadian Institute for Health Information, 2020a).

HEALTH CARE REFORMS

The previous sections presented how the Canadian federal government has steered the direction of its provincial and territorial health systems through Health Accords and bilateral agreements with targeted and conditional spending. Here, we will discuss reforms that have been enabled by strong federal leadership (e.g. medical assistance in dying (MAiD) legislation), or that require such attention (e.g., pharmacare and long-term care).

MAID

In February 2015, the Supreme Court of Canada ruled that the Criminal Code infringed upon the rights and freedoms of individuals seeking medical assistance in dying (Canada, 2016). It ruled that euthanasia for medical purposes would no longer be considered a criminal offense if conducted by a physician under carefully prescribed criteria. In 2016, the Parliament of Canada passed federal legislation that allowed eligible adult Canadians to receive medical aid in dying (MAID). Québec had already legislated medical aid in dying six months prior to the Supreme Court of Canada ruling, although at the time, Québec chose not to characterize this as euthanasia in order to avoid friction with the Criminal Code (Dyer, 2014). After the 2016 ruling, all provinces were obliged to abide to the eligibility requirements outlined in the legislation and the amendment to the Criminal Code. Since then, numerous interest groups and court cases at various legal levels have argued that the MAID policy, as it stands, is too stringent, particularly on the definition of "reasonable foreseeability of natural death"; this is a developing issue that will undoubtedly continue to evolve in the coming years.

Public Financing for Prescription Drugs (Pharmacare)

Canada is the only OECD country with a universal health care system without publicly insured outpatient prescription drugs. Although plans for national pharmaceutical programs have continued to be found on national party platforms in recent years, no concrete policy actions have been made. Pharmaceutical coverage therefore relies heavily on private insurance (i.e., employer-based) or out-of-pocket spending. However, as mentioned above, each province and territory has devised remedial programs to support individuals who do not have private insurance (Campbell et al., 2017). One major exception is Québec, where a public insurance scheme was established in 1997. The *Loi sur l'assurance medicaments* effectively mandated all Quebecers to have drug insurance, either through a private insurer if available through their employer, or if ineligible for private insurance (e.g., low-wage worker, unemployed, retired person), through the public program. In this regard, the plan follows a "private first" approach. The public program is made up of a mix of public premiums, co-insurance and deductibles. In fiscal year 2018–19, 3.7 million Quebecers were registered in the public drug program (RAMQ, n.d.). Since the establishment of the program, access to pharmaceuticals have increased for certain groups, such as the working population and children (Wang et al., 2015). However financial burdens remain for some groups, namely those on social assistance, largely due to the high out-of-pocket payments and deductibles. Concerns around the program's implications for financial equity also remain (Morgan et al., 2017).

Long-term Care

Long-term care (LTC) is care provision for adults with activity limitations in their daily living arising from a health condition or frailty (old age). Long-term care models vary greatly across Canada and were struck hardest in the first wave of the COVID-19 pandemic, particularly in the most populous provinces (see below section on the COVID-19 pandemic). Long-term care is not a publicly insured service under the Canada Health Act, so similar to drugs and other services, provinces and territories have developed different models, policies, subsidies and programs. Access is often means-tested and the level of additional co-payments are income-based. Long-term care is predominantly facility-based or in the community through home care. Privately funded LTC facilities also exist but account for a small segment of the sector. Ownership of LTC facilities is mixed between public and privately owned, with variations across provinces. This has created quality and accountability issues, which were exacerbated during the COVID-19 pandemic. Ostensibly, because of the tragic situation in LTC facilities in Québec and Ontario during the first wave of the pandemic in March 2020, the federal government made the establishment of national standards in quality care in these facilities a priority in its 2022 budget (as described in a subsequent section).

Expanding Scope of Practice

Wait times for both specialist and family physician consultations represent a perennial policy challenge in Canada. Comparatively, Canada has fewer physicians per 1,000 inhabitants: in 2020, the top performers were Norway (5.1 physicians per 1,000 inhabitants) and Austria (5.4 physicians per 1000 inhabitants), Canada was in the lower mid-range of the OECD countries at 2.8 physicians per 1000 inhabitants (OECD, 2022). To remedy wait time challenges in primary care, many reforms have been introduced to expand the scope of practice of allied health professionals since the early 2000s. Such expansions imply enabling allied health professionals to assess, prescribe and even diagnose. For example, although to a varied extent across provinces and territories, pharmacists can increasingly renew, refuse to fill, adjust or substitute prescriptions for preexisting or common minor conditions (Tannenbaum and Tsuyuki, 2013). This allows individuals to curtail wait times to see a physician. Nurses are also increasingly expanding their scope of practice, which also complements the increased professionalization of the nursing work force. However, challenges impose a slow and uneven roll-out across the country, including the reluctance of physicians to forgo their prescribing autonomy and the loss of revenue it may imply in a FFS model, coupled with a lack of comparable payment schemes for allied health professionals who perform the same tasks as physicians.

Health and Health Care Inequalities

In 2019, 61.2% and 67.1% of Canada's population aged 12 years and older reported excellent or very good general health and mental health, respectively (Government of Canada, 2017). Broader demographic trends show that life expectancy at birth stood at 80 years for men and 84 years for women, both of which have been steadily increasing over time (Government of Canada, 2020b). Mortality rates have been declining over time, although the COVID-19 pandemic has contributed to a rise in the avoidable mortality rates. That being said, a steady decline was observed between 2015 and 2019, with 2021 marking an increase for both men

Table 22.5 Population health trends in Canada from 2015–2021, two-year intervals

	2015	2017	2019	2021	OECD (2021)
Life expectancy	81.9	81.9	82.1	82.1	80.3
Male	79.8	79.9	80.0	80.0	77.6
Female	83.9	84.0	84.2	84.2	83
Infant mortality	4.5	4.5	4.4.	4.3	4.0
Avoidable mortality (total)	199.2	195.2	190.2	204.0	237
Male	245.5	242.9	238.3	260.8	-
Female	154.2	148.8	143.5	148.9	-

Notes: Life expectancy is measured at birth and in years. Infant mortality is based on 1000 live births. According to Statistics Canada, premature mortality refers to deaths of individuals who are younger than age 75. The mortality rate is age-standardized and calculated per 100,000 population. OECD average is for 2019.
Sources: Statistics Canada. https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310074401, https://www.oecd-ilibrary.org/docserver/7a7afb35-en.pdf?expires=1702931580&id=id&accname=guest&checksum=C257C35E8040DF9CBBAFF24F52493686

Table 22.6 Causes of death in Canada, 2022

Causes of death	Rank	Number	%	Age-standardized rate*
Malignant neoplasms [C00-C97]	1	82,412	24.7	211.7
Diseases of heart [I00-I09, I11, I13, I20-I51]	2	57,357	17.2	147.3
COVID-19 [U07.1, U07.2, U10.9]	3	19,716	5.9	50.6
Accidents (unintentional injuries) [V01-X59, Y85-Y86]	4	18,365	5.5	47.2
Cerebrovascular diseases [I60-I69]	5	13,915	4.2	35.7
Chronic lower respiratory diseases [J40-J47]	6	12,462	3.7	32
Diabetes mellitus [E10-E14]	7	7,557	2.3	19.4
Influenza and pneumonia [J09-J18]	8	5,985	1.8	15.4
Alzheimer's disease [G30]	9	5,413	1.6	13.9
Chronic liver disease and cirrhosis [K70, K73-K74]	10	4,530	1.4	11.6
Other causes		78,354	23.5	
Total		334,081	100.0	

* per 100,000 standard population
Note: Ten leading causes of deaths in Canada (age standardization using 2011 population), 2022.
Source: Statistics Canada, 2017b, CANSIM table 102-0563.

and women, at 260.8 and 148.9 per 100,000 population, respectively, both up from 2019. The infant mortality rate has however been steadily decreasing. These indicators are on par with the OECD average, as presented in Table 22.5 (OECD, 2020).

At the time of writing, cancers (malignant neoplasms) and heart disease were the two leading causes of deaths in Canada (Table 22.6). In 2022, cancers were responsible for just under a quarter of all deaths (24.7%), while heart disease accounted for 17.2% of deaths (Statistics Canada, 2017b). Since 2020, COVID-19 represented a major cause of death. In 2022, it represented the third leading cause of death in Canada, two years after the beginning of the pandemic (5.9% of total deaths).

Opioid-related deaths have been significantly increasing in Canada. There were 8.4 opioid-related deaths per 100,000 population in 2016 compared with 12.4 in 2018 and 11.5

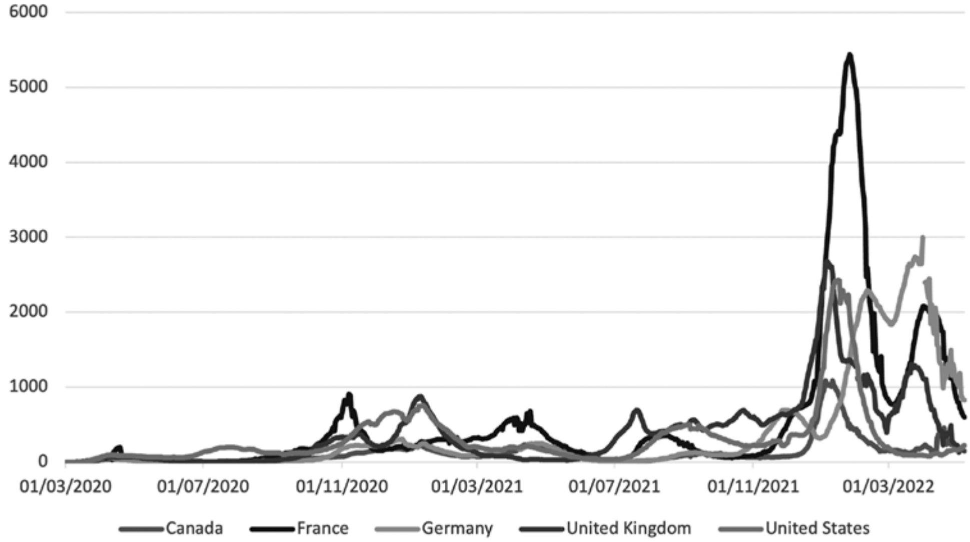
from January to June 2019 (Government of Canada, 2022). Opioid-related deaths are also at the source of the reported stagnating life expectancy between 2016 and 2017 (Statistics Canada, 2019). While opioid addiction originated with prescription drugs, the addition of fentanyl into the illicit drug supply has influenced an opioids crisis (Fischer et al., 2019). The opioids crisis has become a major public health issue in Canada.

The proportion of Canadians engaging in poor lifestyle and health promotion habits has also been declining. The proportion of Canada's smoking population has been decreasing over time (current and occasional smokers), moving from 17.7% in 2015 to 12.9% in 2020. Additionally, the proportion of Canadians engaging in heavy drinking has also been declining from 19.2% in 2015 to 16.6% in 2020. However, little changes have been made in terms of obesity and weight with 28.2% and 35.6% reporting a BMI of obese and of overweight respectively in 2020, with physical activity trends in fact decreasing over time as well, specifically from 56.9% in 2015 to 53.8% in 2020 (Government of Canada, 2020b).

While Canadians report high standards of health and life expectancy on the global scale, this privilege is not evenly distributed in the population. As in other countries, many of Canada's health inequalities follow a social gradient. Although Canada has seen a steady decline in mortality over time, Shahidi and colleagues show that groups that are socially advantaged in terms of income and education have experienced both greater relative and absolute declines in mortality between 1991 and 2016 (Shahidi et al., 2020). The authors also highlight that these disparities have, in fact, remained stable and, in some cases, have widened over time.

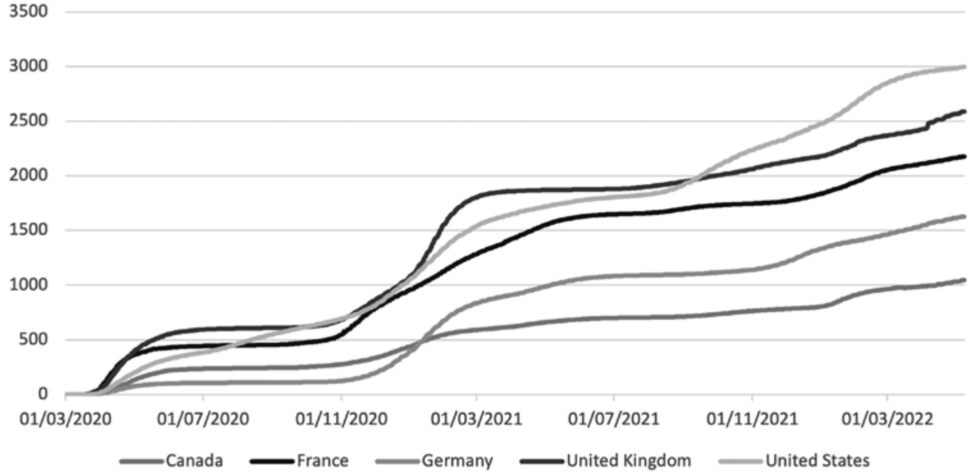
Stark and persistent health inequalities are also observed between Indigenous and non-Indigenous Canadians. The 2021 Census reported that there were 1.8 million individuals identifying as Indigenous, representing about 5% of the Canadian population (Statistics Canada, 2021). The health and well-being of Indigenous peoples in Canada is generally poorer than that of non-Indigenous people, including higher rates of communicable (e.g. tuberculosis) and non-communicable conditions (e.g. diabetes, depression), as well as life expectancy (Garner et al., 2010; Tjepkema et al., 2019). These conditions can be partly attributed to the intersection of social determinants of health, including low levels of education, low rates of employment, high rates of poverty, all of which have also been traced back to legacies of colonization, cultural violence and intergenerational trauma (Levesque and Quesnel-Vallée, 2019).

Access to health care is unevenly experienced across Canada. In 2020, only 85.8% of Canadians reported having a regular health care provider. This proportion further differed between provinces, with top performers such as New Brunswick and Ontario reporting 90.6% of their population having a regular provider, while Québec reported the lowest proportion at 80.6% (Government of Canada, 2020b). Additionally, Canada continues to report long wait times for elective surgeries. In 2016, 30% of Canadians reported waiting two months or more for a specialist appointment, while 18% reported four months or more for an elective surgery. These proportions are amongst the highest compared to peer countries (Canadian Institute for Health Information, 2017). Reasons for disparities in access to care relate to supply side factors, namely with regards to the volume of physicians and their distribution in a country as vast as Canada (population density of 4 people per square kilometer; OECD average population density of 38.3 people per square kilometer) (The World Bank, n.d.).



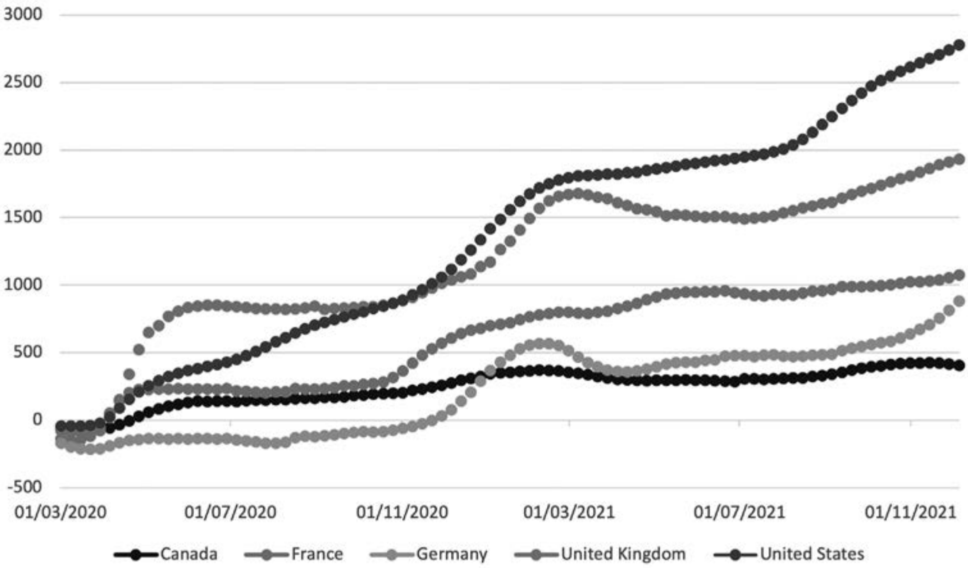
Source: Johns Hopkins University CSSE COVID-19 Data, Human Mortality Database (2021) and World Mortality Dataset (2021). (*COVID-19 Data Explorer*, n.d.)

Figure 22.5 Daily new confirming COVID-19 cases per million people



Source: Johns Hopkins University CSSE COVID-19 Data, Human Mortality Database (2021) and World Mortality Dataset (2021). (*COVID-19 Data Explorer*, n.d.)

Figure 22.6 Cumulative confirmed COVID-19 deaths per million people



Source: Johns Hopkins University CSSE COVID-19 Data, Human Mortality Database (2021) and World Mortality Dataset (2021). (*COVID-19 Data Explorer*, n.d.)

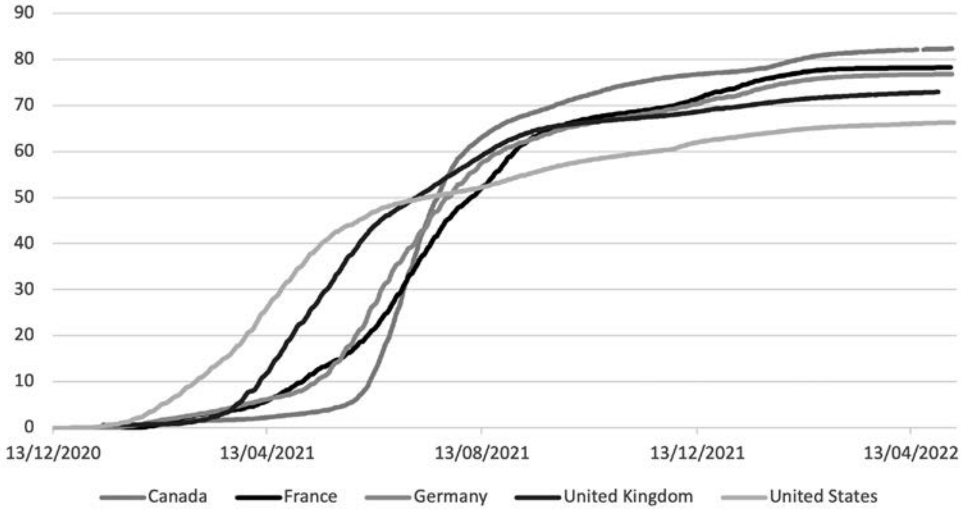
Figure 22.7 Excess mortality per million people

Response to the COVID-19 Pandemic

Comparative evidence presented in Figures 22.5, 22.6 and 22.7 indicate that Canada sustained the lowest COVID-19 case and mortality counts per million population relative to peer countries like the US, UK, France and Germany. Despite a late start relative to these same countries, Figures 22.8 and 22.9 show that Canada also performed enviably in terms of its vaccination effort, with the highest proportion of the population fully vaccinated with two doses (though the much lower proportion of the population boosted might be of concern).

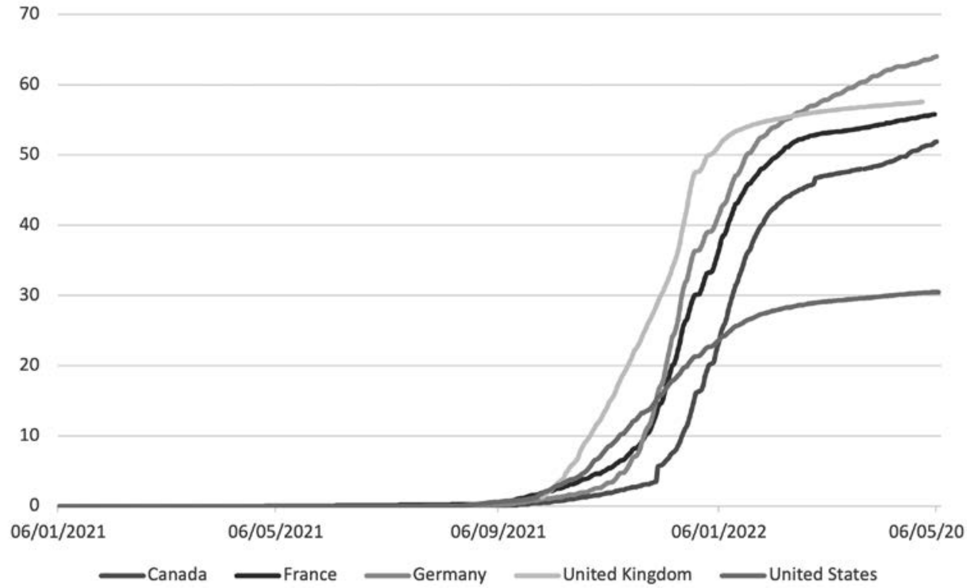
But this national picture masks the diverse provincial realities of the pandemic, as is perhaps to be expected given Canada's federated structure. The pandemic indeed proceeded highly unevenly across the country, with the first wave hitting the two most populous provinces of Ontario and Québec the hardest, and later waves eventually peaking in other provinces as well, while they had subsided elsewhere (Allin et al., 2022). Most tragically, the high death toll associated with the first wave in Ontario and Québec occurred largely in long-term care facilities, which ostensibly provided the impetus for the federal government's targeted funding and establishment of national guidelines for long-term care. While this is undoubtedly a positive development given the dire needs in this area, the targeted funding mechanism used offers no guarantee of sustainability beyond this government.

It is noteworthy to also comment on how the pandemic influenced other care delivery systems in Canada. As elsewhere, as of March 2020, delivery of care quickly transitioned to virtual platforms, what is often considered "telehealth" and "telemedicine". Video and phone appointments with health professionals quickly became the norm. The provinces and



Source: Johns Hopkins University CSSE COVID-19 Data, Human Mortality Database (2021) and World Mortality Dataset (2021). (*COVID-19 Data Explorer*, n.d.)

Figure 22.8 *Population fully vaccinated (per 100 people)*



Source: Johns Hopkins University CSSE COVID-19 Data, Human Mortality Database (2021) and World Mortality Dataset (2021). (*COVID-19 Data Explorer*, n.d.)

Figure 22.9 *Population who received booster doses (per 100 people)* territories rapidly established physician reimbursement fees for telehealth to a varying degree, in order to ensure that physicians would be reimbursed for the services provided (Canadian Institute for Health Information, 2022). From a patient perspective, telehealth efforts were generally welcomed during the pandemic, with many reporting that they wish for some features of telehealth to be maintained after the pandemic (Canadian Medical Association, 2020). In contrast to this, from the provider perspective, many challenges ensued. Burnout for front line workers and those working in long-term care facilities became apparent (Mercuri et al., 2022). Additionally, care infrastructure and procurement such as personal protective equipment, hospital beds and ventilators were scrutinized, highlighting Canada's comparative disadvantage. Implications of limited hospital infrastructure and procurement implied that in certain instances, pediatric wards and hospitals began admitting adult patients and many surgeries were delayed.

This shifting and highly heterogenous epidemiologic context evidently created challenges for the federal government in the early stages of the pandemic in communicating a unified message about the urgency of public health quarantine measures. Accordingly, provincial and even municipal public health authorities often took over, which at times created confusion for the population. In particular, the roll-out – and now, the roll-back – of public health measures was highly variable and uneven across the country. For instance, the province of Québec was the first to adopt a mask mandate in July 2020, but it took until November for the last provinces (British Columbia and Prince Edward Island) to follow suit (Karaivanov et al., 2021).

The federal government did exert a central, leadership role with regards to vaccine regulatory approval and procurement (though with some delays relative to peer countries), but was criticized on other counts, such as provision of personal protective equipment and rapid tests (Allin et al., 2022). This situation gave rise to federal–provincial tensions, as the provinces were ultimately tasked with ensuring the operational distribution of these resources and their health systems were directly impacted by shortages or delays. Finally, we should also recognize that the federal government's many fiscal stimuli in support of the economy and employment layoffs likely played a protective role in the population well-being more generally, though they are not health systems interventions per se.

CONCLUSION

As with so many other domains of society, the COVID-19 pandemic has clearly highlighted pre-existing weaknesses in the Canadian health system, including deficient cross-provincial coordination, insufficient funding for health care (particularly in public health and long-term care), and challenges to collaboration more broadly. Nevertheless, Canada's health care system also showed its resilience, with its federated nature playing a functional role at time by allowing for different jurisdictions to play to their strengths rather than impose a one-size-fits all approach. If cross-provincial communication had been more fluid, this could have led to the roll-out of substantial innovation opportunities. And the fact remains that, despite these challenges, Canadians have overall fared relatively well in this pandemic, when compared with other similar countries. These successes, however, may have more to do with Canadians' trust in institutions than their actual efficiency, much as Canadians may be more attached to the idea of "one" Canadian universal health system than basing this support on its performance.

In sum, this country chapter on Canada highlights a few characteristics. First, although Canada's universal health system is often considered a single health care system in international settings, the nature of federalism in Canada, and the organization and division of powers across jurisdictions (provinces and territories), implies different health care models and experiences across the country. Hence, province/territorial-specific decisions around financing reforms (e.g., Ontario physician payment reforms) or priority setting (e.g., pharmaceutical insurance in Québec) can lead to very different health systems within the same confederation. Second, for those who already know the Canadian health care system(s) well, this chapter highlights the sometimes forgotten role of the federal government in health care in setting priorities through financing (e.g., through the Canada Health Act, Health Accords, or recent bilateral health agreements). Going forward, in the wake of the COVID-19 pandemic, it will be pertinent to pay close attention to the evolution of different levels of government for the future of Canada's health care system.

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23. SUS: the Brazilian health care system[1]

Vera Schattan P. Coelho and Felipe Szabzon

INTRODUCTION

Brazil, South America's largest country in terms of area, has a population of 213 million (IBGE, 2021). While the country saw poverty and inequality decline, especially in the 2000s, there have been major setbacks in these indicators since the 2010s. In 2019, extreme poverty was estimated to affect 5.5% of the population, with 19.2% living in poverty, while the Gini coefficient was 53.7. More recent data indicates that in 2022, after years of economic, sanitary and social crisis that hit the country, 33 million people were in a situation of food insecurity, the worst scenario over the past 30 years (ECLAC, 2020; VIGISAN, 2022; World Bank, 2021).

The country is organized politically as a federation, with 27 states and 5568 municipalities. The population of these municipalities ranges from a few thousand inhabitants (70% of municipalities have a population of less than 20,000) to several million (such as the municipality of São Paulo, where 12 million people live). The country's president, state governors and municipal mayors are elected every four years. In 2021, 24 parties were represented in the National Congress.

A demographic and epidemiological transition has been underway, with urbanization, falling fertility rates, longer life expectancy at birth and a significant increase in the elderly population (Martins, Silva and Guimarães, 2021). Particularly, starting in the 1970s, the under-15 population began to decline, with those over 65 making up a relatively larger share (World Bank, 2005). While there has been a decline in infectious diseases as the cause of mortality and morbidity, there is an emergent double burden of disease, with chronic noncommunicable diseases growing and old and new diseases, such as measles, chickenpox, yellow fever, dengue, chikungunya and zika, still pervasively present in the country.[2]

In 2019, infant mortality was at 13.3 per 1000 live births, varying from 8.5 in the Federal District to 22.6 in Amapá (DF and AP, respectively, in the map below) (Ministry of Health, 2021a). In 2020, life expectancy was 76.6 years, while in the state of São Paulo (SP) it reached 78.9 and in the state of Maranhão (MA) it was 71.7.[3]

In terms of access to health services, the population relies on the Unified Healthcare System (*Sistema Único de Saúde* or SUS), as instituted by the Constitution of 1988, which set forth rules for public and private health services. Public services are financed and delivered to the population for free at the point of delivery, while private services function in a supplementary manner and are paid for by the population through direct payments or private health insurance. The SUS is one of the world's largest public health systems as it aims to ensure that the right to health is guaranteed for all residents of the country, providing a comprehensive set of services, collecting and disposing health data, overseeing the production of health supplies, defining standards and regulating the health sector to virtually 200 million people.

The challenge of promoting a fair and effective health system is huge in a country where political authority is distributed among three levels of government which are, at times, occu-

Source: Brazilian Institute of Geography and Statistics (IBGE), Projected Population, 2010–2060.

Figure 23.1 Life expectancy at birth (in years), Brazil all regions, 2020

pied by authorities with opposing political views, and where socio-spatial standards, demographic profiles and health infrastructure are extremely unequal, whether among the country's regions or among socioeconomic groups. In this chapter, we describe the health system in Brazil and identify recent challenges and key transformations.

HEALTH POLICY IN BRAZIL

The Constitution of 1988 marked the return of a democratic government, bringing an end to the military regime that had been installed in 1964, and declared health and education to be human rights. In the area of health, this right is guided by three basic principles: universal access to health, comprehensive care and social participation.

The principle of universality guarantees equal rights to all citizens, seeking to overcome the persistent economic, social and health inequalities that are characteristic of Brazilian society. The principle of comprehensive care speaks to the policy commitment of offering all services, from primary health care (particularly through health promotion and prevention initiatives) to more complex services, such as cancer treatments and organ transplant surgeries. Social participation assures the citizen's right to participate in the policy process, through participative health councils and conferences that take place at all levels of the system, from basic health units to municipal, state and federal governments. To understand the policy process that made these constitutional principles possible, as well as their institutional entrenchment and capacity for survival, a brief history of how the SUS was formed is discussed below, highlighting ideas and institutions that were important in this process.

Some History

From 1964 to 1984, Brazil lived under a military regime that restricted political rights while promoting some key developments in the field of social rights. According to Dowbor (2009), despite the dominance during this period of a hospital-centric model, there was room for alternative interests to flourish within the Health Ministry. With meager resources, the Ministry was left on the sidelines and thus was more open to the alternative trends of community medicine and innovations in governance. These trends were aligned with approaches used by international health organizations, such as primary health care. In this scenario, public health physicians, who occupied management positions within the Health Ministry, had relative freedom in initiating the "sanitary movement", staffing their teams and increasing coverage programs, especially in rural areas.

During this period, the sanitary movement became a collective actor, encompassing several health care professionals – union-organized doctors, academia and the medical student movement (Coelho and Lieres, 2010; Dowbor, 2009; Escorel et al., 2005). These professionals occupied key posts in public health institutions, advocating for effective universalization of the health system and the institutionalization of citizens' participation in the formulation, management and monitoring of health policy (Neder, 2001). This movement continued to grow during the democratic transition in 1985, with representatives from the sanitary movement taking on new key positions, reinforcing the principles of change: decentralization and, more specifically, municipalization of health services; universal and equal access to health services; comprehensive care; and the development of collegiate institutions (Dowbor, 2009; Noronha and Levcovitz, 1994). Equally noteworthy was the role played by civil society associations. These associations were engaged in a number of local initiatives and also helped to disseminate the notion of health as a citizen's right (Nunn et al., 2009).

In parallel with this movement to guarantee the provision of universal public health services, there were also advocates for private health services, who have been consolidating since the 1940s and exerting their power in the constitutional processes (Santos et al., 2008). The private sector grew by providing services to both the National Institute for Social Security Medical Care (INAMPS), a national institution managed by the government and responsible for offering health services to those employed under formal labour contracts as well as to customers of private services, oftentimes associated with private insurance or direct out-of-pocket payments.

This brief history is a reminder that in 1988, when the Constitution was enacted, the Brazilian health sector had already travelled a long road of reforms, both in the public and in the private sectors. In keeping with this history, the Constitution declared health to be a "right of all and a duty of the State", to be guaranteed through social and economic policies that lead to "reducing the risk of disease and other illnesses and to providing universal and equal access to actions and services for their promotion, protection and recovery" (Federal Constitution, Article 196). It also guaranteed a citizen's right to participate in the health policy process and the private sector's right to provide services.

The Unified Health System, SUS

Public services are offered by public, philanthropic and private providers, although they are paid for by the government and free to the population. Private services are offered by philanthropic and private providers and are paid directly by the user through out-of-pocket payments or through private health insurance. Approximately 30% of the population is affiliated to private health insurance plans (ANS, 2021), while the other 70% relies exclusively on the public system that provide services free of charge. Currently, this figure represents over 159 million Brazilians. Those relying on the public sector are often the poorest and include populations living in rural and hard to reach areas in the country's interior, as well as in large cities, frequently notable for having situations of significant violence and meagre sanitary conditions. In these contexts, the proportion of the population relying exclusively on the public health system can reach up to 94% (ANS, 2021).

Public services make up a national system administered by federal, state and municipal authorities and organized into primary, secondary and tertiary services. Political and clinical coordination across these services has been slowly improving. Clinical coordination improved as a result of efforts to establish digital systems to manage appointments and admissions in clinics and hospitals and to integrate thematic networks (such as cancer, chronic illnesses and women's health). Private services, on the other hand, are more fragmented and generally not organized into networks; nor are they focused on patient trajectories.

In 2020, there were 6642 hospitals in the country, 63% of these were of private nature, being either philanthropic (40.3%) or for profit (59.7%). In 2010, the density of beds in Brazil was estimated at 2.23 beds per 1000 inhabitants, while in 2020, the estimate was 1.91 beds per 1000 inhabitants (FBH, 2020). Up to date, there are 564,385 active physicians in the country, which represents an average of 2.65 doctors for each 1000 inhabitants (CFM, 2023). The PAHO's latest data points to an average of 2.18 physicians per 1000 people in Latin America, while the average of doctors in OECD countries reaches 3.6 (OECD, 2021; PAHO, 2018). This data shows that Brazil is slightly above the regional average but still below well-established health systems of richer countries. In 2019, there were 340 medical schools and 717 graduate level programs (Piotto and Calabró, 2021; Santos Júnior et al., 2021).[4] Despite these figures of the national workforce, doctors are highly concentrated in major urban centres, with fewer of these professionals in more remote areas. For instance, in 2018 nearly 70% of Brazil's cities had less than one doctor per 1000 inhabitants, and the situation was even more critical in smaller municipalities with populations of less than 5000, which had 0.30 doctors per 1000 inhabitants. When it comes to nursing professionals, there are also major regional inequalities. To date, there are 2,786,240 nursing professionals in the country, which makes 7.64 practicing nurses for each 1000 inhabitants. Of this total, 24.6% are registered nurses and 75.4% licensed practical nurses, nursing assistants and orderlies (COFEN, 2023). While the northeast region has 5.41 nursing professionals per 1000 inhabitants, the southeast region has 9.44 per 1000 (Scheffer, 2018).

Supporting the clinical care network are public and private institutions involved with medical research development. In the public sector, for example, there is the Human Genome and Stem Cell Research Center, the Center for Cell-based Therapy, the Oswaldo Cruz Foundation (FIOCRUZ) and the Butantã Foundation, which are also involved in vaccine development and production. There is also a private industrial park of pharmaceutical equipment and products, the latter of which has grown substantially since the 2000s (Vieira and Santos, 2020).

Federal, state and municipal governments also rely on Epidemiological and Sanitary Surveillance Laboratory Networks, which monitor the epidemiological behaviour of diseases and worsening health conditions among the population.

This panorama highlights how citizens' right to health, the public health network and the private sector are strongly entrenched and interconnected in the Brazilian health system. To gain a proper understanding of how the SUS works, it is important to recognize the co-existence of these different sectors and explore how they interact in the SUS's daily routines. One important challenge facing the SUS is how to deal with the public and the private sectors in a way that helps to tackle, and not to reinforce, inequalities, which are deeply entrenched in Brazilian society.

AGENDA-SETTING AND POLICY FORMULATION, IMPLEMENTATION AND EVALUATION

The Brazilian Constitution determines that the SUS must be managed in agreement among the different levels of government – federal, state and municipal. The Ministry of Health counts with seven executive secretariats, which set the guidelines for health policies and programs.[5] There are also governance bodies, as the National Health Council (CNS), which advise the Ministry in defining priorities. Other bodies are also linked to the Ministry, as the National Health Agency (ANS), the National Health Surveillance Agency (Anvisa), the Oswaldo Cruz Foundation (FIOCRUZ), and the National Commission for the Incorporation of Technologies in the Unified Health System (CONITEC). These bodies are responsible for establishing guidelines and regulations for the entire health system. Medium- and high-complexity services are delivered by states and municipalities, while responsibility for primary health care lies with the municipalities. Public health care services are co-financed by the federal government, states and municipalities. This complex arrangement was championed by the federal government and facilitated by the historical trajectory of federal-subnational relationships, which assured decision-making and regulatory powers to the former, as well as by the fact that nearly 50% of public health spending was financed by federal resources (Segatto and Béland, 2021).

The implementation of the SUS started with the Ministry of Health specifying municipal obligations and stipulating the rules that would ensure its financing (Mercadante, 2002). In subsequent years, contracts between the Ministry of Health and subnational governments facilitated the decentralization process in accordance with Ministry guidelines (Arretche, 2004). However, with the advancement of decentralization, it has become evident that for many municipalities, especially those with smaller populations, the supply of comprehensive health care, a SUS founding principle, would only be possible if based on regional arrangements. To move forward in this direction and foster more articulated and cooperative relationships between the municipalities and states, the Ministry of Health created Health Regions in 2011, which should be capable of providing comprehensive care for at least 85% of each region's resident population's needs (Viana et al., 2018).

Starting in the 1990s, federal leadership assured SUS's institutional coordination and allowed for consolidation of a relatively homogenous health policy nationwide, although regional inequalities posed important challenges to its implementation. Below we explore the institutional arrangements that support this health system, co-managed by different governmental bodies and providers from the public and private sectors.

Governance Structure

Governance of the SUS has been operationalized through a complex institutional structure that seeks to coordinate providers, public managers and citizens' representatives. As shown in Table 23.1 below, this structure includes: the Ministry, and Secretariats of Health for the states and municipalities, participative councils and conferences, and intermanagerial councils and commissions.

Table 23.1 Institutional governance structures

Level	Participative Councils	National Commissions	Intermanagerial Commissions
Municipality - Municipal Secretariat of Health	Municipal Health Council (CMS)	National Council of Municipal Health Secretariats (CONASEMS)	
Regional			Regional Intermanagerial Commissions (CIR)
State – State Secretariat of Health	State Health Council (CES)	National Council of State Health Secretariats (CONASS)	Bipartite Intermanagerial Commissions (CIB)
National – Ministry of Health	National Health Council (CNS)		Tripartite Intermanagerial Commissions (CIT)
National Health Agency (ANS)			Government and Private sector

Note: The ANS is an authority connected to the Ministry of Health.
Source: Authors' own tabulation

Ministries and Secretariats of Health are executive branch agencies which are mostly staffed by managers from the State bureaucracy. Upper management positions are appointed by the head of the respective executive branch, who is elected every four years and may run for reelection one time.

Participative councils and conferences exist at the municipal, state and federal levels. These are permanent bodies that consist of citizens, health care providers and public managers. There are currently more than 5500 Health Councils involving almost 100,000 citizens and a vast number of associations. Councillors are elected every two years and may be re-elected. The councils are political forums in which participants discuss issues and may make alliances to help health authorities plan and define priorities and policies. The Basic Operational Norms regulating the SUS stipulate that the number of civil society representatives (citizens) must be equal to the total number of services providers, health professionals and public managers (Coelho, 2006).

The managing councils bring together health authorities. State and municipal health secretariats are represented respectively by the CONASS (National Council of State Health Secretariats) and the CONASEMS (National Council of Municipal Health Secretariats). These bodies are tasked with articulation, information exchange and representation of interests, fostering the exchange of experiences and supporting State and Municipal Health Secretariats.

Additionally, there are Intermanagerial Commissions. The Regional and Bipartite Intermanagerial Commissions bring together municipal and state managers working at these levels of government. The Tripartite Intermanagerial Commission joins municipal, state and federal managers. These Commissions are intergovernmental spaces of a technical and political nature, where planning, negotiation and agreement on public health policies take place, whether municipal, regional or statewide. Decisions should be made on these Commissions through consensus (and not by vote), encouraging debate and negotiations among the parties.

This institutional framework aims to open space for coordination between the different levels of government and different sectors involved in the health policy process. It also calls for multidirectional communication, allowing vertical top-down and bottom-up flows, as well as more horizontal flows. CONASS and CONASEMS saw their role in the policy process grow during the COVID-19 pandemic, when, as will be seen, the usual path of federal-subnational relations was challenged. Even so, these bodies are restrained to play coordinating and advisory roles, as their legal and financial powers are quite limited. These dynamics will be explored further in the next sections.

Governance in Action

The Ministry of Health was the chief driver of health policies up until the end of the 2010s. Its driving power materialized through mechanisms of federal funding to states and municipalities, which made financial transfers conditional upon adoption and strengthening of health programs and, at times, indicators of coverage and performance defined by the Ministry itself.

The federal government regulates important aspects of the system, such as procedures to incorporate technologies and innovation in health (through a national commission called CONITEC). Along these lines, the National List of Health Services and Actions (RENASE) and the National List of Essential Medicines (RENAME) were defined. These lists establish clinical and therapeutic protocols that can be used and paid for under the auspices of public services. Another important regulatory authority for SUS governance is the National Health Surveillance Agency (ANVISA), which controls all products and services that are connected to human health or can have some impact on it (such as drugs, food, cosmetics, sanitizing agents, tobacco byproducts, medical products, blood, blood products and health services). In addition, in conjunction with the Ministry of Industry, Foreign Trade and Services, ANVISA controls ports, airports and borders in affairs related to health surveillance.

Regulation, oversight and assessment of the provision of private services are performed by the National Health Agency (ANS). In addition to private service providers, the private sector is mostly made up of private health insurance and carrier companies. The responsibilities of the ANS include supervision of private health providers and insurance company performance; definition of the list of procedures and health events that are covered by these companies; and pricing policy and regulation of the relationship between companies, service providers and consumers. Brazil is currently one of the world's largest private health insurance markets. This makes the ANS a highly disputed political arena between public health advocates and private companies (Baird, 2020).

Finally, one important SUS institution is DataSUS, which was created in the 1990s and is responsible for centralization and management of all data related to public service production and epidemiological surveillance. Data on service production is used to calculate payments to providers and to support planning activities. In addition, this system provides accessible, free and online information on hospital and ambulatorial production, demographic and epidemiological information, especially the incidence and prevalence of notifiable diseases.

In a movement to update DataSUS, the Digital Health Strategy program was created in 2017. Later, in 2020, the Federal Senate approved Connect SUS, aimed at computerizing health care facilities and integrating information of public and private health establishments and management agencies. The National Network for Health Data (RNDS) was then created, as a national platform aimed at integrating and facilitating the interoperability of health information, allowing for unification of patient charts between public and private networks, including medical care and laboratorial exams. With this, the SUS is charged with centralizing patient information across the country, with data on prescriptions, referrals, medical charts and exam reports. The law also stipulates platform compliance with the requirements of Brazil's General Data Protection Act (LGPD). The implementation of these new strategies and regulations is still a work in progress. Nevertheless, as will be seen in the section on the response to COVID-19, the pandemic helped to accelerate this process and, as an example of the advancements in these areas, from March to September 2020, the RNDS received over 4 million results for COVID-19 exams made at public and private laboratories (Ministry of Health, 2021b).

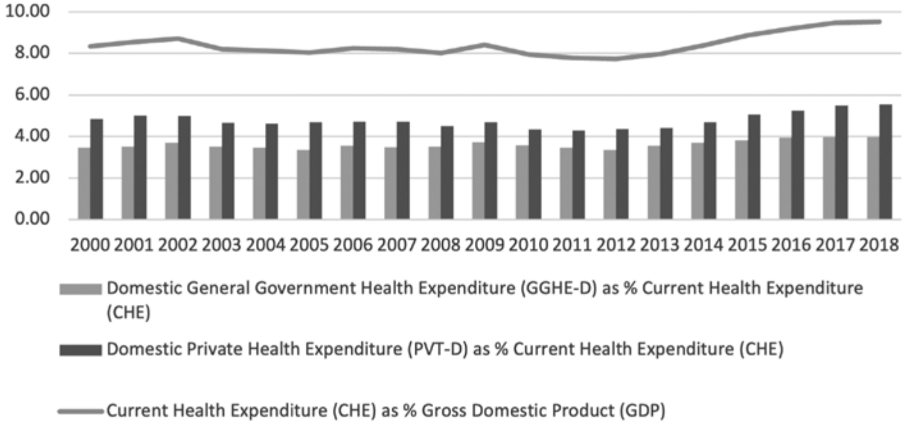
This institutional governance structure helped the SUS gain nationwide penetration and has proven powerful in orienting the public system, which has resulted in a significant expansion in PHC over the last 30 years, with priority being given to the poorest groups, for example.

Moreover, the federal government has tried to strengthen regionalization processes over the last 20 years by creating the aforementioned 438 health regions and proposing establishment of contracts between municipalities to regulate regional relationships and foster stronger thematic networks.[6] Advancements on this front are still tentative. At the state level, some states, like São Paulo, have been experimenting with different models of regionalization, investing in their own medium- and high-complexity service networks, while other states delegate their implementation to the municipalities (Carvalho, De Jesus and Senra 2017; Venancio et al., 2011; Viana et al., 2018). Finally, regarding municipalities, which are responsible for full implementation and management of primary care services (some of them, especially larger ones, also implement and manage more complex services), we find a wide range of management models, which can be at least partially understood as resulting from the diversity of territorial, populational, social, economic and cultural scenarios in the country.

This situation shows how the organization of Brazil's health system demands significant political coordination (whether between federal and subnational bodies, or between politicians and society), sectoral coordination (between public and private, whether in providing public services or in establishing regulations and rules for the private sector) and coordination between politicians, managers and providers as well. Various top-down induction mechanisms (financial and programmatic) and bottom-up communication mechanisms (councils and commissions) have contributed to promoting this coordination and advancement in the supply of public health services nationwide. As will be shown in more detail in the next sections, there is, however, still much to be done in order to reduce inequalities in service delivery and in health outcomes, which remain substantially unequal among both regions and social classes.

HEALTH FINANCING

As shown in Figure 23.2, total health expenditures in 2018 accounted for 9.46% of the Brazilian GDP, being 58.8% of private health expenditure and 41.2% of government health expenditure.



Source: WHO, Global Health Expenditure Database, 2021. Authors' own tabulation.

