4 Global Context and Case Selection

This chapter discusses the historical context for the case studies, justifies the country selection, and presents the methods of analysis. To manage the historical analysis, I define four time periods, each of which has different contextual elements with different implications for the following case studies. The first time period (t0) covers the years between 1880 and 1918, when health care and public health emerged as two different policy sectors. The second time period (t1) focuses on the time frame between 1918 and 1945. In the interwar period, the main theme was the competition between health care and public health. A third time period (t2) covers the years between 1945 and 1980, which entail the establishment of individual health care. Along with the increase of the welfare state services and economic development, facilities of individual health care expanded enormously. Time period four (t3) spans the years 1980 to 2010, during which new policy challenges, such as new infections and noncommunicable diseases, returned to the agenda of health policy and created a demand for more integrated solutions of health care and public health. In the second part of this chapter, I justify why I focus on five countries, namely Australia, Germany, Switzerland, the United Kingdom, and the United States. The main criteria for selecting these nations is that the countries differ regarding their condition of unified government and professionalization of health professions. Then, I present briefly the operationalization and the sources – secondary literature, documents, and interviews – as well as the method of data analysis for the comparative case studies.

4.1 Emergence of Health Care and Public Health as Two Policy Sectors (1880–1918)

In order to understand the economic, social, and technological context of the coevolution of the health care and the public health sectors,

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

I start my analysis in the second half of the nineteenth century. This is the time when modern states began to take concrete forms and to differentiate policy sectors, such as the health care and the public health sectors.[1] During this time, public health policy instruments were very important to respond to the most pressing health problems. Thus, public health legislation entailed the creation of boards – and later on departments – of health, in the beginning mostly at the local and state or regional level. These institutions were responsible for the implementation of sanitary reforms, such as laws concerning food safety, building of sewages, provision of clean water, regulation of medical degrees, planning of hospitals, bacteriological interventions, programs to improve the physical condition of the entire nation, medical inspection of children, and hygiene education for the general population. In addition, infrastructure for the provision of individual health care was developed and improved (Tulchinsky and Varavikova, 2009, 40; Baum, 2008; Leeder, 2007).

Many of the public policy interventions that occurred at this time entailed preventive measures in order to stop rampant epidemics and infectious diseases. The idea of community health, which reappeared in the 1970s in order to integrate health care and public health policies, had emerged around the turn of the twentieth century and included health care and public health measures. It referred to emergency treatment by doctors as well as health counseling, but centered on a doctor and a patient in a more hierarchical way. However, it included preventive work of nonmedical personnel as well. Yet, most of the curative services were provided by doctors on a fee for service basis (M. Lewis, 2003a). At the time, state- run public health services were a good option for doctors to find paid work, because in most cases there was no health insurance paying for individuals' treatment and thereby ensuring payment of physicians (Alber and Bernardi Schenkluhn, 1992). The long economic crisis in the late nineteenth century made this effect even stronger (Capie and Wood, 1997). Public health services provided health counseling and planned population health programs, but they also registered and isolated cases of dangerous infectious diseases and they became the origin for the development of public health professionals with different interests from the medical profession (Porter, 1999).

As this book will discuss in the following case studies, professional politics and health policymaking differed among countries. At this

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

stage it is important to consider the contextual factors to which these policies responded during the first time period:

1. Infectious diseases and sanitary issues were urgent *health problems* in the second half of the nineteenth century and thus a key challenge for health policymakers. For instance, from 1817 to 1912 eight global pandemics of cholera hit the world and inspired public health legislation in many countries (M. Lewis, 2003a).
2. *Technological development* is an important factor, such as in this case, the availability of new and effective drugs and medical equipment. For instance, antibiotics were not yet available, which made finding a cure for some infectious diseases, such as tuberculosis, rather difficult. Advances in research occurred in the area of disease prevention and provided information for public health policies. Progress happened, for instance, in the field of epidemiology. Between 1881 and 1898 many significant pathogenous organisms were detected and isolated, which made it possible to counteract them with public health measures, such as typhus, lepta, malaria, tuberculosis, plague, and many others (Rosen, 1993 [1959]; Gottweis et al., 2004).Yet, research did also advance in areas that are important for health care. For instance, research on antiseptic products and methods improved the efficiency of surgical interventions (Tulchinsky and Varavikova, 2009, 41–42).
3. As a consequence, *ideas* regarding health policy emphasized the importance of prevention as well as the integration of health care and public health. That this time period was also one of nation building enhanced the focus on population health even more. Emerging modern states wanted to improve the health of their fast growing population in order that it would be was fit for modernization and economization as well as competition with other nations. Ideas such as vitality, efficiency, purity, and virtue of the nation – rather than the individual – were important and needed well-organized public health policies, whereas health care for the individual was not yet the most important concern (Baum, 2008). The focus of health policies on the health of the nation and its fitness for the competition with other countries pointed to the importance of the collective rather than the individual in health policy.

The implications of these contextual conditions on the expected relationship of health care and public health is as follows. Due to

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

the pressing problem of infectious diseases and the lack of medical and pharmaceutical technology, the context is favorable to public health policies, but also to responsiveness and unification of health care and public health policies. What is more, the importance of nationalistic ideas should enhance the contextual demand in a way that was favorable to the integration of both sectors.

> ***Contextual condition t0:*** *During t0, the context is favorable for responsiveness and unification of health care and public health, due to the prevalence of infectious diseases and limited medical and pharmaceutical development.*

4.2 The Turn Toward Individual Health Care (1918–1945)

The second contextual sequence concerning the coevolution of health care and public health can be dated to the end of the First World War. This makes sense for two reasons: First, the end of the war marked a turn in the demands for health policies, as the war showed that it is important to pursue population health policies in a directed, more individual-based manner. What is more, at the time, some countries had already established comprehensive health insurance programs, which set the stage for interactions and possible conflicts and cooperation between the two sectors.

