

Comparative Perspectives and Policy Learning in the World of Health Care

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ABSTRACT *The main point of this article is to explore the methodological questions raised by weaknesses in international comparative work in the field of health policy. The core question is how competent learning from one nation to another can take place. The article argues that there is a considerable gap between the promise and the actual performance of comparative policy studies. Misdescription and superficiality are all too common. Unwarranted inferences, rhetorical distortion, and caricatures, all show up too regularly in comparative health policy scholarship and debates. The article first describes the context of the health and welfare state reform debates during the past three decades. In almost all industrialized democracies, rising medical expenditures exacerbated fiscal concerns about the affordability of the mature welfare state. In reaction to pressure for policy change in health care, policy makers looked abroad for promising solutions to domestic problems. The following section takes up the topic of cross-national policy learning. Then, it critically reviews recent debates about health care reforms and addresses the purposes, promises and pitfalls of comparative study in health policy. The next section categorizes existing comparative health policy literature to highlight the character, possibilities and limits of such work. The concluding section returns to the basic theme: the real promise of comparative scholarship and the quite mixed performance to date.*

None of us can escape the “bombardment of information about what is happening in other countries” (Klein 1997). Yet, in the field of health policy that is the subject here, there is an extraordinary imbalance between the magnitude and speed of the information flows and the capacity to learn useful lessons from them.¹ There is, moreover, a considerable gap between promise and performance in the field of comparative policy studies. Misdescription and superficiality are all too common.

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Unwarranted inferences, rhetorical distortion, and caricatures – all show up too regularly in comparative health policy scholarship and debates. Why might that be so and what does that suggest about more promising forms of cross-national intellectual exchange? The main point of this article is to explore the methodological questions raised by concerns about the above weaknesses in international comparison in health policy. The core question is how competent learning from one nation to another can take place in health care policy.

To address that question, this article first describes the political context of health and welfare state reform debates during the past three decades. Section I argues that in almost all industrial democracies rising medical expenditures exacerbated fiscal concerns about the affordability of mature welfare states. Those concerns turned into increased pressure for policy change in health care and, with that, the inclination to look abroad for promising solutions of domestic problems. Section II takes up the topic of cross-national policy learning more directly, addressing some of the promises and methodological pitfalls of such work. The third section focuses on recent debates about health reform, skeptically reviews the claims of convergence among OECD health care systems, and explains the growth of scholarship on comparative health policy. The fourth section addresses the purposes, promises and pitfalls of comparative study in health policy. Section V groups these studies in categories that highlight the character, possibilities and limits of the comparative health policy literature. The concluding section returns to the article's basic theme: the real promise of comparative policy scholarship and the quite mixed portrait of the performance to date.

The Political Context: Welfare State Debates and Health Reforms 1970–2000

There is little doubt about the prominence of health policy² on the public agenda of most if not all of the industrial democracies. Canada's universal health insurance is a model of achievement for many observers, the subject of considerable intellectual scrutiny and the destination of many policy travelers in search of illumination. Yet both the national government and a majority of its provinces in recent years have felt sufficiently concerned about the condition of Canadian Medicare to set up advisory commissions to chart adjustments. The United States has been even more obvious about its medical care worries, with crisis commentary a fixture for decades on the national agenda. Fretting about medical care costs, quality, and access is not limited to North America. Disputes about reforming Dutch medical care have been ongoing for decades. Any review of the European experience would discover persistent policy controversies in Germany (burdened by the fiscal pressures of unification), in Great Britain (with recurrent debates about the NHS), and in Italy and Sweden (with great fiscal and unemployment pressures).³

The puzzle is not *whether* or *why* there is such widespread interest in health policy, but *why now*. And why has international evidence (arguments, claims, caricatures) seemed more prominent at the turn of the twenty-first century than, say, during the fiscal strains of the mid-1970s or early 1980s? What can be usefully said not only about the substance of the experience of different nations, but about the political processes of introducing and acting upon policy change in a national context?

There is a simple answer to these questions that, one hopes, is not simple minded. Medical care policy came to the forefront of public agendas for one or more of the following reasons. First, the financing of personal medical care everywhere became a major financial component of the budgets⁴ of mature welfare states. When fiscal strain arises, policy scrutiny (not simply incremental budgeting) is the predictable result. Secondly, mature welfare states, as Rudolf Klein (1988: esp. 219–224) argued in the late 1980s, face restricted capacity for bold fiscal expansion in new areas. This means that managing existing programs in changing economic circumstances necessarily assumes a more prominent place on the public agenda. Thirdly, there is what might be termed the wearing out (perhaps wearing down) of the postwar consensus about the welfare state. We see the effects of more than two decades of fretfulness about the affordability, desirability, and governability of the welfare state.⁵

Begun in earnest during the 1973–74 oil shock, with high levels of unemployment and persistent stagflation, bolstered by electoral victories (or advance) of parties opposed to welfare state expansion, critics assumed a bolder posture. Mass publics increasingly heard challenges to programs that had for decades seemed sacrosanct.⁶ From Mulroney to Thatcher, from New Zealand to the Netherlands – the message of serious problems requiring major change gained support. Accordingly, when economic strain reappears, the inner rim of programmatic protection – not just interest group commitment, but social faith – weakens, and the incentives to explore transformative but not fiscally burdensome options become relatively stronger. Those factors help to explain the pattern of welfare state review – including health policy – over the past three decades across the industrialized world. But, even accepting this contention, there still remains the question of why these pressures gave rise to increased attention to other national experiences.⁷

