

Foreword

For anyone wondering whether to invest time in reading a new cross-national study of policy making and policy implementation in health care systems, there are three tests. First, does the study provide authoritative new information? Second, does the new information fit into an existing interpretative framework, so that its findings are not randomly idiosyncratic but add to our existing stock of knowledge and theory? Third, and perhaps the most important, does it have an element of challenge and so provoke reflection about at least some of our assumptions about the dynamics of health care policy making and implementation? In short, the most instructive studies offer a mixture of reassurance and surprise, building on existing theory but also raising new questions.

This study passes all three tests, and offers just the right mix of the predictable and the surprising. The authors of the six national studies are all steeped in the history of the health care systems of their countries. Here there are no examples of intellectual tourism or instant, parachute expertise. So the accounts carry authority, although no doubt the national experience has also shaped the interpretations of the authors (the accounts would be dull indeed if they aspired to that scholarly mirage, total neutrality and objectivity: there is a nice critical edge to most chapters). Further, there is analytic discipline: Explanations of policy change are anchored in the comparative literature, so that common themes run through the chapters. Familiar concepts, like path dependency, provide signposts as we move through unfamiliar territory. And, satisfying my last criterion, the accounts yield interesting puzzles as well as insights about the dynamics of policy making in the health care arena.

The insights and puzzles are, in a sense, independent of any interest in the six specific countries covered by the study. The countries are a remarkably heterogeneous lot. There is no obvious reason why anyone interested in Singapore and Taiwan as examples of health care development in the Asian tiger economies should also be interested in Switzerland and the Netherlands as examples of corporatist style policy making, or in New Zealand and Israel for that matter. And conversely so. The variations between the six are remarkable. In terms of size, they range from under five million to almost 23 million. They include the country with the lowest level of health care expenditure among the rich nations (Singapore, spending 3.3% of GDP) to one of the highest (Switzerland, spending 11.4% of GDP). They range from countries with long national histories to those whose independence is a relatively recent phenomenon. Their constitutions differ, as do their political cultures. Although all can be categorized as rich countries, per capita income in the richest among the six is almost twice that in the least well off.

But it is, of course, precisely these variations which make the one characteristic shared by all six so remarkable. They all have comprehensive health care systems covering the entire population. So the first lesson that can be drawn from this study is that economic determinism is not helpful when explaining the performance of developed health care systems. Singapore with the highest per capita income is also the most frugal health care spender. But conversely, the six also provide a warning against ethnic over-explanation in cultural terms. So while it is tempting to explain Singapore's remarkable performance in terms of "Asian values" — such as the emphasis on family self-reliance — the very different course taken by Taiwan would suggest caution in using this explanatory variable.

On the face of it, of course, there are other similarities. The language of choice and competition has become international in discourse about health policy. It has been invoked in policy debates in all six countries, as elsewhere. But the way it is interpreted, and the degree to which it influences policy outputs, varies from country to country. Ideas can slip across frontiers easily, but institutions are national. If there is any common theme to emerge from the six country studies, it is the extent to

which institutions constrain and shape policy making: While they do not determine outcomes, they do set the limits of what is possible. On the one hand, there is the case of policy making in Singapore, a seemingly irresistible and smooth evolutionary process made possible by what is a unique example of single party rule in a democratic polity. On the other hand, there is the case of Switzerland, which remains as an example of a country with multiple veto points (as famously documented by Immergut) where policy making is an obstacle course. But once again the studies provide a warning against facile determinism: The case of New Zealand shows that while institutions do matter to the extent that they permit (or block) rapid policy reverses, they cannot explain the direction of the changes that follow.

So much for ideas and institutions. What about interests? Here the country studies prompt an intriguing puzzle. There is no systematic analysis of the role of interest groups in policy making or implementation, suggesting that they do not play much of a part. Indeed in the case of the Netherlands, the study explicitly notes a decline in the role of interests. Only in New Zealand does the medical profession appears to have been influential, which prompts the question as to why that country is an exception. And there is, of course, a larger question. Interest groups, and the medical profession in particular, have traditionally been the focus of special attention in comparative health care analyses. Why has this changed? Is it because the medical profession and other interest groups have lost ground in the policy arena or because academic fashions have changed or because their influence is to be traced not so much in policy formulation as in policy implementation? And the case of Taiwan, where the medical profession played no role in the creation of the health care system but is now beginning to flex its muscles, prompts a further speculative conclusion: Which is that the role of policy in creating scope for interest groups may be at least as important as the role of interest groups in shaping policy.

Throughout this study the emphasis is as much on how policies work out in practice as on their genesis. It is an approach which pays handsome dividends and provides some notable cautions against accepting conventional assumptions at face value. In particular, the evidence tends to

question the assumption that consumer choice (plus provider competition) will necessarily be the engine driving systems to ever greater efficiency. In the Netherlands, individual consumer choice has been statistically almost invisible; in Switzerland consumers stick with their insurers even when other plans offer lower premiums for the same basket of benefits. Loyalty is the norm. Further, competition may actually reduce consumer choice if insurers contract selectively with fewer providers. Does all this matter, however. Another intriguing question looms up: Could the *threat* of consumer exit be enough to produce the desired result ?

This, then, is a study which provides evidence, questions received wisdom and prompts new questions. All of which should encourage the potential reader to plunge in. The experience will be a rewarding one.

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