The turn toward individual health policy began with the establishment of national health insurance programs that were created in many countries, beginning in Germany in 1883; followed by England in 1911 (Porter, 1999), and France in 1930 (Alber and Bernardi Schenkluhn, 1992), for example In Switzerland, a very limited national health insurance law was put into place, in 1911, after a legislative proposal that followed the German model had failed in a popular vote (Uhlmann and Braun 2011) (cf. Chapter 8). The introduction of comprehensive health policies failed in other countries and was postponed to later periods in time, such as in Australia (M. Lewis, 2003b) and the United States (Schild, 2003).[2] National health insurance plans signal the increasing importance of health care policy as they institutionalize financial support for individual health care and a shift of attention from population-based and preventive policies to more curative health policies. Consequently, this bore the potential for significant conflicts between the two sectors, respectively administrators and professional actors.

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

Yet, public health remained an important part of health policies in many respects during that time. For instance, preventive care for women and children emerged in the late nineteenth century and expanded during the early twentieth century. Public health officials discovered the necessity to expand preventive services to needy and poor groups, which were often women and children, in order to respond to the negative health effects of poor living conditions, bad general hygiene, lack of prenatal care, and scarce nutrition (Tulchinsky and Varavikova, 2009, 44). Public health policies began to change though, as policymakers adapted results of health research, especially bacteriology. Disease specific and restricted interventions were already carried out in the early twentieth century to reduce the prevalence of infections. Some members of the public health profession opposed these policies, for instance, representatives of the Progressive Movement in the United States, who preferred structural interventions to improve public health, such as the improvement of housing and schooling (Porter, 1999).

During the interwar period, governments increased health care as well as public health policies at the national level. With the establishment of the League of Nations, founders also created a League of Nations Health Organization, which attempted to help with the implementation of population health measures in the participating countries (Weindling, 2002, 2006).[3] In addition, the organization carried out and supported cross-national studies concerning population health (Rosen, 1993 [1959]).

With regard to contextual elements that led to the mentioned political situation, specifically the following points are important to keep in mind in order to understand the interwar period.

1. *Health problems:* As in the previous period, between 1918 and 1945, infectious diseases still were amongst the most urgent health problems. Tuberculosis especially was a major issue for health policies in the first half of the twentieth century. The sickness had been present since the early nineteenth century; however, it had been less visible because of infant mortality from gut infections, smallpox, and other pandemics. Once these diseases were under control in the late nineteenth century, tuberculosis became more visible and subject to health policies. Finding a cure was difficult and, consequently, health policymakers focused mainly on pre-

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

venting tuberculosis infections using instruments of public health policies (Porter, 1999, 282; Dubos, 1987; Rosenkrantz, 1994).

2. *Technological development:* The development of new anti-bacteriological technologies continued to advance during the interwar period. Major breakthroughs that helped to control some of the most important public health problems had already been in effect before the First World War. However, a cure for other diseases, such as tuberculosis, was not yet possible. Therefore, infectious diseases remained at the top of the health policy agenda at the time. The development of antibiotics, such as penicillin, did not occur prior to the mid-1940s (Tulchinsky and Varavikova, 1996, 44). The continuing, but slow, improvement of pharmaceutical technologies improved the curability of diseases and enhanced the arguments of those who were in favor of more health care policies. Nevertheless, the demand for more public health policies remained important, due to the obvious shortcomings concerning the curability of certain infectious diseases.
3. *Ideas:* Ideas regarding health policies still focused on the fitness of the nation and the popular body. Especially after the First World War, many European governments sought to regain their strength as a nation. Therefore, it remained an important goal of health policy to improve the health of the entire population in order to keep it fit for competition with other European nations. Such policy ideas included racist policy ideas derived from eugenics (Weindling, 1989; Bashford and Levine, 2010). Subsequently, population-based measures, including medical inspection of children and hygiene education of the population had a high priority in health policy (Baum, 2008). At the same time, however, individual health care became more important and the voices of those who argued in favor of more services of this kind became louder. Consequently, in many countries there was a general conflict regarding the institutionalization of health policy between health care professionals supporting suggestions to establish national health services that would combine population- and individual-based measures and those supporting health insurance schemes, e.g., corporatist, market-based, or more state-centered health care plans (Porter, 1994).
4. *Economic crisis and the Second World War:* Apart from specific health problems, technological development, and ideas, crisis events played an important role for the relationship between the

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

two sectors. During t1, there were two events that potentially had an important impact on the relationship of policy sectors in general. First, the economic crisis of the 1930s had a significant impact on health policy. Demands for public health policies consequently increased and so did the demand of doctors to find employment in public health services because private practice became more difficult. However, in such times of economic hardship we can also expect to find politicized distributional conflicts between professions and other interest groups of both sectors, since some governments responded to the crisis with austerity policies (Eichengreen, 1992). Second, the war between 1939 and 1945 increased the demand for public health policies, above all to support military operations, but also to protect the population at home (Levy and Sidel, 1997). This implies, for the context of coupling of health care and public health, that war and economic crisis should decelerate the development toward more individual health care and keep public health on the political agenda of national governments.

The factors discussed show that the contextual conditions regarding the coupling of the health care and the public health sectors matter in two ways. First, due to the continuing importance of infectious diseases, the limited technological possibilities of curative medicine, and the public health situation in times of war, context should remain favorable to the demands of public health. On the other hand, the tight economic and fiscal situation, especially after the financial and economic crises in the 1920 and 1930s, is likely to create distributional conflicts among the actors of the two sectors.