Figure 23.2 Total health expenditure as a percentage of the GDP and public and private expenditures, Brazil 2000–2018

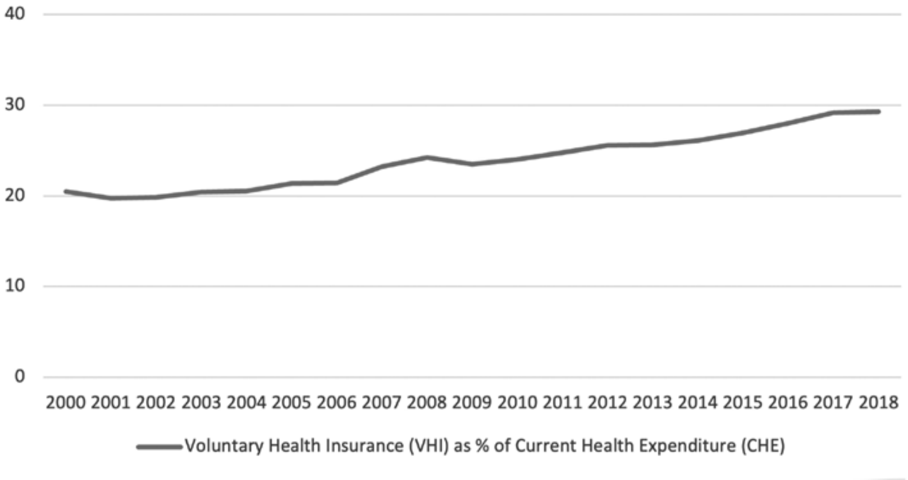
Public Expenditures

Public expenditures are split between the federal government, which is responsible for nearly 50% of available resources, and the state and municipal governments. Legislation passed in 2000 stipulated that the federal government disburse the amount allocated to health care in the previous year to these other federal units, corrected by the variation in nominal GDP. States should invest at least 12% of their revenues in health, while municipalities should invest at least 15%. In allocating federal funding for PHC, per capita criteria prevail, while for medium- and high-complexity outpatient and hospital services, including emergency services, the criteria of installed capacity and services provided are also used.

Since 2006, as a strategy to assure that states and municipalities have greater autonomy to allocate funds for health activities and services, transfers are made in blocks, instead of to programs, as was done before. The blocks are: (i) primary health care; (ii) medium- and high-complexity outpatient and hospital care; (iii) health surveillance; (iv) pharmaceutical assistance; (v) SUS management; and (vi) investments in the health service network. Of the resources allocated, approximately 20% go to PHC, 50% to medium- and high-complexity services, and 5% to drug costs, with the remaining 25% split among the other categories (Mendes, Carnut and Guerra, 2018). Despite the growing investment in PHC in recent decades, medium- and high-complexity (MHC) services continue to receive the majority of health resources.[7]

Private Expenditure

Private expenditure consists mostly of premiums paid to private health insurance plans offered by companies as employment benefits and/or directly purchased by citizens. There are currently 727 carriers who provide insurance coverage that offer different types of health insurance plans to a wide range of people. This sector is undergoing major transformations, with strong growth in business groups that are using supply verticalization strategies; in other words, the carrier providing the insurance controls health services, which provide contracted procedures, differently from the previously predominant model where they operate as intermediaries between insurers and service providers.



Source: WHO, Global Health Expenditure Database, 2021. Authors' own tabulation.

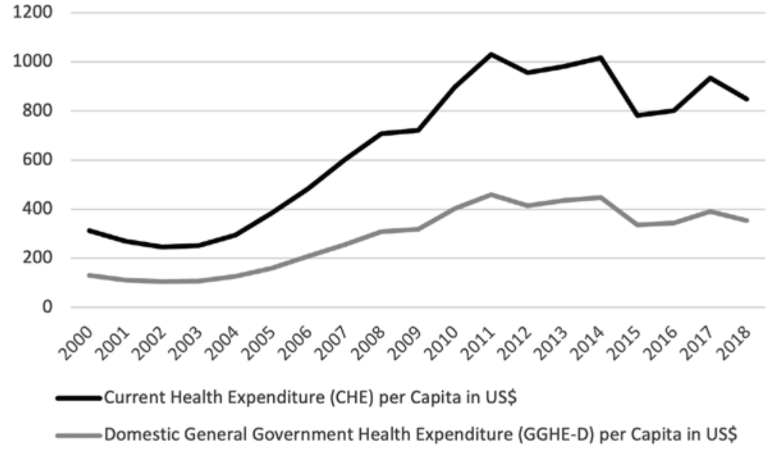
Figure 23.3 *Voluntary health insurance as a percentage of current health expenditure, Brazil, 2010–2018*

The verticalization process has resulted in greater control of the costs through managed care and has resulted in more flexibility regarding prices and competitiveness at carriers; however, because this model demands more capital, it has been restricted to large corporate groups.[8] Furthermore, there has been an important discussion over regulating instruments to oversee cost containment strategies in verticalized companies, especially in higher levels of complexity.

General Features of Health Expenditure

In addition to the costs established in legislation involving direct health care provision, there are also unexpected costs to the public sector, which have been growing in the context of judicialization. Judicialization occurs when the Judicial Branch is called on by individuals or groups of individuals, such as citizens or consumers, for arbitration of their conflicts with the Executive Branch, with private companies and even with individuals. From 2008 to 2017, judicialization in public and private health rose by 130%, while the costs incurred by the Ministry of Health were up by 4600% (Cirico et al., 2019). One characteristic of health judicialization is the urgency of cases, which allows trial court judges to determine the measures to be taken by hospitals and pharmacies, both public and private.[9] The Federal Supreme Court is currently deciding on a general argument, having, up to this point, indicated that the SUS is not required to provide high-cost drugs that are not registered with ANVISA. Medical malpractice can also be judicialized; nonetheless, litigation on these issues is much less common. The majority of judicialization in Brazil, refers, therefore, to the right of coverture rather than medical malpractice.

The rules for financing public services, the favorable economic moment experienced by the country in the 2000s, and the maturing of the private sector contributed to growth in per capita health expenditures from 2000 to 2010[10] (Piola et al., 2018). In 2014, after ups and downs, the total per capita spent in the country reached US$1017 (WHO, 2021). This scenario took a hard blow in 2016, when new regulations were passed in the face of the economic crisis the country was experiencing, setting a limit on expenditures for public services for the next 20 years.



Source: WHO, Global Health Expenditure Database, 2021. Authors' own tabulation.

Figure 23.4 Current health expenditure and government public expenditure per capita, Brazil, 2000–2018

This limit determines that changes to state expenditures on health and other social public policies are restricted to inflation. For example, the 2017 budget on these policies corresponded to the budget available for expenditures in 2016, plus that year's inflation. In 2018, per capita health expenditures had already dropped to US$848. These regulations also stipulated that any change to this regime could only be made after ten years. This is worrisome in the context of an economic crisis, an aging population and, as will be seen in the next section, a quite heterogeneous network of services, which in some regions does not have the minimum capacity needed to serve the population. Several evaluations have pointed to the implications of this austerity policy not only for the health system, challenging its ambition of integrality and universality, but also in terms of restrictions of other social welfare policies, especially on education (Dweck, Rossi and Oliveira, 2020; Menezes, Moretti and Reis, 2019; Rossi and Dweck, 2016).

HEALTHCARE DELIVERY

Federal, state and municipal authorities are responsible for managing public services and they are supposed to work in an integrated and hierarchical manner. Private services are regulated by the National Health Agency (ANS). Public, as well as private, services are quite heterogeneous and contain islands of excellence that offer the latest generation of high-complexity services as well as enclaves of poor quality, exposing regional, social and economic inequalities that are deeply entrenched in the country.

The supply of public services in PHC comes mostly from public providers, while the supply of public diagnostic and medium-complexity hospital services is provided mostly by private providers, although also paid by the State and provided for free to the population under the auspices of the SUS. In high-complexity care, responsibility for providing public services has been split almost equally between the two sectors (Bahia and Scheffer, 2017). This is possible because many private (mostly philanthropic) hospitals, laboratories and diagnostic centres sell their services to the public sector, while the supply of private services is almost exclusively made up of private for profit or philanthropic providers.[11]

Private services are accessed by 47 million Brazilians, mostly through private health insurance plans (ANS, 2021). Access to these plans varies widely according to the regions of Brazil. In the states of São Paulo, Rio de Janeiro and Espírito Santo, more than 30% of the population has private health insurance.[12] While in states in the North region, coverage is between 5% and 10%.[13] Other services provided within the SUS are of a liberal-classic nature, where health professionals provide services and negotiate with their clientele, who pay directly out-of-pocket. Clinical practices run by liberal practitioners are overseen by federal and regional medical councils, which supervise any malpractice and can suspend individual rights to provide medical care.

Private out-of-pocket spending on health has grown as a proportion of household consumption over the past decades. The National Family Expenditure Study (ENDEF 1974/1975) has shown that it in the 1970s it represented 4.2% of household consumption. In the Household Budget Survey (Pesquisa de Orçamento Familiar – POF) of 2002/2003, the share of health expenditure in total consumption of families increased to 6.5%. The same study (POF) of 2008/2009, showed that this share increased to 7.2% and, in 2017/2018, to 8%. Since the 1970s, the total increase in private health expenditure was of 90.5%. Recent data from the latest POF indicates that among those who have a private health plan, these payments represent 58% of the total household expenses with health services (Moraes et al., 2022).

Users mobilize this set of public and private services in different ways. For example, people with private health insurance sometimes use the public system, especially for high-complexity services which can be extremely costly, while public service users sometimes turn to private services to avoid waitlists for more specialized exams and treatment (Santos, Ugá and Porto, 2008).

Primary Care

The expansion of the SUS starting in the 1990s has relied significantly on PHC and was largely supported by the Family Health Strategy (Programa de Saúde da Família or PSF), which provided services at Basic Health Units (Unidades Básicas de Saúde or UBS) and also at patients' homes. In terms of flows within the SUS, the National Primary Care Policy aims to receive, treat and, when necessary, refer users to other levels of care. In this sense, PHC is seen as a gateway to the health system, exercising an important role in coordinating the care network.

PSF teams consist of physicians, nurses, community health workers and other health professionals, who are responsible for providing PHC and, more particularly, for health promotion and prevention actions in the territory surrounding UBSs.

The public services network has 3.6 UBSs per 10,000 inhabitants, offering more than two basic appointments per inhabitant/per year in every region of the country, which exceeds Ministry of Health recommendations (Gragnolati, Lindelow and Couttolenc, 2013). Coverage by family health teams shot up from 46.2% of the population in 2007 to 75.12% in 2022 (Cecilio and Reis, 2018; Ministry of Health, 2023).

To monitor and perfect this strategy, in 2011 the National Program to Improve Primary Care Access and Quality (PMAQ) was implemented. The program proposed a set of strategies for qualification, monitoring and assessment of the work of health teams and increased funding for participating municipalities that achieved improvements in care. In 2019, PMAQ was replaced by the Prevent Brazil Program (Previne Brasil), which focuses on evaluation of outputs and outcomes of PHC.

In keeping with this expansion, Dourado et al. (2011) found evidence in national, regional and state plans that, between 1999 and 2007, coverage under the Family Health Program was a determining factor to reducing hospitalizations associated with primary health conditions. During this period, the rate of these hospitalizations fell by 24% in the national plan, dropping 2.5% more than hospitalizations for other causes.

Medium- and High-complexity

In 2017, the public hospital structure was composed of 4521 hospitals (public or private SUS affiliates), corresponding to 78% of the total number of hospitals in the country (PROADESS 2019). Medium-complexity services, which provide the link between primary care and high-complexity programs, have been identified as a major weakness in the SUS. Part of this fragility is attributed to the overwhelming share of small, low-complexity hospitals, which account for 62% of the hospital system and 18% of current beds, distributed mostly among small municipalities in the countryside. These are establishments with up to 30 beds, located in regions with fewer than 30,000 inhabitants. These hospitals have an agreement with public entities to provide public services; however, they are mostly private or philanthropic (Gragnolati, Lindelow and Couttolenc, 2013).

In high-complexity services, when it comes to ICU beds, there is not as much of a difference in absolute numbers between the supply of public and private beds. The country has around 45,800 ICU beds, 22,800 of which are in the public system and 23,000 of which are in the private system. Nevertheless, when adjusted for the appropriate coverage rates, the public system has 13.6 ICU beds available for every 100,000 SUS users, while this number rises to 62.6 for private sector affiliates (AMIB, 2020).

The presence of an important organ transplant system, organized mostly at public hospitals and financed by public funds, is also notable.[14] In 2019, this system carried out 15,000 corneal transplants and 6000 kidney transplants (30 per million people) (RBT, 2019). Nevertheless, the supply of transplants, as well as other high-complexity procedures, which have consumed nearly 20% of the public resources invested in health to serve less than 2% of the population, has raised questions about how priorities are established within the SUS (Mendes, Carnut and Guerra, 2018; Piola, Benevides and Vieira, 2018; Ugá et al., 2003). After all, if financing cutting-edge research and the development of specialized staff within the public health system contributes to the system's advancement, as well as to keeping professionals within the country's borders, there is also an undeniable need to make sure that decisions on what will be financed, where and for whom, are more transparent and open to public scrutiny.

This set of public and private services represents a complex health system, marked by vast inequalities between regions, whether among services or levels of complexity. The next section investigates this system's contribution to reducing health inequalities between social groups.

HEALTH AND HEALTHCARE INEQUALITIES

As seen in the previous sections, there are significant regional inequalities, whether in relation to health indicators or to the distribution of health services. The public health specialists involved with creating the SUS have been well-aware of these inequalities and have proposed decentralization as one of the main strategies to address them. Notwithstanding this perception, in the mid-1990s, as the system began to be effectively implemented, the challenges of including historically disadvantaged groups became clearer, with increased demands around health policies to meet the specific needs of indigenous, black and *Quilombola* populations, which had the worst health indicators in the country. For example, in the 1990s, the likelihood of a black child dying before reaching the age of one was 1.8 times higher than for a white child, while maternal mortality among black mothers was 3.6 times higher than for white mothers (Cunha, 2008). Despite the countless efforts to address these inequalities, such as the creation of an indigenous health subsystem in 2001, infant mortality among indigenous children was 47.2 per 1000 live births in 2010, while the average for Brazil in the period was 16.3 per 1000 (SIM/SINASC).[15] Below, we explore health inequalities, focusing on a territorial as well as a social perspective, and looking into the possible impacts the SUS has on them.

Census data from 2010 show major steps forward in relation to reducing regional inequalities in health.[16] Improvement in infant mortality indicators between 1980 and 2010 (going from 69.1 to 16 per 1000 live births) and in life expectancy (which went from 62.6 to 73.4) was accompanied by greater homogeneity in these indicators among the five regions and 27 states.[17] Municipalities also saw marked improvement in these indicators; however, reduction in inequalities was modest. In 2010, the infant mortality rate in municipalities with a lower per capita income was more than twice the rate found in municipalities with higher incomes (27.8 and 13 deaths per 1000 live births, respectively) (Coelho and Dias, 2019). In 2016, the infant mortality rate continued to fall, dropping to 12.7 deaths per 1000 live births; however, no gains were found in relation to reduced inequalities between municipalities. When comparing richer regions with the poorest regions of the country in relation to vaccination coverage, there was a major decrease in inequalities between 1997 and 2015. Regarding births, since the late 1990s, practically 100% of births took place at health institutions, in both the poorest and wealthiest municipalities (Paes-Sousa, Chavane and Coelho, 2019). These indicators point to improvement in primary health indicators and a reduction in inequalities between regions, states and municipalities.

Indicators related to inequalities between social groups have also shown that progress has been made. The efforts of the Family Health Strategy (FHS) to increase the coverage of PHC was a welcome and important step in reducing access barriers to health care. Historically, black and mixed-race people have less access to the network of health facilities, with expansion in the FHS contributing to broadening this access. In this sense, Silva et al. (2018) and Hone et al. (2017) showed that expanding the FHS indirectly benefited municipalities that had higher proportions of black populations, insofar as there was greater implementation of this model of care in the northeast region and in municipalities with a lower level of socioeconomic development, which hold a greater proportion of the Afro-descendent population. From 2003 to 2009, coverage by the FHS grew nearly twice as fast in municipalities with larger black populations (where 74% or more of the population is black or mixed race) than in the quartile with the smallest populations (where less than 44% of the population is black). According to Hone et al. (2017), this has contributed to lessening racial inequalities in rates of mortality due to causes sensitive to PHC, especially deaths associated with infectious diseases, nutritional deficiencies, anemia, diabetes and cardiovascular disease. During the period, while mortality due to causes sensitive to PHC fell by 6.8% among the white population, it dropped by 15.4% for the black population, showing an increased effort towards more vulnerable groups. In other words, the FHS has achieved important results in terms of reducing health inequalities. Also worth mentioning is the FHS' capacity of improving the collection of vital statistics and health information of these groups.

These results provide an idea of the advancements made, while also calling attention to the fact that groups who were at greater disadvantage and who gained access to primary care have seen rapid improvement in their basic health indicators. Along these lines, the case of COVID-19, which is discussed below, deserves attention as it highlights important changes that are happening in the governance pattern that has prevailed since the 1990s. During the pandemic, the Health Ministry partially lost its leadership role, while states and municipalities assumed more proactive roles.

COVID-19 RESPONSE

In October 2021, 22 million people in Brazil were confirmed as infected with the Sars-Cov-19 virus and the number of deaths had already surpassed 600,000, meaning that Brazil sadly had the second highest COVID-19 death count globally, trailing only the United States of America and holding seventh place in the death rate per million inhabitants in the world (Cota, 2021). Added to this ranking were the high rates of mortality that disproportionately affected health professionals, pregnant women and the indigenous population. There is also evidence of underreporting, indicating that the actual situation is much more devastating than pictured by these figures (Ferigato et al., 2020).

Brazil effectively took too long to organize a response to the onset of the COVID-19 pandemic. At the time of the pandemic's arrival, the country's president denied the virus's existence and dismantled structures for national monitoring of the evolution of the number of cases; he encouraged crowds, such as at political events endorsing the government position, and promoted large public gatherings. In addition, the Health Ministry endorsed the use of medicines that had no proven efficacy, while also relativizing the need for protective equipment like face masks for the general population. During the pandemic, three Ministers of Health were dismissed and a military minister with no health care experience was appointed in the interim for the majority of the crisis, leaving the country with no leadership in the sector for this entire period. Later on, the federal government dragged its feet in starting negotiations to buy vaccines and in managing the acquisition of needles and syringes for a national vaccination program.

This was an unprecedented scenario, as in the past the Health Ministry played a leadership role in orienting health policies in a coordinated manner with other federal entities. Clashes between the country's president, governors and mayors resulted in judicialization of this topic, with the Federal Supreme Court (STF) ruling that all federal entities must have the autonomy to take normative and administrative measures related to COVID-19. This context forced states and municipalities to adopt their own sanitary measures, supervise enforcement of quarantines, redeploy the health workforce, and even finance vaccine research.

This accentuated the differences in the state strategies and it is plausible to assume that the opportunity was lost to more effectively capitalize on the contribution that PHC could have represented in confronting the pandemic. For instance, frontline workers who could represent a key element in controlling the spread of the virus were not provided with clear guidance by the Health Ministry about their role in the COVID-19 response, nor was appropriate testing provided, despite the presence of a highly penetrated PHC network that could perform massive testing of the population. Hospital care also showed huge differences. For example, while the Southeast region held 51.9% of ICU total beds in the country, the North (5.2%) and Center-West (8.5%) regions did not reach 10% of total available intensive care beds. This inequality and lack of coordination helps to explain the health crisis experienced in the city of Manaus, the capital of the state of Amazonas, where many of those infected did not receive timely care and died (Cotrim Junior and Cabral, 2020).

These factors contributed to significant variations in mortality rates among the states, with Mato Grosso having the highest rate (399,774.31 deaths per 100,000 inhabitants), followed by Rio de Janeiro (395,929.49 deaths per 100,000 inhabitants). The lowest rate was in Maranhão (144,688.88 per 100,000 inhabitants), a state that quickly set up health barriers, mobilizing PHC and promoting widespread testing of its population. States and municipalities led by politicians aligned with the federal government, as well as those where the president received the most votes, in turn had the highest rates of infection and death since, like the president, they disregarded more responsible attitudes toward containing the spread of the virus (Cabral, Pongeluppe and Ito, 2021; Fernandes et al., 2020).

One positive aspect of this time was the passage of Law no. 13.989/2020, regulating telemedicine during the pandemic. With this, from 2020 to 2021, around 7.5 million appointments were held with over 52,000 doctors, 87% of which were in PHC (Saúde Digital Brasil, 2021). In May 2022, after a heated debate, the federal board of medicine authorized the performance of medical practice through virtual communication technologies (Resolution no. 2.314/2022). This autonomy, in line with ethical and legal precepts, is limited to the principles of beneficence and non-maleficence of the patient.

Another positive aspect was the performance of the national vaccination program, which led the National Vaccination Campaign against COVID-19 that started on January 18, 2021. The infrastructure of the national vaccination program guaranteed the means for the country to implement one of the world's largest vaccination programs against COVID-19, managing to apply more than 1 million doses daily. Unlike other countries, the population has been receptive to vaccination, with very low rates of refusal. In early November 2021, 60% of the population had been immunized against COVID-19 (two-dose or single dose regime) and rates of new cases and deaths fell sharply.

In short, during the social and health tragedy caused by COVID-19, the health system was capable of activating mechanisms to defend health in the public and private areas, which were able to respond with reasonable speed to needs to protect the population, even in an adverse political context.

CONCLUSION: MOBILIZING SCALE AND INCENTIVES TO COORDINATE INTERESTS

Back in the 1960s, Charles de Gaulle is alleged to have said that "Brazil isn't for amateurs." Chico de Oliveira, an influential Brazilian intellectual, compared the country to a duck-billed platypus, because it encapsulates the advanced characteristics of mammals and archaic methods used by egg-laying animals (Oliveira, 2003). These characterizations come to mind when writing this chapter. After all, the SUS is a very particular amalgam of progressive projects, conservative interests, dynamism and shortfalls. There are public, private and semi-public institutions, both governmental and non-governmental, driving technical and political competencies and involving different management and command structures that are national as well as regional and municipal, forming a dense institutional web that is at times hard to understand and certainly difficult to coordinate and align to respond to citizens' needs.

This system combines efforts made starting in the 1990s to: 1) Increase the coverage of PHC – mainly through the Family Health Strategy; 2) Listen to citizens – through councils and conferences; 3) Guarantee access to more complex services – through agreements or purchase of services and diagnostic support from a hospital and laboratorial network that is public, philanthropic or private in nature, and also by funding research and professional capacity building; and 4) Build and oversee a private system of services, the pharmaceutical industry and insurance carriers.

Now, if on the one hand this complex network, operating by accommodating a wide variety of interests, contributed to improving indicators and reducing inequalities over the last 30 years, on the other hand, it still carries contradictions that have limited its potential to deepen these gains. As we have seen, some of these contradictions have manifested in confronting the pandemic. After all, how can underutilization of PHC and low rates of testing be interpreted *vis-a-vis* rapid growth in hospital treatments, which are frequently dependent upon costly ventilators and ICU beds?

This final section calls attention to some of these contradictions, particularly those that concern scale, coordination and incentive, which can be tackled in the short term by health managers interested in orchestrating the various interests within the SUS in a more coordinated and favorable way for citizens.

Scale has been a recurrent issue throughout this chapter. There are many small municipalities which, despite spending a significant portion of their resources on health, end up with diseconomies of scale and offering inadequate services to their citizenry. Coordination also appeared repeatedly as several mechanisms – including councils, commissions, regulatory systems and clinical thematic networks – that have been put in place with the aim of fostering political and clinical coordination. Incentives are another issue that has come up many times in this text, and here we would point to a situation that is especially present in smaller municipalities: fragmented financing between, on the one hand, PHC (which receives most of its disbursements based on per capita criteria) and, on the other, medium- and high-complexity services (where payments are made for services provided). This form of financing offers few incentives for municipal managers and providers of more complex services to pay attention to quality and resolution, whether in primary care or in medium- and high-complexity services.

These three aspects – scale, coordination and incentives – can be best equated by regional arrangements that align PHC and more complex services using financing mechanisms, that assure "teeth" to decisions made by political and clinical bodies, in ways that value resolution (Coelho, Costa and Schalch, 2020). Digital health, which gained popularity with the pandemic, could also contribute to this alignment, by integrating information from the public, private and philanthropic systems, as well as from PHC and MHC services, and could even facilitate gains in scale and forecasting. More than this, it could contribute to a leap forward in caring for the population in realities that are marked by social and regional inequalities, including those where there is a systematic lack of qualified health professionals.

The challenges to move ahead, whether in revising financing mechanisms or in adopting digital solutions, are significant, yet a long road has already been travelled. We have advanced in promoting health and reducing inequalities, now lessons learned need to be capitalized. Perhaps we should look for inspiration from health movement leaders who, with great determination and mobilization, have managed to entrench the promise of a universal system to build a fairer society.

NOTES

1. This paper presents the results of the following projects: "SUS's Governance: Tackling Health Inequalities" supported by Fapesp, process 2013/07616-7, Centre of Metropolitan Studies (CEM) and "The Accountability Politics of Reducing Health Inequalities in Brazil" supported by ESRC/DFID-UK.
2. The proportion of deaths of people under the age of 20 went from 12.2% to 7.4% from 2000–2010. In this same period, the likelihood of death in the first year of life fell from 26.6 to 16.2 per 1000 live births. In 2010, NCDs accounted for 73.9% of deaths in Brazil, with 80.1% caused by diabetes, cancer, CPOD and cardiovascular diseases (Campolina et al., 2013).
3. Regarding the differences between the sexes, life expectancy for men in Brazil was 73.1 years, while for women it was 80.1.
4. Inequalities are also great here, with the state of São Paulo having 63 schools with openings for 7130 students each year and Amapá having one school with 60 openings.
5. Secretaries of: Primary Health; Specialized Healthcare; Science, Technology, Innovation and the Health Complex; Environment and Health Surveillance; Indigenous Health; Human Resources and Health Education; and Information and Digital Health.
6. These networks focus on themes such as pregnancy, childbirth and postpartum; chronic illnesses, deficiencies and mental health problems; and urgent care and emergencies.
7. In 2005, transfers of federal SUS resources for MHC services in Brazil accounted for twice as many transfers as those for PHC (CONASS, 2006).
8. Foreign capital began to have a share in these groups after Law 13.097/2015 was passed, opening up the national health market to foreign capital (for more information, see Filippon, 2015).
9. Government purchases require a budget plan, and they must go through a bureaucratic procurement process. When this purchase has to be done in a rush, the best price cannot be guaranteed, and the federated entity (whether a state or municipality) can incur substantial losses.
10. There was a reduction in the country's GDP, which helps to explain why we saw growth in the expenditure as a percentage of the GDP and at the same time a decrease in per capita spending.
11. From 1991 to 1998, regulations were implemented for private health insurance plans, resulting in the passage of Law no. 9.656/98, also known as the Health Plans Act. The supplementary health system is classified into different modalities of operation in the market, such as group health insur-

ance, insurers specialized in health, health insurance cooperatives, philanthropic organizations, self-managed organizations, group dental insurance, dental insurance cooperatives and benefits administrators.

12. Mato Grosso, Minas Gerais and the country's three southern states also have a high range of services, where 20% to 30% of the population has access to supplementary health.
13. The state of Amazonas is the exception, at between 10% to 20%.
14. More complex transplants (kidney, liver, heart, lung and pancreas) are mostly done at university hospitals (RBT, 2019).
15. Since 1999, Brazil's indigenous population has had access to the basic care offered by the SUS through a specific arrangement, the Indigenous Healthcare Subsystem of the SUS (SASI-SUS), whose territorial basis is not a municipality (as is the case of the SUS in general), but rather is the Special Indigenous Health District (or DSEI), whose borders are drawn based on the distribution of indigenous populations (Benevides Ferreira, Paiva Ramos and Shankland, 2019).
16. The 2010 Census was the last census held in Brazil, since the following census, planned for 2020, was postponed and there is still no information on when it will be done.
17. From 1980 to 2010, the standard deviation between states in the case of infant mortality went from 24.6 to 3.8, and life expectancy went from 3.3 to 2.2 (Coelho and Dias, 2019).

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24. South Africa: exploring and understanding how and why universal health coverage policy implementation gaps come about

Janet Michel, Mary Kawonga, Mazvita Muchengeti and Marcel Tanner

INTRODUCTION

A middle-income country, South Africa has a history of a divided and discriminatory health care system, which originated during the colonial era. The population of South Africa is predominantly black (80.9%), with 7.8% of its population being white, 8.8% mixed race (coloured) and about 2.5% Indians. The country spans 470,900 square miles and has a population of 60,142,978 (Statistics South Africa, 2021). When gold and diamonds were discovered in the 1800s, black citizens were expected to supply the mining labour, accompanied by restrictive land possession policies which forced black miners to live in urban slums. Unsanitary living conditions, disease prevalence, poor health care access and poor health conditions marked these townships (Conmy, 2018). Stark differences in disease prevalence between blacks and white have continued since then (Conmy, 2018). The Gini coefficient for South Africa was 67 in 2018, making it the highest in the world (Sulla et al., 2022). Today, almost two-thirds of the population live in urban areas, exceeding the one-third that live in rural areas.

South Africa is known for its progressive constitution, human rights record and its efforts in ensuring all its citizens have access to quality health care (Department of Health, 2015). According to Harrison (2009), the district-based health system was one of the biggest post-1994 innovations, making health management more responsive to local conditions and the distribution of resources more equitable. Primary Health Care (PHC), as an approach to deliver health care, was initially adopted by the South African Government in 1994 (Harrison, 2009). Since then, much has been done to gear up the health system to implement PHC. Nine provincial departments of health have been established out of the fragmented state of pre-1994 South Africa. Racial and gender inequalities in the managerial structures have been largely eliminated. There has been a large investment in infrastructure and building of new clinics and facilities to make health services more accessible. Services have been massively scaled up to deal with the burden of disease that includes HIV and the associated TB epidemic (Harrison, 2009).

In this chapter, we provide an overview of the key aspects of South Africa's health care system, paying particular attention to the development of the primary health care system and its challenges, recent health policy reforms aimed at achieving universal health coverage, involving all three dimensions – health financing, health delivery, health care regulation – and health policy implementation challenges. This overview is followed by a discussion on power issues, time, context, systems thinking, and recent changes associated with the COVID-19 pandemic and digitalization, with an examination of how these areas interact.

OVERVIEW OF HEALTH SYSTEM: FINANCING, DELIVERY, REGULATION

Health Financing

The National Revenue Fund, a collection of all payments to local, provincial and national governments, funds most of the South African health care. Funds are allocated from central government to provinces (for all sectors) and are dependent upon population sizes. Each province has autonomy to decide on how it will allocate these funds to individual sectors e.g., health and education. Provinces therefore command both financial and administrative power (Michel et al., 2020a). Generating adequate sources of funding has been a key challenge for the health system and without funding, policies do not get implemented. One former minister of finance said, "We cannot spend money we do not have, we cannot borrow beyond our ability to repay. We need to ignite growth and generate more revenue."[1]

In 2001, the heads of states of the African Union committed to the Abuja declaration and promised to increase the country's health expenditure to 15% GDP by 2011. South Africa decreased its health expenditure for the period between 2001 and 2009 (Conmy, 2018). It is important to note that despite failing to meet the Abuja declaration, health care funding is the second highest concentration of government funding, making 13.8% of the national budget (Conmy, 2018). South Africa spends 8.8% of its GDP on health. This is higher than its neighbours in sub-Saharan Africa who spend about 5.5% of their GDP (Conmy, 2018). Mozambique spends less than South Africa on health but the patient outcomes are not better (Michel et al., 2020a, 2020c). Brazil, Russia, India, China and South Africa (BRICS) have increased their health spending and also provided subsidies for the poor (Michel et al., 2020a). In 2013, South African health expenditure was estimated to be US$ 23 billion. In 2025–2026, after full NHI implementation, an estimated US$ 111 billion in health care costs are projected (Conmy, 2018). Where is this revenue going to come from?

The three key dimensions of health financing within the health systems are revenue raising, pooling and purchasing. Pooling, defined as the accumulation and management of prepaid financial resources, creating opportunities for resource redistribution, equitable access and greater financial protection. This has been a key issue for South Africa's health system. There are more than 100 medical schemes and each scheme has a number of benefit packages, so there is considerable fragmentation into many small risk pools (Michel et al., 2020a). In addition to the lack of risk pooling between the tax-funded pool and the medical schemes, fragmented pooling arrangements create barriers to redistribution (Mathauer et al., 2020).

Health system financing and major gaps in insurance coverage constitute one of the major issues in South Africa's health system. To date, over 80% of South Africans have no health insurance and have no choice but to seek treatment at governmental hospitals and clinics, hence the public health system burden. Health financing has been characterized by fragmentation in funding pools and high out-of-pocket payments that have disproportionately impacted the low-income groups. Post-1994 attempts to transform the health care system and introduce health care financing reforms were thwarted, leading to the entrenchment of a two-tiered health system, public and private, based on socio-economic status. This system, which continues to perpetuate inequalities, is unsustainable, destructive, very costly and highly curative or hospicentric (Health Department, 2015).

In line with the global trends, costs have been rising in the South African health system, with pharmaceuticals; laboratory services; blood and blood products; equipment; and surgical consumables. However, there were also specific challenges such as higher costs in the private sector, poor quality of health services in the public sector, and maldistribution and inadequate human resources (Health Department, 2015).

Multiple Interconnected Transitions

Like many other African countries, South Africa is in the midst of multiple interconnected social, economic, epidemiologic, demographic, technological, institutional and environmental transitions. These changes have impacts on the health and well-being, and on the capacity, of health systems to respond to health-related problems. Continuation of free-market policies, inadequate economic growth, rapid urbanization, migration, corruption, and poor management of public services threaten to widen disparities. Most South Africans remain severely impoverished despite social grants, with inferior access to health care (excepting HIV/AIDS care (Benatar, 2013)).

HEALTH CARE DELIVERY

Health care services in South Africa are provided by both private and public institutions. This has created a two-tiered system, one for the well to do and another for those without health insurance. The South African public sector facilities are under-staffed and under-resourced.[2] Quality of care depends on available resources – infrastructural, material and human. An estimated 55.5 million (84%) of South Africans depend on the public health sector for their health care, with 16% having medical aid coverage, allowing them to get services from the private health care sector (Maphumulu and Bhengu, 2019; McIntyre, 2015). This system leads to an unequal distribution of resources between the rich and the poor. At the same time, the health system is plagued by a management and leadership crisis, a cocktail of epidemics, implementation gaps and broader socio-economic issues (Michel et al., 2019). The core health services are provided through a district health system.

The District Health System in South Africa

A district health system (DHS) is the cornerstone of the South African health system (Health Department, 2015). DHS refers to a geographically demarcated area with health care facilities to serve that population. Primary health care facilities serve as the first point of contact with the health system, followed by Community Health Centres (subdistrict), which are slightly bigger, with resident doctors doing minor surgeries like incision and drainage. Cases that cannot be handled at this level are then transferred to the district hospital run by a hospital management team under the leadership of a Chief Executive Officer. The district itself is run by a district health team, headed by the District Manager. She is supported by programme managers, primary health care supervisors and subdistrict managers, among others, to provide support to health facilities. The District Manager reports to the Provincial Authorities who in turn report to National Authorities. Primary health care centers are the first level of contact with the public health system for all patients.

District health services include community-based services (ward-based primary health care services, school health and non-governmental home-based care services), social, environmental and port health services, primary health care, community health centres and district hospitals.

A primary health care (PHC) nurse is expected to have knowledge and skills in the following areas:

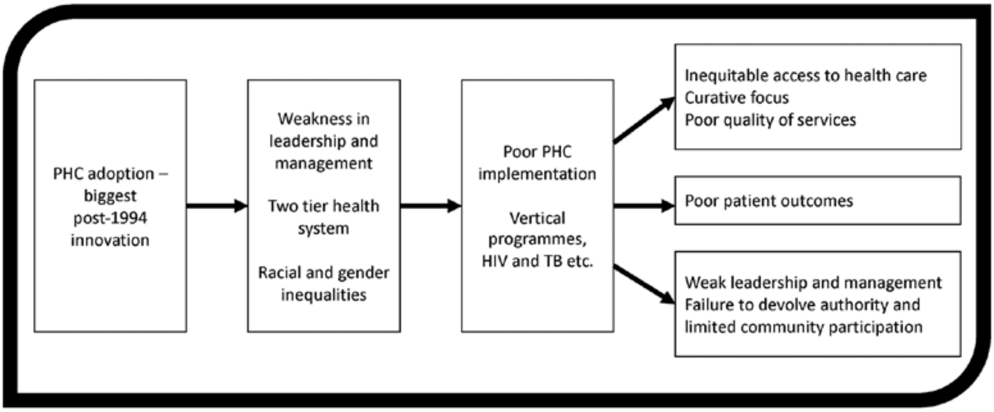
- Chronic diseases and Geriatrics.
- Home Based Care.
- Health Information System.
- HIV/AIDS and STIs.
- Mother and child's health including immunization, integrated management of childhood illnesses, family planning and antenatal care.
- Mental health.
- Minor ailment treatments.
- Prevention of Mother to Child Transmission (PMTCT).
- School Health Services.
- Tuberculosis.

The above programs have to be implemented at clinic level and it is the responsibility of the primary health care nurse to ensure proper assessment, diagnosis, treatment (implementation) evaluation (meeting of targets, monitoring of achievements and non-achievements and remedial action (development of action plans to address failures) to ensure positive patient outcomes (Michel et al., 2019). Hospital services comprise regional, tertiary, central and specialized (such as mental health and infectious diseases) hospitals. Emergency medical services comprise ambulance services, aeromedical services and planned patient transport. The referral policy and implementation guidelines govern the bi-directional movement of patients within the health platform, with community-based services at the base and central hospitals at the top (Health Department, 2015). Gaps in the referral system include lack of guidelines between private sector and public sector referrals, inefficiencies with long waiting times for patients to receive specialist care, which may affect follow-up care and patient outcomes as well as a shortage of specialists.

South Africa's Primary Health Care Approach

In 1994, South Africa adopted PHC, putting it at the centre of health system transformation in the country. The PHC approach has been hamstrung by the failure to devolve authority fully and the erosion of efficiencies through lack of leadership and low staff morale (Harrison, 2009). Below is a diagrammatic summary of PHC in SA from 1994–2010.

Why then did South Africa not achieve PHC the first-time round? According to literature, insufficient attention was given to the implementation of the PHC approach that included taking comprehensive services to communities, emphasizing disease prevention, health promotion and community participation. For the most part there has not been a population focus and insufficient attention has been given to the improvement and the measurement of health outcomes. The massive tsunami of HIV is in part to blame for having diverted much energy, time and resources from focusing on PHC and improving health systems. PHC implementation has been fraught with obstacles including failures in leadership and stewardship, as well



Source: Author's own creation.

Figure 24.1 Historical lines of PHC in South Africa from 1994–2010 (simplified)

as weak management, that have led to inadequate implementation of what are often good policies (Berwick et al., 1997; Ellokor and Gilson, 2012; Leader, 2011).

In 2011, the Minister of Health introduced re-engineering PHC after the realization that unless there was fundamental change in the way in which the health sector functions, South Africa was unlikely to achieve the MDG health indicators for infant, under-five and maternal mortality rates. Nor was it likely to achieve the MDG goal related to HIV and TB. South Africa has selected two vehicles to achieve the ongoing health reforms, namely national health insurance, which constitutes the financing component, and primary health care (PHC) re-engineering, aimed at achieving universal health coverage (UHC). The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services (including social services). PHC re-engineering has been implemented through four streams, namely: municipal ward-based primary health care outreach teams (WBPHCOTs); integrated school health programme; district clinical specialist teams; and contracting-in of private health practitioners at non-specialist level under the leadership of district health management offices (DHMOs). Community health worker and district-based service providers form the foundation of NHI (Conmy, 2018). Most districts now have district clinical specialist teams, contracted General Practitioners and functional school health teams (SyNCH Reporting; Synchronised National Communication in Health). Despite these changes, PHC reforms have, to date, not been able to overcome the challenges in quality of care. Improvement in quality care means fewer errors, reduced delays in care, efficiencies and lower costs (Maphumulu and Bhengu, 2019). Long waiting times, poor infection control practices, and avoidable errors have increased and litigation and poor record keeping have been longstanding challenges (Health Department, 2011; Maphumulu and Bhengu, 2019). Issues with quality of health care in some public health facilities have caused the public to lose trust in the health care system (Maphumulu and Bhengu, 2019). In search for quality, many seek care in the private sector, paying out of pocket (McIntyre, 2015; McIntyre and Ataguba, 2017). Achieving lasting quality improvement in health care seems to be an arduous journey. A recent evaluation revealed inadequate planning, lack of communication, overly bureaucratic organizational culture, non-responsiveness from supervisors and little room for innovation and creativity as barriers to implementing reforms.

South Africa's primary care system also faced key challenges such as the worsening quadruple burden of disease and shortage of key human resources that undermine health reforms in the global South. Similar to other middle-income countries, the public sector in South Africa is criticized for underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure (Health Department, 2015). In 2011, the South African Health review identified three common areas of concern, namely:

- A greatly increased burden of disease, primarily related to HIV and AIDS.
- Significant areas of weakness in health system management.
- Poor health outcomes relative to the country's wealth and health expenditure.[3]
- Over-burdened public facilities.

Human Resource Challenges

Health care practitioners include nurses, physiotherapists, clinical associates, general practitioners, medical specialists, and pharmacists (Marais and Krebs, 2019). According to the World Health Organization, South Africa has a serious shortage: 8 doctors and 50 nurses and midwives per 10,000 population. To worsen this problem, there are vast differences in health worker per population ratios in rural vs urban areas, by province and by private and public sector. The Health Professions Council of South Africa (HPCSA) is a statutory body which governs all health practice in the country and is established by section 2(1) of the Health Professions Act. Studies have been done to calculate the proportion of health professionals who work in the public sector out of total health professionals registered with the HPCSA. While the private sector services cater to approximately 16% of the population who have health insurance, only 49% of nurses, 45% of doctors, 37% of radiographers, 35% of pharmacists, 22% of therapists, 20% of dentists and 15% of psychologists work in the public sector which services 85% of the population. Geographically, Western Cape, Gauteng and Free State have the highest doctor population ratios while Limpopo, North West and Eastern Cape have the worst.[45]

Vacancies are also a serious problem. Recently, 56% of physician posts and 46% of nursing positions were reported to be vacant (Conmy, 2018) threatening the success of these reforms. The South African private sector claim that capacity to train more nurses exists in the country but would allege that the government and regulators like the South African Nursing Council are not cooperating (Staff Writer[Citation], 2022). The recent 2020 South African Public Protector report revealed systemic challenges including staff shortages (Chabalala, 2021).

HEALTH CARE REGULATION

The relevant regulatory authorities in South Africa's health system include the Department of Health, the Health Professions Council of South Africa (HPCSA), the South African Nursing Council, the Allied Health Professions Council, the South African Pharmacy Council and the South African Dental Technicians Council. Health care institutions include treatment facilities that provide a combination of acute, sub-acute, general and specialized services, e.g., hospitals, clinics and other treatment settings (Marais and Krebs, 2019). Although the National Health Act states that a certificate of need (the Certificate of Need) must be obtained prior to the establishment, construction, modification or acquisition of a private health establishment, the provisions relating to Certificates of Need are not yet in effect and consequently the practice is not being enforced by the Department of Health. The licensing of private health establishments takes place at a provincial level, through the applicable provincial department of health, and pursuant to provincial legislation or the General Licensing Regulations, which govern private hospitals and unattached operating theatre units under the National Health Act. Subject to certain exclusions, a 'private hospital' is broadly defined in the General Licensing Regulations and this includes an institution, building, or place that provides treatment and care in cases requiring medical treatment. Under the General Licensing Regulations, no person may erect, alter, equip or in any other way prepare any premises for use as a private hospital without first having obtained the written approval of the relevant provincial department of health.

It is anticipated that, going forward, the requirement to obtain a Certificate of Need will be enforced in respect of all health establishments and that the licensing framework in respect of private health care facilities will be implemented (in future) at the level of the National Department of Health. Under the Medical Schemes Regulations, all health care providers who issue accounts to members of medical schemes must include their practice code numbers (Practice Codes) on their accounts. Practice Code Numbers (PCNs) are issued to private health establishments by the Board of Healthcare Funders of Southern Africa (BHF). The BHF can only issue PCNs to private health establishments that are duly licensed with a relevant provincial department of health (Marais and Krebs, 2019).

HEALTH REFORMS IN SOUTH AFRICA

Currently, South Africa is experiencing the burden of both communicable and non-communicable diseases. In 2021, 8.2 million (19.5%) South Africans were living with HIV/AIDS (Statistics South Africa, 2021) and US$ 1.5 billion has been spent annually on HIV and AIDS programs, a reason also cited for diverting focus and resources from health care system reforms (Conmy, 2018). Non-communicable diseases have a growing burden: in 2018, the ten leading natural causes of death were tuberculosis, diabetes mellitus, cerebrovascular diseases, other forms of heart disease, HIV/AIDS, hypertensive diseases, influenza and pneumonia, ischaemic heart disease, chronic lower respiratory diseases and malignant neoplasms of digestive organs (Statistics South Africa, 2021). Additionally, despite reforms since the end of the apartheid in 1994, health disparities still need to be addressed: life expectancy of white women is 50% longer that of black women, whereas infant mortality disparities among population groups for example 7 per 1,000 for whites vs 67 per 1, 000 for blacks (Conmy, 2018). As discussed in the previous sections, doctor and nurse shortages are creating efficiency gaps in the health care system (Govender et al., 2021) and only a fraction (16%) of South Africans have health insurance. We can add corruption, lack of revenue and fragmented public and private health care systems to this list of problems, which also serve as barriers to health for all.

In order to address these issues, the government recently proposed multiple reforms, which have been framed in terms of the global discourse on Universal Health Coverage (UHC). Included in the Sustainable Development Goals under the health goal, UHC aims to expand coverage and lower out-of-pocket payments. In the case of South Africa, the National Health

Insurance (NHI) bill, brought to the parliament in 2019, was defined as the path to achieve UHC. NHI is designed to improve pooling arrangements so as to better spread risk and improve cross-subsidization. By purchasing services from a mix of public and private providers, the system aims to provide access to quality, affordable personal health services to all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families (Health Department, 2015) through moving from a voluntary to a mandatory prepayment system.