Recent experience illustrates how times of policy change increase the demand for new ideas – or at least new means to old ends. Rudolf Klein once argued “no one wants to be caught wearing yesterday’s ideas” (Klein 1996). Everywhere, policy makers and analysts looked increasingly across the border to search for the latest policy fashion. Just as some American reformers turned to Canada’s example, so a number of Canadian, German, Dutch, and other intellectual entrepreneurs reviewed American, Swiss, and Swedish experience in recent years. In the 1990s, many conferences followed this pattern. Conferees were interested in getting better policy answers to the problems they faced at home. For example, participants in one such conference held in the Netherlands in the mid-1990s were explicit about their aspirations for cross-border learning: how to find a balance between “solidarity and subsidiary”, how to maintain a “high quality health system in times of economic stress”, even an optimistic query about “what are the optimum relations between patients, insurers, providers, and the government?” (Report Four Country Conference 1995). Understood as simply wanting to stretch one’s mind – to explore what is possible conceptually, or what others have managed to achieve – this is unexceptionable. Understood as the pursuit of the best model, absent further exploration of the political, social, and economic context required for implementation, this is wishful thinking.

Others saw the opportunity for an informational version of this intellectual stretching: quests for “exchange of policy information” of various sorts without commitment to policy importation, “exchanging views with kindred spirits”, and

explicit calls for stimulation. All of this is the learning anthropologists have long extolled – understanding the range of possible options and seeing one's own circumstances more clearly by contrast.

But what about drawing policy lessons from such exercises? What are the rules of defensible conduct here and are they followed? The truth is that, whatever the appearances, most policy debates in most countries are (and will remain) parochial affairs. They address national problems, they emphasize national developments in the particular domain (pensions, medical finance, transportation), and embody conflicting visions of what policies the particular country should adopt. Only occasionally are the experiences of other nations – and the lessons they embody – seriously examined.⁸ When cross-national experiences are employed in such parochial struggles, their use is typically that of policy warfare, not policy understanding and careful lesson-drawing. And, one must add, there are few knowledgeable critics at home of ideas about “solutions” abroad. In the world of American medical debate, the misuse of British and Canadian experience surely illustrates this point. The National Health Service was from the late 1940s the specter of what “government medicine” or “socialized medicine” and “rationing” could mean. In recent years, mythmaking about Canada has dominated the distortion league tables in North America.⁹

The reasons are almost too obvious to cite. Policy makers are busy with day-to-day pressures. Practical concerns incline them, if they take the time for comparative inquiry, to pay more attention to what appears to work, not academic reasons for what is and is not transferable and why. Policy debaters – whether politicians, policy analysts or interest group figures – are in struggles, not seminars. Like lawyers, they seek victory, not illumination. For that purpose, compelling stories, whether well substantiated or not, are more useful than careful conclusions. Interest groups, as their label suggests, have material and symbolic stakes in policy outcomes, not reputations for intellectual precision to protect.¹⁰ Once generated and communicated, however, health policy ideas are adopted more readily in some contexts than in others. These patterns of adoption and adaptation have to do with the machinery of government, as well as with local cultural understandings. The autonomy and authority of government in parliament in the UK, for example, as well as its position at the apex of a nationalized health service, means that, “ideas can make a difference more quickly in Britain than in America” (Marmor and Plowden 1991: 810). It may be, too, that policy ideas transfer more easily between similar types of health systems. Institutional similarity – however notional – seems to have facilitated the spread of managed competition ideas among the national health services of northern and southern Europe (Freeman 1998).

This argument must be qualified, however. Lessons from abroad often meet strong local cultural resistance. Giaimo and Manow (1997: 197), for example, observe that “while the market has won in international terms, the national answers to the economic pressures resulting from economic globalization demonstrate that national “markets for ideas” have yet to be fully liberalized”. Morone (1990: 141) similarly remarks of Canada's experience with universal health insurance:

It is difficult to imagine a lesson that is more foreign to the American experience. Instead of hard conscious choices, we have sought painless automatic solutions.

Rather than explicit programmatic decisions Americans prefer hidden, implicit policies. Rather than centralize control in governmental hands, we would scatter it across many players. In short the Canadian lessons . . . are not just different – they challenge the central features of American political culture, at least as they have manifested themselves in health care policy.

It is not clear, then, whether what matters is administrative infrastructure as such or the values and assumptions it appears to embody. For it matters a lot not only how systems are configured in organizational terms but also how they are construed mentally (Freeman 1999). This probably amounts to something more than ideas and values as such, pointing to the significance of ways of thinking or “framing”. Different national policy communities – however well networked internationally – simply see problems differently.