Contextual condition t1a: *During t1, infectious diseases, limited medical technology, and the war situation should create a demand for sectorial responsiveness and unification.*

Contextual condition t1b: *During t1, the difficult economic and fiscal situation should lead to conflicts between actors of the two policy sectors.*

4.3 Dominance of Medical Care and Marginalization of Public Health (1945–1975)

After the Second World War, the relationship between health care and public health changed. In many countries, health policymakers began to focus on individual cure of sick patients, leaving population-based measures to the side, or only employing them in an ad hoc

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

and secondary manner. As a consequence of the medical turn in health policy, preventive health policies often occurred in the form of individual counseling, for instance, by doctors.

Thus, in the aftermath of the Second World War, health care entailed the development of more and more sophisticated medical services, for instance, an increase in the numbers of hospital beds as well as pharmaceutical services, clinical care, and the transplantation of organs. The rationale behind these policies has been labeled the biomedical paradigm, which understands health policy as the need to cure sick bodies of individual patients (J. Lewis, 1999, 154). On the contrary, public health played a marginal role compared to health care (Baum, 1998). The evolution of health expenditures into individual care and prevention illustrates this point. In comparing OECD average numbers from 1970 to 2015, we see that there is a large difference in what has been spent for policies focused on sickness compared to expenditure dealing with health hazards (Figure 4.1) or, to put

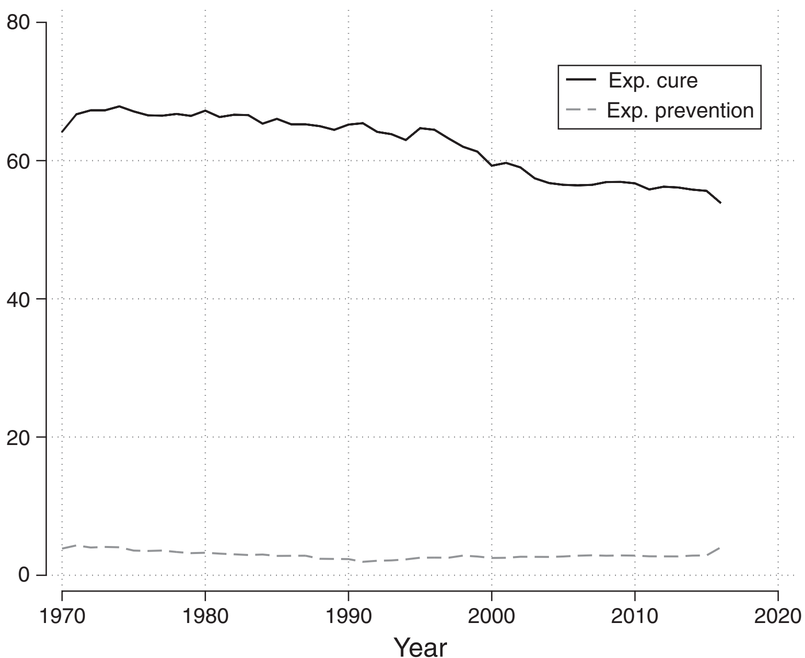

Figure 4.1 Expenditure on prevention and cure I (percentage of health expenditure, OECD average).

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

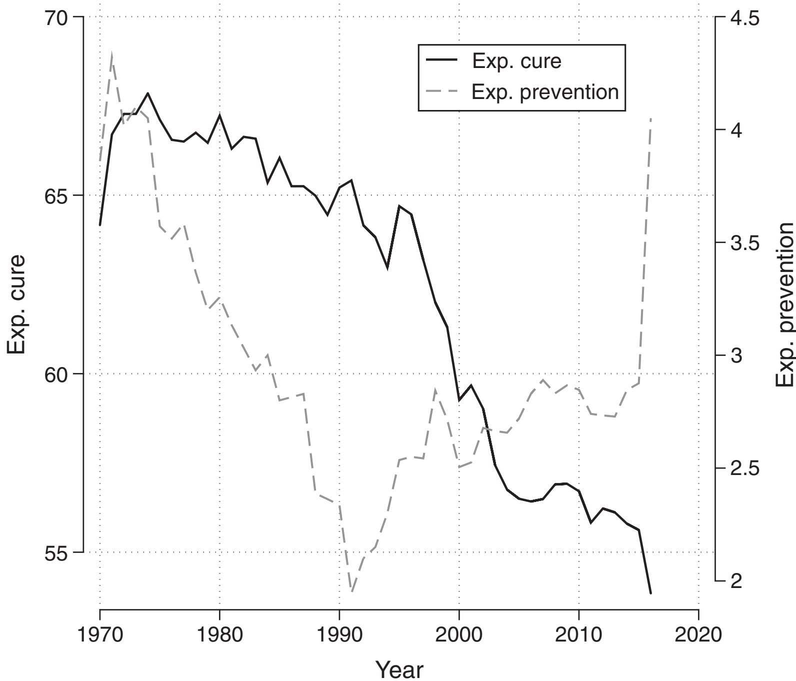

Figure 4.2 Expenditure on prevention and cure II (percentage of health expenditure).

it differently, a large discrepancy between expenditure for curative medicine and for prevention.[4]

The graphs in Figures 4.1 and 4.2 show that from 1970 to 2015, the expenditure share for curative care decreased constantly. However, this was only partially at the expense of more preventive care. Expenditures for public health (preventive care in terms of the OECD) peaked in the 1970s, declined during the 1980s and began to increase again since then. This shows that public health expenditures are very sensitive to budgetary cycles and were cut first when the period of budgetary austerity began in the 1980s. Similarly, in the post-2007 recession, governments in many OECD countries reduced expenses for preventive care again (Morgan and Astolfi, 2015), and increased them again thereafter. Other expenses related to health are those for pharmaceutical products and long-term care, which are not shown here. Both – especially expenditure for long-term care – have increased

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

over time (OECD, 2017). According to the logic of this book, these expenditure categories would mostly be part of the health care sector. One other reason why expenses for care are so much higher than for prevention is that the preventive approach also entails regulative instruments that try encourage and force a specific behavior. Such approaches naturally do not cost as much money as health care services, which are an instrument of redistribution (Levi-Faur, 2014).