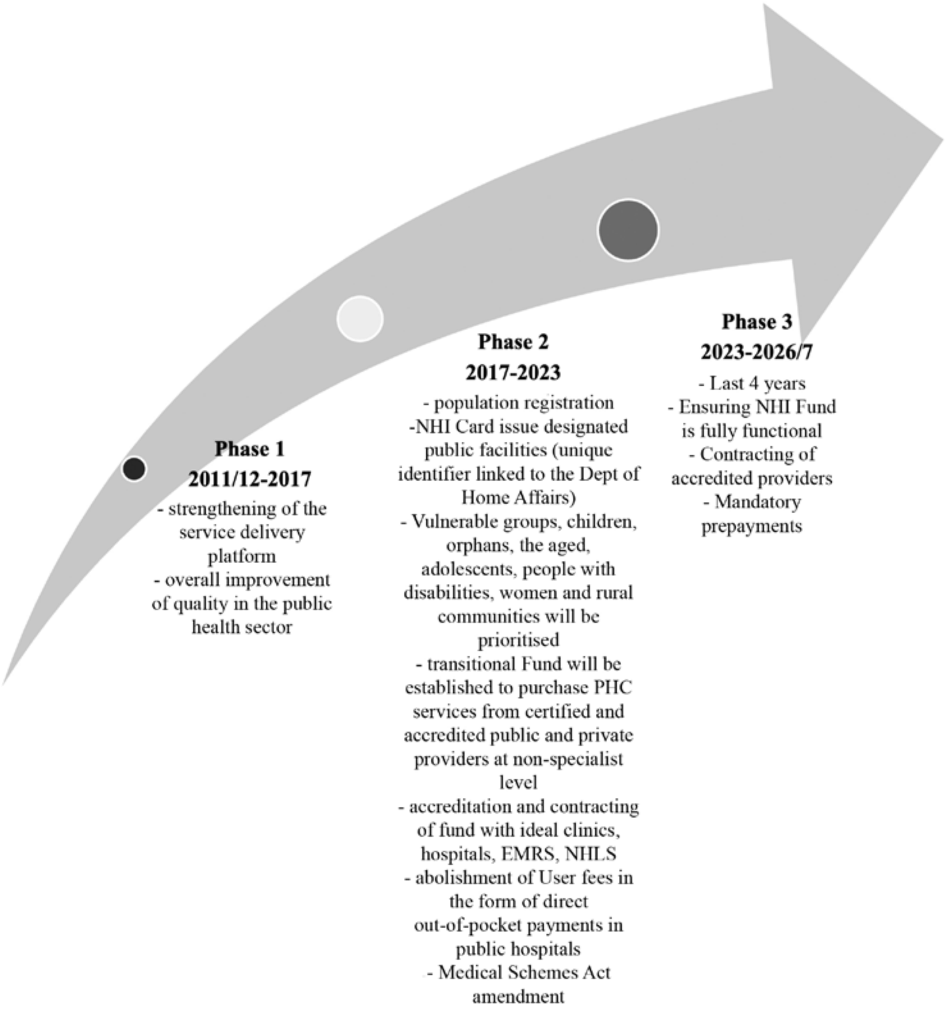
There are additional components in the reform proposals that are explained in terms of health system strengthening and led by the Department of Health in conjunction with other partners. The key components consist of regulatory initiatives aimed at leadership and management strengthening and improving the delivery system such as referral system strengthening, drug supply and supply chain improvement, introducing district clinical specialist teams, ward-based teams as well as school health teams and new methods of general practitioner contracting.

While all these interventions are necessary, unfortunately they have often been implemented in isolation from each other, and without coordination with the overall primary care system. See Figure 24.2 for a diagrammatic summary of the first five years of UHC implementation.

Initial assessment of these reforms described them as ambitious and identified challenges in implementation (Naidu and Basu, 2011). One of the major challenges for policymakers is to demonstrate rapid improvements in the quality of care and service delivery indicators such as waiting time and patient satisfaction; while at the same time addressing the intractable health management issues that bedevil efficiency and drive up costs (Harrison, 2009). Health system strengthening efforts began in 2011/12, and in 2019, only 6% of the public facilities assessed passed muster (70%) (Fusheini and Eyles, 2016).

Governance and stewardship are needed to effectively reform the two-tiered system (Conmy, 2018). The desired and required level of quality services are yet to be reached (Michel et al., 2020c). Many public health facilities have failed to reach the required national core standards score (NCS) (Fusheini and Eyles, 2016) due to human, material and infrastructural challenges (Michel et al., 2019). Additionally, there have been issues in the creation and implementation of the regulatory frameworks, to bridge the gap between the private and public health system tiers. The implementation process, however, has been very slow, partly due to a lack of stewardship, which has been blamed for the stagnation and protraction of reform implementation (Conmy, 2018).

The COVID-19 pandemic and its socio-economic consequences further threatened the UHC agenda. Most South Africans agree, in principle, that UHC is beneficial to all. The road to UHC, though, is fraught with obstacles. A glaring challenge is that the NHI bill, the health financing mechanism, has not yet been passed.[6] The opponents of the NHI bill cite corruption, lack of institutional capacity, leadership, poor planning and foresight and poor states of some parts of the health care system (Michel et al., 2020a; Solanki et al., 2021) as challenges that stand in the way of achieving universal health coverage. Other stumbling blocks are independent medical schemes, the private health sector, consumers that lack trust in public institutions, high unemployment rates affecting the tax base and regressive aspects of value added tax. As key stakeholders, independent medical schemes and the private sector can impede policy implementation if their interests do not align with the proposed policy reforms (Health Policy Project, 2014). The private health care sector in South Africa is flourishing, strong and has



Source: Author's own creation and summary of the NHI plan as described in the whitepaper.

Figure 24.2 Summary of National Health Insurance Pilot envisaged phases: 2011/2–2026/7

a vested interest. The trust in the government to efficiently and effectively manage funding is missing, further compounding the divide. The NHI bill, tabled before parliament in 2019, is still being debated to date. Political will is needed urgently to break the impasse to the UHC agenda (Health Policy Project, 2014; Mazomba, 2017).

IMPLEMENTATION CHALLENGES

The translation from policy to practice has been found wanting (Ellokor and Gilson, 2012; Michel et al., 2019). This section delves deeper into implementation, bearing in mind that health reforms are not an end in themselves and designing policies and rolling them out does not always result in implementation. It is important to understand why South Africa is known for having good policies on paper that do not get translated on the ground. In traditional top-down approaches, it is generally assumed that once formulated, policy will be implemented, thus overlooking process, actors, resources, context, leadership and other critical factors like the lack of implementing actor involvement, how the actors cope, issues of power, communication, context, time and systems thinking (Smith, 1973). This seems to be one of the challenges affecting successful reforms in South Africa. We will examine key factors that explain the disconnect between policy formulation and implementation, paying special attention to the role of leadership, power and context.

Solutions to effective implementation lie in finding ways to resolve the identified issues that make implementation difficult (Michel et al., 2020a). The role of leadership in policy implementation cannot be overemphasized (Michel et al., 2019, 2020a, 2020c). Strong political, economic, education, health, science, institutional and community leaders are needed as a key component of the recent reforms in South Africa such as Primary Health Care (PHC) restructuring (Michel et al., 2020a) and yet there is no blueprint on how to produce leadership. What is particularly daunting is that consequences of leadership are neither immediate nor unambiguous (Ackoff, 2006). Additionally, recent studies revealed that policy implementation could generate both intended and unintended consequences, e.g., ideal reporting, where actors at the frontline report as expected but carry out their work differently and audit driven compliance with national core standards, where health facilities are made ready for assessment visits after which business as usual resumes (Michel et al., 2019). Feasibility assessment, political support and cost effectiveness of a policy and the availability of policy windows (Orpen, 2015) facilitate implementation. John Kingdon describes policy windows as a result of the flow of three streams: the problem stream, the policy stream and the politics stream. When the three streams couple, a policy window opens, facilitating policy change (Guldbrandsson and Fossum, 2009a). The challenge with policy windows is that they open and close quickly. We are of the mind that that the three streams – problem, politics and policy – are still very present in the South African context. South Africa can and has the potential to achieve universal health coverage and provide health for all.

Policy Design, Leadership and Systems Thinking

In the traditional approach to the policy cycle, implementation follows the legislation stage and the operational needs on the ground are often not clear to those in higher offices that often design and decide on policies to be implemented. For example, the primary health care system in sub-Saharan Africa is led primarily by nurses, however (Michel et al., 2018) their involvement in policy development, especially in relation to health reforms aimed at achieving health for all, has been limited. Nurses, along with the other frontline actors implementing reforms, did not understand their roles in policies that were being implemented (Michel et al., 2019). An alignment between the challenges on the ground, as defined by the implementing actors at the frontline, and policy design would not only improve the policy fidelity but would also ensure buy in and increase the frontline worker motivation in South Africa (Michel et al., 2020a, 2020b, 2020c).

Such an alignment will also necessitate seeing change as a paradox. Paradox thinking emphasizes encompassing thinking. It is about holding two truths (and/or) in mind at the same time. The economic, social, technological, climatic, epidemiological and political dimensions of our time have added layers to an already complex and adaptive health care system. In a world plagued with complexities, it is therefore imperative for policy leadership and implementing actors to overcome singular thinking and adopt systems thinking (Fusheini and Eyles, 2016).

Organizations can only cope with so much change and at the same time people have unlimited potential for development and change. Organizational structures, processes and systems on the other hand have life cycles which constrain or enable change in ideas. In a recent study, authors found that implementing actors perceived limits and reported that multiple policy initiatives were carried out without the needed resources (Michel et al., 2019). It takes leadership with systems thinking to ensure that a resources audit is done before a policy is rolled out. Actors associate the lack of resources and preparation for implementation and lack of systems thinking as limiting sustainability (Michel et al., 2020a, 2020b, 2020c).

The ability to handle complexity requires a departure from the one-sided traditional view to incorporating both traditional and paradoxical views through a systems thinking lens. Visionary, inclusive and collaborative leadership with systems thinking capacity is called for. Leadership gaps have been reported widely as a major stumbling block in policy implementation in South Africa.

Power Issues Affecting Policy Reforms

Power is defined as the ability to act or have influence over people or things. It is important to understand who has power in policy implementation in South Africa. Is it those who make policies or those who implement them? One can argue that policymakers have power since they decide on what the policy should contain. On the other hand, the policy implementers are the ones that have to translate policy into practice. So, they have power over the translation or implementation process. Studies in South Africa have documented the extent to which policy actors have complained about having no power over the policy development and the policy adaptation phase when they realize that a policy from above does not fit into their context or needs on the ground (Doherty, 2013; Gilson and Agyepong, 2018; Gilson et al., 2012; Michel et al., 2020b). If we start from the assumption that both the policymakers and the implementing actors have power in implementation process, how can we articulate the types of power and their allocation? Here we can consider the formal and informal powers, both of which can impede or facilitate policy implementation. One possible way to harness these two forms of power is giving the implementers the authority to adapt plans, hire and fire personnel and mobilize resources with the trust they will use this power positively towards achievement of objectives (Michel et al., 2019). Below is a critical analysis of different types of power and how these affect policy implementation.

Different Types of Power

We can identify four types of power in the context of South Africa's health system: coercive power, reward power, legitimate power and referent power. Coercive power involves the use of threats to make people do what is desired. When exercised, people get threatened with demotion or being fired. This kind of power has been used extensively in the health institutions in South Africa. The fallacy of job appraisals has been reported too, with favouritism and sometimes threats to the supervisors if the appraisal is poor. The second type, *reward power* relates to monetary or other kinds of rewards such as benefits or training opportunities, which are used to influence performance. The Performance Management System (PMS) that has been used in the South African Health sector since 2001 is one of the examples that utilizes this power as a way to incentivize and reward employees. However, the PMS was not implemented systematically, often citing lack of funding as the reason. Some studies revealed the PMS as unfair with incentives and promotions dependent upon personal relationships between employees and supervisors rather than on effort (Tyokwe and Naiker, 2021), demoralizing and demotivating the frontline actors.

The third type, legitimate power, comes from having an official position in an organization, e.g., Chief Executive Officer (CEO). This type of power can be tied to reward and coercive powers as an official, e.g., The Chief Executive Officers in the South African health system can theoretically hire, fire, and reward performance to a certain degree. Most of the power however, rests with the province (Chipkin). Finally, referent power emanates from having a large group of followers. This is typically held by charismatic leaders (Different Types of Power). How prevalent this type of power is in the South African health system is not clear. As seen from the above types of power, both policymakers and policy implementers hold power in their respective spheres and harnessing these different types of power would necessitate the involvement of policy implementers in policy development, communication, implementation and evaluation (Michel et al., 2018, 2020b). If, on the other hand, they are not given authority but only responsibilities, implementers are sometimes perceived as usurping power, for example when they engage in ideal reporting, reporting as expected rather than what is actually happening on the ground. The actors are aware of the fact that they are not entitled to do what they are doing but are forced to do so by the situation on the ground (Michel et al., 2019), such as lack of staff, equipment, time and even drugs. Acknowledgement and appreciation of different kinds of power held by implementers could lead to creating better mechanisms for policy development, building on allocation of authority and responsibilities, cooperation and communication, as both groups need each other for policy implementation to succeed.

Tactics Used When the Supervisors Have No Power and Communication Fails

Power to change and adapt policy or mobilize resources is fundamental to successful policy implementation. Communication in both directions is a key facilitator of successful policy implementation. Policymakers, policy implementers, and policy beneficiaries all want to be heard. When not heard, all parties develop coping mechanisms which are either passive or pressure tactics. Studies examining the implementation process have shown that implementers often felt that their requests are ignored by supervisors. Similarly, communities and patients reported how they are ignored by the facility health care workers. In the case of community complaints about facility worker attitudes and behaviours reaching the district management,

Table 24.1 Pressure or passive tactics

	Passive tactic	Pressure tactic
District level	Non-responses to requests and motivation letters from facilities (Michel et al., 2019)	Buck passing, policing supervision, discipline when things go wrong (Michel et al., 2019)
Facility level	Policy adaptation and ideal reporting (Michel et al., 2019, 2020b, 2020c)	Sitting in at the district office by facility staff to make requests heard (Michel et al., 2019)
Patient/community	Threats to staff Writing letters and reporting facility staff to the district (Michel et al., 2019)	Service delivery protests by communities (Michel et al., 2019)

Source: Author's own creation.

supervisors respond with pressure or passive tactics. The implementing actors reported finding themselves caught between the communities they serve and the policymakers at the top (Michel et al., 2019).

Pressure or Passive Tactics When Caught Between a Rock and a Hard Place

Implementation failure can result from policy failure (design), poor implementation, lack of resources, bad luck or too much policy. In a recent study where implementing actors were interviewed, they narrated how they wrote their supervisors requesting for personnel, equipment, etc. and did not receive responses (Michel et al., 2019, 2020a, 2020c). On the other hand, when patients hear of the policy initiatives on radio and TV, they visit health facilities with high expectations, like short waiting times and clean facilities, only to be met with the opposite. In the same study, staff at the frontline revealed that when trying to cope with limited resources, they found themselves answering to both patients and supervisors (who often did not respond to requests) and explaining why the conditions on the ground are not up to standard (Michel et al., 2019, 2020a, 2020c). Although they had no power to change things, nor any control over resources, they often found themselves being blamed for situations beyond their control, witch-hunting and passing the buck. To cope with this, the staff reported using either passive (ideal reporting, audit-driven compliance with national core standards) or pressure tactics like sitting in at district office until they were heard (Michel et al., 2019, 2020a, 2020c). These passive tactics are bringing an added layer to policy-practice gaps in the South African health sector (Michel et al., 2019). See Table 24.1 for both pressure and passive tactics used by both policymakers and implementers.

The Concept Time and Policy Window in Implementation

Another critical concept in reform implementation is time. The issue of time matters even more in pandemic setting as delays in public health interventions can have serious consequences (Stratil et al., 2020). The concept time in the South African reform implementation context emerged as having many different connotations, as described below. A concept of time as a resource. Multiple reforms are rolled out and implementing actors hardly have time to focus and see through one initiative before being pulled over to implement the next one (Oboirien et al., 2018). Against the backdrop of human resource shortages and restless patients in South Africa, this challenge is exacerbated by impromptu meetings and offsite trainings

(Fusheini and Eyles, 2016). Time spent in meetings has been cited as preventing staff from implementing policies.

Time is often conceptualized in the policy literature as a period of opening-policy window where the problem, policy and political streams align (Guldbrandsson and Fossum, 2009a).[7] We observed this happening with funding windows, that is when funds available within a specific time have been associated with accelerated use of guidelines in some countries. Sustainability, however, has been found wanting (Mala et al., 2015).[8] If, indeed, there is a policy window, the role of leadership and of change agents emerge as key elements to maximize the policy window. A mistiming can lead to policies not being implemented.

Time as a context involves multiple aspects such as societal, cultural, environmental and technological contexts. Some actors refer to time meaning this era of technology or COVID-19, etc. Environments can change faster overtaking policy implementation in some instances.[9] The COVID-19 pandemic, the war in Ukraine and climate changes – events of our time – are also affecting policy implementation in South Africa. Time as an opportunity to look back, learn and gain insights and say what worked and what did not work. The HIV denialism in South Africa is estimated to have caused 330,000 premature deaths between 2000 and 2005, as well as 3500 babies born with HIV infections that could have been prevented (Roeder, 2009). Has South Africa taken this as a learning opportunity to avoid policy implementation delays in future? Only time will tell.

Time as a period continuum – process: policy implementation is a process and does not happen overnight. In the study referred to above (Michel et al., 2019, 2020a, 2020c), the actors revealed how important it is to plan for transition states (Michel et al., 2020b). A transition authority could serve the purpose better as the actors also expressed the need to have a contact person in case there is a policy-practice discrepancy. Transitional authorities have the potential to save time and enhance policy implementation. Even in instances where human, technological and other resources required for successful implementation are present, it takes time to put all needed systems in place and to make them work effectively (Weaver, 2010).[10] Support in understanding and adapting policy to context is imperative. The lack of supervisory support in the health facilities in South Africa has been reported widely (Michel et al., 2018, 2019, 2020a, 2020b).

Context

The importance of context in implementation cannot be overemphasized. Context in implementation includes cultural, social, economic, political, legal and physical environments including institutions, stakeholders, their interactions, demographic and epidemiological conditions (Mthethwa, 2012). The health system structure, roles played by the government, NGOs, other private providers and citizens, country and region, also affect policy implementation (Mthethwa, 2012). The contexts in which policies are developed influence the content of policy, nature of policy process, actors involved in policy formulation and implementation (Mthethwa, 2012). Evidence-informed decisionmaking is value laden and often a politicized process (Baltussen et al., 2013; Baltussen and Niessen, 2006; Kapiriri et al., 2019). South Africa is an upper-middle-income country marked by a history of apartheid policies. How colonial public health measures and their authoritarianism affect and continue to affect the health care system in South Africa should be studied carefully, if reforms are to be successfully implemented (Ranger, 1987; Turshen, 1977).

THE COVID-19 PANDEMIC AND NEW TRENDS IN HEALTH CARE DELIVERY

COVID-19 as an Endemic Disease

The SARs-CoV-2 pandemic has made further dents into health systems in Africa by affecting preventive, promotive, curative and restorative health care services, worsening the continent's performance in sustainable development goals (Effiong et al., 2020).[1112] In South Africa, COVID-19 life-saving equipment and protective clothing were found deficient in some hospitals during a 2020 Public Protector visit (Evans, 2021; Public Protector, 2021). The 5th March 2020 was a significant date for South Africa as the National Institute of Communicable Diseases (NICD) announced the first confirmed SARS-CoV-2 positive patient, marking the beginning of an epidemic. The pandemic impacted everyone from the individual, family, and the community to the broader socio-economic and environmental and political structures. The effects were devastating, particularly among the vulnerable populations, children, people living with disabilities, farm workers, migrants and the poor.

An all-of-society response was needed and to that effect the Ministerial Advisory Committee (MAC) was established to mitigate the pandemic effect through provision of evidence-based advice and leadership. World-class home-grown genomic surveillance, clinical and laboratory data analysis, and vaccine efficacy trials, among others, facilitated an effective response to the pandemic. South Africa is currently engaged with the critical issue of how best to manage COVID-19 as an endemic disease and how to integrate it into the health care system (Govender et al., 2021). In Cape Town, for example, self-organizing neighbourhood-level community action networks (CANs) rose to the COVID-19 challenge by pooling resources, often beginning with a WhatsApp group, cooking for neighbours, and retired nurses and grandmothers becoming the first port of call for medical advice. This demonstrated the power of informal networks and collective action in community health systems in times of crisis (Van Ryneveld et al., 2022).[13] Despite such signs of resilience, declines in health care service use observed during the COVID-19 pandemic were attributed to a shortfall in the South African health system resilience (Arsenault et al., 2022).[14] More needs to be done in this regard.

Digitalization Initiatives

The Department of Health in South Africa has embraced digital health to improve access to health care services, promote health behaviours, and increase health care coverage, though poor infrastructure, information technology and connectivity, issues are yet to be resolved (Health Policy Project, 2014). The 2012–2016 eHealth Strategy strengthened governance structures, created integrated platforms for information systems and the use of a unique patient identifier for patients at various health system levels, and enhanced mobile health, for example MomConnect (Department of Health, 2019).[15] The National Digital Health Strategy for South Africa 2019–2024 sets the scene for digital health to play a key role in the National Health Insurance and consequently to the health and well-being of all South Africans. The South African Digital strategy proposes nine strategic interventions to be achieved by 2024, namely:

1. Develop leadership capacity for digital health innovation and adaptive management.

2. Undertake appropriate multi-stakeholder engagement for shared opportunities and successful digital health implementation.
3. Develop sustainable interventions and appropriate investment and funding mechanisms for digital health implementation.
4. Review and strengthen governance structures and oversight mechanisms for the implementation of the strategy.
5. Establish an integrated information architecture for interoperability and effective, safe sharing of health information across health systems and services.
6. Develop appropriate digital applications and services that improve health services for patients and health workers.
7. Establish a robust physical and network infrastructure and broadband connectivity for priority digital health applications and services.
8. Formulate national legislative, policy and regulatory framework for digital health.
9. Develop enhanced digital health technical capacity and skilled workforce for digital technology support and implementation (Department of Health, 2019).

Some digital initiatives have been rolled-out successfully. One such digital initiative is Synch. This initiative allows for online patient registration, selection of approved Pick-up Points (PoP), electronic submission of prescriptions to Centralised Chronic Medication Dispensing and Distribution (CCMDD) service providers, scanning possibilities for patient medicine parcels and automated reporting at various health system levels. Twenty million people were registered on the outpatient registration system at 2900 public health care facilities while 2.1 million users were registered for CCMDD, with 3167 clinics and community health centres giving a 92% coverage (SyNCH Reporting; Synchronised National Communication in Health). Digital health has therefore been embraced and identified by South Africa as a significant driver of the health system transformation (Department of Health, 2019).

CONCLUSION

This chapter provided an overview of the South African health care system with a particular attention to implementation. We have argued that reform development, implementation and evaluation are linked as they are parts of a system (Senge, 1999). Leadership, time, context, human resources for health and the reforms themselves are additional parts that are linked and interact in important ways. A dysfunction in one part of the system affects all the other parts and consequently the outcomes. One key conclusion we would like to highlight involves policymakers who should treat health care as a complex system and apply principles of complexity science, one of which is systems thinking (Senge, 1999). It is also worth noting that, in such a system, consequences of our actions are neither immediate nor unambiguous (Senge, 1999). For example, school closures to contain the spread of SARs-CoV-2 can lead to parents reducing working hours which in turn can lead to shortages of staff in the health care sector and consequently affect service delivery (Stratil et al., 2020). The recent South African 2020 Public Protector report revealed provincial health departments (Limpopo, Mpumalanga, KwaZulu-Natal and Gauteng) experienced systemic challenges that in turn affected health care service delivery (Chabalala, 2021; Public Protector, 2021). Understanding of country context, the multi-faceted concepts of time, the resources, the key actors and how these are linked and interconnected is essential if reforms are to succeed.

The South African health care system is fragile, plagued with many challenges ranging from leadership, a mostly top-down approach to policy design, health financing, human and material resources, infrastructure, resistance from actors with vested interests, realities and challenges of policy windows, and a context with a colonial past among others. The operational needs on the ground are often not clear to those in higher offices that design policies to be implemented. The primary health care system in South Africa is mostly nurse-led (Michel et al., 2018). The involvement of nurses at the frontline in all stages of policy, from policy development to evaluation, is fundamental for effective health reform implementation. Involvement of the frontline actors does not only lead to policy alignment but also ensures buy in and increases their motivation. Policy design is one component of health reforms, successful implementation is another. As South Africa advances the universal health coverage agenda, health financing issues are yet to be resolved. To increase the chances of successful implementation of the current reforms, we recommend conducting a feasibility study and making adjustments accordingly. The three streams – policy, problem and political – have already collided and the policy window, in our view, is still open. South Africa has the potential to achieve health for all.

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25. Russian Federation: conflicting health policy logics

Olga Zvonareva, Ekaterina Borozdina

INTRODUCTION

If asked to characterize Russian health policy in one word, we would propose the word 'contradictory'. After the end of the Soviet Union, far-reaching reforms were initiated, including the introduction of obligatory medical insurance, emergence of paid medical services, the launch of the health care modernization program, and the development of a complex system of medical standards to regulate health care provision. However, these transformations have been driven by multidirectional policy logics that result in divergent and sometimes incompatible institutional designs.

At the core of these conflicting logics in Russia lie uneasy relationships between the state, the market, and health care professionals. The post-Soviet Russian state has continued positioning itself as a guarantor and provider of health care for all and exercising strict control over the health sector. But, simultaneously, market mechanisms have been expected to fill financial and regulatory gaps, which has produced a rapid and inconsistent health care marketization process. In these circumstances, health care professionals possess limited professional autonomy and, despite their specialized knowledge and experience, are barely involved in policy-making. Patients, furthermore, are referenced as recipients of health care services in policies and official statements but excluded from participating in their formulation. Contradictions between the state and the market, together with the position of health care professionals and patients form a general background, are important for understanding health policy and health care delivery in Russia. In this chapter we delineate major tensions and uncertainties produced by this background and trace how they are dealt with in practice by actors on the ground.

Analysis provided in this chapter is rooted in two bodies of scholarship that examine contradictory policy trends and their consequences for Russian health care organizations and practice. The first body of scholarship is social policy studies. It aims to define the types of health care regimes, which have evolved in the aftermath of socialism. When describing the Russian case, social policy scholars concentrate on the partial and inconsistent nature of the post-Soviet transition – they characterize health care regime as a hybrid, which combines Soviet statist legacy with marketization and neoliberal principles of health care governance (Cook, 2014; Matveev and Novkunskaya, 2020). Actual incompatibility of those governing principles that was aggravated by the inconsistencies in their implementation has contributed to the increase in health-related inequalities and proliferation of informal coping strategies. Acknowledging the scope of the later phenomena, some researchers even suggest viewing informality as a distinctive regulatory logic in post-socialist health care, along with market and bureaucracy (Riska and Novelskaite, 2011).

The second body of scholarship focuses on the ground-level transformations and aims to explore practices and identities that inhabitants of the health care institutions develop

(Rivkin-Fish, 2005). This approach is consistent with social policy perspective on post-socialist health care transformations but intends to add more depth and nuance to it by studying how policy solutions translate to the everyday life of citizens. Institutional theory provides us with the assumption that institutional discrepancies, which result from reforms, inevitably stimulate agency of actors who inhabit organizations (Seo and Creed, 2002). Being plunged into the uncertain organizational context, individuals either have to reconcile discrepancies in order to maintain existing arrangements or attempt to use the momentum to their advantage. While still focusing on the issues of state interventions in health care, effects of marketization, and informal solutions, this scholarship highlights the role and agency of ground-level actors.

In what follows, we employ these two analytical perspectives to explore the uneasy relationships among the state, the market, health professionals, and patients that develop within Russian health care. We sketch major transformations in the Russian health system following the dissolution of the Soviet Union and bring to light the contradictions produced, taking account of the daily life of health care facilities.

SHIFTING GOVERNANCE AND REGULATION

During recent decades, the Russian health system has experienced major transformations. One way to take stock of the multitude of changes is to scrutinize the role of the state and attempts to redefine it following the dissolution of the Soviet Union. Below, we trace an uneasy balancing process between different roles the state attempted to adopt, and implications of this process for the health policy landscape in the country.

In the USSR, the state positioned itself as a guarantor of the people's access to care and public health protection (Schecter, 1992). It was the single source of finances, technologies, and guidance. Importantly, the centralized and publicly funded Soviet health system, with no involvement of market elements and an emphasis on universal health coverage, served as an articulation of the communist ideas of society (Zvonareva, 2020). The Soviet health system served as an important avenue for promoting foreign policy goals. Via assistance programs and platforms of international bodies such as the World Health Organization, the USSR transmitted a message to the countries undecided about their allegiances in the Cold War: only by adopting the Soviet form of society, will they be able to provide for the health needs of their citizens (Geltzer, 2012).

In practice, the Soviet health system did experience difficulties. During the first decades of its existence, significant improvements were achieved in areas such as controlling infectious diseases and decreasing maternal and infant mortality. Its architecture was rather effective for implementing broad public health measures, preventing communicable diseases, and responding to outbreaks. However, by the time the disintegration of the USSR was complete at the end of 1991, the health system had already suffered from multiple problems, including chronic underfunding, outdated medical technologies, and bureaucratic rigidity (Cook, 2017). These problems complicated realizing the promise of the Soviet state and produced difficulties and inequalities in accessing adequate care (Shishkin, 2017).

Upon the disintegration of the USSR, the Russian health system, with its accumulated problems, plunged into a fully-fledged crisis. The Russian state, however, did not give up on a broad spectrum of guarantees articulated previously by the Soviet state. It appeared to preserve, at least as a principle of public policy, the right of all citizens to access free care for virtually all kinds of health conditions (Shishkin, 2018). But while realizing this promise was difficult previously, now it was outright impossible. Under conditions of political turmoil and economic decline, state financing for the health system fell by an estimated one-third, salaries of most health care workers barely corresponded to subsistence levels and inherited infrastructure was deteriorating. Qualitative studies that investigated people's experiences with Russian post-1991 healthcare highlight widespread concerns about inaccessibility of care. Informants shared stories about the necessity to pay for services that, formally, were free, traumatic instances when they were unable to receive adequate care and feeling lost and abandoned generally in the atmosphere of indifference (Brown and Rusinova, 1997). At the same time, growing levels of inequality meant that this large strata of people with restricted access to care coexisted with a smaller group of people whose access to highly-skilled professionals and elite well-equipped organizations, was much better, due to their ability to pay.

It is at this moment that attempts to reposition the state with regards to the health system in Russia become discernible. On the one hand, Russia's Constitution came into force in 1993 and its Article 41 reaffirmed the universal right to health protection and care, which should be provided to individuals for free. On the other hand, during the first half of the 1990s, far-reaching market-style reforms were introduced. These reforms can be understood as moving in the direction of de-statization in a sense of systematically diminishing the previously central role of the state. First, sources and mechanisms of health care financing changed. The single-payer public budget financing model was abandoned. Instead, a system combining mandatory health insurance (MHI) with government funding was introduced, not least due to the urgent need to find supplementary sources of funding for healthcare and to reduce pressure on the federal budget (Burger et al., 1998; Sheiman, 1994). MHI system, financed by a combination of payroll tax and regional budget contributions, has not substituted fully the direct government allocations but over the years has been growing in importance. While in 1994 MHI constituted only 24% of total public spending on health, by 2017 it grew to 58% (Shishkin et al., 2019, p. 8). Second, the rise of the private sector in health care delivery was made possible through legally permitting previously prohibited for-profit health services provision, and public institutions were also now allowed to charge a fee for medical services. Concurrently, private health expenditures, which mainly consist of out-of-pocket payments, grew significantly, reaching about 40% of total expenditure on health by 2000 (Popovich et al., 2011). More recently, the World Health Organization estimates that in 2018 private health expenditures still constituted 40% with 2% coming mainly from voluntary health insurance contributions and the remaining 38% being out-of-pocket payments (World Health Organization, n.d.). In comparison, in the EU, countries' private health expenditure on average does not exceed a quarter of total expenditure on health (Shishkin, 2018). Additionally, previously state-controlled pharmaceutical and medical equipment production and distribution were now privatized. Third, alongside privatization, the health system underwent decentralization with more responsibilities being placed upon regions and municipalities.

These reforms were introduced rapidly within the wider tide of transformations aimed at moving Russian society towards market economy and democracy. Amid the reforms, the position of the Soviet state appeared too paternalistic and stifling for the market economy, so the newly formed Russian state experimentally occupied an uneasy dual position. This position involved proclaiming the state guarantees of free health care for all, which seemingly accorded the state the already familiar role of a provider. But simultaneously it involved withdrawal from social welfare provision, giving space to market forces expected to create efficiency and responsiveness via competition, choice, and decentralized coordination. This latter, much less vocally, proclaimed move granted the state a new role of enabler. Since departing from the idea of free health care for all would have been widely unpopular among virtually all stakeholders, the introduction of market forces has been camouflaged behind restatements of citizens' right to free health care. This tension between the state's ambition to be a guarantor and provider of health care for all under the conditions of insufficient resources and reliance on market mechanisms to compensate for insufficiencies continues to characterize health policy landscape in Russia.

Decision-making with regards to health policy in Russia has been characterized, generally, with high speed and low transparency. State actors are accustomed to developing programs and projects under condensed timelines, which necessarily limits possibilities for consultation and feedback (Zvonareva, 2020). Formal evaluation of policy impacts is rarely conducted. Policymakers operate in isolation from society and often from each other; consequently, many decisions arrive suddenly to those affected by them, breeding uncertainty. At the same time, patient organizations and other non-governmental organizations may sometimes exercise an active role in formulating health policy problems and solutions. Having learned 'rules of the game', groups successful in participating in policy-making processes work through 'bureaucratic bargaining', avoiding drastic turns and confrontation (Bindman et al., 2019; Holavins and Zvonareva, 2022).

SEARCHING FOR A NEW MODE OF FINANCING

Neoliberal ideas about market forces animated much of the healthcare reforms in the early 1990s. Market self-regulation was expected to smoothly mediate relationships between the actors in the health system. Implementation of MHI in 1993 – one of the most significant changes in the post-Soviet Russian health policy mentioned in the previous section – bears an imprint of these neoliberal economic ideas. MHI system implied participation of multiple for-profit private health insurance organizations that would compete among each other and purchase healthcare from providers under the 'competitive contracting' model. According to its proponents, such competition would be in the interest of the insured who would benefit from an expanded choice on the two levels. First, insured citizens would be able to choose any insurance organization for themselves and change insurers if they wish. Second, via choosing an insurer, citizens would also be able to choose among alternative care providers contracted by their insurer. Enhanced ability of patients to exercise choice was expected to improve the quality of health care provision since financial resources would 'follow the patients' who, in turn, would choose better providers. Patients' choice was also meant to improve responsiveness since, competing for patients, insurance organizations would be compelled to offer more relevant and efficient services.

However, pre-existing Soviet infrastructure, bureaucratic routines, and entrenched lines of responsibility for health care administration and financing proved to be unexpectedly resilient (Balabanova et al., 2003). Instead of competition, efficiency, and responsiveness, market principles introduced in the post-Soviet context gave rise to a complex public-private mix, underfunded and inconsistently regulated (Twigg, 1998, 1999). From the very beginning, the prospects of a 'competitive contracting' model were limited by the insufficient legal and financial infrastructure and the presence of only a single source of health care provision in many localities. The newly emerged private insurance organizations gradually adopted a role of passive intermediaries in the transfer of finances from regional MHI funds to health care providers (Shishkin, 2018). Influence of insurance organizations and, thus, patients' choice on the allocative efficiency within the MHI resource distribution system, and on the efficiency of health care provision more generally, turned out to be minimal (Gordeev et al., 2011). Furthermore, the openness to new players implied within the initial move towards marketization gave way to the dominance of large insurance companies that lobbied for an increase in the minimal capital requirements for insurance organizations to be allowed to participate in MHI to further complicate market entry (Shishkin, 2018). Finally, the decentralization envisioned as a foundational principle of the MHI system at the onset of the reform was substituted by a series of compromises between de- and re-centralization tendencies (Popovich et al., 2011). One such compromise concerns the relationships between MHI funds and the Ministry of Health. One Federal and 85 regional (one for each administrative region of Russia, some of which additionally have local branches of regional funds) MHI funds manage implementation of MHI. Originally funds were envisioned as independent of the Ministry of Health and its subordinate regional health authorities. But in an attempt to consolidate planning and funding, the Ministry of Health came in control of MHI funds and assumed the responsibility for inspecting the Federal MHI Fund. Another compromise concerns relationships between the Federal MHI fund and regional MHI funds. During the initial implementation period, MHI contributions were accumulated and distributed at the regional level. But, since 1st January 2012, all MHI contributions from employers and regional budgets alike have been accumulated centrally by the Federal Fund that redistributes these contributions to the regional MHI funds, which are now controlled by both the Federal MHI Fund and regional governments. Overall, rapid and radical market-style reforms of the 1990s have met an opposing current (Twigg, 2002). Together, they pull the Russian health care system in different directions creating a patchwork of rules, command channels, and bureaucratic tools (Sheaff, 2005).

The elements delineated above constitute the visible side of the inconsistent marketization of healthcare. There is also a less visible, but no less important, side. It has been termed shadow commercialization and emerged originally in the 1990s in part as survival strategy for health care workers. While the Russian state continued mandating free provision of health services, as discussed above, its public health funding became inadequate to support care provision infrastructure, personnel, and guaranteed services. Health professionals and organizations responded with 'spontaneous and unofficial replacement of free services with paid ones', charging informally for treatments (Blam and Kovalev, 2006; Feeley et al., 1999 cited in Cook, 2017; Gordeev et al., 2014). This presents a vivid example of what Cook (2007) termed Russian 'informalized welfare state': while trying to maintain universal social and health care guarantees, the early post-Soviet state did not have sufficient resources to realize its promises and citizens had to compensate this lack of budgetary funding through unofficial payments for medical services (Fotaki, 2009).

Following an act that permitted public healthcare institutions to provide paid medical services issued by the government in 1996 (Government of the Russian Federation, 1996), the shadow commercialization began taking a different form. Among a widespread uncertainty among the patients about which treatments and which diagnoses are covered under the 'free' benefits package, 'cash register' payments started to, first, complement and, later, partly substitute informal payments. Starting 1998, the government attempted to introduce more precision with regards to which health services exactly must be provided to the population for free.

For this purpose, the program of state guarantees was developed and adopted as obligatory for all Russian regions. It stipulates an extensive list of health conditions to be treated for free and is updated annually. The list of health services not covered by the guaranteed package is small and includes, for example, pharmaceuticals prescribed by outpatient organizations, cosmetic services, and adult dental services (with some exceptions such as veterans). However, the program of state guarantees has not done away with shadow commercialization. As the guaranteed package has continued to promise more health care than the government could fund, public health care organizations have continued to provide a high volume of services for a fee. Since public health care organizations have a right to charge fees for medical treatments provided outside of the guaranteed package or on conditions other than those stipulated in the program of state guarantees, they often turn de jure free services into de facto paid ones. Paying patients may, for example, be granted an opportunity to circumvent waiting lists or visit a particular specialist, while still attending the same facility with the same equipment and staff. As a result, boundaries between free and paid healthcare remain blurred.

REORGANIZING HEALTH CARE PROVISION

It is hard to avoid mentioning the Semashko model when speaking about health care provision in Russia. Named after the first USSR Minister of Health Nikolai Semashko, it refers to a multi-tiered system with strict referral rules and the principle of universal access to care as its basis developed in the USSR. Since the beginning of the 1990s, health care delivery reforms have been taking place in Russia to make the inherited Semashko model more suitable to contemporary conditions. However the Semashko model remained almost untouched because while the design of reforms implied significant changes to care provision their actual implementation has not always corresponded with what was envisioned (Sheiman et al., 2018).

One of the most important features of the Semashko model, the original and the current one, is the patient list. The patient list consists of the people enrolled in a particular primary care facility. This facility is then responsible for the health of the people on its list on a long-term basis. In the original Semashko model it was district physicians (DPs), who were the sole providers of primary care. In that context, DPs were generalists who handled most of the contact with patients independently and referred further those patients who required specialists' attention. Currently, the major provider of primary care is the multispecialty publicly-owned polyclinic. In contrast to the model of self-employed general practitioners (GPs) or group GP practices popular in, for instance, the European Union, in contemporary Russian primary care settings patients have access to a wide range of specialists under the same roof.

This emphasis on multi-speciality polyclinics emerged in the process of restructuring health care delivery, initiated soon after 1991 and aimed at addressing the dominance of inpatient care in the overall care provision. First, the number of hospitals was decreased: between 1991 and 2014 it fell by a factor of 2.3 across the country and by a factor of more than 5 in rural areas (Shishkin, 2018, p. 235). Second, there were attempts to move patients to outpatient settings, including, initially, a shift to a GP model. Plans to rely on GPs as the core of primary care, however, were implemented inconsistently. Few GPs have been trained and the total number of primary care physicians, both GPs and DPs, per resident has been insufficient (Gerry and Sheiman, 2018). As a result, primary care physicians have been overburdened, having to hold more than one position and serving, on average, 2630 patients per position, which is significantly higher than the target of 1700 patients set by the Ministry of Health (Sheiman, 2018). To compensate for this shortage of generalists, the number of specialists in primary care settings began to grow, which resulted in most of the polyclinic services being provided by specialists (about 60–65% of visits) (Sheiman, 2018). This 'extended' primary care composition was formalized in 2011, when the new federal law 'On the fundamentals of health protection in the Russian Federation' specified that primary care consisted of primary care as such to be provided by DPs and GPs and specialized primary care to be provided by specialists. In this way, multispecialty polyclinic became the basic unit of primary care provision, while the primary care itself assumed a very broad meaning, becoming synonymous to the entire outpatient care.

DPs and GPs, apart from being limited in numbers, do not occupy the core position in primary care anymore. In theory, these primary care physicians are supposed to serve as gatekeepers, referring patients, when needed, to specialists and hospitals and ensuring the continuity and coordination of care provided on different levels. In practice, the gatekeeping often malfunctions, with patient visits to specialists bypassing DPs and GPs. DPs and GPs rarely develop patient management plans jointly with specialists, tend to be unaware of their patients' hospital admissions, and seldomly receive timely feedback from specialists they refer their patients to, all of which is indicative of the fragmentation of care (Sheiman and Shevski, 2014). For patients, these problems imply the lack of a long-term relationship with a particular practitioner who would know their history and life circumstances (Zvonareva et al., 2017). Indicative of the difficulties patients experience in navigating the system of primary care provision is the high proportion of patients who visit emergency departments. It is estimated that the frequency of emergency visits is nearly three times higher in Russia than the average for OECD countries. Feeling unable to receive adequate care in their polyclinic, some patients report 'calling an ambulance' as a strategy they routinely rely on to obtain medical help.

Therefore, despite all efforts, inpatient care still dominates the overall system of health care provision in Russia. This is reflected in the distribution of funding: among all items of public health expenditure, inpatient care receives 50.3% while outpatient care – only 33.2% (Fleck, 2015 cited in Sheiman, 2018). Much hope with regards to unburdening the inpatient care level has been placed on the ongoing large-scale federal program of so-called 'dispensarization'. This program specifies that each resident enrolled in a patient list in a particular polyclinic is supposed to have a set of check-ups and screenings every three years. The program has been very effective in detecting new cases due to its substantial coverage. However, the program's positive impacts, including the hoped-for shift from inpatient to outpatient care, are limited due to a lack of consistency in follow-up. It is estimated that no more than half of the cases detected are followed by appropriate long-term management by primary care providers (Sheiman et al., 2018). Thus, it is not rare that early-stage cases reach an advanced stage, acute cases become chronic, and exacerbations occur, all requiring hospitalization and/or advanced technologically sophisticated care.

It needs to be noted that the number of private health care organizations remains small in Russia. For example, as of 2010, 124 private hospitals operated in the entire country, 120 of them in major cities (to compare, there were more than 6500 public hospitals in the entire country in the same year) (Popovich et al., 2011, p. 38). Contrary to the marketization ideals, there are persistent barriers for participation of private health care organizations in the MHI system. On the one hand, theoretically, such elements as fixed-price reimbursement rates for all providers of given procedures and centralized purchasing, both present in the Russian MHI system, could promote competition between public and private providers with positive influence on quality (Krachler et al., 2021). On the other hand, in practice, analysts point to discrimination of private health care organizations when it comes to dividing the amounts of health care services to be provided between organizations and arbitrary requirements set by regional health authorities specifically for private organizations (Shishkin et al., 2019).

Overall, the original Semashko model inherited by Russia underwent a series of reforms and has now transformed into a complex mix of inherited and novel institutions and care routes. Importantly, an overview of health care provision architecture presented above indicates a range of gaps between what was envisioned at an onset of a particular reform and how actual implementation has worked in shifting Russian regulatory context.

NAVIGATING THE (POST-) SOVIET HEALTH SYSTEM

This section elaborates on how contradictions among the governing principles within the transforming Russian health care system, along with the shifts in financing and provision, translate into the organizational life of health care facilities and influence practices of those actors who inhabit this institutional landscape. Similar to the analysis of macro-level policy trends, the understanding of micro-level interactions within the health system is hardly possible without discussing Soviet legacy, which continues to frame clinical encounters.

Both professionals' and patients' agency within Soviet health care was significantly limited by high levels of state intervention in the field (Field, 1957; Freidson, 1970). Legal documents that regulated health care provision in the Soviet period emphasized the idea that the 'health of every member of the society, of every worker is a public property, is a state treasure' (Sergreyev, 1988, p. 12). This paternalistic ideology was embedded in the system of universally available health services and led to the development of what analysts called a Soviet type of patient. The following features of the health care utilization pattern are reckoned as definitive for this type: 1) the passivity and ignorance of Soviet citizens concerning their health lifestyle, 2) instrumental attitude to health, tendency to exploit ones' health resources, 3) willingness to delegate the responsibility for one's health to doctors (Cockerham et al., 2002; Shilova, 1999).

