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Comparative Health Policies

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Synonyms

Comparative health policy analysis; Health policy exchange

Definition

The study, using qualitative and/or quantitative methods, of two or more policies or policy alternatives pertaining to the maintenance, improvement, or restoration of the health of an individual or population, along with their policymaking contexts, for the purposes of deepening understanding, clarifying differences, identifying possible reforms, and/or accomplishing political objectives.

Introduction

Health policy, unlike many policy issues, is deeply and personally important to most individuals. It is also important to communities because the health sector is among the largest at each level of government.

While the world's industrialized countries share the same general conception of health (as well as similarly high standards of living), their health systems finance, regulate, and deliver care differently. As a result, there are many opportunities for policy learning across systems.

This chapter describes the complex field of health policy in industrialized nations, with an emphasis on Canada and the United States (USA), and discusses its comparative study.

Health Policy

Policy Definition

Policy is the course of activities/actions/inactions, declared or undeclared, pursued by an actor or group of actors, typically after being selected from a set of alternatives, to address a problem. A *problem* is a situation, temporary or lasting, that imposes negative outputs or outcomes, small or large, on individuals, groups of individuals, or the public at large.

Policy is made using a variety of instruments, which are limited only by the boundaries of the imaginations of policymakers. Some of the more powerful instruments – constitutional amendments, legislation, and regulation – draw on legal authority. Policies made using legal authorities are often difficult and time-consuming to change. Other authority-based instruments include regulation, self-regulation, advisory committees, and consultations (Deber and Mah 2014).

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Treasure-based instruments – those that involve spending or raising funds – are also powerful. They tend to last because those receiving the funds usually are reluctant to give them up. Examples include taxation, public spending, grants, and user charges. Two additional categories of instruments are organization-based and information-based (Deber and Mah 2014). The former is a broad category that includes the direct provision of goods and services, as well as government reorganization. The latter category entails collecting and disseminating information through vehicles like commission inquiries, press releases, and advertisements.

Policy can be pursued by any person or group interested in it. *Public policy* is pursued by government. Legislators, judges, and public executives and administrators make and implement public policy with the assistance of interest groups, lobbyists, private and nonprofit organizations, political parties, researchers, the media, and citizens.

Definition of Health

Health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (International Health Conference 1946). Many factors related to a person's individual characteristics, behaviors, and physical, social, and economic environments interact to determine health. Specific factors include income; employment; social supports; education; literacy; the physical environment, such as the availability of water, food, and housing; biology; genetics; and health services.

Health can be measured at many levels, including but not limited to individual, family, household, community, demographic group, region, state or province, and nation.

Health problems can be large or small and range broadly from a messy hospital supply room to the current prescription opioid epidemic to dirty drinking water to illiteracy to poor signage at a busy intersection.

Importance of the Health Sector

Without health, it is difficult to thrive and be happy. As a result, health regularly ranks as a top policy priority for people in the United States and dozens of other nations around the world (Harms 2013; Pew Research Center 2014).

Due to its importance, scope, and complexity, the health sector consumes a large proportion of the gross domestic product (GDP, the value of all goods and services produced) of industrialized nations; in 2013, health spending accounted for 8.9% of GDP on average, including 16.4% in the United States (Organisation for Economic Cooperation and Development [OECD] 2015). Per capita spending averaged almost $3,500 US (OECD 2015). In federal political systems, health spending often consumes the budgets of substates. In 2015, Canada's provinces devoted 38% of their budgets, on average, to health care (Canadian Institute for Health Information 2016). Additionally, in most nations, the health and social (social work) workforce comprises a substantial proportion of all civilian employment, including 13.2% in Ireland and 20% in Norway in 2014 (OECD 2016).

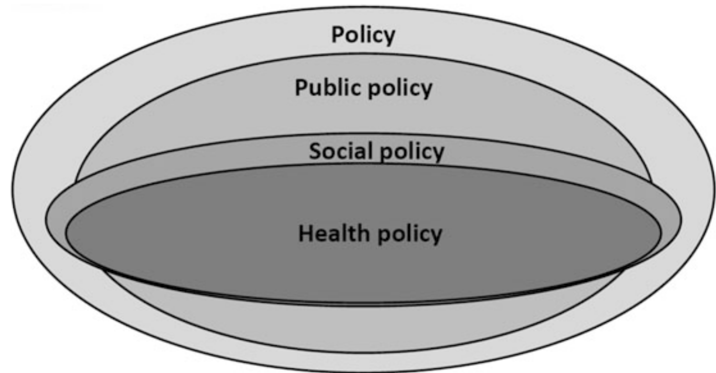
It follows then that health policy occupies a large portion of the policy sphere (Fig. 1).