These differences in expenditure show that the approach of individual curative care has become dominant over preventive and population-based health policy since the Second World War (Trein, 2017a). This remains true, although – as I will discuss later – there are reasons to believe that the relation of the two sectors should have shifted toward more complementarity since the 1980s. Despite the high priority of medical care in national health policies, public health policies remained important, for instance, by large immunization campaigns during the 1950s. Immunizations had already been carried out during the early twentieth century, yet these policies returned to the political agenda after the Second World War. Vaccination, specifically against polio and later on tetanus and pertussis, was the subjects of large public health campaigns because at that time the necessary medicines had been developed (Baum, 2008, 27). Generally speaking, the dominance of health care over public health is related to the following contextual elements:

1. During and immediately after the Second World War, there were important *technological developments* regarding health policy, namely pharmaceutical technologies. Researchers developed more effective drugs, particularly antibiotics, penicillin and streptomycin, which later on became powerful tools to treat infectious diseases. As a consequence, many communicable diseases, such as tuberculosis, could be cured (Shield et al., 2009; Eckart, 2011). Another result of the progress in technological development was the development of vaccinations for dangerous infections, such as immunization against polio (Tulchinsky and Varavikova, 2009). These pharmaceutical innovations allowed for the curing of more diseases, but also shifted public health even further toward individualist approaches and therefore under the umbrella of individual health care. At the same time, new options became available for public health itself, such as fluoridation of drinking water.

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

2. *Health problems:* Due to 100 years of public health policymaking (approximately 1850–1950) and new medication, infectious diseases, which had been the most pressing health problem for centuries, suddenly no longer posed a major problem because they could, in many cases, be cured (Rosen, 1993 [1959]; McKeown, 1979; Haines, 2001; Tulchinsky and Varavikova, 2009; Nathanson, 2007). Longer lives, however, came along with higher prevalence of other diseases related to longevity, notably cancer, stroke, and diabetes. These diseases were known before, but had been less important since the risk of dying from an infection was much greater. Once infections could be cured, the importance of the classical "preventive approach" lost in importance compared to curative medicine (Baum, 2008).
3. *Economic development:* The economic development is another quite important factor regarding the relationship of health care and public health in the postwar period that boosted the dominance of individual health care. This was a time of unprecedented economic growth, especially in Western democracies. Consequently, governments had the option to increasingly invest in individual health services and hospitals, which institutionalized the more prominent position of health care compared to public health, and made medical practice attractive to many individuals (Fee, 1994; Baum, 2008).
4. In this period, *ideas* about social policy changed profoundly, which also had an impact on the relation of health care and public health. Along with unprecedented economic growth, the postwar era was a time of welfare state enlargement and in many countries the range of social policies increased greatly in terms of benefits and recipients. Furthermore, the stronger focus on individualism in many policies opposed to communitarian ideas favored the dominance of the health care sector, particularly in "Western liberal democracies" (Castles et al., 2010). "Communist autocracies," on the other hand, created huge national health services, which unified individual health care and public health policies institutionally, although they also evolved toward a greater focus on medicine opposed to nonmedical health policies, for instance, in the Soviet Union or the GDR (Tulchinsky and Varavikova, 1996; M. Schmidt, 2004). This development of health policy in the former Soviet states led to opposition against public health policies, notably

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

population-based measures, in some Western countries (Fee, 1994). Nevertheless, public health gained importance at the international level. The foundation of the WHO in 1948 was the starting point to lift prevention, control of communicable diseases, and social medicine to the international level (WHO, 1953). Although national health policies in Western democracies focused on health care development and the improvement of individuals' quality of life, the WHO continued to keep the focus on public health measures, which were still very important for less developed countries.

Contextual condition t2: *During t2, new medical technology, the success of prior public health policies, and the cold war competition between political systems reduced the demand for sectorial unification, including policy integration.*

4.4 The Long Return of Public Health (1974–2010)

In the postwar period, health care and public health diverged. However, the landscape of health policies began to change again in the mid-1970s. Prevention and population-based interventions returned to the focus of health policy because the focus on individual health care was not able to cope with the problems that "diseases of affluence" posed for health care. These typically included noncommunicable illnesses that occurred due to behavioral factors such as smoking, drinking, and unhealthy diets (M. Lewis, 2003b).

Public health returned to the political agenda in 1974. One of the most influential documents in this regard was the Lalonde Report for the Canadian government in 1974, where the minister for health demanded the inclusion of individual and population-based policies in national health policymaking and that individual health care should only be one element among others to influence good health (Lalonde, 1974; T. Hancock, 1986). Other countries, especially in the Anglo-Saxon world, published similar documents, such as the "Life: Be in it" (1975) campaign in Australia. Other countries, such as the United States and the United Kingdom, followed (Baum, 2008). Concerning the provision of health, the first new public health efforts, especially community health programs, were put into place. Consequently, in the 1980s and 1990s, health policymakers began to pass public health policies concerning lifestyle factors, such as tobacco, alcohol, and later

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

on obesity, and the focus of health policy shifted from the individual to the collective level (healthy cities, schools, worksites, hospitals) (Hunter, Marks, and Smith, 2010). In the 1980s, disease-focused programs increased with the return of infectious diseases, especially the AIDS epidemic, and gave rise to public health in the domain of infectious diseases (Baum, 2008).