The type of medical professional that co-evolved along with this type of patient, quite paradoxically, was not a powerful one. Content and conditions of Soviet doctors' work were predominantly determined by the state, which exercised tight administrative control over medical education, standards of practice, and activities of professional association (Saks, 2015). Some researchers questioned whether, under these circumstances, Soviet doctors actually could be called professionals or they were just minor bureaucrats who transmitted state paternalistic care to citizens (Freidson, 1970). Caring professions – nurses and midwives – in this context were even more disempowered – they acted as doctors' technical assistants who fulfilled auxiliary tasks and acted only under physicians' supervision. Lacking political and economic influence on the structural level, Soviet medical professionals found some degree of power in establishing authoritative relations with patients on the level of everyday clinical encounters, engaging in a pattern of interaction that was experienced by patients as rudeness and humiliation (Rivkin-Fish, 2005; Shchepanskaya, 2009).

The lack of autonomy that marked positions of medical workers and patients in Soviet health care translated into institutional distrust toward the system (Brown and Rousinova, 2010). This distrust, in turn, gave rise to divergent behavioural patterns beyond the homogeneous appearance of the state-controlled health system. One example of these divergent patterns can be observed in the informal and even dissident strategies developed by the ground-level actors when they grappled with the imbalances in health care provision. In order to ensure effective diagnosis and treatment in a context characterized by institutional distrust, inhabitants of the Soviet health system frequently grounded clinical communications in the relations of personalized trust. These relations depended on unofficial mechanisms of finding a 'good' physician through the network of relatives and friends. Informal payments and gifts to doctors formed an important part of establishing and sustaining these relations (Rivkin-Fish, 2005). Another strategy stimulated by institutional distrust in Soviet health care was avoidance of official medical institutions. Unlike the US or Western Europe, where adherence to alternative medicine coincided with citizens' discontent with pervasive medicalization, in late Soviet period it was more of a dissident act that reflected citizens' relation to the paternalistic state as the main care provider (Belousova, 2012). Such a critical attitude combined with avoidance of biomedical interventions was characteristic not only to lay people, but also to some health care professionals (Brown and Rusinova, 2002), which is indicative of the prevalence of distrust within the system.

Analytical approaches that were coined for understanding late Soviet health care remain relevant for studying the early post-Soviet reforms and current situation in the Russian health system. Health system transformations that unravelled in the country in the aftermath of socialism have had ambiguous consequences for practices and identities of health care actors. Although the centralized and bureaucratized state-controlled health system was never fully dismantled, its rapid and rather incoherent exposure to neoliberal governing principles added new levels of uncertainty in the life of medical institutions making many of its inhabitants potentially vulnerable victims of the reforms (Brown and Rusinova, 2002; Shilova, 2008). Shrinkage of state support of medical services, drop in professionals' salaries, and growing inequalities in access to health care on the ground level exacerbated institutional distrust in the Russian health care system. However, challenging circumstances have become an incentive for the ground-level actors to take more initiative.

Some actors had to invest efforts in reconciling institutional discrepancies that emerged in the course of the health care reforms. One example is the mismatch between different kinds of guidelines that regulate the content of health professionals' work. There are two main types of such documents – standards of medical care and clinical recommendations. The standards are obligatory documents developed by governmental bodies to determine the appropriate amount and cost of medical help for each disease. Doctors view them predominantly as a vehicle of administrative control – the rules that guarantee to all patients, medical services of basic quality, at the expense of limiting professionals' choices to less efficient and outdated schemes of treatment (Kamenschikova, 2018). The recommendations are developed by professional associations and grounded in scientific evidence. Until recently, recommendations have not been binding, but since 2022 they have become the subject of governmental approval and mandatory for implementation. As standards and recommendations are developed by different bodies and with different purposes, they occasionally contradict each other. Russian physicians have to bridge these discrepancies by selectively applying the standards, creatively combining their requirements with those of clinical recommendations or even applying foreign clinical recommendations that are not certified in the country (Borozdina, 2023).

At the same time, in other cases health care workers are able to use the reform context to their advantage. This can be exemplified by midwives' institutional initiatives of creating commercial ‘natural childbirth’ subdivisions in state maternity hospitals or offering such services as part of paid delivery contracts. By responding to the demands of well-off clients for more personalized care, otherwise disempowered and subordinate specialists are able to benefit from health care marketization and to improve their position at the workplace level (Borozdina, 2018). Although such micro-level initiatives contribute to professional autonomy and enhance the quality of care for some patients, their sustainability is questionable due to the lack of structural support.

PROLIFERATION OF HEALTH INEQUALITIES

For different categories of patients, the ever-reforming institutional context of Russian health care has created different structures of opportunities and challenges. The emergence of class differences in previously class-less society has inevitably translated into inequalities in access to health care. In Russian health system, the process of class formation is represented by a new type of actor, which crystallized in the context of marketization – a demanding patient-consumer (Temkina, 2020). These ‘new’ patients belong to the social strata of highly educated urban professionals, who reflectively compare themselves to patients of the Soviet generation and take a more active stance towards health matters. Instead of relying on universalistic state-funded care, these patients want to take responsibility for their health – to acquire knowledge about health issues, to implement this knowledge by leading a healthier life, and to receive individualized medical services in comfortable conditions. Importantly, these high-income patients are ready to spend money on health needs, thus stimulating medical providers to create personalized services of higher quality that would correspond to patients’ demands.

The emergence of a patient-consumer in the context of health care marketization and neo-liberalization is a widespread process in high-income countries (see, for example, Lupton, 1997; McCabe, 2016). Considering specificities of the Russian health care system, namely, the prevalence of informality and institutional distrust, researchers indicate that the behaviour of ‘new’ patients cannot be explained only with the reference to market processes. Studies show that while Russian patients-consumers frequently opt for commercial medical services, they still do not trust their providers fully and are suspicious of over-diagnosis in private clinics (Temkina and Zdravomyslova, 2008). Consequently, patients use not only their money, but also their cultural and social capital to successfully navigate the health system. This can be illustrated by the example of patients’ strategies of accessing gynaecological and antenatal help. While state clinics provide universally available medical services and promote the principle of continuity of care, women frequently utilize services of several facilities and specialists. Typically, women undergo routine check-ups and tests in the nearest state clinic, but in case of pregnancy or serious illness, they double-check the diagnosis and prescriptions with some familiar obstetrician-gynaecologist and/or doctor in private clinics. This results in a cumulative strategy that creatively combines services covered by mandatory health insurance, services of private medical facilities, and advice of an acquainted physician that can be provided either formally or informally (Borozdina and Novkunskaya, 2019).

Recent studies also indicate how institutional distrust and the emergence of a patient-consumer are played out in the context of the health care digitalization (Bogomiagkova, 2022). While services that like making appointments online or online consultations with doctors are steadily established in Russia as a convenience for 'new' patients, in practice, these supposedly depersonalized formats are never completely separated from offline informal networks. For instance, Russian patients rely on the experience of their acquaintances to double check information that is available on the webpage of a clinic.

Informally navigating the health care system and pulling together a network of trusted experts requires from patients quite a lot of competence, financial investment, and effort. Survey evidence confirms the fact that Russians from the top income quintile successfully adapt to the reforms and that, by 2009, around a quarter of this group were utilizing paid health care services (Potapchik et al., 2011). For people from less privileged social strata, rapid and inconsistent transformation of the health system resulted in the increase of inequality. Those who lack resources to exercise health-related agency found themselves in a disadvantaged position and report the feeling of being abandoned by the state (Shilova, 2008).

Attitudes and practices of the actors within Russian health system reflect not only the process of post-socialist class formation, but also the revival of neo-traditionalist gender ideology in the aftermath of Soviet Union. Russian 'patriarchal Renaissance' has influenced health care utilization in three ways. First, while men's mortality presents a pressing problem for the country (with death rates of Russian men of working ages being almost two times higher than the European average (Abankina et al., 2019)), authorities focus on pronatalist agenda and prioritize maternity care as a target of governmental investments. A number of social policy programs that have been introduced since the mid-2000s contributed to significant improvement of medical services for pregnancy and childbirth, and increased their availability to all groups of women. However, this remarkable state care for women-mothers coincides with attempts to influence their reproductive behaviour – in the same period, the list of indications for pregnancy termination was significantly reduced, there was a number of legislative initiatives on removing abortions from the system of mandatory health insurance.

Second, under patriarchal gender norms, care for the health of family members in Russia is exercised predominantly by women. In the context of distrust in the health care system, this means not only providing in-home care to sick relatives, but also acquiring knowledge about health conditions and establishing personalized connections with trusted doctors within the health system. Sociologists suggest the metaphor of a 'hidden health system' to indicate the invisible ground-level efforts that Russian women invest in caring for relatives' health and in navigating the health system on their behalf (Brown and Rusinova, 2010).

Third, ideology and politics of state heterosexism creates health-related inequalities for non-heterosexual Russians. These inequalities are vividly exemplified by administrative obstacles that transgender persons face when trying to have a gender confirmation surgery, but even ordinary medical check-ups can pose problems for queer Russians. A recent survey by the Russian LGBT organization 'Coming Out', shows that in 2020 a dozen people faced refusal in access to medical care in St. Petersburg because of their non-conforming gender identity, 10% of the respondents reported instances of inappropriate behaviour of medical personnel, namely, verbal abuse related to patients' sexual orientation, disclosure of information on patients' gender identity to third parties, etc. (Voronov and Kislitsyna, 2021).

Diversity among the Russian regions forms yet another dimension of health inequalities in Russia. There is a more than tenfold difference in the amount of health care financing between the poorest and the richest regions of the country (Sheiman and Shishkin, 2010). In order to analytically grasp this major regional inequality, economist Zubarevich suggests distinguishing 'four Russias' that significantly differ regarding the development of their social sector, including health services. These are: (1) Russia of big cities with modernized social and health care provision; (2) Russia of industrial towns with less modernized and less commercialized health care (due to lower income of local population); (3) Russia of remote rural settlements that are characterized by limited access to health care services; (4) Russia of less developed republics of the North Caucasus and Southern Siberia, characterized by a peculiar mixture of lack of resources within health care, corruption, and belief in local vernacular healing practices (Zubarevich, 2013). While inhabitants of 'the first Russia' might enjoy health-related agency exercised through utilization of commercial services of higher quality, in other 'Russias' patients' agency is more frequently exemplified by coping strategies. For instance, since the 2010s, health care reforms have been aimed at consolidation of medical help in technologically-advanced medical facilities, which predominantly are situated in the big cities. Smaller medical facilities in remote areas were often deemed 'ineffective' and closed down, hindering local population access even to emergency care. In 2015, 17,500 Russian settlements did not have any medical infrastructure, 11,000 were located at a distance of more than 20km from the nearest medical facility. Those hospitals that remained outside of big cities experienced lack of financing and corresponding lack of medical specialists. People who reside in such areas (the elderly population, in particular) report significant difficulties in getting access to medical care. They have to mobilize help from family or the local community in order to make an appointment with a doctor, to reach the nearest medical facility, to get medicines, etc. (Bogdanova, 2019).

Overall, rapid and rather inconsistent marketization of Russian health care has worsened health-related inequalities. Unlike universalistic Soviet medicine, post-socialist health care has developed as a rather fragmented system in terms of levels of access, quality of care, and opportunities of agency available for populations from different socioeconomic categories.

RESPONDING TO THE COVID-19 PANDEMIC

As in many other health systems across the globe, the new coronavirus infection became a challenge that highlighted strengths and weaknesses of the Russian health system. Cook and Twigg (2020) enlist three strengths of Russian healthcare in the context of the COVID-19 threat. First, the health system that prioritizes universal health care provision via mandatory health insurance have guaranteed COVID-19 diagnostic and treatment for the country's population. Second, the distrust of the elderly population in institutional care has paradoxically constituted an advantage, as in other countries' elderly care facilities have become pockets of COVID-related deaths. Third, researchers acknowledge that the Russian government made timely and appropriate policy decisions in the early stages of the pandemic: it closed international borders quite quickly and introduced an isolation regime across most of the country's regions.

However, other features of the system, which we have already discussed in this chapter, have intensified the pandemic, making Russia one of the countries most affected by this disastrous event. According to the WHO data, in July 2021 Russia was leading the list of European countries with the highest COVID-19 mortality rates (3.7 deaths per 100,000 people per week) and was also the world leader in yearly excess mortality (Karlinsky and Kobak, 2021).

The first problematic aspect of the Russian COVID-19 response was highly centralized decision-making and the incoherence of the authorities' actions informed by political rather than public health reasons (Cook and Twigg, 2020; King and Dudina, 2021). The measures of the infection control during the first wave of the pandemic were heavily politicized as President Putin was advancing the constitutional reform, which would allow him the potential to serve as a president for two more terms. This presidential pursuit determined the early lifting of the COVID-related restrictions: despite the fact that the established epidemiological benchmarks indicated continuation of the pandemic in many parts of Russia, most of the restrictions were somewhat hectically abandoned in order to hold a nationwide vote on the reform in July 2020. Moreover, there are speculations that before the referendum the authorities manipulated COVID-19 mortality data in order to give the impression that the virus was under control. Yet another aspect of the politization of the COVID-19 response was Russian involvement in so called 'vaccination diplomacy' (King and Dudina, 2021). Russia was the first country to announce the development of its own COVID-19 vaccine. While there was skepticism regarding the lack of reliable data on the vaccine efficacy and safety, the government launched a mass vaccination campaign in December 2020 and promoted the vaccine to other countries as a vehicle of the country's political influence.

Ethnographic studies indicate that behind the totality of the centralized response to the pandemic were hidden the discrepancies between regulations and actual clinical routines (Borozdina et al., 2020). State health care facilities suffered from the lack of medicines and personal protective equipment, doctors reported a rapid and rather chaotic change of administrative rules, some medical organizations faced gaps in sanitary measures: for example, authorities did not expect COVID-19 to spread in non-infectious hospital wards, thus during the first months of the pandemic these subdivisions were not formally allowed to introduce measures of infection control.

The management of disasters requires constant adjustment of the regulatory decisions to the uncertainties which proliferate locally under the emergency conditions (Takeda and Helms, 2006). Russian centralized and bureaucratized response to the pandemic followed the opposite route. The majority of Russian medical practitioners still are salaried employees in state-funded clinics. The governance structure within those facilities is highly hierarchical, with limited possibilities for introducing bottom-up innovations or participatory decision-making (Kuhlmann et al., 2019). Thus, in the time of the COVID-19 emergency, Russian health care workers were neither able to influence decision-making, nor voice the problems that they encountered. The country's journalists metaphorically referred to this situation as 'the virus of silence'. Importantly, interviews with medical professionals show that private health care organizations were more successful in adapting to the pandemic context due to being more responsive to local demands (Borozdina et al., 2020).

Along with the centralized decision-making, another factor that weakened the country's response to COVID-19 was regional inequality exacerbated by inconsistent health care reforms (Cook and Twigg, 2020). During the first months of the pandemic, the capacities of medical organizations in the major cities of Moscow and St. Petersburg were overwhelmed, but the repurposing of some hospitals and construction of the new ones helped to handle the situation. However, as the infection spread across the country, it became evident that underfinanced facilities in other regions were not prepared for the challenge. As neoliberal 'optimization' of Russian health care (i.e. down-sizing and closure of medical facilities deemed ineffective) was exercised predominantly at the cost of hospitals in small towns and rural areas, during COVID-19 residents of those settlements faced a dramatic lack in access to medical services.

Some researchers indicate that at the initial stages of the pandemic, Russian regional governments proactively introduced measures to prevent the spread of COVID-19, thus demonstrating the unexpected trend of decentralization (Glezer et al., 2022). However, these initiatives were mingled with political rationale, lacked relevant resources, and relied on the distorted image of the pandemic situation.

Overall, in Russia, the Soviet legacy of universal health care provision constituted an asset for public health response to the new coronavirus. However, the centralized mode of governance coupled with regional inequalities has not resulted in consistency of the infection control measures across the country. Excessive politization of the pandemic, the restricted decision-making at the local level and limited autonomy of medical professionals hindered the effective handling of the emergency situation.

CONCLUSION

In this chapter we delineated the uncertain health policy terrain in post-Soviet Russia. Contradictory logics have driven its development resulting in inconsistencies among different rules, incentives, command channels, and envisioned outcomes. One major contradiction is between market principles and Soviet-style statism in Russian health system governance. After the end of the Soviet Union, the Russian state habitually proclaimed itself a guarantor of free health care for all, simultaneously actively intervening in health care matters and setting up the goals for medical organizations (e.g., by initiating nation-wide policy programs aimed at fulfilling state demographic goals by amelioration of maternity care services). At the same time, at the beginning of the 1990s, market principles were rapidly injected into health governance to leave the command economy behind and bring more efficiency, quality, and responsiveness into healthcare. Statist and market logics have co-existed in Russian health policy since then, producing regulatory tensions, confusion among actors on the ground, and side effects such as significant percentage of out-of-pocket payments in the overall structure of health expenditure.

While nominally the government adhered to the principle of universal health care provision, rapid and inconsistent character of the reforms have dramatically increased inequalities in access to medical services. Researchers most often note socioeconomic and regional differences in access to healthcare, but there are also evident gender differences that emerge in the context of neo-traditionalist state policies. Attention to the micro-level experiences in addition to macro level policy trends has allowed us to discern multiple strategies that both patients and medical professionals develop in order to (informally) cope with institutional discrepancies which have resulted from the reforms. And while for some social groups, such as highly educated urban professionals, reforms have provided an opportunity to access medical services of better quality, agency of other groups is tied to coping strategies. Consequently, in the context of such a fragmented system, different groups of patients have different levels of access to care of varying quality.

The Russian health system has generally recovered from the crisis it faced upon the dissolution of the Soviet Union. However, it continues to rely on contradictory governing principles and remains underfinanced, which puts constraints on fulfilling generous promises of universal health care provision. Already existing uncertainties are likely to multiply, further disorienting actors on the ground and necessitating new informal adaptation strategies. New points of uncertainty may be facilitated by the ongoing COVID-19 pandemic. For example, in the context of a strain experienced by the health care system, discussions are ongoing regarding whether the mandatory health insurance (MHI) should be kept as it is, reformed, or abandoned altogether in favour of direct financing by the government. Continuing financial shortages may further limit opportunities for patient choice of the provider if currently debated prospects of firmly connecting patients' health care access to their region of residence come true. This connection is already clearly manifest in the case of oncological treatments which, starting from 2022, are expected to be provided almost exclusively in the region of a patient's residence. Taking account of a wide regional diversity in terms of health care quality and equipment available, health disparities can consequently grow further (Meduza, 2021).

At the time of finalizing this chapter, the future of Russian health system remains uncertain. Russia's invasion of Ukraine has given rise to dynamics with far-reaching consequences for how care is organized and provided: Russian healthcare is becoming increasingly disconnected from the production and circulation of contemporary biomedical knowledge and novel technologies; physicians with active political stance are fleeing the country, and activities of NGOs are as restricted as ever. Time will show how exactly health and healthcare are going to be affected. However, from this point in time there are reasons to be pessimistic about the prospects.

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26. Health policy in Turkey: from a thriving past to an uncertain future

Volkan Yilmaz

INTRODUCTION

How did Turkey transform from 'a world leader in healthcare' in the 2000s to a disintegrating healthcare system in the 2020s? What happened to 'the Turkish miracle' in healthcare that provided generous access at low cost to the public purse (World Bank, 2018) as it later found itself in a position of the exodus of physicians from the country and extended waiting times for many services? How did ordinary Turkish men, who were known to be respectfully buttoning up their jackets in front of physicians, turn into a threatening group that puts overworked and underpaid physicians and other health workers in the grip of violence every day?

What these questions are pointing to is that Turkish health policy is at a crossroads today, perhaps just like the country as a whole. Medicine and physicians, once a jewel of the Republic, are currently being sacrificed for particularistic political and economic interests. This is evident as Turkish physicians and other health workers are stricken by threats of violence—that are often taken lightly by the judiciary and police (Özgenç, 2022)—or actual encounters with 'lumpen' violence. The Turkish healthcare system, once the strongest and widest-reaching component of the country's overall welfare system, is now disintegrating. This may come as a surprise to many outsiders who consider Turkey a leading destination for medical travel, but this is because the gap between medical tourists' and citizens' experiences with the Turkish healthcare system has been considerably widened in the last decade.

The striking changes that have occurred in the Turkish health system are both due to a series of health policy-specific changes and to a broader political transformation of the country in the last two decades. Focusing on the former, one key driver of these changes was the government's interest in healthcare in the 2000s. This started with the discovery of healthcare policy by the Justice and Development Party before the 2002 general elections as a policy sector that can be used to foster public support (Yilmaz, 2017). It has since continued as the party came to power in those elections and launched a comprehensive reform package in healthcare in 2003. While the direction of policy changes in the earlier phase of the reform displayed features of universalism combined with marketisation elements (Ağartan, 2012), the developments in the last decade exhibit a more fragmented pattern. The current pattern contains both the unfolding of tensions intrinsic to the amalgamation of universalism with marketisation and the government's use of healthcare for multiple ends including, but not limited to, national developmentalism, state entrepreneurialism, and particularistic political and economic interests.

Healthcare has been one of the social service domains where Turkey had developed a significant state capacity long before the Justice and Development Party came to power. Since the country's foundation in the early 20th century, Turkey has been strongly involved in health through subsequent public investments in medical education and healthcare delivery, nationwide public health campaigns and institutional developments in healthcare financing.

Having undergone a comprehensive reform since 2003, the Turkish healthcare system is a social insurance type that also has a tax-funded component for the poor (the unemployed or those out of the labour market and living under the official poverty threshold). Social health insurance is compulsory and offers the same set of entitlements to all. The system grants universal access to primary care, provided by individual family physicians, and hospital care, supplied through an internal market consisting of both public and private providers.

The Turkish healthcare system has been heavily skewed towards curative and hospital care, a trend that was strengthened by the 2003 reform. This general characteristic should not overshadow successes in some public health domains. One area of success is child vaccination, the rate of which places Turkey among the highest in OECD countries (OECD, 2021). Another exception was Turkey's success in reproductive health between the 1960s and mid-2000s. Nevertheless, with the moralistic policy changes in the last decade, a considerable increase was observed in the unmet need for family planning services (Hacettepe University Institute of Population Studies, 2019).

The overall weakness of a preventive approach to health might partly explain the gloomy picture of Turkey's health outcomes. For example, Turkey ranks higher than the OECD average in both infant mortality and potential years of life lost (OECD, 2021). It also faces significant public health problems such as high rates of regular tobacco use and obesity that put the country among the worst group in the OECD (OECD, 2021).

This chapter offers a selective overview of the main features of the Turkish healthcare system, and the ideas underpinning health policy developments in the last two decades. It is organised under the following sections: the 2003 healthcare reform, the key characteristics of the Turkish healthcare system, the regulatory and policymaking structures, and the influential ideas in Turkish health policy.

HEALTHCARE REFORM

The latest fundamental reform in Turkish healthcare is the Health Transformation Programme. This broad reform initiative of the Justice and Development Party governments, with the support of the World Bank, started in 2003. It has affected a wide range of healthcare system components including the organisation, financing, delivery and regulation.

The pre-reform healthcare system was two-tiered as it was characterised by a lack of integration between separately organised primary and hospital care. Primary care was tax-funded, provided to all free of charge and by multidisciplinary primary care units serving a geographical catchment area (Günal, 2010). Hospital care was financed by occupationally-organised social health insurance schemes serving three major groups: civil servants, workers (the majority of the workforce by the mid-2000s) and the self-employed including the farmers (the majority of the workforce until the 1980s). Hospital care providers included public university hospitals, state-owned hospitals and social insurance fund-owned hospitals specifically catering for workers.

The 2003 reform has launched a unified healthcare system by merging the above-mentioned separate institutional arrangements in both financing and delivery of hospital care. During this merger, the modus operandi of the new system shifted from an integrated organisational structure that combined financing and delivery in secondary and tertiary care within each social insurance scheme (which was most visible in the social insurance for workers), to one where purchaser and provider functions have been separated at the system level. The institutional disconnect between primary care and hospital care continued after the reform.

The separation of purchaser and provider functions in hospital care has been complemented by two critical developments. First, on the financing side, the 2003 reform introduced a compulsory and standard social health insurance scheme for all. This has resulted in the abolition of the differences in the benefits packages for all regardless of their employment status and main sector of employment. The same development has also created a single-payer system and brought this system under full government control. Second, on the provision side, the reform has led to the diversification of hospital care providers, and thus, an increase in healthcare provider options for patients. This has been achieved by making all public providers available for all citizens (public university hospitals were privileging civil servants before), bringing workers' hospitals under the control of the Ministry of Health, incentivising private provision, and including private providers in the social health insurance scheme. Overall, the reformed system would rely on public funding and provider competition where public money would follow the patient. In this regard, the 2003 reform could be characterised as an internal market reform.

HEALTHCARE FINANCING

Compared to other OECD countries, Turkey is a low spender on healthcare. As of 2019, the share of total spending on healthcare in its GDP was 4.3 per cent (OECD, 2021). This level of health spending places Turkey at the bottom of the ranking. This might come as a surprise given the country's relative success in granting universal access to primary and hospital care. Five factors might account for Turkey's low spending compared to the healthcare benefits it provides to its citizens: the presence of a relatively strong capacity of public hospital care, the low intensity of its health workforce, relatively low levels of physician and nurse reimbursement, its ability to keep pharmaceutical spending under control, and low administrative costs compared to multi-payer systems.

Government is the main source of healthcare financing in Turkey, making 78 per cent of total health spending in 2017 (OECD, 2021). This spending level puts Turkey above the OECD average of the share of government in total health expenditures. Government financing takes two forms: social health insurance and tax-based funding. Social health insurance is at the centre of healthcare financing. Turkey implements a standardised social health insurance plan for all, and membership is compulsory for all citizens. The Social Security Institution functions as a single-payer. The formally employed are automatically enrolled on the insurance scheme and they (as well as their employers and the state) contribute a specific percentage of their monthly salary as a premium. The formal dependents of the formally employed (parents, married partner and children) also receive insurance coverage without extra cost to them. Others either pay their premiums directly or go through an income-means test that might exempt them from paying premiums. In the latter scenario, their forgone premiums are compensated through general taxation. In the former scenario, they are expected to make a flat rate, monthly contribution.

Private insurance had a marginal role before the reform. But it has been expanding its role in the last decade, ironically in the wake of single-payer reform. Two types of private health insurance are present in the Turkish market: duplicate and supplementary. While the duplicate version has no institutional link with the public sector and existed before the 2003 reform, the supplementary version works in tandem with social health insurance. Supplementary private health insurance, which has been a product of the reform, provides financial protection against co-insurance payments that social insurance holders make in using services that private hospitals offer. In the absence of supplementary private health insurance, social health insurance holders are expected to make co-insurance payments in return for their use of private services. The Social Security Institution regulates these payments in two ways. First, it sets annual reimbursement rates for private services covered by social health insurance. Co-insurance levels are indexed to these reimbursement rates. Second, it imposes an upper limit on the co-insurance levels private providers charge for each service. Supplementary private insurance schemes are subject to the same terms and conditions as duplicate private insurance schemes, including the practice of actuarial rating.

Private health insurance remains a limited but growing source of healthcare financing. In 2019, the share of spending by private health insurance schemes constituted roughly 5 per cent of total health expenditures (OECD, 2021). More importantly, a significant increase in private health insurance uptake has been observed in the last decade. This increase seems unprecedented as it has been occurring at a time when a universalist reform in healthcare has been underway. The number of duplicate policyholders has quintupled between 2008 and 2019 and reached more than 2.5 million, whereas the number of supplementary policyholders has achieved 1 million by 2019 (Hışıl, 2020). The rising uptake of, in particular, duplicate private health insurance in the last decade could be evidence of decreasing trust in the publicly-funded healthcare system among some sectors of Turkish society.

Last but not least, out-of-pocket spending forms a considerable source of healthcare financing in Turkey. The 2019 data shows that out-of-pocket spending makes up approximately 17 per cent of total health spending (OECD, 2021). This puts Turkey in the middle of the ranking of OECD countries. Three forms of formal out-of-pocket spending are present in the Turkish healthcare system: direct purchases from providers and pharmacies, flat-rate co-payments for hospital services and medications, and floating co-insurances for the services of private hospitals included in the social health insurance scheme. Research indicates an increasing prevalence of the latter type and informal payments for private providers over time. This is because, first, the government-imposed cap on the maximum rate of co-insurances that private providers are allowed to charge has risen substantially over time (from one-third to two times the reimbursement rate for a specific medical service) (Yilmaz, 2017). Second, private providers have been evading their obligations under social health insurance by illegally charging patients above the permitted limit and for services that are deemed free of charge (Yilmaz, 2021a). Both these developments have been suggesting poor regulatory oversight and the erosion of the publicness of healthcare. This process might be signalling a de facto shift from an internal market model to a two-tiered healthcare system.

HEALTHCARE DELIVERY

Primary Care

Primary care is a neglected component of the Turkish healthcare system. Its marginal position is reflected in the level of spending. Turkey only allocated less than 5 per cent of its government health spending on primary care in 2021 (The Presidency of Strategy and Budget, 2020), which is exceptionally low compared to the OECD average (14 per cent) (OECD, 2021).

Primary care is provided through family physicians after the reform. Different from the pre-reform provision of primary care through a multidisciplinary team on permanent contracts, family physicians now work as individual contractors and get remunerated accordingly. Patients are free to choose their family physicians among those working in the province of their residence.

Primary care services are free of charge, and no co-payment is required. But family physicians are working under a significant workload. In practice, each family physician serves around 4000 persons, especially in metropolitan cities. In the absence of a functioning referral system, family physicians do not play a gatekeeper role. This is also evidenced in the almost two-fold utilisation of secondary and tertiary care compared to primary care (The Ministry of Health, 2021a, p. 148) and a negligible share of referrals from the family medicine units (The Ministry of Health, 2021a, p. 153).

The Ministry includes preventive health in the mandate of family physicians and presents family physicians as the main provider of these services (The Ministry of Health, 2017). Family physicians' main areas of responsibility include the following: the regular updating of medical records, breast, colorectal and cervical cancer screening, medical monitoring of teenagers, medical monitoring of women in reproductive age group (15–49), issuing medical reports and re-prescription of medications for chronic patients. Nevertheless, in practice, they spend most of their time on primary curative care, issuing medical reports and re-prescription of medications for chronic patients (Istanbul Family Practice Association, 2021). This is partly because two barriers obstruct the effective provision of preventive health by family physicians. First, the overwhelming majority of practising family physicians in Turkey are general practitioners who have not received family medicine speciality training. The Ministry of Health has been providing fast-track training for general practitioners willing to serve as family physicians. Second, many family medicine units lack qualified medical staff such as midwives and nurses, the presence of whom is necessary to provide preventive health services.

Turkish governments showed no interest in taking health in all policies and health promotion into consideration except for a few ineffective initiatives. These include institutions such as Healthy Living Centres, Cancer Early Diagnosis and Screening Centres and Child, Adolescent, Woman and Reproductive Health Units.

Hospital Care

Three types of providers offer hospital care: public sector, private sector, and university providers (that include both public and officially not-for-profit foundations (equivalent to charity status) universities). Despite increasing private investment in the hospital sector in the last two decades, Turkey still lags behind other OECD countries in terms of the hospital bed capacity per population. In 2018, Turkey had less than three hospital beds for a thousand people, while the OECD average was slightly more than five (The World Bank, 2021a). Overall, the existing bed capacity has not been fully utilised. Turkey had one of the lowest bed occupancy rates (68 per cent) among the OECD countries in 2017 (OECD, 2019). The low bed occupancy rate might be explained based on health workforce shortages, which are discussed later in this chapter, rather than on low demand. One exception to the relatively low capacity is intensive care unit beds. Turkey had the highest number of intensive care unit beds per population compared to all European Union member states (The Ministry of Health, 2021a, p. 123). The exceptionally high number of intensive care unit beds can be explained based on improper reimbursement incentives.

Despite a clear privatisation trend in the last two decades, the public sector is still the dominant player in hospital care. In 2019, public sector hospitals controlled roughly 60 per cent of all beds available in the country (The Ministry of Health, 2021a, p. 114) and received around 77 per cent of all patient applications (The Ministry of Health, 2021a, p. 148). But this figure also includes private finance initiative hospitals, also known as city hospitals in Turkey, which were holding 15 per cent of the public sector bed capacity in 2019 (The Ministry of Health, 2021a, p. 115). The public sector was followed by private hospitals constituting around 22 per cent and university hospitals making up 18 per cent of the total bed capacity in the country (The Ministry of Health, 2021a, p. 114). These two hospital types received around 14 and 9 per cent respectively of all patient applications in 2019 (The Ministry of Health, 2021a, p. 148).

The dominance of the public sector has been gradually challenged in inpatient care. Inpatient statistics illustrate that private and university hospitals receive significantly more inpatient applications compared to their shares in total patient applications. Fifty-six per cent of patients used public hospitals for inpatient services (much less than 77 per cent of all patient applications including outpatient services), while the shares of private and university hospitals reached around 29 per cent (compared to 14 per cent) and 15 per cent (compared to 9 per cent), respectively (The Ministry of Health, 2021a, p. 158). In addition, in 2019, the share of private hospitals reached around 41 per cent of the total intensive care unit bed capacity in the country (and more than half of all neonatal intensive care unit bed capacity), while the public sector and universities controlled 44 and 16 per cent (The Ministry of Health, 2021a, p. 121). If these trends would continue, we would expect public hospitals to be more commonly utilised for outpatient services. Increasing the share of private providers in inpatient services might have negative consequences for access, especially in the absence of regulatory mechanisms ensuring their compliance with social insurance regulations, which is explained later in this chapter.

A closer look at figures on health technology and physician distribution across sectors sheds light on a different dimension of the emerging division of responsibilities between public and private sectors. It illustrates that private hospitals are becoming the dominant player in high-cost, technology-intensive and specialist services. First, private hospitals, compared to other hospital types, stand out as technology-rich providers. For instance, despite constituting less than one-fourth of bed capacity, private hospitals had more than half of the MRI and mammography in the country (Ministry of Health, 2021, p. 130). Compared to their share of patient visits (14 per cent in 2019), private hospitals hire a higher proportion of specialists. As of 2019, one-third of all specialists were employed in private hospitals (The Ministry of Health, 2021a, p. 232). These figures indicate that private providers are gaining a competitive advantage over public providers also in outpatient care and diagnostic services. Although public providers still attract the majority of outpatients, the advantageous position of private providers in specialist and medical technology distribution might draw more patients with a high willingness to pay for quicker access to high-technology healthcare.

The last key development in Turkish hospital care has been the launch of an ambitious initiative of private financing of new tertiary public hospitals (namely, city hospitals) in the mid-2010s. The objectives of this initiative were establishing new tertiary public hospitals through an off-balance-sheet investment model, increasing bed capacity and enhancing hospital bed quality in the public sector. The initiative rests upon a public-private partnership model where the private sector finances the construction project and undertakes the operation of the hospital for a minimum of 25 years upon its completion and the public sector provides the land, pays annual rent and employs medical staff services for the hospital during this period. At the end of 25 years, the public sector gets the ownership right. As part of this initiative, the government has contracted out the construction of 18 new hospitals with around 27,000 bed capacity (The Ministry of Health, 2021c). Finalised city hospitals have reached roughly 22,000 bed capacity, which constituted around 15 per cent of the public sector bed capacity in 2019 (The Ministry of Health, 2021a, p. 115). The most important criticism against this initiative has been the high costs it incurs on the public budget and its complete insulation from democratic and judicial oversight (Gün, 2019). This criticism seems to have been validated by the fast increase in the share of public spending on city hospitals. As of 2021, the total payments for city hospitals have exceeded the public spending on preventive health (Sağkal, 2021). Given the contracts for these hospitals are foreign-currency indexed, the ongoing devaluation of the Turkish lira would further increase the share of spending on city hospitals in the coming years.

Emergency Care

Free emergency care is a statutory entitlement, which theoretically includes all providers. No co-payment and co-insurance can be charged to a patient for emergency services and using a public sector ambulance. The main feature of emergency care in Turkey that could stand out in comparative analysis is the exceptionally high utilisation rate. The number of applications to emergency care in 2018, one year before the outbreak of the COVID-19 pandemic, was around 82 million (The Ministry of Health, 2019, pp. 145–147), a number that is almost equal to the entire Turkish population (82.8 million in 2018). This exceptionally high rate of patient applications to emergency care could be explained based on three demand factors and a supply factor. First, patients having difficulties in securing a physician appointment might be resorting to emergency care. Second, patients aiming to avoid making co-payments for outpatient care may be preferring the emergency room, which does not charge any out-of-pocket fees. Third, patients concerned about the urgency of their medical conditions or who cannot visit a hospital during regular working hours might be choosing emergency care. In terms of supply, physicians might be refraining from refusing to serve patients without emergency conditions, especially in the context of high rates of violence against medical staff and the government-induced high expectations of citizens from them.

Long-term Care

Turkey has not yet developed a financing and delivery model for long-term care. Despite the ageing population, policymakers have consistently ignored the growing need for long-term care by assuming that unpaid care work of women in families would suffice to meet such needs. Although the Ministry of Labour and Social Security organises policy debates around long-term care insurance alternatives for Turkey (AA, 2021), ungrounded assumptions about the sustainability of family care seem to dominate the political space.

Overall, long-term care provision capacity is limited and is characterised by a parallel organisation of healthcare and social care. On the social care side, limited institutional care is available through both public and private providers while the private sector interest has been growing in the last decade. Migrant and domestic care workers provide home care, often without formal registration. In addition, a nationwide, income means-tested cash-for-care scheme is available for women undertaking care responsibilities for their disabled or elderly family members. Last but not the least, municipalities offer ad hoc social care support.

On the healthcare side, the Ministry of Health (2015) defined the scope of palliative care services for the first time in 2014. These services have since been included in the reimbursement list (The Social Security Institution, 2014). Nevertheless, the number of palliative care beds was less than 5000 in 2019 (Akcakaya, 2020), and most of these beds have been misused as intensive care unit beds while a considerable number of them have been left vacant (Medimagazin, 2020). Last but not least, the Ministry of Health has also started providing home healthcare services. As of 2020, the total number of registered patients for home healthcare exceeded half a million (The Presidency of Strategy and Budget, 2020).

Although these government initiatives and the emergence of plural actors demonstrate the dynamism in the long-term care provision market in the last decade, the overall long-term care landscape is patchy and inadequate, and how and to what extent such initiatives would form a coherent system is still uncertain.

Health Workforce

One of the defining features of the contemporary Turkish healthcare system is the mismatch between its service delivery (utilisation levels, intensive care unit beds and medical technologies, etc.) and its health workforce. The eased access to services, with some key exceptions such as sexual and reproductive healthcare, has brought into view the health workforce shortages and understaffing. This discrepancy between healthcare utilisation and the health workforce results in exceptionally short consultations (five minutes as of 2021 (Kızmaz, 2021)) and high work pressure on the medical staff.

Turkey ranks lower than all other OECD members except Mexico in the share of employment in the health and social care sector. While the OECD average was slightly more than 10 per cent in 2015, these sectors only constituted 4.2 per cent of total employment in Turkey (OECD, 2017, p. 149). The number of physicians per population in Turkey (1.9 in 2019) is among the lowest in OECD countries (OECD, 2021). This is in contrast to the fact that the number of physician consultations per capita in Turkey is higher than the OECD average in 2019 (OECD, 2021). The 2003 reform has only aggravated this mismatch as the number of per capita visits to physicians in secondary and tertiary care increased more than three times between 2002 and 2019 (The Ministry of Health, 2021a, p. 154). The availability of some specialities in Turkey also seems to be limited compared to other OECD countries. For example, the number of surgeons per 100,000 persons was around 48 in Turkey whereas the OECD average was 68 in 2015 (The World Bank, 2021b). The situation is even worse in the number of nurses per population (2.4 in 2019) based on which Turkey ranks the worst (OECD, 2021).

New trends indicate that this mismatch will be overcome in the future, especially for physicians. Turkey seems to have reached the OECD average for the number of medical graduates per population, with 13.1 per 100,000 persons in 2019 (OECD, 2021), which indicates that the number of physicians in the country will increase considerably. This increase has been achieved with the proliferation of medical schools, mostly as part of allegedly not-for-profit foundation universities. The number of medical schools almost doubled between 2002 and 2015 (The Ministry of Health, 2021a, p. 236) while casting doubt on the quality of medical education in these new faculties. The same trend cannot be observed in the number of nursing graduates (19 per 100,000 persons in 2019) as it remained significantly below the OECD average (OECD, 2021).

Broader political and social trends have exacerbated the health workforce shortages despite the abovementioned fast increase in the graduates of medical schools. One factor has been the dismissal of almost 3500 physicians and 15,000 medical personnel as a result of emergency decrees following the 2016 failed coup attempt (DW Turkish, 2020). Another factor has been the emigration of Turkish physicians mainly to Western European and North American countries, which has steadily gained pace, especially since the mid-2010s. This trend can be explained based on worsening working conditions and the de-democratisation of the country after the transition to the unchecked presidential system in 2017. The Turkish Medical Association declared that the number of physicians who requested a registration certificate to practice medicine abroad increased from 59 in 2012 to 906 in 2019 (Bahcetepe, 2019).

Employment in healthcare constitutes a significant portion of public employment. The healthcare sector accounts for roughly one-tenth of all public employment (The Ministry of Health, 2021a; The Presidency of Strategy and Budget, 2021). The overall negative working environment in the country continues to make public employment in healthcare an attractive job prospect for many as it can potentially bring permanent employment with civil servant benefits. As a result, not only the number of medical schools but also a wide range of mostly private education institutions at the secondary and tertiary levels have started to offer several health-related degrees such as physiotherapy, nutrition and dietetics, healthcare management, medical secretary education and speech and language therapy. As the number of graduates of these programmes increases over time, their expectations to get into the public service have turned into a political demand from the government to increase vacancies in the healthcare sector.

REGULATION

Turkey failed to address the regulatory challenges resulting from a shift to an internal market for healthcare. This failure has manifested itself in the emerging forms of informal payments for private providers that patients have to make to achieve their statutory entitlements (Yilmaz, 2021a). Before the 2003 reform, the prevalence of informal payments for healthcare in public providers was identified as one of the key regulatory challenges of the Turkish healthcare system. The reform (The Ministry of Health, 2012, p. 372) aimed to tackle this problem by prohibiting the dual practice of physicians in the public sector. Nevertheless, a similar problem has emerged with the reform, this time between patients and private hospitals offering publicly-funded services (Yilmaz, 2021a).

Another regulatory failure in the Turkish healthcare system concerns the state of the employment relationship between physicians and private hospitals. Some private hospitals have started entering into subcontract agreements with physicians and keeping them off the payroll for cost-reduction purposes (Bozdemir, 2020). Although physicians might sometimes prefer this arrangement over an employment contract with the expectation of receiving higher rates of compensation, one study (Bozdemir, 2020) finds that these expectations are often unfulfilled. More importantly, this practice contradicts the Turkish labour law that prohibits contracting out the core functions of a business. If left unaddressed, the current practice would pave the way for the adoption of the platform business model in healthcare.

CURRENT DEVELOPMENTS: HEALTH TECHNOLOGY ASSESSMENT AND DIGITALISATION

Health technology assessment is still in its infancy in Turkey. It has been introduced to the Turkish healthcare bureaucracy as part of a World Bank-funded health system strengthening project. The Ministry of Health has established a department dedicated to health technology assessment and has released a strategy document for 2019–2023. Nevertheless, the department could complete a limited number of health technology assessments so far, mostly due to understaffing, and more importantly, political unwillingness. The future of health technology assessment is tied to the policymakers' susceptibility to evidence-based policy development and decision-making.

Digitalisation, however, is a strong trend in the Turkish public sector, including healthcare. Overall, Turkey tops the E-Government Development Index rankings (United Nations, 2020). As part of this trend, Turkish healthcare institutions are going through intensive digitalisation at different levels, covering the information interfaces between the Social Security Institution and healthcare providers to that of patients and healthcare providers. One of the most popular products of the digitalisation process for the general public has been the launch of an online and app-based appointment system for secondary and tertiary public providers (MHRS). Another one has been the development of an online and app-based personal health information management (e-Pulse) through which patients can access all their medical information. This success in the digitalisation of healthcare has become an advantage for Turkey in its pandemic response as the existing digital infrastructure enabled the rapid issuance of electronic medical certificates for COVID-19 vaccination status. However, the extent to which digitalisation has enhanced patient control over medical data is unknown and merits further study. Human rights groups raise concerns about the abuses of personal data in the digital environment. For example, despite the introduction of the Law on the Protection of Personal Data in 2016 that applies to medical records, human rights organisations report cases of HIV status disclosure to third parties without consent (Positive Living Association, 2020).

GOVERNANCE

Healthcare governance in Turkey is split into two institutions that reflect the separation of provider and purchaser functions: the Ministry of Health for organisation and delivery, and the Social Security Institution for financing and coverage. Governance structures in each of these institutions are organised at the national level and mostly rely on a top-down hierarchical model. The only institutional mechanism through which coordinated healthcare governance could be obtained is the presidential cabinet (previously known as, the Council of Ministers) where these institutions are represented by two different ministers.

Healthcare governance structures do not include organised interest groups such as medical professionals and the private healthcare sector. As a result, no organised interest group possesses veto power in the healthcare policy decision-making process. Turkish healthcare governance has never exhibited formal corporatist features, although their high social standing as a professional group had given physicians political leverage over health policy issues before the 2003 reform. Organised interest groups have to resort to non-institutional and ad hoc channels, mostly in the form of accessing government representatives to express their demands and influence policy (Yilmaz, 2017). The ability of these groups to be heard by policymakers and to affect policy is a function of their power resources and the susceptibility of power holders to their ideas and interests.

Overall, healthcare governance in Turkey is highly centralised and it exhibits exclusionary characteristics in terms of the absence of institutional channels for stakeholder, professional and patient involvement. Additionally, this level of centralisation has neither paved the way to closer coordination between ministries in charge of provider and purchaser functions, nor has it enabled a central oversight of the healthcare policy. Rather, it has resulted in fragmented decision-making without a clear health policy target. An all-of-government approach to health and healthcare issues is lacking. With the country's transition from a parliamentary democracy to an unchecked presidential system in 2017, a new presidential committee on health policy has been established that plays an advisory role. The establishment of a new presidential committee on health policy has only aggravated this fragmentation.