Health Systems

The "ensemble of all organizations, institutions and resources...mandated to improve, maintain, and restore health" is a *health system* (World Health Organization Europe 2008).

Health systems operate at many levels – national, subnational, regional, and local – and sometimes congruently. A country's health system may be run centrally by the national government or, particularly in federal political systems, be delegated in whole or in part to substates that further delegate to regional authorities. Or, in both unitary and federal countries, a system may function primarily at the regional or local levels.

Health systems can be thought of as having three main dimensions: financing, service provision, and regulation (Bohm et al. 2013). *Financing* consists of raising money for health insurance (financial protection against health-care costs) and care through mechanisms such as direct taxation, social insurance contributions, or private payment. *Service provision* encompasses delivery location, providers, and technologies. *Regulation*



Comparative Health Policies, Fig. 1 Health policy's portion of the policy sphere

refers to the governance of relationships between financers, providers, and beneficiaries, including how patients access services, what service they can receive (e.g., emergency room visits, physical exams, prescriptions, dental surgery, psychotherapy, and nursing home care), and how financers pay various care providers for them.

State, societal (private nonprofit), or private actors can perform financing, service delivery, and regulatory functions.

Böhm et al. (2013) classified the health systems of 30 OECD countries by the extent to which each type of actor dominated each dimension. Twenty-eight systems fit into four clusters:

- National Health Service = state domination of all dimensions
- National Health Insurance = state financing and regulation with private service provision
- Social Health Insurance = societal financing and regulation with private service provision
- Etatist Social Health Insurance = societal financing, state regulation, and private service provision

The US system did not fit into any of these clusters. Bohm et al. labeled it a uniquely "private" system because private sector actors dominate each of the three dimensions. Due to the predominance of private financing, it is the only health system of the 30 that does not provide universal health-care coverage (Camillo 2016).

Health System Components

No matter the type, the health systems of industrialized nations contain the following components:

- Patients
- Patient advocates
- Hospitals
- Long-term care institutions
- Hospices
- Clinics
- Pharmacies
- Laboratories
- Morgues
- Medical schools
- Nursing schools
- Physicians, nurses, and providers representing dozens of other health-care professions, including dentistry and occupational therapy
- Alternative providers, such as reflexologists and acupuncturists
- Provider associations
- Emergency and nonemergency medical transportation companies
- Nonprofit and private insurance plans
- Lobbyists
- Research institutes
- Drug and medical device manufacturers and salespeople
- Blood banks
- Information technology systems, including those that pay claims and maintain electronic medical/health records
- Accountants
- Quality reviewers

- Data analysts
- Administrators
- Financers
- A wide range of organizations, public, societal, and private, that make health policy and direct and/or monitor implementation

Despite the expansive definition of health adopted by the World Health Organization (WHO) at the 1946 International Health Conference and subsequent pledges by gatherings of nation states to apply it by addressing the social determinants of health, health systems have largely de-emphasized mental and social health care in favor of biomedical care that relies upon technology to diagnose and restore individuals' physical health. For example, the United States did not require private insurance plans to cover mental health care on equal terms as physical health care until 2010. Relatedly, nations with sizable indigenous populations, like Canada, did not incorporate traditional healing methods into their systems until very recently.

Health systems that embrace the WHO's more expansive "population health" approach might also include traditional healers, school systems, teachers, food banks, grocery stores, social service agencies and providers, environmental engineers, urban planners, bicycle shops, justice officials and correctional institutions, and a range of other public, societal, and private entities that directly or indirectly affect well-being.

Health Policy Issues

Most health systems in industrialized nations are trying to develop policies to:

- Achieve financial sustainability
- Determine which services to cover
- Ensure timely access to services
- Eliminate unnecessary services and waste
- Coordinate care across providers
- Treat patients with multiple chronic conditions
- Eliminate socioeconomic inequities
- Ensure safe, high-quality, patient-centered care
- Improve accountability
- Enhance patient and provider experiences
- Transition to an upstream approach that emphasizes health promotion from a downstream one that emphasizes treatment
- Prevent illness by addressing the social determinants of health
- Utilize data and information while respecting privacy
- Encourage the development of appropriate and cost-effective innovations

Additional policy adoption or reform efforts could be prompted by factors like demographic changes, such as the aging of the population, new disease outbreaks, and political demands.

Comparative Health Policy

Purposes

Comparative health policy entails examining two or more for similarities and differences and evaluating those found. Those who compare policies do so for a range of reasons – negative, neutral, and positive.

The most basic reason is to perform "policy warfare," which Marmor et al. (2009) describe as misrepresentation to win policy debates. For example, in the United States, politicians frequently reference longer wait times for certain health services in Canada to dissuade Americans from supporting the adoption of single-payer (publicly financed) health insurance programs like those run by Canada's provinces.