The renewed focus on public health has also been labeled *new public health*. It denotes the renewed focus on population health policies, which included lifestyle-related risk factors, such as tobacco and excessive drinking, as health problems along with the response to new epidemiological problems, such as AIDS. The term *new public health* was formulated in the 1980s in order to distinguish the "new" public health policies at the time from old public health, which mostly focused on quarantine regulations, programs for immunization, clean water, and safe food legislation (Baum, 2008). New public health added elements such as environmental health and health promotion. One of the main proponents of this new paradigm in public health was the World Health Organization (WHO) that evaluated its member states and demanded more preventive health policies (WHO, 2000, 2002). Since the 1970s, there was a series of milestones of reports, international activities, strategies, and treatments with regard to encompassing health policies that included prevention and disease treatment. In the 1970s, it was the abovementioned Lalonde Report and the WHO Alma Ata Declaration of 1978. In the 1980s, goals and targets concerning "health for all" were established in Europe and North America, including behavioral risk factor programs. In the 1980s, the milestone was the Ottawa Charter for Health Promotion, the launch of the European Healthy Cities Programs and the Adelaide Statement on Healthy Public Policy. In the 1990s, there was the 1991 Sundsvall Health Promotion Conference (1991), the UN's Rio Earth Summit Agenda 21, the Global Health Cities Program, and the Jakarta Conference on Health Promotion, in 1997. In 2004, the FCTC (Framework Convention on Tobacco Control) treaty passed, which commits signing members to increase tobacco control policy (Orme et al., 2003; Baum, 2008). In 2013, a global action plan against noncommunicable diseases was passed (WHO, 2013a).

Consequently, the context for health policy changed again. Disease pressures, health policy ideas, and the economic and fiscal context

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

changed in a way that created a more favorable context for the coordination and integration of health care and public health.

1. *Health problems:* There are two important factors with health problems that help us to understand the shift in the health policy agenda. First, there is the increasing importance of noncommunicable diseases that are caused by lifestyle and the return of infectious diseases. Beginning in the 1970s, the prevalence of noncommunicable diseases became increasingly clear. Cancer rates that are related to lifestyle causes peaked in the 1970s, especially lung cancer, which could easily be addressed by tobacco control policies. The development of other kinds of cancer and different noncommunicable diseases, has, however, been an increasing problem since the 1970s (OECD, 2017). Second, with the advent of AIDS, epidemic diseases returned to the agenda of health policies and shifted the focus back to public health. New forms of infectious diseases, such as SARS and HNV1, but also fears of bioterrorism and the increasing occurrence of bacteria that are resistant to antibiotics, such as new tuberculosis bacteria, are part of this development that put the focus back on communicable diseases (Tulchinsky and Varavikova, 2009; WHO, 2013b).
2. *Ideas:* Ideas have been another important element concerning changing relations of health care and public health in the last thirty years. This concerns two levels of the analysis. First, since the 1980s, there has been a time of retrenchment in welfare state policies, which came along with at least a stagnation of social expenditure and budget consolidation in the 1990s. However, most countries did not significantly reduce their health expenditures, certainly not in the sense of investing less in clinical care and at the same time more in preventive and collective services (Wagschal and Wenzelburger, 2008; OECD, 2017); however, the cost of health policy, especially health care, became a topic of public discourses (Baum, 2008, 29). Second, critical voices about the role of medicine became louder. Several authors, most of them doctors, suggested, already since the 1970s, that it is necessary to develop a new medical model, which not only encompasses the aspect of treating existing diseases in a clinical face-to-face intervention, but also includes psychological and social factors in relation to patient,

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

doctor, and disease (Adler, 2009; Fava and Sonino, 2008; McLaren, 1998; Herman, 1989; Schwartz, 1977, 1982; Engel, 1977, 1978, 1980). At this time, these authors demanded the inclusion of the behavioral and social dimension into the education of doctors and nurses, the research of medical systems, and modes and types of treatment (Engel, 1980; Kleinman, 1978).

3. *Economic and fiscal development:* From an economic and fiscal perspective, the context also changed for health policymakers. Beginning in the 1970s, when the oil crises brought constant economic growth to an end and public budgets began to become tighter, there was also an impact on health policy (Pierson, 2001; Korpi and Palme, 2003). Also in the early 1970s, many governments sought to reform the health care sector in order to contain costs, especially for medical treatment. One element of these reforms was the reduction in hospital capacities, but also reforms of hospital financing. As of the 1980s, governments began to reduce capacities in hospitals (OECD, 2017), but tried also to rationalize treatment by introducing DRG programs that aimed to reduce the costs of individual care (Rothgang, 2010), especially in countries where health expenditure continued to rise (Weisbrod, 1991; Braun and Uhlmann, 2009; Gilardi, Füglister, and Luyet, 2009).

As a consequence, the contextual condition changed to be more favorable for public health policymaking as well as the responsiveness, coordination, and integration of both sectors.

> ***Contextual condition t3:*** *During t3, pressure of health problems, experiences with health policy, and the fiscal and economic development made the context more favorable for responsiveness and integration of health care and public health.*

4.5 Implications for the Country Studies

The discussed theoretical conditions lead to expectations regarding the responsiveness and distinctiveness of the health care and public health sectors in various countries. The basic assumption is that – overall – context is more or less similar for all developed democracies, in each time period, and thus we can propose a condition regarding how favorable context is for responsiveness and integration for each time period, which can be applied to all five countries in the sample.

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

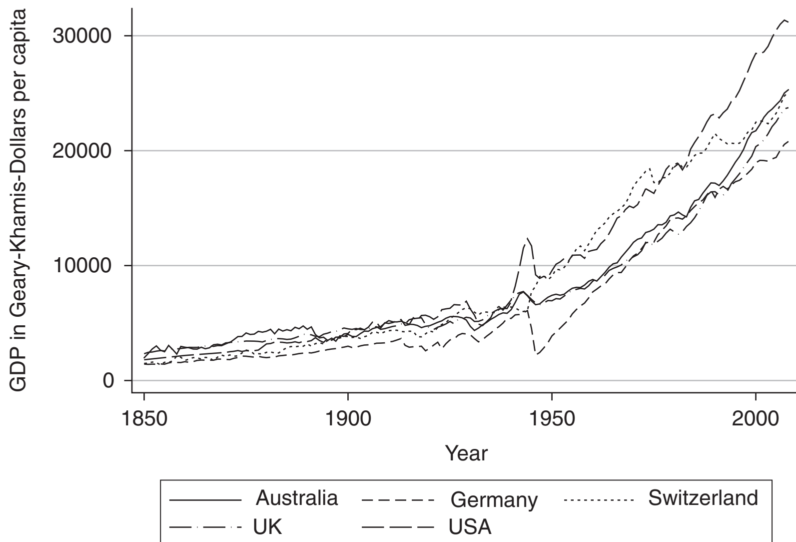

Figure 4.3 Development of GDP in selected countries.