One area in which Turkish healthcare governance has proved effective, in terms of cost-effectiveness, has arguably been pharmaceutical and medical technology pricing and reimbursement. The institutional structure is organised as follows: all products with a health claim, including drugs and medical technologies, have to receive marketing authorisation from the Medicines and Medical Devices Agency. Once this authorisation is granted, the company may apply to the Social Security Institution to include its product in the reimbursement list. The social health insurance-based financing model used in the Turkish healthcare system makes the Social Security Institution the largest buyer of medicines and medical devices. In fact, in 2019, the overwhelming majority of drugs sold in Turkey were on the reimbursement list (The Ministry of Health, 2021a, p. 206). Therefore, most companies are interested in having their products included in the reimbursement list. In cases where the Social Security Institution is also interested in the product, it negotiates with the company to agree upon a below-market price. The Social Security Institution's successful use of its bargaining power led to a decrease in public spending on medications from 1.29 per cent of the GDP in 2005 to 0.84 per cent in 2018 (Statista, 2021). But access to medications has become a challenge with the ongoing devaluation of the Turkish lira since 2018. The devaluation and the government's failure in securing supply under these conditions have resulted in the withdrawal of some imported medications from the Turkish market and considerable access problems (Öztürk, 2021).

On the civil society and business fronts, the health politics in Turkey have become more vibrant in the 2010s as more groups (such as both patient groups and private hospital owners) started asserting themselves as important actors and pursuing diverse strategies (Yilmaz, 2021b). Nevertheless, for non-governmental actors, the current healthcare governance structure is opaque, which makes it particularly difficult for weaker groups (such as patient organisations) and politically dissenting organisations (such as the Turkish Medical Association) to get their views across. Moreover, one of the key challenges for non-governmental actors to formulate their policy positions and engage in meaningful policy advocacy in Turkey is the lack of, or public unavailability of, crucial data on health outcomes and the performance of the healthcare system. For instance, no data is publicly available on the prevalence of common diseases, waiting times for outpatient appointments, diagnosis or treatment (including surgeries).

Formal representation by non-governmental actors including patient organisations, which is common in social health insurance healthcare systems, is absent in Turkey, but there are administrative channels for individual complaints. Five years before the 2003 reform, Turkey issued a patient rights by-law (The Republic of Turkey, 1998), which led to the establishment of patient-rights units in hospitals. These units received a total of around 80,000 patient complaints in 2019 (The Ministry of Health, 2020). Mechanisms for patient complaints have proliferated with the 2003 reform; they currently include hotlines and e-petition mechanisms such as the ones created by the Ministry of Health's Communication Centre (SABIM), the Presidential Communication Centre (CIMER) and the Social Security Institution's (SSI) Labour and Social Security Communication Centre (ALO 170). SABIM was the first, founded one year after the 2003 reform; it handles complaints about provision. This was followed by the Communication Centre of the Prime Ministry in 2006, which was transferred to CIMER in 2015. Unlike SABIM, CIMER is designed as an unmediated communication system through which citizens can register complaints about any issue directly to the Presidency, including complaints about healthcare. In addition, by calling ALO 170, citizens can file complaints about a wide range of issues that include, but are not limited to, social health insurance. These hotlines receive a large volume of citizen complaints in a country with a population of 82 million: 15 million calls to ALO 170 (The Ministry of Family, Labour and Social Services, 2020), 3.1 million to CIMER (The Presidency, 2020) and 2 million to SABIM (The Ministry of Health, 2020).

The diversity and popularity of complaint hotlines may create a false impression that the Turkish healthcare system has become much more accountable in their presence. This could be the case in an ordinary democratic context where healthcare services were not completely instrumentalised to underline government success. In the Turkish case, these hotlines have been turned into a government public relations tool rather than an accountability instrument and they are used as a disciplining mechanism for physicians. As part of the functioning of this disciplinary mechanism, all patient complaints, including unfounded and absurd ones, are automatically turned into official investigations against physicians and physicians have to plead each time. In response, Turkish Medical Association has repeatedly requested the Ministry to take necessary steps to rationalise the patient complaint procedure and to eliminate the negative effects of this procedure on physicians and their working conditions (e.g., Istanbul Medical Chamber, 2020). The non-responsiveness of the government to physician complaints about patient complaint procedures suggests that it might be following an implicit strategy of letting patients hold physicians responsible for the failures of the health system.

IDEAS, POLICY PARADIGMS AND ASPIRATIONS

Turkey's healthcare policy, especially during the 2000s when major healthcare reform was introduced, has been driven by a combination of two ideas: universalism and marketisation (Ağartan, 2012). Each of these ideas has informed different components of the reform. While universalist aspiration was influential in the financing and coverage dimensions, the marketisation push was more visible in the delivery and organisation of healthcare (Ağartan, 2012).

One of the key challenges for the researchers of Turkish healthcare policy in the last decade has been to investigate how and to what extent these two ideas, and the policy dynamics that they have informed, have interacted with each other. The study of the interaction between universalism and marketisation in the Turkish case has broader relevance for healthcare policy literature as the Turkish case offers one of the first developing country cases where these two ideas have been combined in a single reform. The study of the Turkish case has been a valuable scientific endeavour in a global policy context, especially where achieving universalism in healthcare has not been seen in contradiction with private sector presence within the Sustainable Development Goals paradigm. The literature on Turkey has offered valuable insights into how, to what extent, and under which circumstances these two ideas, and policy dynamics, could come to contradict each other.

Efficiency is another key idea that informed health policy. The government saw increasing efficiency in public hospitals as critical for the success of the 2003 reform as the reform aimed at easing access in the context of health workforce shortages. The literature on Turkey has demonstrated that the reform has traded service quality, clinical autonomy and professional standards for faster access to healthcare. One gateway that scholars have used has been focusing on physician perspectives on medical practice. This is because physicians in public hospitals have been experiencing the direct impacts of the New Public Management reforms that were introduced to increase efficiency. Ağartan (2019) finds that physicians describe the new working conditions, which make their remuneration dependent on the volume of services (namely, the pay-for-performance model) they provide, as a challenge to their professional identity. Along the same lines, Aktaş (2020) suggests that, in addition to the pay-for-performance model, physicians feel that their clinical autonomy and their ability to meet the medical needs of the patients have sometimes been compromised due to the adoption of diagnosis-related groups as a basis for hospital reimbursement.

Another policy idea that has been important in the context of the 2003 reform is egalitarianism, or more precisely, socio-economic equity in healthcare access. Two historical factors have motivated scholars of Turkish healthcare policy to adopt an equity lens. First, despite the occupational status-based inequalities in coverage and access in the pre-reform system, the Republican egalitarian orientation was manifest in Turkish healthcare policy debates. Second, the Justice and Development Party government originally presented its healthcare reform as egalitarian that included, but went beyond, achieving universal coverage (The Ministry of Health, 2012). In this context, Yilmaz (2013) argued that the reform had strengthened universalism in healthcare but its egalitarian promise was largely unfulfilled. In the early days of reform, the discourse of egalitarianism even faded away over time in governmental discourse, and the government finally ‘ex post facto rebranded the reform as Universal Health Coverage reform’ (Ağartan, 2021). Therefore, the Turkish case offers a good illustration of how universalism can be disentangled from egalitarianism in healthcare.

Religious conservatism, Islamism in the Turkish case, has been another key paradigm that impacts healthcare policies in Turkey. One manifestation of this has been the emergence of healthcare as one of the platforms where Islamic religious brotherhoods and Islamist business communities have used religion as ‘a network resource’ (Buğra, 1998). As a result, the institutional and human networks around organised Islamic communities with a strong presence in the business world have been cited in the national media as influential (yet otherwise invisible) actors in Turkish healthcare (e.g., Cumhuriyet, 2021). Religious conservatism also has an impact on the scope and content of healthcare. One such area has been sexual and reproductive health—a service domain where Turkey had made significant progress in offering family planning services and making contraceptives available for the general population as part of primary care since the 1960s (Benezra, 2014). In the Justice and Development Party era, Turkey’s success in family planning has come to an end. In the 2000s, the strategy of the government has largely been to let sexual and reproductive healthcare services disappear by themselves in the absence of a political will, adequate funding and human resource. One manifestation of this strategy has been to exclude these services from the performance-based pay for physicians with the 2003 reform. Since the 2010s, the government has adopted a more hard-line approach to sexual and reproductive health while starting to promote an overtly pro-natalist agenda. The government attempted to ban abortion in the early 2010s, which has been available in Turkey since the early 1980s. Despite that the government decided not to carry forward this initiative in the face of women's protests, it has been enforcing a de facto ban on abortion, especially in public hospitals since then (MacFarlane et al., 2016).

The political situation for sexual and reproductive health has deteriorated further in the early 2020s. In this period, religious conservatism has left its place to Islamist fanaticism. This is due to the growing influence of far-right Islamist groups and organised Islamic communities over the governing party. In the context where the government was losing its public support, it has become more responsive to the absurd demands of these far-right Islamist groups and organised Islamic communities to consolidate its core supporters. One more recent example was the launch of a public defamation campaign against a metropolitan municipality that had established a voluntary HIV testing and counselling centre with the permission of the Ministry of Health. A far-right Islamist tabloid published a news story that generated a moral panic out of free condom distribution by municipal health workers on a university campus as part of the World AIDS Day activities in a metropolitan city with a liberal lifestyle. This news outlet's rhetoric to forge a division between the 'people' and the secular opposition resonated with the governing party's local politicians, who took up the issue in the municipal council meeting and accused the mayor of going against the mores of society. In the end, the municipality had to suspend the centre's activities. This was a victory for the Islamist fanatics not only against the secular-run municipality but also the Ministry of Health.

National developmentalism is also a key idea informing the government's approach to healthcare. One area where this perspective is most visible is the policy to enhance the local production of pharmaceuticals. The Turkish pharmaceuticals market was dominated by original pharmaceutical products (64.2 per cent in 2019) based on sales amounts (The Ministry of Health, 2021a, p. 204). However, the share of original products has been slowly declining since the mid-2010s. Turkey's efforts to incentivise local production of pharmaceuticals have led to an international dispute with the European Union, which, in 2019, brought a dispute in the World Trade Organization against Turkey (European Commission, 2019). The European Union has claimed that the condition that Turkey imposes on foreign companies to move their production to Turkey to keep their products on the reimbursement list violates Turkey's obligation to treat domestic and foreign pharmaceutical companies on an equal footing.

State entrepreneurialism in healthcare is another idea that has shaped Turkish health policy, especially since the 2010s. One flagship initiative was the private financing of hospitals, known as 'city hospitals' in Turkey. The government has committed itself to building 18 hospitals with roughly 30,000 beds, mostly in metropolitan cities. The declared purpose of the launch of private finance initiative hospitals was to renew the ageing public hospital infrastructure. Nevertheless, these projects have become a significant burden on the public budget as they resulted in high levels of dollar-denominated debt while the Turkish lira has been losing value since 2018. As a result, the government decided to pause issuing new tenders. Medical tourism is another area where the government's entrepreneurial aspirations connected to healthcare are visible. Different from the national developmentalism observed in the production of pharmaceuticals that could potentially enable the government to keep public healthcare spending under control, the rationale behind the government's interest in medical tourism has no direct benefit for the general public as patients. Moreover, as part of its medical tourism initiative, the government turns public providers, especially newly-built private finance initiative hospitals, into export goods (Yilmaz and Aktas, 2021). This strategy might be considered another step towards a two-tiered healthcare system: one for medical travellers and the affluent, another one for the poor.

HEALTH POLICY RESPONSE TO THE COVID-19 PANDEMIC

Turkey's response to the COVID-19 pandemic, especially its prevention component, has been spotty and patchy. Nevertheless, it has not been part of the group of countries, such as the US under Trump's presidency and Brazil under Bolsonaro's presidency, where the heads of the government have been actively involved in a top-level misinformation campaign that led to substantial preventable human suffering. The increasing impact of Islamist fanaticism on healthcare has not taken a pandemic denial form.

In the Turkish case, designing the health policy response in the early phase of the pandemic, between mid-March and the end of May 2020, was delegated to the Ministry of Health and a newly-formed advisory board composed of physicians. This political choice for the physician-led management of the pandemic response in this period was an unprecedented move in the context of the concentration of power in the hands of a strong president (Bakir, 2020). This move was successful in securing citizen compliance during the first wave. Nevertheless, the political commitment to transparency and prioritising public health over the economy quickly waned with the easing of restrictions in May 2020 (Yilmaz, 2021b).

As of March 2023, Turkey has lost 120 persons to COVID-19 per 100,000 population (Johns Hopkins University, 2023a). Based on mortality data, Turkey was in a relatively better position than countries such as Brazil (329) and the UK (323). However, it was also in a worse position compared to Thailand (48) and South Korea (66) (Johns Hopkins University, 2023b).

Thanks to its reliance on the single-payer financing model, Turkey's access to COVID-19 vaccines has been relatively straightforward. The national vaccination campaign started in mid-January 2021. In terms of vaccination rates, as of the end of October 2021, roughly 68 per cent of the Turkish population had been fully vaccinated which puts Turkey above the world average (Johns Hopkins University, 2023b). Vaccine hesitancy, rather than access problems, might explain the remaining unvaccinated population.

CONCLUSION

The Turkish healthcare system is disintegrating today because its foundations, such as electoral competition and public service ethos, are eroding. This is unprecedented as healthcare is one of the service domains in which Turkey has a relatively strong institutional and human workforce capacity. Starting from the 1920s, the healthcare system was established gradually with developments in preventive health and then combined with the launch of social insurance institutions and the development of service capacity in the 1940s. After a major reform initiated in 2003, the Turkish healthcare system became a social insurance-type system that relies on a single-payer model and internal market for healthcare. The major shortcoming of the system is that its primary care component is underfunded and insufficient to perform preventive health functions. The switch to the internal market led private hospitals to gain an upper hand over public providers in attracting specialists, investing in high technology, and providing high-cost and inpatient services. Both duplicate and supplementary private health insurance have become more common over time, and out-of-pocket payments constitute a considerable portion of healthcare spending. These developments have resulted in the disentanglement of socio-economic equity from universalism. They also signify a movement towards a two-tiered healthcare system: one for medical travellers and the affluent, another one for the poor.

Healthcare governance structures for financing and delivery are separate, organised at the national level and in a top-down hierarchical model. Healthcare governance is fully government-led and does not allow for the representation of organised interests. Policymaking in health had long been a matter of intragovernmental and bureaucratic politics. With the country's transition from a parliamentary democracy to an unchecked presidential system in 2017, however, the previous policymaking structure has been further centralised and fragmented at the same time. This is a recipe for policy disintegration and failure.

Turkish healthcare policy has lost its direction since the mid-2010s for two reasons. First, the combination of universalism with marketisation in the 2003 reform has yielded itself to regulatory failure and political unwillingness to address this failure in the last couple of years. The government has not taken the necessary regulatory steps to ensure the proper functioning of the internal market in healthcare and keep the public character of the system intact. This inertia has resulted in the increasing market and political power of private providers and the erosion of citizen entitlements in practice. Second, health policy has become increasingly marginal in the list of political priorities. The centralisation of power after the transition to an unchecked presidential system and the de-democratisation explain the decrease in the political salience of health. These developments also undermined the relative autonomy of the health and social security bureaucracy that previously provided some coherence to health policy. The loss of political interest and bureaucratic autonomy opened health policy to the influence of myopic economic interests and marginal demands. The revitalisation of electoral competition might change the entire scene and elevate health to a higher level of political priority in the near future.

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27. Health policy in the UK

Alec Fraser and Nicholas Mays

INTRODUCTION

To the outsider looking in, health policy in the UK, dominated as it is by the National Health Service (NHS), and the reverence in which the NHS is held by many British people, might seem rather peculiar. For instance, when London hosted the Olympic Games in 2012, with the eyes of the world watching, the organisers of the opening ceremony chose to pay homage to the NHS as an iconic and quintessentially British institution. Two decades earlier, Nigel Lawson, who had been Chancellor of the Exchequer in Margaret Thatcher's reforming Conservative government, famously lamented that 'the NHS is the closest thing the English have to a religion, with those who practise it regarding themselves as a priesthood.' The popular veneration of the NHS in the UK, and the frustration this has frequently provoked for those outside the Service seeking to substantively alter it, can be traced back to when, why, how, by whom, and for whom the NHS was established in 1948.

The NHS was a key element of the post-World War II settlement which set out a comprehensive welfare state for the British people introduced by Clement Attlee's 1945–1951 Labour government in response to the five 'giants' – idleness, ignorance, disease, squalor and want – as described by the Beveridge Report of 1942. The NHS was established to deliver free access to health care for all, regardless of income, at the point of need. For a population which had never experienced this, having lived through two World Wars and the Great Depression of the 1930s, the NHS and the security it brought alongside an egalitarian ethos cemented the popularity of the institution within the wider population which has endured – unlike some other elements of the welfare state – well into the 21st century.

Notwithstanding this overall popular support for the NHS and what it symbolises, the NHS, at least as much if not more than wider health policy, is, and has been, politically contested and subject to regular reform, especially since the 1980s. Like all nations, this contestation is linked to ideological and economic ideals and realities, influenced by technological and demographic developments and marked by managerial versus professional tensions and power struggles. It is also the case that the UK suffers from poorer health outcomes than other Western European countries for many conditions. For example, five-year cancer survival rates are lower, though gaps substantially narrowed in the period 2000–2014 (Nuffield Trust, 2021).

A key factor of significance in UK health and health care policy relates to the relative ease with which UK governments can legislate to introduce new, reorganise existing, or remove NHS structures and bodies on the one hand, whilst still facing significant resistance to change from within the NHS led by the 'priesthood' to which Lawson referred and its organisational leadership.

Whilst most narratives frame the historical development of the NHS and the British welfare state in national terms, recent scholarship emphasises the colonial history and nature of the British state up to and beyond the 1940s. Such an approach demonstrates how the UK population benefitted through imperial policies of extraction with terrible immediate and longstanding cost to colonial subjects and subsequent independent nations (Bambra, 2021; Mukherjee, 2010). The focus of this chapter is contemporary health policy in the UK, so by definition it must be bounded. However, the material and moral implications of colonialism for the development of the modern UK welfare state should not be ignored (Bambra, 2021). For example, a significant debt that the NHS owes to former colonies is the flow of skilled staff on which the Service has depended more or less since its inception and which the UK has largely taken for granted.

This chapter will analyse some of the political, institutional, economic, and organisational factors of importance to further an understanding of UK health policy development, drawing on illustrative examples from recent years. The chapter will highlight strengths of UK health policymaking as well as structural weaknesses – the latter, in particular, in relation to social care (the British term for long term care) which remains particularly problematic in the UK as exposed by the COVID-19 pandemic.

IDEAS, INTERESTS AND INSTITUTIONS

The UK is a unitary state and is highly centralised compared to many other countries. The political system functions through a first-past-the-post electoral system which, since World War II, has normally delivered stable majorities for one of the two main parties, Labour or the Conservatives, in the lower house of the legislature – the Commons. The unelected upper house – the Lords – may only delay rather than reject government legislation and the vast majority of legislation is initiated by the government of the day. This means that the executive is extremely powerful in the UK system and under normal circumstances should almost always be able to pass its legislation (Pollitt and Bouckaert, 2017). Compared to other countries and different political systems, the UK system provides relatively few veto points (Marmor and Wendt, 2011) which means that a government with a working majority committed to radical health policy reform – such as the establishment of the NHS in 1948 – is legislatively able to do so. It also means, of course, that subsequent administrations have been able to use legislation to reconfigure NHS structures, bodies, and organisations, leading to 'permanent revolution' of the NHS (Hunter, 2005) albeit, until now, respecting its founding principles. Despite all the organisational restructuring (including political devolution within the UK), the fundamental principles set out in the 1946 Health Service Act have not been substantially altered, even by the market reforms of 1991–1997, 2002–2007 and 2010–2013. At the same time, the wider health policy landscape has been less subject to continuous change and typically lower on the policy agenda of successive governments (see below on health inequalities).

Since the late 1990s, the UK has undergone a process of political devolution which has granted increased territorial responsibility for health policy, including the NHS, to the administrations in Wales, Northern Ireland and Scotland (Buse et al., 2023). This has been accompanied by moves to give a modest degree of autonomy in the use of public funding, including for health and social care, to some English metropolitan regions such as Greater Manchester. In England (overwhelmingly the largest of the UK nations), the Department of Health & Social Care, led by the Secretary of State, is responsible for converting the broad policy ideas of governments into potentially implementable policies and providing the impetus for much of the overall health policy direction, supported by so-called 'arm's length', more specialised public bodies, such as the recently merged NHS England and NHS Improvement which between them are responsible for future planning and quality improvement of the NHS in England. The UK also has three politically unaffiliated health policy and management think-tanks, namely, the King's Fund, the Nuffield Trust and the Health Foundation, which, alongside a vibrant university health policy, and health and care services research sector, provide ideas, research and evidence to inform debate and policymaking in the health arena.

Despite significant legislative and managerial reforms initiated by the Conservative Government of Margaret Thatcher to move the NHS toward operating more closely on market principles, and perhaps to her chagrin and that of her colleagues, especially Chancellor of the Exchequer, Nigel Lawson, the original founding commitment of the Attlee government to the idea of a universal, free at the point of delivery NHS funded by national taxation has proven politically too hard to unpick and retains overall public support. Indeed, both main political parties now generally compete to demonstrate their commitment to, and competence in, running the NHS, while arguing about the nature and extent of private sector involvement in the supply of health services and management of infrastructure.

Despite the dominance of the NHS in policy attention, and in the funding and delivery of services – 79% of all health care expenditure in the UK in 2019 came from the government (ONS, 2019) – the UK health and care system is a mixed economy in which the private and charitable sectors both compete and collaborate with publicly-funded health and social care provision. This reflects the fact that the NHS, as it was set up in the 1940s, might be considered a radical-liberal endeavour that delivered *nationalised* as opposed to *socialised* medicine (Powell, 1997). Indicative of this is the fact that general practitioners (GPs) retained independent status and still deliver contracted services to the NHS, and private health care paid for from private insurance or out-of-pocket was never outlawed. Much community dentistry in the UK functions outside the NHS or with substantial user charges within the NHS. Additionally, palliative care, some cancer services, and some social care services which were less of a priority in the 1940s have evolved in partnership with charitable providers over subsequent decades. Social care remained outside the NHS at inception, and this remains the case today (see below).

This all underlines the dominance of acute *hospital* care in UK health services debate and policy. It was principally the previously financially precarious hospital services that were nationalised in 1948. To take Lawson's religious metaphor further – these are the cathedrals of UK health policy. It is clear in the discourse and level of political attention that primary care, public health services and social care receive that they are all subordinate to secondary and tertiary hospital care – in relation to funding, managerial oversight, clinical and academic prestige as well as policy focus leading to an imbalanced health system overall. Despite this, the NHS has relatively limited hospital staffing and bed capacity which was exposed by the pandemic. A more resilient system with greater acute hospital capacity would have been greatly beneficial.

Hospitals, and those who work within them, or provide services or products to them, are key actors that seek to influence health policy in the UK (Buse et al., 2023). Four influential interest groups are: health professionals – the *medical profession* in particular; the pharmaceutical, health technology and clinical supply industries; large national and multinational health care providers, such as Virgin Care – recently rebranded as HCRG; and generic outsourcing companies that provide IT, back office, estates management, security, portering, cleaning, catering, etc., such as Capita and Serco.

AGENDA SETTING, POLICY FORMULATION, IMPLEMENTATION AND EVALUATION

The stages heuristic (Sabatier and Jenkins-Smith, 1993) breaks the policy process down into four stages – agenda setting, policy formulation, policy implementation and policy evaluation (Buse et al., 2023). Though the above interest groups vie to shape NHS policy, the UK politico-administrative system and the high-profile nature and nationalised status of most of the health care system mean that national (UK or devolved) government decisions, including legislation, are the main vehicles through which policy is developed, debated, and amended. A recent example of UK health system policy formulation is the Health and Social Care Act of 2012 which is outlined in Box 27.1.

BOX 27.1 LIBERATING THE NHS?

The New Labour Governments of 1997–2010 increased NHS spending significantly, improving performance and public satisfaction with the Service. However, the Service was increasingly seen as excessively managerially driven (despite being organised as a quasi-market with an increased role for private providers) and subject to a centrally imposed system of 'targets and terror' (Bevan and Hood, 2006). The Conservative opposition promised 'no top-down reorganisation of the NHS' ahead of the 2010 General Election. However, after the Conservatives formed a coalition government with the Liberal Democrats, the Secretary of State for Health, Andrew Lansley, launched a 'reorganisation so big you can see it from outer space' as described by the then NHS England Chief Executive. The Lansley reforms aimed to reduce NHS bureaucracy, reduce (management) costs, empower GPs by giving them more budgetary control over commissioning decisions, increase supplier competition by opening the NHS still further to more private providers, and reduce the ability of the Secretary of State to interfere in the day-to-day operation of the NHS.

The reforms were introduced to Parliament in January 2011 and were spectacularly unpopular. That month, the Lancet ran an editorial titled 'The End of Our NHS' and in March, the Liberal Democrat conference voted against the reform bill. By April, the bill was paused as the Prime Minister started a 'listening exercise'. In July, the British Medical Association (BMA) voted to start a public campaign for the withdrawal of the bill. In December, a House of Lords committee warned the bill would need to be substantially amended. In January 2012, the Royal Medical Colleges and the Royal College of Nursing stated that they could not support the bill and in February key elements of the bill were amended to ensure it maintained the confidence of Liberal Democrat members of the House of Lords.

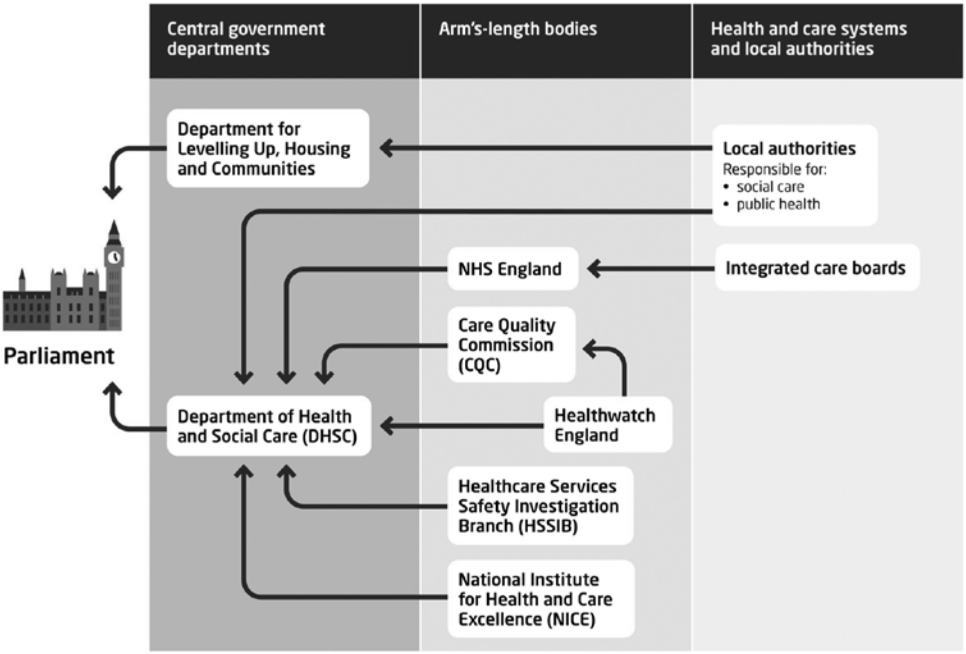
In March 2012, it returned to the House of Commons, with over 2000 amendments, and was passed into law in April 2012. The resultant compromise legislation placed a statutory duty of collaboration on NHS organisations alongside the original measures designed to encourage more competition between NHS providers and the private sector. A poll at that time found the 22% of UK voters felt the NHS was the most important political issue (behind the economy, unemployment, and immigration).

Source: Adapted from Timmins (2012).

The example in Box 27.1 exhibits some unusual features, whilst also highlighting some more generalisable insights relating to agenda setting and health policy formulation in England. The fact that there was, unusually, a coalition rather than a single majority party in power increased the potential for discontent and the executive's need to compromise, so too did the fact that the Conservative party manifesto had not detailed the proposed reforms – this emboldened the House of Lords to challenge elements of the bill which it would not have done for a proposal that had greater democratic legitimacy. Despite all this, and the huge professional and public opposition to the bill, it was passed – albeit in an amended form. Thus, in more general terms, the 2012 reforms highlight the power the executive working through Parliament has enjoyed since 1945 to devise and lead significant health policy reforms using hierarchical policy levers. Such reforms often generate a significant degree of organisational turbulence – for instance, the 2012 reforms included the abolition of significant strata of local and regional NHS managerial bodies, namely Primary Care Trusts (local commissioning organisations) and larger Strategic Health Authorities, and required complex and time-consuming efforts to establish Clinical Commissioning Groups (local commissioners organised around groups of general practices and intended to be more GP-led than their predecessors, now abolished) and new national arm's length level bodies such as NHS England and NHS Improvement (now merged) to oversee key aspects of the English NHS.

Many health policy initiatives across the UK have traditionally been implemented in a largely 'top-down' fashion (Pressman and Wildavsky, 1984), reflecting the character of the British system of government and the enduring hierarchical structure of the NHS; this notwithstanding the waves of reform since the 1980s to refashion the service along quasi-market and New Public Management (NPM) lines (Ferlie et al., 1996; Hood, 1991), as will be discussed later in this chapter. Figure 27.1 outlines the significant relationships and lines of accountability within the English NHS system following the introduction of Integrated Care Systems in 2022. The centrality of the Department of Health and Social Care to most of these inter-organisational relationships is clear.

Within the devolved administrations, similar arrangements exist, albeit on a smaller scale. This is an intrinsic consequence of the very large amount of general tax money going into the NHS and the strong tradition of tight upward accountability to the Treasury and to Parliament for public spending. This top-down model has policy implications – allowing central government to pursue what may seem, on the surface, to be contradictory policy directions such as central planning and targets versus supply-side competition. For instance, the New Labour Governments from 1999 to 2010 published national plans in England for specific diseases (such as cancer, stroke, diabetes, heart disease) linked to national waiting times and quality standards assessed by national clinical audits, while also taking steps to rejuvenate the NHS quasi-market and encourage greater collaboration through regional clinical networks. The accountability of the NHS and the Secretary of State to Parliament for what is currently 40% of public non-capital spending (Zaranko, 2021) means that moves to increase local decision-making autonomy and/or introduce more market-like relationships within the Service take place in the 'shadow of hierarchy' (Héritier and Lehmkuhl, 2008). The positive and negative consequences of the centrally driven nature of UK health system policymaking were clearly seen during the COVID-19 pandemic. For example, in England, the development of testing capacity and vaccine roll-out were both centrally-led and target-driven, the difference being that the former focused on setting up an entirely new system, whereas the latter successfully built on the strengths of existing NHS infrastructure. Such targets, though sometimes



Source: Holmes/King's Fund, 2022.

Figure 27.1 ICS accountabilities diagram

criticised and not always met, have been interpreted as useful in galvanising health sector actors (House of Commons Health and Social Care, and Science and Technology Committees, 2021).

Likewise, evaluation of health policy is often funded and coordinated centrally within the different countries of the UK. The National Institute for Health Research (NIHR) has an annual budget of around £1 billion (NIHR, 2023) to fund clinical, organisational and policy research into English health and health care (other jurisdictions have their own counterpart organisations). Likewise NICE – the National Institute for Health and Care Excellence has, since 1999, provided 'guidance' based on cost-effectiveness which the NHS in England, Wales and Northern Ireland should take into account when deciding which investigations and treatments to offer. At the same time, local pilot, evaluation, and quality improvement programmes are conducted at devolved or regional levels sometimes funded by non-state actors, for instance, larger health charities and the Health Foundation.

GOVERNANCE AND REGULATION

Having highlighted the historical dominance of the executive in policymaking in the preceding sections, when it comes to governance and regulation of the health sector, and particularly of health professionals in the UK, the picture is more mixed. The 1858 Medical Act established the General Medical Council (GMC) granting a system of ‘self-regulation’ to the medical profession in the UK. The GMC maintained a list of ‘registered’ doctors giving it control over entry into, and exit from, the profession. It developed a collegial model of oversight that included standard setting for doctors and oversight of medical behaviour beyond the purview of the state. This granted doctors a significant degree of autonomy. Klein (1990) famously described the accommodation between the state and the medical profession during the first 40 years of the NHS’ life as the ‘politics of the double bed’ signifying that whereas the state set the financial limits without direct reference to the profession, the profession was given a high degree of autonomy to decide the pattern of services delivered with those resources and to define good medical practice.

Whilst the second half of the 20th century saw a general waning of public and managerial deference towards professionals across the Western world that challenged professional dominance (Freidson, 2001), a series of medical scandals in the UK over the past 30 years – especially the case of murderous GP, Harold Shipman (Smith, 2004), and the failure of paediatric cardiac care at Bristol Royal Infirmary (Bristol Royal Infirmary Report, 2001), undermined medical self-regulation in the UK (Department of Health, 2007; Dixon-Woods, Yeung and Bosk, 2011). In 2007, the government gave increased power of oversight to the Chief Medical Officer who represents the state and sits above the GMC, thereby increasing public accountability and effectively increasing government and managerial control over the medical profession (Waring, Dixon-Woods and Yeung, 2010). In practice, the government ended medical self-regulation and increased the transparency of oversight and disciplinary processes, including bringing lay people into these processes by right. One of the other strands of reform from the late 1990s was the invention of the term ‘clinical governance’ (now widely used across the globe) and the establishment of an entirely new system of oversight of the quality of clinical practice within NHS organisations (Walshe, 2002).

Recent years have also seen an expansion of the roles and responsibilities of nursing, pharmacy and the allied health professions (AHPs) such as physiotherapists and occupational therapists – for instance, in relation to prescribing and wider service delivery. Services both in hospital and outside are typically delivered by a range of staff from different professions working in task-focused multi-disciplinary teams reflecting the technical and organisational complexities of modern health care. As managerial roles have increased in provider and commissioning roles since the 1980s, new regulatory bodies have been developed to oversee different aspects of health care. As outlined in Box 27.2 below, sometimes financial and clinical priorities may conflict, and regulatory oversight may fail to ensure patient safety in such situations – leading to significant problems.

BOX 27.2 THE MID-STAFFORDSHIRE SCANDAL

The Mid-Staffordshire General Hospital is located in the English Midlands. Between 2005 and 2008 ‘conditions of appalling care’ flourished in the hospital. A public enquiry led by Robert Francis QC highlighted how a dangerous culture had developed at the hospital. Senior managers prioritised hitting government process targets (linked to A&E department, cancer and general waiting times) and financial targets, which ultimately drastically harmed patient care. This was closely linked to the desire for the hospital to achieve ‘NHS Foundation Trust’ status which gives greater autonomy from hierarchical control.

While patient, public and professional voices raised concerns for over a decade, they were ignored. Even more damning was the fact that the multiple regulatory and governance bodies which ought to have stepped in to identify and rectify problems also failed to do so. These included:

- The regional *Strategic Health Authority* and national *Department of Health* which scrutinised the hospital as part of its application for 'Foundation Trust' status.
- *Monitor* – the independent regulator of NHS 'Foundation Trusts' at the time – which assessed the hospital and found it largely compliant with the quality standards then required by the quality inspectorate – *Healthcare Commission*.
- The *NHS Litigation Authority* which signed off the risk management systems at the hospital.
- Local scrutiny committees and public involvement groups which 'detected no systemic failings'.

The Francis Report made 290 recommendations. The most important included '*putting the patient first*' at all times and in all situations. It was also recommended that all NHS staff behaviour be concordant with the fundamental standards of the NHS constitution and that there should be a '*single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts*' (Francis Report, 2013).

Chambers et al. (2018) explored the impact of the Francis Report five years on with a key focus on changes in board leadership and governance in English NHS hospitals. They found that the Mid-Staffordshire hospital tragedy and consequent Francis Report recommendations appeared to have encouraged NHS hospital boards to focus more closely on improving patient safety, patient-centred care and to develop more open organisational cultures with better staff engagement. However, the policy context in the UK in the years following the Francis Report were noted to be particularly challenging – potentially limiting the ability of boards to deliver safe, compassionate, and effective patient care.

The Mid-Staffordshire scandal highlights the conflicting priorities of the organisations involved in the governance and regulation of health care organisations. There are numerous state actors involved in the governance and regulation of UK health care – often themselves undergoing repeated reconfiguration and organisational re-branding exercises. For instance, the Commission for Health Improvement was established in 1998 by the New Labour Government as the first statutory regulator of quality to cover all NHS organisations in England (Obe, 2011). This was reorganised in 2004 and renamed the Healthcare Commission, now tasked with also overseeing private health services. Five years later, this was replaced by the Care Quality Commission – with an even wider remit to cover social care. The Care Quality Commission continues to 'monitor, inspect and rate' health and social care services in the UK alongside other professional and lay public groups. Whilst regulatory bodies have increased and broadened their remit over the past couple of decades, it remains the case that local whistle-blowers, the press and ultimately, independent inquiries, are often required to highlight serious failings and rectify problems.

HEALTH FINANCING

Total government expenditure as a percentage of gross domestic product (GDP) has risen from around 12% before World War I to around 40% in 2021 – boosted in response to COVID-19 (King's Fund, 2022). The majority of UK taxes continue to be collected at a national (rather than a local) level and these finance the NHS. In 1950, the annual budget of the NHS was £460 million. This had risen to around £160 billion by 2020 – in real terms, this represents a ten-fold increase and a doubling of the share of GDP from around 3.5% to 7.1% over the past 70 years (Appleby, 2018). So, spending on health in the UK has grown considerably both in cash and GDP percentage terms over the past century and, whilst the rate of spending increases tends to fluctuate over time (for instance the first decade of the 21st century saw significant increases under New Labour, whilst the second decade saw significantly smaller increases under Conservative administrations, the lowest ever rate of increase), the overall trend towards increased health sector spending is clear. It is worth noting that the UK spends a lower share of GDP on health services than most G7 countries but is currently middle ranking among the much larger group of OECD countries in terms of health spending per capita. Its public share of total spending is among the highest in the OECD at 79%, only exceeded by Norway, Denmark, Sweden and Iceland (ONS, 2019).

Health spending sits in stark contrast to other sectors – for example, defence – which has experienced radical decreases in spending as a percentage of general government expenditure since the 1950s – down from over 25% to less than 5% over the second half of the 20th century (Clark and Dilnot, 2002). Some other (non-health) sectors have been significantly cut in the 'austerity years' following the 2008 Global Financial Crash. Spending in the Department of Transport is on track to be 32% lower in real terms in 2024–2025 than it was in 2009–2010, the Department for Work and Pensions will be down by 40%, and the Ministry of Justice will be 15% lower over the same time period (Resolution Foundation, 2021). Conversely, the Department of Health and Social Care will enjoy a rise of 40% over the same period, meaning that by 2025, the percentage of central government spending on health and social care will account for 46% of such spending – up from 34% in 2009–2010 (Resolution Foundation, 2021).

This increased health and social care spending as a share of total public spending has coincided with an ageing population but is more causally linked to the rising costs of new health care technologies and treatments, alongside political de-prioritisation of resources for other sectors, and a resistance to direct tax increases. Nonetheless, one might question how long this trend can continue before it raises greater political attention. Indeed, it is arguable that the UK has reached the point where there is no more that can be done to reduce spending in other areas and taxes will have to rise to pay for decent health and other public services.

As responsibility for the NHS and social care has been devolved to Wales, Northern Ireland and Scotland, there are small but politically salient differences in financial arrangements across the UK. Each devolved administration receives an annual budget for all its public services which they can allocate as they see fit, including the share going to the NHS, wider public health and social care. In addition, some have chosen to remove some user charges (e.g., GP prescription charges in Wales, 'personal care' for the over 65s in Scotland covering help with things like personal hygiene, medication and eating) and, in the case of Scotland, the right (modestly) to vary rates of income tax.

In terms of how finance is turned into the delivery of health services, the Treasury allocates a budget each year to the Department of Health and Social Care for the NHS in England. In 2018–2019, this was £130 billion. Of this, just under £6 billion went on capital spending and £12 billion was allocated for vaccinations, some public health services (most currently the responsibility of elected local government, not the NHS), and NHS training and health care regulation. NHS England, an arm's length public body which oversees the commissioning of NHS services, received £112 billion. NHS England allocated just over £28 billion for highly specialised services planned at a national level, such as rare cancer treatments, and also held some money in reserve. NHS England passed £85 billion to local commissioning organisations to enable them to secure services from NHS and non-NHS providers through a complex series of locally negotiated contracts (see below). The amount allocated to each area is based upon population size, demographic structure and socioeconomic deprivation. Healthcare providers thus receive funds from local commissioners as well as NHS England and a small amount from local government (King's Fund, 2021) (see Figure 27.1). It is notable that the majority of the overall budget is spent on secondary and specialist (hospital) care, with around 10% spent on primary care and less than 3% on public health services (IFS and Health Foundation, 2018).

Whilst structural reforms related to how NHS finance flows within and across different organisations are relatively common, changes to how professional and other NHS staff are paid are rare – perhaps reflecting the unionised status of the NHS workforce as well as the complexity of tinkering with the pay and conditions of such a large group of workers. It is notable that the way that hospital specialists are remunerated has not fundamentally changed since the inception of the NHS (salary plus some form of largely peer determined supplement). A final point to make here relates to the use of financial incentives in the delivery of payments for NHS organisations and workers. Since the 1980s, there have been many reforms and much development of NPM approaches in the English NHS, in particular, there have been efforts to incentivise improvements in health care, most notably the introduction of activity-based reimbursement for acute hospitals (the misleadingly named Payment by Results scheme) and performance-related payments to GP practices (the Quality and Outcomes Framework), with disputed positive and negative impacts (Farrar et al., 2009; Maynard, 2012).

HEALTHCARE DELIVERY

Healthcare delivery in the UK, as with other countries, is generally categorised in terms of primary care, secondary care, tertiary, or highly specialised care, public health and preventive services and finally social care services (largely outside the NHS). Primary care is delivered by general practitioners (GPs), practice nurses, pharmacists and other AHPs away from hospital settings. GPs have been contractors to the NHS since 1948 and have also been encouraged by reforms both in the early 1990s and as part of the Lansley reforms of 2012 (see above) to take on service commissioning roles through their involvement in local Clinical Commissioning Groups (CCGs) and in this way have had some influence over service planning and resource allocation in the NHS. From July 2022, following the Health and Care Act 2022, the commissioning responsibilities of CCGs were transferred to the boards of 42 larger Integrated Care Systems (ICSs) that include local authorities, NHS hospitals, GPs and third sector organisations. This change was accompanied by some relaxation of the 2013 requirement for compulsory competitive procurement of all clinical services. The day-to-day work of commissioning continues to be undertaken by general managers who negotiate and monitor the contracts between ICSs and provider organisations – mostly NHS hospital and other providers – but also private and sometimes third sector organisations.

The question of private sector involvement in the NHS is a vexed and much debated one. The reality is that the private sector has always provided non-clinical services and, increasingly, a small proportion of clinical services free at the point of use to the NHS. Figures for 2019–2020 show that the NHS in England paid just under £10 billion on services delivered by private or independent sector organisations. This represents just over 7% of the overall NHS budget – a share that has remained relatively static over a number of years (Kings Fund, 2021). Although the NHS is often described as a comprehensive, universal service, free at the point of use, this has never been strictly true. For example, NHS community dental services mostly attract a substantial user charge and have been provided by private contractors since the inception of the Service. Likewise, the NHS offers a community vision test but there is a user charge.

By far the costliest and most powerful organisations delivering health care in the UK system are the NHS hospitals delivering secondary, tertiary and specialist services. The power of some of these organisations pre-dates the NHS – particularly in London and some other big cities where large hospitals enjoy historic close affiliations with local internationally renowned universities. The links with medical schools to deliver medical student training and opportunities for research partnerships are highly significant in cementing the dominance of hospitals in the UK system. Some of these elite hospitals also have significant non-NHS revenues such as charitable funds and private patient income. The dominance of the hospital sector in the NHS can be explained in terms of 'path-dependency' since it long predates the NHS. The NHS hospital workforce is large, extensively professionalised and highly unionised in comparison to other sectors of the NHS and the wider economy. Efforts to reform, or 'reconfigure' hospital services often flounder in the UK. The example in Box 27.3 bucked this trend but only as a result of an extraordinary effort in strategic planning and mobilisation of key actors.

BOX 27.3 RECONFIGURING STROKE SERVICES IN LONDON

In 2008–2012, the delivery of stroke care in London was radically changed. Before 2008, over 30 different London hospitals treated stroke patients using different protocols and delivering very different outcomes. The evidence-driven reconfiguration of stroke services reduced the number of hospitals accepting acute stroke patients to just eight. These patients were treated in Hyper-Acute Stroke Units and all received the same highly specialised care through a closely monitored pan-London treatment protocol. As a result, stroke patients in London have enjoyed better outcomes – reduced mortality and reduced length of hospital stay – compared to other parts of the country (shown in Morris et al., 2014).

However, the interorganisational processes to move to this specialised model with fewer hospitals providing better care were complex, contested and highly political. They required a very powerful central London strategic management oversight team that was prepared to battle NHS hospitals and specialists invested in the *status quo ante*. The strategic managers framed the reconfiguration using the discourse of 'evidence-based' change, brought together clinical 'champions' and third sector supporters of reform, and ultimately, when challenged by some hospitals and clinicians who were unhappy with the proposed care model, drew on hierarchical NPM levers (e.g., hands on, active, organisational control through setting explicit standards and performance management) to drive the reforms through (Fraser et al., 2017).

In contrast to the dominance of the acute hospital sector, the public health sector in the UK remains small and historically marginalised – though at a national level, WHO targets are taken seriously. Responsibility for public health has moved between the NHS and elected local government twice since the inception of the NHS in 1948 and now somewhat uncomfortably straddles the two with the main responsibility vested in local government. Some public health and preventive services are provided by primary care practitioners (e.g., smoking cessation), others via hospitals (e.g., some sexual health services) and others still through local authorities (e.g., food hygiene standards). This leads to highly fragmented services which are also vulnerable to funding cuts. In the UK, public health and prevention remain 'Cinderella services' and there is little drive to focus on up-stream causes of ill health and social deprivation (Smith, 2014) despite endless government reports (e.g., Marmot, 2010, 2020).