For all this, the field of health policy is notable for the absence of studies which set out to investigate the process of transfer or learning in any specific instance. Bennett refers to the “paucity of systematic research that can convincingly make the case that cross-national policy learning has had a determined influence on policy choice in a particular jurisdiction at a particular time” (Bennett 1997). But, paucity of studies on policy learning does not apply to cross-national studies of policy origins, implementation, and change. Indeed, for that broader field of work, there are large and growing clusters of quite different sorts of scholarship and advocacy that address medical care cross-nationally.

None of these considerations are new – or surprising. But the increased flow of cross-national claims in health policy – both in the world of academia and politics – generates new reasons to consider the meaning of cross-national policy learning.

The Promise and Perils of Cross-national Comparative Policy Research

The presumptions of such cross-national efforts are important to explore, even if briefly. One is that the outside observer can more easily highlight features of debates that are missed or underplayed by national participants. The other is that comparative commentary may bring some policy wisdom as well as illuminating asides about national debates. The common assumption is that cross-cultural observation, if accurate and alert, has some advantages. It brings a different, “foreign” and arguably illuminating perspective to the debate.

A similar rationale lies behind much of the enthusiasm for contemporary comparative policy studies. Welfare state disputes – over pensions and medical care most prominently – are undoubtedly salient on the public agendas of all industrial democracies. There is in fact a brisk trade in panaceas for the various (real and imagined) ills of welfare states. As will be obvious in later comments on the comparative literature, however, many cross-national investigations are not factually accurate enough to offer useful illumination, let alone policy wisdom. But, properly done, studies that compare what appear to be similar topics have two potential benefits not available to the policy analyst in a single nation inquiry.

First, how others see a problem, how options for action are set out and evaluated, how implementation is understood and undertaken – all offer learning opportunities even if the policy experiences of different polities are not easily transplantable as

“lessons”. Secondly, where the context is reasonably similar, comparative work has features of a quasi-natural experiment. So, for instance the adaptation of reference prices for pharmaceuticals in Germany and in the Netherlands – two countries with very similar institutional arrangements in health care – provides an interesting example of policy learning. The policy of reference pricing constrains drug outlays in the short term. But those gains are somewhat dissipated as the actors strategically adapt to the new policy reality (Report Four Country Conference 2000).

Cross-national sources of information have proliferated to the extent that it has become almost impossible for a policy maker in any given country not to know something about what is going on elsewhere. But know what, exactly? What part can and should comparative policy analysis play in these debates? Ruud Lubbers, the former Dutch prime minister, provides a striking example of trying to draw lessons from American experience, apparently without much understanding of its policy realities (Lubbers 1997). In a 1997 article for the *International Herald Tribune*, Lubbers contrasted what he called the “lean welfare state . . . with rapid job growth” of the United States with “costly social welfare system[s] with persistently high unemployment in most of Europe”. He went on in the rest of the article to laud Holland’s “third way”, one that “tackled” the unemployment problem while “remaining within the European tradition that emphasizes quality of life rather than growth at any cost”. This rather self-congratulatory theme seems odd in comparison with contemporary Dutch complaints. But the point here is that the United States functions as a poorly analyzed symbol of a type of welfare state to avoid. Citing President Clinton as his source, Lubbers went on to write most of the article about the so-called Dutch miracle: a more flexible workforce, less unemployment, and a somewhat more restrained welfare state, all the result of the famous corporatist Wassenaar Agreement of 1982.

The American example is in fact hardly discussed, treated mostly as a negative symbol of what the Dutch have avoided.¹¹ Nowhere is there any recognition that the American welfare state is in fact quite extensive fiscally, concentrated on its older citizens, and with spending levels that – when properly accounted for in tax expenditures, direct program outlays, and the like – are hardly lean. Indeed, the point of recent books like Hacker’s *The Divided Welfare State* (2002) is precisely to set aside this common but mistaken impression of American social policy as concentrated on the poor; miserly in its levels of benefits; and, depending on one’s ideology, splendid or horrible in its social and economic results.¹²

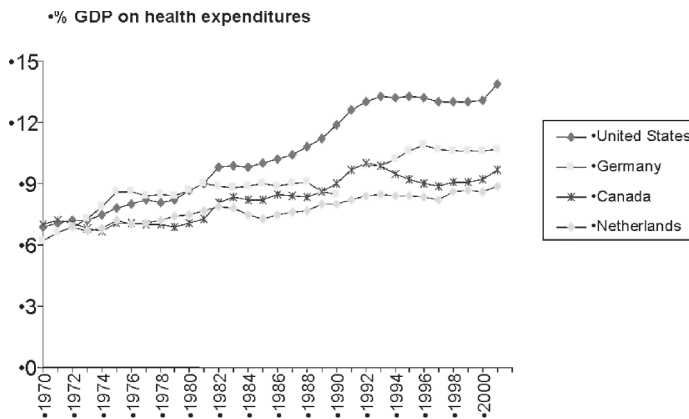
The paradox is that the post-1970 decades witnessed the rapid expansion of public policy research, of which a significant proportion claimed to provide comparisons across countries as a base for drawing lessons. But most of those studies, in fact, consisted of mere statistical and descriptive portraits of health systems, ignoring the methodological issues of comparison. So the argument here underlines the truism that policy making and policy research are often – if not always – pursued with little reference to each other. Nevertheless, the question remains as why that truism should apply so fully in this particular, costly area of public policy: health care. Why are claims about system convergence so widespread in the face of persistent patterns of continuity in national models of health care?