It is reasonable to assume that in the long run, disease pressure adapts similarly across countries, for example, tuberculosis cases, as long as the absolute economic development is similar, which is the case for the countries selected for this study (Colgrove, 2002; McKeown, 1979) (see Figure 4.3).

During the first sequence, t0, health care and public health emerged as two different policy sectors. The contextual condition at that time was favorable to public health and the unification of both sectors. The reason for this was that infectious diseases were the most pressing health problem. At the same time, the possibilities that medical care provided to cure infections were limited. Eventually, this was a time period in which policymakers conceptualized policy interventions aiming at preparing the population for competition with other nations. During the second sequence, t1, the contextual condition regarding the relation of health care and public health changed slightly. Overall, context was still favorable for public health policymaking and the unification of both sectors; however, the economic situation worsened in the interwar period. Due to the long economic and fiscal crisis, we can expect distributional conflicts between the two sectors (Table 4.1).

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

Table 4.1. ***Summary of contextual conditions of health care and public health.***

Sequence	Contextual elements	Contextual condition
t0 1850–1918	Infectious diseases very problematic, limited medical possibilities, competition of nations	Favorable to responsiveness and unification
t1 1918–1945	Infectious diseases still important, improved medical possibilities (immunization), competition of nations, economic crisis	Favorable and not favorable to responsiveness and unification
t2 1945–1970	Success of prior public health policies: infections under control, economic prosperity, public health associated with autocratic and Communist governments	Not favorable to responsiveness and unification
t3 1970–2010	Noncommunicable diseases, criticism of medical focus in health policy, end of economic growth and begin of budgetary austerity (especially in 1990s)	Favorable to responsiveness and unification

In the postwar period (t2), the contextual condition changed and became less favorable to policy integration. The main reason for this was the success of the public health policies that had been put into place as well as the milestones in medical development, especially during the 1940s. The latter permitted the development of cures for infections and immunization of the population. Another reason was the change in the ideational context during the postwar period in which some governments in Western Europe, North America, and Australasia associated public health policy with Communist ideas, because this had encompassing state governed health systems. Yet, the contextual condition changed again during the fourth sequence (t3) and became more favorable to public health policies and policy coordination and integration of the two sectors. One reason for this is that the pattern of disease changed toward more noncommunicable

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

diseases, which are difficult to cure and need to be prevented, such as promoting nonsmoking. Another element that shifted the context for health policymaking was that many scholars criticized the prevalent medical model as focusing too much on individual medical care while neglecting sociological elements.

With these contextual premises in mind, the next sections will discuss the research design of the country studies, which form the main part of the empirical analysis in this book.

4.6 Case Selection for Country Studies

With the case studies, the research design of this book follows prominent authors in political science who pursue comparative historical analyses. According to Mahoney and Rueschemeyer (Mahoney and Rueschemeyer, 2003), comparative historical analyses have a long tradition in the social sciences. Works in the field focuse on the evolution of welfare states (Esping-Andersen, 1990; Immergut, 1992; Huber and Stephens, 2001; Pierson, 2004), political economies (Thelen, 2004; Steinmo, 2010), state formation, and the emergence of democratic and authoritarian regimes, among other topics (Linz, 1996; Mahoney, 2001). Some of these authors have argued that comparative historical analyses are often used to tackle big questions in political science through comparative analyses of historical sequences (Tilly, 1984; Pierson, 2000, 2003), which allows for a careful tracing of causal mechanisms by analyzing a small number of cases in a contextualized manner (Mahoney and Rueschemeyer, 2003). This is a suitable approach since it is the goal of this book to improve our understanding of the historical development of sectorial coupling and coevolution.

This book combines historical analysis with concepts rooted in comparative public policy analysis. Public policy analysis often focuses on one specific policy, in a certain time period, or an important reform in a policy field (Fischer, Miller, and Sidney, 2006; Howlett, Ramesh, and Pearl, 2009; Knoepfel et al., 2011; Weimer and Vining, 2005). Thereby, agenda setting and decision-making processes are at the center of attention, including partisan influence (M. Schmidt, 1996) or broader actor constellations, such as advocacy coalitions (Sabatier, 1993). Oftentimes public policy analysis takes a comparative approach, such as a comparison of one

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

or several policies in different countries or different policies in the same country (Dodds, 2012), frequently with the goal to promote learning between policymakers (Rose, 2004). The following analysis combines some of the actor-centered concepts of comparative public policy with a comparative historical analysis. This allows to forge a connection between professionalism, unified government, context, and the coupling of policy sectors at different analytical levels, namely actors, policies, and institutions over a long time period (Pontusson, 1995).

To carry out the country level analysis, this book proceeds with a comparative analysis of the coevolution of the health care and the public health sectors in Australia, Germany, Switzerland, the United States, and the United Kingdom. The selection of these countries follows a similar systems design (George and Bennett, 2005; Gerring, 2007). From the outset the comparative case study approach follows what Blatter has called a covariational approach. Ideally, this approach explains the variance in the outcome y based on the variation in the independent variable x, whereas some control variables are kept constant (Blatter and Blume, 2008; Blatter and Haverland, 2012). The selected countries are similar in the sense that they are developed democracies, OECD members, and followed similar paths in their evolution into modern states. They vary, however, in professionalism, institutions of interest intermediation, and unified government. Therefore, we can expect to find differences in the coupling of the health care and the public health sectors (Geddes, 2003).