When done in a methodologically sound manner, comparison facilitates negative learning – the identification of undesirable or unworkable components or characteristics. Randomized, controlled experiments, for instance, can identify prescription drugs that do not cure or ameliorate illness.

Sometimes comparison improves understanding. By comparing one policy to another, we can essentially see the first in relief, meaning we can recognize previously indistinct features. When Canadians compare provincial/territorial health insurance plans, they discover that while they share the same mandate to provide comprehensive

care, they differ in significant ways, including in what services they cover. For instance, Prince Edward Island's health system is the only one that does not cover abortions performed in-province, which might reflect previously unknown unique economic and/or cultural circumstances.

Comparative study can help hold health system leaders accountable. The US Medicare program's Nursing Home Compare website encourages the family members of individuals needing a nursing home level of care to compare facilities on a range of quality measures, which incentivizes facility managers to provide excellent care in order to keep beds full.

Comparison generates policy ideas. Policymakers can compare their own facilities, practices, insurance plans, or programs with similar ones to identify what they do differently for the purpose of developing new workable ideas (i.e., for the purpose of positive learning). State Medicaid programs in the United States regularly "borrow" policy ideas from one another in this manner.

Finally, comparison facilitates good policymaking. Government briefing notes, options papers, cabinet decision items, and other such working documents compare policy alternatives on decision-making criteria in order to determine which alternative would best solve the policy problem at issue. Without multiple alternatives to consider, policymakers might adopt insufficient policies simply because they were the only ones presented.

Comparative Study Forms

Marmor et al. (2009) identified four clusters of comparative health policy work at the national level:

1. Descriptive documents providing statistical data, including some drawn from surveys, about a number of similar countries. Occasionally these documents include rankings.
2. Parallel case studies describing the health systems of multiple nations using a common template. The WHO European Observatory on Health Systems and Policies in transition series is an exemplar.
3. Books that employ a common framework to explore a particular health policy topic, such as privatization, in a number of individual countries.
4. Cross-national studies with a fundamental theoretical orientation that examine a specific health policy topic or question, sometimes utilizing empirical data.

Comparative work at the subnational and regional/local level falls into the same categories, although it seems to skew even more heavily toward the first two.

Increasingly, comparisons are available online as downloadable papers or in the form of data tables. In the case of the first category, they often come with self-directed comparison tools.

A wide range of users – consumers, members of the media, policy analysts, advocates, practitioners, policymakers, etc. – utilize comparative health policy studies, especially works in the first two categories. The latter two categories are mostly the province of scholars.

Scholars working for academic institutions, think tanks, foundations, or consulting firms produce most of the studies. They might receive input or support from government organizations, but public employees generally do not serve as lead authors.

No single peer-reviewed academic journal is devoted to the comparative study of health policy, although numerous journals focus on health and do publish comparative studies. Canada's *Health Reform Observer – Observatoire des Réformes de Santé* is an open access, peer-reviewed, online journal that aims to facilitate the flow of evidence about health reforms between scholars and decision-makers. One of the four types of articles it invites is comparative health reform analyses.

It is important to note that much comparative health policy analysis is conducted informally or confidentially by practitioners for the purposes of generating or selecting policy alternatives, not for the purposes of informing a wider audience. So, for example, three state health policy leaders might participate on a conference panel to share

lessons with their peers on how to finance global budgeting, as was the case at the 2016 National Academy for State Health Policy (NASHP) conference, but might not publish presentations for dissemination to the broader health policy community.

Comparative Methods

Quantitative, qualitative, and mixed methods are used to compare health policies. The content of policies (such as regulatory text) are compared, as well as inputs, outputs, and outcomes. Inputs consist of the resources – human, financial, physical, and virtual – and processes a policy utilizes. They influence the outputs and outcomes of a policy, although not always positively or directly or in well-understood ways. Outputs are the work and waste generated by a policy. They are typically quantifiable, so they are often measured to evaluate policies, but there is not necessarily a direct relationship between outputs and outcomes. Outcomes are the effects of the policy, or components thereof, on the health of the population or population subgroups. In the case of the expansion of US state Medicaid programs as authorized by the Affordable Care Act, inputs were the resources the states used to expand their programs, outputs included the number of additional individuals enrolled in those programs, and outcomes included changes in insurance rates.

Studies in the first two clusters tend to use description and descriptive statistics. Description could take many forms, like the written experiences of patients with the same disorder who are receiving different therapies or a side-by-side analysis of the components of two pieces of legislation. Descriptive statistics are compiled using primary and secondary administrative and survey data (and, to a lesser extent, clinical data). Recent advances in information technology enable the relatively quick development and administration of surveys. Plus, they make it possible for health systems and statistical agencies, such as the US Census Bureau or Statistics Canada, to share large administrative databases with the public for secondary analysis. Grounded theory – a qualitative approach through which theory is developed from an iterative analysis of data – and sophisticated statistical techniques, like regression analyses employing multiple independent and dependent variables, are commonly used for the third and fourth categories of comparative policy work. Study methods also vary according to purpose, policy issues, and level of analysis (national, substate, local, etc.).