Convergence in the Health Reform Debate: Claims and Realities

The bulk of the ideological and fiscal debates about health reform took place within national borders, largely free from the spread of “foreign” ideas. To the extent that similar arguments arose cross-nationally, these mostly represented what might be described as “parallel thinking”. That is to say, the common questioning of health policy reflects similarities in circumstances and problem definition. This was obvious in the common preoccupation with rising medical care costs. Figure 1 portrays the upward pressure of medical care expenditures in four OECD nations since the early 1970s. Even while the four countries’ health expenditure rose steadily, they also varied in the growth rates over time. Obviously, some countries, in some periods, were more successful than others in reigning in health costs. This raises the question whether – and if so, to what extent – common pressure will cause system convergence.

One can think of convergence as “a kind of soft technological determinism”, the logic of which is that, across systems, “the common features will increase at the expense of the differences” (Field 1989: 13). This sense of convergence has intensified by the emergence in the late 1980s and 1990s of active international and supranational actors in both general welfare state disputes and, in particular, health policy. These actors include the European Union (EU), the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and the World Bank. But, however powerful these institutions are in some areas, their role in domestic policy making within the OECD world remains indirect and limited. The European Commission has established a policy competence in public health and has become a sponsor of biomedical research. Yet recent rulings of the European Court of Justice have had important spillover effects on national healthcare policies. EU legislation designed originally to ensure the freedom of goods, people, capital and services across borders no longer exempts the domain of health care. (Report of Workshop on EU Law and National Health Policy 2004). The WHO struggles to lead

Figure 1. Health expenditure in The Netherlands, Germany, Canada, US, 1970–2000 (percentage of GDP)



Source: OECD Health Data 2003.

health policy discussions, but remains a minor actor in the funding of medical care. And the World Bank, particularly powerful in the transformation of health care in eastern Europe, expresses some of the reform ideas found in the western industrial democracies, but does not wield its influence there. Finally, OECD reports certainly affect the discussion of welfare state issues, but at one step removed from policy decision making. But in spite of their limited direct role in health policy, the international agencies have become platforms for debate and carriers of policy ideas across borders.

Almost everywhere, health care became relatively more expensive as public budgets were more constrained – but how much more expensive and how much more constrained has varied substantially between countries. These pressures, in turn, are mediated by different sets of actors and institutions. It is important to note that debates over controlling health care expenditures took place everywhere, regardless of actual levels or growth rates of health spending. In short, the apparently common pressures on health systems are themselves uneven and indirect. And this is the essential difficulty in taking convergence as a framework for studying – or advocating – reforms in health policy. Quite simply, there is as much evidence of continued difference (or divergence) in national arrangements for the finance, delivery and regulation of health care as there is of increasing similarity. As a former official of the OECD's health policy unit claimed, “[T]he delivery and finance of healthcare vary between nations more than any other public policy” (Poullier 1989). One does not have to agree with Poullier's conclusion to see that reducing variation has been neither the purpose nor the effect of health reform in the past decades. In health care no more than in other areas of public administration are there good arguments or evidence that “one size fits all”.

To be fair, this variation is one of degree rather than of kind. At the most general level, it seems perfectly clear that some countries with roughly similar constellations of political interests, economic and political institutions and resources develop *broadly* comparable arrangements for health care. And so, in turn, when social structures, patterns of economic organization, and expressions of political interest begin to change, health care arrangements will face pressures to change also. But what matters is what that formulation leaves unsaid. While there is value in pointing to the structural and technological context of health policy, policy makers faced not only with multiple pressures but also with myriad proposals for change tend to choose options that are politically feasible in the short term. To them, an appeal to convergence seems anodyne, reductionist or superficial. Conditions are not determining. They explain only why there should be pressure for reform, but not whether or not change will indeed occur, let alone what shape or direction it will – or should – take.

Nonetheless, these conditions do help to explain why – if not when or where or how – cross-national trade in policy ideas should be going on and why it is increasing. For the more similar countries become in general, the more they may believe they can learn from each other. Getting it right in health policy – ensuring universal access to high quality health care without breaking the bank – makes for significant competitive advantage in the domestic political arena as well as in the international economy. Convergence in circumstances creates opportunities for learning, as well as an increased interest in applying lessons from abroad. Convergence theory, then, offers useful clues about why adaptive change might take place. It says much less, however, about the form it takes,

about why one solution to a problem should be preferred over others. And for that topic, the next section addresses the purposes, promises and pitfalls of comparative studies in health policy.

Purpose, Promise and Perils of Comparative Inquiry in Health Policy

The emphasis in this part of the discussion is on the following, perhaps obvious, distinctions among the purposes comparative analysis in health policy can serve: learning *about* national health arrangements and how they operate, learning *why* they take the forms they do, and learning policy lessons *from* those analyses. While these distinctions should be obvious to scholars of the subject, much of the comparative commentary on health care neither clarifies the different modes of comparison nor addresses the difficulties of drawing policy lessons from the experience of other countries.