According to the configurations of professionalism, interest group inclusion, and unification (strength) of government, we should find differences regarding the coupling of the health care and the public health sectors (see Table 1.1). The United States is a case of politicized health professions and pluralist interest intermediation on the one hand and fragmented government on the other (Henisz, 2000; Hall and Soskice, 2001; Macdonald, 1995, 66–99). Consequently, we can expect that there is loose coupling of the health care and the public health sectors. Switzerland has politically weak health professions and a corporatist form of interest group inclusion. In addition, government is fragmented and has many veto points (Vatter, 2014; Macdonald, 1995, 66–99; Hall and Soskice, 2001). Therefore, both sectors should be decoupled. To analyze a case of tight coupling, this book examines

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

Australia, because it displays a combination of unified government, i.e., a centralized federation (Painter, 2009), and high professionalism (Macdonald, 1995, 66–99) as well as pluralist interest intermediation (Hall and Soskice, 2001). To account for the fact that federalism is important, and there might be a difference between centralized federations and unitary countries (Hueglin and Fenna, 2006), we also include the United Kingdom in the analysis, which is a case of unified government, but also strong professionalism (Macdonald, 1995, 66–99) and pluralist interest intermediation (Hall and Soskice, 2001). I expect to find decoupling in both Australia and the United Kingdom. Finally, Germany combines low professionalism (Macdonald, 1995, 66–99) and corporatism with unified government (M. Schmidt, 2005a), because it is a centralized federation. Accordingly, there should be noncoupling of health care and public health.

I assume that contextual factors are similar for all countries. In other words, these countries became rich democracies during the twentieth century in contrast to non-OECD countries (Figure 4.3).[5]

The selected countries are also similar regarding the evolution of diseases. In a nutshell, along with these nations' economic development, infectious diseases became less visible in all five countries. At the same time, noncommunicable diseases increased, especially different forms of cancer. This chapter does not present the exact figures for each country regarding the evolution of diseases because the available statistics are not really comparable. Nevertheless, the trends are similar in all the countries under consideration in this book.[6]

4.7 Data, Operationalization, and Method

To examine the coevolution of the health care and the public health sectors, this book analyzes the institutional and organizational development of health policy, actor constellations, relationships between private actors of both sectors regarding the politicization of the other sector, and the coordinated and integrated policy output of both sectors over time. This allows me to trace the distinctiveness and responsiveness of the two policy sectors at the level of actors and institutions. This book examines the actor groups that are important to put the main issues of the policy sector on the political agenda and whether they belong to one of the two sectors. Furthermore, the analysis examines whether the actors of the two sectors are

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

responsive to one another, for instance, if they support the other sector with regard to agenda setting or lobbying for specific issues or if they form a discourse coalition. Concerning the institutional level, I research if the main laws, jurisdictions and public sector organizations for health policy create distinctive institutional arenas. In addition, this book examines if the sectors are connected by common policies and policy programs that entail prevention and care in health policy or individual and population level approaches against certain diseases.

Table 4.1 shows the operationalization of distinctiveness and responsiveness more precisely and the specific indications used to understand the coupling of the health care and the public health sector, which were discussed in the previous chapters. This book examines distinctiveness and responsiveness of coupling in policy sectors. Distinctiveness is at issue if the health care and the public health sectors are located in different institutions, such as ministries or administrative units. Another indication of sectorial distinctiveness is if the sectors are located on different levels of government. Responsiveness analysis relies on qualitative information, more specifically, this book looks at whether private actors, such as professional organizations of both sectors are politically active and visible in the political process. If this is the case, and they are supportive of the problems of the other sector (especially if the medical profession supports public health policies), responsiveness is present. In contrast, if there are conflicts between both sectors' actor groups, responsiveness is absent. As far as policy integration is concerned, this analysis researches whether there are specific policies integrating both policy sectors, such as health strategies combining prevention and cure for cancer patients.

Despite the logically covariational approach to the case studies, the analysis focuses on the dependent variable, i.e., distinctiveness and responsiveness of health care and public health. The observation of the independent variables remains in the background of the analysis. To put it differently, the narrative accounts for changes in unified government, i.e., the de/centralization of legislative competences and veto points at the national level, conditions for health professions' and interest groups' political activity, and contextual changes are in the background of the analysis.

The main sources of information for this book are secondary literature and some documents that contain information concerning

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

the relation of the two policy sectors to each other. Most important are, however, books and articles in scholarly journals. These are mostly works by historians, but also political scientists and public health scholars. In order to find these works, I conducted searches in catalogues of libraries and Internet search engines, using a series of keywords. Among these keywords were "public health," "public health policy," "health policy," "public health care," and "prevention" mostly in combination with one of the five country names (Australia, Germany, Switzerland, UK/England/Great Britain, US/United States). Respective equivalents were used in German such as "Gesundheitspolitik," "Öffentliche Gesundheit," and "Prävention" in order to find the essential books and articles for Germany and Switzerland. To select among the numerous articles and books retrieved by the search, the analysis focuses on those that mention public health policy in general and/or with regard to the historical development of public health or health care policies. Furthermore, articles on specific public health issues, such as tobacco control, were added to the analysis if they made a general contribution to public health policymaking in one of the countries or examined public health policymaking from a comparative perspective. Most of the journal articles could be accessed online and the necessary books for Europe and North America through interlibrary loan. I had the opportunity to access some additional books on Australia, that were not available in Europe, during a research stay at the National Library of Australia in Canberra.