HEALTHCARE REFORMS

As outlined already, the NHS (including in the devolved countries since 1999) has undergone waves of reform, with different levels of ambition. In broad terms, it can be argued that the three and a half decades from 1948 were characterised by a relatively stable paradigm of traditional 'public administration' characterised by Weberian hierarchical bureaucratic principles and 'consensus management' by teams of administrators, senior doctors and senior nurses. Whilst there were strategic developments in the 1960s – notably the 1962 Hospital Plan that led to the development of a network of small–medium-sized District General Hospitals (Rivett, 1998) – these did little to alter the power balance and overall medical dominance of the system and policy more widely. The reorganisation of 1974, informed by management consultants McKinsey, reinforced 'consensus management' while decisively organising the Service into a territorial hierarchy modelled on the large corporations of the day.

The mid-1980s marked a decisive shift away from many aspects of public administration towards the New Public Management (NPM) (Hood, 1991). The rise of the New Right on both sides of the Atlantic represented by President Reagan and Prime Minister Thatcher ushered in a more challenging political environment throughout the 1980s and 1990s, in which a 'value for money' and commercially-minded discourse pervaded the relationship between government and public services. The role of the government was reframed so as to 'steer' rather than to 'row' (Osborne and Gaebler, 1992) – in essence, the state should increasingly purchase rather than provide public services. On a practical level, in the health care sector, 'consensus management' was rejected by the influential Griffiths Enquiry into NHS Management in 1983 and replaced by general management modelled on the practice of large private sector organisations (Harrison and Lim, 2003; Hood, 1991). Along with strengthening NHS management of clinicians and encouraging supply side competition through mimic or 'quasi-markets' involving a purchaser-provider split within the NHS introduced in 1991, came more efforts to measure performance in the shape of benchmarking and league tables, characteristic of the wider public service reforms of the period (Ferlie et al., 1996). Public utilities and public services, including the NHS, especially in England, were split into purchasers, providers and regulators. One result was an ‘audit explosion’ (Power, 1997) as the power of managers and managerialism increased.

Whilst both the New Labour administrations of 1997–2010 and the following Conservative-Liberal Democrat coalition government diverged rhetorically from some aspects of the NPM paradigm, and both introduced reforms that pointed towards more collaborative principles and network governance (Newman, 2001), in practice, many of the key facets of the NPM approach remain embedded. More broadly, hierarchical, market-like and networked forms of governance and accountability have long co-existed and continue to co-exist in health policymaking and management in the UK (Exworthy, Powell and Mohan, 1999), though the blend has altered considerably over time in response to intellectual fashion, technological change and economic conditions. Jones (2017) refers to the idea of ‘sedimented’ regimes of governance in relation to English health policy reforms – in which different reform efforts (sometimes complementary, often contradictory) become superimposed. In the very recent past, from approximately 2012 to 2020, the NHS in England has operated within legislation and policy guidance which has simultaneously encouraged supplier competition for some services as well as inter-organisational collaboration in the name of ‘integration’ for others.

In fact, ‘integration’ has recurred as a policy goal frequently over the past three or four decades. Coordinating services better between the primary, hospital and increasingly social care sectors is seen as something of a panacea to resolve the perceived fragmentation prompted by the market-based reforms since the 1980s and the longstanding divisions within the NHS between primary and secondary care, and between the NHS and long-term care sectors (Dunleavy et al., 2006). This is an issue that continues to consume the interests of both policymakers and researchers as seen in the Health and Care Act 2022 – however, the evidence for the effectiveness of inter-organisational integration in the UK remains underwhelming (Hughes, Shaw and Greenhalgh, 2021).

HEALTH AND HEALTHCARE INEQUALITIES

Compared to many other European countries, the UK is a deeply unequal society with entrenched class, race, gender and regional disparities in morbidity and mortality (Wilkinson and Pickett, 2009). Numerous high-profile reviews over the past 40 years have highlighted the systemic problems linked to health inequalities – from the Black Report in 1980 to the Marmot Reviews of 2010 and 2020 (Marmot, 2010, 2020). The most recent review from Marmot found that improvements in life expectancy have stalled and declined for the poorest 10% of women over the previous decade. In addition to this, the period of public sector financial austerity that began in 2010 has exacerbated the ‘health gap’ between the richest and the poorest in the UK. Geography has a significant independent effect on health, despite the universal NHS, in that a person living in a deprived area of the Northeast of England has a lower life expectancy than a similar person living in a similarly deprived area in London (Marmot, 2020).

These issues are long-standing and complex. There is a well-developed literature on the social and commercial determinants of health in the UK (McKee et al., 2021). These issues transcend health and health care policy per se – straddling housing policy, employment and industrial policy, education policy, welfare policy and transport policy sectors to name just a few. However, this highlights a possible weakness in the overall approach to health policy in the UK. There remains a serious lack of attention in wider public policy to mitigating the 'upstream' causes of ill-health and health inequalities. As noted already, public health as a branch of UK health policy and practice has historically been marginalised and poorly funded in comparison to health care delivery – especially hospital care despite the major contribution of UK researchers to this field. Preventive services and interventions (which could be used to ameliorate the perpetuation of structural inequalities in health and health outcomes) have few consistent policy champions at the political level since they would involve substantial redistribution of resources within society, including tax rises on the better off. Indeed, New Labour's flagship Sure Start policy that provides targeted help for young children and their families, particularly in poor areas, was severely damaged by the Conservative-Liberal Democrat coalition government after 2010 through significant cuts to Local Authority budgets. Therefore, health policy reform and claims for new funding continue to focus on curative services and, to a lesser extent, care rather than public health and these problems remain unchallenged.

In the next section, some of these structural issues are explored in relation to the COVID-19 policy response in the UK. We combine this with a discussion of some of the challenges faced by vulnerable older people – in particular those living in long-term residential care as they were particularly badly hit by the first wave of the pandemic in 2020. The pandemic ruthlessly exposed the weaknesses in the social care sector, its disconnect from the NHS and its historic marginalisation.

COVID-19 AND SOCIAL CARE

Social care (i.e., long-term care) was not prioritised at the inception of the NHS. There were understandable reasons for this. In the 1940s, life expectancy was lower than today, so long-term care needs and attention to the care of older people were less of a policy priority. The agenda of policymakers was more concerned with setting up a health care system that could attend to the needs of children and working-age adults. Social care in the 1940s lacked powerful interest groups, such as the teaching hospitals, to champion its cause. In many ways, this remains the case in the 2020s. The disparity between health care and social care remains – there is an element of path dependency to this, but it can also be explained by the relative power of the different professional groups in each sector. Unlike primary care and hospital care, the social care workforce is not dominated by well-paid, politically-well-connected, medical professionals, but by a poorly paid, less qualified, predominantly female and often immigrant workforce. Public knowledge of what comprises social care, and how it is paid for is also very limited. On top of this, most long-term care takes place in the private sector through a heterogeneous array of many small residential facilities, alongside a few large residential care chains or in people's own homes. In this way, it is less visible or newsworthy than hospital care. Over the past 40 years – reflecting the NPM drive towards what was hoped would be improved quality through marketisation and greater efficiencies – almost all publicly subsidised social care provision has been outsourced to private contractors, and the amount of funding that local authorities have available to pay for social care has fallen relative to population needs during the austerity years since 2010.

The King's Fund identified eight key problems affecting social care in England. These are: (1) means testing – social care is not universally free in England (though the 'personal care' element of long-term care is free in Scotland – which generally seems to offer a better, and more integrated service than in England). This leads to (2) very high costs for a significant number of social care users, alongside (3) a rising amount of unmet need for many vulnerable individuals. A significant problem relates to (4) the quality of care. Many social care interactions are incredibly rushed – for instance 15-minute home visits which are clearly problematic for both clients and caregivers. (5) Workforce pay and conditions are problematic – staff are very poorly paid and undervalued – leading to high staff turnover and tens of thousands of vacancies. Alongside the workforce issues, (6) market fragility is a significant problem with care providers frequently making losses and going out of business. (7) Care is disjointed – with poor integration between primary care, hospital care and social care and frequent delayed transfers from hospital to homes or care homes. Finally, there is (8) a so-called 'postcode lottery' with unacceptable variation in care quality and availability in different parts of the country (Bottery/King's Fund, 2019). Ultimately, many local authorities lack the funds to afford to pay for a decent standard of care for the service users they subsidise. Instead, they rely on residential care providers allowing private payers to cross-subsidise publicly subsidised clients.

The COVID-19 pandemic hit a social care sector that was already vulnerable and had a devastating impact. Around 30,000 excess deaths had been recorded in residential care homes in England and Wales, and 3500 excess deaths amongst those receiving domiciliary care by June 2020 (Bottery/Kings Fund, 2020; ONS, 2020). Whilst other European countries also suffered significant loss of life in care homes – England had the worst figures in Europe (ECDC, 2021; House of Commons Health and Social Care, and Science and Technology Committees, 2021). The extent of COVID-19-related sickness and loss of life amongst social care staff was also very high (PHE, 2020). These failures can be attributed, in part, to political incompetence and mismanagement. But they also highlight something deeper and systemic in UK, and especially in English, health policy. The *cri de cœur* of the government during the COVID-19 crisis was 'protect the NHS, save lives'. The imperative for NHS services not to be overwhelmed, especially hospital intensive care and acute medicine, so as to be able to treat the sickest people with COVID-19 and prevent their deaths, led tragically to a mass discharge of elderly and vulnerable patients from NHS hospitals into care homes which in turn introduced the COVID-19 virus to settings entirely unprepared in terms of equipment and skills to manage a novel viral illness which was especially lethal in the very old and those with underlying health conditions. The lack of joined-up thinking which lay behind this decision is emblematic of a health and social care system which is poorly integrated and structurally unequal.

Looking forward, post-COVID-19, social care, including its relationship with the NHS, remains a key problem for policymakers in the UK. The decision to leave the European Union appears likely to exacerbate the workforce issues which bedevil the sector. Despite much commentary and acknowledgement in government that the social care sector must be made more resilient, the signs are not reassuring. The December 2021 White Paper, *People at the Heart of Care* (Secretary of State, 2021) was widely regarded by experts as offering very little in relation to the workforce crisis and spread new money very thinly. The funding outlook looks bleak. In order to boost NHS and social care public funding, the Government had planned to introduce a new Heath and Social Care Levy in stages from April 2022. However, this was reversed in September 2022. The rationale given was that a low tax economy in which people can keep more of their own money and businesses have more to invest is the best way to increase economic growth and living standards. This overlooks the evidence that effective health services and good social care support the labour market and increase productivity rather than acting as a drain on the economy (Smith, 2018).

CONCLUSION

The emotional attachment that the British people have had to the NHS since its inception endures. The response of the NHS workforce and organisations to the COVID-19 crisis has further cemented the centrality of the NHS as a key institution binding British people together. After a decade of historically low investment, the coming years promise some increased NHS and social care funding which will be needed as the backlog in non-COVID-19 care increases in political and public salience. The best estimates suggest this funding will be insufficient to meet the backlog and remedy the glaring weaknesses in social care. Since health and social care spending is predicted to account for almost half of direct government spending by the mid-2020s, health and care system policy will become increasingly prominent. There are many challenging questions that will need to be faced by policymakers. How should the NHS and social care workforce be recruited and rewarded? How can the post-pandemic longer waiting lists be tackled? How can the longstanding health inequalities in the UK be mitigated? How can the NHS and social care sectors become more resilient, with greater capacity to deal with a future pandemic?

It seems clearer that the battles between professionals and managers heralded by the NPM reforms of the 1980s and 1990s are less significant now, with the role of general management within provider and commissioning organisations more embedded and accepted. Nonetheless, tensions between central government, its agencies and the local NHS, remain, and it would be surprising if we do not see further reconfigurations of the NHS' structure and governance, and related service provision. The Health and Care Act of 2022 indicates that England, at least, is likely to be entering a period when the executive in the shape of the Secretary of State for Health and Social Care increases its legal powers to direct and intervene, especially in the NHS. As highlighted – such a move is highly consistent with the grain of the UK political system with its tradition of extensive executive power and its intolerance of regional and local autonomy, and diversity. There is also very little public tolerance of variation within the NHS. The biggest challenge to central government remains the reform of social care. This is a sector that seriously requires change and a fairer funding settlement. Time will tell whether it receives these.

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28. Health policy in Germany

Thomas Gerlinger

INTRODUCTION

The German healthcare system is considered the prototype of the Bismarck systems. In fact, since the end of the 19th century, various countries have modelled their healthcare systems on the principles of the German system, and in particular on its financing mechanisms. Already in its formation phase, health policy of industrial-capitalist Germany had numerous special features distinguishing it from other health insurance countries that only in part followed the German example. In later years, changes in politics and society, political structures and power relations, goals, problems and problem interpretations, as well as the development of medicine and healthcare contributed to the health policy and the institutionalization of the healthcare system of the 21st century. This article argues that Bismarck principles still apply in German health policy. At the same time, health policy has become highly differentiated and today deals with issues which often go beyond principles associated with the classical health systems' typology (Wendt and Bambra, 2021). In particular, since the 1990s, highly dynamic changes in health policy have been taken place.

This chapter introduces core ideas, basic interests, and institutions of German health policy, followed by a section on main characteristics of regulation and governance in statutory health insurance. Later, data is presented on health expenditure and financing, with current features and problems of the healthcare system being discussed. On this basis, the following section sets out challenges arising from the dual system of statutory and private health insurance. Then, the focus moves to, healthcare delivery and finally, to health policy reforms. The concluding sections cover health policy and management related to the COVID-19 pandemic as well as characteristics and recent changes in Germany's health policy and healthcare system.

IDEAS, INTERESTS, AND INSTITUTIONS

Health policy is a sector close to the state (Mayntz and Scharpf, 1995). In Germany, the state's claim to shape this policy field arises, above all, from two articles of the German constitution: first, the task of guaranteeing the life and physical integrity of everyone is assigned to the state by Article 2 of the Basic Law, resulting in requirements for action in various fields of disease prevention. Second, the definition of Germany as a "democratic and social federal state" in Article 20 of the Basic Law, often referred to as "welfare state imperative" (*Sozialstaatsgebot*), also includes the responsibility to enact provisions on access to healthcare.

The competences for legislation in the fields of disease prevention and healthcare are divided between the Federal State and the Länder, and responsibilities for the implementation of prevention and healthcare are strictly separated from each other. The healthcare system in Germany is based on the insurance principle. A main characteristic is the divide into a statutory health insurance (SHI) and a substitutive private health insurance (PHI). This coexistence is a consequence of the traditional regulation of access to SHI, which primarily referred to occupational status and income level. The Bismarckian health insurance system had been established in 1883 as a workers' insurance scheme and has gradually been extended to other population groups (e.g., other groups of employees, pensioners, spouses and children of SHI members) in the following decades (Alber, 1992). This was based on historically changing ideas about which groups were considered in need of support and which were not. Certain groups – currently: high-paid employees, civil servants and the self-employed – have always remained exempt from compulsory health insurance up to the present (Böckmann, 2011). The idea of a healthcare system that makes access to healthcare dependent on citizenship status has not been enforceable in Germany until today – apart from the special path taken by the German Democratic Republic between 1949 and 1989.

Today, according to Social Code Book V (*Sozialgesetzbuch V* – SGB V), codifying SHI law, anyone living in Germany is obliged to take out health insurance, either in the SHI or the PHI system. Mandatory coverage in either statutory or private health insurance for the overall population, however, was not introduced before 2009. The core institution of the health system is the statutory health insurance (SHI) scheme, which is run by 96 (2023) health insurance funds (GKV-Spitzenverband, 2023a: 25). Around 89% of the population (in 2023: 74.1 million people) is insured under this scheme (GKV-Spitzenverband, 2023a: 23). For the majority of the population, SHI is compulsory. This applies especially to all employees with a regular earned income above €520 per month (mini-job threshold) and below a certain income limit (2023: €5550 per month, i.e. €66,600 per year), pensioners in the statutory pension insurance scheme (who have been in the SHI for most of the latter half of their working lives), and the unemployed. Those who are not compulsorily insured can choose between SHI and private health insurance. Within SHI, non-working family members are covered at no extra charge.

The individual entitlement of the insured to benefits is based on the respective need for treatment (need principle) and is independent of the amount of insurance contributions paid (solidarity principle). SHI contributions are levied as a percentage of gross wages and are transferred by employers to the federal healthcare fund. The insured persons are entitled to all benefits that are necessary for the treatment of the respective illness according to the state of medical knowledge. At the same time, the principle of economic efficiency applies: the SHI benefits "must be sufficient, appropriate and efficient; they must not exceed what is necessary" (§ 12 para. 1 SGB V). SHI is based on the benefit-in-kind principle while PHI is based on the cost-reimbursement principle.

Around 10.5% of the population (2021: 8.72 million people) hold a private health insurance policy (GKV-Spitzenverband, 2023a: 25). The regulations governing private health insurance differ significantly from those governing the SHI. Public officials (*Beamte*), the self-employed and high-paid employees (above a certain income threshold, see above) can opt for PHI. Once PHI has been opted for, switching back to SHI is severely restricted by law and almost impossible from the age of 55. Unlike in statutory health insurance, insured persons can opt for certain insurance packages and health insurers may reject applicants for insurance.

Although compulsory health insurance has been in effect since 2009, a small group of people is not insured – neither statutorily nor privately. In 2019, 61,000 people reportedly did not have any health insurance (Statistisches Bundesamt, 2020: 31). However, the actual number was probably higher. Among them, the proportion of self-employed without employees or with only one employee is above average. Uninsured people have to pay for their treatment or rely on informal care services, often provided by welfare organisations.

The framework of health policy is set out by the legislating bodies. Even if the state, and in particular the Federal Ministry of Health, represents the institutional centre of health policy, a large number of actors are involved in agenda-setting. Together with various associations of doctors, the SHI funds and their associations fill out the legal framework by self-administration. Thus, health policy decisions, including decisions on the benefit package and on overall reimbursement in out-patient healthcare, are usually the results of negotiation processes in which, in addition to the state, corporate actors bring in their interests and power resources.

Therefore, different interests collide in the process of policy-making. SHI funds have a strong interest in low additional contributions because they are the most important parameter in their competition for insured persons. In addition, they are interested in a good quality of care for their members and strive for a large scope of action in the design of care contracts with service providers. Service providers, in turn, are interested in high incomes, respective profits and the greatest possible professional autonomy. On the part of the state, a growing interest in improved population health can be observed. This is to be seen, above all, in the context of economic interests, which have gained in importance in the course of demographic change. Improved prevention and healthcare are expected to limit costs of health treatment and long-term care. It should help – not least in view of a widespread shortage of skilled workers – to quickly reintegrate those who have fallen ill into the work process, to improve the working capacity of ageing workforces and to postpone the retirement age. Furthermore, good health is an important prerequisite for old people to take on tasks in care and other fields of social care as relatives or volunteers, thus relieving the burden on public finances (van Dyk and Lessenich, 2009). Thus, health policy does not only aim at improving the quality of life for individuals and society, but also at increasing social and economic productivity. In this sense, it is also part of a social investment strategy that is pursued in other fields of social policy (Hemerijck, 2017; Midgley et al., 2017).

The organisation of the health system within the framework of a federal multi-level system, the extensive institutional separation of responsibilities for prevention and healthcare, the separation of health insurance into SHI and PHI, and the self-administration of health insurance with numerous semi-autonomous actors, contribute to the complex German health system in which different and partly competing interests are represented.

REGULATION AND GOVERNANCE

Basic Characteristics

Two features are constitutive for regulation and governance in German health policy: the political system's federal structure and the principle of self-administration. The federal level has the legislative right regarding fundamental aspects of prevention and health promotion (e.g., occupational health and safety, infection control, consumer protection, and health-related environmental protection) as well as for social insurance including health and long-term care insurance. In many cases, decisions of the parliament, i.e. the Bundestag, require the approval of the Länder chamber, the Bundesrat. The Länder have important independent competences in both fields. In prevention policy, they are responsible for public health and, in this context, also regulate the responsibilities of the health offices (Gesundheitsämter) operating at the municipal level. In healthcare, the Länder have the legal mandate to ensure hospital care.

To this end, they develop hospital plans and have to cover the investment costs of hospitals (Simon, 2020). In addition, the Länder are responsible for implementing any federal law.

The term "self-administration" refers to two different aspects of regulation: first, it describes the social self-administration by representatives of the employers and the insured in the bodies of SHI funds and their associations, which decide on issues that are of fundamental importance for the SHI funds. Second, it describes the joint self-administration of doctors and health insurance funds (and their respective associations), concretizing the legal framework mostly in collective negotiations or in decisions of the respective competent bodies. In its decisions, self-administration must adhere to the framework formulated by the legislator.

The SHI funds negotiate and conclude contracts with doctors and hospitals at the federal and at the Länder levels in order to ensure service delivery according to legal provisions. In view of the federal multi-level interdependence, the institutionalized influence of associations and their interests, the formation of coalition governments, which is common in view of the German majority voting system, and the strong role of the courts (especially the Social Courts and the Federal Constitutional Court), the regulatory system is higly complex and open to numerous veto players (Immergut, 1990). This combination makes rapid and far-reaching change in health policy difficult (Gerlinger and Rosenbrock, 2023).

Sectoral Regulatory Arrangements

The regulation of SHI healthcare is highly fragmented depending on the sector of care (e.g., outpatient care, inpatient care, pharmaceutical care, rehabilitation, long-term care). These sectors each have their own regulatory systems with specific mixes of state, collective-contracting by self-administrative actors, and market-related elements. Despite great diversity, collective-contracting by associations of self-administration is of particular importance for German health policy. It is characterized by a regulatory health policy framework set by the state and delegates competences to subordinate associations (mostly doctors, hospitals, and SHI funds) in order to concretize and implement the broad provisions (Gerlinger and Rosenbrock, 2023). On behalf of their members, the associations fill out this framework through collective negotiations and agreements and by doing it create sub-legislative law. The decisions and agreements made at the meso level concretize the legal framework and are binding for the actors at the micro level (individual SHI funds, doctors, hospitals, insured persons, and patients). The state, in turn, supervises the bodies and associations of self-administration. Their decisions and contracts are subject to approval by the supervisory authority, which is the Federal Ministry of Health or the Federal Office for Social Security and the respective state ministries at the Länder level. Under certain conditions, the supervisory authority can also resort to a substitute measure, i.e., regulate the subject matter in question itself. In this respect, such a performance of public tasks by associations is always "self-organisation in the shadow of the state" (Scharpf, 1999: 327). Thus, the state becomes the most important point of reference for the involved actors.

In SHI, the outpatient sector is the area in which collective contracting is most widespread (Gerlinger and Rosenbrock, 2023). The associations of SHI funds and of panel doctors (*Kassenärztiche Vereinigungen*) negotiate and conclude contracts on remuneration, quality, and other aspects of care. The associations of panel doctors have statutory mandate to ensure outpatient care for SHI patients, which allows them to design the supply structures and enter into negotiations with the funding agencies on behalf of all panel doctors in their district.

In hospital care, the Länder have the mandate to ensure hospital care, and in this context are responsible for hospital planning and paying for hospital investments (Simon, 2020). In addition to their own legislative competences, they are also able to block or exert a lasting influence on federal decisions via the Bundesrat in all matters of hospital care. Their legislative power provides the Länder with a position in hospital care that is even stronger than the position of panel doctors in outpatient care. Furthermore, in inpatient care, the associations of SHI funds do not conclude care contracts with the hospital associations but with each individual hospital included in the respective hospital plan. Hospital associations at the federal and at the Länder levels play a much smaller role in hospital care than their SHI-accredited counterparts do in outpatient care.

The long-term care (LTC) system in Germany is organized similarly to its healthcare system (Gerlinger and Rosenbrock, 2023). In long-term care insurance (LTCI), the principle applies that "long-term care insurance follows healthcare insurance". Accordingly, all SHI members are automatically insured in social LTCI, and all members of a PHI in a private LTCI. By the end of 2021, 73.1 million citizens were covered by social LTCI and 9.2 million by private LTCI (Bundes ministerium für Gesundheit, 2023b: 1). Like in healthcare, LTC regulation is characterized by the interplay of governmental framework and self-administration. However, the regulation of this sector has a number of special features. First, although the associations of health insurance funds conclude framework agreements with the associations of service providers on the quality and remuneration of services, the service contracts are concluded individually between service providers and beneficiaries. Second, it is not the service providers but the LTCI funds that determine the care needs of the beneficiaries by assigning them a care grade. Third, Länder and municipalities have the task of ensuring an adequate LTC infrastructure and are thus involved in self-governance. Fourth, there is no planning of the need for care facilities in LTC as it is the case in hospital care, but the assumption is that supply and demand will balance out. Overall, in the regulation of LTC, the funds are in a much stronger position and service providers in a much weaker position compared to their respective roles in outpatient and inpatient healthcare (Gerlinger and Rosenbrock, 2023).

FINANCING OF HEALTHCARE AND LONG-TERM CARE

The healthcare sector is of great importance for the German economy. Total health expenditure was about €474.1 billion in 2021 (€5699 per head) and 13.2% of GDP, respectively. Around 75% of expenditure is financed by statutory insurance (SHI, LTCI, Statutory Accident Insurance and Statutory Pension Insurance) and private insurance. The SHI alone accounts for 54% of health expenditure (Statistisches Bundesamt, 2023a). However, in the course of the COVID-19 crisis, spending by public households has more than doubled (from €18.2 billion in 2019 to €40.9 billion in 2021) and its share of total health expenditure increased from 4.4% to 8.6% in this period. Furthermore, the health system is a key driver for employment. In 2021, 6 million people were either employed or self-employed in the healthcare system (Statistisches Bundesamt, 2023b), accounting for around 13% of the total workforce.

The SHI is mainly financed out of income-based contributions equally collected from employees and employers. The contribution rate is determined by employees' and pensioners' gross incomes and does not depend on individual health conditions or age. The general contribution rate is currently fixed by law at 7.3% each for employers and employees (14.6%

in total) and applies to all SHI funds. However, the revenue from general contributions is, in general, not sufficient to cover the individual SHI's total expenses. If expenditure exceeds revenues, SHI funds have to charge an additional fund-specific contribution rate. In May 2023, the additional fund-specific contribution rates varied – depending on the SHI fund – between 0.3% and 2.0% of gross income (GKV-Spitzenverband, 2023b). A contribution assessment ceiling applies, i.e. an income limit up to which the contribution rate may be levied. For people with higher income, the relative contribution burden decreases as income increases. In 2023, the contribution assessment ceiling was at a gross income of €59,850 per year (€4,987.50 per month).

Since 2004, these revenues have been supplemented by federal subsidies. Since 2017, the federal subsidy for statutory health insurance has been fixed at €14.5 billion (Bundesministerium für Gesundheit, 2023a). In view of the revenue shortfall during the COVID-19 crisis, the subsidy was gradually raised and amounted to a total of €28.8 billion in 2022 (GKV-Spitzenverband, 2023a: 27) which was around 10% share of total revenues of SHI (Bundesministerium für Gesundheit, 2022). Without an increase of this tax-financed subsidy, the additional fund-specific contribution rates would have increased considerably. The federal subsidy had already been raised in the course of the 2007–2009 financial market crisis. Economic and political reasons are decisive for the increase of tax-financed subsidies during both crises. From an economic point of view, the competitiveness of companies and the purchasing power of the insured should not be restricted by increasing contributions. From a political point of view, the federal government wanted to avoid the legitimacy risks associated with rising contribution rates.

Most SHI benefits are free of charge, but certain services, products or other benefits (e.g., drugs, aids and remedies) are subject to co-payments. Co-payments usually amount to 10% of the cost per prescription, with a minimum of €5 and a maximum of €10. During hospital stays, patients pay €10 per day for a maximum of 28 days per year. Supplements have to be paid for medicines and other items (in particular for dental care, dentures, and glasses). Co-payments and additional payments for SHI patients have increased significantly compared to the 1990s (Gerlinger and Rosenbrock, 2023). The sum of individual co-payments (not included: additional private payment for dental care, dentures, and aids) is limited to 2% of the gross income of the insured and 1% for the chronically ill. However, many of those who qualify do not make use of it. The introduction of fixed subsidies and a restrictive benefits law have contributed to a system today on which patients have to bear a considerable part of the costs for dental care themselves. An additional and highly significant problem can be seen in the high private share of LTC cost, since LTCI only provides basic coverage. Nursing home costs, in particular, represent a major burden which is often too high for the individual patient (this is discussed later in the chapter).

In PHI, premiums are calculated on the basis of the health status and risk factors, including age, at the time of insurance entry. Care costs are borne (according to the individual contract, in whole or in part) by the insurance (cost-reimbursement principle). For civil servants, the state usually pays 50% (and for pensioners 30%) of the costs as an allowance. PHI premiums rise with age and, for certain groups of PHI members, premiums account for a growing share of their household costs and may even become unaffordable as they get older.

Like SHI, social LTCI is financed through income-related contributions equally borne by employers and the insured. As of 1 July 2023, the contribution rate is 3.4% of gross income for people with one child, with payment to be divided equally between employers and employees.

For each additional child (up to five children) the contribution rate is reduced by 0.25%. The contribution rate can therefore decrease by up to 2.40%. As the employer's contribution rate remains constant at 1.7%, employees with five children only pay a contribution rate of 0.7%. Childless contributors are required to pay an additional contribution rate of 0.6% and thus have to pay 4% (employee contribution rate: 2.3%). Children and spouses with an income of less than €520 are co-insured at no extra cost. The LTCI covers only part of the LTC costs, leaving a very high private share. If care recipients are overburdened, the remaining costs are to be covered by social welfare. Contribution rates have been increased sharply in recent years due to improved LTCI benefits and growing numbers of beneficiaries due to demographic change and easier access to LTCI benefits. With effect from 2022, an annual tax-financed federal subsidy for social LTCI has been introduced to stabilize contribution rates. Still, LTCI expenditure is expected to continue to rise sharply in the coming years.

THE DUAL SYSTEM OF STATUTORY AND PRIVATE HEALTH INSURANCE

The dualism of SHI and PHI produces a variety of negative effects. First, privately insured persons do not support the SHI's solidarity system, although their average income is significantly higher than that of SHI members. Second, the status of privately insured patients leads to certain privileges in healthcare. In particular, waiting times for appointments with specialists in outpatient care are often much shorter than those for SHI patients (e.g. Lüngen et al., 2008) because doctors receive higher remuneration when treating PHI patients. Third, these differences in the remuneration of services are also an important reason for the unequal distribution of physicians at the expense of economically and infrastructurally disadvantaged regions, because physicians prefer to settle in regions or districts with a high proportion of PHI patients. Fourth, there is also risk selection between the two systems at the expense of SHI. Among those with freedom of choice between the two systems, the "good" risks usually opt for private health insurance, i.e., those individuals who do not have pre-existing conditions or risk factors for chronic diseases and do not have to insure non-employed family members.

Furthermore, the coexistence of the two systems has negative effects on the solidarity system within SHI, because an important motive for the existence of the contribution assessment ceiling favoring higher earners is to give people with freedom of choice a financial incentive to choose SHI. It is true that SHI has an interest in the existence of an income threshold because it increases the chances that higher earners will choose SHI even if they are not among the "bad" risks. The price to be paid, however, is a relatively lower burden of contributions for higher earners as those with an income which is twice as high as the maximum contribution threshold only pay 50% of the contribution rate of those who are not allowed to opt out.

The plans for a solidarity-based citizens' insurance system offer concepts that are suitable for overcoming the dualism outlined above and its negative effects. They are supported among the parties by the Green, the Left and the Social Democratic Party, as well as by trade unions and some welfare associations. Despite all the differences in detail, the core element is that the entire resident population is to be included in a unitary health insurance scheme on the same terms. Accordingly, the compulsory insurance limit for higher-earning employees and the special access rights for civil servants and the self-employed to PHI are to be abolished. Furthermore, in addition to income from dependent employment, other sources are to be used to finance health insurance in the future, regardless of whether this is to be done through the individual levying of contributions on corresponding income, e.g., on income from renting and leasing, on interest and capital income (The Green and The Left Party), or through the permanent establishment of a tax-financed, dynamized federal subsidy (Social Democratic Party). The introduction of a citizens' insurance system would reduce or perhaps even eliminate existing inequities in financing and access to benefits. Particularly in conjunction with an increase or even elimination of the income threshold, it would also lead to a substantial reduction in health insurance contributions (Rothgang and Domhoff, 2017). However, the introduction of a citizens' insurance scheme is unlikely in view of the political majority situation, because Liberals as coalition partners and Conservatives at the Länder level are blocking such a reform.

HEALTHCARE DELIVERY AND WORKFORCE

Main Characteristics

Healthcare in Germany is doctor-centred. In general, non-physician health professionals, especially nurses, have little autonomy in healthcare delivery. A system of primary care in the sense of the WHO Declaration of Alma-Ata, i.e. a community-based, multi-professional, integrated type of organization that combines tasks in health promotion and prevention, primary health care, in social and psychotherapeutic counselling and care (World Health Organization, 1978), does not exist. Multi-professional primary care concepts are of minor importance in healthcare provision (Schaeffer and Hämel, 2020). Furthermore, healthcare is traditionally characterized by a strong segmentation of the care sectors, i.e. outpatient, inpatient and rehabilitative care as well as long-term care. This leads to unnecessary costs and, above all, to a reduction in the quality of care (Sachverständigenrat, 2018). The integration of care is therefore an important goal of health policy (see later discussion).

The physicians decide on the kind of treatment needed, but this applies only within the scope of the fundamental decisions taken by the Federal Joint Committee, the most important body of self-administration. They decide whether new diagnostic methods and therapies and new medicines, dressings, therapies and aids, may be provided or prescribed at the expense of SHI funds.

The number of physicians and beds per 1000 inhabitants is high compared to other healthcare systems in Europe and to the OECD average (OECD, 2023). By the end of 2022, the total number of practicing doctors was almost 421,300, corresponding to a physician density of 5.1 per 1000 inhabitants (Bundesärztekammer, 2023: 2, 3). As the SHI benefits catalogue is quite comprehensive and almost everyone holds a health insurance scheme, access to healthcare can be, by and large, assessed as good. Thus, Germany can be characterized as a "supply- and choice-oriented" public system (Reibling et al., 2019: 616).

At the same time, access to healthcare services is limited by various factors (Gerlinger, 2018). First, high co-payments are likely to limit the utilization of dental services. Second, primarily in rural and remote regions with poor economic performance and infrastructure or in deprived metropolitan areas with high shares of poor people, unemployed persons or welfare recipients' availability of medical care is sometimes insufficient (Bertelsmann Stiftung, 2014). Third, the number of family doctors is falling short of demand. This is one reason for the inadequate coordination of healthcare. Fourth, the divide into SHI and PHI leads to a situation in which SHI patients often face longer (sometimes unacceptably long) waiting times for a doctor's appointment. Fifth, in psychotherapeutic care, patients often face long waiting times, as well as, most recently, in inpatient paedriatic care. Sixth, the number of people without any health insurance, while small, remains a persistent problem. Seventh, during the first 18 months of their stay in Germany, asylum seekers' healthcare entitlements are limited to the treatment of acute illnesses and pain conditions (Janda, 2023). Eight, though the list of benefits provided by the SHI scheme is considered to be comprehensive, access to medical innovations for SHI patients is sometimes not granted as quickly as possible, even though these innovations are, in principle, available. A major reason is that the approval process is sometimes considered to be too slow (Walendzik et al., 2021).

Outpatient Care

Outpatient care is mostly provided either by doctors in private practice or by doctors in Medical Supply Centres (*Medizinische Versorgungszentren*) that were approved for outpatient care for SHI patients in 2004. On the whole, 165,600 physicians and psychotherapists were providing outpatient care by the end of 2022 (Bundesärztekammer, 2023: 2, 10). The number of doctors working in outpatient care as employees has been rising particularly sharply – from 8271 at the turn of the century to 55,571 by the end of 2022 (Bundesärztekammer, 2023: 8), many of them in Medical Supply Centres (Kassenärztliche Bundesvereinigung, 2022). Almost all outpatient care is provided in surgeries or Medical Supply Centres as well by general practitioners and by specialists, while hospitals play only a marginal role in outpatient care. SHI patients enjoy the right of free choice of doctors when seeking outpatient care, including the right to consult a specialist without referral by a general practitioner. In contrast to PHI patients, persons who are insured under the SHI scheme may use the hospital for outpatient treatment only in exceptional cases which, however, is increasingly done.

Despite the high density of doctors, there is a shortage of general practitioners. Between 2013 and 2022, their share of all contract physicians and psychotherapists declined from 33.5% to 29.7%, despite numerous efforts to counteract this trend (Kassenärztliche Bundesvereinigung, 2023a). This trend is likely to continue due to the large proportion of GPs retiring from medical practice in the next few years, as 36.5% of them are over 60 (Kassenärztliche Bundesvereinigung, 2023b). By 2035, up to 11,000 general practitioners' practices may have to close down (Nolting et al., 2021), especially in disadvantaged areas. In recent years, new obligations and incentives have been put in place to address the shortage of general practitioners in rural areas, including – above all – financial incentives, but a resounding success has not yet been achieved (Gerlinger, 2021).

Inpatient Care

In 2021, there were just under 484,000 beds in slightly less than 1900 hospitals (Statistisches Bundesamt, 2022a: 10). The hospital sector is characterized by a diversity of providers. Besides public hospitals, there are community hospitals, charitable organizations (churches, welfare services, associations, foundations), and large for-profit hospital corporations who are major players. Twenty percent of beds (38.8% of hospitals) were privately run for profit, 32.2% (32.2% of hospitals) run by charity organizations, and 47.8% (29% of hospitals) by public authorities (Statistisches Bundesamt, 2022a: 15). The significant increase in the number of privately run hospitals is one of the most striking developments in hospital care in recent decades. Privatization is due to both financial and political motives. In the past, municipalities in particular often tried to get rid of loss-making hospitals. In addition, some municipalities in the 1990s and 2000s also followed neoliberal concepts, according to which the privatization of municipal tasks is considered a suitable instrument to reduce costs and improve quality.

The number of acute hospital beds per 1000 inhabitants fell from 7.5 in 1995 to 5.8 in 2021. In 2019, around 19.4 million patients (1991: 14.6 million) were treated in hospitals (Statistisches Bundesamt, 2022a: 10), corresponding to a ratio of 233 cases per 1000 inhabitants. The temporary decline in patient numbers to 16.7 million patients in 2020 and 2021 was a consequence of the COVID-19 pandemic. The average length of stay in hospital has fallen sharply, and was down to 7.2 days in 2021 (1991: 14.0) (Statistisches Bundesamt, 2022a: 10). The introduction of Diagnosis Related Groups has contributed to reducing the length of stay in hospitals. However, compared to other healthcare systems in Europe, the number of hospital beds per 1000 inhabitants, the average length of stay, and the number of hospital cases are still high (OECD, 2023).

Hospital care faces major challenges. Firstly, working conditions are poor, especially for nursing staff. Staff shortages, high workloads, and low salaries are reasons for widespread dissatisfaction and high turnover (Schmucker, 2020). The reasons are complex, but the growing importance of financial incentives in hospital care driven by the DRG system plays an important role. For many years, the resulting pressure on operating costs was mainly reflected in savings in nursing staff, which were achieved through low salary increases and a low number of recruitments. Thirdly, the structures of hospital care need to be reformed. In metropolitan areas, there is often an overprovision of hospital beds. At the same time, many smaller hospitals often carry out complex diagnostic treatments and operations without the necessary experience and therefore, too often, not to the required quality. Against this background, a concentration and specialization of hospital care is considered necessary (Busse and Berger, 2018).

Long-term Care

Benefits are funded by the contributions-based LTCI scheme. LTCI distinguishes between five care grades, determined by limitation of independence or incapacitation in six fields (mobility cognitive and communicative abilities, behaviour patterns and psychological problems, level of self-sufficiency, health restrictions, demands and stress due to therapies, and structure of everyday life and social contacts). This concept came into force in 2017 with a comprehensive reform that makes access to benefits dependent on whether, and to what extent, people's independence is limited (Wingenfeld, 2017). Until the end of 2016, the condition of being "in need of care" had been measured by the person's ability to perform activities of daily living (e.g., personal hygiene) independently and the time they needed assistance in these activities. The 2017 reform has improved access to LTCI benefits in particular for persons with limited everyday competence, i.e., above all for dementia patients. The assessment of need for LTC is carried out by the Medical Service which is an independent institution, and on the basis of its recommendation, the LTC fund decides on the degree of care. Long-term care benefits are granted on the basis of the care grade and how care is provided (at home or in a residential home for elderly). In general, a recipient may choose between three different arrangements: care allowance, home care (in kind), and residential care, as well as certain additional services (e.g., short-term care). Regarding benefits, there is no difference between social and private LTCI.

By the end of 2020, around 4.9 million people were beneficiaries under the LTCI scheme, among them 4.61 million people in statutory LTCI and 0.29 million in private LTCI. They included around 0.90 million people (18.3%) living in nursing homes. The remaining 4.0 million people were being cared for at home by close relatives, mostly by women, or by domiciliary care services (Bundesministerium für Gesundheit, 2023: 1). In recent years, the number of people in need of care has risen significantly, mainly due to demographic change and the 2017 legislation has intensified this process through the extension of access to care according.

By the end of 2021, LTC was provided by about 15,400 outpatient care services and about 16,100 nursing homes (Bundesministerium für Gesundheit, 2023: 16). Delivery of LTC is dominated by private providers. In total, 42.7% of all nursing homes were private for-profit providers, 52.8% private not-for-profit, and 4.5% publicly owned and run (Statistisches Bundesamt, 2022b). In domiciliary care, as many as 67.8% of providers were private for-profit, 30.8% private not-for-profit, and 1.3% publicly-owned and run (Statistisches Bundesamt, 2022b). Almost 443,000 (mostly qualified) persons are employed in domiciliary care service, and more than 814,000 (also mostly qualified) persons are employed in nursing homes (Bundesministerium für Gesundheit, 2023b: 17). Around 84% of all people in need of LTC are cared for at home, with 75% of them only by relatives or volunteers and 25% of them by domiciliary care services alone or in cooperation with family members or relatives (Statistisches Bundesamt, 2022b).

A major problem for LTC is the shortage of nurses. This is due to working conditions in LTC that are worse, and wages that are lower, than for nurses in healthcare (Schmucker, 2020). The shortage of nurses is probably the most important reason for problems in LTC quality. While there are indications of slight improvements over time, significant deficiencies persist. Without a thorough improvement in working conditions and increase in wages, the shortage of nurses – and thus LTC quality – will not significantly improve.

MAJOR HEALTHCARE REFORMS OF RECENT DECADES

Between the mid-1970s and the beginning of the 1990s, health policy was characterized by moderate reforms that attempted to achieve the goal of cost containment by holding on to previous structures. Since then, health policy has made far-reaching changes to the health system and at the same time established new fields of action, especially quality assurance and in long-term care.

Regulated Competition

Since the beginning of the 1990s, a number of reforms have been passed that were oriented towards the model of regulated competition. Of particular importance for this shift was the Health Structure Act passed in 1992. From 1993 onwards, policy instruments were adopted that were either new to SHI or gained such weight that they significantly changed the incentives for the actors involved, in the beginning, in particular, for the SHI funds. Probably the most important new steering instrument was the introduction of free choice of SHI funds for the insured persons. Previously, most insured persons had been assigned to certain health insurance funds based on their occupational status. With free choice of sickness funds coming into force, it was expected that the SHI funds would come under increasing pressure to limit expenditure and that they had to take the needs of the insured more into account. However, the implemented control instruments did not realize these expectations. Competition between the SHI funds is largely limited to price competition, namely to the goal of keeping the individual SHI's additional contribution rate as low as possible. In this context, however, it created a strong incentive for the SHI funds to select good risks, i.e., healthy or health-conscious insureds as they cause below-average costs and thus promise to bring competitive advantages to the SHI fund (Bundesversicherungsamt, 2018).

Since the second half of the 1990s, SHI funds have been pushing to conclude individual contracts with individual or certain groups of service providers (*Selektivverträge*), a regulation that deviates from the traditional collective contracting framework. Selective contracts have been negotiated in numerous care areas especially in the 2000s (Götze et al., 2009). This primarily affected certain segments of outpatient care (GP-centered care; disease management programs for certain chronic diseases; integrated cross-sectoral care), and later also parts of pharmaceutical care (discount contracts for generics), and the provision of medical aids (e.g., tenders for contracts with SHI funds). Thus, selective contracts were established in selected healthcare areas alongside the collective contract system, which remained dominant (Gerlinger and Rosenbrock, 2023). It was mainly the federal legislator and the SHI funds that sought to increase the importance of selective contracts, because they saw the collective contract system as an obstacle for improving quality and efficiency. Selective contracting was expected to put pressure on service providers because they would have to compete when contracting with SHI funds (Gerlinger, 2013). However, to date, competition between SHI funds tends to be focused more on price than on quality. Risk selection, i.e., increasing the appeal of SHI funds for people in good health, can be considered as a major instrument of competition.

This shift towards regulated competition took impulses from the international managed care discussion whose promises quality improvements and cost savings inspired numerous countries to implement respective reforms of their healthcare systems (Wendt, 2013). From the 1990s to the early 2010s, calls for more competition in healthcare were encouraged by neoliberal hegemony. In recent years, however, they have not been raised and accepted like in earlier years.

Integrated Care and Quality Assurance

Healthcare is characterized by a strong segmentation of care sectors (see this chapter's discussion). The German healthcare system generates comparatively high costs but seems to lag behind other countries regarding quality of care, especially for the chronically ill (Sachverständigenrat, 2018). Quality assurance, which until the end of the 1980s had largely been a matter of medical self-administration hardly regulated through legislation, has become an important health policy field since the 1990s. In this context, the integration of care has become a major health policy target, and a highly differentiated body of statutory regulations for quality assurance has emerged. The Joint Federal Committee, the most important body of joint self-administration of doctors and SHI funds, has been given far-reaching powers for assessing the benefits and economic efficiency of new treatment methods and issue regulations for quality assurance. In addition, specific institutions for quality assurance have been established. The "Institute for Quality and Efficiency in Healthcare" (IQWIG) was launched in 2004 for determining and evaluating the state of medical knowledge on diagnostic and therapeutic procedures for selected diseases and for developing evidence-based guidelines for the treatment of epidemiologically significant diseases. The "Institute for Quality Assurance and Transparency in Healthcare" (IQTIG), founded in 2014, is intended to strengthen facility-based and cross-sectoral quality assurance in the healthcare system and, above all, enable comparisons between healthcare facilities.