First, there is the goal of learning about health policy abroad. Comparative work of this sort can illuminate and clarify national arrangements without addressing causal explanation or seeking policy transplantation as aims. Its comparative element remains for the most part implicit: in reading (or writing) about them, we make sense of other systems by contrasting them with our own and with others we know about. The process of learning entails, which is obvious once noted: appreciation of what something is by reference to what it is like or unlike. This is the gift of perspective, which may or may not bring explanatory insight or lesson drawing.

The second fundamental purpose served by comparison is to generate causal explanations without necessarily seeking policy transplantation: that is, learning why policies develop as they do. Many of the historical and developmental studies of healthcare fall into this category. This approach uses cross-national inquiry to check on the adequacy of nation-specific accounts. Let us call that a defense against explanatory provincialism. What precedes policy making in country A includes many things, from legacies of past policy to institutional and temporal features, that “seem” decisive. How is one to know if a feature is decisive as opposed to simply present? One answer is to look for similar outcomes elsewhere where some of those factors are missing or configured differently. Another is to look for a similar configuration of precedents without a comparable outcome.

A third and still different approach is to treat cross-national experience as quasi-experimental. Here one hopes to draw lessons about why some policies seem promising and doable, promising but impossible, or doable but not promising. All of these approaches appear in the comparative literature. And, with the growth of such writing, there was widespread optimism about the promise of lesson drawing from comparative policy analyses. But is that optimism justified?

One useful starting point to address this question is a cross-national generalization that at first sight seems misleading but, upon reflection, helps to clarify differences in the framing of policy problems. A 1995 article on European health reform, for example, claims that “countries everywhere are reforming their health systems” (Hunter 1995). It asserts that “what is remarkable about this global movement is that both the diagnosis of the problems and the prescription for them are virtually the same in all health care systems”. These globalist claims, it turns out, were mistaken (Jacobs 1998, Marmor 1999). But the process of specifying more precisely

exactly what counts as national healthcare problems – whether cost control, poor quality of care, or fragmented organization of services – turns out to be quite clarifying. In this instance, the comparative approach first refutes the generalization, but then helps to discipline the process of describing national health “problems”. So, to illustrate further, the European researcher coming to investigate Oregon’s experiment in health care rationing would soon discover that it was neither restrictive in practice nor a major cost control remedy in the 1990s (Jacobs, Marmor and Oberlander 1999). To do so is to see the issue of rationing more clearly.

Offering new perspectives on problems and making factual adjustments in national portraits are not to be treated as trivial tasks. They are what policy craftsmen and women might well spend a good deal of time perfecting. All too many comparative studies are in fact caricatures rather than characterizations of policies. A striking illustration is the 2000 WHO report mentioned above on the ranking of the performance of health systems across the globe. Not only was the ambition itself grandiose, but its execution evoked sharp criticism from serious scholars¹³ (Williams 2001). That criticism in itself should not serve as a deterrent to serious scholars who seek to compare experiences. But it is a warning against superficiality.

An often cited advantage of comparative studies is that they serve as an antidote to explanatory provincialism. An example from North American health policy provides a good illustration of how and how not to proceed. Some policy makers and academics in North America regard universal health insurance as incompatible with American values. They rest their case in part on the belief that Canada enacted health insurance and the US has not because North American values are sharply different. In short, they attribute a different outcome to a different political culture in the US. In fact, the values of Canada and the United States, while not identical, are actually quite similar (Lipset 1990). Like siblings, differences are there, sure, but Canada’s distribution of values is closer to that of the United States than any other modern, rich democracy. In fact, the value similarities between British Columbia and Washington State are greater than those between either of those jurisdictions and, say, New Brunswick or New Hampshire along the North American east coast. Similar values are compatible with different outcomes, which in turn draw one’s attention to other institutional and strategic factors that distinguish Canadian from American experience with financing health care (White 1995, Maioni 1998). One can imagine many other examples of such cautionary lessons, but the important point is simply that the explanatory checks are unavailable from national histories alone.

The third category of work is directly relevant to our inquiry. Drawing lessons from the policy experience of other nations is what has financially supported a good deal of the comparative analysis available. The international organizations have this as part of their rationale. The WHO, as noted, is firmly in the business of selling “best practices”. The OECD regularly produces extensive, expensive, hard to gather, statistical portraits of programs as diverse as disability and pensions, trade flows and the movement of professionals, education and health care. No one can avoid using these studies, if only because the task of collecting data and discovering “the facts” in a number of countries is so daunting. But the portraiture that emerges requires its own craft review. Does what Germany spends on spas count as public health expenditure elsewhere or does it fall, as in the United States, under another category?

Often the same words do not mean the same things. And different words may denote similar phenomena.

For now, it is enough to restate that learning *about* the experience of other nations is a precondition for understanding why change takes place, or for learning *from* that experience. Looking at the large and growing volume of comparative studies in health policy, we found that the vast majority of studies do not deliver on their claim to provide a sound base for drawing lessons from the experience of other countries. The section below categorizes the studies in four groups, each with its distinct purpose and applications. This grouping shows that the majority of reports and studies available (the first and second categories) provide, at best, a sound base for further analysis but hardly any ground for learning from experience abroad. The few studies that are based on more solid analysis (the third and fourth group) are less frequent, less wide in their geographical application and more modest in their claims about policy lessons.