The second source of information are semistructured expert interviews, which were conducted in the context of a research project by the Swiss National Science Foundation.[7] We conducted interviews with experts, interest groups, members of the administration, and policymakers. A detailed (anonymous) list of all interview partners and an example of the interview guidelines can be found in the appendix to this book. The interviews were thematically structured around two topics: public health and health care policy in general, and tobacco control policy.[8] The interviews were conducted on the basis of a guide with some basic questions/topics, which we shared beforehand with the interview partners when needed. We recorded the interviews and made a summary of the results with regard to the most important variables of this research project, namely distinctiveness and responsiveness of health care and public health as well as the importance of unified government and professionalism (Table 4.2).

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

Table 4.2. *Operationalization of key variables and sources.*

	Measures	Sources
Dependent variable (coupling of policy sectors; main focus of analysis)	*Distinctiveness*: events institutionalizing health care and public health (appendix). i.e., public health legislation, such as public health acts regarding food safety or quarantine, but also protection against risk factors. Health care legislation, for example, the establishment of a national health insurance or a national health service. *Presence of distinctiveness*: location of sectorial institutions in different ministries and administrative units and/or different levels of government. *Absence of distinctiveness*: sectorial institutions in the same ministry/administrative units/levels of government.	Secondary literature, interviews
	Responsiveness: behavior of private and public actors. Support of health professions and interest groups for the other sector. Interaction of public actors from both sectors. *Presence of responsiveness*: private actors of sectors publicly support policies of the other sector (mutual support for agenda setting) – discourse coalition; e.g., doctors and medical organizations are politically active regarding public health policies, such as tobacco control policies. *Absence of responsiveness*: private actors are not politically active regarding the policies of the other sector, i.e., doctors are only interested in health care governance; conflicts between actors from both fields, for example, conflicts regarding expenditure for health care vs. public health policies or about research funds.	Secondary literature, interviews

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

Table 4.2. ***(cont.)***

	Measures	Sources
	Policy integration: common policies that combine health care and public health principles. For example, tobacco strategy, noncommunicable disease strategy, cancer strategy.	Secondary literature, interviews, official homepages (e.g., ministry of health)
Independent variables (back-ground of analysis)	*Unified government*: development of the distribution of competences between the national and the subnational governments; i.e., is there increasing centralization of legislative competences, in general? Changes in veto structure or type of government over time	Secondary literature, interviews
	Professionalization/Institutions of interest intermediation: Political activity of health professions in general. How visible are they in the political process independently from the relationship between sectorial actors	Secondary literature, interviews
	Context: Information presented in chapter three. In addition, this book uses some of the information that came out of the case studies, but no directed search for contextual elements in the countries	Secondary literature, interviews

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

This book relies mostly on qualitative data analysis, which entails on the one hand the recording of events (Braun and Trein, 2014), such as in the case of legislation/institutionalization of the health care and the public health sectors. On the other hand, this book looks at actor coalitions to understand who are the actors, interest groups, and members of public administration that support public health issues and bring them to the political agenda and keep them on it. The strategy for the presentation of the results comprises qualitative historical case studies that discuss distinctiveness and responsiveness of the two policy sectors (Chapters 5–9). In Chapter 10, I also demonstrate the coevolution of the health care and the public health sectors based on a quantitative description reform activity over time.

4.8 Discussion and Summary of the Approach

The research design and method used in this book is in some ways unusual for comparative public policy analysis. Notably, this book approaches its topic with a historical analysis of institutions providing interesting and unique insights on the development of two related policies. This analysis shows how the health care and the public health sectors evolved over time by taking into consideration the relation of both fields to each other. Such an analysis could also be used to examine the relation of other policy sectors to one another.

However, the long time period and the many countries under consideration necessarily come at a cost. In particular, it is not possible to assess the relationship between the two policy sectors at the same level as it is usually done in comparative public policy analyses that are based on qualitative case studies focusing on single or very short time periods. This is less of a problem with institutional distinctiveness, since institutions evolve slowly and if there are important changes they are hard to miss. Concerning responsiveness between policy sectors, it is difficult to get an entire picture of all the important events in which private actors have supported the issues of another sector, especially because this research is primarily based on the reading of secondary literature. Therefore, this book cannot give the same granular account of sectorial responsiveness compared to analyses that focus on one or two specific policies.

Nonetheless, the long time period and broad definition of policy sectors provide an historical overview and connect the emergence of

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press

the health care and public health sectors to their context. Although this approach forgoes a more formal analysis of actor relations, the case studies presented in the following provide an impression for the actor coalitions that connect the two sectors in these five countries. What is more, the interview material for three of the five countries helps to fill this information gap.

Another caveat that needs to be addressed is that the information acquired through the sources presented before is not the same for every time period. Since the interviews cover only the more recent periods, there is a considerable asymmetry in the available information. This can be an advantage as well as disadvantage, because on the one hand the analysis is more fine-grained, at least for the last time period, which is a good thing. Though, on the other hand, this is a shortcoming, because the interviews do not cover the coupling of health care and public health in the other time periods. Nevertheless, there is no satisfying solution for this problem because interview information for earlier time periods cannot be generated. To account for this shortcoming, this book relies on extensive and encompassing research of secondary literature.

To sum up, the research design of this book combines a covariational approach to case studies with a comparative historical analysis of five different countries, namely Australia, Germany, Switzerland, the United Kingdom, and the United States. Using a comparative historical design permits me to trace the historical origins and the relation of the health care and the public health sectors, including public health policymaking. The countries were selected based on their configuration of the main independent variables, namely unified government and professionalism as well as institutions of interest intermediation. Starting from secondary literature and expert interviews, this book will now examine institutional distinctiveness as well as responsiveness between policy sectors on the actor level from a historical perspective. This allows to demonstrate how the health care and the public health sectors are coupled and how the coupling evolved over time, but by including a focus on the interaction of actors and the integration of policies between the sectors.

https://doi.org/10.1017/9781108670883.004 Published online by Cambridge University Press