Different disciplines dominate depending upon the policy issue and the country. In the United States, economists have a particularly large presence in the study of health policy.

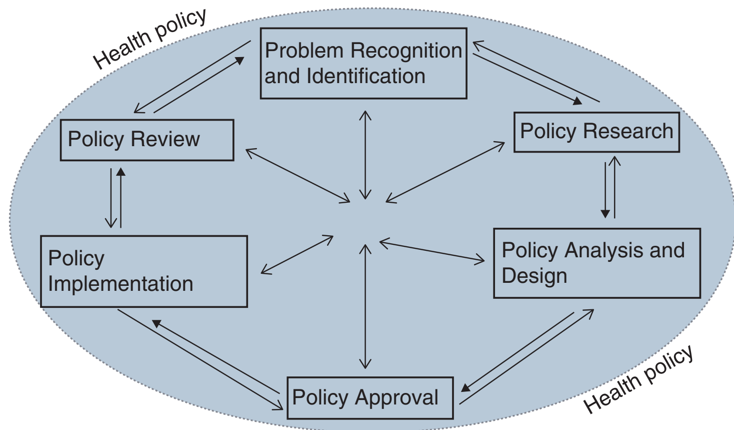
Challenges

Comparative health policy study presents a few special challenges above and beyond regular health policy study.

Collecting data from multiple jurisdictions/sites requires more approvals and paperwork. Furthermore, collected data typically needs more standardization because jurisdictions/sites usually develop codes independently.

All data, especially qualitative, require more interpretation because the underlying policy and policymaking contexts differ significantly. To effectively compare policies, one must take into account these differences. Contextual factors describe a policy's setting, effectively outlining what policy or reform is possible. Political scientists argue that institutions (e.g., political systems and government organizations), ideas (to include political ideologies and principles, such as accessibility, sustainability, and comprehensiveness), and interests (stakeholders) shape policy decisions. So do policy legacies (previous policies). In analyzing 63 quantitative comparative health policy studies that used the US States as the unit of analysis, Miller (2005) found 43 policymaking determinants, such as nursing home beds, liberal opinion, and advocacy groups, that consistently predicted policy outcomes. These determinants shape policy at all stages of the complex, nonlinear policymaking process (Fig. 2) and vary significantly from one jurisdiction to another.

Physical distance and differences in language/terminology can hinder study teams' communication unless the teams include representatives from each jurisdiction/site, which is more costly. Yet, due to comparative study's seeming irrelevance to



Comparative Health Policies, Fig. 2 Policymaking process model

some, financial and other support can be difficult to obtain, especially from public officials who must justify it to taxpayers.

Findings

After analyzing the comparative study of health policy conducted at the national level over the last three decades of the twentieth century, Marmor et al. (2009) concluded that the field is growing, partly because supply induces demand, but has yet to fulfill its promise, especially in the western world. They blame a disconnect between practitioners and academics, which keeps policymakers from reading the most sound studies (those that fall into their third and fourth categories of comparative literature, as described above).

At the subnational and local levels, scholars in the United States and Canada have largely evaluated the success of comparative study by assessing policy diffusion and the spread of innovation. In summarizing a special issue (2017) of the Journal of Health Politics, Policy, and Law devoted to understanding the diffusion of Affordable Care Act (ACA) policies in the United States, editor Colleen Grogan drew a similar conclusion as Marmor et al. – there is a desire for information about other jurisdictions but its usage is dictated by the political aspects of the policymaking process. Specially, she wrote: "...those who want the reform are busy implementing and learning from similarly reform-minded states, and those who are against reform are busy fighting to stop it and learning from similarly resistant states." Writing around the same time, the editor of one of Canada's leading health policy journals was inspired by evidence that health innovations had scaled and spread in several settings (Zelmer 2015).

Conclusion

It seems unquestionable that comparative health policy study will continue to grow as the health sector of most economies expands and technological advances improve information dissemination.

Suggested next steps for the field are to accept that politics within all health-related organizations – public, societal, and private – limit the application of learning; to focus on understanding and documenting how policymakers and policy implementers gather and use comparative information in order to enhance their effectiveness; and to improve communication between comparative health policy analysts/researchers and policymakers/implementers.

Cross-References

- ▶ Bioethics and Health Policy
- ▶ Comparative Healthcare Systems
- ▶ Comparative Policy Analysis
- ▶ Health-Care Policy in America
- ▶ Health Policy: Innovative

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