Comparative Health Policy Analysis: Clusters of Writing

Health policy in the OECD world is, at the same time, a matter of insistent national debate, a frequent topic of descriptive, statistical portraiture for international organizations, a sometime subject of publication in the comparative journals, and only very infrequently in its cross-national comparative form the object of book length treatment. For many years, readers had to turn to Anderson's (1972) treatment of Swedish, British and American medical care developments in the post-World War II period for acute, well-informed judgments.¹⁴ There were many other individual country studies, but few if any that employed a systematic, comparative method of policy analysis. In contemporary debates about Dutch health care, for instance, there appears little evidence of detailed understanding about German – or American – policy experience with health care reform in the 1990s. What is true for medical care applies just as well to other fiscally important areas of the welfare state. So, for example, American discussions of disability policy in the early 1980s drew very little from Dutch experience, though there were knowledgeable scholars in both countries who sought to have influence (Wilensky 2002).¹⁵

By the end of the 1980s, political scientists – particularly North American ones – had become interested in comparing relations between the medical profession, as a particular kind of interest group, and the state (Tuohy 1974, Stone 1984, Freddi and Bjorkman 1989, Wilsford 1991, Immergut 1992, Pierson 1994). Their theoretical focus was by and large on the institutions of government and the different ways in which they shape health care politics. Slowly, the field began to produce genuinely comparative political analyses of substantial industry and competence.

The ten years and more since then have witnessed a rapid expansion of cross-national health policy literature. The quality of these works varies enormously – whether measured by the standard of intellectual rigor, theoretical perspective, descriptive accuracy, or concern for systematic policy learning across borders. There are, roughly speaking, four separable but not mutually exclusive categories of such writing (Marmor and Okma 2003).

The first includes the well-known statistical, largely descriptive documents that provide data on a number of countries assumed to constitute a coherent class. It also includes more specialized surveys that deal with public opinion, health care

and health policy (Blendon and Brodie 1997). In that way they supply much of the basic information that policy commentators explore. The OECD Health Data series has become a staple of both academic and more applied analyses alike. These studies typically neither provide behavioral hypotheses nor test explanations for why certain patterns exist. Nor do they, generally speaking, explicitly deal with the promise and pitfalls of cross-border learning. In a wider sense, the recent efforts to rank systems, countries or institutions by means of benchmarking techniques belong to this group, too. In the report we noted above, the WHO used its comparative data to rank the performance of national health care systems (WHO 2000).

The second category of comparative studies – by far the largest number – includes collections of international material, that we label as “parallel” or “stapled” national case studies. Examples of this kind of cross-national study are the volumes by Ham *et al.* (1990), OECD (1992, 1994), Wall (1996), Altenstetter and Bjorkman (1997), Ham (1997), Raffell (1997) and Powell and Wessen (1999) as well as the national portraits of the WHO European Observatory. These are usually country reports bound together, accompanied by an editorial introduction and summary conclusion. For the most part, the authors are intent on setting out “how things work” in whichever country they are writing about. They are mostly descriptive, but with some assessment of performance and the flagging of issues prompting political concern. As such, they represent a qualitative correlation of the quantitative statistical studies described above. Done carefully, they are an invaluable resource for cross-national understanding. In many cases, they leave readers to find what is relevant and, as far as policy learning is concerned, leave them to do the work.

Thirdly, there are books about a number of individual countries that employ a common framework of analysis, usually addressing a particular theme in health policy, for example competition or privatization. That means, in principle, that comparative generalizations are possible, though not all such works actually draw them.¹⁶

Fourthly, there are cross-national studies with a fundamental theoretical orientation that take up a specific medical care theme or question as the focus of analysis.¹⁷ One of the interesting features of this fourth category of comparative studies is that there appears a necessary trade-off between theoretical depth and the number of nations studied. The disciplined treatment of broad topics by a single author almost inevitably addresses a more limited set of countries.¹⁸

In this latter category, Tuohy’s (1999) *Accidental Logics* offers both a theoretical and empirical analysis of policy change and continuity in three English speaking nations. The book addresses a limited range of countries but combines theoretical sophistication with command of the relevant factual data, and causal analysis in addressing the quite different patterns of policy change during the post-World War II years in Britain, Canada and the United States. The likelihood of major policy changes, for Tuohy, differs according to each nation’s particular “institutional mix”. By that, she means the degree of governmental hierarchy, market forces and professional collegiality in medical decision making and the “structural balance” between the state, medical providers and private financial interests. Directed at understanding, Tuohy’s work is of clear relevance to policy makers concerned with questions of timing for reform initiatives.

Works in this fourth category of scholarship typically use comparative methods to explore and to explain policy developments. Their practical limitations for policy makers include the relatively restricted range of countries studied and, to some degree, their reliance on the theoretical perspective known as historical institutionalism. There is some irony in the fact that the most careful cross-national analyses tend to have reinforced a sense of the contingency and specificity of the way things work out at different times in different places. This kind of comparison seems to ignore (if not implicitly deny) the cross-national exchange of information and ideas in health policy that is so much part of the very intellectual environment in which it has been produced. The most powerful studies are at the same time the most academic; the practical learning which might result from comparison is largely left implicit. Often, those books do not reach the desks of policy makers. There is much less here which speaks directly to the policy maker seeking to use evidence and experience from elsewhere in any straightforward way. Nonetheless, in the course of little more than a decade, the comparative analysis of health policy became a specialized field of academic inquiry, highly developed and successful in its own terms, but limited so far in its policy impact. So, we turn back to the question: how should we evaluate the purposes and performance of comparative policy research?