The improvement of the quality of care is also to be strengthened by new forms of care that have been established alongside standard care. Of particular importance are GP-centered care and disease management programs (DMPs). The SHI funds must offer their insured persons such programs with voluntary enrollment.

GP-centered care is intended to strengthen coordination. In this type of care, in case of illness insured persons agree to see their GP first and to seek specialist care only after referral. Special requirements for this type of care go beyond standard GP care and include the obligation to participate in structured quality circles for drug therapy and in special further training for GPs as well as treatment according to evidence-based and practice-proven guidelines. More than 6 million patients and more than 16,000 GPs participate in these kinds of programs (Hausärzteverband, 2022).

DMPs are structured treatment programs for selected widespread chronic diseases. They focus on the application of evidence-based guidelines, on improved cooperation between the service providers involved, continuous quality management and specific training for patients and service providers, as well as continuous evaluation. By the end of 2022, a total of more than 8.5 million insured persons were enrolled in such programs. The DMPs for diabetes mellitus type 2 alone accounted for around 4.4 million and the DMPs for coronary heart disease for almost 1.9 million enrollments (Bundesamt für Soziale Sicherung, 2023).

Evaluations of these programs indicate that they contribute to improving the quality of care. However, the corresponding findings are not always unambiguous, and some of the differences in healthcare quality between participants and non-participants could also be the result of a social selection bias. Differences between the care of participants and non-participants making use of standard care also indicate that healthcare for many chronically ill people is still not based on evidence-based guidelines (Gerlinger, 2021).

The improvement of quality in hospital care was a subject of recent legislation. It provides for the introduction of quality-based remuneration, the introduction of quality as a criterion in hospital planning, and more effective control of the rise in the number of hospital surgeries medically not indicated to be pursued by a second opinion policy (Gerlinger and Rosenbrock, 2023).

Financing of SHI Funds

In the post-war decades, payment of health insurance contributions in equal parts by employers and insured persons had developed into a traditional feature of the SHI system. Since the first half of the 2000s, this mode of financing has been subject to repeated reforms. In 2005, a special contribution was introduced only to be paid by the insured. In 2009, this was supplemented by an additional contribution for each individual SHI fund, which also had to be paid by the insured only. Various reforms have introduced additional financial burden for insured persons (Gerlinger and Greß, 2018). For a certain period, this additional contribution had to be paid as a flat rate independent of income (*kleine Kopfpauschale*), with a tax-financed subsidy for low-income earners. The main objective of the reforms was to relieve employers of SHI contributions. The significant increase in co-payments for SHI services in 2004 also served this purpose. These measures also reflected the increasing importance of neoliberal concepts in German health policy. From 2019 onwards, however, insured persons and employers pay the additional contribution on a parity basis based on gross income. Under strong pressure from drastically declining voter approval, the Social Democratic Party finally decided to return to parity financing. Moreover, the high level of employment and increasing revenues of the SHI funds facilitated the re-introduction of equal pay.

Remuneration of Medical Care

In outpatient care, the previously dominant remuneration on a fee-for-service has been replaced by a mixed system with fee-for-service and flat-rate payment. In primary care, in particular, flat rates play a major role (Wissenschaftliche Kommission, 2019). The most important change in recent decades, however, has been the switch in the remuneration of hospital services to Diagnosis Related Groups (DRGs), which have been fully in force in German hospitals since 2010. In the DRG system, the level of payment is based on the severity of the patient's illness and the surgeries and procedures performed. A hospital is now reimbursed according to average costs determined for the respective case and no longer for its real costs. DRGs create incentives for hospitals to reduce costs per treatment case and to increase the number of treatment cases for those diagnoses and surgeries where costs are significantly lower than DRG revenues. Financial calculation in the provision of hospital care has become considerably more important with the introduction of the DRG system (Simon, 2020).

DRGs are the subject of controversy. While its proponents emphasize that performance transparency and equity are improved and the incentive for rationalization of care is strengthened, numerous studies point to negative effects (Braun et al., 2010; Dieterich et al., 2019; Naegler and Wehkamp, 2018). According to these studies, cost pressure causes hospitals to make primarily short-term-oriented staff savings and often do not lead to meaningful, quality-neutral rationalization measures. As a result, the personal attention to the patient suffers in particular. Furthermore, the reform of hospital remuneration leads to increased costs for post-hospital care as well as high burdens for patients (e.g., due to an increasing number of preoperative hospital visits) and their relatives, who must ensure care at home in the event of early or premature discharge from the hospital. Finally, physicians and nurses often perceive conflicts between quality of care and cost pressures (Braun et al., 2010; Naegler and Wehkamp, 2018).

Long-term Care

The introduction and reform of the LTCI is one of the most important issues in health policy in recent decades. Its introduction in 1995 was a response to demographic change and the increasing number of people in need of LTC. Reforms since then have focused on four policy areas. First, the number of beneficiaries was significantly increased with the reform that came into force in 2017. This expansion was necessary because a large number of dementia patients previously had no or only insufficient access to LTCI benefits. Secondly, health policy aimed to strengthen informal home care by relatives and volunteers through numerous financial incentives, because this form of care corresponds to the preferences of many people involved.

Furthermore, costs are significantly lower than care in a nursing home. Thirdly, attention was given to tackle the shortage of skilled workers by improving working conditions and raising wages. Thus, minimum wages for care were introduced and gradually increased, service providers were obliged to adhere to collective agreements, funds were provided for additional positions in care homes and the gradual introduction of a staffing assessment procedure in nursing homes has been started. However, it has become clear that the efforts made so far are not sufficient to overcome the shortage of nurses. Fourthly, the high private share of care costs, which has risen sharply in recent years, has become an important issue in health policy (Rothgang and Kalwitzki, 2021). It is obvious that the high private costs, especially for nursing homes, overburden many people in need of care. Thus, around 30% of those living in nursing homes were dependent on welfare grants (Statistisches Bundesamt, 2022c). In view of this problem, since 2022 the personal contribution for care in nursing homes has been reduced on a percentage basis. The additional costs of this reform are financed, among other things, by the introduction of a tax-financed federal subsidy for LTCI. However, the real relief for the insured persons is small. In mid-2022, the average financial burden per nursing home resident still amounted to €1,976 per month (Rothgang and Müller, 2022: 26). In contrast, the monthly average pension in the statutory pension insurance was €1,046 at that time (Deutsche Rentenversicherung, 2023). As of 1 January 2024, the supplements for care in nursing homes will be increased to 15% in the first year of stay in the nursing home, to 30% in the second year of stay, to 50% in the third year, and to 75% from the fourth year onwards.

CHALLENGES POSED BY COVID-19 AND POLICY RESPONSE

Until the end of 2021, Germany had managed the COVID-19-crisis fairly well. By then, both the number of people who died from COVID-19 and the number of those infected, as far as it has been recorded, were quite low. Furthermore, it was possible to avoid triage in the care of the critically ill. In this respect, the high number of hospital beds, including intensive care beds, which has often been a matter of critique, proved to be highly useful.

Nevertheless, the COVID-19 crisis has revealed serious deficiencies in German health policy. They concern above all the role of the Public Health Service (PHS) and its lower-tier health authorities. The PHS has been drained financially and experienced staff cuts (Schmacke 2013), mainly because of the efforts of the Länder and municipalities to reduce their expenditure in order to consolidate their budgets. After decades of neglect, the COVID-19 pandemic has refocused public and political attention on the importance of PHS. It quickly became apparent that the reductions in both financial resources and personnel had limited the PHS's ability to effectively contain the pandemic. In many municipal public health offices, tracing the contacts of infected persons was no longer possible, nor could adequate counselling and support be provided for the population and important institutions. Besides the lack of staff, the inadequate technical infrastructural structure, especially insufficient digitalization, was criticized.

Against this background, the federal government, in agreement with the Länder, passed a "Pact for the Public Health Service" in 2020, according to which the federal state will provide an additional €4 billion until 2026 in order to better equip the PHS. This amount was intended to create a total of 5000 new positions by the end of 2022 and to improve the technical infrastructure of the municipal public health offices (Bundesministerium für Gesundheit, 2020).

The number of new posts to be created represents a significant increase. By the end of 2021, at least 21,460 people were employed on a permanent basis in the PHS – 2615 more than at the beginning of the pandemic (Statistisches Bundesamt, 2022). The number of physicians working in public health offices has also significantly increased in recent years and amounted to 3529 by the end of 2022 (Bundesärztekammer, 2023: 12–21).

In addition, it became apparent that many municipal public health offices did not sufficiently focus on prevention of infections and vaccination of vulnerable groups. This problem was exacerbated by poor staffing and technical resources but also because insufficient attention has been paid to these groups in earlier times – what can be considered as a major problem in public health policy.

In healthcare and long-term care, the pandemic revealed problems that were already known before, but their serious consequences only became obvious in the pandemic. Despite good equipment with hospital beds and medical technology, treatments and procedures on critically ill patients had to be postponed to provide care for COVID-19 patients. A significant proportion of COVID-19 deaths were in nursing homes. In the course of the COVID-19 pandemic, the shortage of skilled staff proved to be a particularly serious problem. In both sectors, there have been complaints about poor working conditions and low wages for many years. During the pandemic, the number of available intensive care beds declined because of staff shortages. The COVID-19 crisis has demonstrated that efforts to improve working conditions have so far not been sufficient.

One of the greatest challenges is the future financing of healthcare, as the consequences of the pandemic have led to a high SHI funds' deficit. As far as healthcare financing is concerned, the government is faced with a dilemma: on the one hand, there is a broad consensus among the governing parties to keep all insurance premiums together below 40% and not to increase the public debt. On the other hand, deficits of health insurance funds are increasing and coping with challenges such as demographic change, staff shortages, and consequences of the pandemic requires additional financial resources. Thus, distribution conflicts in SHI which, due to high economic growth, were of minor importance in the last decade, can be expected to intensify. In this context, it can also be expected that benefit exclusions and increased co-payments for patients will again become an issue of political and public debate.

CONCLUSION

Since the 1990s, health policy has led to accelerated change in the German health system – after decades of rather moderate, incremental reforms. Traditional features of the German healthcare system, some of which date back to the foundation of SHI and some of which have evolved over the decades, persist to this day: in *financing and insurance*, it is the characteristics of a health insurance system, gross income-based financing by insured persons and employers, the principle of solidarity, the dualism of SHI and substitutive PHI, the coexistence of different funds in the SHI system ("multiple payer system"); in *regulation*, it is the interactions of framework legislation by the state and self-administration with a prominent role of the collective contract system, the distribution of responsibilities in a multi-level system of the Federal State and the Länder; in *healthcare provision*, it is the comprehensive entitlements to benefits (principle of need), the central role of doctors and a high doctor density, the segmentation and insufficient coordination of the healthcare sectors, the outpatient care monopoly of registered doctors, and the minor importance of hospitals in outpatient care.

With the reforms initiated since the 1990s, new instruments were used and new issues were put on the agenda. Probably the most fundamental change was the introduction of regulated competition. A particularly important step towards its implementation was the competition between SHI funds brought about by the free choice of funds for insured persons. Competitive elements were also introduced on the side of service providers through extended possibilities for SHI funds of selective contracting. Financial incentives were also expanded through the reform of remuneration for service providers. Finally, there have been attempts to relieve employers of health insurance contributions through reforms of the financing system and the raise of co-payments. Thus, the neoliberal hegemony of the 1990s and 2000s has also left its mark on health policy. However, the social health insurance type, based on the principle of solidarity, and a healthcare system close to the state with self-administration based to a large extent on the collective contract system are still well recognizable. Moreover, in recent years the goal of cost containment has no longer been as central to health policy as it was in the years before. Important reasons for this are that the health sector is perceived more strongly in terms of its economic importance – as an employment and growth sector – and in terms of its role in maintaining and improving employability and thus productivity in other areas of the economy.

At the same time, health policy also took up new issues, especially the growing need for LTC in an ageing society and quality assurance in healthcare. The problem of the need for LTC was addressed with recourse to the social insurance tradition. In the field of quality assurance, a large number of regulations were passed, many of which aimed at better integration of care. The introduction of the LTCI has brought important improvements for beneficiaries. Political efforts for better integration of care have led to moderate improvements.

However, important problems persist. The dualism of SHI and PHI entails several malfunctions. In healthcare, there is a coexistence of over- and undersupply. There are considerable difficulties in ensuring the provision of healthcare in disadvantaged regions. Coordination and integration of healthcare is still highly inadequate. Many LTCI beneficiaries are overburdened with paying their share of the costs. The COVID-19 pandemic has demonstrated that the public health service must be strengthened and that working conditions in hospitals and nursing homes need to be significantly improved and salaries increased. The solution to these and other problems is made difficult, above all, by the complexity of the regulatory system, by the multitude of actors and veto players, as well as their different interests. With the COVID-19 crisis, the economic and fiscal framework conditions for political action have been weakened, and health policy is unlikely to remain unaffected.

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29. Health policy in France

William Genieys and Patrick Hassenteufel

INTRODUCTION

Statism and conservative-corporatist welfare principles have historically shaped the French health system. Though the state has been responsible for hospital care since the French revolution (first at the local level and then, since World War II, at the central level), a social insurance system has developed based on Bismarckian principles and organization with the 1928 law, creating a health insurance system for salaried workers with incomes below a given threshold, in the industrial and agricultural sectors. After World War II, the French government decided to extend social security within an employment-based social insurance framework rather than a universal state-run system like the UK's National Health Service (NHS).

The Bismarckian-flavoured post-war system with its state control first took shape with the introduction of a statutory health insurance (SHI) scheme in 1945. This included health insurance for employees in commerce and industry, followed by agriculture (1961) and the self-employed (1966) (Palier, 2002). Despite the introduction of SHI, important parts of the pre-war system remained: public hospitals owned and financed by the central state, private doctors' fee-for-service in ambulatory care, the freedom to set fees beyond the reimbursement level, competition between private practitioners, and, until 1971 the absence of national agreements between private practitioners and sickness funds. This uneasy compromise between the goals of Beveridge (universality, unity and uniformity) and the means of Bismarck (Palier, 2010) left France with a healthcare system more similar to the Bismarckian welfare regime: institutional fragmentation, employment-related entitlement, earnings-related benefits focused on the male breadwinner, contribution-based financing, an autonomous medical profession with a doctor–patient dyad subject to limited interference by third-party payers (*médecine libérale*, or liberal medicine), and social partners (representing employers and employees) with a management role in sickness funds at local and national levels. Combined with the 1958 Debré Reform, which established teaching hospitals (*Centre Hospitalo-Universitaire*, CHU), granted full-time hospital doctors civil servant status and developed public hospitals, the extension of the Social Security system has triggered the increase of healthcare provision (especially the number of doctors and hospitals), and has progressively absorbed public health policies, historically established separately with the 1902 Public Health Law, and then the creation of the Ministry of Hygiene (1920) in the aftermath of World War I and the Spanish flu epidemic.

In the 1970s and 1980s, healthcare reforms tried to address expenditure growth, which had outstripped GDP growth since the early 1970s. At first, the primary means of expenditure control was price regulation, including reducing hospital day tariffs, minimizing increases of doctors' fees, and setting prescription prices at a relatively low level in comparison to other European countries with Bismarckian features. Since these measures were compensated by an increase of medical activity and prescriptions, subsequent reforms focused on boosting revenues via rises in employee contributions and 'public health taxes' (e.g., alcohol and tobacco) and on regulating healthcare demand via increased co-payments, first for ambulatory care, then in hospitals (in 1982). Efforts to 'save social security' were translated into annual reform plans from 1975 to 1995 and were only interrupted in election years. Because these plans had only a short-term effect and had some flaws in their conception, a growing number of state actors called for more structural reforms (Palier, 2004). This is what we pinpoint in the first part of this chapter, which analyses the institutional transformation of the French healthcare system at the end of the 20th century, in relation with the agenda setting of cost containment policies and the role played by a programmatic group inside the State. In the second part we present the main developments of French health policies in the 21st century, increasingly focused on healthcare coverage and provision issues in a context of new crises.

THE INSTITUTIONAL TRANSFORMATION OF THE FRENCH HEALTHCARE SYSTEM

In the 1990s, new diagnoses of the difficulties of the welfare state in the European continent began to gain popularity among experts, politicians and even trade unionists, which implied that the health system in France was not simply a victim of economic slowdown, but partly responsible for France's social, economic and political difficulties. With these new diagnoses, the main bases of the post-war compromise characterizing the system came to be seen as the cause of these problems: protecting workers no longer supported social integration but led to social exclusion; the system no longer contributed to economic growth but impeded it through its financing mechanisms; *démocratie sociale* no longer sustained social peace but allowed demonstrations and blocked reform. Experts and civil servants accused the social partners of having hijacked the social security funds, of abusing their position within the system at the expense of the common good, and of not taking responsibility for containing costs. These new criticisms underpinned a change in the political discourses and agendas of all governments during the 1990s: from rescuing the *Sécurité sociale*, the aim became to transform it, especially in healthcare. Within the governmental sphere, there was a growing expectation for the state to get better at containing the growth in health expenditures (Bonoli and Palier, 1996).

STRENGTHENING THE ROLE OF THE STATE IN THE FRENCH HEALTHCARE SYSTEM

Healthcare reforms have been gradually implemented to empower the state within the system at the expense of the social partners, mainly since the "Juppé Plan", adopted in 1996. Specialists of the French healthcare system agree that this 1996 reform made a break with the old governance model by increasing the role of the state (Bouget, 1998). The most important institutional aspect was the adoption, in February 1996, of a constitutional amendment obliging Parliament to vote every year on the social security budget by adopting an organic law known as the Social Security Finance Act (*Loi de financement de la Sécurité sociale*, LFSS). In the context of the strong dominance of the Executive in France's Fifth Republic, this constitutional change helps the government to control the social policy agenda. Instead of having to legitimize its intervention in a realm under the purview of labour and employers, the government, has the right to adopt health insurance measures every year, especially relating to cost-containment.

This new institutional instrument also introduces a new logic of intervention. Instead of trying to find resources to finance social expenditure driven by insured persons' demand, the vote of a yearly *loi de financement de la Sécurité sociale* implies that a limited budget should be allocated for social expenditure, in a more Beveridgean logic. Since most of the social benefits are still contributory, it is difficult to define a limited budget completely *a priori*, but governments have endorsed this new logic and Parliament has since voted new policy tools aimed at this purpose, such as limited global budgets for hospitals and for ambulatory care, creating ceilings and growth limits for social expenditures.

This *loi de financement de la Sécurité sociale* (Social Security Finance Act) "reinforces the power of the government—in the sense of the ministers of the moment—and of the civil service since funding authority remains in the regulatory rather than the legislative sphere, and the parliament has only minimal technical expertise at its disposal in this field and is heavily dependent on civil service for information." (Hassenteufel and Palier, 2007: 592). Its implementation changed the course of institutional governance of the social security and the health care systems. Often presented as a state budget bill *bis*, the Social Security Finance Act (LFSS) provides an unprecedented opportunity for those who shape them to pass reforms. However, the LFSS has been completed by several reforms to make its implementation more effective.

The new organization of powers resulting from the LFSS establishes a close institutional partnership between the Directorate of Social Security (DSS), who initiates the bill which must be a governmental project, and the different social security funds (for health insurance, pensions, family allowances, unemployment, so as complementary insurance funds and for specific regimes) reduced to the role of operators. In healthcare, the goal is to ensure that stakeholders comply with the National Health Insurance Spending Objectives (ONDAM). At the same time, the social partners and a fraction of the political class opposed the implementation of the reform. The related policy instruments, such as the National Health Spending Objectives (ONDAM) and the Objectives and Management Agreements (*Conventions d'Objectifs de Gestion*, COG) were not mobilized completely by the social partners. In the early 2000s, the National Health Spending Objectives were voted at 4% while achieving 7%. During the same period, the Employer unions (MEDEF) left the administrative board of the national sickness fund organization (CNAMTS) in January 2000. This resignation meant the end of the French "*paritarisme*" and prefigured the vanishing of the social security governance model established in 1945.

In the hospital sector, the "Juppé Plan" created new regional state agencies to determine and audit the budget of public hospitals; these have also taken on the powers previously held by the sickness funds over private hospitals. The regulatory powers of these "*Agences Régionales de l'Hospitalisation*" (ARH, regional hospital agencies) were increased in 2003. They also received specific budget resources for financing the restructuring program of hospitals. According to figures from the Ministry of Health, there were several hundred regroupings (mostly small facilities) or mergers of activities between 2003 and 2007. The ARHs control the hospital production volumes, using two levers. First, they have the power to grant, withdraw or suspend authorizations for public hospitals and private healthcare professionals to practice. Second, under the new generation of regional health plans, the ARHs must set quantified objectives determining the location of services and costly equipment as well as a framework of activity, including length of stays, number of visits and surgical procedures. The ARHs concluded multi-year contracts with hospitals, defining objectives and means, such that hospitals will only get the funding if they achieve the agreed objectives (Or, 2008).

They were merged in the new *Agences Régionales de Santé* (ARS – regional health agencies) created by the 2009 *Loi hôpital, patients, santé et territories* (hospital, patient, health and territory act). These new state agencies replacing the ARH bring together, in one entity, all public-sector actors that are responsible for organizing and financing healthcare at the regional level. They have the mission of establishing regional-level objectives to assure fair access to care, improve coordination between hospitals and private ambulatory care providers, and to enhance quality and prevention. Each hospital (public or private) must sign an annual contract with them to secure funding.

This move to strengthen the role of the state was taken further with the 2004 law on health insurance (*Loi sur l'assurance maladie*) which created the National Union of Sickness Funds (UNCAM) directed by a senior civil servant appointed directly by the government (in the same way as the directors of the ARH and then the ARS). Consequently, the director leads the negotiations with the different medical professions (every five years, a medical agreement is negotiated to fix the tariffs of medical procedures) and has the power to appoint directors of local sickness funds. The 2004 law replaced the administrative board, where the social partners were represented, by advisory boards. This is clearly a shift of power from the board to the general director (Polton and Mousquès, 2004). The 2004 reform also created the "*Haute Autorité de Santé*" (High Authority on Health, HAS), built on the former National Agency for Accreditation and Evaluation in Health Care (ANAES), with an extended role. This independent Authority has to assess the medical efficiency of procedures, drugs and devices, elaborate and disseminate practice guidelines, conduct medical audits of independent professionals and provide hospital accreditation. With these broad missions, the HAS plays a key role in the improvement of the evaluation of effectiveness and efficiency of healthcare. The creation of the HAS is part of a wider process of the creation of agencies in public health that started also in the late 1990s with the creation of the *Agence du sang* (Agency for blood transfusion), the *Agence de sécurité sanitaire des aliments* (Agency for the security of food) and the *Agence du Médicament* (Agency for drugs). They were political answers to public health scandals (HIV contaminated blood, mad cow, abusive use of the Mediator drug …), which triggered the affirmation of a "health security doctrine" and the reinforcement of expertise based on new bureaucracies outside the ministry of health, but at arm's-length of the state (Benamouzig, Besançon, 2005). Therefore, these evolutions can be analysed as the growth of a regulatory healthcare state, corresponding less to the extension of the public sphere than to the reduction of the autonomy of non-state actors who traditionally played a central role in healthcare policies (especially the social partners represented in the sickness funds boards and, to a lesser extent, physicians), through reliance on independent agencies, whose mission is to enforce either clinical standards or budgetary efficiency, and new public management tools. This pattern can be characterized as a gradual loss of autonomy of the sickness funds organization complemented by the creation and strengthening of arm's-length regulatory agencies playing a key role in the remote steering of the healthcare system by the state. This institutional and governance transformation of the French healthcare system is not only linked to the agenda setting of cost containment since the oils shocks and public health scandals but also to the role of a group of actors inside the state, promoting institutional reforms, then holding strong positions in the new healthcare institutions and acting as custodian of the continuity of a long-term reform path.[1]

THE ROLE OF A NEW POLICY ELITE: FROM PROGRAMMATIC ACTORS TO CUSTODIANS OF HEALTH INSURANCE POLICIES

The last two decades of the 20th century corresponded with the rise of a new policy elite inside the state, with a project of far-reaching reforms of the governance of the French Welfare State, especially the health insurance system (Genieys, 2010; Genieys and Hassenteufel, 2015). In empirical research conducted over time,[2] we have shown that the advancement of the new governance model of the health system on the political agenda is concomitant with the rise in power of a group of senior civil servants characterized by similar social backgrounds and career paths, that we have labelled as the "programmatic elite" (Hassenteufel, and Genieys, 2021). On the basis of socio-biographical analysis, we have shown that the first generation of programmatic actors was composed by magistrates of the *Cour des comptes*[3] struggling against the actors historically governing the social security and the healthcare systems: on the one side, senior civil servants of the *Conseil d'État* and on the other side, non-state actors (especially trade unions and physicians' organizations), defending the 1945 model and the healthcare system centred on public hospitals and "*médecine libérale*". Indeed, we observed the development of a group of actors sharing an institutional reform program sustained by the aim to strengthen the autonomy of the state vis-à-vis the traditionally powerful non-state actors (Genieys and Hassenteufel, 2015; Hassenteufel et al., 2010). These actors share policy ideas based on the same diagnosis of the problems facing the French healthcare system, and a common interest to gain "autonomy" vis-à-vis powerful actors such as former policy elites, interest groups, or cross-sectoral actors (such as the Ministry of Finance), by increasing their policy capacity through institutional reforms. The shaping of a "programmatic group" involved in intra-elite competition (Genieys and Smyrl, 2008) provides a plausible explanation for the empirical observation of governance changes towards a regulatory state in healthcare in France. Our studies also show the need to analyse reform in the long term: the strengthening of programmatic actors is not only a cause but also a consequence of former governance reforms, which increased their resources (especially their strategic position in the policy decision and implementation processes). The constitution of a policy core executive in health insurance policy is a long-term process which started in the 1990s and explains continuity in the reform path. Since the 1980s, the first generation of programmatic actors took power inside the Directorate of Social Security (*Direction de la Sécurité sociale*, hereafter DSS),[4] a key institution of the Ministry of Social Affairs and Health. The members of this first generation asserted themselves at the head of the directorate because they were the bearers of a new technical know-how and of a major reform project for the governance of the Social Security system.

The 1996 reform increased the power of the Directorate of Social Security (DSS) in the policy formulation process, particularly because of its steering role in controlling healthcare spending. Since the 2000s, this ministerial directorate has become the cornerstone of an *Iron Triangle* for the career path of the second generation of programmatic actors, becoming custodians of the reform path. The DSS is the place to be if you want to become a health or health insurance advisor in a minister's *cabinet*, a director of a national social security fund, a member of a "high authority" (*hautes autorités*) or an agency director in the sector (Darviche, Genieys and Hassenteufel, 2022). During this period, the DSS systematically placed its young office managers in the key position of advisors in the ministerial staffs (*cabinet*). The Director of Social Security thus benefited from precious relays at the heart of the Ministry to make his voice heard on health policies. Moreover, at the end of their governmental mission, these new young custodians, enriched by their experience in the Ministerial *cabinet*, extended their career path either by returning to the DSS or by heading a fund. In addition to the organizational or institutional aspect, another element supports the strategy pursued by the custodians: the shift from financing the system through social contributions to financing it through taxation, which started with the creation of the CSG in 1991.

Unlike social insurance contributions, the CSG is levied on all types of personal incomes, including wages (even the lowest ones), but also extending to capital revenues and welfare benefits. The introduction of this earmarked tax has two main outcomes, which entail a partial shift towards a more Beveridgean system (Hassenteufel, 2001). First, since financing is not received exclusively from the working population, the CSG breaks the link between employment and entitlement. Access to CSG-financed benefits cannot be limited to any social group. The shift in financing has thus created the conditions to establish citizenship-based social rights, especially in healthcare. Second, it leaves the social partners with less legitimacy to participate to the decision-making and the management of healthcare provision. This shift towards taxation constitutes a lever to transfer political control from the social partners to the state.

The policy learning process of cost containment policies in the 1980s and early 1990s also played a central role for the formation of this programmatic group. For a long period, the senior civil servants in the health insurance sector faced the experience of being defeated by interest groups whenever they tried to implement measures to solve the problems of the structural financial crisis. Three main failures of previous cost containment policies had been identified in several public reports on the health insurance system since the beginning of the 1990s: the lack of constraints on doctors, the limits of hospital budgets, and the lack of control by the state. The senior civil servants have been aware of the de facto veto power of non-state actors at least since the early 1990s when the socialist government failed to implement capped budgets (global envelopes) because of the strong mobilization of the health profession's organizations, especially doctors (Hassenteufel, 1996).

The aim to restrict the power of interest groups and to give the state even more direct regulatory competencies bound together leading civil servants despite their different party-political affiliations. This strategy was complemented by common problem perceptions and policy goals. The leading figures of the health administration shared a vision of a state that takes the financial constraints seriously and has the power to set and implement targets for expenditures. They internalized the problem of financial constraints, rather than allowing these to be imposed externally by the Ministry of Finance. This, in turn, contributed to consolidating the collective identity of these actors, who must not only give evidence of their internal coherence, but show that they can do better than their competitors in their own terms. In this context, the affirmation of the centrality of the role of the state in healthcare policies can be seen as the key element of their collective strategy. The objective of the programmatic actors was twofold: to ensure the future financing of the *Sécurité sociale* and to establish a universal coverage system in France (Rodwin, 2003). To this end, their program consists of operationalizing a comprehensive reform of the governance of the *Sécurité sociale* by giving greater regulatory power to the State while achieving the universal health coverage in France (Nay, Béjan, Bénamouzig et al., 2016).

What followed from both the political and the policy goals was a general critique of the Bismarckian inclusion of interest groups in health policymaking. While the structural financial crisis of the health insurance system has been a necessary background for the formation of the programmatic elite, it does not provide a sufficient explanation for the reform program. The civil servants did not only learn from political experience but also had a common platform to develop their program. Of major importance was a planning commission led by Raymond Soubie in the early 1990s where the main principles of the institutional changes in the reforms passed in 1996, 2004 and 2009 were defined (Bras and Tabuteau, 2009). The most important elements of these reforms, moreover, were directly intended to precisely empower this programmatic group.

This programmatic group used the opening of policy windows (Kingdon, 2010) by the financial context and the intervention of political actors in governmental positions to push the three major reform steps concerning the governance structures of the French system: the "plan Juppé" in 1996, the law on health insurance (2004) and the "Hospital, patient, health and territory act" in 2009. In these three cases, senior civil servants from the Social Security Department (DSS) and ministerial staffers (the French *cabinets* are mainly composed of senior civil servants) were key actors in the decision process. The 1996 "plan Juppé" was not passed by law but by governmental decrees ("ordonnances"): it was elaborated by a small group of senior civil servants (advisors of the Prime Minister, advisors of the President, and Social security specialists coming from the DSS); the institutional aspects of the 2004 health insurance law were worked out by the head of the DSS; the changes in the governance of the health system included in the 2009 law were decided in the more general administrative reform framework of the "révision générale des politiques publiques" (Bezes, 2010), directly organized by the general secretariat of the French President. The creation of regional health agencies (ARS) was negotiated mainly between senior civil servants: advisors of the President, of the Prime Minister, of the Health Minister and members of the DSS.

After 1996, a second-generation of programmatic actors, whose career path is shaped within the *Iron Triangle* of healthcare governance (top position in the DSS, direction of the UNCAM and head of new agencies), emerged and played the role of custodian of the reform path following the initial program and of the new regulatory institutions created. They also formulated new policy instruments to reinforce the health expenditure control policy: the most important and contentious is the prospective payment system in hospitals based on medical activity (*Tarification à l'activité:* T2A adopted in 2003 (Bras, 2017)). In the same period, these custodians of health insurance policies had to struggle to maintain their position against the Ministry of Finance, especially during the decision-making process of the 2004 health insurance reform. In 2007, the DSS was put under the supervision of the Ministry of Finance in addition to the Ministry of Health and Social Affairs. This institutional change was seen by some of the senior civil servants of the Ministry of Finance as an opportunity to extend their policy of budgetary rigor to health insurance policies, with the merging of the Social Security Finance law (LFSS) into the Finance law, thus bringing the Social Security budget (at least the "revenue" part) within their sphere of action.

Such an outcome would have drastically reduced the health insurance policy custodians' power over health policy: therefore, they engaged in a struggle for the defence of their leading position. To address this challenge, the second generation of custodians, coming from the IGAS or the corps of the *Administrateur civils*, with career paths within the *Iron Triangle*, developed their own knowledge of the budgetary issues of social insurance policies. They negotiated and obtained the reimbursement of payroll tax exemptions (*charges sociales:* contributions charged on salaries). This has mobilized the second generation of custodians around a collective identity and interest. To this end, they emphasized their capacity to design solidarity policies (health insurance, family and pensions) beyond budgetary austerity. In the formulation of these policies, primacy is given, according to them, to the objectives of protection and coverage of citizens. The logic of (financial) sustainability intervenes at a later stage as a policy adjustment variable. Faced with this political and institutional challenge, they succeeded in skilfully reconciling the management of the budgetary constraint with a universal health coverage in line with social demand. The second generation of custodians was finally successful in strengthening its power and marginalizing their rivals in the governance of the healthcare system after the DSS' (partial) integration into the Ministry of Finance and Budget (Darviche, Genieys and Hassenteufel, 2022).

EXTENSION OF MEDICAL COVERAGE AND THE ISSUES RELATED TO HEALTHCARE PROVISION IN A CONTEXT OF MULTIPLE CRISES

The last decade of health policies in France, corresponding to the presidential mandates of François Hollande (2012–2017) and Emmanuel Macron (from 2017), cannot be characterized only by the achievement of the reform program of the custodians of health insurance policies, even if free access to healthcare has been extended (as we will see first). We will pinpoint that the issue of access to healthcare has been formulated more extensively by other policy actors who included the territorial dimensions. Since 2003, the problem of the existence of "medical deserts" (i.e., the lack of medical provision, especially GPs, in underserved areas) has been put permanently on the health policy agenda and triggered changes in the organization of healthcare provision, especially for primary care, aiming to improve coordination. Therefore, a shift from the priority given to cost containment policies since the 1980s to the improvement of healthcare provision is on the way and has been reinforced by the COVID-19 crisis, as we will underline in our last point.

SOCIAL INEQUALITIES AND THE UNIVERSALIZATION OF HEALTH COVERAGE: FROM CMU TO PUMA

The issue of ensuring universal coverage is not new: as early as 1977, Jean-François Chadelat emphasized the need to generalize access to the health insurance coverage system. The 1978 Law, promoted by Minister Simone Veil, opened a breach in the 1945 model by dissociating the benefit of health insurance coverage from the obligation to be employed (Chadelat, 2012). This already announced the departure from the Bismarckian model. Then, the socialist government, headed by Michel Rocard (1988–1991), extended health coverage to the beneficiaries of the new universal minimum income: the *Revenu minimum d'insertion*, RMI (December 15 1988 Act). In 1995, the announcement of the "*Juppé Plan*" included the principle of a universal health insurance, which was introduced only four years later by the socialist government of Lionel Jospin in the July 27 1999 Act, creating Universal Health Coverage (*Couverture Maladie Universelle*, CMU). It includes three major changes in access to health insurance: i) basic insurance for all residents; ii) complementary coverage for the most disadvantaged (CMU-C), whose care will be free of charge via a waiver of advance payment; iii) State medical aid for people who do not meet the criteria for legal residence.

After ten years, Chadelat's assessment of the implementation of the Universal Health Coverage (CMU) is positive: at the end of 2011, 2.2 million people benefited from it, and 4.4 million people had access to the Universal Complementary Health Coverage (CMU-C *mutuelle complémentaire*). In addition, opposition from professionals in the sector, especially physicians, dentists and insurers, has gradually declined. Even the question of its cost, put forward by its opponents, no longer seems to be a problem in retrospect. The growth of the average cost of care covered by the Universal Health Coverage (CMU) remains, in fact, lower than that of the National Health Spending Objectives (*Objectif national des dépenses d'assurance maladie*, ONDAM) since its creation.

However, several difficulties have arisen over time. First, the Universal Health Coverage (CMU) did not simplify pre-existing arrangements. Programmatic actors quickly realized that, as it stands, the Universal Basic Health Coverage (CMU) is not fully universal because it has become the residual part of the system. Indeed, it works as a last chance for those without any coverage. Employment is still the norm for accessing the system. In addition, the Universal Complementary Health Coverage (CMU-C), although hailed as an important social advancement, is rejected by a minority of physicians, mainly specialists working in the ambulatory sector 2 (characterized by the freedom to fix fees beyond the reimbursement level), who refuse to treat CMU patients because they fear not being paid by the sickness funds. Moreover, a part of the population in an extremely precarious situation (especially undocumented migrants) remains outside its perimeter.

To overcome these shortcomings, the programmatic elite improved the system. A medical agreement (*convention médicale*) signed on January 7, 2005, integrates the extra-fees of ambulatory sector 2 "specialists" into the existing system. Indeed, a *Médecins du monde* 2006 report revealed that 14% of doctors in big cities refused to take patients of the Universal Health Coverage (CMU).[5] This failure has been corrected by the *Hôpital Patients Santé et Territoires* Act (July 21, 2009) proposed by the right-wing Health Minister Roselyne Bachelot: any discrimination against Universal Health Coverage (CMU) patients has since been prohibited.

Then, under the socialist presidency of François Hollande and the ministry of Marisol Touraine (2012–2017), healthcare coverage was improved in different ways: overbilling in specialized ambulatory sector 2 was limited by the medical agreement negotiated in autumn 2012; in 2013, complementary health insurance was made compulsory for all companies with more than 50 employees and the LFSS for 2016 included the Universal Healthcare Protection (PUMA). It confirms the role of the senior civil servants of the Directorate of Social Security in the affirmation of a new social protection model based on the principle of universality, social rights being only related to legal residence in France. PUMA avoids a rupture of rights in case of divorce or firing. The administrative procedures for accessing the Universal Health Coverage (CMU), which had to be completed every year or every three years depending on the person's status, were also withdrawn. The last step, up to now (2023), was the introduction of a basis 100% coverage of glasses and for dental and ear prosthesis in 2018, under Emmanuel Macron's first term.

The paradox of this evolution is that it has been perceived as a set of scattered technical measures, whereas taken as a whole, these measures of universalization of social protection fundamentally change the meaning of the 1945 Social Security model which has incrementally changed towards a "Great Social Security" (HCAAM 2022) integrating complementary insurance and increasing the level of reimbursement of healthcare expenses, initiated since the

1990s by the programmatic elite. It is another move towards a more Beveridgean system, i.e., more universal, uniform and unique.

LACK OF DOCTORS AND THE TERRITORIAL REORGANIZATION OF PRIMARY CARE

Another important change of the last 15 years is the transformation of primary care provision, linked to the evolution physician's demography. In France, public discourse on medical demography was historically dominated by the fear of a "medical plethora" (Bungener, 1984). In the early 1970s, leading physician organizations saw their claim for the *numerus clausus* in medical education converging with the new attention given to cost containment (Deplaude, 2015). This national ceiling of the number of medical students was introduced in 1971 in order to regulate medical supply and to limit supply-induced demand. In the early 2000s, the dominant discourse of the medical profession shifted suddenly. Official reports pinpointed two new trends: a forecasted decline of the number of physicians and the worsening of territorial disparities. The expression "*déserts médicaux*" (medical deserts) has since been systematically used by physician's representatives, in public reports, by the media and by elected politicians (Véran, 2013). It referred not only to isolated rural areas, but also to suburbs of big cities (*banlieues*), especially around Paris. It also has origins in the governmental decision to withdraw the obligation for doctors in the outpatient sector to guarantee the 24-hour permanence of medical care, because of the massive GP strike in 2002. The end of permanent availability of physicians gave the population the feeling of a lack of medical providers. This fear was reinforced by overbooked physicians' growing refusal to accept new patients.

Local politicians (especially the mayors directly concerned by the lack of physicians) have been very active in denouncing the increase of "medical deserts". Their claims have been supported by the influential national mayors' associations, and the Senate (the high parliamentary chamber representing local authorities), which published several parliamentary reports and made law proposals. The issue of "medical deserts" has become one of the main aspects in the health policy programs of presidential election candidates since 2007, and in the last 15 years more than 60 public reports have been published in relation to this issue, which is now permanently on the political, media and policy agendas, as the "Great national debate" organized between January and April 2019 in the context of the "yellow jackets" movement.[6]

The strong capacity of doctors to veto constraining measures in relation to the defence of the principles of the "*médecine libérale*" explains a political strategy based on incentives rather than on coercion followed by the different governments since 2003 (Hassenteufel et al., 2020). The first financial measures aiming to tackle the issue of the lack of medical provision and territorial inequalities based on settling stimuli were taken in 2004 by the sickness funds (CNAM). They created financial incentives (bonuses and higher fees) for doctors settling down in underserved areas. Because some activities of medical doctors such as promoting cooperation between health professionals, best practices, or long-term treatment, were not covered by the fee-for-service system, new payment mechanisms ("*nouveaux modes de rémunération*" NMR) were tested by the sickness funds in 2008. A few months after the election of François Hollande, at the end of 2012, a "Territorial Health Pact" (*Pacte santé territoire*) was proposed to doctors by the new Health Minister (Marisol Touraine) to attract them to underserved areas. It was later extended and included in the Health system modernization law ("*Loi de modern-*

isation de notre système de santé") adopted in Parliament in January 2016. This pact is also based on incentives: bonuses, higher fees, specific payments, financial engagement contracts for doctors in training (€1200 monthly if they settle down in underserved areas afterwards),and guaranteed minimum income (€3640 monthly for two years) for doctors adopting the status of territorial practitioner ("*praticiens territoriaux de médecine générale*") in underserved areas. At the end of 2015, only 1325 "public service engagement contracts" had been signed by doctors in training and only 480 young doctors had adopted the status of territorial practitioner.

Incentives were also introduced in the national medical agreement negotiated between the national sickness fund organizations and self-employed doctors' associations. Already, in 2005, the level of the fees for doctors in group practice in underserved areas was increased by 20%. In the 2011 agreement, two new kinds of contracts were created: the "demographic option" (i.e., financial aids for doctors in group practice in underserved areas: around €15,000 yearly) and the "health territorial solidarity option" (i.e., financial support for doctors accepting to work one month every year in an underserved area). They were extended in the national medical agreement signed in August 2016, with the creation of four new contracts (replacing the previoust ones).

Another important measure adopted was the increase of the number of medical students, a claim of the medical profession corresponding to a parametric change. Since 2005, the number of medical students has increased as a result of loosening the *numerus clausus* (from 3500 students in 1992 to 5600 in 2005 and 8205 in 2018), which was completely withdrawn in the 2019 Healthcare Orientation Act ("*Santé 2022*"). During the same period, in 2003, the government also gave medical doctors the possibility of combining limited practice with receiving retirement pensions.

This new problem of shortages of medical provision applies mainly to primary care. This issue is increased by an ageing population and the prevalence of chronic diseases needing regular care. This is why the different health reforms mentioned above strongly targeted the reform of primary care. In this context, actors deeply involved in the development of new doctor's associations played an important role as "medical entrepreneurs", promoting innovations in the primary care system as a solution to under-supply, and, more importantly, being able to find administrative and political allies to support their proposals framed in relation to the issue of local medical shortages, put at the top of the health policy agenda by other policy actors (Hassenteufel et al., 2020).

Unlike the far-reaching institutional reforms and the cost-containment policies analysed above, reforms in primary care were proposed by actors coming from the medical profession, and then endorsed by administrative and political actors. First, the role of the creation of a specific GP trade-union (*MG-France*) in 1986 (Hassenteufel, 2010) has to be emphasized. Stressing the declining role of GPs with regard to the movement of specialization, the new organization claimed the necessity of giving GPs a new role in the healthcare system in order to control the movement of patients. This should serve both to limit ineffective expenditure and to improve the monitoring of the patient and the coordination of treatment. The main ideas were to assign to the general practitioner the role of a "coordinating doctor" (who must be seen before any specialist consultation), to have a medical file circulated among all those involved in the treatment of a patient, and to institute healthcare networks (e.g., teams of practitioners). These proposals were endorsed by political and administrative actors. Claude Evin (socialist Minister of Health), under the Rocard government (1989–1991), supported the idea of "health contracts" and tried to include them in the national medical agreement. This failed, however, because of the opposition of the established physician's organizations. Then, in 1996, the Prime Minister Alain Juppé introduced the notion of a "referring physician", based on the proposals of MG-France, and allowed the negotiation of a specific collective agreement for GPs in the 1996 Social security reform. It was replaced, in the 2004 Health insurance act, by a soft gatekeeping system, in which every insured person has to choose (and first consult) a "treating doctor", generally their family doctor, playing a new coordination role in the healthcare system. Another important issue for of MG-France was the increased importance of Family Medicine in medical education. Family Medicine departments were created in medical schools in 1997, but the implementation of an academic curriculum of Family Medicine was very slow to be recognized as an academic field. However, Family Medicine was recognized as a speciality in 2004, with a new diploma of speciality (DES). In 2007, a few positions were created to establish a specialized academic staff within medical schools (Bloy, 2010).

The strengthening of the role of GPs in primary care in the 2009 HPST Act was also the result of close contacts between MG-France leaders and the then Health Minister, Roselyne Bachelot. It defined community-based care and the role of GPs for the first time, stressing their role as coordinators, and promoted the objective that all medical students should do an internship in a generalist's practice. The HPST Act also gave legal bases to the creation of new multi-professional primary care practices ("*maisons de santé pluri-professionnelles*" MSP). It was associated to the abovementioned new payment mechanisms based on capitation (NMR) tested in 2008, then generalized in the official agreements signed between doctor's organizations and SHIs in 2015, and in the inter-professional agreement (ACI) in 2017. The Territory Health Pact gave a new impulsion to the creation of MSP: their number grew from 174 in 2012 to 1200 at the end of 2018, and to more than 2000 in 2022.