Perhaps the most important lesson we can draw from the overview in the current literature is that the development of a serious body of comparative work takes more time and effort than health policy makers are willing to spend. They feel pressures to take action and feel they cannot wait. At the same time, policy errors based on misconceptions of the experience abroad can be costly. The eagerness of some health ministers to embrace and import policy models from the US like the managed care models, the benchmark methodology or the medical savings idea without a proper assessment of how those ideas and models worked out in practice may lead to policies that will require repair action soon, can force politicians to reverse policies and can erode the popular support for health policy altogether. The unwillingness of some politicians to delay action in order to study experience with similar policy elsewhere contrasts sharply with the practice of some Asian countries that have spent much time and attention before adjusting certain measures to their own national policy environments. The good news is that the last two decades have brought a large body of comparative research that can serve as the base for the next generation of studies that take the above warnings into account. The statistical data are there, the materials are there, the experience in drawing portraits of individual countries is there and all of these are necessary conditions for the next phases of learning about policy causation and the crossnational transfer of policy experience.

Summary and Conclusions

The last decades have seen a growing body of comparative study in health policy, but this growth was not matched by a growing understanding of the processes of policy learning from the experience of other countries. There is, in fact, little attention to methodological questions about this learning process.

The confluence of economic, demographic and ideological factors that led to extensive debate about the future of the welfare state also created pressure to reform health care systems. Fiscal strains and declining political support for an active role of

the state undermined support for welfare state expansion and that strain also affected health policy. There was, indeed, growing pressure to seek out new policy solutions abroad. That pressure also gave rise to a new body of research within national communities as well as international agencies like the World Bank, OECD, WHO and European Union. However, to date most of that research consists of merely descriptive studies of health care systems and policy measures within national boundaries. The studies pay little attention to the question of what experience can be applied in another country under what circumstances. Institutional and cultural factors are important elements in the policy context as determinants of successful reception and implementation of ideas.

In practice, there is much mislearning and misrepresentation by omission. Policy makers and politicians feel pressured to change, but have little or no time (or willingness) to critically assess claims about policy experience across the border. Potentially, comparison can bring learning opportunities as other countries can serve as natural experiments, in particular when the policy contexts are similar. Some lessons apply across many different countries. Similar pressure can create opportunities for learning, and international organizations serve as platforms for debate and potential sources for comparative studies. Existing research largely ignores the important difference between the process of learning about other countries' experience, learning why certain change takes place, and drawing lessons from that experience. But the basic ingredients for improved policy learning are there: the statistical database, the first generation of descriptive country studies and the experience of academics and international organizations.

Notes

1. This skeptical argument is advanced, with Anglo-American examples from medical care and welfare, by Marmor and Plowden (1991: 807–812). On the other hand, there is very rapid communication of scientific findings and claims, with journals and meetings regarded as the proper sites for evaluation. As yet, there is no journal in the political economy of medical care that has enough authority, audience, or acuteness to play the evaluative role assumed in the medical world by *The New England Journal of Medicine*, *Lancet*, *BMJ*, or *JAMA*.
2. Readers may be puzzled by our reluctance in this note to treat “reform” as the object of commentary. This paragraph’s parade of substitutes – health policy, concerns, worries, and so on – reflects discomfort with the marketing connotations of the “reform” expression. That there are pressures for change are obvious and understanding them is part of our gathering’s point, but reforming can obviously be a benefit, a burden, or beside the point.
3. In the 1990s work in English on health policy learning was for the most part concerned with a single topic, managed competition. This topic dominated reform discussion across countries between the mid-1980s and the mid-1990s. However, the focus was largely on the transatlantic relationship between the US and the UK (Klein 1991 and 1997; Marmor and Plowden 1991; Mechanic 1995; Marmor 1997; Marmor and Okma 1998; O’Neill 2000). There were complementary treatments of western Europe (Freeman 1999), southern Europe (Cabiedes and Guillen 2001) and New Zealand (Jacobs and Barnett 2000).
4. Technically, this is not strictly true of course, as is evident in the sickness fund financing of care in Germany, the Netherlands, and elsewhere. But, since mandatory contributions are close cousins of ‘taxes’, budget officials must obviously treat these outlays as constraints on direct tax increases. Moreover, the precise level of acceptable cost increases is a regulatory issue of great controversiality.
5. The bulk of this ideological struggle took place, of course, within national borders, free from the spread of “foreign” ideas. To the extent similar arguments arose cross-nationally, as Kieke Okma has