This incremental change process in primary care towards coordinated and multi-professional organizations (the increase of "medical centres" where health professional are salaried is also to mention), framed as an answer to the "medical deserts" issue, is part of a broader territorialization process in health policies, based on the growing involvement of the decentralized local authorities in healthcare issues (Alam et al., 2015) and the new healthcare provision organization role of the regional health agencies (ARS). The 2016 Health System Modernization Act (*Loi de modernisation de notre système de santé*) strengthened the role of the ARS in the organization of healthcare delivery and defines four territorial regulation levels: regional health projects, territorial health councils (*conseils territoriaux de santé*, CTS) at the department level, territorial (public) hospital groupings (*groupements hospitaliers de territoires*, GHT) and territorial professional communities for primary care (*communautés professionnelles territoriales de soins*, CPTS). This territorial reorganization of healthcare organization was followed by the 2019 Organization and transformation of the health system act (*loi d'organisation et de transformation du système de santé*) which includes the reinforcement of territorial health projects and territorial professional communities, in order to better coordinate hospital and ambulatory care. The implementation of the law started at the same time as the COVID-19 pandemic which had an acceleration effect on this transformation trend in the organization of healthcare provision.

THE COVID-19 CRISIS AND THE REINFORCEMENT OF THE ISSUE OF HEALTHCARE PROVISION IMPROVEMENT

The handling of the COVID-19 pandemic by the French Executive has been the subject of a lot of criticisms concerning the lack of preparedness for the crisis, in particular relating to access to protective masks, tests and intensive care beds, during the first waves (Bergeron et al., 2020; Hassenteufel, 2021). The controversy over the number of protective masks made available to health professionals and the public has been the most intense. At the beginning of the pandemic, the wearing of masks was not binding and was even initially declared not to be helpful in reducing infections. The communication and the strategy of the French government changed only when masks were available in higher numbers: in May 2020, when the lockdown, which had ultimately lasted eight weeks, was progressively lifted. It triggered a long-lasting debate on the sincerity of the government and health authorities' positions concerning the benefit of wearing protective masks.

The limited number of intensive care beds (11 per 100,000 inhabitants in France) was also strongly emphasized, as was, more generally the lack of specialized medical staff. However, hospital services were reorganized to increase the number of intensive care beds (from 5000 at the start of the crisis to 14,000 at the end of the first wave), patients were transported from hospitals in the most heavily impacted areas to those in less affected areas or were even transferred to other EU countries. These measures prevented hospitals from becoming completely saturated and avoided massive patient triage, but it did not avoid a high number of deaths. The parliamentary committee of inquiry re-launched the debate on this issue at the end of July 2020, highlighting the decrease in the proportion of people over 75 years old being admitted to intensive care during the first lockdown period; this rate had fallen from 25% at the beginning of March to 14% at the beginning of April 2020.

Two main problems concerning the care of dependent older adults were also highlighted: the high mortality rate in a certain number of elderly care homes (EHPADs), where one-third of the deaths were recorded during the lockdown, and the deterioration of their living conditions during the lockdown due to the ban on visits and staff shortages. Finally, shortages of medicines, particularly anaesthetics, and the low level of strategic medicine stocks, which had halved between 2015 and 2019, have been reported by the parliamentary inquiry commission.

Generally speaking, therefore, there was a broad public and political debate on the French state's inadequate preparation for a public health crisis. This "executive blaming" has also been triggered by the centralized handling of the pandemic. The main decisions were taken by the "Defence council", convened and chaired by the French president and composed of the Prime Minister and the ministers discretionarily selected by the President. These decisions have been made public by President Macron himself, in most cases, especially regarding the details of the introduction of the lockdown, its lifting and the curfew for the second wave.

This centralization of political authority also had a territorial dimension, with the government relying on its territorial representatives: the "*préfets*" and the Regional Health Agencies (ARS), who have opposed a number of local initiatives. As local and regional authorities have no direct competencies for health, the territorial steering of health policy has primarily involved ARSs reporting directly to the National Health Ministry. They have, in particular, steered the reorganization of beds and the cancellation of non-emergency medical interventions, the supply of health personnel with masks, patient transportation and coordination between the public and private sectors. However, the lack of consideration for territorial actors and the focus of ARS on issues related to hospitals to the detriment of outpatient care have been denounced both by local elected officials and by organizations of health professionals.

This concentration of political and social pressure on the executive is an important factor in the change of prime minister at the beginning of July 2020. The roadmap of Jean Castex, a senior civil servant and former head of the Organization of Healthcare Provision Department, covered both the methods of formulating public policies, by emphasizing consultation with local authorities and social partners, and the content of these policies, in particular by putting changes in health and social care policies on the government agenda.

This change was concretized by the organization of the "*Ségur de la santé*",[7] a consultation that lasted seven weeks, in the form of four working groups, in which some 300 representatives of healthcare stakeholders participated. The conclusions of the consultation, made public by Health Minister Olivier Véran on 21 July 2020, partly introduced in the Social Security Financing Act (LFSS) for 2021, focused on three main aspects.

The first was the increase in resources devoted to healthcare, with a budget of €8.2 billion to raise the salaries of hospital caregivers and a budget of €6 billion for investments in hospitals, EHPADs and digital technology;[8] the acceleration of career advancement; the increase in the number of trained paramedical professionals and the opening or reopening of 4000 hospital beds. The logic of improving healthcare supply has become a clear priority over cost-containment in healthcare.

The second aspect was the reduction in the share of activity-based financing of hospitals, the strengthening of medical power within hospitals and the adoption of new rules for determining the National Health Insurance Expenditure Target (ONDAM) voted for every year in the LFSS. The question is now how far these measures will change hospital policy, which has been dominated by budgetary and managerial logics since the 1980s, with bed closures, the affirmation of the power of hospital directors over health professionals and the introduction of activity-based pricing based on Diagnosis Related Groups (T2A). This policy instrument has been the subject of strong criticism since it came into force in 2004 (Juven et al., 2019). Professionals in the sector, as well as left-wing experts, have for years loudly denounced its perverse effects on hospitals. The contestation of the budgetary constraints on hospitals was particularly obvious from March 2019 with the beginning of a long-term strike in emergency units and the organization of several days of national demonstrations. This movement, which received a lot of media coverage and was still in progress when the lockdown was implemented, called for a general increase in salaries, hospital expenditures and medical staff, for the end of activity-based pricing and of the bed closure policy, so as to reform hospital governance. It has been reactivated in 2022.

The third aspect was the decentralization of the organization of healthcare by strengthening the role of local elected authorities, through the right to finance healthcare provision and medical staff and their representation in the ARSs boards. These measures, included in the 2022 Differentiation, Decentralization, Deconcentration and Simplification ACT ("*Loi 3DS*"), also aimed to improve the coordination of healthcare between health professionals in hospitals, outpatient clinics and medico-social establishments.

Thus, the health crisis linked to COVID-19 is more an accelerator of change than a radical turn in health policies. This accelerating effect can also be noted in the field of care for dependent elder adults, with the creation of a fifth branch of social security to deal with this "new" social risk linked to ageing in order to pool funding and to establish new revenues, a project dating back to the 1990s (Frinault, 2013).

CONCLUSION

Since the oil shocks of the 1970s, French health policies have been shaped by crises. The numerous economic crises from the first oil shock to the Great Recession have triggered the cost-containment agenda which has been endorsed by a new policy elite coming from the central social administration which succeeded in reinforcing the role of the State, through institutional changes, and the progressive universalization of health and social care coverage. In the last decades, crises linked to the health system itself (public health scandals, lack of doctors, contestation of cost-containment policies in hospitals, new pandemics, etc.) have progressively changed the orientation of health policies towards the improvement of healthcare provision, based on the increase of workforce in healthcare, the territorialization of the healthcare system and its reorganization towards more coordination, which has been accelerated by the COVID-19 pandemic. It has reactivated the need to articulate the budgetary rigor, in a context of a strong growth of public debt due to the "whatever it costs" economic policy during the pandemic and the explosion of the Social Security deficit,[9] with new expenditures to better manage collective health risks, both in terms of entitlements to coverage and in terms of healthcare provision (especially healthcare workforce). These new priorities have been progressively endorsed by the new generation of the programmatic group that have steered French healthcare policies since the 1990s towards a progressive shift from Bismarckian foundations to Beveridgean principles.

NOTES

1. Philip Selznick had defined "custodians of policy" as individuals protecting certain "social values" in order to assert leadership, group identity and autonomy within an organization (Selznick, 1957: 120–121). The concept of custodians of state policies characterizes the groups of elites that confront each other within the state, offensively and/or defensively, with policy programs (Genieys, 2010).
2. To this end, we have replicated three major empirical research surveys on the transformation of the French social insurance elite structure: (i) The Franco-German program [2018–2022] ANR-DFG ProAcTA (ANR-17-FRAL-0008-01 / DGF BA 1912/3-1) on the conflicts between "custodians of health policy" and fiscal austerity advocates over the period 2007–2018, with William Genieys [French PI] and Nils Bandelow [German PI]. (ii) The two programs supported by the *MiRe* (1997–1999), hereafter *MiRe 1* (Patrick Hassenteufel [PI], Myriam Bachir Virginie Bussat, William Genieys, Claude Martin, Marina Serré, *L'émergence d'une "élite du welfare"? Sociologie des sommets de l'État en interaction*, 1999); and from 2005 to 2008, hereafter *MiRe 2* (Patrick Hassenteufel [PI], William Genieys, Javier Moreno, Marc Smyrl, Anne-Laure Beaussier, Louis Hervier, *Les nouveaux acteurs de la gouvernance de la protection maladie en Europe*, 2008).
3. We have already carried out a sociographic study of social background and career path of these elites of the *Cour des Comptes* in previous academic publications (Report Mire 1; Genieys, 2010; Genieys and Hassenteufel, 2015).
4. The DSS (the Directorate of Social Security) it is a key administrative unit in the Social Security government. It is responsible for drafting the law (Social Security Code), monitoring the Social Security Finance Act since the 1996 reform, and overseeing the implementation of public policies in the sector. Finally, since the 1980s, it has become a key institution in the institutionalization of the new elite of the sector.
5. *Le Monde avec AFP*, "4% of general practitioners refuse patients receiving state medical aid, according to Médecins du monde", *Le Monde*, 16/10/2006. https://www.lemonde.fr/societe/article/2006/10/16/un-generaliste-sur-trois-refuse-les-soins-aux-plus-demunis_824233_3224.html.

6. It was one of the main topics put forward by participants to stress territorial inequalities. See F. Beguin "Les enjeux du grand débat. Santé: des territoires délaissés", *Le Monde*, 28/2/19, pp. 14–15.
7. This name refers to the location of the Ministry of Health, avenue de Ségur in Paris, where this consultation took place.
8. The personal digital medical record planned in the 2004 Health Insurance act was at last fully implemented in 2022 and the use of e-health – remote consultations are paid on the same basis as face-to-face consultations since an agreement negotiated in 2018 – has been facilitated by new incentives.
9. The increase in the deficit since the COVID 19 pandemic (€39.7 billion in 2020, €24.3 billion in 2021 and €19.6 billion in 2022) is largely due to the health insurance deficit (€30.4 billion in 2020; €26.1 billion in 2021 and €21 billion in 2022).

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30. Health policy in Sweden: striving for equity and efficiency

Paula Blomqvist and Ulrika Winblad

INTRODUCTION

The Swedish health care system is an NHS-type system, characterized by tax-based funding, universal access to health services between different social groups, and public ownership of most health care facilities. The basic principles on which the system is founded is equality in access, needs-based distribution of resources and democratic governance. Elected regional governments are responsible for providing health services to their constituents and raise most funds for this themselves through regional income tax. Long-term care is provided by local governments, or municipalities. The role of national authorities is mainly to provide framework legislation, disseminate knowledge and conduct quality monitoring. Health politics in Sweden is shaped by the system's decentralized structure, which means that many political conflicts concerning health care and its provision are played out in regional parliaments. The complex division of power between the national authorities, regions and municipalities in Swedish health care also gives rise to struggles over jurisdictions and resources between these actors.

The period 1990–2020 saw significant changes in the Swedish health system, foremost with regards to its provision structure. The former virtual public monopoly on health services provision was abandoned and the share of private care providers increased, particularly in the outpatient sector. This development has led to a more pluralistic system with more choices for patients and a stronger element of demand in the distribution of care resources. Another change has been the rationalization of hospital care, which has led to increased specialization among hospitals and a significant reduction in hospital beds. In recent years, the most salient issues in Swedish health politics have been the needs of an ageing population and a perceived lack of staff and a shortage of beds in the hospital sector. In order to rationalize the system and provide services in closer proximity to patients, in 2018, the government launched a program aimed at shifting resources from the hospital sector to the primary care sector.

The COVID-19 pandemic was challenging for the Swedish health care system. In contrast to many other countries, Sweden's strategy to combat the pandemic relied primarily on voluntary measures, for instance regarding social distancing and home-based working, and a full lock-down of society was never enacted. The strain on the health care system was manifested in the shortage of resources in the acute care sector during the first wave, in terms of beds, staff and equipment; as well as the poor coordination between the regional health care and municipal long-term care services. During the pandemic, national authorities assumed a stronger role in coordinating responses between the regions which gave rise to new discussions regarding the role of regions and possible drawbacks of a regionalized system in times of crisis. The pandemic also exposed persisting health inequalities within the Swedish population, as some groups, most notably the low-educated and foreign-born, were disproportionally affected by COVID-19 infection (Greve et al., 2021).

In this chapter, we provide an overview of how the health care system is governed in Sweden, and how it has evolved in recent decades. We show that, even though much health policymaking is pragmatic, particularly at the regional and local levels, ideological conflicts are always present, for instance in issues concerning the distribution of resources and the role of private actors within the system. Furthermore, it is clear that the past three decades of market-orientation in health services provision has left a strong mark on the system in that consumerist and entrepreneurial interests play a larger role today than in the past.

INSTITUTIONS AND IDEAS IN THE DEVELOPMENT OF THE SWEDISH HEALTH CARE SYSTEM

The institutional origins of the Swedish health care system dates back to the 1500s, when the Crown seized control over early care institutions operated by the Catholic Church. In 1862, responsibility for establishing and running hospitals was transferred to newly created regional governments (known as *landsting*). Outpatient care was provided at this time by a mix of private medical practitioners, operating mainly in the cities, and a nationwide system of state-employed physicians set up in 1776. These institutional legacies reflect a long tradition of state involvement in the funding and provision of care for the ill and disabled in Sweden (Gustafsson, 1987). The modern Swedish health care system was created in the postwar period, guided by a political reform agenda intent on universalizing access and establishing public control over provision of all health services. The central driving force behind the reforms was the political wing of the Swedish labour movement, the Social Democratic Party, which was in government between 1932 and 1976.

Universal health insurance was legislated in 1947 and fully implemented in 1955. Over the following decades, responsibility for all outpatient care, including primary care, was transferred to the regions. The hospital sector was expanded and modernized while a system of district-based primary care centers was created. During this period, planning and regulation within the system was largely centralized, guided by ideals of rationalization and standardization (Anell and Claesson, 1995). In 1970, a last step towards a fully public system was taken with the so-called Seven Crown reform which set the patient fee for all primary care visits to a mere seven crowns while at the same time severely restricting conditions for private medical practice. The reform, which was strongly opposed by right-wing groups and the Swedish Medical Association, led to virtually all health care provision in Sweden becoming a public, tax-funded, service and medical professionals being exclusively employed by regional governments (Immergut, 1991). The establishment of local health centres with geographical catchment areas, employing multi-professional teams, was also part of a political ambition to invest more in preventive care in order to reduce health inequalities within the population. Health policy goals became formulated not only as equality in access, but in promotion of equality in health *outcomes*, for instance with regards to morbidity or health status. During the 1970s and 1980s, responsibilities for the organization of health care was further decentralized, as the regional governments became more autonomous. These changes were codified in the 1982 Health and Medical Services Act, which remains the central statute regulating Swedish health care.[1]

In the 1990s, new political winds blew within the system as ideas about public sector renewal and new public management (NPM) became influential. A series of reforms enacted foremost by right-wing governments led to private care providers re-establishing within the system, only this time in the form of for-profit companies. It should be noted, however, that the social democratic left also came to embrace NPM as a means to increase economic efficiency within the health care sector (Blomqvist, 2004). During the same period, the search for economic efficiency also led to structural reforms, foremost in the form of rationalization of the hospital sector and a transfer of responsibility for long-term care from the regions to the 290 municipalities. Both NPM reforms and hospital care rationalizations were contested by the medical professions.

Summarizing developments in Swedish health politics since the mid-20th century, it can be argued that political conflicts have developed mainly along three value dimensions: state vs market; national unity vs regional self-government; and professional vs bureaucratic steering. The *state versus market dimension* refers to the preferred mechanism of resource distribution within the system, a division which also follows class-based lines of conflict both at the national and the regional government levels. Historically, it is clear that the state dimension has dominated, leading to firm public control over resource allocation and provision of care services within the system, but that the market dimension gained ground after 1990. The *national unity versus regional autonomy dimension* can be seen in the on-going power struggles between the state and regions that characterize much of health politics in Sweden. Since 1990, conflicts over the division of power between the national and regional levels of governance have increased, as the national level has sought to re-centralize power within the system. The last value dimension, *professional versus bureaucratic steering*, is perhaps the least visible, but it is present in many decisions taken within the system, particularly at the clinical level where conflicts between public regulation and professional discretion always exist. Bureaucratic steering in the form of laws, directives, guidelines, budgets and recommendations are present at every level in the system and is often resented by professionals, sometimes to the point of open protests or mass resignations.

THE ORGANIZATION OF THE CURRENT SWEDISH HEALTH CARE SYSTEM

Financing

The Swedish health care system is still organized at the regional level. In 2019, the former geographical administrative unit ‘landsting’ was renamed as ‘region’. The health care system is mainly funded by regional income tax, complemented by state grants. In 2020, the regional tax constituted approximately 80% of the total health care funding, while state grants and patient fees accounted for 15% and 3%, respectively. In 2021, total spending as a share of GDP was 10.9% and the share paid by the regions to private providers (excluding dental services) was about 18%. Private funding in the form of health insurance accounted for less than 1% of the total funding. Patient fees are determined by each region but are generally low by international standards. In 2020, the fee for a visit to a general practitioner varied between 10 and 30 Euro, while a visit to a hospital specialist cost between 20 and 40 Euro. Importantly, patient fees in Sweden are also capped, which mean that the maximum that an individual can pay out-of-pocket, in a given year, is 120 Euro (SALAR, 2021b). Although private health insurance still comprises a very small part of total health financing in Sweden, there has been a notable increase in the number of insurance holders since the 2000s. In 2020, 690,000 people, or 6.7% of the population, had private health insurance in Sweden (Insurance Sweden, 2021). Such insurance, in most cases obtained as an employment benefit, is generally duplicating, which implies that it covers the same type of services as the public health care system. Its attractiveness lies foremost in that it guarantees speedy access to care in the outpatient sector (Kullberg et al., 2019).

In order to compensate for regional differences in income and age structure, resources are also transferred between the regions. Since 2005, a national redistribution model has been employed which equalizes regional income and estimated costs, which are calculated foremost on the basis of demographic differences (SALAR, 2021c). Usually, the larger regions in urban areas, with a younger population, are net-payers to regions in the north with smaller and older populations.

Systems for funding hospitals differ across the regions but tend to follow largely similar trends. In 2022, most regions used global budgets combined with some form of pay-for-performance, implying that hospitals reaching specified quality targets received extra payments. Private outpatient specialists are usually reimbursed by the regions on a fee-for-service basis. Only a small share of them take only privately-funded patients (who pay out-of-pocket or have a health care insurance). Primary health care centers, most of which can be both privately and publicly owned, are funded by the regions through a mix of per capita payment (per listed patient) and a payment per patient visit. In most regions, the capitation is given weight in the reimbursement formulas (between 60–100 percent). Usually, they are adjusted for socioeconomic variables, age and sex. Under law, reimbursement models are the same for public and private health care providers in order to create fair conditions for competition. For the same reason, private care providers receiving funding from the regions are not allowed to charge higher patient fees than the regional ones.

Delivery of Care

The Swedish health care system has traditionally been hospital-centric. Hospital care (excluding ambulance care) accounted for almost 40% of total health care costs in 2020, which is higher than most other OECD countries (OECD, 2021). Less advanced health care services are offered at about 20 county hospitals (*länssjukhus*) and 40 county district hospitals (*länsdelsjukhus*). These provide both inpatient and outpatient care, although the county district hospitals have a more limited scope of services. There are also seven university hospitals, and some regional hospitals (*universitets/regionsjukhus*), which provide more specialized health care services and treat rarer and more complicated diseases. Apart from providing medical services, the university hospitals cooperate closely with the medical universities and colleges on education and research. Finally, the most specialized care services, such as burn care or heart transplantations, are concentrated at the national level at five of the university hospitals. The vast majority of all hospitals in Sweden are owned and operated by the regions. In 2020, a total of six hospitals were operated by private actors.

Outpatient specialist care has a considerably high share of private specialists, particularly in larger cities (Andersson et al., 2014). In 2019, specialized somatic care (for both in-patient and outpatient services) from private health care providers amounted to 8% of the total costs for somatic care – a figure that has remained constant since the early 2000s (Pramsten, 2020). In contrast to many other European systems, the Swedish system does not have a formal requirement for referral in order for patients to seek private specialists, even though several of the regions require referrals within some specialties (for instance dermatology, cardiology and neuropsychiatric evaluations), as a method of gatekeeping.

Primary care in Sweden is mainly organized in the form of local primary health care centers (PHCCs) staffed with multi-professional teams, typically doctors, nurses, occupational therapists and psychologists. This is a quite unusual structure compared to the rest of Europe, where primary care clinics are usually smaller and built around individual practitioners (Kringos et al., 2013). This organizational structure partly explains why the proportion of general practitioners in the medical profession, and the number of doctor visits per inhabitant in outpatient care, is lower in Sweden compared to other European countries (SAHCSA, 2017). A major problem in recent years has been the shortage of general practitioners, particularly in rural areas (NHCC, 2022). The PHCCs have a mixed ownership structure of public (regional) and private actors, with most private PHCC being owned by for-profit firms. Patients are asked to list their choice of PHCC or general practitioner, after which regional funds are allocated to the PHCCs. Following a reform in 2010, private providers are free to establish PHCCs and receive public funding on the basis of the number of listed patients on the same conditions as regional PHCCs. Primary care provided by private health care providers amounted to 40% of the total costs of primary care in 2019 (SALAR, 2022).

Overall, the number of doctors is relatively high in Sweden with 4.1 doctors per 1000 inhabitants, which is more than the EU average of 3.6 (only Germany has more doctors, 4.2 per 1000 inhabitants). The number of registered nurses is also significantly higher in Sweden than in other EU countries; 11.1 RN per 1000 inhabitants compared to the EU-average of 8.4 nurses per 1000 inhabitants.

Long-term Care

Long-term care in Sweden is funded and provided by the 290 municipalities. Like health care, long-term care in Sweden is a universal, tax-funded public service, accessible to all permanent residents on the basis of need. The long-term care sector caters mainly to the needs of the elderly and includes health and care services provided in the home as well as institutionalized care. In addition to municipal income tax (about 80 percent), long-term care is also financed by state grants (12 percent) and user fees (about 8 percent). Access to care services is based on needs assessment, which is carried out in each individual case by municipal social workers. In 2020, about 18 percent of all individuals aged 80+ were living in residential care facilities and just above 30 percent received home-based services. Most municipalities also organize home-based health services (*hemsjukvård*), which can also be provided by the regions. Like in primary care, the LTC sector has undergone partial privatization since the early 1990s. In 2020, about 20 percent of all residential care beds were located in privately operated facilities and 24 percent of all hours in home-based care services were delivered by private organizations. The vast majority of the private providers were for-profit companies, while the non-profit sector provided about 2–3 percent of all care services (SAHCSA, 2021a).

Despite its relatively generous public funding by international comparison, long-term care in Sweden has often been portrayed in public debates as lacking in quality. The fact that the majority of the private long-term care providers are for-profit has generated fears, especially within the Left, that quality is reduced by these to save costs. Actual quality assessments, both by the NBHW and independent researchers, point to there being no significant differences in quality between public and private LTC providers; a fact that can be attributed, at least in part, to the fact that they are funded, regulated and monitored on the same terms by public authorities (Blomqvist and Winblad, 2020; Spangler et al., 2019; Winblad et al., 2017).

GOVERNANCE AND AGENDA-SETTING WITHIN THE SWEDISH HEALTH CARE SYSTEM

Governance within the Swedish health care system is organized at three geographical levels: the national, the regional and the local. At the *national* level, a central role is played by the government's expert agencies, which operate with a large measure of independence in relation to the government and parliament. Given that the main responsibility for financing and delivering health services in Sweden rests with the regions, the role of the government and national agencies can be described mainly as regulating and supervising the system in order to ensure that the regions deliver services that are of the same high quality across the country and that all citizens enjoy equal access to needed services. The Health Service Act also places a special responsibility on the national level to promote efficiency of resource utilization within the system (SFS, 2017:30). Governance at the national level takes four main forms: binding, or hard regulation, soft regulation, knowledge-dissemination and supervision. *Binding regulation* can either be created in the form of legislation from the parliament or regulation issued directly by the national agencies. The latter is far more common, and if formal laws in the area are passed, they usually have the character of framework legislation. The most important national expert agencies in the field of health care are: The National Board of Health and Welfare (NBHW), the Health and Social Care Inspectorate (HSCI), the Public Health Agency (PHA), the Agency for Health Technology Assessment and Assessment of Social Services (AHTAASS), the Dental and Pharmaceutical Benefits Agency (DPBA) and the Swedish Agency for Health and Care Services Analysis (SAHCSA). Of these, the NBHW issue most directives and regulations that are mandatory to comply with for actors within the system, for instance regarding professional jurisdiction, patient safety and clinical work. The national expert agencies also govern the system through *soft regulation* such as non-binding recommendations, for instance regarding clinical guidelines issued by the NBHW. Another form of soft governance is through negotiated agreements between the central government and the regions. The 21 regions are represented in such negotiations by their interest organization, the Swedish Association of Local Authorities and Regions (SALAR).

National expert agencies also govern through *knowledge dissemination* as they produce frequent reports and data made available to the regions and municipalities as well as the public. A central role in knowledge dissemination within the system is also played by SALAR which, in addition to its own knowledge production, often provides region and municipalities with advice on how to follow national regulations. SALAR also acts as an employer organization for the regions and municipalities, representing them in negotiations about collective labour agreements with unions over matters concerning wage-setting and working conditions. A final form of governance at the national level of the system is *supervision*, which involves quality assessment and evaluation. This task is shared by several agencies, particularly the NBHW, HSCI and the AHCA (Blomqvist and Winblad, 2021).

Governance at the *regional* level is conducted by the regions, which are governed by political assemblies elected in regional elections every four years. The executive regional board is organized in committees, often one for hospital care and one for outpatient and dental care. In 2021, a total of 4600 representatives were elected at the regional level in Sweden, the majority of which (94 percent) were unsalaried (SALAR, 2021a). Regional politics largely mirrors national politics, where the same eight main political parties compete for power through their regional branches. In October 2021, nine exclusively regional health care parties were listed by the Election Authority in Sweden, most with a distinct health care profile (SALAR, 2023).

The regional public authorities implement political directives, both from the national and regional levels, and organize health care delivery. They also levy regional taxes which varied in 2021 between 11 and12 percent of earned incomes. An important task on the part of the regional authorities is to assess the health needs of regional populations and ensure that services provided are adequate and of good quality. The allocation of public funds between different health care sectors is usually done through budget allocations. Following the most recent election in 2022, eight regions were governed by right-wing political majorities and two by left-wing, while 11 regions had coalitions that included parties from both sides (SALAR, 2023).

Governance within the system at the *local*, or municipal, level is similarly based on local elections where most parties are also represented on the national political arena. In contrast to the regions, whose main task is to provide health care, the municipalities have a wide range of responsibilities, including primary and secondary education, recreation and all forms of social care. Long-term care for the elderly is, however, one of their largest and most resource-consuming areas (approximately 19 percent of their budget) (Ekonomifakta, 2023).

The fact that governance in Swedish health care is structured on a multi-level basis makes it hard to determine exactly where the agenda-setting power lies. Sometimes new ideas come from individual regions, sometimes from their central organization SALAR, and sometimes from the national government or its expert agencies. Generally, governance within the system can be characterized as consensus-oriented, as reform proposals are usually discussed extensively in various arenas within the system and the opinions of different stakeholders are taken into consideration before they are formally launched.

REFORMS WITHIN THE SWEDISH HEALTH CARE SYSTEM, 1990–2020

Since the early 1990s, the Swedish health care system has undergone significant reformation. Below, five reform trends during this period are identified: 1) the search for cost control and efficiency; 2) privatization and marketization; 3) strengthening the role of patients; 4) enhanced efforts by national authorities to measure output and quality; and 5) digitalization.

Cost Control and Efficiency

During the 1980s, increasing demands on the Swedish health care system due to an ageing population and new technological innovations led to longer waiting times for care. This was compounded by a financial crisis in the years 1989–1994, during which public national debt rose and many of the regions suffered financial difficulties. The mounting cost pressure within the health care system led to an increased concern with the system's efficiency and paved the way for both marketization and rationalization reforms. In the first half of the 1990s, rationalization reforms in the hospital sector included mergers of hospitals, concentration of specialist care, and the closing of smaller hospitals. As a result, the number of hospital beds decreased by 67 percent, or from 15 to 5 beds per 1000 inhabitants, during the period 1985–1995 (Gralén et al., 2019) and has continued to diminish to the present figure of 2.5 beds per 1000 inhabitants (OECD, 2021). Most of these changes were initiated by regional politicians. In recent years, critics have argued that the reduction of hospital beds has gone too far and that the shortage of beds in many hospitals wards is a threat to patient safety (Siverskog and Henriksson, 2022). Rationalization reforms in the beginning of the 1990s also included a shift in responsibility for elderly patients with non-acute care needs and the mentally disabled, from the regions to the municipalities (Markström, 2003; Szebehely, 1998). As a consequence, patients treated within the municipal long-term care sector now have greater medical care needs than previously.

The rationalization reforms in the 1990s led to significant cost reductions. However, during the 2000s, total health care costs increased again in Sweden. Explanations for this include population growth, a marked rise in doctors' wages and an increased cost for drugs (Gralén et al., 2019). Another cost-driving factor often pointed to is a general lack of capacity in the primary care sector, which leads to patients being treated in hospitals when their needs could have been met at a lower level of care (Swedish Public Commission, 2016: 2). This has led to new efforts in recent years to shift resources from the hospital care sector to primary care.

Marketization and Privatization of the Swedish Health Care System

Another reform trend in Swedish health care has been the marketization of the system, a political reform trend reflecting the wide influence of New Public Management (NPM) ideas in the 1980s and 1990s. Following a shift in government in 1991, a centre-right government initiated a series of reforms with the aim of opening up the then virtually all-private system to private care providers. In 1992, new legislation on public procurement made it possible for the regions and municipalities to contract out health care provision to private actors, including for-profit firms. The so-called General Practitioner-reform (*Husläkarlagen*) gave general practitioners the right to establish freely and to receive regional funding based on the number of listed patients. Around the same time, private specialists obtained the right to be reimbursed by the regions on a fee-for-service basis. The regions could also, for the first time, contract out the operation of hospitals. In practice, this last form of privatization has proved rare, due to lack of interest both from the regions and private firms. Instead, privatization of care provision has been confined foremost to the out-patient sector.

In addition to the national privatization reforms, many of the regions initiated local reforms with the intent to marketize health care provision during the 1990s, for instance through purchaser/provider splits, performance-based financing, and new forms of target-based steering (Anell, 2011; Blomqvist and Winblad, 2021). Regional marketization reforms were most common in, though not restricted to, regions led by right-wing majorities (Saltman and Bergman, 2005). Even if some of these regional reforms were later modified, they had the effect of raising cost-awareness and introducing more managerial leadership within the health care sector. During the 2010s, the most significant marketization reform became the 2010 Primary Care Choice Reform (PCCR) which was introduced by a right-centre government and can be seen as a more comprehensive version of the 1993 general practitioner reform. The

PCCR required that all regions introduced a “choice-system” in primary care which allowed private actors to freely establish primary health centres and then receive reimbursement from the regions on the basis of listed patients, on the same conditions as public primary care centers (Fredriksson et al., 2013; Vengberg et al., 2019). The main political motives behind the reform were to improve access to care, stimulate private entrepreneurship in the health care sector and provide patients with a free choice of care provider. The PCCR led to a rapid increase in the share of private primary care providers (about 40 percent on average in 2022), the overwhelming majority of which is for-profit.

Strengthening the Role of Patients

The strong impact of NPM ideas in Sweden in the 1990s also came to include a political will to strengthen the role of patients as consumers of care. Several reforms were initiated during the 1990s and into the 2000s to expand patients’ choice of care providers. A partisan divide on the position of choice could be discerned as right-wing parties linked choice to privatization, while the Left saw patient choice foremost as a means to increase efficiency and user participation within the public health care sector (Blomqvist, 2004; Fredriksson et al., 2013). The first choice-based reform was initiated in 1989 and gave patients the right to freely choose amongst the care providers within their region. Before this, patients were limited to seeking care within their geographic district of residency. In the mid-2000s, some of the county councils introduced their own choice models for primary care. In 2010, the most comprehensive choice reform to date, the Primary Care Choice Reform (described above) was introduced, linking patient choice in the primary care sector to a mixed, competitive, market for primary care. The adoption of the Patient Rights Act in 2015 became another way to increase patient power. The act strengthened the position of patients by stating various rights of patients in the health care system, such as the right to information about treatment alternatives to co-determination in treatment decisions, and – in cases of serious medical illness – to second opinion (SAHCSA, 2021b). The 2010s and early 2020s has also seen a policy movement towards making Swedish health care services more person-centered, for instance by including references to this goal in various policy documents, such as agreements between the Government and SALAR. Generally, person-centered care has been interpreted in Sweden to mean involvement of patients in decisions regarding their care and treatment (Winblad et al., 2020).

Taken together, evaluations indicate that reforms aimed at strengthening the role of patients within the Swedish health care system since the 1990s have not been wholly successful, at least not in the eyes of patients themselves. Recent patient surveys indicate that patients are still not fully satisfied with their participation when interacting with care providers, particularly with regards to encounters, co-determination, and access to care. A particularly big problem is the waiting times in specialist health care, which have also increased during the pandemic (NBHW, 2022).

Increased Quality Control and Supervision

An additional reform trend in the Swedish health care system in the 1990s and 2000s was efforts made by the national government to strengthen performance monitoring and quality control. One example of this was national agencies such as the NBHW taking a more active role in issuing national guidelines for treatment, starting in 1996 with the Diabetes guidelines.

Guidelines for treatment, developed in cooperation with medical expertise, are formally non-binding, but strongly recommended. Their primary goal is to ensure that diagnostic and treatment methods are evidence-based and uniform across the whole country. An additional measure taken during the 1990s to improve quality and reduce quality differences among providers and regions was the establishment of national medical quality registers which contain reported individualized patient data on medical interventions and treatment outcomes (Levay, 2016; Örnerheim, 2018). In 2022, over 100 registers for different diagnoses were in use in Sweden.

Another innovation which can be linked to the quest for enhanced performance monitoring on the part of national authorities is the so-called *Open Comparisons* introduced in 2006. The open comparisons refer to a system of annual publications of comparative data on the performance of the regional health care providers by NBHW and SALAR, for instance on medical diagnoses, costs, outcomes and patient satisfaction rates (SALAR, 2020). Together with the guidelines and medical quality registers, the open comparisons are believed to have contributed to general quality improvements as well as an equalization of quality within the system, as regions and care givers with low performance marks are given incentives to improve (Fredriksson et al., 2014). The political reform trend towards increased quality control has been in part contested by the medical professions as it is seen as having led to a heavier administrative burden at the clinical level (Swedish Public Commission, 2016: 2).

The clinical treatment guidelines, medical quality registers and Open Comparisons have become important regulatory tools in Swedish health care, used by national authorities to strengthen national coordination and priority-setting. In this sense, they can be seen as part of attempts to re-centralize power within the system by the national government. The trend towards centralization is also manifested in the establishment of several new auditing authorities at the national level in the 2010s, such as the Health and Social Care Inspectorate (HSCI) and the Swedish Agency for Health and Care Services (SAHCA). This trend towards re-centralization only concerns the regulation of the health system, as funding remains mainly a matter of regional responsibility.

The Emergence of Digital Health Care Services

In recent years, there has been a rapid increase of digital health care services in Sweden, such as e-prescriptions, electronic medical record systems, and online appointment booking. This development is supported by a national vision and action plan for eHealth that the Swedish government and SALAR have agreed upon. The coordination, and implementation of these initiatives has mainly been facilitated by a national authority called the Swedish eHealth Agency. A prominent sphere of digitization so far has been online doctor appointments. These types of appointments were predominantly used only by private providers, but in recent years, all regions have begun to develop systems for online appointments. Other examples of digitization within the system are telemedicine and online medical records, the latter nowadays used in all regions. The COVID-19 pandemic contributed to the digitalization of the system by speeding up the use of digital media to connect with vulnerable patient groups (NBHW, 2021). More critical voices in the discussions of digital health care have also been heard, for instance that it reduced face-to face contact between patients and care givers. Recently, government agencies have identified the need for further policy measures to support digitization in health care, such as harmonizing legislation, education of professionals, and better communication among different IT systems. Moreover, the increased use of online appointments has been criticized as constituting a threat to the idea of equal access to care, as this option is used more frequently by younger and healthier patients (SAHCSA, 2020).

PUBLIC HEALTH AND HEALTH EQUITY IN SWEDEN

Public health has been recognized as the most important area for reducing health inequalities in Sweden. Governing in this area is complex, as the most important causes behind health inequalities lie outside the health care sector and concern matters like education, labour market, housing, and lifestyle (WHO, 2008). Even so, Swedish public health policies have long been ambitious, with the explicit goal of reducing avoidable differences in health within the population (Government Bill, 2017/2018: 249). At the national level, the Public Health Authority has the task of monitoring and analysing population health and disseminating scientifically-based knowledge to promote health. Its main objective is to reduce differences in health within the population (PHA, 2021a). As with other health care tasks, the main responsibility for implementing public health policies lies with the regions. The main sectors for preventive care at this level are maternal and child health, including vaccinations. Maternal health is organized through a public system of maternal health clinics, led by midwives, which are open to all expecting mothers free of charge. Preventive child health services are organized through a public system of local Child Health Centres (CHCs) where all newborn children are enrolled. The CHCs are nurse-led, employing multi-professional teams of physicians, psychologists, speech-therapists and dieticians. Their role is to monitor children's development and offer parental guidance and education. After the age of six, the responsibility for preventive child health services is shifted to the public system of school health services. The CHCs and school health services are also responsible for administering vaccinations to all children free of charge in accordance with the Swedish Child Vaccination Program (CVP).

Generally, public health in Sweden is good by international comparison and has improved further during the last decades. Life expectancy increased from 80 years for women and 75 years for men in 1990 to 84 and 80 years respectively in 2019. Infant mortality decreased during the same period from 5.9 in 1990 to 2.1 per 1000 in 2019, placing Sweden among the top-ten countries in the world. Smoking decreased markedly during the same period, as did mortality in most of the deadliest diseases, including cardiovascular and tumor diseases (PHA, 2020). The positive developments in public health during recent decades is believed to be the result of increased living standards, reduced smoking and improvements in the medical treatment of the deadliest diseases like cancer or stroke (PHA, 2020). There are also some negative public health trends in Sweden. Obesity has increased in the last decades, along with poor self-reported mental health among the young, particularly women (ibid.; Löfstedt et al., 2017).

However, behind the figures showing a general improvement in population health during the last decades in Sweden, is a pattern where differences in health and mortality between social groups persist, and, in some cases, widen. Individuals with pre-secondary education have higher mortality in most serious diseases and also run a higher risk of violence and injury, compared to those with post-secondary education. Life expectancy is markedly lower, and has not increased as much as for those with post-secondary education as for other groups since 1990 (PHA, 2021a). Public health in Sweden is also affected by a growing share of foreign-born, which amounted to 20 percent in 2022 (Statistics Sweden, 2023). Most foreign-born in Sweden are refugees from the Balkans, Africa and the Middle East, groups which have been known to run higher health risks as they tend to have lower education, a higher rate of unemployment and lower "health literacy", or knowledge about and motivation to improve individual health, than the native population (Mårtensson et al., 2020). This pattern of health risks was also reflected in the considerably higher rate of COVID-19 and related death among those born in low-and middle-income countries as compared to the native Swedish population (Diderichsen, 2021; Valeriani et al., 2020). In this sense, the COVID-19 pandemic has highlighted the fact that health inequalities in Sweden today follow not only social, but also ethnic divisions.

THE COVID-19 PANDEMIC AND SWEDISH HEALTH CARE

The Swedish health care system was placed under severe strain during the COVID-19 pandemic. While the country experienced moderate excess mortality rates compared to most other countries in the EU, mortality rates were significantly higher than in neighboring Nordic countries. As of October 2022, more than 17,000 persons have died during the COVID-19 pandemic in Sweden, most of them over 85 years of age. The COVID-19 pandemic impacted long-term care facilities particularly hard, with almost half of all mortalities occurring among nursing home residents (Winblad et al., 2021). The Swedish response to COVID-19 was characterized by a reliance on voluntary measures, strategic decision-making by expert agencies, and a decentralized/collaborative health care response. Key policy goals were to secure health care system capacity, protect high-risk groups, and ensure that measures were implemented at the right time (Winblad et al., 2021).

In line with Sweden's governance tradition of strong and independent national expert agencies, the Public Health Authority (PHA) assumed a leading role in communicating and coordinating the Swedish COVID-19 response. The agency's double goal of both disease control and public health led to a strategy which avoided lock-down and tried to keep society open as far as possible, such as schools and shopping malls. Most of the measures to contain the virus were voluntary in nature and relied on individual responsibility in practicing social distancing, hand washing, and working from home. Mandatory measures were also taken, for example restrictions on public gatherings and specific regulations for restaurants, bars, and cafes.

During the pandemic, efforts were made by the regions to increase intensive and intermediate care unit capacity which resulted in a doubling of beds in such units (from 500 to over 1100 respirator-equipped-beds). Testing capacity also increased markedly over time, but the regions and agencies were initially criticized for a slow ramp-up. Towards the end of the pandemic, the government also started to take a more prominent role in communicating the Swedish strategy and issuing restrictions. Most importantly, a temporary pandemic law (*pandemilagen*) was enacted, enabling the government to issue more restrictions directed to businesses and the community. Altogether, the vaccination campaign has been viewed as successful, even though some groups, such as those born in Africa and the Middle East, were reported as having a lower vaccination rate than the population in general (PHA, 2021b; Winblad et al., 2021).

The COVID-19 pandemic exposed both weakness and strengths of the Swedish health care system. One weakness turned out to be the coordination of responses between the national and regional levels. While collaboration between the regions improved during the pandemic, the multilevel governance model and the autonomous regions complicated the handling of the pandemic, for instance regarding testing and contact tracing. Another problem was a lack of stockpiles of medical equipment in many regions and municipalities, leading to material shortages, particularly in the beginning of the pandemic. As a result, the re-centralization trend was further reinforced during the pandemic in that the government mandated national authorities to take a more active role in coordinating regional activities, for instance regarding distribution of medical equipment, patient transfers between them, and the procurement of vaccines on the international market (Pierre, 2020; Winblad et al., 2021).

Another weakness of the system that became exposed during the pandemic was the difficulty in preventing the spread of the disease in long-term care facilities, which has been taken as a sign of the quality problems within this sector (Swedish Public Commission, 2020: 80). One problem that was identified was the high prevalence of non-permanent staff, which has been found to be one of the determinants of COVID-19 spread. Another was the poor coordination between the municipal eldercare and the regional health care systems, which, among other things, resulted in a lacking attendance of physicians in municipal long-term care facilities (ibid). Taken together, the experiences during the pandemic led Swedish health care policy makers to question whether the regionalized system is possible to steer effectively in times of crisis, with some calling for a stronger role for the national government in its governance. The pandemic also made visible some of the Swedish health care system's strengths. One was the relative flexibility of the system that results from its decentralized governing structure, which made it possible to rapidly increase the capacity of Intensive Care Units (ICUs). Another documented strength is the high level of trust in public vaccinations within the population, which facilitated and sped up the administration of the COVID-19 vaccine to the population.

CONCLUSION

This chapter has provided an overview of the Swedish health care system and its governance. As described, the system was constructed in the postwar era with the aim of ensuring equality in access to high-quality health services which led to a uniquely public system, both in financing and delivery. In recent decades, the system has undergone marketization reforms, leading to a return to a more mixed provision structure in the outpatient sector while hospitals remain publicly owned and managed. Due to the relatively strong autonomy of the regional health authorities, most health governance in Sweden is soft in nature. Policies are implemented in large part through non-binding recommendations, norm-setting, and knowledge dissemination and agreements between the government and the regions. The regional structure of the system also leads to most health policy debates in regional parliaments rather than in the national one.

Traditionally, most political struggles in Swedish health care have been shaped by class divisions and the Left/Right ideological spectrum. This has also been the case in recent decades, particularly with regards to the question of privatization of care provision, which has been pursued foremost by right-wing governments. At the same time, policy discussions in Swedish health care are often pragmatic in nature, focused on matters such as raising efficiency, strengthening the role of patients and improving medical quality. This is especially true at the regional level, where governing coalitions including both left- and right-wing parties are common, in sharp contrast to the national level where ideological left/right divisions tend to be more cemented.

At the beginning of the 2020s, Swedish health care remains a firm NHS-type system where public provision strongly dominates the hospital sector while the out-patient sector has become more mixed in its delivery structure. Complementary private health insurance has become more common, foremost though employment, but as a share of total health funding it is still a negligible phenomenon. Social equity remains a central guiding principle within the system, even if critics see it as challenged by reforms that have stimulated the development of a more demand-driven, entrepreneurial, health care sector, particularly in the larger cities. At the same time, increased immigration to Sweden in the form of refugees from low- and middle-income countries since the 1990s has contributed to a widening of social disparities in health and living conditions. To meet the demands for accessible, top-quality, health services on the part of the urban middle classes, while at the same time catering to the needs of those with the lowest health status, will be an increasingly difficult challenge for the system in the years to come.

NOTE

1. Hälso- och sjukvårdslag (2017: 30), previously Hälso- och sjukvårdslag (1982: 763).

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