- noted, most represent “parallel development” (Report Four Country Conference 1995). But there are striking contemporary examples of the explicit international transfer and highlighting of welfare state commentary. Some of this takes place through think-tank networks; some takes place through media campaigns on behalf of particular figures; and, of course, some takes place through academic exchanges and official meetings. Charles Murray – the controversial author of *Losing Ground* (1984) and co-author of *The Bell Curve* (1994) – illustrates all three of these phenomena, as our British conferees can attest. The medium of transfer seems to have changed in the postwar period. Where the Beveridge Report would have been known to social policy elites very broadly, however much they used it, the modern form seems to be the long newspaper or magazine article and the media interview.
6. This is the argument developed in Marmor, Mashaw, and Harvey (1990: esp. ch.3). The wider scholarly literature on the subject is the focus of a review essay (Marmor 1993).
 7. The turning to US health policy experience for lessons about cost control or insurance coverage seems particularly puzzling to American scholars preoccupied with health care problems at home.
 8. Some readers have suggested this article is too pessimistic about the field of cross-national policy learning. And it is certainly true that some cross-national investigations have been enormously illuminating and helpful. For example, the 1964 Royal Commission on Health Services was an exemplary investigator of the experience of other countries. In the 1990s comparative policy investigations by Japanese and German analysts were important in nursing home reforms in both countries.
 9. For an elaboration of this point, see Marmor (1994: ch.12). A particularly careful and extensive treatment of the North American experience is the review article by Evans, Barer, and Hertzman (1991).
 10. The political fight over the Clinton health plan vividly illustrates these generalizations. The number of interest groups with a stake in the Clinton plan’s fate – given the nearly \$1 trillion medical economy – was enormous; there were more than 8,000 *registered* lobbyists alone in Washington and thousands more trying to influence the outcome under some other label. The estimates of expenditures on the battle are in the hundreds of millions; one trade association, The Pharmaceutical Manufacturer’s Association, spent \$7 million on “public relations” by 1993. The most noted effort was that of the Health Insurance Association of America, which produced the infamous Harry and Louise advertisements. Washington was awash in interest group activities during the health care reform battle of 1993 – 94, but the character, impact, and meaning of those activities are far from clear.
 11. One of the Dutch policy commentators in a chapter dealing with cross-national perspectives on the Dutch welfare state and its health system strikingly illustrates how one can oddly justify not learning much from comparative policy studies. “Comparative studies”, he writes, “are generally backward looking, so don’t always provide us with the right answers for the future” (personal interview 2004). The restrictive definition of the purpose of comparative inquiry – getting the “right answers” – limits greatly what this Dutch public servant would consider useful.
 12. As Hacker (2002: 7) rightly points out, the “share of the US economy devoted to social welfare spending is not all that different from the corresponding proportion in even the most generous of European welfare states”. The “sources” of the spending – tax expenditures and employment-benefits especially – are what distinguishes the American case. The same myth of the “lean” American welfare state was the object of criticism in a book published a decade earlier (Marmor, Mashaw and Harvey 1990).
 13. The 2000 WHO report seeks to rank health systems across the globe. The WHO posed good questions about how health systems work: are they fair, responsive to patient needs, efficient, and do they provide good quality health care. But it answered those questions without much attention to the difficulties of describing responsiveness or fairness or efficiency in some universalistic and reliable manner. What is more, the report used as partial evidence the opinions of WHO personnel to ‘verify’ what takes place in Australia, Oman, Turkmenistan, or Canada. Moreover, while the report claims to provide data in order to improve health systems across the globe, it is hard to see how a health minister of a country ranked, say, at place 125, has any stake to climb the ladder. Predictably, most of the uproar about the report was the battle between the countries that ranked high but not highest. Many journalists and members of parliament quoted the report as a critical comment on the failures of the national health system whereas, unsurprisingly, the French minister

saw the number one ranking of his country (that in the end turned out to be based on a calculating error) as proof of the effectiveness of his policy. With comparisons like that, one can easily understand why some funders of research regard comparative policy studies as excuses for boondoggles. But that should not drive out the impulse for serious cross-national scholarship and learning.

14. For a retrospective appreciation of Anderson, see Freeman and Marmor (2003).
15. There is a rich scholarly disability literature, with a good deal of knowledgeable commentary on comparative policy developments. See especially Aarts and De Jong (2003).
16. Good examples are Freddi and Bjorkman's *Controlling Medical Professionals* (1989) and Ranade's *Markets and Health Care* (1998); another is White's *Competing Solutions* (1995), written at the Brookings Institution to draw lessons from OECD experience for the universal health insurance debate in the United States. Sometimes journals present work of this kind: see the case studies of priority setting in *Health Policy* (1999), for example, and the *Journal of Health Politics, Policy and Law* (2001) for international commentary.
17. A good example of this genre is the book edited by Bayer and Feldman (1999) on the politics of contaminated blood in Germany, France, Japan, Canada, Denmark, and the United States: *Blood Feuds*. The theme is taken up in Bovens, 't Hart and Peters's (2002) *Success and Failure in Governance*, which also looks at medical professions and health care reform.
18. For instance, Pierson (1994) compares retrenchment politics in Reagan's America and Thatcher's England; Immergut (1992) compares the disputes over national health insurance in France, Switzerland, and Sweden in the early part of the twentieth century; and Maioni (1998) the different paths to national health insurance taken in Canada and the United States. Moran (1999) assesses the political economy of health care in Britain, Germany and the United States, Freeman (2000) the politics of health care in five European countries.

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